The Effect of EU Integration on Health Care in Central and Eastern Europe

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Abstract The effect of EU policy and its legal framework on health care in CEE member states has been complex. In relation to health care access and financial sustainability, it has been detrimental in certain parts of CEE. This has primarily been the result of economic/fiscal governance instruments of the EU and free-movement rules facilitating outflows of health care professionals. Although there has been a general improvement in access to health care since accession to the EU, the instruments the EU has used to handle the economic crisis have somewhat offset this improvement. Additionally, outflow of health care professionals has resulted in retention strategies such as salary increases and investments in medical infrastructure in some CEE member states, increasing the standard of health care. Still, differences between East and West in terms of important health indicators continue to exist, and EU instruments aimed at compensating this generally lack power to provide meaningful solutions. It seems more solidarity between member states is the only way to increase legitimacy of the European integration in CEE member states and thus prevent them from feeling as outsiders within the EU. Without such a development, CEE countries will continue to lag behind other parts of the Union.

Keywords access to health care, Central and Eastern Europe, European Union, fiscal governance, free movement

Health care is one of the crucial fields of public policy making in most countries of the world. The political, social, and economic choices this field of human activity entails regularly come to the forefront of public debates, with various interest groups and stakeholders trying to affect decision making by the relevant public authorities. The described situation can also

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be observed in the European Union. Even though health care represents a primary competence of the member states, according to article 168 of the Treaty on the Functioning of the European Union, influence of the European integration in this field should not be ignored. This is particularly the case in the areas of economic governance, free movement of health professionals and patients, and regulation of medicines, where EU law has affected national policies and regulatory frameworks to a significant extent (see, for instance, Hervey, Young, and Bishop 2017). Differences in the levels of economic development, fiscal capacity, and historical context between the health care systems of Central and Eastern European (CEE) member states and those of other member states (especially western and northern) also represent a factor that needs to be taken into account when analyzing the overall health care legal and policy framework in Europe (Eurostat 2019a).

This article is focused on the impact of EU integration on health care in CEE countries with a special emphasis on the areas where the EU-level developments have been most far reaching, namely, economic crisis and governance instruments along with free-movement rules. The aim is to identify certain general trends in the mentioned member states and present potential future developments as well, with a focus on access to health care and financial sustainability of national health care systems. It should be mentioned here that Central and Eastern European member states are in themselves pretty diverse, as will be shown in the following sections, a fact that is taken into account. Thus the focus is on the issues that are common to most CEE member states and are somehow unique or specific to this part of the EU, which will be further elaborated below. Central and Eastern European countries for the purposes of this article include Croatia, Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, and Slovenia.

First, the article analyzes the economic crisis and the instruments the European Union has used in this respect related to CEE member states, notably since the start of the crisis. The most important areas of EU health law and policy, such as free movement of health professionals and patients, are presented next, emphasizing their impact on CEE health care systems, especially their financial sustainability and access to health care. Finally, potential developments in the years to come are discussed, concerning CEE countries in the mentioned areas. Emphasis is placed on potential actions necessary for CEE member states' health systems to converge more with the western and northern parts of the Union, thereby increasing the legitimacy of the European integration in the "new" Europe.

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Economic Crisis and Governance Instruments

The effects of European Union mechanisms of fiscal control like the Stability and Growth Pact and the excessive deficit procedure in case of breach of fiscal criteria have been analyzed in another article in this issue. Therefore, this article will not provide a detailed exposition on this general issue but will focus on the impact the said mechanisms have had on CEE member states. Still, it needs to be mentioned that the Stability and Growth Pact was enacted, essentially, to maintain the stability of the European Economic and Monetary Union by imposing limitations on public spending by the member states. Thresholds of 3% of gross domestic product (GDP) for public deficit and 60% of GDP for public debt represent the crucial parts of the system. In case of breach of these limitations by a member state, the council may initiate excessive deficit procedures that can, in extreme circumstances of noncompliance, result in financial penalties imposed on the country in question.[1]

An important role in this respect has also belonged to the instruments set up through the European Semester for coordination of economic policy. In this area, a "soft" framework related to national social and employment policies has complemented EU-level coordination of member states' fiscal and macroeconomic policies that are based on the Stability and Growth Pact. Council guidelines made each year are based on the annual growth surveys by the European Commission and provide the basis for national reform programs prepared by the member states. The commission reviews the program and publishes country reports for individual member states, providing analysis of their social and economic policies. Finally, the council issues country-specific recommendations (CSRs). Strict procedures for prevention, detection, and correction of national macroeconomic imbalances have also been set up by European Union legislation to ensure national implementation. Lack of compliance with the CSRs may result in policy warnings and, finally, financial penalties.[2]

1. On the Stability and Growth Pact and the excessive deficit procedure, see TFEU article 126 and TFEU protocol 12 along with, for example, Council Regulation (EC) 1467/97 of July 7, 1997, on speeding up and clarifying the implementation of the excessive deficit procedure [1997] OJ L209/6.

2. See, for example, European Parliament and Council Regulation (EU) 1173/2011 of November 16, 2011, on the effective enforcement of budgetary surveillance in the euro area [2011] OJ L 306/1; European Parliament and Council Regulation (EU) 1174/2011 of November 16, 2011, on enforcement measures to correct excessive macroeconomic imbalances in the euro area [2011] OJ L306/8; European Parliament and Council Regulation (EU) 1176/2011 of November 16, 2011, on the prevention and correction of macroeconomic imbalances [2011] OJ L306/25. See also Baeten and Vanhercke 2017.

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The economic crisis that started in 2008 has definitely affected the health care systems of CEE countries. These effects have been mixed. Several CEE member states reported cuts in their health care budgets from the start of the crisis until 2011, including Bulgaria, Croatia (not a member state at the time), Estonia, Hungary, Latvia, and Romania. Some of these cuts have amounted to more than 20% of the entire health budget, as in Bulgaria and Latvia. Conversely, in countries like the Czech Republic, Poland, and Slovakia, health insurance revenues and expenditures have increased. This was due partly to the fact that the economic effects of the crisis were less dire, but also due to the countercyclical contribution rate paid by the state for economically inactive people in Slovakia (the revenues of which actually increased during the crisis because of rising unemployment—a similar development also took place in Lithuania). Per capita spending on health care was reduced in Croatia (by 7.1%) and Latvia (by 10.7%) between 2007 and 2012 (Jowett, Thomson, and Evetovits 2015: 52; Mladovsky et al. 2012: 15).

The described situation highlights the complex nature of the issue. There were various reasons for the cuts in health budgets, such as rising unemployment, which reduced state revenue from social insurance contributions. On the other hand, in countries like Lithuania and Slovakia rising unemployment resulted in additional revenues for public health insurance systems. These systems had built-in mechanisms protecting health revenue in times of crisis. Additionally, Bulgaria, Hungary, Latvia, and Romania were all subject to excessive deficit procedures at the time. In the case of Bulgaria, the government deficit reached 3.9% of GDP in 2009, which exceeded the threshold set by the Stability and Growth Pact. This was a result of a strong economic downturn during the global economic crisis, which resulted in negative annual GDP growth of 5% in 2009. For this reason, the excessive deficit procedure was initiated in 2010. As a result, the general government deficit dropped to 3.1% of GDP in 2010, followed by a decrease to 2.1% of GDP in 2011. The correction of the deficit happened mainly because of control of expenditure growth, which included freezing salaries in the public sector and pensions. The expenditure-to-GDP ratio fell by 5.5 percentage points between 2009 and 2011. Despite the reductions during the crisis and the excessive deficit procedure, the share of health care spending in national GDP increased from 6.5% in 2007 to 8.2% in 2015, but the share of public expenditure has decreased when compared to private spending (Dimova et al. 2018: 53–55; European Commission 2010, 2012). In Hungary, the excessive deficit procedure was already

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opened in 2004. After Hungary failed several times to comply with council recommendations, the council concluded in 2009 that Hungary had taken effective action regarding the recommendation from 2006. Owing to the severe economic downturn caused by the global crisis, the council issued a new recommendation, which set 2011 as a new deadline for the correction of the excessive deficit. Since Hungary had not corrected the deficit by the end of 2011, it was asked to do it in 2012 in a sustainable and credible way, that is, to go even further and reduce the deficit to 2.5% of the GDP and to take measures necessary for the deficit to remain below 3%. The result was that the deficit was reduced to 1.9% of the GDP in 2012. This happened, inter alia, due to structural measures related to government expenditure. The latter included a review of social benefits and constraints of expenditure in the public sector, including a nominal freeze of salaries (European Commission 2013a).

