Health Care Systems in EU Pre-Accession Countries and European Integration

This paper will briefly analyse health care system developments and problems of those ten countries in Central and Eastern Europe (CEE) which are currently in the process of negotiating their accession to the European Union, namely Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia, i.e. it will neither deal with other CEE countries (e.g. Croatia) nor with other pre-accession countries (i.e. Cyprus and Malta).

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After the breakdown of the Eastern bloc in 1989/90, policy-makers in the CEE countries faced a number of problems in their health care systems: Arguably, the three main ones were 1. the high numbers of some health care inputs (especially hospital beds, to a lesser degree physicians) but equally an undersupply (or at least unequal distribution) of others, mainly pharmaceuticals and high technology, 2. low incentive levels for health care providers, often leading to a certain under-performance of the health services), and 3. the excessively overcentralized structure of the health care system. To address these problems, a number of similar strategies was pursued in all countries, but no country managed to tackle all three issues successfully.

Decentralization and privatization

One strategy used in all countries was the transformation of the health sector (and societies in general) into a more pluralistic, decentralised make-up, including devolution of responsibilities to local and, often newly created regional levels (which often became responsible for owning and managing sub-tertiary care hospitals), and to a lesser degree, and varying between countries, *delegation* of decision-making to physicians chambers, insurance funds etc., as well as *privatization* which also varied in extent between countries but included ambulatory care providers such as GPs, dentists and pharmacies in almost all countries.

In general, the early 1990s saw a creation of the new legal frameworks, often dominated by an emphasis on economic change, i.e. privatization of ownership and the development of the private sector in general – though this was usually less pronouced in health care as the almost total non-privatization of hospitals demonstrates. One problem with this transformation of the CEE societies was an almost total lack of theoretical knowledge about public law and public economics. Most of the legislators had (and still have) a socialist legal education and were unable to adapt to the new system of private and public law. Policy-makers and politicians did not have this essential knowledge and, varying between countries, even believed that the public sector was no longer necessary and could be gradually substituted by private activities – to the point that, at least in the Czech Republic, some even believed that the Ministry of Health could be abolished.

Many actors contributed to the formation of new institutions. One of the key criteria in development evaluation is the extent of actors' preparedness in terms of expertise, knowledge, skills and motivation, but many actors concentrated on a rather uncritical and simplified copy of western models. Many also used the process of social changes to pursue their own particularistic interests, rather than the public interest. In this respect, arguably one of the major mistakes made in several countries was to believe that the health ministry should defend the interests of health care providers and business activities in health services. The ministries were thus at least strongly influenced by the professional medical associations, the producers of pharmaceuticals and medical technology, health insurance funds (if existing) etc. In other cases, doctors even dominated the process of the drafting of health legislation.

Among them, some held (and might still hold) the belief that by becoming independent legal subjects (i.e. autonomous), they would be operating in a completely private sector and thus the state should not intervene in their activities. In that way, they also assume that processes such as price-setting for health care medical performances should not be regulated, but left entirely to market mechanisms.

The breaking-up of the formerly centrally coordinated structures in favour of a more pluralistic model also de-

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Table 1: Total expenditure on health in US$ purchasing power parities per capita and ratio to EU average

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
EU average	1271	1342	1478	1509	1571	1683	1758	1783	1849	-
EU country with lowest exp. (Portugal 1990-97; Greece 1998)	614 (0.48)	731 (0.54)	804 (0.54)	874 (0.58)	942 (0.60)	1051 (0.62)	1090 (0.62)	1151 (0.65)	1167 (0.63)	-
Czech Republic	575 (0.45)	501 (0.37)	530 (0.36)	748 (0.50)	804 (0.51)	902 (0.54)	917 (0.52)	930 (0.52)	930 (0.50)	993
Estonia	-	-	301 (0.20)	209 (0.14)	271 (0.17)	252 (0.15)	-	-	453 (0.24)	-
Hungary	510 (0.40)	540 (0.40)	600 (0.41)	623 (0.41)	685 (0.44)	678 (0.40)	662 (0.38)	672 (0.38)	705 (0.38)	-
Poland	258 (0.20)	296 (0.22)	331 (0.22)	339 (0.22)	349 (0.22)	420 (0.25)	473 (0.27)	448 (0.25)	496 (0.27)	508
Slovenia	311 (0.24)	311 (0.23)	448 (0.30)	654 (0.43)	743 (0.47)	975 (0.58)	1030 (0.59)	1086 (0.61)	1101 (0.60)	-
Bulgaria	244 (0.19)	262 (0.20)	289 (0.22)	222 (0.15)	214 (0.14)	-	-	-	-	-
Latvia	161 (0.13)	196 (0.15)	170 (0.12)	126 (0.08)	130 (0.08)	139 (0.08)	-	177 (0.10)	223 (0.12)	-
Lithuania	162 (0.13)	200 (0.15)	155 (0.10)	131 (0.09)	193 (0.12)	188 (0.11)	-	215 (0.12)	341 (0.18)	-
Romania	79 (0.06)	-	73 (0.05)	101 (0.07)	121 (0.08)	134 (0.08)	128 (0.07)	112 (0.06)	147 (0.08)	-
Slovakia	-	-	334 (0.23)	407 (0.27)	479 (0.30)	471 (0.28)	623 (0.35)	668 (0.37)	693 (0.37)	-

Source: based upon WHO Health for all database 6/2001

Table 2: Total expenditure on health as % Gross Domestic Product and ratio to EU average

