UNIVERSAL HEALTH CARE SYSTEMS (?): CEE REALITY

SYSTÉMY VŠEOBECNÉ ZDRAVOTNÍ PÉČE (?): REALITA STŘEDNÍ A VÝCHODNÍ EVROPY

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ABSTRACT

The paper deals with the issue of the universality of access to health care in Central and Eastern Europe. It shows that universality is still the constitutional principle for the majority of countries. However, it also documents that, in reality, the universality of access to health care disappeared in the region after 1989. Only three countries – the Czech Republic, Slovakia and Slovenia are close to the aim to provide their citizens with a universal access to health care; however even these countries show apparent limitations.

Key words: *Keywords: health care, access, Central and Eastern Europe*

JEL classification: I14, I18

1 INTRODUCTION

Compared to many (most) other parts of the world, Europe "delivers/wants to deliver" a comprehensive welfare state to all its citizen. The universal health care coverage is one of the social rights of the European citizens – and the majority of countries declare that they want to exercise this right: the European Social Charter, Article 13, signed also by countries like Armenia, Bosnia and Herzegovina, Moldova, Montenegro, FYROM or Turkey:

"With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition."

Among the new EU members, only the Czech Republic (a special case, as the country has not ratified the new version of the Charter yet) and Slovenia did not adopt this Article, but in reality, both countries are expected to apply it, because of their duties as EU members).

However, the (political) statements and the reality may differ significantly – taking this into account, the aim of this conference paper is to assess, by selected indicators, to what extent the universal coverage is not only a promise, but also the reality in the Central and Eastern European (CEE) region.

The preparation of this article was supported by the Slovak Grant Agency APVV, project APVV-15-0322 and by the Czech Grant Agency, project 19-06020S.

2 CEE HEALTH CARE SYSTEMS AND UNIVERSAL ACCESS IN LITERATURE

Health developments in the CEE region are subject of several, but not many analytical studies. Institutionally, the core sources of information are the World Health Organization (Saltman and Figueras 1997, Mackenbach and McKee, 2013, Jakubowski and Saltman, 2013, Papanicolas and Smith, 2013), the European Observatory on Health Systems and Policies, hosted by the WHO Regional Office for Europe (edition "Health systems in transition"), the OECD (OECD

Reviews of Health Systems) and health care is also an issue for the International Monetary Fund.

Apparently, only three academic books have endeavoured to cover the region directly (Rosenbaum, Nemec and Tolo, 2004; Shakarashvili, 2005; and Bjorkman and Nemec, 2013). Also only a few articles in academic journals present comparative policy-analysis studies of health-care reforms in CEE in an "outside" perspective – like Osterle (2007 and 2010), Roberts (2009), Deppe and Oreskovic (1996), Waters et al. (2008) and Ensor (2004). The number of articles written by "regional" authors is a little more comprehensive – most countries in the region have academic experts who analyse their situation or even write comparative studies.

Concerning our research topic, the existing studies indicate that – despite the promises mentioned above – the situation in the CEE region from the point of view of universality of access differs significantly. Obviously, the best situation is in the EU member states, but it is by no means perfect. For example, Slovenia (Setnikar-Cankar and Petkovšek, 2013) and Slovakia (Nemec, 2013) have to cope with relatively high level of private co-payments, while Romania (Chereches, 2013) has to deal with informal payments and limited resources and Bulgaria has insufficient resources (Kostadinova et al., 2013). At the other end of the "scale" are countries which in their current reality significantly divert from the principle of universal access (provided in socialism) – most of them (like Ukraine) did not sign Article 13, knowing that universal access to health services is today a "mission impossible" in their country (but still making promises at a national level – see later text).

Taking this into account, we may already state that the universal health care coverage is mainly a political promise in the CEE region. To analyse the situation in depth, in the following parts of this paper we analyse the reality of two core pre-conditions for the universal access – a proclaimed political will to guarantee such access and the availability of resources in the region as a whole. In the last part we deal with a specific issue – the "hidden/black hole" issue – the fact that specific groups with limited access exist even in most developed health care systems in the region, looking at the example of two of the three best performing countries (see Bjorkman and Nemec, 2011): Slovakia and the Czech Republic.

3 POLITICAL WILL TO GUARANTEE THE UNIVERSAL ACCESS TO HEALTH CARE IN CEE

Most, if not all countries in the region still formally claim that the key principle within their health system is to maintain a suitable level of access and quality, that their health system is expected to provide citizens with equal access to health services and a level of care appropriate to their health regardless of age, income, sex, employment or place of residence, and that at the same time, all members of society contribute to health care funds on the basis of fairness and solidarity.

The above indicated rights are directly provided for in national constitutions.

We will quote some examples from different socio-economic conditions:

"Everyone shall have the right to protection of his or her health. The citizens shall have the right to free health care and medical equipment for disabilities on the basis of medical insurance under the terms to be laid down by a law."

Constitution of the Slovak Republic, Article 40

"Everyone has the right to the protection of his health. Citizens shall have the right, on the basis of public insurance, to free medical care and to medical aids under conditions provided for by law."