In Latvia, the government deficit reached 4% of GDP in 2008, exceeding the threshold set by the Stability and Growth Pact. A strong economic contraction in 2009 resulted in a grim forecast for the following time period, and the excessive deficit procedure was thus opened in 2009. The procedure ended in 2013, as a result of strong fiscal consolidation. The share of government expenditure was reduced by two percentage points in 2012, and the deficit was reduced to 1.2% in the same year. Fiscal consolidation measures included increasing copayments, reducing hospital financing, lowering prices of medicines, and reducing salaries of health care professionals (European Commission 2009a, 2013b; Mitenbergs et al. 2012: xix). In Romania, a large 2009 recession led to a significant decline of government revenue. This resulted in the government deficit rising to 9% of GDP, despite a reduction in government expenditure. The deadline for the correction of the deficit was extended, and the deficit was reduced to 6.8% of GDP in 2010, 5.6% in 2011, and finally 2.9% in 2012. This correction was mainly a result of strict control of government expenditure growth. This included strict control of salaries in the public sector, a reduction in all social security benefits except pensions, and a pension freeze. Romania was also subject to a memorandum of understanding, which was a prerequisite for financial assistance. This memorandum contained more detailed instructions concerning the health care sector. These included reduction in spending for medicines (based mainly on more use of generic medicines), wider use of e-health, reform of hospital payment systems, budget control, introduction of health technology assessment, reduction of number of hospital beds and health professionals financed from the state

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budget, higher copayments, and reduction of social security health packages. All this resulted in shifting a large percentage of health care costs from the state budget to patients. There was also an increase in the number of private health care providers, visible for instance in the fourfold increase in the number of private hospitals, to 161, in 2014 (European Commission 2009b, c and 2013c; Stamati and Baeten 2015: 187; Vlădescu et al. 2016: 77).

The execution of the European Semester in CEE countries has been rather mixed. The CSRs on the reform of health care/long-term care have been issued only for three member states in 2011, emphasizing the focus on economic governance and fiscal discipline. This number increased in subsequent years, with the recommendations generally becoming more multidimensional. Cost-effectiveness and sustainability remain the focal points, but access to health care has become a topic in some of them as well (European Commission 2019c; Stamati and Baeten 2015: 186–87). If one looks at CEE countries, health care is mentioned in 10 CSRs (Bulgaria, Croatia, Czech Republic, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, and Slovenia). Out of these, lack of effectiveness and efficiency in the health care sector is mentioned in the cases of Croatia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, and Slovenia. The problem of limited access to health care is mentioned in the cases of Bulgaria, Croatia, Hungary, Latvia, Lithuania, Poland, Romania, and Slovenia. It is interesting that the CSRs for Bulgaria and Latvia recognize problems that the EU austerity policy has brought to their health care sectors. In the case of Bulgaria, for instance, it is stated that the low level of public spending, low social security health coverage, and uneven distribution of already limited resources have resulted in limited access to health care. Lack of and differences in availability of health professionals also affect access to health care in a negative way. There are several ways in which these problems should be tackled. The Bulgarian CSR recommends improving access to health care services, inter alia by reducing out-of-pocket payments and addressing the lack of health professionals such as doctors and nurses. Increase in quality, accessibility, and cost-effectiveness is recommended in the case of Latvia, where it is recognized that state financing of health care is below the EU average, and high out-of-pocket payments risk lowering access to health treatments for some social groups, resulting in adverse health outcomes (Council of the European Union 2018a–k; European Commission 2019c).

Previous analysis has demonstrated that the EU instruments of economic (primarily fiscal) governance have had a negative impact on access to

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health care in certain CEE countries, in some cases offset by the overall higher standard and economic growth since acceding to the EU, which will be further demonstrated. Of course, access here does not refer to physical availability/accessibility of health care facilities, which is not lacking in most EU countries. A more important question relates to costs of treatment, the responsibility for which falls mostly on the social security systems of the member states. These can be defined as statutory systems based on solidarity, which provide protection from a lack of earnings or particular costs if a recognized social risk occurs (Pieters 2006: 2–3; for a discussion, see Hervey and McHale 2015). These systems differ between one another in terms of sources of funding, personal scope of application, and range of covered health treatments. There are three dimensions of coverage: height, depth, and breadth. Height relates to the extent (percentage) of covered treatment costs; depth refers to the character and number of covered health care services; and breadth refers to the extent of population covered (Smith 2010: 344).

Previous analysis has shown that fiscal control and austerity measures imposed by the European Union in certain CEE countries, like Bulgaria, Latvia, and Romania, have adversely affected all three dimensions of health care coverage. This has, in some cases, been offset by the overall higher standard and economic growth since acceding to the EU. Where the EU role in health care decision making has been the strongest, through excessive deficit procedures and memorandums of understanding, the emphasis was put on privatization, cost containment, and shifting the burden of financing to patients. Romania, for example, has seen a steady rise in out-of-pocket payments since the early 2000s. On the other hand, the proportion of the population reporting an unmet medical need because of the price of health care services decreased from 11.3% in 2007 when Romania acceded to the EU to 9.1% in 2013 (Vlădescu et al. 2016: 139), which is still higher compared to the EU average of 2.4% in 2013. In Latvia, there has been an overall reduction in the share of population reporting unmet medical needs because of prices from 16.8% in 2005 to 8% in 2009, but it increased to 13.5% in 2010, due to the consequences of the economic crisis (Mitenbergs et al. 2012: 162). It can be seen that access to health care has generally improved since CEE accession to the EU, but the economic crisis and fiscal austerity due (partly) to the EU instruments of economic/fiscal governance, where strongly implemented, can have a negative impact in this respect. Of course, EU policies were not necessarily the only reasons behind national austerity measures. In Latvia, the national policy of establishing conditions for a stable fiscal policy, economic growth, and restoration of international

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trust was an important driver of the reforms, assisted by EU economic surveillance mechanisms (Dovladbekova 2012: 4).

Specific national contexts and problems in CEE countries can be highlighted by touching on two specific issues related to access that are relevant for this part of Europe. The first issue concerns informal payments. Unfortunately, a large share of patients in CEE member states resort to these kinds of payments, thereby distorting priorities and limiting access for those patients who need treatment the most. This is a complex phenomenon, since the moments (before or after treatment) in which patients make these additional payments differ across member states, and so too the reasons for doing so (Williams, Horodnic, and Horodnic 2016: 49, 55). These practices are more present in countries where the governments tolerate this kind of behavior and even rely on it as an additional source of revenue for the health care sector (Stepurko et al. 2015: 56). Low salaries caused by austerity are a major factor (but not the only one) contributing to this type of corruption. This has been recognized by some CSRs, as in the cases of Lithuania and Romania, where informal payments have been emphasized as a major obstacle to access, along with lack of medical infrastructure. In Romania, in response to CSR, a monitoring system to curb informal payments has been set up, with its impact still to be assessed (Council of the European Union 2018i, 2019b). Additionally, different national retention strategies for the health care workforce, including salary increases, will be shown in the analysis of free movement of health professionals provided by EU law. These should also partly alleviate the problem of informal payments, even though in some countries like Lithuania this approach has proven to have limited results (Stepurko et al. 2015: 56). In general, EU austerity policies resulting in lower salaries for health care personnel and deficient medical infrastructure may be seen as contributing to the existence of informal payments in CEE, even though this problem has been in existence before accession to the EU and deeply rooted in some of the national health care systems. The latest CSRs have started to address this problem, with their future impact still being hard to assess.