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
EU average	7.82	8.12	8.46	8.61	8.54	8.56	8.68	8.59	8.62	-
EU country with lowest % (Portugal 1990; Luxembourg 1991-98)	6.4 (0.82)	6.5 (0.80)	6.6 (0.78)	6.7 (0.78)	6.5 (0.76)	6.3 (0.74)	6.4 (0.74)	6.0 (0.70)	5.9 (0.68)	-
Czech Republic	5.0 (0.64)	5.2 (0.64)	5.4 (0.64)	7.2 (0.84)	7.3 (0.85)	7.3 (0.85)	7.0 (0.81)	7.1 (0.83)	7.2 (0.84)	7.6
Estonia	-	-	4.5 (0.53)	5.5 (0.64)	6.3 (0.74)	6.2 (0.72)	6.1 (0.70)	5.5 (0.64)	5.9 (0.68)	6.9
Hungary	6.1 (0.78)	7.3 (0.90)	7.8 (0.92)	7.8 (0.91)	8.2 (0.96)	7.6 (0.89)	7.2 (0.83)	6.9 (0.80)	6.8 (0.79)	-
Poland	5.3 (0.68)	6.6 (0.81)	6.6 (0.78)	6.4 (0.74)	6.0 (0.70)	6.0 (0.70)	6.4 (0.74)	6.2 (0.72)	6.4 (0.74)	6.3
Slovenia	5.6 (0.72)	5.2 (0.64)	7.4 (0.87)	7.7 (0.89)	7.9 (0.93)	7.8 (0.91)	7.8 (0.90)	7.7 (0.90)	7.7 (0.89)	7.7
Bulgaria	5.2 (0.66)	5.4 (0.67)	6.8 (0.80)	5.2 (0.60)	4.7 (0.55)	-	-	-	-	-
Latvia	2.5 (0.32)	2.6 (0.32)	2.8 (0.33)	4.1 (0.48)	4.1 (0.48)	4.2 (0.49)	4.5 (0.52)	4.5 (0.52)	3.9 (0.45)	4.4
Lithuania	3.3 (0.42)	3.7 (0.46)	4.2 (0.50)	4.2 (0.49)	4.8 (0.56)	4.9 (0.57)	4.7 (0.54)	5.1 (0.59)	5.3 (0.61)	-
Romania	2.8 (0.36)	3.3 (0.41)	2.6 (0.31)	2.7 (0.31)	3.0 (0.35)	3.0 (0.35)	2.8 (0.32)	2.6 (0.30)	2.6 (0.30)	-
Slovakia	5.4 (0.69)	5.0 (0.62)	5.1 (0.60)	6.4 (0.74)	7.1 (0.83)	6.4 (0.75)	7.6 (0.88)	7.5 (0.87)	7.2 (0.84)	-

Source: based upon WHO Health for all database 6/2001

stroyed what was probably the main advantage of socialist health care, i.e. its organizational set-up with the coordination and co-operation among individual segments and health care providers (Preker 1994).

Introduction of health insurance

Partly influenced by the self-interest of health ministers with a medical background, partly motivated by the recognition of de-facto low wages in the health care sector in comparison with other sectors and the resulting low incentives, the second line of action was to increase the financial resources available for health care. In 1990, CEE countries only spent between 79 US$ PPP (Romania) and 575 US$ PPP (Czech Republic) or between 6% (!) and 45% of the EU average on health care (Table 1). In relation to the GDP, the health care share was also below EU average in all countries, ranging from 2.8% in Romania to 6.1% in Hungary (Table 2).

Two main roads towards putting more money were pursued, namely the change to a social health insurance (SHI) system based on the Bismarckian model and an increase of the share of private financing. Over the course of the decade, all ten countries – with the debateable exception of Latvia – introduced a SHI model, and the share of private financing increased everywhere, explicitly and visibly through the introduction of co-payments or implicitly and invisibly (in statistics) through under-table payments improving provider income or even guaranteeing the purchase of necessary devices.

Regarding the introduction of SHI, two waves can be clearly differentiated – an early wave with an introduction in 1992/93 and a late wave with an introduction in 1998/99. The early wave consisted of the Czech Republic, Estonia, Hungary, Slovakia and Slovenia, while Lithuania, Romania, Poland and Bulgaria constituted the late wave. Both Lithuania and Romania had already introduced health insurance-type mechanisms in the first half of the 1990s but these had remained very limited in scope. Alongside its Baltic neighbours, Latvia had introduced 35 sickness funds in 1993 and reformed its system from 1998 (e.g. a reduction to 8 funds) but has remained a purely tax-financed system, in which the funds act as spenders of the tax-money (i.e. they actually resemble more health authorities in NHS countries).

Clearly, the introduction of SHI was also influenced by several factors, some valid for all countries, some only for

some. But, for example, the fact that is was dissimilar with the old state-controlled system applied to all countries does not explain the differences – neither does the intention to secure a stable share for health care financing which is independent of a shrinking tax-base. What does explain a part of the pattern is the fact that four of the five „early adopters" are countries within the borders of the former Austro-Hungarian empire which had adopted Bismarck's model of health insurance ("Back to Europe – back to Bismarck" [Deppe & Oreskovic 1996] – Bismarck, by the way, did not invent SHI as he had originally preferred a tax-based system but was forced by parliament to build a system upon the existing sickness funds). In effect, for the Czech Republic, Hungary, Slovakia and Slovenia, the introduction of SHI was „only" a return to the health financing system which had covered a substantial part of the population – but not all – until the introduction of the Semashkov model in the early 1950s. Another factor to be taken into account is the proximity of these countries to Austria and Germany which caused a high visibility of differences in physician income west of the borders, i.e. the attractiveness of the SHI system for physicians was especially strong here, and, given their power (see above), led to this rapid introduction.

Forgotten (or purposely not mentioned) was the fact that not the change from taxes to wage-based contributions or the existence of sickness funds per se guaranteed high levels of physician income but a fee-for-service (FFS) system – which paradoxically Germany had just modified in favour of regional capitation payments in 1989 – in combination with a strong economy/ high GDP. One should, however, not necessarily blame CEE decision-makers for simply regarding FFS as part of SHI, as many health system researchers make the same mistake up to the current day!

While all countries introduced some form of SHI, the forms actually vary quite a lot in respect to the organization of funds, their governance, and contributions. Regarding the organization of funds, four broad types can be differentiated: (1) a single fund for the entire population of a country; (2) single funds serving geographically distinct populations within a country; (3) multiple funds serving the population in the same geographic area but which do not compete for insurees; and (4) multiple competing funds (Normand & Busse 2002). Out of the first wave countries, two – Hungary and Slovenia – went for the first option, one – Estonia – for the second and two – the Czech Republic and Slovakia – for the fourth. In January 2001, Estonia changed to the first model as the 17 sickness funds were regarded as being too small for a country of 1.4 million inhabitants. Two countries of the second wave – Poland and Romania – use a modified version of model three by having in principle regional monoploy funds but additionally one or two country-wide funds, in the case of Romania one for members of the Ministry of Transportation and one for members of the ministries and institutions related to national security (Ministry of Interior, Ministry of Defence, Ministry of Justice, Intelligence Agencies).

Governance of the funds varies widely: While the Hungarian National Health Insurance Fund does not have an elected board and its supervision is shifted on an almost yearly basis between the Ministry of Health, the Ministry of Finance and the Prime Minister's Office (currently it's back with the Ministry of Health), other funds have elected boards and the right to choose their general directors through public competition (Estonia, Slovenia). Most countries have chosen a tripartite structure for their boards, i.e. employers, employees/ members and the government or parliament elect/ nominate one third of the members. In this way, the government retains a double influence over decisions as it is firstly involved in the decision-making process at fund-level and then has to secondly approve those decisions as the supervising institution.

