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WHY HAS PUBLIC SPENDING ON HEALTH REMAINED HIGH IN THE TRANSITION COUNTRIES OF CENTRAL AND EASTERN EUROPE DESPITE FALLING TOTAL GOVERNMENT EXPENDITURE?

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Abstract

This paper accounts for divergent levels of public health spending in Central Europe from 1991 to 2000 in terms of inherited distortions, domestic fiscal constraints, and international involvement. Panel regression analysis confirms that a communist past has precipitated higher levels of public health spending that income level, government size, or demography would predict. Cross-country regressions suggest that after a decade of transition, government size still explains much variance and that Central Europe has shown no single model of health finance. Two case studies evaluate national reform experiences with fiscal and external pressures in light of a common legacy of high welfare state spending. Whereas Poland experienced a steady drive to lower health spending fueled by intra-governmental conflict and perceived fiscal pressures from the EU, Croatia maintained high public health spending owing to mandatory insurance contributions substituted for budget sources and World Bank neglect of programmatic health planning. Though distortions from the communist period left transition countries with high initial public commitments to health, considerable national autonomy exists to confront this legacy within the confines of unique national fiscal constraints and differing relationships with the international community.

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O n e

Introduction

Once heralded as among communism's greatest victories, publicly funded and universally accessible health care has become to many Central European reformers, politicians, and observers a key impediment to market reform. A decade of recession and dwindling government capacity has yet to erase unusually high levels of public health spending in transition economies despite oscillating prosperity, shrinking government, and growing distrust in the redistributive function of government on the heels of the communist experience. Though faced with fiscal constraints and pressures from the international community to curb spending, Central European governments have retained considerable autonomy to either perpetuate high health spending or reshape health finance based chiefly on domestic considerations.

This paper accounts for levels of health spending financed through the national budget in Central Europe from 1991 to 2000 in terms of inherited distortions, domestic fiscal constraints, and pressures from international observers such as the European Union and World Bank. While distorted government sizes from the communist period could

almost fully explain high spending in 1991, unique fiscal constraints and international obligations are necessary to explain either the persistence or reversal of high public health spending by 2000. Conspicuously absent from the "Washington consensus" holy trinity (stabilization, privatization, and liberalization) health finance reform has proceeded slowly owing to inherent complexities – the wide network of concerned actors, the multiple veto points within the system, the seemingly low costs of politicians of delaying action, and the intrinsic slowness of recasting public expectations of social services (Nelson 1997). Yet fifteen years into post-communist transition, sufficient time has elapsed for datasets to allow meaningful cross-country comparisons not just between Central Europe and the Former Soviet Union but among the diverse reform cases of Central Europe.

Despite a common legacy of centralization of finance and delivery, hierarchical decision-making, and state paternalism (Kornai and Eggleston 2001, 62), the first decade of transition has shown no signs of a Central Europe model of public health spending. The most advanced reformers have experimented with medical insurance programs financed through payroll taxes consistent with an OECD model (Åslund 2002, 322-3) and attempted to influence EU accession prospects by unilaterally struggling to keep budget deficits within 3% of GDP as stipulated by the Maastricht convergence criteria. Less-advanced and less-dedicated reformers have conversely struggled to finance even basic health services with minute state revenues while pushing through neo-liberal reforms demanded by foreign lenders. Understanding how fiscal constraints and international pressures against a legacy of high public health spending have yielded diverse national finance models can both offer a road-map to less-advanced transition countries seeking to benefit from the experience of successful reform cases and empower reformers to pursue policies in line with social choices despite a legacy of high public health spending.

This paper follows the following structure. Section 2 justifies this study by arguing that Central European countries have devoted higher shares of national budgets to health from 1991 to 2000 than income level, government size, or demography predict. Section 2.1 reviews existing literature while sections 2.2 and 2.3 supplement this literature with panel regressions stressing inherited distortions of high public health spending and cross-country regressions that conclude no Central European health finance model has emerged. Section 3 considers the divergent national experiences of Poland and Croatia. Whereas a domestic push for decentralization coupled with perceived fiscal pressures from the EU steadily lowered Poland's high health spending over the first decade of reform, Croatia has maintained high public commitments to health owing to compulsory insurance contributions and neglect of programmatic health planning from the international lending community. Section 4 concludes by reconsidering the extent to which health spending can reflect public choices.

T w o

Has public spending on health in transition countries been high?

Assessing the uniqueness of transition health finance

This section analyses both earlier literature on health finance reform in transition and presents empirical evidence that the transition countries of Central and Eastern Europe have in general seen larger public commitments to health spending than more developed market economies of either the EU or OECD. I augment previous empirical work on transition health finance by considering an expanded dataset of all post-communist countries (for which data are available) rather than simply the most advanced OECD members or EU accession countries. Panel regressions indicate that controlling for income level, government size, and demographics, a communist past has consistently precipitated higher public health spending than control variables would predict. To assess the dynamic uniqueness of health spending as transition has progressed, I consider two separate cross-country regressions employing 1991 and 2000 data, respectively. From these cross-country regressions, I conclude that a decade into the transition, initial distortions in government size continue to prompt high public health spending though

the magnitude of this distortion has fallen remarkably. Moreover, I conclude that while the Former Soviet Union has clearly diverged as a region, Central European states have shown no single health finance model but have responded to bloated public sectors, fiscal constraints, and international lending conditionality differently.

Table 1 reports the balance of public and private spending on health services and the trend level of public health spending over the first decade of transition. No single Central European finance model emerges; rather, from Croatia to Azerbaijan public health expenditure varies from 135% to 11% of the EU average.

TABLE 1: LEVELS OF PUBLIC AND PRIVATE SPENDING ON HEALTH SERVICES (% OF GDP), 1991-2000.

	Public		Private		Public trend	% of EU-15 average
	1991	*2000*	*1991*	*2000*	*1991-2000*	*2000*
Albania	4.4	2.1	1.5	1.3	-2.3	35.8
Armenia	..	3.2	..	4.3		53.8
Azerbaijan	3.1	0.6	0.9	0.2	-2.5	11.0
Belarus	2.7	4.7	..	1.0	2.0	80.0
Bosnia	..	3.1	..	1.4		52.6
Bulgaria	4.2	3.0	0.5	0.9	-1.2	51.3
Croatia	10.1	8.0	2.0	2.0	-2.1	135.6
Cyprus	..	4.3	..	3.6		72.0
Czech Rep	5.1	6.6	0.2	0.6	1.5	111.5
Estonia	1.8	4.7	0.9	1.4	2.9	79.3
Georgia	4.1	0.7	..	6.4	-3.3	12.6
Hungary	5.9	5.1	1.4	1.7	-0.7	87.2
Kazakhstan	4.3	2.7	..	1.0	-1.6	45.9
Kyrgyz Rep	3.2	2.2	1.1	2.2	-1.1	36.7
Latvia	2.8	3.5	0.7	2.4	0.8	60.0
Lithuania	3.4	4.3	0.6	1.7	1.0	73.6
Macedonia	11.2	5.1	1.3	0.9	-6.2	85.9
Malta	..	6.0	..	2.8		102.2
Moldova	4.0	2.9	0.8	0.6	-1.1	48.9
Poland	5.0	4.2	1.6	1.8	-0.8	70.9
Romania	3.3	1.9	2.0	1.0	-1.4	31.4
Russia	2.4	3.8	0.2	1.5	1.4	65.1
Slovakia	4.6	5.3	0.4	0.6	0.7	89.6
Slovenia	5.2	6.8	..	1.8	1.6	115.0
Tajikistan	4.5	1.0	1.4	..	-3.6	16.1
Turkmenistan	3.8	4.6	0.6	0.8	0.8	77.7
Ukraine	3.3	2.9	..	1.2	-0.4	48.7
Uzbekistan	4.6	2.6	1.6	2.6	-1.9	44.7
Yugoslavia	..	2.9	..	2.7		48.4

