TOO ILL TO FIND THE CURE? – HEALTH CARE SECTOR SUCCESS IN THE NEW DEMOCRACIES OF CENTRAL AND EASTERN EUROPE

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This study examines the factors that have contributed to the success of some Central and Eastern European countries to improve their health care sector in the post-communist period, while leaving others to its demise. While most literature has been focused on the political and economic transition of Eastern Europe, very little research has been done about the welfare aspects of the transition process, especially the health care sector. While the focus on political consequences and main macroeconomic reforms has shed light on many important processes, the lack of research of health care issues has lead to consequences on our ability to understand its impact on the future of the new democracies and their sustainability. This model looks at the impact of international (World Bank) and domestic institutions, corruption and public support and how they affect the ability of some countries to improve and reform their health care sector in the post-transition period.
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CHAPTER I
INTRODUCTION

In the early 1990s, the post communist countries of Central and Eastern Europe were undergoing a dual transition. Faced with challenges in the early transition period, some were struggling to secure the hold of the new democratic regime. Others seemed to enjoy a more stable post-transition environment, and were focusing on the successful advancement of economic reforms. However, all of them came face to face with some challenges in the very first stages of the transition process.

The transition to the market economy brought immediate economic crises as consequence of price liberalization, involvement in international trade, privatization and other processes that were part of the first wave of economic reforms. The resulting temporary economic downturn had multiple consequences. It affected public support for the dual transition, although only temporarily in those countries that recovered quickly from shock therapy. It also affected the quality of life of people in all of the countries because of hyperinflation, rising unemployment, and other negative effects of shock therapy. Some of the indicators of the economic downturn were declines in life expectancy, rise in cancer mortality, and other health consequences. Declining life expectancy and rising cancer mortality rates have in turn negative consequences not only for the economy of these countries, but also for the morale of people. However, following the initial drop in health indicators, some countries were able to reverse the declining trend to the pre-transition levels and even improve it beyond the pre-transition level. Figure 1.1 illustrates this point more succinctly. It illustrates the different trends in life expectancy in Hungary, the Russian Federation, and Slovenia from 1980 until
2003. It is evident that Slovenia improved its average life expectancy beyond the pre-transition level, despite the initial post-transition decline. On the other hand, it is also clear that the Russian Federation experienced a continuous decline in life expectancy ever since the transition took place and it never recovered to the pre-transition level.

Figure 1.1: Life expectancy in Hungary, Russian Federation and Slovenia, 1980-2003.

The third country, Hungary, finds itself in the middle path between Slovenia and Russian Federation. Hungary also experienced some decline in life expectancy at the transition point that continued shortly thereafter, but it was able to recover to the pre-transition level, though at a slower pace than Slovenia. What accounts for the differences in life expectancy in the three countries? Why has life expectancy taken a
drastically different path in these countries, given their common communist and socialist history and the experience with the dual transition process?

Significant negative trends in indicators such as life expectancy and rising cancer mortality are symptoms of an ineffective health care sector. Where the health care sector is not able to guard public health against the illnesses that increase death rates from otherwise treatable ailments (such as heart disease and cancer), indicators of public health never fail to reflect such failure. This leads to the next questions: why do health care sectors of some CEEC perform more effectively than others at combating the incidence of diseases? Given that prior to the dual transition all CEE countries had a system of socialized medicine with free and universal coverage and suffered from similar sector inefficiencies, why have some countries been able improve the effectiveness of their health care sector while others have not?

I looked at both domestic and international factors to explain the differences in health care sector performance in CEEC. At the domestic level, I looked at the effects on health care sector effectiveness of corruption, institutional effectiveness, public support, country performance, population age distribution, prior market experience, and electoral system representativeness. At the international level, I evaluated the impact of World Bank funding on health care sector effectiveness. In chapter 3 I hypothesize that lower corruption and more effective institutions are likely to improve health care sector effectiveness because they alter the incentive system for both patients and providers and increase public support for health care sector reform. Given that health care reform is an unpopular issue, higher public support enables the government in office to pursue health care reforms. Strong economic and political performance during the transition
process is also likely to improve the health care system because the country achieves macroeconomic stability sooner and is then able to address health care sector issues in the second wave of reforms (chapter 2). Chapter 4 lays out the hypothesis that World Bank funding is likely to increase health care sector effectiveness not only because the Bank tends to award countries that perform well in the transition, but also because more funds increase the resources available to that sector. Finally, a more representative electoral system is likely to increase public trust in the government to pursue health care reform. Chapter 6 ties all the chapters together. Chapters 7 and 8 analyze the cases of the Russian Federation and Hungary to illustrate in detail the factors that account for the differences in health care outcomes between the two. Chapter 9 presents the research design while Chapter 10 presents the analysis short- and long-term effects of variables on health care sector effectiveness.

I found that corruption, institutions, age distribution, prior market experience and political performance of the regime all have a significant effect on health care sector effectiveness, as hypothesized. On the other hand, World Bank financing has the opposite effect of lowering health care sector effectiveness.
CHAPTER II

THEORETICAL FRAMEWORK

1: The Evolution of the Health Care Sector in Central and Eastern Europe

While western governments were still concerned with the Soviet threat and the nuclear arms race, the events that would soon surprise the entire world by bringing down the Berlin Wall in the Autumn of 1989 were brewing under the surface of Central and Eastern European countries (CEEC) \(^1\). The revolutionary events that followed the 1989 collapse of the Wall had a number of consequences both internationally and internally to the countries. In the international system, they transformed international relations by ending the Cold War bipolar structure. In the domestic arena, they ended the dominance of the Soviet-backed Communist Party rule and allowed the dual transition to political democracy and market economies.

Because the arrival of these events was unexpected, it drew the attention of many scholars who have studied the domestic and international events of this dual transition, as well as developments that would follow it. They studied the performance and stability of these newly democratic regimes by looking at factors such as electoral system and party system (Geddes, 1996; Lipsmeyer, 2002). They looked at the post-communist institutional variations and how these would affect prospects for democracy. Finally, they were concerned with how economic transformation strategies, such as shock therapy versus gradual reforms, would affect the stability of new regimes given their implications for economic development (Marangos, 2002; Sachs, 1991, 1996).

\(^1\) The countries referred here as CEEC (Central and Eastern European) include both the Central and Eastern European countries and many of the countries of the former Soviet Union while acknowledging that some of the former Soviet countries are partly located in Asia.
What all these studies have in common is their concern with democratic consolidation, and the prospect of these democracies surviving beyond the immediate post-transition period. As Huntington (1991) points out, every wave of democratization has been followed by periods of reversal to non-democratic regimes in some newly democratized countries. Much current research on the survival of new democracies attempts to determine what factors would explain and predict why some countries reversed from the democratic regimes while others continued on the path of democratic consolidation (Przeworski et al, 2000).

