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Variations on Bismarck: Translations of Social Health Insurance in Post-Communist Healthcare Reforms in Central and Eastern Europe—The Role of Vertical and Horizontal Interdependencies

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1 Introduction: Adoption of Social Health Insurance in Post-Communist Central and Eastern Europe

After the breakup of the communist regime, countries in Central and Eastern Europe (CEE)¹ embarked on a massive political, economic and social policy transformation. This process included comprehensive

¹Central and Eastern Europe countries include Albania, Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, as well as the successor states of the Socialist Federal Republic of Yugoslavia: Bosnia and Herzegovina, Croatia, Kosovo, Montenegro, North Macedonia, Serbia and Slovenia.

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healthcare reforms which led to the adoption of social health insurance (SHI) across the region.

All CEE countries—except for Albania—had previous, pre-World War II experience of SHI-based healthcare. Some of them adopted SHI already in the late nineteenth century as most of the region was either under Prussian or Austro-Hungarian rule in that period. After World War II, Soviet domination entailed the introduction of a Soviet model of medical provision, the so-called Semashko system, in all countries of the region—with the exception of the Socialist Federal Republic of Yugoslavia, which maintained its SHI-based healthcare system. The new healthcare system was a part of the command economy but its needs were regarded as subordinate to “productive” (industrial) sectors of the communist system. It was based on “state monopoly and bureaucratic centralization coupled with the shortage economy”, with most of the medical professionals working as employees in state-owned hospitals and clinics (Kornai and Eggleston 2001, 6). The new healthcare systems provided formally universal basic public health services and citizens “enjoyed security, solidarity, and (at least declared) equality, albeit at an extremely low level” (Kornai and Eggleston 2001, 6). However, distribution of scarce resources was inefficient, quality of care lacking, and autonomy of physicians and patients restricted. General dissatisfaction with the healthcare system’s performance and deteriorating health outcomes in the population led to reform attempts in a number of CEE countries already before 1989, but major changes were not possible due to the Brezhnev Doctrine which limited the sovereignty of the member states of the “Warsaw Pact” controlled by the Soviet Union.

Once the communist system collapsed, all CEE countries with Semashko healthcare systems initiated reforms aiming at (re-)introduction of SHI and completed the process within a decade, the only exception being Latvia which after a number of reform attempts steered back towards tax-based healthcare. The shift away from the Semashko system has redefined the right to provision of healthcare in CEE from universal entitlement to contribution-based, but otherwise, rather than a unifying convergence, the outcomes of the SHI reforms in CEE have displayed a large variety in terms of institutional designs (see the observations of Kuhlmann and ten Brink [2021] on transnational policy dynamics in

general). The diffusion of SHI across CEE produced heterogeneous institutional set-ups, with differences, *inter alia*, in the level of contributions and their source (in a number of countries, the contributions are actually payroll taxes, sometimes split between employers and employees), the organisation of health insurance funds (Czech Republic and Slovakia established multi-payer systems, while the other countries settled for single health insurance funds), the actual share of SHI in current health expenditure (CHE), and the level of out-of-pocket payments (OOP), which in some CEE countries exceed 30 percent, suggesting strong privatisation of risk (Kaminska and Wulfgramm 2019) (see Table 35.1). Moreover, what sets the CEE healthcare systems apart from the German SHI system, which can be referred to as an ideal type (see Rothgang et al. 2010), is the mode of governance. In Germany, despite recent reforms tending to bring in more statist features, self-regulation continues to play an important role in healthcare governance. To the contrary, in CEE, although physicians have re-established their self-governance bodies and self-regulation now plays an important role in clinical issues, in terms of SHI governance the role of self-regulation is limited by a strong role of the state (Kaminska 2013). Moreover, the autonomy of health insurance funds in some CEE countries (e.g. Poland, Hungary) is very limited in favour of the state, too. Thus, rather than strictly following the Bismarckian blueprint, CEE countries have over the last three decades developed hybrid healthcare systems, combining Bismarckian, Beveridgean and market elements.

The existing literature examining the ideational sources behind the post-communist diffusion of SHI in CEE countries tends to offer two contrasting explanations: one pointing to external sources behind the idea to move “back to Bismarck”, and another indicating domestic triggers. The former body of research suggests that the adoption of SHI in CEE countries was inspired, if not imposed, by international organisations, the World Bank in particular (Deacon et al. 1997; Cerami 2006), while the latter sources argue that the idea to introduce SHI originated within the domestic context (Marrée and Groenewegen 1997; Roberts 2009; Rechel and McKee 2009) (for a broader discussion, see Kaminska et al. 2021).