EU-15	6.1	5.9	1.7	2.1	-0.1	100.0
OECD	5.6	5.8	1.9	2.2	0.1	97.5
MEAN	5.1	4.7	1.6	2.1	-0.3	79.9
STDEV	1.9	1.8	1.2	1.3	1.6	31.2

Source: World Bank (2003).

2.1 Literature review

Previous academic work on the uniqueness of transition health finance has slowly shifted from emphasizing common determinants and challenges of high spending in the early transition to stressing unique regional or national responses to those challenges as transition has progressed.

Kornai (1992) coined the phrase "premature welfare state" to refer to social spending levels in post-communist states higher than their national income levels would predict; Kornai (1997) concludes that both fiscal pressures threatening the supply of health services and demand pressures for scarce services compel health finance reform against this common backdrop. For Preker and Feachem (1994), the common challenge of inherited macroeconomic imbalance in the early transition requires policies both to limit public health spending to contain budget deficits and prevent a crowding-out problem and to cultivate extra-budgetary sources of health spending (Preker and Feachem 1994, 305-6). Empirical work – confined by data limitations to advanced OECD countries – emphasizes common determinants of health spending stemming from per capita income, labor force participation, and public sector involvement. Gerdtham and Löthgren (1998) establish a relationship between health expenditure and per capita income levels in 19 OECD countries from 1960 to 1995, but acknowledge that demographics and the share of health spending in the public sector may influence the long-run connection between health spending and GDP. Gerdtham and Jönsson (2000) argue using both panel and cross-country data that aggregate income explains most

variation in health expenditure between countries. Goldstein, Preker, Adeyi, and Chellaraj (1996) confirm this positive relationship between health expenditure and per capita income in transition countries; however, relative to countries in the same income bracket, Central European countries have tended to spend a larger share of GDP on health. Kornai and McHale (2000) present econometric evidence that total health spending in ten Central European countries has been higher than an OECD model would predict controlling for per capita income levels and high old-age dependency ratios. The authors identify a negative relationship between the public share of health spending and per capita income, female labor force participation, and political variables capturing support for center-right parties. While presenting evidence of a unique transition approach to health finance, Kornai and McHale raise the possibility of convergence on an OECD finance model in the Hungarian case (Kornai and McHale 2000, 392-395).

More recent work has highlighted diverse responses to a common inheritance of high public health spending both between the regions of Central Europe and the Former Soviet Union and among Central European cases. Åslund (2002) contends that although "national variations [in health spending] are considerable without any strong pattern," differing depths of initial distortions in the health sector has separated Central Europe and the FSU (Åslund 2002, 321-2). Preker, Jakab, and Schneider (2002) identify three reform groups. Group A countries (Croatia, the Czech Republic, and Hungary) have maintained high public spending despite output falls and government weakness through complex reform programs establishing social insurance, introducing new revenue collection institutions, and dividing health finance responsibility between national and regional actors. In Group B countries (Albania and Russia), spending has decline and reform has been slow though new payroll taxes partially finance health expenditure. In group C (Azerbaijan, Georgia, and Moldova), individual out-of-pocket payments constitute a majority of health expenditures as public finance collapse has destroyed the nationally financed health sector.

Thus previous academic literature on transition health finance has shifted from a focus on a communist legacy of high public health spending common to all post-communist countries to a focus on diverse regional and national responses to that shared legacy. Sections 2.2 and 2.3 continue to emphasize diversity by reconsidering previous empirical work in an expanded dataset of all post-communist reformers.

2.2 Further empirical evidence of unique transition health finance

Previous empirical work investigating the uniqueness of transition health finance has relied heavily on OECD data; while these data offer both completeness and accuracy, they limit researchers to the wealthiest and more advanced market economies of North America, Western Europe, and East Asia and the most advanced post-Communist reforms: Poland, Hungary, and the Czech and Slovak Republics. I instead employ World Bank data for public health spending as a share of national GDP to broaden the universe of considerable cases to fifty-four.[1] This expanded dataset includes all advanced OECD countries as well as all countries from the former Communist sphere; applying previous regression analysis to these World Bank data allow for broader conclusions concerning not just the uniqueness of the most advanced transition countries but *all* reformers in Central and Eastern Europe.

Previous econometric inquiries into the uniqueness of transition welfare state spending have frequently considered Central Europe as a homogenous region; establishing divergence from OECD or EU models of health finance has consisted of demonstrating that as a region Central Europe exhibits a different blend of public and private contributions to health care. Utilizing the more complete World Bank data allows

[1] All data come from the World Bank Development Indicators online database (2003) except for BUDGET (EIU 2003) and AC10/AC12 (European Commission 2003). The countries included are Albania, Armenia, Australia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Canada, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Kazakhstan, Korea, Kyrgyz Republic, Latvia, Lithuania, Luxembourg, Macedonia, Malta, Moldova, Netherlands, New Zealand, Norway, Poland, Portugal, Romania, Russia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, Turkey, Turkmenistan, Ukraine, United Kingdom, United States, Uzbekistan, Yugoslavia.

for meaningful comparisons of national variations within Central Europe and facilitates an inquiry into convergence among transition countries. Moreover, critically re-examining the notion that there is a singular transition model of health finance avoids the historical determinism incumbent upon comparisons with any aggregation of developed market economies.

Table 2 considers panel regressions of data from these fifty-four countries from 1990-2000 of per capita income (in constant 1995 dollars), government expenditure as a share of national GDP, and the percentage of the national population over the age of 65 on public health expenditure (expressed as a share of national GDP).

TABLE 2: PANEL REGRESSIONS, 1990-2000. DEPENDENT VARIABLE: PUBLIC HEALTH EXPENDITURE AS SHARE OF GDP.