One factor that determines the consolidation of new democracies is the ability of the new democratic regime to deliver economic benefits. The success of the new democracy at delivering economic goods to the people affects the popular experience with the new regime and support for it. Even in consolidated democracies the occurrence of economic crises can undermine the evolution of democratic political culture and support for democracy and jeopardize its survival. One feature of the pre-transition Leninist regime was its provision of universal welfare benefits, including health care. Thus, a new democracy succeeding a system that had as part of its claim to legitimacy the provision of universal health care has to be more sensitive to the necessity to deliver similar benefits in the post-transition period if it seeks to consolidate support for democracy. After all, it is the obligation of the state to provide access to effective and reliable medical care to its entire people. This is especially important in light of the different approaches to welfare benefits guarantees between the communist and non-communist systems, where the benefits of the same type are mostly absent in the latter. Given the complexity of a dual transition which involves a
political change and the transition to the market economy (which initially brings additional economic hardships), the new government is faced with the challenges of guaranteeing the delivery of health care services to all people.

Health care sector performance is a largely understudied area within the literature that has evolved around the third wave of democratization. While political scientists have been preoccupied with the study of democratic transition, democratic consolidation and topics such as civil war and social revolutions, the study of how the social welfare system changed, or did not change, during the third wave has not been addressed adequately. The study of the impact of health care sector provision is crucial, given that the old regimes based their legitimacy in part on the ability to deliver universal health care benefits. Furthermore, its importance is evident since it provides a safety net during the turbulent times that dual transitions bring.

The situation of the CEEC is different from that of most other democratizations because it involves a dual transition. It includes a political transition involving a complete change in regime type (from communism to democracy), as well as an economic transition, from a command economy to one guided by free markets. The nature of the dual transition adds another challenge to the success of the democratic transition because the success (or lack thereof) of the democratic transition and consolidation depends upon the success of the economic transition. For example, if the economic transition involves perverse liberalization pervaded by lack of transparency of the process where the benefits accrue to a few preferred groups, then the support for democratic consolidation will waver. The inefficiency of the post-transition social welfare
programs (especially the health care sector) can trigger dissatisfaction with the new system and fuel movements not supportive of the newly formed democratic regimes.

Only a few political scientists have addressed issues of welfare politics in the third wave. Part of the reason for the lack of attention to these issues is the fact that the third wave of democracy in Eastern Europe differs from the transitions that occurred in Southern Europe, Latin American and East Asia the 1970s and 1980s. While most of the democratic transitions at the beginning of the third wave were just changes in political structure (a large transformation in itself), the Central and Eastern European countries underwent a dual transition, both political and economic. Indeed, Latin American and Asian countries that transitioned to democracy already enjoyed market economies and were integrated into the global economy, though their position in it introduces another set of arguments. Furthermore, most of these countries had previous experiences with democracy in the recent past. They had a plurality of parties and civic associations that simply needed to be rebuilt at the onset of the democratization process. On the other hand, Central and Eastern European countries had to build their new democracies and market economies from scratch. Even more significant is the fact those the pre-transition political and economic systems were substantially different from that of other countries (e.g. Latin American countries). More specifically, the transition from the command to the free market economy represented a great shock to a system where private ownership was largely banned in the past. This was coupled with newly discovered political freedoms, so the economic and the political transitions were inextricably interrelated.
1.1: Health Care in a Socialist System

Numerous authors have placed significant effort in explaining the status of the health care sector in CEEC during their socialist years in order to show how the structure and operation of the old system affected the future of health care in the transition period and beyond. The fact that the health care sector had been given little priority during the socialist years was a by-product of the Marxist-Leninist philosophy of political economy. This philosophy justified the low priority of the health care sector by claiming that the national income was generated by productive sectors of the economy such as heavy industry (especially the arms industry) and agriculture, then consumed by non-productive sectors of the economy such as health institutions (Davis, 2000).

This particular characteristic makes the case of former socialist countries very different from other third wave countries. In socialist economies health care sector financing came from extra budgetary funds and, therefore, it did not have a regular, guaranteed allotment in the budget. As a consequence of its low priority, the health sector was largely under-funded and uncoordinated, as compared to other sectors such as defense, although its budget did grow with the growth of the overall economy (Kornai and Eggleston, 2001). This led to under-supply of personnel and equipment, which became obvious in the late 1980s when the system, by then pervaded with obsolete technology and run down facilities, was experiencing rising mortality rates.

During the command economy period, the central or local government owned the hospitals. The pay scale was also determined by the central government, where the pay

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2 Janos Kornai (2001), Christopher Davis (2000), Janos Kornai and Karen Eggleston (2001) have been very thorough at explaining the status of the health care sector during the socialist years.
of doctors was, and still is, only 1.5 times the average income (Kornai, 2000).³ Thus, the supply shortage in the health care sector led to excessive demand. Unlike the case with capitalist countries with socialized medicine, that excess demand could not be satisfied within the bounds of the law by private sector alternatives. Instead, the excess demand was directed toward a “shadow” economy marked by corrupt practices in the supply of health care services. The only way to get the highly demanded services faster was to offer under the table payments to doctors and/or nurses. However, even this shadow economy did not produce favorable performance, since the system operated on a “first come, first served basis”. Preventive services were poor and the cost of health care was kept low by the personal physician acting as a “gatekeeper”. Common citizens had no input into how the process was conducted and no freedom of choice as to the quality and quantity of the health care they received (Kornai and Eggleston, 2001). This practice was in agreement with the philosophy of the communist party: “We will look after you. You will receive free health care. We, on the other hand, will decide what care you receive and how much of it” (p.137).

Davis (2001) further states that the financing and organization are one of the most significant factors influencing the volume and quality of the medical system. In the pre-transition system the low priority of health care was reflected in the low spending on health care, equaling no more than 2.5 to 5.5 percent of GDP, which is much lower than what OECD nations devoted to health care (World Bank, 2005). Most western countries spend between 8 and 12 percent of their GDP, while some such as the U.S.A spend up

³ In Croatia, a medical doctor employed at a state hospital earned approximately $500 per month in 1996. When one takes into consideration that most other expenses, such as housing, food and transportation costs are comparable to West European countries, it is evident that they are grossly underpaid. A physician in Germany for the same year made 7572 per month (LABORSTA, 2005).
18 percent of GDP (World Bank, 2005). The amount of funds spent on a particular sector reflects the importance that the state attaches to that sector. Davis also states that during the pre-transition period, “Other indicators of low priority were the unresponsiveness of resource allocations that reflected in higher mortality rates, below-average wages of highly trained medical staff, and high shortage intensity in the medical system....” (p.10, 2001).