The second issue that needs to be touched on concerns access to health care for the Roma population, which is numerous in certain CEE member states. Unfortunately, Roma still face large obstacles in terms of access to health care. These include lack of social health insurance, lack of information, geographic isolation, communication obstacles, and direct discrimination and human rights violations. The obstacles are, to a large extent, caused by socioeconomic factors, but not entirely (Földes and Covaci 2012). The problem has also been mentioned in some CSRs, such as the

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ones related to Bulgaria and Slovakia in 2019 (Council of the European Union 2019a, c). To address these challenges, the European Commission created the "EU Framework for National Roma Integration Strategies up to 2020" in 2011. Reducing the gap in health status and access between the Roma and the rest of the population was set as one of the priorities, with limited results. Prevention and detection programs, including vaccination campaigns, health mediation, and awareness raising, and improving health conditions and access to health care, have been the main achievements, but discrimination and lack of social health insurance still persist as major challenges to be tackled (European Commission 2011, 2019a). Because EU mechanisms of forcing member states to implement the framework are rather weak, the Union's role in resolving these problems is severely limited.

One concrete area where the European Union can act and which is closely connected to the European Semester, is the cohesion policy. This policy, primarily aimed at reducing inequalities in terms of development between different regions of the EU, has also had an impact in the field of health care. The cohesion policy funds were first focused on building hospital infrastructure. However, the Union priorities for the 2014–20 period (covered by the EU seven-year budget, the Multiannual Financial Framework) have shifted from capital investments toward projects related to establishing links between social and health care services, human resources training, and other "softer" types of investment that support integrated care approaches, especially transition from institution-based to community-based care. Still, lack of basic infrastructure in some CEE member states, hampering equity and access to health care, along with higher political visibility of this type of investment, is the main reason infrastructure remains a priority for many national governments (European Commission 2019c: 10). In the future, a balance between these conflicting priorities needs to be found, thus allowing cohesion policy funds to be even better used to tackle health inequalities, especially related to access in the most deprived regions and for vulnerable groups like the Roma. Synergies between the cohesion funds and other instruments, especially those related to workforce planning, can also be developed, which can provide added value to the already existing separate EU policies.

All in all, the effect of the European Union on health care coverage and access has been multidimensional. The Eurostat data on the percentage of self-reported unmet medical needs because of costs show that this share has generally decreased in CEE countries since their accession to the European

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Table 1 Share of Persons Aged 16 Years and Older Reporting Unmet Needs for Medical Examination or Treatment, by Detailed Reason in 2016

		Reasons related to the health system				Reasons other than those related to the health system					
	All reasons	Total	Too expensive	Too far to travel	Waiting list	Total	No time	Did not know of a good doctor or specialist	Fear of doctor, hospital, examination, or treatment	Wanted to wait and see if problem got better on its own	Other
EU-28[1]	4.5	2.6	1.7	0.1	0.8	1.9	0.5	0.1	0.2	0.7	0.4
Belgium	2.8	2.4	2.2	0.2	0	0.4	0	0	0.1	0.2	0.1
Bulgaria	4.3	2.8	2.2	0.3	0.2	1.5	0.2	0.1	0.1	0.9	0.2
Czech Republic	4.3	0.7	0.2	0.2	0.3	3.6	0.7	0	0.2	2.3	0.4
Denmark	7.8	1.3	0.2	0.1	1.0	6.5	0.9	0.2	0.5	2.5	2.4
Germany	0.9	0.3	0.2	0	0.1	0.6	0.2	0	0.1	0.1	0.2
Estonia	16.9	15.3	1.1	0.7	13.5	1.6	0.2	0.6	0.1	0.2	0.5
Ireland[3]	3.3	2.8	2.0	0	0.8	0.5	0.1	0	0.1	0.2	0.1
Greece	14.5	13.1	12.0	0.2	0.9	1.4	0.4	0	0.2	0.7	0.1
Spain	1.2	0.5	0.2	0	0.4	0.7	0.2	0	0	0.4	0.1
France	4.1	1.3	1.0	0	0.3	2.8	0.7	0.1	0.2	1.5	0.3
Croatia	5.2	1.7	0.7	0.6	0.4	3.5	0.7	0.1	0.3	1.8	0.6
Italy[2]	5.7	5.5	4.9	0.1	0.5	0.2	0.1	0	0	0.1	0
Cyprus	0.8	0.6	0.6	0	0	0.2	0.1	0	0	0.1	0
Latvia	11.7	8.2	5.3	0.5	2.5	3.5	0.8	0.3	0.2	2.1	0.1
Lithuania	3.7	3.1	0.7	0.2	2.2	0.6	0.2	0	0	0.4	0
Luxembourg[3]	4.9	0.9	0.7	0	0.2	4.0	0.9	0	0.2	2.5	0.4
Hungary	6.5	1.3	0.9	0.2	0.2	5.2	1.4	0.1	0.3	2.9	0.5

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Table 1 *(continued)*

		Reasons related to the health system				Reasons other than those related to the health system					
	All reasons	Total	Too expensive	Too far to travel	Waiting list	Total	No time	Did not know of a good doctor or specialist	Fear of doctor, hospital, examination, or treatment	Wanted to wait and see if problem got better on its own	Other
Malta	2.8	1.0	0.7	0	0.3	1.8	0.2	0	0.1	0.3	1.2
Netherlands	0.8	0.2	0.1	0	0.1	0.6	0.0	0.1	0	0.2	0.3
Austria	0.7	0.2	0.2	0	0.1	0.5	0.1	0	0	0.3	0.1
Poland	12.3	6.6	2.3	0.4	3.9	5.7	2.3	0.1	0.6	2.1	0.6
Portugal	4.1	2.4	2.0	0	0.3	1.7	0.5	0	0.3	0.6	0.3
Romania[2]	8.6	6.5	5.3	0.6	0.7	2.1	0.3	0.1	0.4	0.8	0.5
Slovenia	0.8	0.4	0.1	0	0.3	0.4	0.1	0	0.1	0.1	0.1
Slovakia	6.2	2.3	0.8	0.3	1.2	3.9	1.0	0.4	0.5	1.4	0.6
Finland	4.9	4.1	0.1	0	4.0	0.8	0	0	0	0.0	0.8
Sweden	10.2	1.6	0.4	0.2	1.0	8.6	1.7	0.7	0.2	3.3	2.7
United Kingdom	1.8	1.0	0.1	0	0.9	0.8	0.1	0.1	0.1	0	0.5
Iceland[3]	8.4	4.3	3.3	0.3	0.7	4.1	0.1	0.2	0.1	1.0	2.7
Norway	2.3	1.1	0.4	0	0.7	1.2	0.1	0.1	0	0.1	0.9
Switzerland	2.2	0.5	0.5	0	0	1.7	0.4	0.1	0	0.6	0.6
Former Yugoslavian Republic of Macedonia[3]	6.0	2.9	2.1	0.3	0.4	3.1	0.1	0.1	0.6	2.0	0.3
Serbia	10.5	4.5	2.6	0.6	1.2	6.0	2.0	0.1	0.6	1.9	1.4

Notes: 1 = estimates; 2 = provisional data; 3 = 2015.
Source: Eurostat (online data code: hlth_silc_08).

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Table 2 GDP per Capita in Purchasing Power Parity (PPS) as a Percentage of EU Average in CEE Countries

Country	2007	2018
Bulgaria	40	50
Croatia	61	63
Czech Republic	82	90
Estonia	69	81
Hungary	60	70
Latvia	57	70
Lithuania	60	81
Poland	53	71
Romania	43	64
Slovakia	67	78
Slovenia	87	87

Source: Eurostat 2019a.

Union (Alexa et al. 2015: 135–36; Mitenbergs et al. 2012: 162; Vlădescu et al. 2016: 139), owing in large part to the overall economic growth in these countries. On the other hand, the said percentage increased during the crisis in those states hardest hit by it and the EU instruments of economic governance, and it is still above the EU average in Bulgaria, Latvia, Poland, and Romania. The data on unmet medical needs in different member states are shown in table 1, and the overall economic growth following accession of CEE countries to the EU is shown in table 2.