The health insurance system in the CEE candidate countries varies in regard who is collecting the contributions and who pays for non-waged members. The funds collect the contributions, for example, in the Czech Republic, Romania and Slovakia while the national tax agencies are responsible in Hungary and Estonia (where, until 1998, the funds did it themselves). In Slovenia, the health insurance fund legally has the authority to collect but has transferred the actual collection the tax authority. Regarding contributions for non-wage earners, a wide range of options has been chosen: dependants are generally covered through the contribution of the contributing family member (with the notable exceptions of the Czech Republic and Slovakia), other non-wage earners such as the retired are covered for free (Estonia) or for a reduced contribution (Romania). In the Czech Republic and Slovakia, all non-wage earners, i.e. retired, unemployed, housewives, children etc., are individually insured and have their contributions transferred from the general tax-financed budget to the sickness funds. As these contributions were several times smaller than legally required, the reliance on tax-financed contributions proved to be one of the major sources of the financial difficulties in the system. (The governments were, however, not the only contribution-evader as the lower than expected contribution incomes in other countries, for example Bulgaria, demonstrate.)

In all countries where there is more than one (competing or non-competing) fund, risk pooling among them becomes an issue. Risk pooling should ensure that funds with high cost and/ or low-income members subsidise those with low cost and/ or high-income members but it is politically and technically difficult. The base for reallocation (and the formulae used) in CEE countries are still in their infancy. In Romania, for example, only 25% of income of the district health insurance funds is liable to redistribution; in the Czech Republic it is 60%. Only Slovakia has recently changed to a system of reallocating 100%.

The cases of the Czech Republic – and to a lesser extent that of Slovakia – are the most widely publicised in the West. Two aspects are especially often mentioned, namely the drastic increase in expenditure after the introduction of SHI and FFS and the difficulties for the system caused by

multiple funds. Ad 1. There were drastic increases in the first two years by about 2 percentage points of GDP but it may not be forgotten that an increase was intended and that expenditure did not increase further from 1995 (as a percentage of GDP). Ad 2. Not the number of funds per se but the limited degree of regulation caused problems. One aspect was the insufficient reallocation of income (a problem which still exists in the Czech Republic) and the other that both insufficient financial reserves and insufficient management capacities occurred in the case of several sickness funds. In recent years, 18 out of 27 health insurance funds have disappeared from the market. Some of them went bankrupt, while others were abolished by the government for not meeting legal requirements. The causes for these problems were diverse: for example, inadequate underwriting for small funds, high overhead costs for small funds, and too many special programmes (e.g., for the chronically ill, such as asthmatics). Some of the funds merged and others closed down. In recent years, 18 health insurance funds have disappeared from the market. Some of them went bankrupt, while others were abolished by the government for not meeting legal requirements. The causes for these problems were diverse: for example, inadequate underwriting for small funds, high overhead costs for small funds, and too many special programmes (e.g., for the chronically ill, such as asthmatics). The bankrupt funds are also part of the cause for the debts in the system – debts which accumulate as unpaid providers cannot pay their staff or their suppliers. Financial difficulties were concentrated mainly in the hospital sector, where the majority of hospitals were operating at some degree of deficit. The cumulative deficit at the end of 1999 was estimated at 4.2 billion CZK (about 120 million Euro) or approximately 4% of annual health expenditure.

The initial idea that the health insurance funds would compete by offering different services proved to be a mistake. At first, various services were offered in addition to a basic package in the competition for members. However, it became evident that many health insurance funds did not have sufficient funds to cover even basic health care services. Reimbursement of services in addition to the basic package was restricted by law in 1994 and the scope for competition among funds based on supplementary benefits was completely abolished by legislation in 1997. At the same time, regulation on founding and managing funds was also tightened.

Overall, given the complexity of the task – to not only introduce the necessary legislation but to set up the sickness funds, find people managing them, let them collect the contributions from the insured, establish contracts with providers (including length lists necessary for FFS reimbursement) and actually pay them according to these contracts – the introduction of SHI in the early adopters was, however, surprisingly smooth and successful. As mentioned, part of this success was an increase in health care expenditure. In fact, by the end of the decade, spending on health care compared to the EU average had mainly increased in the „early SHI adopters", most visibly in Slovenia which spent 60% of the EU average in 1998 compared to just 24% in 1990. In addition, Poland had experienced an increase in expenditure even before the introduction of health insurance but remained at a rather low level in absolute terms.

Of the early adopters, only Estonia had problems with increasing its health care expenditure. The reason for that was, however, not a failure within the SHI system (e.g. by not being able to collect all contributions) but the economic recession which severely hit Estonia (as well as Latvia and, though on a lower level, Lithuania) and halved its GDP compared to the EU average from 40% in 1990 to 21% in 1995 (Table 3). This decrease could not be compensated as regards health funding via health insurance, especially as Estonia had established a very ambitious SHI funding system by totally relying on wage-related contributions and excluding any tax subsidies – the explicit link between health care expenditure and national economic performance was even an explicit aim when health insurance was introduced.[1]

Regarding the second strand of increasing health care financing, i.e. privatization, data a sparse – in fact many of the publicly available data (including those in Tables 1 and 2) only count public expenditure. That additional private expenditure can be substantial is, for example, demonstrated by Romania where a household survey in 1996 showed that private expenditure added ca. 40%, i.e. that the percentage of GDP was 4.1% instead of 2.9% (Marcu & Butu 1997).

One of the issues most often mentioned when it comes to rising costs are pharmaceuticals. The size of the problem is then usually expressed in percent, i.e. how much of total health care expenditure is spent on health. Where such data are available, they do look impressive (Table 4): The share is around 25% in the Czech Republic, Hungary and probably Slovakia – but has, due to cost-containment measures, remained rather stable at that level since the early or mid-1990s. In other countries with available longitudinal data – Estonia, Romania and Slovenia – the share has risen constantly, with current values around 20%.

While such expenditure levels do indeed present a challenge for health policy and sickness funds, several factors tend to be overlooked in the discussion: First, such levels are not unusual for some EU countries. Second, the drug market has changed substantially since 1989/90. In Slovakia, for example, domestic production accounted for about 80% of drug consumption. This has fallen to 17.6% and Slovak-owned pharmaceutical companies produce only 11% of the domestic drug market. In Romania, the retail value of market for domestic products was expected to grow from US$ 169 million in 1998 to US$ 210 million in 2000 but imported products were expected to grow from US$ 195 in 1998 to US$ 348 million in 2000, i.e. increasing their market share from 54% to over 62%.