Constitution of the Czech Republic, Article 31

"Equal access to health care services, financed from public funds, shall be ensured by public authorities to citizens, irrespective of their material situation. The conditions for, and scope of, the provision of services shall be established by statute."

Constitution of Poland, Article 68

"Every person shall have the right to physical and mental health."

Constitution of Hungary, Article 20

"Everyone shall be guaranteed social security at the expense of the State in old age, in case of an illness, disability, loss of the bread-winner, for upbringing of children and in other cases established by law."

Constitution of the Russian Federation, Article 39

"Everybody has a right to the health protection, health care and health insurance. The state creates terms for effective and accessible medical service for all citizens. In state and communal establishments of health protection health care is delivered for free, the existent network of such establishments cannot be brief."

Constitution of Ukraine, Article 49

The texts of the national constitutions do not show major diversions from the principle of the universal access, as provided (at least to some extent) by the former socialist regimes (Shakarashvili, 2005). Even countries, where universal access for sure does not exist (like Ukraine), did not decide to reflect on this in their national constitutions. The question is obvious:

Why do most countries not want to formally detour from the principle of universal access to health care?

The response is also obvious – despite the fact that free health care does not exist, that the right to health cannot be executed, politicians (and maybe not only politicians in the CEE region) prefer to make promises to informing their citizens about the reality and delivering legislation which would reflect such a reality. According to many experts, the lack of sense of individual responsibility, paternalism and fiscal illusion remain important features of citizens' behaviour. For example, a few years ago in Slovakia, 67% of respondents believed that their problems need to be solved by the state (Bunčak et al., 2009) – today this proportion is probably the same. In the Czech Republic, the issue of co-payments in health care significantly influenced the regional elections in 2009; Social Democrats used their introduction as the main fighting tool against the governing party (Maly et al., 2013) – people still feel that "there is a free lunch". In such situation, politicians can make promises – and citizens are not ready to punish them for totally unrealistic promises. Traditional neoclassical economics of rational choice adapted to the public sector (e.g., Stiglitz, 2000) does not provide a satisfactory explanation of this situation, but more and more frequent behavioural studies and experiments (Spalek, 2011) document that voters' behaviour favours populist over realistic politicians and political proclamations.

4 RESOURCES FOR HEALTH CARE IN CEE

The current political environment may allow politicians to claim that everybody has the right to universal (or even "free") health care in their country. However, "free access" cannot exist and universal access is possible only with necessary public resources available – as all health economic "gurus" confirm in their books and studies (e.g., Feldstein, 1993). Health economists (except for extreme right positions) are of the common opinion that covering "bad risks" and low-income groups with health care access is possible only via massive involvement of public resources. Total health expenditures and the share of public expenditures in it are – because of the above – really effective benchmarks to check the reality of universal access. The following two tables (with slightly older data – but still sufficient to deliver the picture) show the health finance situation in the CEE region sufficiently.

Tab. 1 » Total health care expenditures per capita in CEE region (USD).

Country	2009	2010	2011
Albania	238	220	255
Armenia	129	134	142
Azerbaijan	286	307	357
Belarus	311	320	307
Bosnia and Herzegovina	461	453	493
Bulgaria	463	480	522
Croatia	1,095	1,051	1,138
Czech Republic	1,494	1,403	1,507
Estonia	1,004	898	987
Georgia	251	272	328
Hungary	977	1,002	1,085
Kazakhstan	326	395	455
Kyrgyz Republic	60	60	71
Latvia	784	762	841
Lithuania	836	782	875

Tab. 1 » continues on the next page (p. 11)

Country	2009	2010	2011
Macedonia, FYR	297	300	334
Moldova	190	190	224
Mongolia	98	124	161
Montenegro	621	584	664
Poland	815	851	899
Romania	431	457	500
Russian Federation	527	670	807
Slovak Republic	1,474	1,445	1,534
Slovenia	2,231	2,064	2,218
Tajikistan	44	49	54
Turkmenistan	89	105	129
Ukraine	200	234	263
Uzbekistan	71	80	88

Note: http://data.worldbank.org/indicator/SH.XPD.PUBL/countries

Even the countries with the highest level of health expenditures (Slovenia, the Czech Republic and Slovakia) are in absolute figures far below the average level of health expenditures in the developed countries – if price levels (especially labour costs) are taken into account, their situation looks better, and the given level of financing might potentially (with high technical efficiency) be sufficient. Even in this group of countries, the proportion of private financing in Slovakia and Slovenia is rather high.

Tab. 2 » Share of public expenditures on total health care expenditures in the CEE region.