The European Union's legally strongest instruments and possibilities to influence national health care policies lie in fiscal control. Conversely, concrete instruments for offsetting the consequences of fiscal austerity to health care access are much more limited in terms of scope and legal strength. In this sense, the commission has identified three crucial issues concerning health care access in the EU: cost sharing, traveling distance, and waiting time. Cost sharing and waiting times are especially connected with the economic crisis and fiscal austerity imposed on certain CEE member states' health systems (European Commission 2014: 8). Unlike economic governance, instruments for resolving these issues and other problems concerning access to health care, such as health insurance for the Roma population, are limited to "soft" law tools like recommendations, without real legal or fiscal power to address the problem in a meaningful way, apart from cohesion policy funds to some extent. All of this can be observed particularly in CEE countries.

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Free Movement of Health Care Professionals

Free movement of health care professionals has proven to have a strong impact on health care systems of CEE countries. The relevant legal framework in this sense concerns EU rules on free movement of workers, freedom of establishment, and freedom to provide services. Article 45 of the Treaty on the Functioning of the European Union prescribes abolition of any nationality-based discrimination between workers from the EU member states concerning remuneration, employment, and working conditions. Workers are entitled to move freely within EU member states for the purpose of seeking and accepting employment; accept employment offers actually made; stay in an EU member state for the purpose of employment according to the national rules on employment of its own citizens; and remain in a member state after the end of the employment relationship under the conditions prescribed by the European Commission. An employment relationship entails a situation in which, for a certain time period, a person performs services for another person and under the direction of that person in return for remuneration, as stated by the Court of Justice of the European Union in *Lawrie-Blum*.[3] These rules are applicable to health care professionals employed in hospitals and similar institutions.

According to article 49 of the Treaty on the Functioning of the European Union, all restrictions concerning freedom of establishment of nationals of one EU member state in the territory of another EU member state are prohibited. This prohibition also applies to restrictions on the establishment of branches, agencies, or subsidiaries by nationals of an EU member state living in another member state. This freedom entails the right to pursue and take up activities as a self-employed person, under the conditions prescribed by the member states in which the establishment is effected. Thus freedom of establishment is applicable to self-employed health care professionals such as medical doctors or dentists who want to set up their own office in another member state. It is important that the health care professional participates, on a continuous and stable basis, in the

3. In the context of free movement of health care professionals, the second situation is relevant. See Deborah Lawrie-Blum v. Land Baden-Württemberg, 66/85 (CJEU, 1986). The case was about a British national who had passed the first stage of teacher training in Germany but was refused entry to the second stage by the state authorities because teachers in Germany are considered civil servants, and such posts could only be held by German citizens. Lawrie-Blum took the case to the court on the grounds that she was a worker and therefore entitled to obtain employment in any state of the European Economic Community, which was accepted by the court.

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economic life of an EU member state that is not his or her state of origin, as stated by the Court of Justice in *Gebhard*.[4]

Finally, it is prescribed by article 56 of the treaty that all restrictions related to free provision of services within the EU are prohibited concerning nationals of member states who are established in a member state other than that of the service recipient. According to the judgment in *Gebhard*, the difference between freedom of establishment and freedom to provide services is that the latter includes activities of a temporary nature. Four different situations can occur here: first, recipients travel to the service provider's member state (for example, a patient travels abroad to receive health care); second, service providers travel to the recipient's member state (for example, a medical doctor temporarily offers health services in another member state because he or she offers cheaper rates or provides treatments of a better quality than domestic health care providers); third, both the service provider and the service recipient cross the border; fourth, the service itself is provided cross-border, without the provider or the recipient crossing the border (for example, e-health).[5] As stems from the mentioned case law, all of these free-movement rules prohibit discrimination on the basis of nationality, but also those rules which do not (directly) discriminate, but make the pursuit of professional (economic) activities in other member states subject to certain conditions. For example, the fact that nationals of an EU member state who pursue their occupation in another member state must comply with the rules that govern the pursuit of the said occupation in the latter member state may represent an obstacle to free movement of workers, establishment, and services. Restrictive national rules that limit free movement may be justified by the protection of general interest, but the member state must prove that their rules are necessary for achieving this purpose.[6]

Apart from the described rules of EU primary law, free movement of health care professionals is also protected by the Union's secondary law

4. In the context of free movement of health care professionals, the second situation is relevant. See Reinhard Gebhard v. Consiglio dell'Ordine degli Avvocati e Procuratori di Milano, C-55/94 (CJEU, 1995). The case was about a German lawyer who lived in Italy, called himself an "avvocato," and set up chambers to practice as a lawyer. He was suspended by the Milan Bar Council because he had not been registered in Italy. Italian lawyers complained that he used the title of "avvocato" in his practice with mainly German customers in Milan.

5. See Alpine Investments BV v. Minister van Financiën, C-384/93 (CJEU, 1995); Commission of the European Communities v. French Republic, C-154/89 (CJEU, 1991); Raymond Kohll v. Union des caisses de maladie, C-158/96 (CJEU, 1998). In the context of free movement of health care professionals, the second situation is relevant.

6. See Commission of the European Communities v. French Republic, 96/85 (CJEU, 1986). See, on some of these issues for example, Hancher and Sauter 2010.

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regulating recognition of professional qualifications. This legislation, enacted through the Professional Qualifications Directive to facilitate free movement of workers, establishment, and services within the EU, has been reasonably well implemented by the Union member states.[7]

Within the context of CEE countries, permanent movement of health care professionals, either to work as employees or to open their own practices in other member states, is of particular importance. Described legal frameworks, along with better working conditions and salaries in some member states, have resulted in significant shortages of health care professionals in some CEE member states. The Bulgarian 2018 CSR, for example, recognizes that district-level differences in the number of doctors and the low number of nurses represent a problem. It also notes that the number of physicians leaving Bulgaria has dropped recently, which is logical since the economic situation has improved since the economic crisis and excessive deficit procedure. In the case of Hungary, the 2018 CSR recognizes that the shortage of health care professionals hampers access to treatment, although recent salary increases have improved the situation. In Poland's case, the 2018 CSR notes that the number of doctors and nurses in some specializations is below the EU average, which also affects access to health care. The situation is somewhat better in Slovakia, but the lack of general practitioners in certain areas is a problem.

As noted in the literature, the increase in outflows of health care professionals became evident at the time of the accession to the EU. In this sense, the biggest source of data concerns one's intention to leave, which stems from the system of recognition of professional qualifications. Documents verifying the degree a professional has obtained are provided by the member state where the degree has been issued. Of course, not all persons who request such verifications permanently leave the country, but still, a general pattern can be observed. The highest numbers of these documents were issued in the first two years of the accession, with the numbers dropping afterward. Major destination countries have been the United Kingdom, Germany, Austria, France, Belgium, Spain, and Finland. The overall effect of this mobility in CEE has varied between different countries (table 3). For example in Estonia, the numbers of recognition certificates peaked in 2004, with 283 for medical diplomas and 118 for nursing, while dropping

7. See European Parliament and Council Directive 2005/36/EC of September 7, 2005, on the recognition of professional qualifications [2005] OJ L255/22 (Professional Qualifications Directive). This directive has also been extensively analyzed in the literature. See, for example, Costigliola 2011; Peeters 2005; and Peeters, McKee, and Merkur 2010.

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Table 3 Yearly Outflows/Outflow Intentions of Medical Doctors from Selected 2004 and 2007 CEE Member States in the First Years of Accession

Country	Indicator	2004	2005	2006	2007	2008	2009
Estonia	Intention to leave (percentage of active workforce)	283 (6.5%)	79 (1.8%)	87 (2.0%)	75 (1.7%)	79 (1.8%)	106 (2.4%)
Hungary	Intention to leave (percentage of active workforce)	906 (2.7%)	889 (2.7%)	721 (2.2%)	695 (2.1%)	803 (2.4%)	887 n/a
Lithuania	Intention to leave (percentage of active workforce)	357 (2.7%)	186 (1.4%)				132 (0.9%)
Poland	Intention to leave (percentage of active workforce)	n/a	3,579	1,535	1,123	901	n/a
Romania	Intention to leave (percentage of active workforce)				4,990 (10.2%)	2,683	n/a
Slovakia	Intention to leave (percentage of active workforce)	442	594	376	267	250	217

Source: Maier et al. 2011.