By the 1980s, when the inefficiencies of the system started to be felt most, the dissatisfaction of patients not having any control over their decaying health services, coupled with the low morale of the medical staff, resulted in a phenomenon that had been pervading many other sectors of the economy: corruption. However, the inefficiencies of the command economy were starting to be addressed in many CEEC with the introduction of partial private ownership. At the same time that some other more important parts of the economy were changing, the health sector was not.

1.2: Health Care after the Transition

At the onset of the transition, the economy is liberalized, which makes it susceptible to hyperinflation, high unemployment and negative economic growth. In light of the desire of countries to improve their economic condition and stabilize faster, governments request funds from international aid agencies and are expected to comply with austerity measures imposed by the international lending agencies. Normally, health care reform is excluded from the first wave of reforms. More specifically, the austerity measures imposed on countries that are candidates for loans are stabilization measures that include fiscal austerity, balance of payments requirements, and other
measures that reduce the role of the government in the economy and restructure it in a manner that gives more direct influence to market forces. Most often, this includes reducing social safety nets available by cutting government spending on social welfare benefits. These are referred to as first wave reforms. Thus, the health care sector's performance continued to decline in the first part of the transition period. Increasing and unalleviated economic hardships brought on by market liberalization contributed to the overall increase in the underground economic activity, including health care, where surging unemployment and inflation left most of the population vulnerable. The transition process was harsher than expected because the governments of CEE countries were unprepared for what their actions should have been short of the dissolution of the old system. This led to political difficulties in implementing the structural adjustment measures suggested by the same international organizations because the direct experience with the rising costs of economic transition undermined the popular support for reforms (Ellman, 1994). The lack of transparency and questionable privatization programs observed by the people undermined their trust in the willingness and ability of the newly formed institutions to deal with rising corruption. Furthermore, the vacuum created during the transition period is inherently considered negative because it provides a temporary state of lawlessness where the old political and economic system is dismantled while the new one is being created. In a state of lawlessness where new institutions have not yet taken root, there is a tendency to free ride where some gain at the expense of others. Such practices, if not restricted in time, can seriously undermine the purpose of the dual transition.
The primary pursuit of macroeconomic stabilization policies exacerbated the economic hardship in the economy because no resources were being invested in the reform of sectors that provided safety nets in such hard times (such as social security, unemployment, and health care). Kumssa and Jones (1999) describe the dangerous side effects of economic transitions to a market system. They claim that the transition to a market economy, while desirable and even necessary in order to be globally competitive, can be dangerous unless a balance can be struck between the market and the creation of social safety nets that mitigate the effects of ruthless capitalism. More specifically in the case of Central and Eastern Europe, there is a need to downsize the central government and limit its role in the economy in order to give way to more market influences. However, there is still the need to preserve the social safety nets that protect the weak in order for the state to fulfill its promise to the public to preserve a healthy and productive population. When the state is not able to do so, as has been the case of the Russian Federation, the productivity of the population decreases. This leads to a number of effects such as high unemployment, social costs, and eroding public support for the government, which ultimately undermines the transition effort.

In light of the need to preserve the benefits of universal health care, while reforming the health care sector, countries have pursued different policies. During the first wave of reforms, most countries increased government spending on the health care sector. However, they failed to address crucial issues such as corruption and ineffective use of health care resources that would improve the sector’s performance by alleviating the demand pressures on the system. An additional method was to offer alternatives by allowing for some private health care services. This is what Croatia did.
However, this did not resolve the fundamental problems that impeded the improvement of the public health care sector because it only created a competing line of services that often colluded with the public health care sector and produced no overall improvement in patient well being. It merely offered alternatives to the few who could afford it. As a consequence, in countries such as Russia and other former Soviet republics, support for democratic consolidation started falling as a consequence of the failed reforms, both in general and those specific to the health care sector. Other countries such as the Czech Republic improved their health care sector by addressing key issues such as health care financing. Here the universal insurance provision has been privatized so that people contribute to their own health care fund. This helps cut down on moral hazard, as well as offering an alternative source of financing. At the same time, universal health care is still being fulfilled. The State’s ability to improve the health care sector increased the confidence of the public in the ability of the government to deliver those economic benefits, and it consolidated support for democracy.

Finally, the puzzle that I try to answer here is: why have some Central and Eastern European countries been able to create a more effective health care sector in the post-transitional period while others left it in decay? As the following chapter explains, public opinion is one of the channels through which other factors affect the likelihood of achieving a more effective health care sector. More specifically, pre-transitional factors such as corruption, communist regime performance, and market experience, and post-transition factors such as country performance, institutional

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4 Moral hazard is the likelihood that a person who, for example, has health insurance will also behave in a more risk prone manner knowing that if they get injured they will not have to pay for the cost of their care. In other words, if they have the assurance of having their health care costs paid for, their behavior is likely to be less risk averse.
Effectiveness, age distribution and institutional design are all filtered through the eye of public opinion. Public opinion and trust in government and its ability to implement efficient reforms, among other factors, then determine how effective the government will be at achieving a more effective health care sector.

2: Dual Transition and Popular Support: The Mechanism

The theory set forth in this dissertation uses multiple factors to explain, among other things, why some post-communist regimes have developed a more effective health care sector than others in the post transition period. Factors that may help explain such differences and that will be discussed in detail later include variations in the institutional inheritance, corruption, public support, international funding, electoral system, and the success of the dual transition. In order to bring all these seemingly distinct factors together one has to find out what are the underlying mechanisms supporting the changes that lead to more or less effective health care sectors in the post transition period in Central and Eastern European countries.

The factor that is most critical to the success of the dual transition in Central and Eastern European countries is public support of the transition process. More specifically, there are four main areas in which public opinion has had a decisive impact: political transition, economic transition, government support, and support for the health care sector reforms in particular and of the social welfare system in general. The presence or absence of popular support of these four dimensions of the dual transition has been crucial in determining the success of the transition. Support for the political and economic transition affects its success, which then affects the government’s ability
to achieve health care sector effectiveness. At the same time, initial success of reforms (or lack thereof) can affect the public support for further reforms. For example, public trust and support of the government can allow it to pursue the necessary and often painful political and economic reforms that may not be welcome initially but are needed to achieve economic success and political transformation. Thus, where the government enjoys the support of its polity, the transition is more likely to be completed without undermining the stability of the system.

