Health Reforms in South East Europe: An Introduction

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Introduction

Over the past two decades, the health systems of South East Europe (SEE) have undergone far-reaching reforms, triggered by the search for more effective and efficient health care provision, attempts to introduce new sources of revenues, upward cost pressures associated with new technologies and population ageing, and the overall context of transition from socialist to market economies. Deteriorating population health in the early 1990s was another major concern, with life expectancy decreasing in several countries of the region due to the economic collapse in the early years of transition, the effects of war and conflict in the Yugoslav successor states, and a breakdown in basic health services (Adeyi et al. 1997; Rechel et al. 2004; Rechel and McKee 2006).

Health reforms in South East Europe have involved in most cases the creation of social health insurance systems, the privatization of primary health care, and the introduction of family medicine delivered by general practitioners. There were also attempts to reduce costs through introducing various forms of (quasi-) market arrangements which promoted competition between providers of both primary and secondary care. This sometimes resembled reforms seen in the United Kingdom in the late-1980s, when the quasi-market model had been promoted by the Thatcher Government, alongside a purchaser–provider split and the contracting of services from competing hospitals (Le Grand and Bartlett 1993; Ham 1996; Allen et al. 2012). Many of these ideas were picked up by policymakers in SEE, both in the early 1990s and thereafter. Policy transfer from Western Europe was clearly evident in the number of countries throughout Central and Eastern Europe that introduced capitation payment for primary care and payment based on
An Introduction
diagnosis-related groups (DRGs) for secondary care services. In several
countries of SEE, however, reforms were delayed by various political
factors: in Croatia due to the conflict that started in 1991; in Bosnia
and Herzegovina, due to the war that afflicted the country in 1993–5;
in Bulgaria and Romania due to the lack of firm political agreement on
the speed of reforms until about 1997; and in Serbia and Montenegro
(including Kosovo) due to lack of any reformist political change during
the 1990s and a virtual freezing of the reform process. In all countries
of the SEE region, the transition led to severe social and economic
disruptions associated with falling levels of GDP during the 1990s,
although in former Yugoslavia this was already preceded by economic
crisis and deteriorating population health in the 1980s (Kunitz 2004).
This economic decline severely impacted the ability of governments to
organize effective and affordable health systems. After the fall of the
Milošević Government in Serbia in 2000, and the electoral rejection of
the Croatian Democratic Union (HDZ) Government in Croatia, a new
wave of reforms began, often assisted by foreign donors.

Many accounts of the economic and social transition in the former
socialist or communist countries emphasize the importance of path
dependency, and the influence of the legacy of the past on contem-
porary policy decisions (Rechel 2008). This perspective is also relevant
in the case of heath reforms. It is important to understand the key
features of the health systems which were in place under the socialist
or communist systems in SEE, and in relation to which health reforms
in the transition period were designed. Two main types of health sys-
tems were established under communism in SEE: the Yugoslav health
system and the Soviet-style Semashko system in Albania, Bulgaria, and
Romania. There were two main differences between these systems. First,
the former was based on a system of national health insurance (mainly
based on payroll taxes paid by employers and employees and on state
contributions), while the latter was based on central budget funding
(similar to the national health systems in the United Kingdom and the
Nordic countries). Second, family medicine played an important role in
the Yugoslav system, where it was delivered through local polyclinics
known as community health centres, whereas family medicine was gen-
erally not officially recognized or promoted in the Semashko system,
which instead relied on a system of specialist polyclinics (Švab et al.
2004). In the centrally planned economies, the health systems suffered
from lack of patient rights, low quality of care, and little technological
improvement (Kornai and Eggleston 2001). On the other hand, they
provided universal service and equal access, at least formally, since