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afterward and again increasing during the economic crisis. In Hungary and Lithuania, during the first year of EU membership, around 2.7% of all medical doctors obtained recognition certificates, and the numbers decreased afterward. In 2005 approximately 3% of Polish medical doctors were issued recognition certificates, and around 6.5% of Estonian doctors were issued them in 2004. About 3% of all medical doctors left Romania in 2007, and estimated annual outflows have rarely exceeded 3% of the domestic workforce in CEE countries in the first year or two following accession (Ognyanova et al. 2014: 81). The outflows have generally been more emphasized in the most deprived regions and countries. Thus the examples of Bulgaria, but also certain regions of Romania, which has been subject to a very strict mode of fiscal control due to the economic crisis, show that these outflows can have dire consequence for health care access in certain areas of CEE.

On the other hand, CEE countries like Estonia, Lithuania, and Poland have employed various retention strategies, such as increasing salaries and improving working conditions and medical infrastructure, thereby increasing the quality of health care provision; these measures have resulted in return migration (Ognyanova et al. 2014: 85). For example, hospital doctors in Poland received a 40% payment increase in 2006 (Holt 2010: 222), and those in the Czech Republic received around 33% in 2011 after a quarter of them threatened to leave the country (Stafford 2011: 342). Health professional mobility, or threat thereof, has also had positive consequences on the national health care systems of Central and Eastern Europe.

Free Movement of Patients

The free movement of patients across the borders of EU member states has been thoroughly debated since the first judgments of the Court of Justice in 1998. These judgments have focused on the entitlement of persons socially insured in one of the EU member states to obtain health care in another EU member state, on the basis of article 56 of the Treaty on the Functioning of the European Union. The court interpreted the treaty as providing an entitlement to health care abroad paid by the country in which a patient is socially insured (state of affiliation) according to its own coverage rules, without the person in question having to obtain prior authorization in some instances. The case law has thus created a system of covering cross-border health care parallel to the long-existing system based on the EU coordination of social security systems. Under the latter system,

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the patients are entitled to the same cover as the patients insured in the state of treatment, paid for by the state of social insurance.[8]

The casuistic nature of the case law, with many questions as to the applicability of freedom to receive health care services outside the state of social insurance, and the impact of that market freedom on the financial sustainability of social health systems, emphasized the necessity to regulate the matter by way of secondary EU legislation. The first proposal by the commission had been made in 2008, but it took three years before the directive was adopted in 2011, with the negotiations and bargaining taking part in the midst of the economic crisis. The legislative procedure contained several different versions, but the final version adopted by the council and the Parliament additionally limited patients' entitlements to receive cross-border health care services when compared to the case law and the first proposal by the commission.[9]

It should be emphasized that the transposition period ended on October 25, 2013. Still, certain member states were late in implementing the directive, and there were some cases in which the transposition had not been done properly. After the transposition deadline expired, the European Commission initiated 26 infringement procedures for incomplete or late notification of transposition measures. Following this process, all EU member states notified their complete transposition measures. If one looks at the impact of free movement of patients in CEE countries, it appears to be marginal, similar to other EU member states, since the vast majority of national health care budgets is spent domestically. In terms of patient flows, CEE countries are not the focal point of patients' free movement, compared to other member states like France or Spain. In the case of treatment not requiring prior authorization, for example, France has the largest number of patients traveling to other member states. The next most frequent cases of patients' movement were patients traveling from Denmark to Germany, followed by Poland to Czech Republic. Most of patient mobility concerned neighboring countries, indicating proximity as one of the main reasons for traveling for health care abroad (European Commission 2018b).

8. See, for example, on the case law, VG Müller-Fauré v. Onderlinge Waarborgmaatschappij OZ Zorgverzekeringen UA and EEM van Riet v. Onderlinge Waarborgmaatschappij ZAO Zorgverzekeringen, C-385/99 (CJEU, 2003). On coordination see, for instance, article 17-35 of Regulation (EC) 883/2004 of the European Parliament and of the council on the coordination of social security systems [2004] OJ L166/1. See also, for example, Flear 2004.

9. See Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare [2011] OJ L88/45; and Commission (EC) Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border health care COM(2008) 414 final, July 2, 2008. The directive has been extensively analyzed in the literature; see, for example, de la Rosa 2012; Peeters 2012; Raptopoulou 2012; Strban 2013; and van de Gronden et al. 2011.

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Table 4 Patient Mobility under the Directive 2011/24 in 2016

Country	Incoming patients	Outgoing patients
Bulgaria	686	5
Croatia	1,680	200
Czech Republic	12,300	401
Estonia	10,044	80
Hungary	4,169	na
Latvia	167	27
Lithuania	369	19
Poland	6,545	8,647
Romania	1,003	130
Slovakia	259	6,110
Slovenia	117	1,835

Source: ECA 2019: 7–8.

The number of Union citizens requesting reimbursement for health care received abroad under the directive amounts to only around 200,000 claims a year, which is less than 0.05% of EU citizens. The largest number of coverage requests in general is related to the rules on the coordination of social security systems, whereby around 2 million requests are made annually for unplanned health treatments abroad. Expenditure on cross-border health care based on the directive is estimated at 0.004% of the EU-wide annual health budget. In Central and Eastern Europe, some countries treat more incoming patients than reimburse outgoing patients under the directive (ECA 2019: 7–8; table 4). It can be presumed that one of the reasons for the latter development is that, under the directive, a patient needs to pay up front and ask for reimbursement afterward, which means that the system favors patients traveling to those countries in which treatments are cheaper at the point of delivery. Of course, other factors such as language barriers, lack of information, and geographic distance also need to be taken into account, as stated by the Court of Justice in *Müller-Fauré*, which is the case with mobility in general.[10] There is also a potential for positive impact on CEE member states, such as reduction of bottlenecks

10. The case involved two women insured in the Netherlands who underwent health treatment in other member states. Ms. Müller-Fauré underwent dental treatment in Germany, while Ms. Van Riet was subjected to arthroscopy in Belgium. Both patients obtained their treatment without prior authorization and reimbursement was denied. The court concluded that, in the case of nonhospital treatment, the prior authorization requirement cannot be justified, since it is unlikely that significant numbers of patients would travel to obtain nonhospital health care abroad because of the distances, linguistic barriers, lack of information, and costs.

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within their health care systems and cross-border cooperation to achieve better planning of resources (by developing cross-border reference networks, for instance). Additional research for better understanding of the factors underlying this phenomenon is needed.

Despite the fact that patient mobility still represents a marginal phenomenon and that some CEE countries treat more incoming patients than covering foreign treatments, some of its implications may prove to be problematic for CEE member states, especially their most deprived regions. A good example of this is represented by the Court of Justice of the European Union judgment in *Petru*, concerning social security coordination regulations. Ms. Petru, a Romanian national, needed to have open heart surgery. Believing that the infrastructure in the Romanian hospital establishment was not adequate for such a treatment, Ms. Petru traveled to a clinic in Germany, where the surgery was carried out. Ms. Petru requested her social health insurer to cover the cost of the procedure and was refused. In support of her action, Ms. Petru claimed that the hospital conditions in Romania were particularly inadequate, basic medical commodities and medication were lacking, there was an insufficient number of beds, and it was because of the complexity of the medical procedure and the poor conditions that she had decided to leave that institution and go to Germany to receive the treatment. The court concluded that the authorization under EU rules could not be refused where it is because of a lack of basic medical supplies, medication, and infrastructure that the hospital care in question cannot be provided in good time in the insured person's member state of residence. The question of whether the provision of care is impossible to obtain must be determined by taking into account all the hospital establishments in the member state that are capable of providing the treatment and the timeliness of the treatment itself.