The same is true for the health care and welfare reform. Where the public supports the political transition but is discontent with the elected government, they are more likely to employ democratic channels to replace the elected government rather than undermine the democratic experiment altogether by resorting to non-democratic practices that would put them at risk of relapse into the old system, or some authoritarian alternative. Public opinion demands reforms in the area of welfare and public health care, but the precise design of these changes is controversial (Nelson 1997). The ability of the government to adopt appropriate reforms is directly connected with the ability of policymakers to create institutions that are transparent and accountable, thus lowering the negative consequences that corruption has on the health care sector’s effectiveness. On the other hand, lack of public support impedes the ability of a government to construct and consolidate the new political and economic institutions before the vacuum created by the collapse of the old order generates a backlash of public opinion that could undermine the dual transition process in all its complexity. Cases such as the Russian Federation, Romania and Yugoslavia illustrate this point. In the Russian Federation, the economic transition clearly and seriously
undermined public support for the democratic process. In addition, the failures of Russia’s economic transition had crippling effects on the general economic reform process and severely limited the ability of the elected government to earn popular support. In 1996, 84.5 percent of the people surveyed in Russia stated that they were not satisfied with the standard of living (Mason and Kluegel, 2000). The difficulties in reestablishing macroeconomic stability after the economic liberalization produced shocks of hyperinflation and double-digit unemployment destabilized popular support for the economic transition. To illustrate the point, Russia experienced negative GDP growth until 1998 (World Bank, 2005). At the same time, political freedoms came under fire as the government tried to silence the voices of some media groups who were openly criticizing the government for its inability to stabilize the economy and for taking part in the nepotism that plagued the perverse privatization of the state enterprises.

Having illustrated the complex interrelationship of the impact of public support on four aspects of the dual transition, the question that comes to mind is: how was public opinion formed and what is its impact on the dual transition and how does public support impact health care sector effectiveness?

2.1: Public Support and Health Care Sector Effectiveness in the Post Transition Period

Public support for the dual transition in Central and Eastern Europe has varied both between countries and within countries at different points in time since the transition process began in 1989. Some of the factors that affected public opinion are fixed and independent of the success of the transition process itself while others are affected entirely by the level of success of both the economic and political transition
process. Fixed factors include age distribution of the population, prior experience with
the market economy and prior experience with individual freedoms. Factors that vary
over time with the transition process include issue salience, success of reforms and
issue type (hard vs. soft issues). This section examines the impact of both fixed and
variable factors on public opinion formation in Central and Eastern Europe and how
these in turn impacted the ability of the governments there to complete a successful
transition and build an effective health care sector.

2.1.1: Fixed Factors

2.1.1.1: Senior Population

The two main components of the dual transition process (economic liberalization
and political democratization) have enjoyed periods of both high levels of public support
as well as times of turbulence where public opinion demanded the reversal of the
transition process back to the old system of governance and state socialism. In addition
to the direct impact of the experience with transition itself, age very often impacts an
individual’s support for economic and political changes. While older people are more
retrospective in their voting, younger people are more willing to give the government the
opportunity to improve conditions in the future, as their discount rate of the future is
smaller (Mackuen, Erikson, and Stimson, 1992). This has been the case with many
nations involved in the last portion of the third wave of democratization.

The impact of age on public support for reforms is evident especially with respect
to economic, or pocketbook, voting. During the transition to democracy-market
economy, those who had lived most of their lives during the socialist period were less
supportive of the transition because they had been used to the certainties that came with the old system, where if you worked all your life the system will take care of you in your old age. The system certainly fulfilled its promise without doubt. Once the new transition to the market economy brought with it the uncertainty of bankrupt pension plans, high unemployment and new co-payments for medical care, among other things, older generations learned that the system that had delivered benefits all of their lives had been lost and that the new system was not promising, based upon their most recent experience.

Thus, older generations are more likely to vote retrospectively (Mackuen, Erikson, and Stimson, 1992). Although the economic voting theory has usually been applied to the voters of western democracies, there is no reason not to believe that the same could be assumed for their eastern European counterparts. In fact, because the older generations have lived through the Leninist system, which provided universal and free health care and secure pension benefits, their experience would serve them when comparing and evaluating options in the post-transition period. Retrospective voters in the west are more risk averse and base their support for the incumbent government on past private experience. They do not look beyond current conditions nor do they take into consideration future implications of current policy or economic forecasts.\textsuperscript{5} This is also true for Central and Eastern Europe because the new government is literally new – there is no prior experience with which to judge how well it will perform (compared to the old regime) in the future. In the case of the dual transition in Central and Eastern Europe, this means that the initial reaction from the older people at the beginning of the transition is likely to be negative, since economic liberalization initially brings economic

\textsuperscript{5} See Fiorina (1981) for more on retrospective voting.
shocks in the form of hyperinflation, higher unemployment and low, often negative, economic growth. These shocks negatively impact the private experiences of all people, and especially older generations who have a limited earning capacity. Thus, they tend to be at the forefront of those who firmly resist the transition process, often supporting a reversion back to the previous system.

On the other hand, younger generations are more inclined to vote like bankers⁶ (Mackuen, Erikson, and Stimson, 1992) in that they have just begun their careers during the transition period. Because they have less invested in the previous system and have a longer remaining lifespan to adapt to the new system and compound its benefits, they are more willing to take risk on the one hand and are more likely to be optimistic for the long run prospects for reform. Therefore, they are less likely to be punitive to the incumbent government. Kinder and Kiewiet (1979) call this prospective voting or “sociotropic voting” because the voters use the current health of the economy as a sign of the incumbent government’s current economic competence when they assess their prospects for future economic prosperity. Younger generations have low trust in the post-transition government’s ability to keep delivering the same pre-transition system benefits, which opens up room for reforms.⁷ Thus, they are more likely to support the government in its attempt to improve the health care sector effectiveness. Younger generations also have lower demand for health care and are thus more willing to support reforms that bring short-term hardship, if long-term prospects are good.

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⁶ Bankers, as opposed to the peasants, are more likely to use prediction of future performance as base for their investment practices and are thus forward looking. Younger generations, having a larger discount rate of the future, are more willing to stick with the system.

⁷ See Nelson (1997) for more on the old vs. young generations and welfare sector reform.
The impact of the older generations on public support for health care reforms increases with their number, especially since advancement in the field of medical care has increased life expectancy significantly in developing countries in the past four decades. Furthermore, the number of early retirees increased dramatically after 1989 as a part of the changes that were introduced in the systems. Early retirement often amounted to forced retirement because the firms they worked for went out of business. Thus, the increased number of people in the retirement group coupled with the newly acquired right of self-expression through voting can represent a roadblock for institutional or policy reform by the post-transition political regime. Since older people tend to vote in greater numbers than young adults, pensioners may account for as much as 30-40 percent of the voters (Slay and Vinton, 1997). They not only oppose economic liberalization, but also punish with their votes any incumbent government that sponsors liberalizing economic reforms. This can undermine popular support for the new political system, thus jeopardizing the survival of the democratic transition as well.