Table 3: Gross Domestic Product in US$ purchasing power parities per capita and ratio to EU average

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
EU average	16057	16344	17284	17384	18203	19474	20046	20589	21339	22086	-
EU country with lowest GDP (Greece)	9239 (0.58)	9883 (0.60)	10695 (0.62)	11066 (0.64)	11737 (0.64)	12834 (0.66)	13367 (0.67)	13560 (0.66)	14095 (0.66)	14740 (0.67)	-
Czech Republic	11532 (0.72)	9558 (0.58)	9780 (0.57)	10440 (0.60)	11003 (0.60)	12378 (0.64)	13026 (0.65)	13149 (0.64)	13004 (0.61)	13125 (0.59)	- [0.60]
Estonia	6438 (0.40)	8090 (0.49)	6690 (0.39)	3803 (0.22)	4294 (0.24)	4062 (0.21)	-	-	7682 (0.36)	- [0.36]	- [0.38]
Hungary	8359 (0.52)	7407 (0.45)	7683 (0.44)	7979 (0.46)	8308 (0.46)	8973 (0.46)	9229 (0.46)	9735 (0.47)	10373 (0.49)	10968 (0.50)	- [0.52]
Poland	4899 (0.31)	4500 (0.28)	4993 (0.29)	5330 (0.31)	5809 (0.32)	6963 (0.36)	7339 (0.37)	7272 (0.35)	7704 (0.36)	8079 (0.37)	- [0.39]
Slovenia	-	9159 (0.56)	8901 (0.51)	9205 (0.53)	9976 (0.55)	12500 (0.64)	13200 (0.66)	14100 (0.68)	14293 (0.67)	- [0.71]	- [0.72]
Bulgaria	4700 (0.29)	4813 (0.29)	4250 (0.25)	4320 (0.25)	4533 (0.25)	4604 (0.24)	-	4010 (0.19)	4809 (0.23)	- [0.22]	- [0.24]
Latvia	6457 (0.40)	7540 (0.46)	6060 (0.35)	3070 (0.18)	3178 (0.17)	3297 (0.17)	-	3940 (0.19)	5728 (0.27)	- [0.27]	- [0.29]
Lithuania	4913 (0.31)	5410 (0.33)	3700 (0.21)	3110 (0.18)	4011 (0.22)	3843 (0.20)	-	4220 (0.20)	6436 (0.30)	- [0.29]	- [0.29]
Romania	2800 (0.17)	-	2840 (0.16)	3727 (0.21)	4037 (0.22)	4431 (0.23)	4580 (0.23)	4310 (0.21)	5648 (0.26)	- [0.27]	- [0.27]
Slovakia	-	-	6690 (0.39)	6400 (0.37)	6800 (0.37)	7400 (0.38)	8200 (0.41)	8900 (0.43)	9699 (0.45)	- [0.49]	- [0.48]

Source: based upon WHO Health for all database 6/2001; data in [ ] are from DG Enlargement (11/2000 and 11/2001)

In short, the pharmaceutical sector is an area which is dominated by western products at western prices, i.e. it cannot be measured in the same way as, for example, hospital services where the bulk of expenditure is for local personnell working at local salary levels. In absolute numbers (i.e. in US$ PPP), the Hungarian pharmaceutical expenditure in 1996 at 174 US$ exactly equalled that of Denmark in 1997, i.e. that of the EU country with the lowest percentage. The Czech Republic spent 238 US$ in 1998 while Portugal spent 319 and France even 446 (and also more than 20% of total expenditure). CEE countries have tried alomst the whole array of measures used in western EU countries to cost-control this area: co-payments, negative and positive lists, reference prices, reducing profit margins for whole-salers and pharmacies etc. As long as the gap in GDP between western pharmaceutical producing countries and consuming countries in CEE is as large as is it, the problem will not go away though (and even with higher GDPs, pharmaceutical expenditure will remain a worry). Overdoing cost-containment in this area by delisting effective drugs or mandating co-payments which effectively prevent people from using drugs would be counter-productive and risk the benefits achieved by pharmaceuticals. Both in the Czech Republic and Hungary (but not in Slovenia), therapeutic control of hypertension has, according to the EUROASPIRE studies (EUROASPIRE I and II Group 2001), improved drastically between 1995-96 and 1999-2000, from 38% to 54% in the former and from 49% to 59% in the latter – compared to only 49/ 45% in France, 44/ 47% in Finland or 42/ 34% in Germany.

Table 4: Expenditure on pharmaceuticals in % of total expenditure on health (EU average not available)

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
EU country with lowest % (Denmark)	6.6	8.1	8.4	8.3	8.5	8.5	8.4	8.5	9.2	9.1
EU country with highest % (Portugal)	24.9	24.3	24.7	25.6	25.2	25.2	26.3	26.9	25.8	-
Czech Republic	21.0	18.4	21.1	19.4	24.7	25.6	25.5	25.3	25.5	25.1
Estonia	-	-	-	-	-	-	17.0	17.0	16.6	21.9
Hungary	5.0	27.3	26.3	28.2	28.2	25.0	26.3	-	-	-
Poland	-	-	-	-	-	-	-	-	-	-
Slovenia	10.4	13.8	12.9	15.3	19.5	18.9	17.4	17.9	18.9	19.0
Bulgaria	-	-	-	-	-	-	-	-	-	-
Latvia	-	-	-	-	-	-	-	-	-	-
Lithuania	-	-	-	-	-	-	-	-	-	-
Romania	-	-	11.0	14.0	18.0	17.0	19.0	17.0	20.0	-
Slovakia	16.8	18.1	23.6	-	-	-	-	-	-	-

Source: based upon WHO Health for all database 6/2001

Planned reduction of health capacities

Part of the Soviet legacy in most CEE countries were rather high numbers of certain health care inputs, especially hospital beds. With the exception of Poland and Slovenia, number of beds in acute care hospitals were about one third to 100% above the EU average (Table 5) – with the exception of the Baltic republics not higher than in Germany, though. This high number of beds in conjunction with the often outdated infrastructure necessitating renovations should have made a capacity reduction a priority in most countries.

