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A EUROPEAN BARGAIN
INVESTING IN CEEC HEALTH

REPORT OF A CEPS TASK FORCE

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This report is based on discussions in a CEPS Task Force on Health and Enlargement. The members of the Task Force participated in extensive debate in the course of several meetings and submitted comments on earlier drafts of this report. Its contents contain the general tone and direction of the discussion, but its recommendations do not necessarily reflect a full common position reached among all members of the Task Force, nor do they necessarily represent the views of the institutions to which the members belong. A list of participants and invited guests and speakers appears at the end of the report.

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CONTENTS

PREFACE

A large majority of my colleagues in the European Parliament want enlargement to succeed. As Rapporteur in the Parliament for the health aspects of enlargement, I was supported in my view that the process must not be a set of obstacles or even exam questions. It is a process whereby we work together to enable each member of our European family of nations to join us in a way that makes them and us feel comfortable with the Union. And it is a process that is in our mutual interest.

Limiting the focus to the *acquis*, the obstacle course, fails to address the concrete problems of systemic transition and of sustained, and sustainable, economic development. It is time to put away the rule book and get out the guide book. This report attempts to do just that for health.

So what does Europe expect from its applicant friends? In formal health *acquis* terms, the answer is 'not a great deal', but that is to miss the wider health-linked *acquis* and to miss the developing *acquis* that has come from recent EU treaties and notably the Treaty of Amsterdam. It is also to miss the economic problems of some of our new partners.

Affording adequate healthcare is a challenge for all of us. People are living longer, with a disproportionate amount of health and social care resources inevitably going to older people. Medical science moves on at an exciting but expensive pace, with new queues forming for new drugs and treatments and public demand for access to what is available. Consider the fact that current EU members spend a weighted average of 8.75% of GDP on health, whereas mainland applicant countries spend an average of 5.8%. If one measures this in terms of cash per citizen, the awesome comparison is €1930 per EU citizen vs. only €389 per applicant country citizen. It is then no wonder that infectious diseases, vaccination programmes, life expectancy figures and disability rates are among the problems to be faced.

We have time to tackle the basic *acquis* problems before accession; but not too much time. Then we can tick the health box on the application form and get on with the much more important and longer-term task of working together to meet the healthcare challenges of the 21st century.

The European Union is nervous about health. Member states are hung up on the subsidiarity issue, terrified that there will be a new and uncontrollable bill to be paid, if the Union gets its sticky hands on the provision of health services. So those who wish to see Europe improving its health – for all the economic as well as social and equity reasons referred to in this report – talk in a subsidiarity code. I will say, for example, that 'the EU has no competence for health services and it will raise health standards not by prescription but by description of best practice.' We then wait for the citizens of Europe, armed with the weapons of knowledge, to clamour for better provision.

Happily, no such complex need constrict us in this exercise of discussion, research and polemic, within the independent environment of CEPS. We can be more straightforward, as we consider the wider health interests of East, West and Central Europe and the challenges and opportunities that the accession process can bring.

John Bowis
Chairman of the Task Force

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EXECUTIVE SUMMARY

The Copenhagen criteria – the framework for the integration of ten Central and East European countries (CEECs) into the Union – take an appropriately fundamental view of this process as regards political institutions, values and practices. Every other aspect of the 'European model', in which social security has a central place, is included in the accession process only if there is a body of legal rules – the *acquis.* Moreover, the *acquis* is also considered a valid substitute for an economic strategy that would target directly the very specific and indeed staggering problems of transition. The focus is on institutions and rules, not outcomes. Relatively modest money transfers for *acquis*-relevant institution-building and infrastructure complete the current instruments of intervention.

Health policy is one of the victims of this approach. There is no health 'chapter' to be negotiated, because the healthcare system itself remains largely off-limits to the Union under the subsidiarity rule.

This report argues that health is of strategic importance for the success of enlargement. It is directly relevant to the future economic development of the candidate countries and to the social and financial sustainability of that development. Moreover, 'free movement' makes health performance in the CEECs relevant to the health of citizens in the old Union; and to the political acceptance of enlargement on both sides.

In looking at these issues and practical ways of dealing with them, the report takes a deliberately technocratic approach, relying on economic efficiency arguments rather than ethical concerns over death and suffering. Although the impetus for policy innovation must come from the Heads of Governments, it is the finance ministers who must ultimately be convinced.

There are two 'technical' arguments for a greater EU effort at targeting the health system of the candidate countries. The first is the finding of a growing number of detailed economic studies, which show that investment in human capital, including health, has an impact on economic growth several times larger than the EU's preferred vector, infrastructure. The second argument relates more narrowly to the cost-effectiveness of health spending in public budgets, and to public expenditures in the social field caused by failures of healthcare systems to protect individuals from debilitating conditions making them unfit for work.

The report puts both the general and the specific problems of health in the CEECs in the context of transition. At the general level, transition has generated, and will continue to generate stresses on the population, ranging from unemployment to budget constraints causing the emergence of a very un-European dual economy, with an additional town-country component. At the level of healthcare systems themselves, the reform process is of central significance.

All CEECs have begun the process of shifting from a centralised hospital-based system with central funding to more decentralised models of care based on insurance payments. The report notes that transition from one system to another is incomplete. There are important gaps in access to healthcare, which – together with life-style changes – explain the emergence of new epidemiological threats which need to be urgently addressed even in the narrow self-interest of the old Union itself. Secondly, reforming healthcare systems is more than an administrative

exercise. It requires a new physical and human infrastructure, ranging from smaller hospitals and local clinics to training and equipment for GPs and other doctors, as well as informatics-based management systems to allocate resources effectively and respond to epidemiological crises. The reform process in many candidate countries is at a critical stage, likely to stop halfway for lack of financial means – with long-term consequences.

Combining the macroeconomic view of health as a growth factor with the sector-specific perspective of health reforms failing for lack of infrastructure leads us to a concept of EU intervention rigorously conceived and executed as a programme of investment. It also offers the quickest methodology for finding and allocating new financial resources within the present institutional context of enlargement.

The World Bank in cooperation with other UN agencies and NGOs has prepared a number of reform-sustaining programme loans, based on rigorous cost-benefit analysis. With a small contribution from Union grant money presently allocated to other forms of infrastructure, these programmes could be scaled up and accelerated without lengthy procedures.

Grants to the health sectors which are allocated according to public banking criteria, i.e. as if they were loans, avoid lengthy new decision-making procedures which would be needed if the methodology were based on priority health needs as such. Moreover, the considerable intellectual and diplomatic capital accumulated by the World Bank in designing and negotiating programme loans with the candidate countries will be lost on accession. There is also an opportunity for the EIB to 'buy into' this capital for the longer haul.

No new money is needed; surpluses are being generated from Phare and ISPA allocations for transport and the environment which are not taken up because of the complexities of project preparation and decision making. By contrast, channelling perhaps 5% of ISPA funds to investment in health would require the most minimal organisational structure on the Commission side with the methodology suggested here.

In addition, in order to respond to the epidemiological crisis, we propose an investment programme targeted specifically at vaccinations, comprising infrastructure for a (refrigerated) supply chain, training of professionals, and central crisis management systems. Funding for this initiative, to be managed e.g. by the WHO, could in part come from interested member states and major insurance companies, pledging resources in a donor conference which would yield direct benefits to their own constituents. The pharmaceutical industry can usefully be associated with this initiative, allowing them to supply at low prices that internal market rules would outlaw as discriminatory.

CHAPTER 1
INTRODUCTION

This report looks at health as an issue in enlargement from an economic perspective with particular reference to the process of transition. As such, it limits itself to Central and Eastern Europe, ignoring the Mediterranean candidate countries.

The framework for enlargement was set in Copenhagen in 1993.[1] This framework, and the bureaucratic machinery it has created, look increasingly narrow and dated. Policy thinking in the European Union – under attack for being out of step with the concerns of citizens – is beginning to embrace broader goals, identifying both specific problems and solutions to promote a better future. By contrast, the basic approach to accession remains institutional, ranging from the Union's own legislative *acquis* – the core concern – to structures respecting 'shared values' regarding democracy and human rights. To the extent that accession is understood as an economic process, this is implicitly left to the beneficial effects of introducing the Union's market rules. The process of *acquis* compliance is supported by technical assistance and modest investment flows in the pre-accession phase. Only after accession with its much more substantial flows from the Structural Funds will the problems of economic transition be faced in full.

1.1 Enlarging the scope of policy

Perhaps wisely, given the state of knowledge at the time, the Union failed to develop a concrete strategic view of the economic and social transformation process itself which accession inevitably accelerates and defines. But in limiting itself to the rule-making and institutional aspects, it largely lost sight of the ultimate goal of any regime of governance – economic and social development. Successful development, however, will be the real test of the success of enlargement. An enlarged Union with a permanent 'Mezzogiorno' in the East would require a level of solidarity – both budgetary and political – that has proved to be difficult to maintain even within highly integrated nation states. Thus, accession may succeed but enlargement fail.

This report takes a look at one crucial part of social and economic development, health, which has 'naturally' been excluded as an important focus of the accession process. 'Naturally', because this sector – large in both its economic and social importance – falls largely outside the Union's rule-making machinery under the well defined subsidiarity strictures in the treaties.

Less naturally, if the accession process is seen as a special case of accelerated transformation, with its very specific poverty-generating implications. These arise from unemployment/structural adjustment; from general budget constraints which are, inter alia, imposed by the Maastricht criteria for accession; and even from modernisation of welfare systems, including healthcare, which has proven extremely difficult even in Western Europe.

Less naturally, also, if health is seen as a precondition of successful economic development. This report embraces recent economic evidence on the importance of human capital as equal to, and by some measures, more important than physical 'productive capital' and infrastructure. Starting from this premise, it looks at areas where the EU's accession-related transfer mechanisms could be adapted to make a small, but high-return investment in human capital in the health sector of the accession countries of Central and Eastern Europe.