	(*1*)	(*2*)	(*3*)	(*4*)
Constant	-0.089 (-0.369)	0.339 (1.271)	0.091 (0.389)	0.289 (0.960)
GDP per capita	4.08E-05** (8.920)	4.15E-05** (6.413)	5.41E-05** (11.505)	2.17E-05** (4.344)
Government share of GDP	0.166** (14.648)	0.167** (15.507)	0.144** (12.402)	0.179** (12.092)
Old-age share of population	0.127** (7.227)	0.095** (5.667)	0.113** (6.327)	0.121** (5.402)
CEE dummy		0.652** (3.682)	0.478 (0.711)	
FSU dummy		-0.607** (-3.450)		0.130 (0.273)
GDP_CAP*CEE			0.003** (6.086)	
G/GDP*CEE			0.043 (1.604)	
POP65*CEE			-0.111* (-2.392)	
GDP_CAP*FSU				0.003** (2.586)
G/GDP*FSU				-0.039 (-1.769)
POP65*FSU				-0.093* (-2.465)
N	542	542	542	542
R^2	0.567	0.620	0.644	0.618

OLS estimators. T-statistics in parentheses. * indicates significance at 5% level. ** indicates significance at 1% level.

These findings are broadly consistent with Kornai and McHale (2000). In regression (1), control variables for income, government size, and demography all exhibit explanatory power over the level of health spending in the public sphere. Moreover, the coefficient on each explanatory variable is positive and significant at greater than the 1% level; that is, countries with higher per capita income, larger governments, and an older population tend to spend more public money on health services.

Regression (2) augments this elementary conclusion with the addition of two regional dummies: CEE is coded as 1 for all formerly Communist countries in Central and Eastern Europe not included in the Soviet Union and 0 for all others while FSU is coded as 1 for all former members of the Soviet Union and 0 for all others. The original macroeconomic and demographic determinants of public health spending – income, government size, and population age – all retain their significance and positive coefficients. However, both regional dummies now enter with strong statistical significance. The coefficient on the Central and Eastern European (CEE) dummy is significant at the 1% level and positive, implying that all else equal Central European governments spend roughly 0.65% of GDP more on health services than control variables would predict. And strong negative coefficient on the Former Soviet Union dummy suggests the opposite; FSU governments have under-spent by nearly 0.60% of GDP from 1990-2000. Notably, the addition of these two regional dummies considerably improves the fit of the regression.

Regressions (3) and (4) introduce interaction terms to capture the specific interplay between income, government size, and demography. Multi-collinearity between the dummy variables necessitates separate consideration. In regression (3), the control variables retain strong significance and positive coefficients while the added regional dummy becomes positive but insignificant. The interaction term of per capital income in Central and Eastern Europe displays a positive coefficient with greater than 99% confidence. An interaction term of elderly population share in Central and Eastern

Europe becomes negative at the 5% level while the interaction of government size and the regional dummy displays a weakly positive coefficient. The fit of the regression further improves over both regressions (1) and (2). These results tentatively suggest that the political economies of Central and Eastern Europe have indeed been unique from 1990-2000 in that relative to their level of per capita income their governments spend more on health services than their wealthier OECD counterparts. Furthermore, they may spend relatively less on health services given their demographic age-dependency burden. Regression (4) replicates these results for the Former Soviet Union with almost identical results: relative to their level of economic development as captured by per capita income, governments in the FSU also tend to overspend on health services.

Thus, Kornai and McHale's (2000) broad conclusion that public health spending in post-Communist Europe tends to exceed expectations given the level of local development holds in this expanded dataset of all countries undergoing post-Communist transition. However, considering panel data during a decade of tremendous institutional upheaval and fundamental rethinking of the ideal relationship between state and market risks overlooking movement in public health spending during this ten-year window.

2.3 Empirical evidence of convergence and non-convergence

This section empirically evaluates convergence hypotheses based on initial distortions, domestic financial constraints, and pressures imposed by foreign donors using separate sets of cross-country data from 1991 and 2000. This analysis suggests that even after a decade of reform, initially distorted government size remains the best determinant of public health spending though the magnitude of this relationship has fallen dramatically. While the former FSU has diverged as a region, Central European countries have displayed neither clear convergence on the OECD finance model nor a distinct regional model of their own. Thus, while bloated public sectors can account for

initially high levels of public health spending, case studies are needed to isolate the relative impact of domestic and external pressures for reform of public spending on health services as transition has progressed.

The literature suggests three categories of reasons we might expect convergence in terms of public spending on health services (controlling for income levels) among transition economies and European Union and OECD member states: inherited, domestic, and external. *Inheritance* implies that the over-centralized nature of health finance (and provision) under the old system left post-Communist states with generally bloated public sectors and initially limited purchasing power to fuel private sector alternatives. As reformers sought to reshape the balance between public and private provision of goods and services (consistent with Kornai's broad definition of privatization as the process by which the majority of production comes to take place in the private sector), the government spending should in general decline. *Domestic* pressures for convergence stem from the limited fiscal capacity of the state to maintain such high levels of public health expenditure faced with a transformational recession and the gradual evolution of reform goals from buffering the social tensions associated with market reform to shaping the longer-term character of the national political economy (Nelson 1997). Lastly, *external* arguments for convergence indicate that EU hopefuls faced the demands of adopting the EU *acquis communitaire* and the eventual aims of monetary union (characterized by controlling fiscal expenditure within the Maastricht framework) while all countries in the regional interested in World Bank or IMF loans faced conditionality associated with fiscal austerity programs.

I operationalize these hypotheses as follows. To assess the extent to which the *inheritance* of dominant state ownership of productive resources remains, I consider the share of total national production that occurs in the public sector following Kornai; whereas 1 on this small suggests the inherited balance of state and market forces largely

remains, a score of 0 indicates a marginal role for inheritance.[2] Concerning fiscal limitations in the *domestic* bargaining process, I suggest the government budget deficit as a share of national income as a proxy for limited spending potential in the public sphere. Lastly, to address the potential impact of *external* EU conditionality on public finance reform, I augment the dataset with EU accession dummy variables, coded as 1 for successful applicants and 0 for all others.

Tables 3-4 regress the share of national income devoted to public health expenditure on control explanatory variables for income level, government size, and demography in addition to variables designed to test convergence hypotheses.

TABLE 3: CROSS-COUNTRY REGRESSION, 1991 DATA. DEPENDENT VARIABLE: PUBLIC HEALTH EXPENDITURE AS SHARE OF GDP.

	(*1*)	(*2*)	(*3*)	(*4*)
Constant	1.104 (0.849)	0.853 (0.380)	0.853 (0.380)	-0.293 (-0.149)
GDP per capita	5.49E-05 (1.729)	2.93E-05 (0.625)	2.93E-05 (0.625)	5.85E-05 (1.542)
Government share of GDP	0.159** (3.234)	0.338** (3.488)	0.338** (3.488)	0.368** (3.946)
Old-age share of population	0.023 (0.296)	-0.161 (-0.999)	-0.161 (-0.998)	-0.197 (-1.249)
CEE dummy	1.198 (1.519)			
FSU dummy	-0.505 (-0.625)	-1.566 (-1.060)	-1.566 (-1.060)	
BUDGET		-0.024 (-0.158)	-0.023 (-0.158)	-0.110 (-0.869)
AC-10		3.419 (1.656)		4.368* (2.339)
AC-12			3.419 (1.656)	
N	47	23[3]	23	23
R^2	0.444	0.375	0.375	0.370

[2] While a large share of national consumption undertaken by the government itself can and does occur throughout many developed, capitalist economies of Western Europe and North America, the government share of GDP still tended to be higher in transition countries in the early transition. As transition progressed and the productive orientation of the economy shifted to private hands, the government share of GDP consistently fell. That is, though an imperfect measure of specifically *communist* distortions, this ratio shows a significant correlation with the elapsed time since the end of communism.