In reality, though, only Estonia and Romania – and to a lesser extent Latvia – tackled this issue in the first few years. Estonia started to reduce its hospital capacities as early as 1992; a second noticeable decrease occurred in 1994 when accredition of hospitals was introduced and a significant number of hospitals failed to meet the criteria for acute-care provision and were turned into nursing homes. At the same time, Estonia pursued a careful autonomisation of its public hospitals by transferring some of them

Table 5: Number of beds in acute care hospitals per 1000 population an ratio to EU average

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
EU average	5.32	5.40	5.30	5.14	5.03	4.91	4.82	4.65	4.65	-
EU country with highest number (Germany)	-	8.3 (1.54)	8.1 (1.53)	7.7 (1.50)	7.6 (1.51)	7.5 (1.53)	7.3 (1.51)	7.1 (1.53)	7.0 (1.54)	-
Czech Republic	8.1 (1.52)	8.1 (1.50)	7.9 (1.49)	7.6 (1.48)	7.4 (1.47)	6.9 (1.41)	6.7 (1.39)	6.6 (1.42)	6.5 (1.43)	6.3
Estonia	9.2 (1.73)	8.1 (1.69)	7.6 (1.43)	7.4 (1.44)	6.3 (1.25)	6.4 (1.30)	5.9 (1.22)	6.1 (1.31)	6.0 (1.32)	5.6
Hungary	7.1 (1.33)	7.1 (1.31)	7.0 (1.32)	7.1 (1.38)	7.2 (1.43)	6.3 (1.28)	6.3 (1.31)	5.8 (1.25)	5.8 (1.27)	5.7
Poland	6.6	6.5	6.4	6.4	6.3	6.3	6.2	6.1	6.0	-
Slovenia	5.0 (0.94)	5.0 (0.93)	4.9 (0.92	4.84 (0.93)	4.8 (0.95)	4.8 (0.98)	4.7 (0.98)	4.7 (1.01)	4.6 (1.01)	4.6
Bulgaria*	9.8	9.8	10.2	10.5	10.2	10.4	10.5	10.3	8.4	7.5
Latvia	-	-	-	-	-	-	-	-	6.6 (1.45)	6.4
Lithuania	-	-	-	9.5 (1.84)	9.0 (1.79)	8.7 (1.77)	8.4 (1.74)	7.4 (1.59)	6.7 (1.47)	6.4
Romania*	8.9	8.9	7.9	7.9	7.7	7.6	7.6	7.4	7.3	7.3
Slovakia	7.4 (1.39)	7.6 (1.41)	7.6 (1.43)	7.9 (1.54)	7.1 (1.41)	7.5 (1.53)	7.5 (1.56)	7.3 (1.57)	7.1 (1.55)	7.0

** beds in all hospitals, therefore no ratio to EU average is given*
Source: based upon WHO Health for all database 6/2001

into joint-stock companies or not-for-profit foundations working under private law (Jakab et al. 2002).

In Romania, the number of hospital beds was reduced by 28,000 or more than 10% from 1991 to 1992. At that time, the Ministry of Health performed a significant, planned reduction of hospital capacity. The beds targeted for reduction were the excess ones in departments with low bed occupancy. Low occupancy was the result of both the blockage of the overcentralized decision-making process in the 1980s (resulting in the stable number of beds before) and of changes in health care demand in the early 1990s as consequences of the social and economic transition. The most striking examples of the latter category were the drop of the birth rate after the legalization of abortions and the provision of contraceptives and the decrease of admissions of children to hospitals. The latter can be partly explained by: 1. changed legislation, giving mothers the right to care for their children up to the age of two and receiving a financial allowance during that period, instead of only one year and with very little support previously; and 2. some improvement of living conditions at home, affecting children health, due to abolishing restrictions to supply of heating and electricity, which were very common in the late 1980s. As a result of decreased demand, occupancy rate of paediatric beds, for example, was below 50% in 1991 and some of the largest reductions – more than 9,000 beds, i.e. over 25% of 1991's capacity – occurred here.

The Czech Republic and Slovakia, at the other extreme of the spectrum, a reduction of hospital capacities as a result of planning was no priority. If the problem was seen, it was believed that the other two measures – i.e decentralisation with or without privatization and the health insurance system – would solve it. This was clearly not the case. While in the Czech Republic some hospitals were privatized in the 1990s with the number of private beds rising from 0.3% in 1992 to 9.4% in 1997 (and to 10.0% in 2000), these were mostly small hospitals – as money was not available for larger investments and hospitals were not a promising field for private investors –, i.e. privatization did not address the capacity problem. This was only addressed when governmental priorities (due to a change in government) changed in the mid-1990s. The targets are to reduce acute beds to 5 per 1000 population and to increase long-term beds to 2 per 1000. The 2000 figures show that progress is being made with one-third of the reduction already achieved. Leaving aside political issues about closing hospitals, 5.0 beds per 1000 could accommodate the current population of hospital patients assuming an 85% instead of 70% occupancy level. At the same time these measures were decided upon, the process of privatising hospitals came to a stop and is unlikely to resume in the near future (Busse et al. 2001).

Possibly ironically, the new social-democrat government in Romania regards the privatization of medical care facilities, including hospitals, as a means to increase health care efficiency. It intends to privatise 25% of the facilities owned by the Ministry of Health and Family. Private hospitals may be for-profit and the aim of privatization is to take the burden of financing from the state, hoping that private property will bring incentives for efficiency (Busse & Dolea 2001). If this „privatization" will mean incorporating public hospitals under private law (the Estonian approach), then this could be successful – if it means privatization to private investors (the original Czech approach), then doubts seem to be justified.

Population health status

From a public health perspective (but not from the policy-makers' perspective in the early 1990s), the health status – and especially the trends in its development – constitute another challenge for the CEE countries. In 1990, life expectancy was between between 69.6 years in Latvia and 74.1 years in Slovenia, with only the latter reaching the level of the EU country with the lowest level (Table 6). The gap in life expectancy to the EU average was therefore between 6.9 years and 2.4 years. But instead of improving, the situation got – in six of the ten countries – worse in the early 1990s. Life expectancy dropped by up to one year in Hungary and Romania, by 1.2 years in Bulgaria, by 2.8 years in Lithuania, by 2.9

years in Estonia and even by 4 years in Latvia. The lowest point was reached at different times during the 1990s, varying from as early as 1992/93 in Hungary via 1994 in the Baltic republics to as late 1996 in Romania and 1997 in Bulgaria, thereby closely following the economic situation (cf. Table 3).

In 1997, life expectancy in the CEE candidate countries was therefore as much as 8.9 years below EU average, while Slovenia as the other end of the spectrum still only reached the level of the EU country with the lowest level. Compared to the EU average, life expectancy over the course of the 1990s has actually only improved in the Czech Republic where the gap was reduced from 5 to 4 years. In four countries (Hungary, Poland, Slovakia, Slovenia), it has increased in line with the EU average, but five countries have seen a relative decline (Table 6).