[1] 'Membership requires that the candidate country has achieved stability of institutions guaranteeing democracy, the rule of law, human rights and respect for and protection of minorities; the existence of a functioning market economy; as well as the capacity to cope with competitive pressure and market forces within the Union. Membership presupposes the candidate's ability to take on the obligations of membership including adherence to the aims of political, economic and monetary union.' European Council Conclusions, June 1993.

While such an effort may have appeared utopian only a few years ago, the political mood in Europe has shifted substantially since the technocratic framework for accession was laid down in Copenhagen. On both sides of the former East-West border, the perceived narrowness of the Union's approach is leading to not dissimilar processes of disaffection. The European Council is becoming increasingly sensitive to this issue and has, for the first time, developed elements of a *project de societé*: broad but substantive notions about the future evolution of European society, notably the 'knowledge society' and sustainability.

Sustainability as defined by the Commission reflects the growing realisation that long-term issues need to be addressed today as a matter of practical policy to avoid irreversible or financially crippling outcomes in the not-so-distant future. It includes an important public health component, including a focus on the rise of treatment-resistant communicable diseases. One of the first instruments for implementing this strategy is a review of 'single track' European regulations under the new, broader perspective. The enlargement process as such has not been identified as a target for new reflection. It is, however, a prime candidate since it represents the single most invasive case of social engineering ever undertaken by the Union while also using one of the most narrowly technocratic, rules-based approaches.

There are, however, straws in the wind. In a recent intervention, the European Commissioner responsible for Social Affairs, Anna Diamantopoulou, made the following statement:

> For the new Members, it is crucial that the Commission initiates a reform in-depth of the Structural Funds. While in the past the CEECs had established structures which tended to provide a certain social protection, these countries now find themselves in a state of vulnerability. Of course, they are in the process of adopting the Community legislation, but legislation by itself is not sufficient to develop their human capital. There must be a targeted Community support for investment in human capital which rises to the challenge.[2]

This was indeed broadly the conclusion reached by the Working Party early on in its deliberations on the nexus between health and enlargement. We therefore make concrete suggestions for 'targeted Community' support. Our conclusions differ, however, regarding the timing: there are both technical and political reasons why there should be a programme of interventions already in the pre-accession phase. As regards the latter, there is a growing need to alter perceptions of the accession process in the candidate countries. A Union with a human face implies more than an obstacle course of *acquis* compliance.

1.2 The relevance of health policy in enlargement

Health has multiple relevance to transition and enlargement. First, it is an indicator of sustainable economic development. Mortality and morbidity rates reflect a host of physical and psychological conditions of life, while their uneven social incidence reflects broader problems of social equality. Such problems have a political and economic quality directly related to the transition towards enlargement. Enlargement (and transition in general) induces a rapid withdrawal of the state from a direct role as an economic agent while the core public functions themselves are being reformed.

Stringent caps on public spending – as required both by the EMU criteria and the IMF – make such reforms anything but smooth. Thus we often see paper reforms without adequate physical and financial resources, which not only fail the population at large, but in particular leave sections of the population no longer adequately covered by the welfare system. When these 'supply' problems of the social protection systems meet with rising demand for welfare from

[2] Speech by the Commissioner at the 'Forum de cohésion' in Brussels, 22 May 2001 (unofficial translation from the French).

losers in the transition process, the legitimacy of the 'Western' reform project itself is compromised. Popular hostility to enlargement is one political consequence.

Health system reforms in the CEECs are at a critical stage. Striking a balance between the private and public elements, enhancing efficiency while preserving equity, is proving difficult in all OECD countries. Mixed systems, which include both the market, traditional public management and public functions delegated to autonomous actors, are notoriously difficult to control, leaving ample room for the misallocation of resources and less-than-optimal outcomes. But to develop such systems is doubly difficult in the candidate countries, owing to the physical and institutional inheritance of the past centralised systems and a general shortage of resources. Budgetary constraints inhibit transition while at the same time putting an even greater premium on success in improving social and economic efficiency.

Secondly, health is a factor in the quality of human capital – people considered as an economic resource. In a 20-year perspective, which corresponds to its historical scope, the success of enlargement will depend not just on *acquis* implementation, but on the rate and quality of economic growth actually achieved under the new system of economic governance.

As to the rate of that growth, it has to be twice that of the old Union. As will be explained in Chapter 3, health is a factor of economic growth. Considering investment in health as a capital investment significantly alters its cost-benefit calculations and, moreover, opens the way for integrating practical steps in this field into established Community frameworks for financial intervention.

This report thus takes the view that health in the CEECs:

- is a potential obstacle to the rapid economic development on which the success of the enlargement project ultimately depends as much as on *acquis* compliance;
- poses problems of social equity which are more acute there than in the present Union;
- raises particular and unique problems of transition that derive from its inherent link to the public sector, requiring reform from within without the benefit of a clear market framework that guides transformation in the rest of the economy; and
- has a specific epidemiological cross-border dimension which touches narrow issues of self-interest in the present Union.

Our approach to the subject differs in significant respects from one likely to be adopted by public health professionals. Our starting point is not human need, social equity or other ethical concerns. We are convinced that, as regards the candidate countries, these concerns – which we of course share – can best be advanced in the very short term by remaining, as much as possible, within the technocratic framework for accession already established. Adjusting that framework at the margin is at least a possibility even in the short term. This means stressing arguments that make sense to finance ministers – the only really relevant decision-makers. These arguments thus stress the developmental efficiency of investing in human capital; and the possibility of avoiding growing budgetary strains on the Union and the accession countries after enlargement (financial sustainability) as a result of underperforming health systems. We also stress selfish Western European motives regarding communicable diseases in the CEECs and their certain epidemiological impact on its own populations and hence health budgets in later years.

CHAPTER 2
THE STATE OF HEALTH IN THE CANDIDATE COUNTRIES

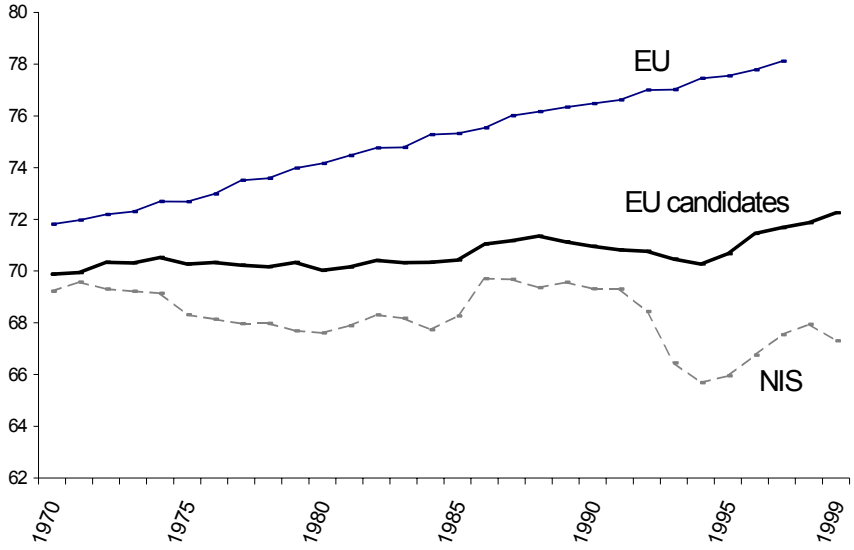
This chapter first presents comparative statistical evidence on, and analysis of the evolution of health in the candidate countries, notably as these relate to transition; secondly, it gives a synoptic overview of the state of the healthcare systems and their reform, again putting emphasis on transition-related issues.[3]

2.1 A long-standing East-West gap

Figure 1 below shows that health measured by life expectancy in the EU candidate countries has hardly been improving for the last three decades – while the newly independent states (NIS) of the former Soviet Union have performed even worse, despite having made substantial improvements during the Gorbachev years and its anti-alcohol campaign; there was a short-lived deterioration of life expectancy right after the onset of transition, reflecting the low point in the economic adjustment crisis; and there is a significant gap with the EU average without a clearly converging trend.

We include NIS data not only to show that problems there are even more pressing, but also because, in the common 'European house', these problems will continue to have an impact on the health of the enlarged Union itself. The narrow, accession-related strategy proposed in this report thus has to be complemented by a wider international strategy in which the EU must assume a leadership role.

Figure 1. Life Expectancy at birth in years for EU, candidate countries and NIS



Note: EU candidates exclude Cyprus, Malta and Turkey. NIS includes Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

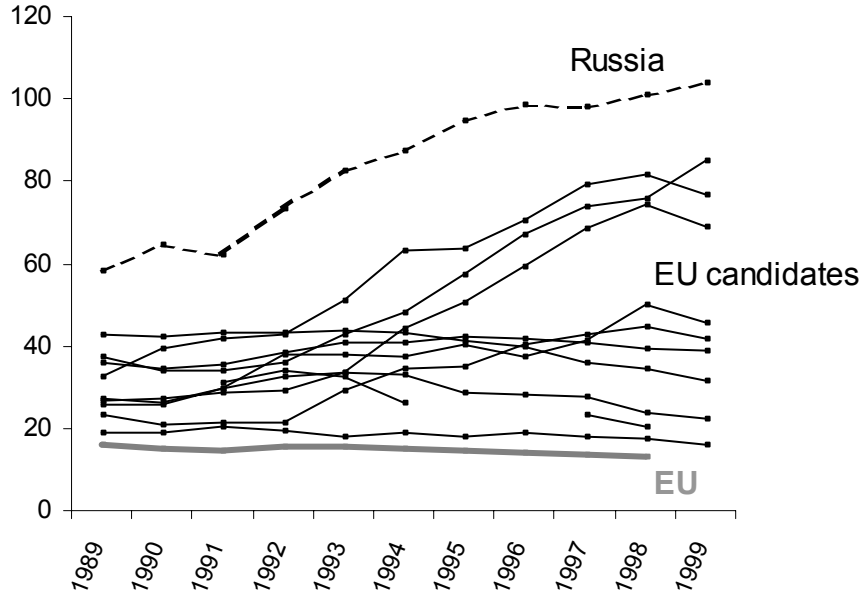
Source: UNICEF, TransMONEE database and WHO, *Health for All* database.