[3] Limited data availability for government deficit as a share of GDP (BUDGET) reduces the number of usable observations in regressions (2)-(4) to 23.

OLS estimators. T-statistics in parentheses. * indicates significance at 5% level. ** indicates significance at 1% level.

Regression (1) considers only the control variables along with regional dummies. As in table 2, the government share of GDP exhibits a strong statistical significance and a positive coefficient, suggesting that on the margin increasing the government size by 1% of national income would increase public expenditure on health by about 0.16% of GDP. Significantly, both regional dummies for Central Europe (CEE) and the Former Soviet Union (FSU) – though displaying the anticipated signs from earlier regressions – have no explanatory power; that is, government size fully captures variation in public health expenditure in all countries with a communist past.

Three further regressions introduce variables capturing the government budget deficit as a share of national income (BUDGET) and EU accession dummies (AC10, AC12) to determine if public health spending responds to fiscal pressures and EU conditionality, respectively. Each data series merits a caveat. Though budget deficits in Central Europe were high at transition's onset, they were seldom higher than in more mature economies: Germany and the United States, for example, posted shortfalls of 2.95% and 4.55% of GDP, respectively, while Hungary and Russia showed deficits just below 3%. All conclusions based on fiscal pressures in 1991 must acknowledge incomplete data; though time-series data for OECD members extends through 1991, reliable data from many transition countries does not appear until the mid-1990s. Moreover, two dummy variables – AC10 and AC12 – capture those transition countries slated for EU membership in 2004 and 2007.[4] To imply that EU pressure influenced public spending priorities as far back as 1991 – prior to both the Copenhagen or Essen summits – would be at minimum historically deterministic. In 1991, the EU had yet to commit in principle to enlargement; rather, EU pressure on public finance was channeled through EU disbursements within IMF conditional loans (Stone 2002). Though

[4] Simply stated, the AC12 series mimics AC10 with the addition of positive coding for Romania and Bulgaria, which have both received "pre-in" accession status slated for 2007.

accession dummies allow for more robust conclusions in 2000, I include them in table 3 for symmetry and to serve as a possible proxy for the presence of reformist governments with plans for ultimate EU membership.

Government share of GDP displays robust statistical significance in all regressions using 1991 data. The budget deficit shows an intuitive negative sign but without statistical significance. AC10 and AC12 – perfectly correlated owing to incomplete data for Romania and Bulgaria – are likewise insignificant but with a positive coefficient, consistent with previous empirical work establishing high initial spending in the most advanced transition economies. The omission of the FSU dummy in regression (4) allows the closely correlated AC10 to display strong positive significance – future EU members devoted over 4% of GDP *more* to public health expenditure than control variables predict. The addition of the BUDGET and AC10 series in regression (2) weakens its overall fit, though this may follow from the contracted universe of cases rather than the extra explanatory variables. Thus, if government size can be considered a proxy for the depth of initial distortions under the communist system, these regressions suggest inherited distortions prominently influence differing public health spending between transition and EU/OECD countries; by contrast, fiscal constraints and international pressure offer little addition explanation at the start of transition.

Reconsidering this spending model for 2000 data in table 4 suggests public health spending in transition countries has diverged as distorted government sizes interact with new fiscal and external influences.

TABLE 4: CROSS-COUNTRY REGRESSION, 2000 DATA. DEPENDENT VARIABLE: PUBLIC HEALTH EXPENDITURE AS SHARE OF GDP.

	(*1*)	(*2*)	(*3*)	(*4*)
Constant	0.554 (0.703)	0.995 (1.087)	0.769 (0.819)	-0.638 (-0.605)
GDP per capita	2.59E-05 (1.537)	2.15E-05 (1.458)	1.84E-05 (1.163)	5.18E-05** (3.156)
Government share of GDP	0.192** (5.659)	0.176** (4.803)	0.185** (4.838)	0.182** (3.931)
Old-age share of	0.070	0.071	0.083	0.112

population	(1.485)	(1.218)	(1.358)	(1.550)
CEE dummy	0.017 (0.032)			
FSU dummy	-1.363* (-2.592)	-1.913** (-4.394)	-1.848** (-4.109)	
BUDGET		0.002 (0.039)	-0.003 (-0.068)	-0.054 (-0.915)
AC-10		0.717 (1.675)		0.573 (1.064)
AC-12			0.347 (0.773)	
N	51	37	37	37
R^2	0.722	0.731	0.712	0.572

OLS estimators. T-statistics in parentheses. * indicates significance at 5% level. ** indicates significance at 1% level.

Utilizing 2000 data boosts the case universe to 37. As in table 4, government size retains strong statistical significance and a positive sign. However, in all regressions that include BUDGET and AC10/AC12, the magnitude of the government size coefficient falls considerably – from between 0.338 and 0.368 with 1991 data to between 0.176 and 0.185 with 2000 data. Acknowledging that a large government share of GDP need not indicate a communist past, this fall may suggest that while larger governments still spend more on health, a decade of transition has mitigated the strength of this relationship. An additional 1% of GDP in the public sector corresponded to 0.34% of GDP more spent on health in 1991 but just 0.18% by 2000. Establishing causality requires case studies, but intuition suggests shifting government priorities and a changing balance of public and private forces may drive this relationship.

Table 4 tells a story of partial regional divergence: the FSU dummy establishes that FSU governments spent less on health in 2000 than control variables predict but the CEE dummy sheds little light on convergence within Central Europe. Whereas the FSU was in line with Central European public health spending at the start of transition, the FSU dummy now enters robustly with a negative sign at greater than 99% confidence. By contrast, the CEE dummy is insignificant. The budget deficit likewise has no explanatory

power. The AC10 EU accession dummy is of borderline significance at the 10% level in regression (2) and weakly positive, raising the possibility that the first-round of new EU members may have actually upped their public contribution to health finance ahead of membership; this result however is inconclusive and requires case studies to assess further. Substituting AC12 for AC10 has a noticeable deleterious effect on its T-statistic; intuitively, the slower reformers Romania and Bulgaria should respond less aggressively to EU pressure to adjust public finances. The removal of the FSU dummy in regression (4) allows per capita income to enter with statistical significance (suggesting that the cases coded 1 for FSU have lower levels of income) but does not affect either the budget deficit or accession dummy variable.