Table 35.1 Social health insurance in post-Semashko healthcare systems in Central and Eastern Europe

	CHE as % GDP ^a (2017)	Post- communist adoption of SHI ^b	Single vs multiple payers ^b	Contributions ^b	SHI as % of CHE ^b	OOP as % of CHE ^a (2017)
Albania	5.9% ^c (2008)	1994	Single payer	3.4% of gross salary ^c	N.A.	56% ^c (2008)
Bulgaria	8.1%	1998	Single payer	8% of individual income (of which employees pay 40% and employers 60%)	42%	46.6%
Czech Republic	7.2%	1991	Multiple payers (7 SHI funds, 2014)	13.5% of pre-tax monthly wages (contribution base), with employees paying a 4.5% share and employers a 9.0% share	77.9% (2012)	14.8%
Estonia	6.4%	1991	Single payer	Social tax covering both health and pension Contributions: 13% and 20%, respectively, of employee wages and of self-employed individuals' earnings; employers pay on behalf of employees	65% (2016)	23.7%

(continued)

Table 35.1 (continued)

	CHE as % GDP ^a (2017)	Post- communist adoption of SHI ^b	Single vs multiple payers ^b	Contributions ^b	SHI as % of CHE ^b	OOP as % of CHE ^a (2017)
Hungary	6.9%	1989	Single payer	Employers pay a so-called social tax at a fixed percentage, employees pay a social health insurance Contribution: 7% of gross wage	59% (2009)	26.9%
Latvia	6.0%	-----	-----	-----	-----	42.0%
Lithuania	6.5%	1998	Single payer	9% of taxable income	61% (2010)	32.3%
Poland	6.7%	1997	Single payer	9% of gross wages net of social insurance contributions for old age pension, disability pension and unemployment benefits; paid entirely by employees	60% (2016)	23%
Romania	5.2%	1999	Single payer	10.7% of gross salary (employees pay 5.5% and employers 5.2%) (2015)	67% (2015)	20.5%
Slovakia	6.7%	1994	Multiple payers (3 SHI funds, 2015)	14% of gross monthly income (employees pay 4% and employers 10%) (2016)	69.6% (2014)	18.7%

Sources: ^aWHO (2020); ^bHSPM (2020); ^cBredenkamp et al. (2011) and Szigeti et al. (2019)

This contribution reformulates the question about triggers behind SHI diffusion in CEE in more specific terms, and examines at what level(s) of policy change international interdependencies were potentially influential in the shift away from Semashko systems and towards adoption of SHI. In conceptualising the levels of policy change, this contribution relies on Hall's distinction between "the overarching goals that guide policy in a particular field, the techniques or policy instruments used to attain those goals, and the precise settings of these instruments" (Hall 1993, 278). Accordingly, a first-order policy change is defined as a change in settings (in healthcare this would refer, for example, to the level of contributions collected from employers and/or employees, or the content of the basket of services), without altering "the overall goals and instruments of policy" (Hall 1993, 278). A second-order policy change occurs at the level of the instruments of policy and their settings, while the overall goals of policy remain the same (Hall 1993, 279). Finally, a third-order policy change entails a radical shift in the policy paradigm, whereby "simultaneous changes in all three components of policy: the instrument settings, the instruments themselves, and the hierarchy of goals behind policy" are altered (Hall 1993, 279). Here, the concept of policy paradigm—in Béland's take on Hall's work—refers to "a set of structured assumptions about existing policy problems and the instruments capable of solving them" (Béland 2016, 737).

The following analysis relies on data that have emerged from the research on post-communist reforms in CEE, conducted between 2018 and 2020 within the CRC 1342 and involving numerous interviews and archival research (for a detailed presentation of results on single countries covered in this research, see e.g. Kaminska et al. 2021; Chap. 27; Druga forthcoming; Malinar forthcoming). The empirical evidence presented below suggests that in CEE healthcare systems, the idea to change the paradigmatic framework and shift away from a Semashko system to SHI originated domestically. However, in terms of second-order change, or defining the level of instruments and parameters, domestic policy-makers relied on the expertise of external experts. Here, the data point, on the one hand, to a major role of horizontal interdependencies, embodied by German experts who were actively involved in defining the organisation of the SHI framework in numerous CEE countries, and on the other hand, to the involvement of the World Bank as an example of vertical interdependency.