[3] A significant part of the material presented in this section draws on Chapter 3 in the forthcoming report: UNICEF (2001). The report also reviews health and health policy in the non-accession countries.

These aggregate figures, however, hide important black spots within each of the 'successful' countries – black spots that together help to account for the significant gaps in the chart between the EU graphs and most CEECs. Moreover, they could well endanger the countries' future health status and significantly slow down their catching-up process in the near future. The health issues of greatest current concern are:

- Sexually transmitted diseases (STDs)
- Infectious diseases (especially TB, see Figure 2)
- HIV
- Women's health (e.g. abortion rates, etc.)
- Lifestyle (tobacco, drugs, alcohol)
- Continued high burden of disease due to cardiovascular disease and external causes.

Figure 2. Tuberculosis incidence (new cases per 100,000 population)



Source: UNICEF, TransMONEE database and WHO, *Health for All* database.

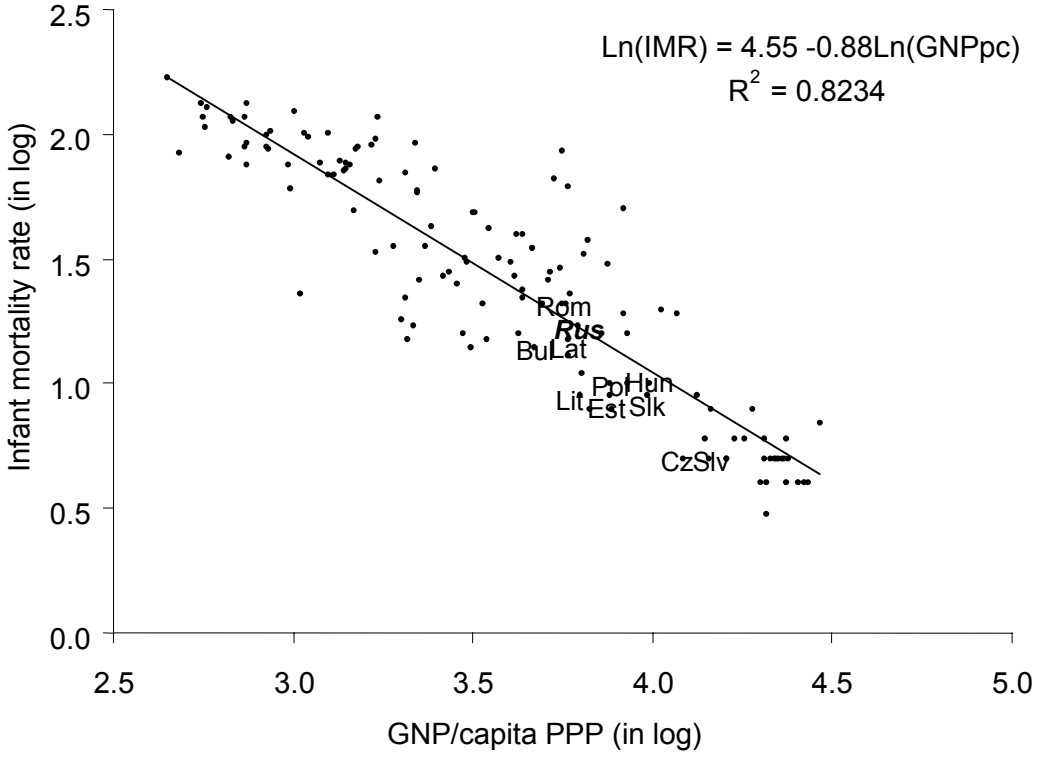
Thus, in analysing the current state of health in the CEECs, one needs to distinguish between aggregate measures, such as life expectancy, and significant structural problems which are obscured by these aggregates. Among the latter, inadequate access to health by the poor in general, and the rural poor in particular, stands out. The recent rise of certain communicable diseases, such as HIV, TB, and hepatitis – with a delayed impact on morbidity, which is not yet reflected in current mortality statistics – also needs to be addressed on its own merits, and thus urgently, without drawing comfort from aggregate improvement in life expectancy.

Moreover, although we lack good statistics on the uneven social incidence of health, the rise of communicable diseases is itself an indicator of a serious social problem, reflecting in part a dysfunctional health system itself and in part the tendency of economic transition to create gaps between winners and losers.

2.1.1 Building on a valuable asset

From the perspective of a future united Europe, disparities in health outcomes merit attention. However, from an economic development perspective, a different interpretation is possible. In a global comparison, the state of health in the CEECs is significantly better than suggested by its GDP ranking (see graph below).

Figure 3. Infant mortality in middle-income developing countries, 1998



Source: World Bank (2000), *World Development Indicators 2000*, Washington, D.C.

Even if infant mortality is again an aggregate indicator that hides underlying problems, health performance in the CEECs is thus not just a handicap, but on the contrary potentially provides a headstart in the growth stakes. This asset, inherited – together with high education levels and infrastructure – from a long history as advanced, largely urban industrial societies, must be safeguarded from erosion through the public and private consequences of transition, and built upon as part of general economic development strategy.

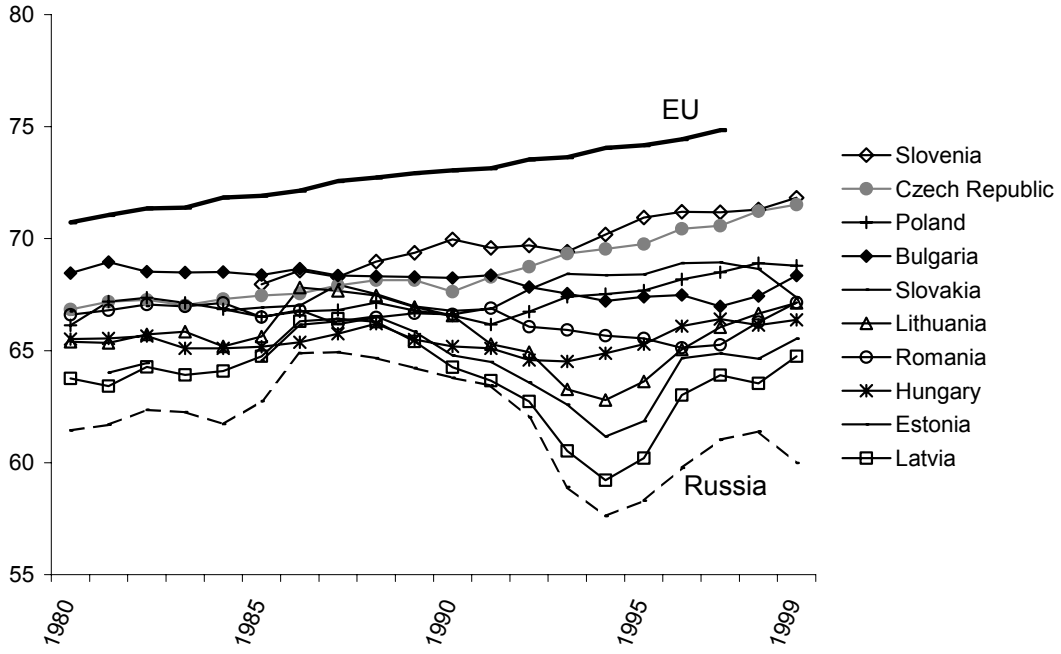
2.2 Has transition been bad for health?

As the figure below again demonstrates, the health status among the accession countries – here measured by male life expectancy – has become far more diverse during transition compared to pre-transition. On average male life expectancy has improved between 1989 and 1999 in eight out of the ten countries. However, improvement has not brought the countries significantly closer to the EU average, since merely three countries (Czech Republic, Poland and Slovenia) have seen a greater average improvement than the EU benchmark.

It is striking how closely the curves reflect the timing of reforms. Some 'post-communist' regimes, notably Bulgaria (1997) and Slovakia (1999), delayed adjustment leading to much later

'transition crises' in the economy. The Czech Republic data reflect the 'short sharp shock' approach by showing the low point in 1991; Poland in 1992.

Figure 4. Male life expectancy at birth in the CEECs



Source: UNICEF, TransMONEE database and WHO, *Health for All* database.

The three Baltic countries 'shadow' the evolution of fellow ex-Soviet country Russia, since the break with the past was much sharper, and incomes lower. The other CEECs had experimented with market reforms for decades before 1989. The improvement in the Baltics, however, is also particularly rapid – in contrast to Russia.

What can explain this evidence? Paradoxically, transformation itself explains both the decline and the improvement in life expectancy. Evidence of transformation as a cause for deteriorating performance emerges if one looks at the groups and types of diseases involved. The rise in mortality due to both circulatory diseases and ischaemic heart conditions was particularly pronounced. In Latvia, they accounted for around 55% of deaths in 1994. These are known to be affected by social and psychological stress. The increase was also concentrated in working-age males over 40. Together, these data suggest that the economic collapse itself had health consequences.

Transition from centrally planned, non-democratic societies to the Western form of social organisation initially destroyed the livelihoods of many, notably skilled workers, in heavy industry. It also put severe strains on public institutions, both financial and organisational, which exist to protect people from harm. The effects on life expectancy were dramatic, in particular in the countries of the former Soviet Union.

Is this analysis only of historical interest? The answer must be no. First, because in many countries, the move towards accession status and accession itself will produce a second transition crisis. Agriculture is one example. But in some candidate countries heavy industry, too, is still propped up by state subsidies, often disguised as credits from the state banking apparatus which will have to be removed before accession. Secondly, the reform of the welfare system in general and the health system in particular is still work in progress: the capacity to

deal with the social consequences of a second adjustment crisis cannot be assumed to exist. If this analysis is correct, it supports the case for urgently improving health systems in the CEECs.

2.2.1 Poverty – The rise in inequality

The link of poverty and inequality to poor health is amply documented in the literature. New economic growth has raised average incomes in most CEECs above pre-transformation levels. Nevertheless, poverty has increased sharply and income inequality has risen.[4] The welfare system has suffered disproportionally, as public budgets have been cut in favour of private consumption and investment.