Of course, standards of health care provision in the European Union are not harmonized, as significant differences exist between member states. Central and Eastern European countries like Bulgaria or Romania, which are not able to dedicate nearly the amount of resources on health care per capita as western and northern European countries, may face problems in this respect. In terms of per capita health care spending, Romania is at the bottom of the EU, preceded by Bulgaria, Poland, Latvia, Croatia, Hungary, Lithuania, Slovakia, Estonia, and the Czech Republic. Out of CEE member states, only Slovenia is a bit better in this respect. Highest expenditures per capita are present in Luxembourg, Sweden, Denmark, Ireland, the Netherlands, and Germany. Health outcomes like infant mortality also follow this divide, whereby CEE countries underperform when compared to

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northern and western member states. Unmet medical needs, due to treatment prices and waiting lists, represent a bigger problem in CEE countries when compared to other member states (Dimova et al. 2018: 186–87; Eurostat 2019b, 2019c). The case law by the Court of Justice opens up possibilities for patients to travel to member states in which higher standards of health care provision apply, to receive health care paid for by the state of social health insurance. These possibilities have not been utilized to a significant extent so far, but that does not mean it will not happen in the future, as EU citizens become more aware of the rights Union law provides them.

Convergence as a Way Forward?

The effect of EU policy and legal framework on health care in CEE member states has proven to be complex. In terms of access to health care and financial sustainability of national systems, this effect has been detrimental in certain parts of CEE, mostly the most deprived ones like certain regions of Bulgaria and Romania. This has primarily been the result of EU economic/fiscal governance instruments and free-movement rules facilitating outflows of health care professionals to western and northern member states. Although there has been a general improvement in access to health care since the accession to the EU, the instruments the EU has used to handle the economic crisis have offset this improvement to a significant extent. Also, outflow of health care professionals has resulted in retention strategies such as salary increases and investments in medical infrastructure in some CEE countries, increasing the standards of health care. Despite this, differences between East and West in terms of indicators like health outcomes still exist. Free movement of patients across national borders is also important because it may impose additional financial burden on national social security systems in CEE, although this has not transpired in a significant way. The EU instruments used to compensate for some of the problems are mostly confined to "soft" law without any significant power behind them to provide meaningful solutions.

Certain CEE member states have a long way to go to broadly match standards of health care provision available in western parts of the EU. Convergence in this sense can hardly be achieved without help from the EU level, particularly its cohesion policy. Unfortunately, proposals from the commission concerning this issue seem to take a step back instead of a step forward. The general reduction of funds dedicated to cohesion policy, originally proposed by the commission for the period 2021–27, should be emphasized in this respect. Furthermore, there was no specific health

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program in the proposed Multiannual Financial Framework for the same period. The European Social Fund Plus was proposed to serve as the European Union's main financial instrument related to investment in people and implementation of the European Pillar of Social Rights, including health policies. This program included € 413 million for the health strand, a feeble amount that can hardly make a difference in reducing disparities between member states and regions. The COVID-19 crisis has resulted in a more ambitious proposal that includes a much larger self-standing health program, but its fate remains uncertain due to the opposition of some member states in the European Council (European Commission 2018a, 2020; European Council 2020).[11]

There is also a proposal from the European Commission to tie funding from the EU budget to rule-of-law protection in the individual member states. This means that respect for the rule of law is a necessary prerequisite for confidence that Union spending in member states is sufficiently protected. The proposal is that measures against "problematic" members should be based on a council decision following a proposal from the commission. A decision shall be deemed to have been adopted by the council, unless it decides, by qualified majority, to reject the commission proposal within one month of its adoption. The council may amend the commission's proposal through qualified majority.[12]

The commission proposal is problematic on several levels. First, there is a question of legal basis. Article 322(1)(a) of the Treaty on the Functioning of the European Union prescribes that regulations may be adopted, through ordinary legislative procedure, concerning the financial rules that determine in particular the procedure to be adopted for establishing and implementing the budget and for presenting and auditing accounts. There is no mention of responsibility and rules of law in this treaty article, and it is very hard to infer it, since rule of law is regulated by other provisions of the treaty, notably article 7 of the Treaty on European Union. The procedure prescribed by article 7 requires unanimity by other member states when determining the existence of a serious and persistent breach of EU values by a member state. Only after that is suspension of a member state's rights possible. Such a

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11. See also European Commission Proposal for a Regulation of the European Parliament and of the Council laying down common provisions on the European Regional Development Fund, the European Social Fund Plus, the Cohesion Fund, and the European Maritime and Fisheries Fund and financial rules for those and for the Asylum and Migration Fund, the Internal Security Fund and the Border Management and Visa Instrument COM(2018) 375 final, May 29, 2018.

12. See article 5 of European Commission Proposal for a Regulation of the European Parliament and of the council on the protection of the Union's budget in case of generalized deficiencies as regards the rule of law in the member states COM(2018) 324 final, May 2, 2018.

decision represents an extreme course of action, and the prescribed procedure and majority required should not be circumvented by invoking other treaty provisions that are not related to the basic principles of the rule of law. Finally, presumption in favor of a negative decision for a member state (proposed by the commission), whereby a qualified majority is necessary to decide the opposite, disrupts the balance of power between the commission and the council in favor of the commission.

Contrary to the commission's restrictive original proposal and opposition to increased EU investments in health care by some member states, previous analysis has shown that a stronger cohesion policy is necessary to reduce disparities between standards of health care provision in the EU. Member states that have benefitted the most from the EU internal market, attracting highly skilled workers from CEE countries (including health care professionals), should financially offset the negative consequences CEE countries have faced because of EU economic/fiscal governance and outflow of highly educated population to other parts of the Union. This is the only way to increase legitimacy of the European integration in CEE member states and prevent them from feeling as outsiders within the EU. Thus cohesion policy funding should not be reduced (despite Brexit, which results in the UK's not contributing anymore to the EU budget), and health care should become one of the EU's priorities, which now clearly is not. Without such measures, disparities in health care provision within the EU will not be reduced, to the detriment of the most deprived parts of Central and Eastern Europe.

Conclusion

The effect of European Union policy and legal framework on health care in CEE member states of the EU has been complex. In relation to access to health care and financial sustainability of national systems, this effect has been detrimental in certain parts of CEE, mostly the most deprived ones like certain regions of Bulgaria and Romania. This has primarily been the result of EU economic/fiscal governance instruments and free-movement rules facilitating outflows of health care professionals to western and northern member states. Although there has been a general improvement in access to health care since the accession to the EU, the instruments the EU has used to handle the economic crisis have significantly offset this improvement. Additionally, the outflow of health care professionals has resulted in retention strategies such as salary increases and investments in medical infrastructure in some Central and Eastern European member states, increasing the standards of health care.

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Still, differences between East and West in terms of per capita health care spending and indicators like health outcomes continue to exist. The EU instruments aimed at compensating some of the problems are limited mostly to “soft” law without any significant power behind them to provide meaningful solutions. One possible solution to resolve some of these issues is more solidarity between member states. Countries that have benefitted the most from free movement and the internal market should help strengthen the EU budget, despite Brexit, if one wants to see more convergence between national health care systems in terms of health outcomes and standards of health care provision. These kinds of policies are the only way to increase legitimacy of the European integration in CEE member states and prevent them from feeling as outsiders within the EU. Without such a development, CEE countries and their health systems would continue to lag behind other parts of the European Union in the future.

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References

Alexa, Jan, Lukáš Rečka, Jana Votápková, Ewout van Ginneken, Anne Spranger, and Friedrich Wittenbecher. 2015. *Czech Republic: Health System Review*. Copenhagen, Denmark: World Health Organisation.

Baeten, Rita, and Bart Vanhercke. 2017. “Inside the Black Box: The EU’s Economic Surveillance of National Healthcare Systems.” *Comparative European Politics* 15, no. 3: 478–97.