2 Diffusion of Social Health Insurance Across Central and Eastern Europe: What Role for International Interdependencies?

In terms of the ideational sources behind the third-order change, or the paradigmatic shift from Semashko to SHI-based healthcare, the collected evidence clearly supports the domestic hypothesis. The change of paradigm followed from a backlash against the pre-1989 communist healthcare model due to huge dissatisfaction experienced both by health professionals and patients, and to the rejection on ideological grounds of policies that approximated the previous system. These were repudiated in favour of policies that resembled, on the one hand, Western European SHI models, especially the German one, which was perceived as very successful, and on the other hand, the pre-World War II SHI arrangements in CEE countries, which were used as a clear historical reference (Interview Jacobs; Interview Kloiber; Interview Włodarczyk; Kaminska et al. 2021). Moreover, the analysed data indicate, first of all, that when CEE countries were facing the question of a possible paradigmatic change in healthcare, the World Bank—rather than pushing for introduction of SHI—actually promoted tax-financed healthcare with an enhanced state role, and recommended steering away from neoliberal ideas in CEE. Second, these World Bank recommendations met with resistance on the part of domestic policy-makers in CEE, an expression of the rejection of the “old” systemic features (Kaminska et al. 2021). Thus, the World Bank’s ideational impact or the ability to influence agenda-setting in terms of the choice of paradigm for healthcare in the new post-communist reality was limited.

As for the second-order change, or policy formulation at the level of instruments and parameters that would define the new organisational and institutional set-up of CEE healthcare systems, the collected evidence shows that—unlike in the case of the paradigm shift—CEE policy-makers were inclined to rely on the expertise and assistance of external actors. In particular, German experts were actively sought after by CEE policy-makers (Interview Kloiber; Interview Crusius; Interview Włodarczyk; Kaminska et al. 2021). Germany was recognised as the oldest SHI system in Europe and worldwide, with a very good reputation

among CEE physicians regarding working conditions and remuneration. The cooperation with German experts was also embedded in the historical ties between CEE countries and Germany: most CEE countries adopted SHI before World War II following the Prussian or Austro-Hungarian blueprint.

The first German organisation to get involved in CEE healthcare reform processes was the German Medical Association (*Bundesärztekammer*), which was contacted by different CEE actors. For example, in Poland it was the members of the first democratically elected Parliament—in Latvia, the Medical Association; in Romania and Bulgaria, health ministries—that reached out to the German Medical Association for expertise (Interview Crusius; Interview Kloiber; Interview Podnar). The representatives of the German Medical Association could rely on their experience with the process of integrating the healthcare sector in post-GDR *Bundesländer* into the Western German healthcare system (Interview Crusius; Interview Kloiber). Other institutions that were involved in CEE healthcare reforms introducing SHI included the Institute for Healthcare Research (*Institut für Gesundheitssystemforschung*) in Kiel, the Association for Social Security Policy and Research (*Gesellschaft für Versicherungswissenschaft und -gestaltung*) in Cologne, the Centre for Radiation and Environment Research (*Gesellschaft für Strahlen- und Umweltforschung*) in Munich, the Institute for Health and Social Research (IGES) in Berlin, the Institute for Applied System Research (BASYS: *Beratungsgesellschaft für angewandte Systemforschung*) in Augsburg, as well as two of the largest insurance funds in Germany: the *Allgemeine Ortskrankenkasse* (AOK) and the *Techniker Krankenkasse*. The involvement of German experts in CEE was financed among others by the central government, the German Ministry of Health, the regional governments, but also through PHARE² projects.

² Following the collapse of communism in a number of CEE countries in 1989, the European Economic Community set up a programme for aid and development focused on post-communist transformation and reforms in many policy sectors. Originally designed for Poland and Hungary and called PHARE—Poland and Hungary Assistance for the Restructuring of the Economy—the programme later extended to cover other countries in the region, and became one of the EU's main financial instruments supporting the accession of CEE countries.