While this in itself would explain poor health in substantial parts of the population, the health system itself may have become less responsive to the needs of the poor. Throughout the region there has been the shift from general revenue-financing to a social insurance system. As will be explained further below, a well functioning social insurance system is difficult to implement, particularly in turbulent economic times and with institutional capacity yet to be fully developed. In many countries, the state pays the insurance premia for people without income. A significant number of people, however, are not properly registered. Moreover, the recent rise in informal payments[5] to be made by patients reduces effective access to healthcare.

More generally and on a global scale, the failure to eradicate poverty is increasingly the focus of a critique of the market system itself. While there is no single cure – neither massive transfers nor retreat from the market would help – it is important to seize opportunities for intervention where they exist. As regards the CEE health systems, the 'homework' has been done and the means of cost-effective intervention exist.

It should be noted that the link between health and poverty runs both ways. Improving health is a key strategy for reducing poverty directly, complementing the inevitably lagged 'trickle-down effects' of the general rise in the GDP expected from accession.

Health finance in the CEECs and equity

Membership in a health insurance scheme is generally compulsory. Members have to pay contributions to the insurance fund in the form of income-related insurance contributions (typically at a single rate), and entitlement to health insurance benefits is usually linked to the payment of the contribution. Although the law typically stipulates exceptions to this rule for the unemployed, the disabled, pregnant women and children, this principle is a significant departure from the previous system, which guaranteed universal access. Funding through health insurance is thus less grounded in the principle of solidarity than is funding by general taxation.

In practice, health insurance may also be more regressive than general income taxation because the contribution rate fails to rise with the level of income and because in some countries (e.g. Czech Republic and Slovakia), there is an upper ceiling on the total contributions to be paid by a single member. The observed rise in informal payments in some countries – a consequence of low official pay for health professionals – is the most regressive form of health financing.

(See UNICEF, 2001.)

2.3 Health reform

The evolution of health systems in the CEECs is at a critical stage. One clear bottleneck is investment in buildings, equipment and people to match the transition from the past 'factory' system. Action now can remove what may become long-standing sources of concern, with

[4] See Chapter 2 on income inequality and poverty in UNICEF (2001).

[5] In the West, much of the same effect is obtained by better-off patients whose supplementary insurance allows them to be treated as 'private patients'. Such a system is only acceptable, however, if there is genuine universal access to adequate healthcare. 'Under-the-table payments' may exclude the poor altogether.

implications for future EU budgets as well as the convergence of CEECs to mainstream Union standards.

It was not the job of the Task Force to develop a vision of a 'best practice' health system. The WHO has recently published an important report on performance improvement in health systems (WHO, 2000) and the European Observatory on Health Care Systems exists to bring well researched and authoritative commentary on healthcare reform to the attention of the policy community (www.observation.dk). Rather, the Task Force attempted to identify bottlenecks in the implementation of reform and to reflect on ways to improve final outcomes.

The evidence suggests considerable variations both in health outcomes, health systems and reform efforts in the candidate countries. These differences preclude one-size-fits-all solutions. Nevertheless, the systems have common shortcomings inherited from the past and, more importantly, face common problems in pushing reform far and fast enough. Not surprisingly, given the absence of (the prospect of) competitive pressures from the internal market or a guiding framework from an *acquis*, health-sector reform has proceeded more slowly than that of other sectors of the economy or public administration.

The consensus on shortcomings of healthcare systems can be summarised as follows:

- ineffective mechanisms for optimisation of co-ordination and planning;
- the fragmentary nature of the financing structure and ill-defined 'basket' of services;
- an excessive number of low-quality hospitals;
- disproportionate human resources (too few skilled nurses and managers);
- restrictions on the ability of patients to choose a medical establishment; and
- ineffective public health policies and programmes to address high-priority health problems.[6]

Health reform in the CEECs has generally followed the following common pattern:

- Budget resources for healthcare are derived from central government directly and supplemented by subscriptions from health insurance funds.
- Attempts are made to reduce hospital monopoly in the provision of care and to move towards the Western pattern of GPs and specialists working in private practice.
- The introduction of a role of GPs as 'gatekeepers' for referral to hospitals, in an attempt to limit self-referral by patients and unnecessary treatments designed to occupy excessive bed and personnel resources of the hospitals.
- On the other hand, greater autonomy/responsibility of hospital managers, which provides a pseudo-private incentive to maximise output in quantitative terms.

There seems to be a consensus that even the reformed systems often continue to be largely self-referential, i.e. designed to maximise the benefits of producers rather than consumers/patients. In particular, resources typically go towards personnel expenditure, leaving too little money for equipment[7] and medicines,[8] or allocating these resources poorly. Many candidates still devoted

[6] Latvian Ministry of Welfare*, Health Care Reform,* undated (see http://www.lm.gov.lv/pdf/finan_arv_res/1_health_care_reform.pdf).

[7] Most countries have made paradoxically high investments in high-end diagnostic equipment, such as MRIs and CAT scanners. Several of these countries have higher dissemination of such technology per capita than rich European countries. At the same time, these countries have been running down their basic infrastructure, such as buildings and basic equipment. This is because the systems are managed by physicians who care about high-tech equipment but have very little economic rationale in their thinking.

an excess of resources to secondary care and to the specialist areas of medicines. Salaries are low and the infrastructure has not been adequately supported with investment. The funding shortfall has been rendered more intense by the pressures of enlargement, with claims for new expenditures in infrastructures coupled with the budgetary ceilings required for monetary union (and in some cases, NATO membership).

One of the key questions is how to encourage a strategic shift of resources from hospitals to primary care and community-based services. More particularly, how can funding systems be reformed through social insurance models that do not cement the status quo or allow certain groups or certain purposes to remain underfunded and undersupplied?

Unlike other areas of institutional reform in the candidate countries, there is no generally accepted 'Western' model that can serve as a guide. Generally, the Western socio-economic model being adopted as part of enlargement preparations seeks to reduce the role of the state in the economy. In health, however, Western Europe has seen a strengthening of the role of the state in response to the failure of self-governing systems to deliver value for money. Thus, *dirigiste* measures, such as cash-limited budgets, quotas for hospital beds and particular services, selective lists of economically approved pharmaceuticals and price controls, have taken the place of more open-ended systems of self-regulation by health-sector stakeholders. Universal coverage of healthcare was only introduced during the last 20 years in Italy, Portugal, Spain and Greece, while the Netherlands expanded the range of services universally covered (see Mossialos, 1999).

This fundamental, i.e. intrinsic, public-sector element in health systems means that greater efficiency must be achieved with self-imposed disciplines from within the system, a process vulnerable to obstructionism by significant parts of the healthcare system itself. Outside resources can, however, help to remove some of these bottlenecks by offering new opportunities, rather than just reducing old ones.

Thus, the needed 'build-down' of centralised hospitals can be eased by providing investment for newer, more attractive and smaller facilities closer to the public. Similarly, the difficult transition for doctors from prestigious specialist status to the more useful General Practitioner, or family doctor role can be eased by training and, in particular, micro-credit schemes for basic equipment for newly independent doctors. The assigned new role of GPs and other independent doctors as 'gatekeepers' for hospital referrals is a key to achieving efficiencies. It cannot be adequately fulfilled without diagnostic equipment (and independent laboratories) available outside the hospital framework.

Apart from investment in medical facilities, reform also requires a step-change in the quality of management at all levels. Even this requires physical investment: in informatics systems able to exercise controlling functions at the centre as well as a means to coordinate the complex multi-institutional provision system. Most World Bank-funded reform programmes include an important investment in the upgrade of central management capacities as an essential first step.

[8] In the pharmaceutical sector, there are suggestions that treatment patterns fall short of modern practice, despite apparent similarities in the level of consumption. Whether this matters depends on the effect that availability of modern medicines could have in improving economic productivity and supporting the process of resource re-allocation away from secondary care.

CHAPTER 3
THE RELEVANCE OF THE *ACQUIS* FOR ENLARGEMENT

In most policy areas, preparation for enlargement follows a single pattern centred around the adoption of the *acquis*. In such discussions the candidate country is examined in terms of institutional and other shortfalls from full *acquis* capability, while, as regards the present Union, the question of transition periods and technical and financial assistance is posed. Although the Health Ministries in the candidate countries all seem to have 'accession' departments (each larger than the relevant unit at the Commission), health is not a 'chapter' in its own right. There are good reasons for this.

Most of the European Union's formal powers lie in the area of law-making, not the allocation of public resources; the laws, moreover, are overwhelmingly targeted at the functioning of markets. Other matters of social organisation are the responsibility of member states, subsidiarity wisely reflecting both the democratic deficit of the Union and the diversity of situations and values within. Accordingly, Article 152 of the Amsterdam Treaty excludes the harmonisation of laws and regulations of member states in the field of healthcare. While committing the Union to take account of health in the definition and implementation of all Community policies, the healthcare system proper is largely out of bounds.

The subsidiarity rule will apply to the countries of Central and Eastern Europe[9] after the accession. The question is whether it need, and indeed, should apply during the pre-accession phase. This report argues for a departure from a narrow, *acquis*-based concept of the health-enlargement nexus to a broader economic development view which can and should be taken during the pre-accession period. Moreover, by focusing on economic development rather than rule-making, a clear perspective for post-accession intervention with the Structural Funds is opened up. This, indeed, is in keeping with the remarks by Commissioner Diamantopoulou quoted in Chapter 1.

There are, however, elements in the existing *acquis* that could be used as supplementary support for such a broader view (Micklewright and Stewart, 2000). Thus a text-based rationale for EU action could be derived from a wider interpretation of the Copenhagen criteria, especially the 'human rights' principle and 'Economic and Social Cohesion'. Health can be considered as a human right; and cohesion is defined as 'greater equality in economic and social opportunities … raising living standards and the quality of life'.