Costigliola, Vincenzo. 2011. “Mobility of Medical Doctors in Cross-Border Healthcare.” *EPMA Journal* 2, no. 4: 333–39.

Council of the European Union. 2018a. “Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Bulgaria and Delivering a Council Opinion on the 2018 Convergence Programme of Bulgaria.” September 10. eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32018H0910(02)&from=IT.

Downloaded from http://dup.silverchair.com/jhppl/article-pdf/46/1/147/849957/147sokol.pdf by guest on 20 April 2024

Council of the European Union. 2018b. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Croatia and Delivering a Council Opinion on the 2018 Convergence Programme of Croatia." September 10. eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32018H0910(10)&rid=3.

Council of the European Union. 2018c. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of the Czech Republic and Delivering a Council Opinion on the 2018 Convergence Programme of the Czech Republic." September 10. eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32018H0910%2803%29.

Council of the European Union. 2018d. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Estonia and Delivering a Council Opinion on the 2018 Stability Programme of Estonia." September 10. eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32018H0910%2806%29.

Council of the European Union. 2018e. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Hungary and Delivering a Council Opinion on the 2018 Convergence Programme of Hungary." September 10. eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32018H0910%2816%29.

Council of the European Union. 2018f. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Latvia and Delivering a Council Opinion on the 2018 Stability Programme of Latvia." September 10. eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32018H0910%2813%29.

Council of the European Union. 2018g. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Lithuania and Delivering a Council Opinion on the 2018 Stability Programme of Lithuania." September 10. eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32018H0910%2814%29.

Council of the European Union. 2018h. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Poland and Delivering a Council Opinion on the 2018 Convergence Programme of Poland." September 10. eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32018H0910(20)&from=EN.

Council of the European Union. 2018i. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Romania and Delivering a Council Opinion on the 2018 Convergence Programme of Romania." September 10. eur-lex.europa.eu/legal-content/EN/TXT/?qid=1538474984830&uri=CELEX%3A32018H0910%2822%29.

Council of the European Union. 2018j. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Slovakia and Delivering a Council Opinion on the 2018 Stability Programme of Slovakia." September 10. eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32018H0910%2824%29.

Council of the European Union. 2018k. "Council Recommendation of 13 July 2018 on the 2018 National Reform Programme of Slovenia and Delivering a Council Opinion on the 2018 Stability Programme of Slovenia." September 10. eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:32018H0910(23).

Council of the European Union. 2019a. "Council Recommendation of 9 July 2019 on the 2019 National Reform Programme of Bulgaria and Delivering a Council

Downloaded from http://dup.silverchair.com/jhppl/article-pdf/46/1/147/849957/147sokol.pdf by guest on 20 April 2024

Opinion on the 2019 Convergence Programme of Bulgaria." July 9. op.europa.eu /en/publication-detail/-/publication/41535492-cff8-11e9-b4bf-01aa75ed71a1 /language-en.

Council of the European Union. 2019b. "Council Recommendation of 9 July 2019 on the 2019 National Reform Programme of Lithuania and Delivering a Council Opinion on the 2019 Stability Programme of Lithuania." July 9. op.europa.eu/en /publication-detail/-/publication/8f1e3309-cffc-11e9-b4bf-01aa75ed71a1/language -en.

Council of the European Union. 2019c. "Council Recommendation of 9 July 2019 on the 2019 National Reform Programme of Slovakia and Delivering a Council Opinion on the 2019 Stability Programme of Slovakia." July 9. eur-lex.europa.eu /legal-content/EN/TXT/?uri=CELEX%3A32019H0905%2825%29.

de la Rosa, Stephane. 2012. "The Directive on Cross-Border Healthcare or the Art of Codifying Complex Case Law." *Common Market Law Review* 49, no. 1: 15–46.

Dimova, Antoniya, Maria Rohova, Stefka Koeva, Elka Atanasova, Lubomira Koeva-Dimitrova, Todorka Kostadinova, and Anne Spranger. 2018. *Bulgaria: Health System Review*. Copenhagen, Denmark: World Health Organisation.

Dovladbekova, Inna. 2012. *Austerity Policy in Latvia and Its Consequences*. Berlin: Friedrich Ebert Stiftung.

ECA (European Court of Auditors). 2019. "EU Actions for Cross-Border Healthcare: Significant Ambitions but Improved Management Required." www.eca.europa.eu /Lists/ECADocuments/SR19_07/SR_HEALTH_CARE_EN.pdf (accessed August 18, 2020).

European Commission. 2009a. "Commission Opinion on the Existence of an Excessive Deficit in Latvia." July 2. ec.europa.eu/economy_finance/economic_governance /sgp/pdf/30_edps/104–05/2009–07–02_lv_104–5_en.pdf.

European Commission. 2009b. "Commission Opinion on the Existence of an Excessive Deficit in Romania." June 24. ec.europa.eu/economy_finance/economic_governance /sgp/pdf/30_edps/104-05/2009-06-24_ro_104-5_en.pdf.

European Commission. 2009c. "Memorandum of Understanding between the European Community and Romania." May 6. ec.europa.eu/info/sites/info/files/ecfin_ publication15409_en.pdf.

European Commission. 2010. "Commission Opinion on the Existence of an Excessive Deficit in Bulgaria." July 6. ec.europa.eu/economy_finance/economic_governance /sgp/pdf/30_edps/104–05/2010–07–06_bg_126–5_en.pdf.

European Commission. 2011. "An EU Framework for National Roma Integration Strategies up to 2020." April 5. eur-lex.europa.eu/legal-content/EN/TXT/?uri= celex%3A52011DC0173.

European Commission. 2012. "Recommendation for a Council Decision Abrogating Decision 2010/422/EU on the Existence of an Excessive Deficit in Bulgaria." May 30. op.europa.eu/en/publication-detail/-/publication/ae092d32-a7a3-409f-b702 -6c6b682e1172/language-en.

European Commission. 2013a. "Recommendation for a Council Decision Abrogating Decision 2004/918/EC on the Existence of an Excessive Deficit in Hungary."

Downloaded from http://dup.silverchair.com/jhppl/article-pdf/46/1/147/849957/147sokol.pdf by guest on 20 April 2024

May 29. op.europa.eu/en/publication-detail/-/publication/660b1030-2bda-4262-80fd-7390fa77f7a1/language-en.

European Commission. 2013b. “Recommendation for a Council Decision Abrogating Decision 2009/591/EC on the Existence of an Excessive Deficit in Latvia.” May 29. ec.europa.eu/economy_finance/economic_governance/sgp/pdf/30_edps/126–12_council/2013–05–29_lv_126–12_council_con_en.pdf.

European Commission. 2013c. “Recommendation for a Council Decision Abrogating Decision 2009/590/EC on the Existence of an Excessive Deficit in Romania.” May 29. ec.europa.eu/economy_finance/economic_governance/sgp/pdf/30_edps/126–12_council/2013–05–29_ro_126–12_council_con_en.pdf.

European Commission. 2014. “Effective, Accessible and Resilient Health Systems.” April 4. ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/com2014_215_final_en.pdf.

European Commission. 2018a. “EU Budget for the Future.” ec.europa.eu/commission/future-europe/eu-budget-future_en (accessed August 18, 2020).

European Commission. 2018b. “Report from the Commission to the European Parliament and the Council on the Operation of Directive 2011/24/EU on the Application of Patients’ Rights in Cross-Border Healthcare.” September 9. eur-lex.europa.eu/legal-content/EN/TXT/?uri=COM%3A2018%3A651%3AFIN.

European Commission. 2019a. “Report on the Implementation of National Roma Integration Strategies—2019.” September 5. eur-lex.europa.eu/legal-content/GA/TXT/?uri=CELEX:52019DC0406.

European Commission. 2019b. “ESI Funds for Health Investing for a Healthy and Inclusive EU.” Brussels: European Commission. www.esifundsforhealth.eu/sites/default/files/2019-03/Final%20Report%20ESI%20Funds%20for%20Health_2.pdf (accessed September 15, 2020).