What conclusions does this empirical evidence allow to support or refute convergence hypotheses that inherited distortions, domestic financial constraints, and external demands influenced public health spending over the first decade of transition? The preceding regression analysis suggests four tentative conclusions. After a decade of transition, variations in government size among developed market economies and transition economies can still explain much of the variation in public commitments to fund health programs. However, as the initial distortions of the communist system have faded and new spending priorities have emerged, governments of the same size tend to devote less money to health programs. Fiscal constraints and EU accession do not appear to explain variation in public health finance, though this result is ambiguous and should be supplemented with case study analysis. Lastly, only the FSU has behaved consistently as a region, unambiguously devoting a smaller share of national income to health programs through public channels than either Central European countries or OECD member states.

Empirical analysis establishes that a common legacy of central planning, financing and provision of health and health care services has precipitated an abnormally high public commitment to health finance at the start of post-communist transition. Yet

as the countries of Central Europe confront unique domestic and international constraints under the backdrop of a common legacy, this analysis fails to account for divergent reform paths within the region. Our discussion now turns to case studies of national reform experiences to elucidate how domestic and external pressures have shaped public health spending during a decade of tumultuous reform.

Three

What motivates high public health spending?

Divergent national experiences with public health reform

Despite common legacies of centralized finance and administration, over-specialization, and a pervasive attention to technology rather than primary care services, political economies of Central Europe responded to high public health spending in light of unique domestic political and financial constraints as well as distinctly national relationships with the international community. Having established in Section 2.2 that the public share of health spending in the region has indeed been anomalously high and in Section 2.3 that Central Europe has neither converged on an EU/OECD funding model nor displayed a clear alternate model of its own, I now address the question of divergent national reform experiences within Central Europe.

I choose two representative but distinct cases: Poland and Croatia. As one of the most advanced transition countries and clear front-runner for EU accession, Poland has confronted domestic impediments to expeditious reform stemming from party and ministry competition as well as budgetary limitations while simultaneously attempting to conform to EU social policy demands within the Maastricht budget constraint. Croatia,

by contrast, has confronted ethnic warfare and issues of stateness while beginning its reforms on the basis of the unique Yugoslav health finance model. More affected by World Bank loan conditionality and technical assistance than the (still uncertain) prospect of eventual EU accession, Croatia has enjoyed generous financial support for health programs from the international community – well beyond that to Poland. The aim of these case studies is neither to exposit the detailed politics of health finance reform nor to normatively evaluate competing models of health finance; rather, I consider the Polish and Croatian approaches to health finance to assess what impact domestic political and fiscal constraints as well as international involvement have on either perpetuating a legacy of high public health spending or precipitating a decline in government financial support for health care services.

3.1 Poland: domestic pressures under international constraints

Often lauded as a successful post-communist reformer based on progress with EU accession negotiations, Poland has addressed health finance reform in light of both domestic political and fiscal constraints against the backdrop of international re-integration. From 1991 to 2000, public health spending as a share of GDP fell steadily from 5.0% to 4.2%, while private[5] health spending increased only slightly from 1.6% to 1.8%. Yet far from falling into line with an EU health finance model, Poland has struggled to fund adequate health care services during the first decade of transition. By 2000, the Polish government devoted just less than 71% of the EU average to publicly funded health care. In 1996, Polish health care expenditure – drawn largely from public sources – of $219/capita (in purchasing power terms) ranked among the lowest in Europe

[5] Official statistics for private health spending may significantly underestimate actual spending by ignoring out-of-pocket payments (such as bribes or "envelope payments"); household survey data from the mid-1990s suggests informal side-payments account for as much as 38% of total health expenditure (Karski 1999, 15-17).

compared to the EU average $1645 and behind other EU candidate countries such as the Czech Republic ($749), Slovenia ($743), and Hungary ($562) (Karski 2003, 23).

Though the state has retained a leading role in health finance during the first decade of transition, Poland's approach to health finance has been characterized by steady decentralization, devolution, and privatization. I argue that (1) domestic fiscal constraints imposed by budget shortfalls and intra-governmental competition along with (2) fiscal discipline perceived as necessary for EU accession combined to steadily erode Poland's communist legacy of high national health spending. After the first decade of transition, Poland's public health spending has plummeted to among the lowest in Europe as the conjunction of financial pressures and EU conditionality deteriorates an inheritance of generous public spending on health. Frequently associated with the "shock therapy" school of market reform, Poland was slow to undertake health finance reform but has nonetheless seen a relatively quick contraction in public health spending. Understanding the relative importance of domestic and external reform pressures can both serve as a model for politicians to debut pressure for welfare state extension and a warning to less-advanced reformers over the consequences of slow reform.

Domestic processes

Two domestic pressures depressed public health spending at the national level during the 1990s: (1) political moves towards decentralization and (2) fiscal constraints. Following the initial centralization drive in health administration consistent with the introduction of communism in 1945[6], three pre-1989 waves of reform sought to expand free health coverage to state workers and agriculturalists, integrate medical care and social service facilities on the regional level, and decentralize administration of health care from the national to regional (*wojewódstwo*) and local (*gmina*) levels (Karski 1999, 5). As post-communist reform proceeded, reformers debated various models – limiting the

[6] The Polish health administration model deviated from the orthodox Soviet system in that private medical facilities were afforded some freedom to operate, though the number of private care facilities dropped significantly post-1945 (Karski 1999, 5).

state's role to primary care, establishing a competitive health insurance market, funding health care through point-of-service fees, or devolving responsibility for health care to the municipal level – but were slow to settle on a regional insurance system funded by mandatory contributions (Bossert and Wlodarczyk 2000, 3-4).