By stalling the process of essential reforms, negative public opinion led by older generations also undermines the ability of the government to rebuild an effective health care sector in several ways. First, because the process of tackling the essential economic issues such as macroeconomic stabilization and privatization is stalled, welfare and public health care sector reform, which are of lower priority on the reform list, is also delayed. Second, since older voters are the most frequent users of public health care, they do not support changes in the health care sector that might involve higher out of pocket payments, even if such changes are needed and justifiable. Third, incumbents in government and their opponents are more likely to try to appease the
older generations by avoiding necessary reforms in the health care sector. This may be good for them as they try to preserve themselves in office in order to be able to implement those other, less popular reforms. However, the longer the restructuring of the health care system is delayed, the harder it will be to reverse the consequences of a decaying system. Because of their involvement in potentially strong institutions such as unions and specialized organizations, older voters represent sectors of the population whose vote may significantly impact those politicians’ ability to remain in or gain office (Nelson, 1997). All of these issues have a negative effect on the prospect of achieving through reform an effective health care sector in Central and Eastern Europe. Following this argument, the proposed testable hypothesis is that:

Hypothesis 2.1. The larger the number of senior voters, the larger the decline of in health care sector performance.

2.1.1.2: Prior Experience with Market Economy

The second fixed factor that has a significant impact on the ability of a state to successfully complete the dual transition and achieve an effective public health care sector is its prior experience with the market system and with the notion of individual freedoms and private property. Prior market experience affects public opinion in two different ways. On the one hand, those who already have experienced the benefits of the market economy, such as those who lived under mixed economies (e.g. Yugoslavia, Poland) are more open to and trusting of the changes when the time for full economic liberalization comes because they are familiar with its workings. In countries where prior market experience is non-existent, knowledge about the working of the market economy is limited and possibly distorted. The former Soviet Union is an example of a country
where the market economy was non-existent up until the Gorbachev era. Here the lack of knowledge about the workings of the market economy at the elite level was due to the impossibility of conducting any positive research on the subject. Rather, “the blatantly ideological nature of the studies and lack of necessary sources due to the restricted access to the books published in the West made this field of economics unattractive for many intellectually serious scholars” (Savchenko, 2000; p. 47).

The influence of the existing value system about the market economy and individual property rights is crucial for the support and success of economic liberalization because supportive values shape the creation of efficient institutions, which are essential for the creation of the market economy (Savchenko, 2000). At the same time, prior existence of laws that permit some private property rights sets up the institutional basis of future expanded private property rights in the post-transition period. As a consequence, when the full transition occurs, it is easier to transition from one institutional setup into another, thus bringing about more benefits sooner.

Hypothesis 2.2. The greater the prior experience with the market economy and individual freedom, the more effective the health care sector.

Evidence of this impact is easily observable among the countries of Central and Eastern Europe. Although all of the countries of CEE shared the common political ideology of communism and the economic policies guided by socialist state, there was wide variation between countries in how they applied these principles. There are three basic divisions that are easily observable and by which the countries can be distinguished. First, there are the states of the former Yugoslavia. Given the schism

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8 Even in 1991 during the Gaidar government, the inherited economic system had 77.5 percent of the employed population working in the state sector and another 5.3 percent worked on collective farms, which were essentially owned by the state as well (Schleifer and Treisman, 2000).
that occurred in 1948 between Tito and Stalin, Yugoslavia became a member of the non-aligned countries. At the same time it adopted a more liberal version of the political system, and it allowed a mixed economy to flourish. The more liberal regime, though still communist, meant that politically people were not subject to the oppressive practices witnessed by the Soviet regime. Indeed, Yugoslavs had the freedom to travel both to the non-communist countries with democratic regimes as well as to the countries behind the iron curtain. Yugoslavs could also take jobs in West Germany as gastarbeiter, or guest workers. At the same time, people from both communist and non-communist countries could travel to Yugoslavia as well, which they did as tourists regularly. Economically, a mixed economy allowed for the importation of some foreign goods and, more importantly, for a limited amount of private ownership. Some countries of the Warsaw Pact such as Poland and Hungary also had more experience with the market economy, even though in Hungary this experience was interrupted by the invasion of the Soviet Union and its imposition of economic planning. Furthermore, Leninist regimes in the USSR date back to 1917 whereas they were imposed on the rest of the Warsaw Pact in 1948. Thus, when the transition period came and some initially negative consequences associated with it were felt, public opinion in support of the dual transition was much more resilient in Yugoslavia, Poland and Hungary. At the same time in the former Soviet Republics, resistance to the transition grew and nostalgia for the old communist regime threatened the survival of the new system.

Similar to the effect of prior experience with the market economy is the experience with individual freedoms. The two most often coexist in Central and Eastern Europe. In other words, countries that enjoyed a mixed economy until the 1990s also
had more individual freedoms.\textsuperscript{9} Having enjoyed a certain level of personal freedoms they are more likely to support the complete transition when it occurs, even when the negative effects of the dual transition are initially felt. They have inherited a higher level of civic culture and democratic attitude.\textsuperscript{10} In line with Haggard and Kaufman’s (1997) argument that economic crisis undermines support for democracy, those who had a longer experience with individual freedoms are more likely to support the transition and have faith in the democratic process, even in the face of crisis.

2.1.1.3: Variable Factors

The previous section spelled out some testable hypotheses on how age and experience with both the market economy and individual freedom affect public support for the dual transition. In addition to these factors that are related to the individuals, there are other factors that also affect the public support of the dual transition, for the incumbent government, and for the health care policy specifically: issue salience, issue type, and success of initial reforms.

When looking at the public issues that were popular during the dual transition, one is quick to notice that in many though not all countries of Central and Eastern Europe health care policy reform has not been addressed significantly as an issue in the electoral cycle by the policymakers. This is a reflection of the general lack of public demand to prioritize it because there are other issues deemed more urgent. Concerns with private property laws, building permits, and especially privatization have dominated

\textsuperscript{9} For example, while citizens of countries of the former USSR and Warsaw pact could only travel within the Eastern bloc area, those in the former Yugoslavia could travel freely both within the Eastern and Western bloc.