Table 6: Life expectancy at birth in years and ratio to EU average

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
EU average	76.5	76.6	77.0	77.0	77.5	77.6	77.8	78.1	-	-
EU country with lowest life exp. (Portugal)	74.0 (0.97)	73.9 (0.96)	74.5 (0.97)	74.3 (0.96)	75.2 (0.97)	75.0 (0.97)	74.9 (0.96)	75.3 (0.96)	75.4	-
Czech Republic	71.5 (0.93)	72.1 (0.94)	72.4 (0.94)	73.0 (0.95)	73.2 (0.94)	73.1 (0.94)	74.0 (0.95)	74.1 (0.95)	74.8	74.9
Estonia	70.0 (0.92)	69.8 (0.91)	69.2 (0.090)	68.3 (0.89)	67.1 (0.87)	68.0 (0.88)	70.3 (0.90)	70.5 (0.90)	70.2	71.1
Hungary	69.4 (0.91)	69.5 (0.91)	69.1 (0.90)	69.1 (0.90)	69.5 (0.90)	96.9 (0.90)	70.4 (0.90)	70.8 (0.91)	70.7	70.8
Poland	71.0 (0.93)	70.7 (0.92)	71.2 (0.92)	71.7 (0.93)	71.8 (0.93)	72.0 (0.93)	72.4 (0.93)	72.8 (0.93)	73.1	73.2
Slovenia	74.1 (0.97)	73.7 (0.96)	73.8 (0.96)	73.6 (0.96)	74.2 (0.96)	74.9 (0.97)	75.2 (0.97)	75.3 (0.96)	75.4	75.8
Bulgaria	71.5 (0.93)	71.5 (0.93)	71.2 (0.92)	71.2 (0.92)	70.8 (0.91)	71.0 (0.91)	70.9 (0.91)	70.3 (0.90)	70.9	71.7
Latvia	69.6 (0.91)	69.2 (0.90)	68.6 (0.89)	66.7 (0.87)	65.6 (0.85)	66.4 (0.86)	68.8 (0.88)	69.4 (0.89)	69.9	70.6
Lithuania	71.6 (0.94)	70.7 (0.92)	70.5 (0.92)	69.1 (0.90)	68.8 (0.89)	69.4 (0.89)	70.6 (0.91)	71.5 (0.92)	71.09	72.4
Romania	69.8 (0.91)	70.1 (0.92)	69.6 (0.90)	69.5 (0.90)	69.04 (0.90)	69.4 (0.89)	68.9 (0.89)	69.2 (0.89)	69.9	70.6
Slovakia	71.1 (0.93)	71.1 (0.93)	72.1 (0.94)	72.6 (0.94)	72.5 (0.94)	72.5 (0.93)	73.0 (0.94)	73.0 (0.93)	72.8	72.0

Source: based upon WHO Health for all database 6/2001

While looking at average life expecancy, it should not be forgotten that this value hides even more worrying developments for certain population groups (i.e. middle-aged male in the Baltics). It is also used here only as an indicator for overall population health status; the existence of health status problems in almost all CEE candidate countries are, however, supported by most key indicators in comparison to the EU average. Infant mortality, for example, is significantly higher in all CEE candidate countries, with the exceptions of Slovenia and Czech Republic, extending to over three times the EU average in Romania.

One problem deserving closer attention is the fact that the introduction of health insurance in the CEE countries led to a wider than necessary and beneficial gap between health services (funded through health insurance and provided by contracted providers) and public health (still tax-financed and government-run, albeit usually decentralized).

Accession to the European Union

In the second half of the 1990s, institutional development in the CEE countries was to a large degree shaped by the planned accession to the European Union. Many health policy-makers focused exclusively on the aspects of EU accession to the detriment of the endogenous problems of their country. Now the topic of accession often serves to promote vested interests, which are falsely claimed to be necessary for the accession to EU, one example of which is the necessity to install a system of private health insurance.

In March 1998, accession negotiations were formally opened with six countries: the Czech Republic, Estonia, Hungary, Poland, Slovenia and Cyprus (so-called „Luxembourg group"). The process was widened in February 2000 to include six additional candidates: Bulgaria, Latvia, Lithuania, Malta, Romania and the Slovak Republic (so-called „Helsinki group"). While groups of countries have started the negotiation process, this does not imply that negotiations will be concluded at the same time.[2]

To accede to the European Union, candidate countries must be able to comply with the 'Copenhagen criteria'. The criteria outline three areas: stability of institutions guaranteeing democracy; the existence of a functioning market economy and capacity to cope with competitive pressure and market forces; and the ability to take on obligations of membership including political, economic and monetary union. Table 3 summarises the economic development of the ten CEE candidate countries over the 1990s, expressed as GDP in purchasing power parities per capita and as a ratio to the EU average. Possibly surprisingly, two of the economically strongest countries, the Czech Republic and Hungary, are still where they were in 1990/91, i.e. at 60% and 52% of EU average respectively. The same is true for the Baltic republics Estonia and Lithuania, while Latvia's position has, together with Bulgaria's, actually decreased. Relative to the EU average, GDP per capita has only improved in four countries: Romania (to 27%, i.e. still a very low level), Poland (to 39%), Slovakia (to 48%) and Slovenia (to 72%, i.e. a level higher than that of Greece). Table 3 also demonstrate that Slovakia, which was excluded from the first group of candidate mainly due to political reasons, actually occupies economically a middle position if compared to the countries in that group while the GDP of the other four countries in the second group is still below 30% of EU average.

Formally, the *accession negotiation* process takes the form of bilateral intergovernmental conferences between each of the candidate countries and the EU member states and focuses specifically on the terms under which candidate countries adopt, implement and enforce the *acquis communautaire*. The „acquis" is a term that defines the whole body of Community legislation that has accumulated since the Treaty of Paris establishing the European Coal and Steel Community in 1951. It includes the provisions of the Treaties, all regulations and directives passed by the Council of Ministers, and the judgements of the European Court of Justice. In order to access to the European Union, candidate countries have to adopt the acquis. The acquis contains more than 80,000 pages of legal texts and is organised by 31 chapters.[3] The Commission proposes common negotiation positions for the EU for each chapter which is to be approved unanimously by the Member States. Negotiation sessions are held by the foreign ministers or deputies of EU member states and ambassadors or chief negotiators for the candidate countries. Results of negotiations are incorporated into a draft accession treaty which is submitted to the Council of Ministers for approval and the European Parliament for assent. The treaty is then submitted to EU Member States and candidate countries for ratification. When the treaty takes effect, the candidate country becomes an EU Member State.