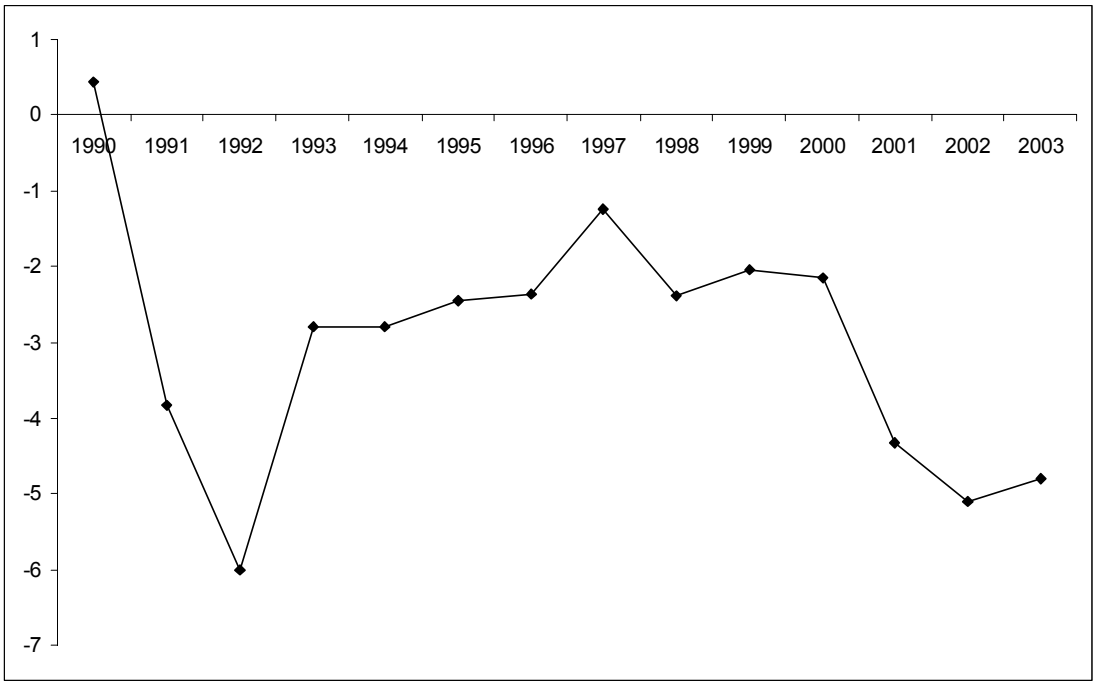
While health finance remained in the national purvey for most of the 1990s, piecemeal efforts at further decentralization transferred health care administration from the national Ministry of Health and Social Welfare to the regional level (1991), devolved ownership of health facilities to the regional level (1993), and only addressed the finance issue head-on in 1997. Passed by the Polish Parliament, or *Sejm*, in 1997 but entering into force in 1999, the *General Health Insurance Act* created 16 autonomous regional health insurance funds with the intent both to reduce the role of the national government in financing health care services out of a shrinking budget and ease the requirements of government administration by allowing care providers to interact directly with the regional funds. Though legislation succeeded in shifting the finance burden away from the state budget, the state retains a role in financing some general (non-patient specific) health services, some organ transplant procedures, and the provision of select expensive prescription drugs (Karski 1999, 5-16).

A decade of piecemeal reform steadily reduced the health spending obligations of the national government; scholars attribute this slow decentralization to indecision and ideology. Bossert and Wlodarczyk observe that while compromising on reform was both slow and highly political, a lack of political party identification with health finance reform proposals complicates a stakeholder analysis that seeks to consider reform in light of preferences of key interest groups and political actors (Bossert and Wlodarczyk 2000, 4-6). These authors stress the absence of a coalition of political actors – political parties as well as interest groups – consistently committed to a single health reform proposal (Bossert and Wlodarczyk 2000, 21). For Preker et al. the push for decentralization was above all politically motivated. Though construed to bolster links between producers and

consumers of health services, decentralization has instead fragmented scarce budgetary resources and enabled significant regional inequity. The authors cite Estonia and Hungary as examples of repentant de-centralizers where efforts to re-nationalize ownership and control are already underway (Preker et al. 2002, 96).

While political bargaining sought to devolve health spending to the regions, fiscal pressures similarly bolstered the drive for decentralization by precluding generous health spending at the national level. Along with the fall in national production associated with Kornai's "transformational recession," Poland – like many Central European states – saw a contracted tax base as productive activity fled to the informal sector, a lessened administrative capacity to collect taxes in the early transition, and an unstable macroeconomic environment that encouraged firms to delay tax payments by the Olivera-Tanzi effect (Preker et al. 2002, 83; Schelkle 2002). As the Polish government experienced a decline in revenue, pressures to maintain social spending to cushion the severity of transition "shock therapy" remained; some foreign observers chided governments for maintaining levels of public expenditure "typical of rich welfare states" through deficit spending (Tanzi and Tsibouris 2000, 23). During the first decade of transition, the national budget deficit as a share of GDP ranged from -3.83% in 1991 to -2.033% in 1999 as the *General Health Insurance Act* entered into force. Chart 1 diagrams a decade of fiscal imbalance.

CHART 1: STATE BUDGET BALANCE (% OF GDP) IN POLAND, 1990-2003



Source: Economist Intelligence Unit (2003).

Though the *General Health Insurance Act* only took effect in 1999, the share of Polish health spending financed through the state budget declined steadily throughout the 1990s, ranging from 94% in 1990 at transition's onset to 73% in 1997 at the time the legislation was approved. Simultaneously, the share of the government's budget necessary to meet this declining contribution rate has remained roughly constant: the state devoted 16% of its budget to health in 1991 and 15.4% in 1996 (Karski 1999, 5-16).

International involvement

A broad and growing literature assesses the ambiguous benefits to European Union applicants of tying policy-makers' hands to vague and variable conditions for membership emanating from Brussels (Bronk 2002, Grabbe 2002, Grabbe 2002*b*); as such an aspirant, Poland has attempted to conform its public finances to an EU model imputed from the diverse national models of current EU member states. I contend that the 1993 Copenhagen Criteria constitute no blueprint for health finance reform; rather,

any EU impact on public health spending comes from a preemptive effort by accession countries to curb fiscal deficits in line with the 1992 Maastricht convergence criteria. World Bank reform proposals have been inconsistent with domestic pushes for decentralization and therefore played a marginal role in influence public health spending.

Grabbe claims public finances in accession countries face a "triple whammy": implementing EU legislation, co-financing EU transfers, and trimming budget deficits strain fiscal policy (Grabbe 2002*b*, 6). Yet pre-accession assistance from the European Union must be evaluated in light of its objectives – the successful integration of Poland into the Union rather than the overhaul of Poland's health system in line with domestic needs. Health finance receives little mention in the voluminous *acquis communitaire* (Bowis and Hager 2003); just four chapters address health issues: 1 (free movement of goods), 7 (agriculture), 13 (social policy and employment), and 23 (consumer protection). The 1997 Amsterdam Treaty mentions health in Article 152, obligating the EU to take actions to ameliorate public health and insure community legislation remains consistent with health protection (Rechel and McKee 2003, 77-8; European Commission 2003*b*). Indeed in terms of evaluating or reforming Poland's funding balance of public versus private sources, the EU code of law provides little practical guidance and certainly no blueprint for reform.

Where the European Union has influence public health spending – in current member states and accession countries alike – is through the budget deficit restriction imposed by the Maastricht Treaty and Stability and Growth Pact. Despite little encouragement from Brussels to substitute fiscal austerity in lieu of social spending, Poland and other leading accession countries have perceived EU accession as a competitive, zero-sum game. Where progress in negotiations is perceived – by politicians, the media, and the public – relative to its neighbors, Poland has strived to unilaterally prepare itself for monetary union in advance of its May 2004 EU entry date. As current EU members have discovered, the stringent Stability and Growth Pact limits national

freedom to fund generous social programs absent sizeable revenue; as previously discussed, Poland posted budget deficit up to 6% of GDP (*see* table 1). However, since this external influence – not specifically imposed by the EU but imposed unilaterally from certain applicant countries – pushes for budget cutbacks just as such fiscal pressures would normally, the marginal impact of EU accession cannot be easily distinguished.