\textsuperscript{10} See Almond and Verba (1963) and others for more on civic culture.
the policy agenda during electoral campaigns since the 1989 transition in Warsaw Pact nations and the end of the wars in the republics of the former Yugoslavia. Even pension system plans have received more substantial attention than health care system reform, even if not all reform policies have been successful. Having witnessed the dire conditions in which the public health care sector finds itself in many CEE countries, why has the public not concerned itself with problems in health care policy with the same urgency they have assigned to issues of taxation, voting, privatization, and others? There are two reasons for this: the first is whether the issue is hard or soft (Carmines and Stimson, 1980) and the second is issue type, that is, a reflection of agenda setting in partisan politics, generally known as “issue evolution” (Carmines and Stimson, 1986, 1989).

In order to explain the absence of public support for the priority of health care reform, one has to look at the type of issue involved. When issue voting occurs, there is a distinction between what the literature calls hard issue voting and soft, or easy issue voting. Hard issue voting involves the belief that people conscientiously and rationally weigh the consequences of their voting choices and that their preferences guide them in making such decisions. Upon considering all the positions presented by the candidates in an election, voters choose the one that is the closest to their issue space (Davis et al. 1970; Brody and Page, 1972). Hard issues assume that the voters are well informed on the intricacies of the issue at stake and that they make their decisions based upon careful analysis of costs and benefits.

On the other hand, soft issue voting involves issues that have been long established in the political arena. People feel strongly about them when they are
deciding on how to vote, but the nature of the issue does not require them to think through their decisions by weighing options (such as the issue of ethnicity). It has been found that people vote more frequently on soft issues than hard ones precisely because all they need is their gut response. Thus, voters “easily” identify their position on the issue. Where does support for the dual transition and health care in particular fit in all of this?

Health care sector reform is a very complex topic where the concern of the issue is not only with the policy end result (as it is typically with soft issues) but also with the process of reforming the sector, a characteristic of the hard issue voting. Health care sector reform is a hard issue because it takes a large amount of information and knowledge about the process that needs to occur in order to make a reform successful. To illustrate further the complexity of health care reform and its position as a hard issue, one of the reasons international organizations such as the IMF and World Bank (nor for that matter the incumbent government) did not get involved in pushing for health care reform is the lack of a clear blueprint on how to conduct a successful health care reform.

The problem becomes even more complex when one takes into consideration the fact that formerly socialist countries had a system of universal healthcare available to all. On one hand, in order to appease the population and avoid a backlash in terms of votes, the new system will have to follow in the footsteps of the old one to some

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11 Carmines and Stimson (1980) stipulate that the degree to which hard issues are voted on depends on the individual voter. More interested, more informed, and more involved citizens are more likely to punish politicians by hard issues than are their less interested and less informed counterparts.

12 Joanne Nelson (2001) states that because there is no dominant model for health care reforms comparable to the one available for pension reforms, the knowledge on how to go about it in CEEC is also missing. There are difficulties in assessing the goals and to procure measurement and valuation.
degree. At the same time, in order to avoid severe human consequences in light of market failure, it will try to create a more effective and efficient system with respect to cost.\(^\text{13}\) This creates cross pressures and incentives for the candidates to avoid the issue altogether. Even in wealthy nations, the health care system and its success vary widely and are subject to constant debate and criticism. Thus, politicians also often steer clear of the issue.

Issue type is responsible for not only the lack of public rallying around the issue, but also for the absence of issue evolution by those running for government, whether incumbents or part of the opposition. One of the ways in which issue evolution, or the translation of issues from the political elites into the public opinion, occurs is when an issue “fits well into an opportunity provided by the evolving political environment” (Carmines and Stimson, 1989; p.4). Thus, it is not that the issue is more important than some other issue; rather, it is the ability of the policy makers to situate it into a context fertile for expansion and retention of the issue in the domain of the public arena. Because of the risky nature of the issue, those striving to win the vote of the public will view the issue of health care as potentially hurting them, or as not surviving as a viable issue for too long (what Carmines and Stimson (1989) call “unsuccessful adaptations”) because they are too complex, technical, or non-salient. They are not likely to align the voters along one party, since the issue cannot be communicated clearly to the general public.

\(^\text{13}\) In the study of economic health care policy, it is known that because of the difficulty for insurance companies to “detect the individual type” with respect to illness propensity, the increase in price in order to offset such uncertainty punishes those who are healthy (by restricting the benefits to healthy types) and thereby decreasing their utility.
Existing theories of public opinion also have found evidence of dynamic representation in the political process. More specifically, Stimson, Mackuen, and Erickson (1995) define dynamic representation to be the public policy response to public opinion changes. They found that political actors usually respond to the public opinions and demands in a strategic manner. This means that they are acutely aware of the general public opinion on certain issues. In order to preserve their survival during the next election cycle, they act preemptively on those issues and demands that public opinion deems important. Thus, in the case of Central and Eastern Europe, those reforms that were pushed forward as a priority, such as stabilization and privatization policies, were used as strategic moves by policymakers who anticipated a sense of dissatisfaction with high unemployment, inflation, and rising controversies over the privatization process. Thus, these reforms took priority over others, such as health care, where the consequences of inaction would be felt much later. Given that the issue of health care reform was not anticipated to represent a critical point of contention by the public in the next election cycle, it remained virtually ignored. To sum up the impact of issue voting and dynamic representation: where health care reform is not introduced by politicians in the public arena, and where the public does not rally around the issue, policymakers are less likely to address the problem of a decaying health care sector.

Finally, and independently of the effect of age mentioned earlier, the success of the first wave of reforms significantly impacts public support for the government and for reforms in general. Before the reforms are initiated, people have high expectations for the future benefits of reform implementation. Consequently, public support for reform is high. In Eastern and Central Europe, support for transition to democracy was high, and
the most important element of democracy was considered to be “economic prosperity in the country” (McIntosh and Maclver, 1992). However, no matter what kind of economic reform strategy a country adopts (gradual vs. shock therapy), the initial effect of the reforms is negative in terms of economic indicators: falling and often negative GDP growth, hyperinflation, and double digit unemployment, to name just a few. These initial effects are caused by the liberalization of prices and the opening up of the economy to the world market. The mechanism that leads to the short-term economic fall is simple: price liberalization introduces the market forces of demand and supply that influence prices of goods and labor (i.e. wages). Liberalization leads to a sharp increase in prices because they are now allowed to fluctuate with world prices, whereas before they were kept at an artificially low level by the government. However, the price of labor does not adjust as fast as the price of goods and services due to structural limitations. This leads to a drop in consumer surplus as the purchasing power of people drops, even though they are flooded with new products from other markets. Though there is a debate over how economic liberalization should be implemented to overcome these initially destabilizing effects, some have advanced the theory that the implementation of any kind of reform is more successful if undertaken in a radical method (shock therapy) because the support for reforms by the population tends to fade as the time goes by simply because they are faced with the actual short-run cost of the transition (Przeworski, 1991; Sachs, 1996; Marangos, 2001). In fact, Mason (2000) finds that the support for economic reforms declined in countries of Central and Eastern Europe between 1991 and 1996, the period of the first wave of reforms.¹⁴