The health ministries of candidate countries do not usually participate in the negotiation processes. Yet, there are acquis, sometimes referred to as „health acquis", that relate to health and health care. The „health acquis" is scattered amongst all the different chapters, mostly in chapter 1 (free movement of goods), chapter 2 (freedom of movement for persons), chapter 3 (freedom to provide services), chapter 7 (agriculture), chapter 12 (statistics), chapter 13 (social policy and employment), chapter 17 (science and research), chapter 18 (education and training), chapter 21 (regional policy and coordination of structural instruments), chapter 22 (environment) and chapter 23 (consumers and health protection).

A recently concluded study has assessed the „health acquis" in the area of the Single European Market (i.e. the first chapters of the acquis). In its first phase, it analysed the „interventions" of Community policy and the European Court of Justice (ECJ) in relation to the four Single Market freedoms with at least potential effects on the health systems of the Member States in terms of the number of interventions, their frequency and timing, and the regulation density for various health service sub-categories. The results can be summarised as follows (Wismar & Busse 2002):

- The creation of the European dimension in the health service did not first come about with the widely publicised ECJ rulings on Decker and Kohll in April 1998, but was commenced directly on the formation of the European Economic Community through the Treaty of Rome in 1957.
- Since the 1970s, the frequency of interventions has become more dynamic and peaked in the first half of the 1990s.
- In total, a substantial number of some 250 interventions with at least potential effects on the health systems of the Member States could be identified. About two thirds originate from Community policy and one third from the ECJ.
- The interventions which have potential effects on the health systems of the Member States are usually based on powerful instruments, particularly directives[4] and requests for preliminary rulings[5].
- The regulation density is particularly high as regards the free movement of persons and goods. The interventions affect the EU-wide labour market for physicians, dentists and other occupations in the healthcare sector on the one hand, and short-term and long-term visits by tourists, employees etc. on the other. The intervention density as regards the free movement of goods can mainly be explained on the basis of the markets for pharmaceutical products. On the whole, the supply side is affected by more interventions than the demand side.

Table 7 provides a glimpse of the number of issues and EU directives regulating the pharmaceutical market as part of the „free movement of goods". All mentioned directives have to be transposed into national legislation – and to actually implemented. Several directives (83/570/EEC, 87/22/EEC) during the 1980s were intended both to develop a mutual recognition system and to initiate a process for shaping a single procedure for approval of new drugs for the entire EU market. Overall, the harmonisation process was considered to be too slow and after several years of co-operation between national approval agencies at European Union level, the EU Council adopted Directive 93/39/EEC, which replaced or changed Directives 65/65/EEC, 75/318/EEC and 75/319/EEC. In June 1993 Council regulation 2309/93/EEC provided the legal basis for the establishment of a new European system for the authorisation of medicinal products. The European Medicines Evaluation Agency (EMEA) was established in 1995 in London. This new organization involves centralisation and stronger co-ordination of the approval and safety procedures (Rehnberg 2002). New pharmaceuticals approved by EMEA are licensed via an EU decision and may be marketed throughout the EU, including obviously any new Member States after their accession.

The main directive addressing the issue of harmonisation of prices and reimbursement (89/105/EEC) is, however, rather vague. It relates to the transparency of measures regulating the prices of medicinal products for human use and their inclusion in the scope of national health insurance systems. Regarding the latter, the directive requires that objective and verifiable criteria are used for the decisions to include a drug on a national Drug Benefit System (Rehnberg 2002). While this would ensure national autonomy over the decision to not include a EMEA-licensed drug into the benefits' catalogues, it may be expected that it will be difficult for a CEE country to find „verifiable criteria" excluding a drug if it has been included in (all) western EU Member States, i.e. the cost pressure in the pharmaceutical sector will even grow after accession.

Table 7: Mafor directives and regulations affecting the movement of drugs

Area of invervention	Direktives (excluding replaced directives)	Other EU regulations
Market authorisation and safety	83/570/EEC; 87/22/EEC; 93/39/EEC changing 65/65/EEC; 75/318/EEC and 75/319 EEC	Council regulation 2309/93/EEC
Distribution of drugs and public producement	65/65/EEC; 87/21/EEC; 91/356/EEC; 92/25/EEC 92/26/EEC; 92/27/EEC, 93/36/EEC; 93/37/EEC	
Price control, regulatin and trade of drugs	89/105/EEC for price control and reimbursement	Treaty of Rome (Articles 23 and 24), verdicts from ECJ regarding trade an distribution

In the area of the free movement of workers and other individuals, no directives have to be transposed into national legislation, but the Community's coordination rules require technical adaptation of legislation. For example, Regulations 1408/71 and 574/72 will become directly applicable and binding in the new Member States. Its means that at the moment of becoming a Member State the national social security administrations and institutions should be ready to implement EU law effectively.

At the same time the administrative capacity to implement the coordination rules is one of the cornerstones for the effective operation of the regulations. Community coordination of national social security laws does not just require correct, consistent interpretation of the underlying rules, as provided by the case-law of the Court of Justice: to be effective, it also relies on the cooperation of the authorities and institutions of the Member States. In other words, the principle of mutual administrative assistance is the key to the smooth running of the machinery of coordination.

Administrative procedures with regard to the abovementioned legal requirements of EU coordination rules are quite complicated. The model forms drafted by the Administrative Commission of the European Communities on Social Security for Migrant Workers for implementing the regulations are practical measures likely to affect the implementation. In some applicant countries there is a lack of experience dealing with the forms even if bilateral agreements on social security exist.

The key issue in the field of sickness and maternity is that an individual who is entitled to benefits in kind in one Member State obtains these benefits for himself and his family even in case of a temporary stay or residence in the territory of another Member State. Thus the entitled person pays contributions in one Member State according to its effective legislation while being able to obtain benefits in kind in another Member State according to the laws of that country. The regulations entitle employed or self-employed person to obtain benefits in kind in one country while residing and/ or working in another. He and the family has right to obtain benefits in both countries even when the family members do not actually reside in the same country as the employed or self-employed individual himself. There are somewhat different, complementary provisions for frontier workers, the unemployed, pensioners and their families.