European Commission. 2019c. “The European Semester.” ec.europa.eu/info/business-economy-euro/economic-and-fiscal-policy-coordination/eu-economic-governance-monitoring-prevention-correction/european-semester_en (accessed August 18, 2020).

European Commission. 2020. “EU4Health Programme for a Healthier and Safer Union.” ec.europa.eu/info/sites/info/files/eu4health_factsheet_en.pdf (accessed August 24, 2020).

European Council. 2020. “Special Meeting of the European Council (17, 18, 19, 20, and 21 July 2020): Conclusions.” July 21. www.consilium.europa.eu/media/45109/210720-euco-final-conclusions-en.pdf.

Eurostat. 2019a. “GDP per Capita in PPS.” Updated June 1, 2020. ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tec00114&plugin=1.

Eurostat. 2019b. “Health Care Expenditure in the EU.” ec.europa.eu/eurostat/web/products-eurostat-news/-/DDN-20181129-2 (accessed August 18, 2020).

Eurostat. 2019c. “Mortality and Life Expectancy Statistics.” Updated July 2020. ec.europa.eu/eurostat/statistics-explained/index.php/Mortality_and_life_expectancy_statistics.

Downloaded from http://dup.silverchair.com/jhppl/article-pdf/46/1/147/849957/147sokol.pdf by guest on 20 April 2024

Eurostat. 2019d. “Share of Persons Aged Sixteen and Over Reporting Unmet Needs for Medical Examination or Treatment, by Detailed Reason.” ec.europa.eu/eurostat/statistics-explained/index.php?title=File:Share_of_persons_aged_16_and_over_reporting_unmet_needs_for_medical_examination_or_treatment,_by_detailed_reason,_2016.png.

Flear, Mark. 2004. “Case C-385/99 V. G. Müller-Fauré v. Onderlinge Waarborgmaatschappij O. Z. Zorgverzekeringen U. A. and E. E. M. van Riet v. Onderlinge Waarborgmaatschappij Z. A. O. Zorgverzekeringen, Judgement of the Court of 13 May 2003.” *Common Market Law Review* 41, no. 1: 209–33.

Földes, Maria, and Alina Covaci. 2012. “Research on Roma Health and Access to Healthcare: State of the Art and Future Challenges.” *International Journal of Public Health* 57, no. 1: 37–39.

Hancher, Leigh, and Wolf Sauter. 2010. “One Step Beyond? From Sodemare to Docmorris: The EU’s Freedom of Establishment Case Law Concerning Healthcare.” *Common Market Law Review* 47, no. 1: 117–46.

Hervey, Tamara, and Jean McHale. 2015. *European Union Health Law*. Cambridge: Cambridge University Press.

Hervey, Tamara, Calum Young, and Louise Bishop, eds. 2017. *Research Handbook on EU Health Law and Policy*. Cheltenham: Edward Elgar.

Holt, Ed. 2010. “Doctors in Eastern Europe Prepare to Walk out Over Pay.” *Lancet World Report* 376, no. 9737: 221–22.

Jowett, Matthew, Sarah Thomson, and Tamas Evetovits. 2015. “Changes to Public Funding for the Health System.” In *Economic Crisis, Health Systems, and Health in Europe: Impact and Implications for Policy*, edited by Sarah Thomson, Josep Figueras, Tamás Evetovits, Matthew Jowett, Philipa Mladovsky, Anna Maresso, Jonathan Cylus, Marina Karanikolos, and Hans Kluge, 51–77. Maidenhead, UK: Open University Press.

Maier, Claudia, Irene Glinos, Matthias Wismar, Jeni Bremner, Gilles Dussault, and Josep Figueras. 2011. “Cross-Country Analysis of Health Professional Mobility in Europe: The Results.” In *Health Professional Mobility and Health Systems: Evidence from Seventeen European Countries*, edited by Matthias Wismar, Claudia Maier, Irene Glinos, Gilles Dussault, and Josep Figueras, 23–66. Copenhagen, Denmark: World Health Organisation.

Mitenbergs, Uldis, Maris Taube, Janis Misins, Eriks Mikitis, Atis Martinsons, Aiga Rurane, and Wilm Quentin. 2012. *Latvia: Health System Review*. Copenhagen, Denmark: World Health Organisation.

Mladovsky, Philipa, Divya Srivastava, Jonathan Cylus, Marina Karanikolos, Tamás Evetovits, Sarah Thomson, and Martin McKee. 2012. *Health Policy Responses to the Financial Crisis in Europe*. Copenhagen, Denmark: World Health Organisation.

Ognyanova, Diana, Claudia Maier, Matthias Wismar, Edmond Girasek, and Reinhard Busse. 2014. “Mobility of Health Professionals before and after the 2004 and 2007 EU Enlargements: Evidence from the EU PROMeTHEUS Project.” In *Health Professional Mobility in a Changing Europe*, edited by James Buchan, Matthias Wismar, Irene Glinos, and Jeni Bremner, 65–94. Copenhagen, Denmark: World Health Organisation.

Downloaded from http://dup.silverchair.com/jhppl/article-pdf/46/1/147/849957/147sokol.pdf by guest on 20 April 2024

Peeters, Miek. 2005. “Free Movement of Medical Doctors: The New Directive 2005/36/EC on the Recognition of Professional Qualifications.” *European Journal of Health Law* 12, no. 4: 373–96.

Peeters, Miek. 2012. “Free Movement of Patients: Directive 2011/24 on the Application of Patients’ Rights in Cross-Border Healthcare.” *European Journal of Health Law* 19, no. 1: 29–60.

Peeters, Miek, Martin McKee, and Sherry Merkur. 2010. “EU Law and Health Professionals.” In *Health Systems Governance in Europe: The Role of European Union Law and Policy*, edited by Elias Mossialos, Govin Permanand, Rita Baeten, and Tamara Hervey, 589–634. Cambridge: Cambridge University Press.

Pieters, Danny. 2006. *Social Security: An Introduction to the Basic Principles*. Alphen aan den Rijn, the Netherlands: Kluwer Law International.

Raptopoulou, Kyriaki. 2012. “The Directive on Cross-Border Health Care: Signalling the Coordination or the Harmonisation of Public Health Systems?” *European Journal of Social Law*, no. 3: 193–212.

Smith, Samantha. 2010. “The Irish ‘Health Basket’: A Basket Case?” *European Journal of Health Economics* 11, no. 3: 343–50.

Stafford, Ned. 2011. “Czech Doctors Win Wage Increases after Three Year Campaign.” *British Medical Journal* 342, March 1. doi.org/10.1136/bmj.d1371.

Stamati, Furio, and Rita Baeten. 2015. “Varieties of Healthcare Reform: Understanding EU Leverage.” In *Social Policy in the European Union: State of Play 2015*, edited by David Natali and Bart Vanhercke, 183–214. Brussels: European Trade Union Institute.

Stepurko, Tetiana, Milena Pavlova, Irena Gryga, Liubove Murauskiene, and Wim Groot. 2015. “Informal Payments for Health Care Services: The Case of Lithuania, Poland, and Ukraine.” *Journal of Eurasian Studies* 6, no. 1: 46–58.

Strban, Grega. 2013. “Patient Mobility in the European Union: Between Social Security Coordination and Free Movement of Services.” *ERA Forum* 14, no. 3: 391–407.

van de Gronden, Johan, Erika Szyszczak, Ulla Neergaard, and Markus Krajewski, eds. 2011. *Health Care and EU Law*. The Hague: T. M. C. Asser Press.

Vlădescu, Cristian, Silvia Scîntee, Victor Olsavszky, Cristina Hernández-Quevedo, and Anna Sagan. 2016. *Romania: Health System Review*. Copenhagen, Denmark: World Health Organisation.

Williams, Colin, Ioana Horodnic, and Adrian Horodnic. 2016. “Who Is Making Informal Payments for Public Healthcare in East-Central Europe? An Evaluation of Socio-Economic and Spatial Variations.” *Eastern Journal of European Studies* 7, no. 1: 49–61.

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