Country	2009	2010	2011
Albania	44.9	42.2	44.8
Armenia	43.5	40.5	35.8
Azerbaijan	22.9	21.9	21.5
Belarus	64.0	77.7	70.7
Bosnia and Herzegovina	68.1	68.1	68.0
Bulgaria	55.4	55.7	55.3
Croatia	84.9	84.8	84.7
Czech Republic	84.0	83.8	83.5
Estonia	75.3	78.9	78.9
Georgia	22.3	23.6	22.1
Hungary	65.7	64.8	64.8
Kazakhstan	59.2	59.1	57.9
Kyrgyz Republic	55.7	55.7	59.7
Latvia	59.5	60.9	58.5
Lithuania	72.8	72.9	71.3
Macedonia, FYR	64.8	61.8	61.4
Moldova	48.5	45.8	45.6
Mongolia	56.0	57.0	57.3
Montenegro	71.3	66.5	67.0
Poland	71.6	71.7	71.2
Romania	78.9	80.3	80.2
Russian Federation	67.0	58.7	59.7
Slovak Republic	65.7	64.5	63.8
Slovenia	73.2	72.8	72.8
Tajikistan	24.9	26.7	29.6
Turkmenistan	55.9	60.4	60.8
Ukraine	55.0	56.6	51.7
Uzbekistan	46.8	49.0	51.4

Note: http://data.worldbank.org/indicator/SH.XPD.PUBL/countries

Slovenian authors (Setnikar-Cankar and Petkovsek, 2013) argue that the growth of private financing is related to the fact that the insurance companies offer voluntary health insurance covered by private funds. Since the introduction of voluntary health insurance in 1992, the proportion of public spending on health care in Slovenia has declined, while private spending has increased with intermediate fluctuation. The burden of additional financing for health care has partly shifted to private spending by the population also via direct payments – in 2011 direct household spending accounted for 13.7% of total health expenditures, or 47.9% of all private health expenditures. However, they also claim that the increased level of private contributions does not significantly undermine the universality of access (to some extent, equality is the concern) – these who are able to pay, pay via private channels (and in many cases for "extras"), but these in need are sufficiently covered from public funds.

The Slovak case is different (Nemec, 2013) – there is no private co-insurance and the relatively high share of private payments is the result of co-payments and direct payments – in such a regime, the universality is problematic.

In all other cases the total health expenditures and the related percentage of public spending are not able to safeguard universal access – we included in the above tables also the Central Asian countries (as former members of the Soviet Union) to show most complicated cases – Tajikistan with app. 10 USD public health expenditures per capita is the most warning example.

From EU members, the situation is critical especially in Bulgaria and Romania – insufficient public financing delivers long waiting lists. Thus formally (for example) no Bulgarian has been denied medical care at any level of service – primary, specialized and hospital care – whatever the ethnic, cultural and social differences (Kostadinova et al., 2013) – but in reality the access to specialized outpatient care is limited due to the restricted financial resources provided by the National Health Insurance Fund. In specialised care, the Fund pays for a defined number of monthly visits to specialists and medical-diagnostic laboratories (based on available resources) and any examinations that exceed this number are put on a waiting list or are paid by the patients themselves (officially or unofficially).

Tab. 3 » Universality of access clusters in CEE

Universality of access is only a political promise	Examples: Ukraine, Moldova
Universality of access lost, almost lost (but recent attempts to "come back")	Examples: Armenia, Russia
Some level of universality of access, resources insufficient	Examples: Bulgaria, Romania
Universality of access "at risk"	Slovakia
Universality of access somehow guaranteed by public spending	Czech Republic
Universality of access somehow guaranteed, but high private spending	Slovenia

Source: own construction based on different resources

5 SPECIFIC ASPECT – IS THE COVERAGE IN "BEST PERFORMING" COUNTRIES REALLY UNIVERSAL?

In this last part of this paper we shall look into one specific "black hole" of universality in the Czech and Slovak health care systems. Both countries claim that everybody is health insured – however, the reality is that everybody is expected (shall be) health insured. The existing estimates (by rather isolated expert studies or popular media messages) indicate that in both countries there is a relatively large group of people who do not pay – and as the results their health insurance status is rather problematic. No official figures – and official interest to investigate the situation – exists; our estimate based on different inputs is that in the Czech Republic (10m inhabitants) approx. 400,000 people do not pay for their health insurance and in Slovakia (5.5m inhabitants) approx. 500,000 people do not pay for their health insurance.

Especially the Slovak situation is dramatic – the figure is close to 10% of all inhabitants. Moreover, compared to the Czech Republic, where the only risk is bankruptcy, the Slovak health care legislation states that this group of citizens has only the right to "neodkladna zdravotna starostlivost" – which can be translated as access only to emergency care. No law or secondary legislation explains what

"neodkladna zdravotna starostlivost" is – thus the real status of these people is rather problematic. And not only this – the doctors and medical facilities do not have legal certainty about how to deal with this group of people – and in most cases deliver care which may not be reimbursed by health insurance companies.

6 CONCLUSIONS

The constitutions of CEE countries still continue to speak about right to health, free health care – but our paper clearly documents that, in the majority of cases, such statements are pure political proclamations. Only three CEE countries (the Czech Republic, Slovakia and Slovenia) spend on health care in absolute figures sums that may be somehow sufficient to finance universal access in local economic conditions. And even these three countries have certain country-specific limitations – like high percentage of private payments or the existence of non-insured persons. In all other countries – including EU members – the funds available to pay for health care services are insufficient – and because of the limited performance of national economies, short term solutions are not available.

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