The indicators used to measure cohesion – i.e. average income and employment – skew the distributional mechanisms towards geographical criteria rather than social groups at risk. However, while the bulk of cohesion-related assistance of the Structural Funds is devoted to physical and 'productive' infrastructure, human capital development is already addressed as regards education, through EDF support for training. The obstacles to extending this perspective to health are thus the failure of those setting the terms of reference for cohesion-focused programmes to take account of the health-development nexus (see Chapter 4), especially at the present stage of development in the CEECs.

Lastly, there is a relatively obscure Council Recommendation on convergence of social protection objectives of 1992 which could be used as *acquis* leverage at the level of health delivery systems and reform. In its health chapter, it calls for universal access to affordable healthcare.

[9] This report looks at structural issues common to transition economies and thus does not cover Cyprus or Malta.

3.1 The health *acquis* to date

The health *acquis* consists of:

- dispersed pieces of legislation related to free movement or competition that touch on subjects related to health or healthcare; and
- Community policies explicitly targeted at (public) health.

As regards the first category, the relatively few instances of 'hard' legislation related to health tend to be derived from the EU's traditional core business, the market – competition, trade and free movement – and its social pendant, consumer protection. Hence, it includes product and safety standards for pharmaceuticals, food, toys, etc., rules on (tobacco) advertising, intellectual property rights and the mobility of medical staff. Except for the latter, little of this concerns the healthcare system as such. At any rate, these matters are discussed as part of their respective chapters and, unlike, say, environmental legislation, do not require large-scale investment for effective *acquis* compliance. (Some investment in 'capacity-building', notably standards testing and certification, is needed.)

What about the Community's health policy proper? Its legal basis is Article 152 of the Treaty.[10] Although it runs over two pages, the key provision is its final short paragraph, point 5:

> Community action in the field of public health shall fully respect the responsibilities of the Member States for the organisation and delivery of health services and medical care.[11]

With the lines of subsidiarity thus clearly drawn, what is the positive content? Rather than citing paragraphs, the present state of play is best illustrated by the new Programme of Community action in the field of public health (2001–2006)[12] adopted by the Council in June 2001.

The first relevant fact is the budget for the programme, amounting to about €50 million a year. With the EU health sector accounting for well over half a trillion euro annual value-added, this corresponds to < 1/100 of one promille.

With these resources, the Commission intends to do three things:

- information/monitoring,
- warning, coordination of responses to health hazards, and
- public promotion.

Information, including benchmarking, is becoming a key tool of Union policy in areas, notably social policies, where its legal powers are weak. Its utility ranges from 'look and learn' from best practice to 'name and shame' sub-standard performance.

In the words of the programme, it will develop and operate (!):

> a well-structured and comprehensive system for collecting, monitoring, analysing, evaluating and imparting comparable and compatible health information and knowledge to all key partners and actors, by ensuring a dialogue with them, by incorporating their expertise in the development of an efficient and transparent

[10] Formerly Article 129.

[11] A second sentence re-enforces the point by citing the 'national provisions on the donation of medical use of organs and blood' as being unaffected by a commitment under 4a to set high standards in this area. Similarly, point 4c speaks of 'incentive measures designed to protect and improve human health, excluding any harmonisation of the laws and regulations of the Member States.'

[12] Amended proposal …, COM (2001) 302 final, 1 June 2001.

> Community knowledge base on health and by undertaking assessment of and reporting on health status and health-related policies, systems and measures.[13]

This vast agenda suggests the need for an Agency, on the lines of the European Economic Area (EEA) in Copenhagen and the new Food Authority, whose annual budget will be on the scale of the total health programme.[14] At present, however, the institutional question is left open. The potential gap between ambition and means thus created is even more critical as regards the second objective:

> To enhance the capability of responding rapidly and in a coordinated fashion to threats to health by the development, strengthening and assistance (!) to the capacity, operation and inter-linking of surveillance, early warning and rapid reaction mechanisms covering health hazards.

This activity builds on the network for epidemiological surveillance and control of communicable diseases in the Community, but with new procedural rules laid down in the programme.

The immediate, cross-border relevance of this second objective in the context of enlargement, and the infrastructure and organisational capacity needed to participate effectively, suggests giving immediate priority to the 'opening' of the programme to the CEECs mentioned, almost in passing, in the Preamble to the Decision.

The third objective is focused on public health activities largely outside the curative healthcare system, i.e. on preventive measures and changing human behaviour. The aim is to:

> address health determinants through health promotion and disease prevention measures, through support to and the development of broad interdisciplinary health promotion activities and disease prevention actions, such as immunisation campaigns.

Again, from the point of view of allocative efficiency in the perspective of an enlarged Union, the place where such actions are most needed and would show the greatest overall benefit would be the CEECs. This is true both for the 'behavioural' part, including diet, smoking, and sexual behaviour, as for immunisation (see Chapter 5).

3.2. EU policy thinking to date

One of the preambles (43) to the decision on the new public health programme deals with non-member European countries. Only after mentioning cooperation with the EFTA/EEA countries, it states: 'Provision should also be made to open the programme to participation of the associated Central and Eastern European countries in accordance with the conditions established in the Europe Agreements…'. There clearly is no sense that health in the CEECs has a different quality, both as regards domestic social and economic salience and as regards the European significance of these issues.

The link between health and enlargement was first addressed in a Commission staff paper in 1998 (European Commission, 1998). The following issues were identified as deserving particular attention in relation to accession preparations:

[13] Op. cit., Article 2.2 (a).

[14] Proposal for a Regulation of the European Parliament and of the Council laying down the general principles and requirements of food law, establishing the European Food Authority (COM92000) 716 final.

- the lack of clear, modern public health policies equal to the challenges facing the health system and the relatively low priority given to this sector;
- the increasing level of communicable diseases, and the decline in vaccination coverage;
- the increase in drug use;
- the need for better emergency facilities;
- the low social and economic status of health professionals and the consequent potential pressures on migration resulting in a crippling exodus or unwarranted influx;
- the relative lack of appropriate and sufficient involvement of the civil society in health issues and the paucity of relevant institutions and associations; and
- the continued negative impact on health of poor environmental conditions.

As regards the last point, enlargement involves a considerable effort by both sides to implement the environmental *acquis* and mobilise financial resources for investments (Hager, 2000). A recent study has estimated the socio-economic benefits of these efforts at 4% of GDP in the candidate countries, most of which is due to the value of improved health from an improved environment.

When it comes to intervening in the health sector directly, however, the Staff Paper's list of possible actions reflects the narrow scope allowed by subsidiarity:

- encourage all the candidate countries to participate in each Community public health programme;
- assess and encourage the improvement of the know-how and facilities related to surveillance of communicable diseases and encourage early participation in the Community network on disease surveillance and control;
- organise regular meetings on specific health-related accession topics between member states and individual candidate countries to identify priorities for cooperation;
- exchange information on establishing priorities related to resource allocation and investment allocations;
- promote participation of experts from the candidate countries in the Commission's expert groups, whenever possible;
- facilitate cross border cooperation;
- develop health research, including on accession-related health issues and exchange of experience on the use of information systems and technologies related to healthcare;
- further promote participation of experts from the candidate countries in the Community health and healthcare-related research activities, notably in the 'Quality of life and management of living resources' and 'Creating a user-friendly information society' programmes; and
- foster exchanges and links between NGOs in the member states and the candidate countries active in the field of health.

The European Parliament's report, (European Parliament, 2000), while duly citing legal paragraphs, implicitly takes a wider view of the issue. As the EP's Rapporteur and Chairman of the CEPS Task Force put it, enlargement is 'a process whereby we work together to enable each and every one of our European family of Nations to join us in a way that makes them and us feel comfortable with the Union.' Nevertheless, the European Parliament, too, is constrained by subsidiarity in its proposals.

It is not clear why this should be so. The world community, including notably the WHO and the World Bank, is cooperating at a very operational level with the administrations of the candidate countries, devising programmes and funding investments. The Commission has concluded a Letter of Understanding with WHO, modestly co-funding some of its projects in the health sector. Nevertheless, the international organisations have to allocate scarce resources on the basis of need on a global scale. The Union, by contrast, has a special strategic stake in a group of countries due to become full members. It can and should take a view – and assume a role – that reflects this strategic stake, taking account of issues of economic and social balance for which, after accession, it will share responsibility.

As stated, this report therefore explores avenues of action beyond the *acquis* proper. However, the group has identified a variety of technical issues arising from the application of the present *acquis* that deserve a fresh look by the Commission and candidate countries alike. These are summarised in the box below.

Beyond the *acquis* proper: Implications for healthcare

- Healthcare treaty commitments will become a dead letter, unless they are redefined in terms of baseline levels of provision.
- The single market, as currently defined, regulates the behaviour of producers of medical supplies, inter alia by outlawing geographical price discrimination. Yet, arguably, price discrimination is exactly what is needed, at least for certain sectors of the CEE market. Without that, the adoption of best practice – an important part of reform – may be constrained by the availability of medicines at affordable prices.
- The EU intellectual property regime is essential to sustain research and development of new medicines, but cannot ensure their wide availability.
- Community competence in public health includes the capacity to respond to crises. Disparities in the availability of medicines mean that crisis responses may need to include more than extended surveillance. There is a need for more active management of pan-European health issues. Vaccines, AIDS and key lifestyle diseases are obvious areas.
- Competition policy: The Community impetus to introduce competitive mechanism into the provision of healthcare is very weak, because of subsidiarity. Nevertheless, leading EU member states and candidate countries are now looking closely at 'managed competition'. In this, they are trying to parallel some of the gains that deregulation has achieved in other sectors without letting go of the reins. Here, the Community role re-emerges, in that the EU has a strong interest in promoting economic transition and inward investment. This points to the case for direct investment, but also for a need for fuller consideration of the relationship between private industry and public sector provision, in the context of the future economic development of Central and Eastern Europe.
- Subsidiarity is an important element of the EU healthcare system, but should not be equated with self-sufficiency. The candidates have quite striking differences in the mix of human and capital resources devoted to healthcare, compared with the existing EU. This may lead to an expansion of the role of cross-border provision of services, a relatively embryonic area, but one that has received some support from the Commission.