¹⁴ Mason used survey polls from ISJP (International Social Justice Project) and analyzed Russia, Poland, Bulgaria, Hungary, the Czech Republic and Germany in a comparative study.
Based upon the von Neumann-Morgenstern theorem of the maximization of present value of future consumption, even when the population is in favor of radical reforms and is aware of the short-term cost, public support tends to fade as they are faced with the actual cost. However, despite the inevitability of the initial cost, if reforms are advanced successfully, then the benefits from them are felt in time and people are more likely to continue supporting the reform process in general. Reforms that need to take place in order to yield long-term reform benefits include both macroeconomic reforms as well as institutional reforms that will ensure that the process is transparent and that the policymakers are accountable to the people. Needed macroeconomic reforms include cutting government spending, downsizing the role of the government in the economy, and achieving of the balance of payments. Structural reforms include privatization, in particular the reform of the banking system as this system represents a basis for future entrepreneurial growth. Additionally, successful institutional reform curbs corruption, and this has a positive effect on public support for the reform process generally, not only because it builds trust, but also because the economic effects of corruption play a significant role in an economy’s well being.

Public support for the reforms and the government that is undertaking them also empowers the government to continue onto other much needed reforms, such as health care reform. If the initial reforms are uncoordinated, slow or simply unsuccessful, the initial costs will not only persist over time but are also likely to have other negative social and economic consequences. The lack of success undermines public support for the new economic and political system. The consequence of the lack of public support is that it makes it harder for either the incumbent or newly elected government both to
continue trying to rehabilitate the failed reform sector and to embark on any additional reforms. Thus, the ability of the government to implement reforms early and successfully in the transition process will determine its ability to carry through the rest of the reforms as well, given that the support decreases and the number of opposing interest groups increases with time.

The presence or absence of public support is of particular significance for the health care sector. This is particularly important because the negative effects of liberalization are felt both through negative economic growth as well as a sharp decline in health of the people.\(^\text{15}\) Besides the effect that public opinion has on the ability of the government to implement reforms, it also has a direct consequence on the health of the economic system. Health care reform, along with other welfare sector reforms, is usually part of the second wave of reforms that is undertaken after the country has established macroeconomic stability following the initial wave of liberalization and adjustment. There are multiple reasons for such a strategy. One is the reform model imposed by the international organizations (IMF, World Bank). These organizations, who often supply the funds needed to achieve economic stability, impose a number of austerity measures as conditions for the structural adjustment loans. Another reason is evidenced in the fact that in the absence of these initial reforms continued economic crises would ensue, which would destabilize a country politically and make it difficult to sustain the transition process. Thus, the success of the first wave of reforms has an important impact on the ability to create an effective health care sector through its effect

on public opinion and on the ability of the government to achieve an effective health care sector in the second wave.

Hypothesis 2.3. The more successful the first wave reforms, the more effective the health care sector.

Successful explanation of why some Central and East European countries have been able to achieve a more effective health care sector than others requires an accounting for all the major factors influencing the political process. This chapter has laid out the mechanism that account for how public opinion affects the ability of the post-transition state to build an effective health care sector. This explanation accounts both for the process by which public opinion is formed in CEE and how in turn it affects their likelihood of succeeding with the health care reforms in particular and the dual transition in general.

The following chapter examines how corruption and institutional effectiveness affect the likelihood of achieving an effective health care sector. Throughout the chapter I will also explore how corruption and institutions can affect public support for the new regime and how corruption and institutions thus affects the health care sector through multiple channels.

3: Corruption, Institutions, and Health Care Success

An ethnographer from a faraway land who visited Hungary these days and carried a hidden camera would notice a strange tribal custom when medical doctors and patients meet. The conversation often ends with the patient bringing out a plain envelope and handing it to the doctor with a gratified smile: “Thank you so much, Doctor, for your kind attention,” the patient will say. Then the doctor makes a dismissive gesture: “No, I can’t accept that.” “Oh no, Doctor, I beg of you!” The exchange may continue for a while longer, but in the end, the physician pockets the envelope after all. Alternatively, the ritual may take place
silently: the patient slips the envelope onto the doctor’s desk surreptitiously, but to a place where it will soon be seen and opened when the patient has gone.

“Hidden in an Envelope: Gratitude Payments to Medical Doctors in Hungary”
Janos Kornai

Since the most recent phase of the Third Wave of democratization in Central and Eastern Europe most of the literature on the consequences of transitions has focused on the distinction between gradual and shock therapy reforms, as well as their short and long term macroeconomic impacts. The aspect of democratic transitions largely neglected has been the reform of the welfare sector, particularly the health care system. Among all sectors of the economy the social welfare services sector suffered the worst deterioration during the dual transition. This occurred in spite of the important role it plays as a safety net for an economy in transition.

Evidence from transitional processes shows that some Central and Eastern European countries have been able to create more effective health care systems than others. Evidence of lower mortality rates and better preventive medicine are proof of this. At the same time, other countries have let their already ineffective health care system deteriorate further. Among the more successful countries at reforming the health care sectors were the Czech Republic and Poland, while some of the least successful are Croatia and Russia. Table 2.1 shows how different CEECs have performed differently both in the economy as well as the health care sector in the pre- and post-transition period. The first column presents the average levels of corruption in the pre- and post-transition period, measured by the level of the unofficial economy. The second one shows the average values of life expectancy in the two periods, and column

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three illustrates the average GDP per capita level for the two periods. The countries where the level of corruption improved (declined) are in bold letters. What is interesting to be observed is that not all countries where corruption declined experienced a rise in life expectancy.

This chapter approaches the issue of the health care sector reform by examining the impact of corruption in the health care sector on its ability to provide an effective means of fighting the effects of disease and preventing mortality during the transition period. More specifically, this chapter first looks at the communist legacy and the lack of priority that it placed on the health care sector for nearly fifty years. Then, I will show how this neglected position of the sector encouraged the growth of corruption in the pre-transition period, which in turn has had detrimental consequences on the ability of policymakers to make the sector more effective, in the post-transition period. In addition to the economic inefficiencies of the socialist system, growing corruption further concealed the problem of health care ineffectiveness by inhibiting any desire for change. Finally, corruption has inhibited any potential for reform by giving misleading information on the state of the health care sector. This distorted picture of the state of that sector has become the basis for policy and budgetary decisions.
Table 2.1: Average values for all countries in pre (1980-90) and post-transition period (1990-2002).