The World Bank has likewise played a minimal role in influencing public health spending despite early input in the reform process and an upfront disbursement of $130 million to assist health finance reform (World Bank 2003*b*). Negotiated between the World Bank and Poland's first post-Solidarity government, Poland's health package focused on maintained centralized finance and distribution – unique both in terms of other World Bank lending packages and also other reforms taken by the Polish government. Approved in April 1992, the World Bank health proposal called for "retaining central budgetary funding with new taxes, local government contributions, and co-payments… providers would be paid through budgetary transfers rather than free for service or capitation." (Bossert and Wlodarczyk 2000, 10) Despite participation of Ministry of Health officials in the negotiations, the World Bank proposal attracted little support from political leaders for retaining the centralized character of the socialist system rather than stressing neo-liberal market reforms. The proposal was signed and funds disbursed, but future reformers marginalized the World Bank's suggestions; as Bossert and Wlodarczyk observe, "the recommendations… played no role in influencing concepts applied in the reform process. They were soon superseded by… competing proposals." (Bossert and Wlodarczyk 2000, 10).

Assessing the Polish health finance model

The sluggishness with which Poland approached health finance reform coupled with fiscal pressures constituted domestic pressures for a decline in state budgetary spending on health. Foreign financial assistance from the European Union and World

Bank has constituted a small fraction of health expenditure and has played a limited role in thwarting decentralization. Austerity pressures emanating from the EU Stability and Growth Pact have re-enforced fiscal pressures to curb Poland's budget deficit by reducing social spending. Yet though Poland has seen a steady decentralization drive lowering its public health spending over the first decade of transition, deep initial distortions in the balance between public and private forces in health care spending take time to overcome; high public health spending apparently stems from this inheritance while little evidence suggesting a desire to maintain a generous welfare state.

3.2 Croatia: international involvement in a new national framework

A cursory read of table 1 immediately suggests Croatia's exceptional approach to health finance; from 1991 to 2000, public health spending fell from 10.1% of national GDP to 8.0% while the private commitment remained relatively constant (controlling for transformational recession effects) at 2.0%. A decade into post-communist transition, Croatia devoted a larger share of its national income to publicly funded health services than any other country in Central Europe – indeed, more than any other country eligible for World Bank assistance through its Europe and Central Asia office (World Bank 2003*b*). Along with Albania, Bosnia and Herzegovina, and Bulgaria, Croatia is one of a handful of post-communist states to finance health care almost exclusively within the public sphere (Vulić 1999, 21). On the heels of a decade characterized by ethnic warfare, central questions of state-ness, recession, and at times hyperinflation, Croatia's public health program remains among the most generously funded in the world.

Croatia's rapid transition from war-torn dictatorship to EU hopeful – unique in Central Europe – complicates cross-country comparisons. The Open Society Institute (2003) identifies three aspects of high social spending uniquely relevant for SE Europe: (1) new states require new bureaucracies to address health issues, (2) the old division of

ministries ignores public investment complementarities in education, housing and health, and (3) ethnic issues affect distributing and targeting services (OSI 2003, 8-10, 25). While Croatia's unique inheritance and exceptional reform path – emergency lending, identity questions, allocation of health care services based on ethnicity, and a desire to supersede the Yugoslav bureaucracy with a Croatian model – has been exceptional in Central Europe, I emphasize two areas – domestic politics and international involvement– likely to inform other national experiences. I argue that Croatia's generous and unlikely welfare state stems largely from (1) a new national framework following the dissolution of the Yugoslav Federation that introduced compulsory social insurance and (2) neglect of programmatic health finance reform by the international lending community. Croatia's national experience suggests considerable national autonomy to construct a generous welfare state in the face of fiscal pressures and substantial foreign involvement.

Domestic processes

Within the Yugoslav Federation, Croatia ran a national health system characterized by the same inefficient use of resources, focus on hospitals rather than primary and preventative care, and hierarchical decision-making as other communist states. Three phases of reform from 1945 to 1990 established compulsory health insurance administered on the local level and financed both through income-related contributions and state budget, integrated health insurance and pension administration on the federal level, and introduced "community management" whereby care facilities were consolidated beyond efficient levels, hospitals received most funds, the government established its leading decision-making role in health finance, and private health care services were reduced (Vulić 1999, 5-6). The dissolution of the Yugoslav Federation – along with its health finance system – created an opportunity for Croatia to reshape its health finances by drawing on a usable past of locally-administered compulsory health insurance. Though the disintegration left Croatia with a deep initial health crisis and

limited resources to address this crisis, the demands of nation-building were paramount: "where new states have been created, each must now develop its own national frameworks for disease prevention and control, and build capacity to monitor and implement these plans." (OSI 2003, 9-10)

Seeking to address a wartime legacy of poor public health with limited state coffers, the Croatian Parliament, or *Sabor*, essentially resurrected the 1945 health finance model, financing public[7] health through both the state budget and compulsory national health insurance. The latter provides the majority of funds; through the 1993 Health Insurance Act, the *Sabor* established mandatory contributions to the national insurance fund shared equally between workers and employers (Vulić 1999, 14). Since the establishment of the Croatian Health Insurance Fund, the relative contribution of statutory insurance has steadily risen (from 70% in 1991) and currently accounts of 95% of public health spending. The state budget accounts for just 4% of health spending and carefully targets those groups most adversely affected by transition: low income-earners, the elderly, and children under 15 with high medical needs. In addition, the state continues to pay for "antenatal and maternity care [and] school health services… the state also pays for health care for war veterans and the military, and the additional costs of health care in remote regions…" (Vulić 1999, 14) The remaining 1% of public health expenditure stems from local government contributions to off-set point-of-service fees for underprivileged social groups. Point-of-service fees for primary care services supplement public contributions for all but the poor, unemployed, and young. Significantly, corruption (brides or extra payments) remains scarce in Croatia in contrast to much of Central Europe (Vulić 1999, 14).

Reverting to the post-war health finance model based on compulsory insurance addressed issues of national identity by building on Croatia's own history and dovetailed with fiscal weakness by shifting the finance burden away from the state budget. Yet in

[7] Official statistics suggest public contributions mostly fund health care services in Croatia but may systematically understate the total health expenditure since often national account exclude private side-payments (Vulić 1999, 13).

shifting health finance burden to employees and employers, Croatia has side-stepped fiscal constraints only by raising the wage bill faced by firms. Further research will be necessary to assess the impact of compulsory insurance contributions on new enterprise creation and employment levels since the 1993 legislation.

International involvement

International involvement in the Croatian health sector stems chiefly from World Bank and European Union lending. Though a small fraction of total health spending, international assistance carries the potential both to position health within the larger public finance reform debate and "[encourage] reforms that put a greater emphasis on public health." (Rechel and McKee 2003, 76) Yet despite relatively generous financial assistance, international involvement has not prompted fiscal austerity. Croatia's experience suggests external impotence in curbing high public health spending owing to three factors: (1) a short-term focus on emergency humanitarian disbursements to cushion the crisis brought on by the civil war in the early 1990s, (2) a sluggishness undertaking programmatic policies to address Croatia's long-term health finance needs, and (3) a general neglect of the health sector in the larger reform agenda. As one of the largest recipients of international assistance to the health sector, Croatia offers a compelling test case for the international community's ability and inability to influence social policy in Central Europe.