CHAPTER 4
THE ECONOMIC CASE FOR INVESTING IN HEALTH

The recently published *Human Development Report for Slovenia* (Hanzek, 2000) states:

> Development in the modern world is becoming increasingly more dependent on the human factor – knowledge, health, values, culture, social organisation – and increasingly less on physical capital. A study made by the World Bank covering 192 countries has shown that only 16% of growth can be attributed to physical capital (machinery, buildings, infrastructure), 20% to natural resources and as much as 64% to human and social capital.

4.1 Health and CEEC growth

The economic challenge of enlargement should not be underestimated. In a 20-year perspective – which corresponds to the historical scope of enlargement – success will depend not just on effective *acquis* implementation, but on the rate and quality of economic growth. As the box below shows, substantial rates of growth are required to bring candidate countries to levels of income representing 75% of the EU average. To put this in context, over the next 20 years, the candidates will need to achieve consistently a rate of growth that is twice that which has been achieved over 20 years in the existing Union.

What is required to meet this challenging target? There is now considerable evidence that, in parallel to the development of infrastructure and industrial investment, economic growth requires societies to invest in their people: investment in human capital. In the developed countries, the value of the human capital stock is now some three to four times the value of the stock of physical capital (Becker, 1997). However, it is also now increasingly recognised that human capital investments have greater value at the margin than physical investments. In other words, investment in human capital now dominates investment in physical capital as a driving force for growth and development.

Growth rates required to reach 75% of the EU average in 20 years:

Slovenia	2.4%
Czech Republic	3.1%
Hungary	4.1%
Slovak Republic	4.4%
Estonia	5.6%
Poland	5.7%
Latvia	6.6%
Lithuania	6.6%
Romania	7.3%

In the context of health, the returns from investment in human capital come from the value that individuals enjoy from additional years of healthy life. Some individuals will choose to devote a part of additional healthy life years to market activities (working longer or more productively) and so directly boost gross domestic product (GDP). In other words, poor health has a direct impact on the potential, marketable output of workers. Good access to services may also become an increasingly important issue in determining the migration decisions of workers. Decisions by the most mobile and productive to leave relatively depressed regions, in part to secure better access to health facilities, can contribute to a downward spiral of productive potential in already disadvantaged regions.[15]

There is, however, a second economic link between the performance of the healthcare sector to economic growth: the short-, medium- and long-term productive efficiency of the sector seen as a component of GDP in general, and of public sector expenditure in particular.

[15] Similarly, in the context of the Single Market, countries with ill-equipped healthcare facilities will find it increasingly problematic to recruit qualified healthcare staff. There are well documented cases of existing staff shortages in some medical specialities, for example, pathologists in Hungary.

Increasingly, economic units compete in the global market inter alia through a reduction of the state's share in GDP. The CEECs, in addition, are budget-constrained by the Maastricht criteria. A common reaction (in both East and West) to these imperatives is either to cut social expenditure, or investment in essential public infrastructure, or both. Follow-on costs of such a strategy are considerable: stagnant productivity in public services, leading effectively to rising costs; and unplanned social expenditures further down the road, as the consequences of neglect become apparent. Lower macroeconomic growth will result from both the general fiscal constraint imposed by non-compressible public expenditures and the general dead-weight loss to the economy of social dysfunctionality. The Union's new sustainability focus is beginning to address these subtle but very real relationships.

The best way to cope with this dilemma is to invest effort and money into the efficiency of public services, including health. This reduces long-term budgetary costs, while the improved output (better health) reduces the number of cases that require social intervention (in health itself, disability, unemployment, etc.).

As pointed out in Chapter 2.2, the reforms of the healthcare delivery systems of the CEECs are only now moving from plans on paper to building the new administrative systems, personnel structures and physical infrastructure needed to make them work. This provides a once-in-a-lifetime window of opportunity to set them on a course of long-term efficiency. The immediate social and political benefits are, of course, a non-negligible bonus.

4.1.1 Human capital and economic development

The World Bank has recently published a major, multi-country study of the drivers of sustainable growth and development in the modern world (Thomas et al., 2000, p. 18). Its conclusions are unambiguous:

> No country has achieved sustained development without investing substantially and efficiently in the education and health of its people.

The study cites, inter alia, a review of the growth experience of 20 mostly middle-income countries over the period 1970 to 1992. There is clear evidence that the pace of growth based mostly on physical capital accumulation, that is to the neglect of human capital, is not sustained. Market reforms can accelerate growth. But if the reforms are not accompanied by investments in human capital, growth is likely to flag.

Furthermore, as human capital increases, the positive link to economic growth becomes larger. At low levels of human capital, its link to economic growth is negligible, but at higher levels of human capital it becomes larger, with the marginal effect of the stock of human capital on growth always increasing.

These are powerful arguments which, the authors claim, apply to both education and health investment. They clearly demonstrate that an over-emphasis on investment in 'traditional' physical infrastructure to the detriment of investment in 'human capital' distorts economies and jeopardises development potential.

Other studies confirm these findings. Thus Sala-i-Martin (1997) carried out an analysis of the determinants of economic growth in order to check which ones of the 63 potential factors, taken from a large body of previous empirical growth literature, would turn out as the most robust determinants of growth. In the more than 30,000 regressions he found in 96% of the cases that the initial level of life expectancy (as a proxy for non-educational human capital) is significantly and positively related to the subsequent growth performance.

Bloom and Sachs (1998), analysing a large sample of developing and developed countries for the period 1965 to 1990, founded that in 1965 an increase of life expectancy by 1% accounted for an acceleration of GDP per capital of over 3% each year of the subsequent quarter century.

Using a similar sample of countries, Hammoudi and Sachs (1999) found that a reduction of infant mortality by two per 1000 live births accounts for a 1% acceleration of growth rates over the subsequent quarter century.

The evidence suggests that the remarkably robust correlation between economic and health indicators cannot simply be attributed to the fact that richer populations are better able to maintain good health. It seems likely therefore that the relationship between good health and economic status might result from a circular feedback in nature: Improved health may bring about economic success, just as economic success brings about improvements in health. Simultaneous effects of health on wealth imply the existence of multiple equilibria (good and bad ones). Under the bad one, ill health brings about poverty, which brings subsequent ill health; a population remains invariably sick and invariably poor in the long term. Under good equilibrium conditions, improved health brings about economic growth, which enhances human longevity and well-being.

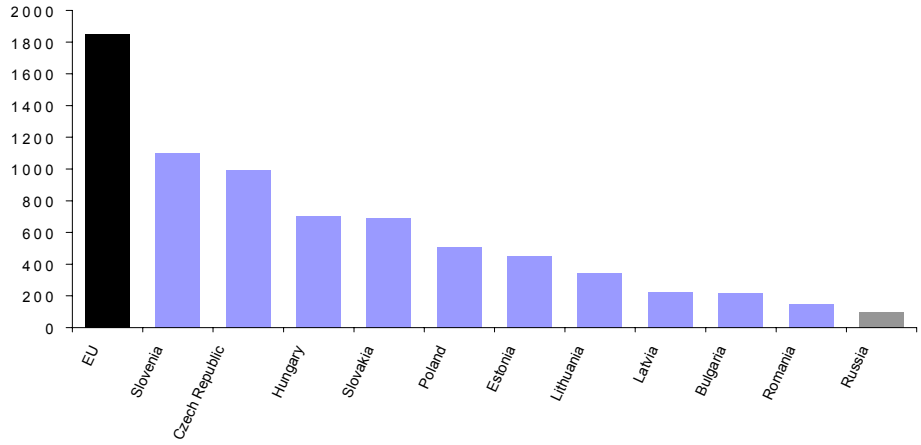
This finding was confirmed by the analysis of Ranis et al. (2000) of the empirical and theoretical interlinkages between 'human' development (i.e. health, education) and economic growth. The authors find that countries that tend to focus more on human than on economic development, are more likely to trigger a virtuous cycle of good human development and good economic growth than those that have narrowly focused on economic growth. It is thus a direct empirical application of the Hammoudi/Sachs-idea of multiple equilibria, the crucial difference being that while Hammoudi/Sachs did not attribute a more important role to either human or economic development, Ranis et al. found that a comparative advantage in human development can indeed kick off a virtuous cycle.

These results have obvious implications for the accession countries. As Figure 3 has shown and as was argued earlier, the CEECs still appear to have a relative advantage in terms of human as opposed to economic development. If maintained, this gives them the unique opportunity to launch a virtuous cycle of good human development and good economic growth. The underlying transition-related and structural health and health sector problems, however, critically endanger this favourable starting point. This would not only be bad for health itself but would also entail substantial costs in terms of (hitherto underestimated) foregone economic growth potential.

The need for human capital investment within the candidate countries is both clear and more pressing than the need for further physical capital formation. To develop, candidates need investment in education (and the capital required to deliver educational services). They also require investment in health, and the capital needed to deliver healthcare services.

But although countries in Central and Eastern Europe have greater health needs than the EU as a whole, they commit fewer resources to addressing these needs. Just over 8.5% of GDP is spent on health in the EU and the health sector, together with the social sector, accounts for 9% of total employment. In comparison, the share of GDP devoted to health sector in the 10 candidate countries is around 4.5%. In the EU the average per capita expenditure on health is around €1500; in the candidate countries for which data are available, it is on average below €300.

Figure 5. Total health expenditure in PPP$ per capita (latest year available)



Note: Data refer mostly to 1998, except in the Czech Republic and Poland (1999), in Bulgaria (1994) and in Russia (1995).

Source: WHO, *Health for all database.*

CHAPTER 5
INVESTING IN HEALTH

5.1 Introduction

The analysis in Chapter 3, which looked at health not in social or ethical terms, but as an element of human capital formation, opens a politically and administratively feasible route towards re-allocating a small part of EU grant finance presently earmarked for infrastructure development to investment in health.