The assistance of German experts was demand driven. They offered advice on re-establishing CEE Medical Chambers which were banned under the communist regime, and on designing institutional and technical solutions for SHI-based healthcare. The assistance on the latter topic included advice on financial simulations, the role of professional self-government (Medical Chambers) in SHI systems, mechanisms of redistribution among health insurance companies, contractual relations with healthcare providers, the role of private health insurance in SHI systems, competition between health insurance funds, execution of health insurance tasks at the central and regional/local level, information systems for registration and contribution collection. In the case of CEE countries that introduced SHI insurance systems shortly after the end of the communist regime (like Hungary, Czech Republic and Slovakia), German experts were involved in refining the SHI systems (Jacobs and Leber 1996; Wasem and Jacobs 1998; Schneider and Jacobs 1996, 1998). In the case of countries that postponed SHI introduction until the late 1990s (e.g. Poland and Romania), German experts were directly involved in the process of preparing SHI legislation where they were asked to evaluate and contribute to the draft bills on SHI introduction (Jacobs et al. 1996; Jacobs and Wasem 1998). German experts would also organise exchange visits, seminars, training and workshops for different stakeholders in CEE healthcare reforms. Importantly, German experts involved in formulating policies that would define the set-up of SHI systems in CEE did not prescribe a one-size-fits-all solution. Instead, efforts were made to take the domestic contexts and needs into account when formulating advice (Interview Jacobs; Interview Marek; Jacobs et al. 1996; Jacobs and Wasem 1998).

Moreover, although the World Bank was unable to convince CEE countries to refrain from changing the healthcare policy paradigm in favour of SHI-based healthcare, its experts played a role in defining the set-up of instruments and parameters of the new SHI system. For example, as discussed by Druga (Chap. 27 in this volume) although the Albanian policy-makers refused to follow the World Bank's advice to retain tax-based healthcare, the World Bank's recommendations in the policy formulation phase were readily accepted.

3 Conclusions

At the level of paradigmatic change, the evidence presented above supports Hall's (1993) and Weir and Skocpol's (1985) argument that "the interests and ideals that policymakers pursue at any moment in time are shaped by 'policy legacies' or 'meaningful reactions to previous policies'" (Hall 1993, 277). In CEE, the previous, communist healthcare policy paradigm was perceived as unsustainable by virtually all domestic stakeholders. In Hall's terms, it proved "genuinely incapable of dealing with anomalous developments" (Hall 1993, 280). The failure to address these anomalies undermined its authority and eventually resulted in repudiation of that paradigm by CEE policy-makers. This was reinforced by the positive image of SHI in Western Europe, as well as of the historical CEE experiences with SHI in the pre-communist period and attempts to establish symbolic continuity with the pre-World War II past. Consequently, to use Marmor and Plowden's terms, the rejection of the World Bank's ideas at the paradigmatic level was mainly determined by this local setting, rather than the intrinsic validity of the SHI option (Marmor and Plowden 1991, 812). The World Bank's policy recommendations simply did not fit into the post-communist narrative. This is consistent with Klein's observations about transnational policy learning: "(r) eceptivity to foreign ideas is a function of the extent to which they reinforce or fit in with existing policy predilections and prejudices" (Klein 2009, 308).

At the level of instruments and parameters, external influences played a role in policy-making. In particular, horizontal interdependencies between numerous CEE countries and Germany have proven to be significant. In some countries (e.g. Albania) the World Bank also played a role in defining the design of the SHI system. The external experts contributed to the policy formulation process which defined the set-up of the emerging SHI systems in CEE. They did not pursue a strategy of offering a one-size-fits-all solution across the region. Instead, to paraphrase Klein (2009, 307), they proved to be able to translate foreign experiences into recommendations that were suitable for diverse national environments. This facilitated the process of policy learning and adapting the external

advice to local circumstances in CEE. Consequently, the domestic interpretations of the Western European blueprints have diverged not only from their Western points of reference but also among each other.

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Interviews

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- Interview Dr. Michal Marek, expert at the Ministry of Health, Poland. 25 September 2020.
- Interview Dr. Otmar Kloiber, Secretary General of the World Medical Association, France. 16 September 2019.

Interview Prof. Dr. Andreas Crusius, President of the Medical Association of Mecklenburg-Vorpommern, Germany. 22 June 2020.

Interview Prof. Dr. Cezary Włodarczyk, Institute for Public Health, Jagellonian University, Poland. 20 March 2020.

Interview Prof. Dr. Klaus Jacobs, Managing Director at the WIDO Research Institute, Germany. 25 March 2020.

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