Though often accompanied by either bilateral loans or aid disbursements, official development assistance from both the World Bank and European Union dwarfs other external sources of financial assistance to the health sector. Since the start of transition, the World Bank has contributed $69 million to health programs in Croatia through the IBRD lending window. The World Bank undertook a four year, $54 million health financing and reform program in 1995 (pre-Dayton Accords) only to follow up with an additional $29 million for primary health from 1999 until 2004. In relative terms, the

World Bank's $15.68/person specifically for health in Croatia ranks just behind its commitment in Albania, Serbia and Montenegro, and Bulgaria but well ahead of lending in Poland ($3.37), Slovenia ($4.75), and Hungary ($9.01) (World Bank 2003*b*). Moreover, during the first decade of transition – from 1991 to 2000 – the EU contributed €367 million in development assistance; of this sum, a majority prior to the cessation of hostilities in Croatia went to humanitarian assistance, while in the latter half of the decade most assistance supported refugee return (Rechel and McKee 2003, 83).

Despite tremendous potential to maintain health care services while spurring reform, World Bank development assistance in this area in SE Europe has been primarily confined to emergency humanitarian assistance rather than programmatic planning. OSI attributes this neglect of serious finance reform to a slow recognition of the connection between its health care finance agenda and the larger missions of poverty reduction and social exclusion (Rechel and McKee 2003, 76). By devoting resources to emergency humanitarian care and refugee support in the early transition, both the World Bank and the European Union have admirably attempted to address a humanitarian crisis while overlooking longer-term reform. The situation has recently changed; whereas the World Bank initially focused on emergency assistance, by 2001 it had expanded to financing health projects specifically: "improving health care services, reducing costs, rehabilitation of hospitals, reducing over-consumption of drugs, and making emergency health care more accessible…" (Rechel and McKee 2003, 83). Moreover, sluggishness in undertaking programmatic policies also appears in a lending bias towards capital-intensive infrastructure investments rather than technical assistance. Even in cases where financing has been contingent on policy reform, borrowers in SE Europe have channeled World Bank assistance to delivery infrastructure rather than human capital modernization while sidelining foreign technical assistance (Rechel and McKee 2003, 77).

The European Union, conversely, has followed more programmatic lending practices to support transition and create the possibility of eventual enlargement to SE Europe though without a specific health focus. The European Union sought to ameliorate a deteriorating public health situation in the "Western Balkans[8]" with the 1997 Stabilization and Association Process (SAP). Established "to encourage and support the domestic reform processes these countries have embarked on," the SAP has consisted primarily of technical assistance, preferential trade agreements, and cooperation in third pillar issues of justice and home affairs. Along with Macedonia, Croatia has signed a formal Stabilization and Association Agreement with the EU, codifying its progress in terms of economic reform and the development of administrative capacity – consistent with the EU's objectives of building regional stability and opening the door to eventual expansion (Rechel and McKee 2003, 78). Yet EU assistance, though carefully targeted, has mostly overlooked the health sector.

Assessing the Croatian health finance model

Fiscal constraints and conditionality imposed by foreign lenders have yet to weaken the Croatian government's ability to generously fund health care services. By restructuring health finance in line with Croatia's own post-war system, Croatia succeeded in constructing a model that relies almost entirely on compulsory insurance, maintains a safety net for targeted groups, and addresses the issue of national identity. Compulsory insurance enables high public health spending despite fiscal constraints because employers and employees effectively fund their own health care through publicly mandated channels. The national budget continues to finance health care for targeted social groups – low-income earners, the unemployed and vulnerable demographic groups. Recalling Nelson's (1997) spectrum of motivation for social spending, this targeting

[8] The EU subdivides SE Europe into three regional groupings: the west – Albania, Bosnia and Herzegovina, Croatia, Serbia and Montenegro, and Macedonia, east – Romania and Bulgaria, and Moldova (Rechel and McKee 2003, 78).

suggests the Croatian government uses budgetary resources to fund health programs primarily to cushion the social tension incumbent upon the transition process.

Far from promulgating "Washington consensus" policies of fiscal austerity in Croatia, the World Bank and EU have not depressed high public health spending despite extensive involvement. By financing emergency humanitarian assistance exclusively in the early transition, failing both to programmatically target assistance to bolster reform and to make future disbursements conditional on austerity, and by frequently overlooking the importance of the health sector in transition, the World Bank and the EU have had little influence. Where the Croatian government has used international assistance, it has channeled external resources towards capital-intensive investments while offering only limited acceptance for technical assistance. Using foreign money for more expensive infrastructure projects inevitably frees government resources to address its own priorities – chiefly primary care and preventative health care – out of the limited national budget.

Four

Conclusion

Empirical and case study evidence from the first decade of post-communist transition does not support the existence of a single Central European model of public health spending. Despite similar inherited distortions in terms of centralization, technological emphasis, and consistent reliance on government, the diverse country experiences of the region suggest that Central European states have addressed initially high levels of public health spending in light of unique domestic financial constraints and differing relationships with the international community. Empirical evidence from 1991 to 2000 suggests that while post-communist health spending has in general been high over the first decade of transition, panel regressions mask the diversity of national spending models. While large governments inherited from the communist period continue to explain variation in public health spending in 2000, budget deficits and EU conditionality have no uniform effect. Case study evidence from Poland and Croatia supports national freedom to alter or maintain high health spending from the communist period; fiscal pressures and international obligations can either justify cutbacks or

constitute surmountable obstacles depending on domestic politics. In Croatia, public health spending remained high despite fiscal constraints and international involvement because the government succeeded in re-establishing a post-war finance model that relied on compulsory insurance contributions rather than the national budget and because the World Bank and the EU were slow to address programmatic responses to the challenges of health finance reform. Conversely, in Poland public health spending has been high during the 1990s because a push for decentralization – supported by fiscal pressures and perceived EU conditionality – takes time to reverse high levels of public health spending inherited from the communist period.

Åslund's conclusion that high health spending simply means "people care about their health and can direct spending to it" (Åslund 2002, 321-2) overlooks complex and variable motives underpinning health spending – from preventing a backlash to building political economies where state and market forces collaborate to yield optimal public health results. This analysis suggests that far from providing a predetermined public finance model, a communist legacy simply provides a starting point for reforms that reflect unique national political situations and relations with the international community. Politicians can neither excuse nor condemn high public health spending as the inevitable consequence of communism; rather, the considerable national variation to have emerged after just a decade of transition forces a discussion of social choice in public finance. Despite their inheritance, Central European leaders have an opportunity to reflect social choices in determining health spending – either to heed a public call to buffer the social costs of transition or to reflect public perceptions of the optimal relationship between state and market forces in social service provision. Future research into popular support for high public health spending and electoral ramifications for leaders that either maintain or cut spending should clarify this relationship between government and public choices of health expenditure levels.

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