Moreover, an investment approach – in contrast to other rationales – offers a ready-made methodology for the allocation of funding. Projects can be subject to cost/benefit analysis used in (public) banking. This has a double practical advantage. First, the 'homework' has largely been done – by the World Bank preparing programme loans for the accession candidates. These are inevitably underfunded or stretched in time to accommodate, not least, host-country budget constraints. A small injection of additional grant money would thus allow scaling-up or acceleration. Secondly, and importantly, a banking methodology has the best chance of convincing EU finance ministers – the decisive arbiters in any attempt to alter the terms of reference for pre-accession aid.

In addition, a focus on investment with an economic development purpose is less vulnerable to arguments of subsidiarity than health as such. One of our key points is that Union action towards the CEECs in the pre-accession phase need not be constrained by subsidiarity. That constraint is introduced into policy design by a narrow limitation of the purpose of pre-accession aid, i.e. preparing candidates for the ability to observe the rule-based *acquis*. Success of enlargement, however, will depend on a much broader goal, notably the ability to develop rapidly and within socially acceptable conditions – without ruining public finances. Investment in health thus serves both the new goals of sustainability and economic and monetary union.

The narrow focus of aid on the *acquis* helps to provide structure and purpose as well as built-in limits to what could be open-ended demands for assistance. Nevertheless, it sometimes leads to allocations that counteract stated Union policy preferences because these have not needed to be canonised in Directives. This allocative distortion reflects a broader deficit in the Union's transition planning: confusing (a limited range of legal) means with ends, i.e. rapid convergence of the CEE economies and societies to Western European standards. From such a perspective, targeting bottlenecks that are specific to transition, including social effects with long-term implications, would have supplemented the legal-technocratic view of the enlargement project. We have argued that public health constitutes such an area.

Health would not be the only area where EU grants are divorced from the *acquis*. Investment in transport infrastructure – half of pre-accession grant aid – is only loosely related to the *acquis* and generally justified on economic grounds. Human capital investment and assistance directed at one particularly difficult transition problem – health reform – could make a similar (if much smaller) claim on resources.

The next few years, i.e. those preceding enlargement, present particularly urgent needs and opportunities for Community intervention to strengthen the health sector in the candidate countries. The critical moment for the reform of health policies is now, not after 2005 when the new – decentralised and 'mixed' – health provision systems will have solidified. There are also urgent epidemiological interventions which – if only for reasons relating to 'free movement' – need to be taken early at a fraction of the cost of later intervention.

There is, however, a 'technical' reason on a quite different level for acting now rather than later: the need to utilise intellectual and political capital built up by the World Bank in Central and Eastern Europe which risks being lost once the Bank leaves the CEECs after enlargement. Indeed, 'buying into' existing programmes is the most effective way to deliver results.

5.2 Grant transfers as investment

The human capital/developmental perspective on health and enlargement has direct consequences on the methodology for choosing areas of intervention, assessing the utility of individual projects, and managing the execution of programmes.

In an economic rationale, health expenditure is considered as an investment that yields a monetary return. This is different from merely assigning monetary values to quality-of-life improvements or the value of a life. From a strict public banking perspective, one looks for gains both for public finance – cost effectiveness of the health system itself plus tax revenues from workers avoiding disability or death – and from the economy at large (again, productivity of workers.) The investment perspective serves to underline the analogy with other forms of social capital formation supported in the accession process. It also provides a methodology for measuring the efficiency of expenditure in admittedly narrow terms.

As mentioned above, an important practical advantage is that much of the homework for efficient investment in the health system has been done by the World Bank (in collaboration with a host of UN and European agencies, NGOs and host governments). It may be thought that 'bankability' tests made for the purposes of programme lending to public authorities are needlessly restrictive for a possible programme to be financed by grants. But there is in principle no difference between an IFI public sector loan and an effective grant. Both are paid by the taxpayer. In the case of a loan, the taxpayer of the candidate country ultimately pays, not the 'donor' IFI. With grants, it is the EU taxpayer.

Under a loan, the donor (IFI) adds value to the planned expenditure by lowering the cost of borrowing (i.e. of buying time); and giving technical guidance on effective expenditure. It must make sure that government can repay the loan from computed savings on expenditure or future increases in tax revenue through improved overall economic performance. A grant that is subjected to the same banker's test of economic efficiency can thus be fully justified as a contribution to economic development.

The methodology and institutions for investing in improved health provision in the CEECs are available and working. Spending under World Bank programmes is directed towards of a mix of critical physical resources, knowledge and knowledge systems at the central and local level, and reform-promoting measures. This mix typically varies between different countries. But the variance is less than would result from addressing a different question: What are the most urgent health needs of the candidate countries? Finding an answer to that question would take years of bureaucratic study, committee work cum negotiation, while the subsequent result would still have to be 'sold' to finance ministers as a charitable transfer rather than as an investment.

The EIB committed itself to investing in health at the Köln summit but lacks staff resources (and a mandate) for devising public policy reform programmes. It could, however, co-finance World Bank loans from a small part of its €7 billion accession facility, easily doubling IFI resources available for the health sector in the CEECs. Moreover, while the World Bank is limited to lending to governments, the EIB can lend to any creditworthy entity, public or private. Mention should also be made of the Council of Europe Development Bank (CEB) which is active in the CEECs' health sector, e.g. through a €11 million programme loan to Bulgaria, mostly co-financing for World Bank projects.

Debt finance, however, may not always be the best answer. IFI loans, as mentioned above, are a claim on future taxpayers in the accession countries. New public debt – for any purpose – is subject to strict ceilings on public deficits, which are part of the accession criteria.

The alternative, clearly, is to leverage IFI loans through grants. ISPA funds, presently limited to investments in physical infrastructure (transport and environment) run at a level of €1 billion a year to 2006. There is growing evidence that this money cannot be spent, or spent well, because of the technical problems associated with large projects. Transferring 10% of this amount to health investment would yield some €500 million over the period, roughly equivalent to the total value of World Bank-funded health support programmes in the CEECs.

In addition, there is a growing conviction that the overall level of transfers after enlargement will need to be raised beyond the present limit of 4% of GNP for any single country (and beyond the limit of 0.45% of European Union GNP). If this were to occur, the Union would risk running out of economically useful projects unless the definition of 'investment' is widened to include the area of human capital, of which health would be an important component. A pre-accession programme would create such an option, although the direction of specific funding would need to change once the process itself of building health systems has been completed.

5.3 Targeting an investment programme

Possible areas of intervention have to be selected with care. They must fulfil the following criteria:

- Entail no permanent commitment of resources beyond the accession date; quick-start capability and
- Demonstrate a link to problems of enlargement and transition as such.

This has led us to consider action under two headings:

- Investment assistance to the reform process and to improve equal access to healthcare, and
- A vaccination programme.

5.3.1 Health reform as a vector for European Union investment

It was not the task of the CEPS Task Force to develop a vision of the best curative health system. As mentioned earlier, the European Observatory on Health Care Systems exists to bring well researched and authoritative commentary on health reform to the attention of the policy community (www.observation.dk). Rather, the task of the Task Force is to identify bottlenecks in the implementation of reform and to reflect on ways in which money could help to remove these.

The intrinsic public sector element in healthcare systems means that greater efficiency must be achieved with self-imposed disciplines from within the system, a process vulnerable to obstructionism by significant parts of the health system itself. Outside resources can, however, help to remove some of these bottlenecks by offering new, rather than just reducing old, opportunities. The key question is how to encourage a strategic shift of resources from hospitals to primary care and community-based services. This cannot be simply be achieved by administrative fiat.

Thus, the needed 'build-down' of centralised hospitals can be eased by providing investment for newer, more attractive smaller facilities closer to the public. Similarly, the difficult transition for doctors from prestigious specialist status to the new GP-gatekeeper role can be eased by training and, in particular, by micro-credit schemes for the purchase of diagnostic equipment for newly

independent doctors. Specialists continuing in their chosen field but setting up practice outside the hospital system similarly require capital equipment.

More generally, the more complex interactions between central government, public service institutions, semi-autonomous insurance funds and hospitals require new management systems and an efficient informatics infrastructure to provide feed back, control and the capacity to allocate resources efficiently and quickly. That same organisational and physical infrastructure is needed to permit the accession countries ability to effectively interface with the Union's epidemiological surveillance network.

5.3.2 Real world examples

Looking at World Bank projects in the CEECs, we find a broad range of recipients. Some are stand-alone interventions to fund hospital equipment, community health services, vaccines, ambulances, etc. Other loan-financed expenditures, however, are targeted at removing bottlenecks in the reform process, notably the shift from an excessive reliance on hospitals to decentralised primary healthcare.

Thus, the World Bank's loan for a Health Reform Investment Programme in Bulgaria addresses directly the issue of 5000-8000 surplus physicians by paying 1000 of them six months' to one year's salary if they leave the profession. This addresses both the problem of unneeded (hospital) admissions and, indirectly, the brain drain danger, as salaries of remaining physicians can be raised. Similarly, the programme will provide equipment for 80 hospitals; while co-funding the redundancy of 2800 of the staff laid off by the closure of 100 hospitals.

Other reform-promoting loans will fund a micro-credit programme to equip 1500 primary healthcare practices, mainly outside large urban areas. It also provides funding for training of GPs, and office information systems. This advances the reform objective of shifting from hospital-centred to GP and small clinic-based primary care, where the new GPs must also perform a 'gatekeeper' function for referral to (previously self-serving) hospitals. Basic diagnostic and other equipment can be made available under the scheme.

A loan to Slovenia, by contrast, is targeted upstream to improve the allocative and managerial capacity of the Ministry of Health, the Institute of Public Health, the Health Insurance Institute, and even the Ministry of Finance. A strong information technology capacity is at the centre of the Slovenian programme.

The World Bank loan to Romania, by contrast, in addition to supporting managerial improvements and a shift to primary health case, also responds directly to an absolute shortage of resources.

'Many of our buildings and equipment are obsolete, poorly maintained, or unsuitable for providing good-quality health services. Modern management skills are scarce. Services are over-centralised and unresponsive to local initiatives and needs.'