Article 22(1)(a) of Regulation 1408/71 provides that insured employed and self-employed persons and their family members have the right to immediate benefits during a temporary stay within the territory of another Member State (using the so-called E-111 form). Most obviously, this relates to unexpected reasons and emergency or urgent care resulting from these. On the other hand, many chronic – i.e. preexisting – diseases can become "acute" (or simply requireing continuous treatment) and thresholds are difficult to define. The ambiguity of this point provides some basis for cross-border "consumer choice" for medical services of higher quality.

Possibly even larger (financial) problems for CEE countries will arise in cases in which the employed or self-employed person has obtained permission from the competent institution to go to another Member State to receive there the treatment appropriate to his condition (Article 22(1)(c) of Regulation 1408/71; requiring the use of the E-112 form). This permission cannot be refused where the treatment in question is among the benefits provided for by the legislation of the Member State, where he resides and where he cannot be given such treatment within an appropriate time in the Member State of residence, taking into consideration the state and progress of the disease. This regulation statement therefore could constitute a driver for patient streams towards systems of higher quality and/ or shorter waiting lists. This may result in a difficult situation for the competent State's insurance system, especially if the stream of patients were to become voluminous, given the difference in expenditure.

The problematic areas concerning pensioners should also be analysed briefly. Regulating health and sickness insurance is mainly initiated from the principle that a pensioner will get benefits where he is insured and resides. However, if the pensioner were to live in another Member State where he is not entitled to pension and benefits, he shall nevertheless receive such benefits for himself and for the members of his family insofar as he would be entitled thereto under the legislation of the Member State competent in respect of pensions if he were resident in the territory of such State. Guaranteeing such benefits solves the situation where the pensioner has started to reside into a country where the basis for benefit paying is primarily residence. Expenses in the above mentioned cases will be covered by the competent institution guaranteeing the insurance and the money is transferred. Further attention should be paid to Article 31 of the Regulation stating that pensioners and their family members are entitled to benefits even when they stay but not reside in another Member State.

Attention should be paid to reimbursement principles. Generally, benefits in kind provided in another country will be covered by the competent country using the fee-schedule or costs in the country of treatment. This can be done either on proof of actual expenditure or on the basis

of lump-sum payments. In case of actual expenses the methodology of performed accounting becomes important. If this cannot be done, the refund is based on the lump-sum method. Article 36(3) of the Regulation provides for other methods or may waive all reimbursement between institutions under their jurisdiction. This phrasing provides a remarkable opportunity for CEE countries. Obviously, the current Member States are also aware of the dangers involved. In that respect, a consensus on a waiver between Estonia and, for example, Portugal will be, due to distance and accordingly low numbers of services provided, easy to reach – which will not necessarily be the case between Poland and Germany or Hungary and Austria.

The main problem for this area – as many others – is that expenditure on health care services in the EU countries is (still) significantly higher than in CEE countries, so that any reimbursement from East to West will most likely result in higher expenditure for the sickness funds in the CEE countries. If waiver agreeament could be reached, they would have similar implications for the current EU member states when candidates accede.

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Not seperately referenced are the „Health Care Systems in Transition" profiles, published by the European Observatory, on Bulgaria (1999), Czech Republic (2000), Estonia (2000), Hungary (1999), Latvia (2001), Lithuania (2000), Poland (1999), Romania (2000), Slovakia (2000) and Slovenia (2001).

Footnotes

1 The common assumption that SHI countries „automatically" rely mainly on wage-based contributions to finance their health systems has to be questioned. In international statistics on sources of health care funding it is often unclear whether expenditure through taxation includes tax-financed payments to the SHI financing system or whether these are included as SHI expenditure. To estimate the degree to which countries rely on SHI wage-based contributions, two factors have to be combined therefore: the percentage of SHI income through contributions and the percentage of overall health expenditure covered through SHI (Normand & Busse 2002). In some CEE countries, the need to consider both factors becomes very clear. For example, while in both the Czech Republic and Slovakia the state pays contributions for all non-waged persons, representing more than 50% of the population as this group includes not only pensioners and the unemployed, but also non-working spouses and children (i.e. persons covered as dependants in western Europe), wage-related contributions cover around 65% of total health care expenditure, i.e. as much or even slightly more than in Germany or the Netherlands and more than one and a half times as much as in Belgium. This apparent contradiction is due to the very low contributions the state is making (constituting a major source for the financial difficulties in those countries). Estonia's corresponding value was 68% in 1998 while Lithuania's was well below 50% and that of Latvia 0%.

2 For comparative purposes, the tables accompanying this text differentiate beween the two groups (but exclude Cyprus and Malta).

3 The 31 thus constitute the total when the European Commission publishes data on how many chapters have been „opened" and „closed" (i.e. negotiations have been concluded) in the term of the negotiation process. In November 2001, the number of „opened" chapters was 29 for all CEE candidates but Bulgaria (23) and Romania (17) while the number of „closed" chapters varied between 22 (Hungary) and 18 (Latvia, Lithuania and Poland) in these eight countries.

4 Community policy has five instruments. The weakest instrument are Recommendations which are generally addressed to all Member States and thus have a universal character. However, this instrument is not binding in any way. Other resolutions are binding, but are exclusively addressed to the institutions and the administration of the EC. These resolutions have no potential direct effect on health services. Decisions have a universal character and are binding. However they regulate individual cases and not general matters. The instruments which are really relevant and which have a binding, general and universal character are directives and regulations. Directives define an objectives. The means employed to achieve it are a matter for the Member States. Regulations harmonise not only the political objectives, but also the means and can thus be regarded as the most powerful instrument in Community policy (Wismar & Busse 2002).

5 Of the six instruments of the ECJ, four are only only of minor significancesignificance for this areaquestion, i.e. proceedings for annulment, proceedings for failure to act and actions for damages always relate to the actions or the failure to act of the Community institutions or to their failure to act and not directly to the Member States. The same applies with regard to the actions of to appeals heard by the ECJ for remedies. The instruments of the ECJ relevant to this area are the request for a preliminary ruling and proceedings for failure to fulfil Treaty obligations. Both types of proceedings are engines of European integration. One is aimed at bringing about a harmonisation of interpretation and application of Community law and the other at enforcing its implementation in the Member States. Requests for a preliminary have the objective of bringing about a consistent interpretation and application of EC law throughout the whole of the Community. Only courts of the Member States may request a preliminary ruling from the ECJ. This will be the case if the outcome in a national case is largely dependent on Community law. The ECJ decides how European law should be interpreted with binding effect. The ruling on interpretation is returned to the national court which then has to apply the law as it has been interpreted by the ECJ. The request for a preliminary ruling is therefore a very important hinge between EC law and the national courts. This hinge function is intended to make national courts „guardians of Community law" (Wismar & Busse 2002).