The loan, to be disbursed over the next 5-6 years, contains the following components:

(millions of $)		
Planning and Regulation	1.92	2.7
District Hospitals	25.81	36.8
Primary Development	8.04	11.5
Emergency Medical Services	22.73	32.6
Public Health	10.38	14.8
Project Administration	0.96	1.5

One advantage with all these programmes is that they are devised as relatively short-term pump-priming exercises, with follow-on expenditures to be assumed by normal public budgets and insurance funds – with the savings generated by the programmes themselves.

The kind of cost-benefit analysis undertaken for such programmes can be illustrated with the example of Lithuania (for which we happen to have the data.) It refers to a loan that targets both support to health reform ($8.5 million) and Health Services Restructuring ($24.1 million).

5.3.3 Improving vaccination infrastructure

We have included vaccination and other epidemiological measures in our list of priority interventions because, in addition to their economic merits, they are of direct interest to Western Europe under a free movement of labour perspective. Vaccination is also linked to transformation, both of the general economy and of the healthcare system as such.

The specific measures we propose are, in keeping with our approach, investments; i.e. they involve small but critical spending on capital goods which offer a high and long-term return. Last, these are measures which should be initiated before accession, as costs of dealing with the problem of the new epidemics will rise the longer they are delayed.

Official statistics suggest that sufficient quantities of vaccines are available and dispensed to the population. All the accession countries have the classic WHO-recommended essential vaccines (diphtheria, tetanus, pertussis, polio, BCG, measles) in their national programmes and have recently included the newer vaccines against hepatitis B and rubella (except Romania). The problem is the effectiveness of the vaccines at the stage of delivery, and the quality of the delivery itself.

Under socialism, paediatric vaccinations were obligatory, provided free of charge by the state and delivered through the state healthcare system (principally by specialists in polyclinics) – a system in some ways more effective than in many Western European countries at the time. healthcare reforms have led to a (otherwise desirable) decentralisation of the system, with often poorly prepared and motivated GPs increasingly charged with carrying out this crucial task of preventive medicine. At the same time, the transition from the old command economy to market economy has complicated the budgetary allocations both for vaccines and the associated medical services, while general budget constraints have caused difficulties in sustaining supplies, introducing new essential or improved vaccines and supporting the necessary infrastructure such as the supply chain. Poorer, rural areas are particularly at risk of inadequate vaccination coverage. As a result, many CEE countries have in recent years experienced a resurgence of previously controlled diseases such as measles, diphtheria (particularly in CIS and the Baltics) and polio (as recently as this year in Bulgaria) that has necessitated emergency international aid programmes. The countries are generally not in a position (financially and organisationally) to meet emergency vaccination demands, especially community outbreaks (e.g. hepatitis A) or following natural disasters such as flooding.

The classical vaccines were mainly supplied by local state-owned manufacturers in the past but the economic reforms and lack of investment have meant that most face closure or privatisation. Also, none operates under modern GMP conditions (a requirement within the EU) raising concerns about the safety and efficacy of locally produced vaccines. For both budgetary and political reasons some countries are unable to make the switch to modern base vaccines produced under GMP conditions.

Changes in ‘lifestyle’, notably drug use and sexual promiscuity, have led to rising rates of sexually transmitted diseases (STDs), notably HIV and hepatitis B, to epidemic proportions in some countries. These particularly affect the adolescents and young adults, i.e. the most mobile and productive groups. Hepatitis B is a serious problem in many CEECs with a carrier rate of 2-3% of the population, and as high as 10-12% in certain high-risk groups. The effects of the

increasing infection rates are therefore not only reflected in acute morbidity and mortality rates, but also 10-20 years from now when 25-30% of those who become carriers develop chronic liver disease and/or cancer. In addition, TB has become a major problem throughout the region, partly linked with increasing HIV infections and partly due to poorer socio-economic conditions for large sections of the communities as well as to inadequate treatment regimens which have led to the rise of resistant strains.

The importance of hepatitis B is recognised in all the countries and therefore has been included in the national paediatric immunisation programmes. However, these programmes will take 10-15 years before they become effective and most countries do not have the resources to target a programme to the highest-risk group, the adolescents. It is also worth noting that hepatitis B is recognised as an occupational hazard through legislation within EU.

5.3.4 Targeting capital assistance to improved vaccination

Where could an outside injection of money make a long-term difference to the quality of vaccination programmes and public health? One problem is refrigeration in the vaccine supply chain. Under the old system, supplies were stored in hospitals. Under the decentralised system, they must be transported to intermediate storage sites and to GPs. This requires refrigerated vans, for which little or no budget provisions have been made. Moreover, GPs and other practitioners may not have adequate refrigeration facilities in their surgeries. The result may be spoilt – i.e. no longer effective – vaccines, or simply non-availability in significant parts of the decentralised health system.

A capital investment programme directed at upgrading the supply chain – vans and small refrigerators for GPs – is thus a first order of business. One van would suffice for a medium-sized city or rural district. An expenditure of €2.5 million for, say, Bulgaria, or a total of €30 million for those candidate countries that need it, would dramatically improve the quality of distribution, for the price of 200 metres of motorway per country. Supplying GPs and other doctors with small reliable refrigerators would cost doctors perhaps €500, making the cost of supplying 10,000 GPs €5 million. Both these expenditures could be financed by a combination of grants and loans, possibly to a private, non-profit organisation and operated as a single supply system in each country that accepts such a scheme. It could be supervised by an NGO, such as the International Red Cross, WHO or UNICEF, all of which run worldwide vaccination programmes.

A second problem caused by decentralisation is inadequate preparation of GPs and other medical personnel charged with carrying out vaccinations. Under the socialist system, specialists knew the vaccines and basic immunisation practices. A targeted information and training programme is needed in this area as well as the development of written national immunisation guidelines and recommendations. Here, Phare[17] technical assistance programmes could complement the investment programme.

A third problem is monitoring. Under socialism, hand-written ledgers were kept in central hospitals. Today, nothing short of a computer-based reporting system can provide vital information on coverage of individuals and the population generally. This does not require new expenditure, since such a system should already be part of the broader (epidemiological, etc.) reporting system which is part of any modernisation programme and a priority for the European health strategy. A system of national vaccination cards and support for epidemiological surveillance are also needed.

A Union-supported programme would also need to be designed to correct the failure of many existing systems to reach the socially disadvantaged in general, and ethnic minorities like the

[17] Originally the **P**oland and **H**ungary: **A**ction for the **R**estructuring of the **E**conomy programme.

Roma in particular. This is not only an issue of principle (derived from the Copenhagen criteria for membership), but also one of epidemiological effectiveness. Rural areas, and the poor in general, remain persistent sources of epidemics and hence a threat to the more prosperous and well supplied parts of the country (and Europe as a whole). One obstacle to reaching out to such populations is the lack of GP services and incentives – under the broad contracts typically concluded with the new Health Authorities – to propose and carry out vaccinations. Making budgetary and administrative provisions in this sense should form part of any implementation agreement concluded between a candidate country and the Union. Such a contract would also need to contain a commitment to raise the quality of the vaccines used to meet general EU standards.

5.4 Funding

During the pre-accession phase, the Union is assisting the candidate countries through three channels: technical assistance and investment (Phare), investment for transport and environment infrastructure (ISPA) and the loans (EIB).

The nature of the tasks identified suggests an allocation of funding responsibilities as follows.

Technical assistance to health reform projects is already funded under Phare assistance programmes. Here, the political task would mainly consist of increasing the proportion of total funding devoted to health and health reform. Such an improved allocation would be broadly compatible with the subsidiarity constraint, and correspond to the ambitious aims of the new programme of action in the field of public health (2001-2006) discussed in Chapter 3.

As regards additional grants, however, these should be handled under broad framework contracts with the World Bank and WHO, with ex-post rather than ex-ante scrutiny of spending. This will help to gain precious time and not subject relatively small programmes to the increasingly complex control procedures of the Commission.

Mobilising larger investment resources would require adjustment to the statutory – Cohesion Fund-inspired – limitation of ISPA funding. These funds, presently limited to investments in physical infrastructure (transport and environment), run at a level of €1 billion a year to 2006. There is growing evidence of bottlenecks in spending this money because of the technical problems associated with large projects. Transferring 10% of this amount to health investment would yield some €500 million over the period. This is roughly equivalent to the total value of World Bank-funded health support programmes in the CEECs. There are also a number of other sources of Commission support that could be more closely aligned with needs for human capital investment. Phare has a budget of €1.5 billion per year available for pre-accession support beyond 2000. Further funds are available under the Special Preparatory Programme for Structural Funds, which are designed to pave the way to access to post-accession structural funding.[18]

The European Union also has readily available methodologies and institutions for investing in improved health provision in the CEECs. In terms of methodologies, valuable World Bank programmes, directed towards of a mix of critical physical resources, knowledge and knowledge systems at central and local level, have already been established for most candidate countries. In terms of delivery, the Union can also draw on the services of the European Investment Bank (EIB) – its 'in-house' financing institution. The EIB has had a mandate to lend to economically worthwhile health projects in candidate countries since 2000. Although EIB loans are typically available on the finest terms available in the market, even highly economically worthwhile projects may not be affordable to candidate countries. The ability to draw on ISPA funding to

[17] For details, see http://europa.eu.int/comm/enlargement/pas/phare/pt/ssp.htm

'subsidise' loans, whilst retaining existing economic tests of the viability of projects, could make a significant impact.

Our second priority – funding an epidemiological programme – does not entirely fit this scheme. It does have an infrastructure component – monitoring networks – and a training component which could be accommodated by ISPA and Phare. However, vaccination programmes also involve current expenditures on manpower and medicines which are neither technical assistance nor investment in a technical sense.

Since the rules of engagement of the Union are virtually impossible to adjust within a useful time scale, the solution could be an ad-hoc programme based on national contributions. The Commission would ask its cooperation partner, the WHO, to present a funded project proposal, including priorities. The Commission would then call a Donor's conference for the specific purpose of gathering pledges from individual member states for a programme which is in their own short-term interest. The pharmaceutical industry may wish to make a collective offer of supplies for this specific programme.

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