<table>
<thead>
<tr>
<th>Country</th>
<th>Pre-Transition Corruption</th>
<th>Post-Transition Corruption</th>
<th>Life Expectancy Pre</th>
<th>Life Expectancy Post</th>
<th>GDP per capita Pre</th>
<th>GDP per capita Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armenia</td>
<td>0.60&lt;sup&gt;2&lt;/sup&gt;</td>
<td>0.83</td>
<td>70.25</td>
<td>72.51</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>0.60&lt;sup&gt;2&lt;/sup&gt;</td>
<td>3.45</td>
<td>69.63</td>
<td>68.97</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Belarus</td>
<td>0.60&lt;sup&gt;2&lt;/sup&gt;</td>
<td>1.26</td>
<td>71.22</td>
<td>68.70</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>1.65&lt;sup&gt;3&lt;/sup&gt;</td>
<td>0.92</td>
<td>71.04</td>
<td>72.76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bulgaria</td>
<td>0.54</td>
<td>1.07</td>
<td>71.51</td>
<td>71.03</td>
<td>2,732</td>
<td>5,700</td>
</tr>
<tr>
<td>Croatia</td>
<td>1.65&lt;sup&gt;3&lt;/sup&gt;</td>
<td>0.90</td>
<td>70.94</td>
<td>72.05</td>
<td>8,057</td>
<td></td>
</tr>
<tr>
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<td>3.90&lt;sup&gt;1&lt;/sup&gt;</td>
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<sup>1</sup> The years included in the measure are from 1982-1993 due to different years of transition.

<sup>2</sup> Aggregate values for former USSR are used.

<sup>3</sup> Aggregate values for the former Yugoslavia are used.

<sup>4</sup> The transition in Yugoslavia did not occur until mid 1990s so the values should be taken with some caution.

Underlined countries are the ones that experienced civil war in the post-transition period.
Countries in bold are those whose level of corruption decreased in the post-transition period.

A second factor that explains the success/or lack thereof in the health care sector in CEEC is the strength of post-transitional institutions of the government. Institutions diminish transaction costs and ensure property rights, so institutional effectiveness could remedy the inherited legacy of corruption in the health care sector. For countries where government institutions were strong, corruption was inhibited during the transition
period, and the outlook for successful reforms was brighter, even when the pre-transition corruption level was high. On the other hand, where post-transition government institutions were weak, even a situation of low pre-transitional corruption would have an adverse effect on post-transition health care effectiveness because of the institutional inability to curb corruption. Corruption would be further exacerbated by the hardships brought about by macroeconomic stabilization measures characteristic of the reforms process. To summarize, this chapter addresses the differences in the success of health care reform in the CEEC by taking into consideration the consequences of corruption inherited from the socialist system and its escalation or diminution during the transition period as a function of the strength of post-transition institutions.

3.1: Corruption, Institutions and Health Care: from the Socialist Legacy to the Future

Corruption in the health care sector of CEEC appears in two distinct forms: 1) informal payments and 2) misallocation of government funds. Informal payments (in cash or in kind) are made to service providers (persons or institutions) by those people who are entitled for the services, in addition to any legally defined payment (Central and Eastern European Health Network 2002). Essentially, informal payments are payments for services that are already supposed to be provided under the terms of universal health care and are funded from the national budget. Misallocation of government funds involves committed budgetary allocations not being properly disbursed and being diverted to other purposes or appropriated by corrupt public officials. Both forms of corruption occurred under the command economy system, and both have continued into
the transition era. Misallocation occurs because of unclear policy directives with respect to the allocation’s purpose and lack of transparency in the budget allocation process. Furthermore, there is weak service delivery characterized by lack of accountability, inefficiency, and poor quality. In other words, there is no supervision or accountability as to how funds disbursement is conducted and what steps are taken to ensure budgeted funds reach their destination. Because the formally committed budgetary allocations are not properly disbursed and get diverted to other purposes or are appropriated by corrupt public officials, even funding from international organizations (such as the World Bank) dedicated to health care sector improvement is likely to be misallocated and not produce the expected results. Although corrupt practices are not a direct consequence of the lack of accountable institutions, weak institutional frameworks create an environment suitable for the flourishing of such practices.

At the microeconomic level, informal payments and increased corruption lead to inefficiencies in the economy. Economic activity that is untaxed does not provide revenues to fund services that are supposed to be provided by the government (health care). It leads to underestimated indicators of economic performance, such as GDP, which in turn leads to faulty economic policy prescriptions. It also affects the eligibility of countries to receive outside funds. Although there is usually knowledge of the unofficial economy and its approximate size, this data cannot be used in the official budgetary planning. In the health care sector, informal payments inhibit any possibility of successful reforms because physicians and other agents involved in the health care sector who benefit from corruption do not have an incentive to reform the sector. On the other hand, patients lose disposable income because they are forced to pay for
services that are supposed to be included in the universal health care program. At the macroeconomic level misallocated funds cause a discrepancy between the amount of funds that are supposed to reach health care facilities and the amount that actually does. This produces an overly optimistic picture of the state of health care financing in that budget funds sufficient to produce desired outcomes are not producing such outcomes. This then leads to misguided policy in terms of what policies may still be needed. Since corruption is inherited, the level of corruption from the pre-transition period affects the level of corruption in the post-transition period. Thus, one would expect higher levels of corruption before transition to be reflected in higher levels of corruption in the post-transition period.

Numerous authors have offered explanations for the status of the health care sector in CEEC during the socialist years. These analyses provide some insight into how the pre-transition status of the health care system affected the delivery of health care in the transition period and beyond. ¹⁷ All of the CEEC had a somewhat corrupt and ineffective health care sector in the pre-transition period. In CEEC the health sector was largely under-funded. Its budget grew with the growth of the overall economy, but at a slower pace (Kornai and Eggleston 2001). This led to under-supply of personnel and equipment, which all became visible to both the patients, doctors and policymakers in the late 1980s. By then, the system was pervaded with obsolete technology and run-down facilities. Consequently, mortality rates were rising whereas they were declining in other industrial nations. Still, some countries have been able to improve their health care system during the post-transition period more than others. What remains to be

¹⁷ Janos Kornai (2001), Christopher Davis (2000), Janos Kornai and Karen Eggleston (2001) have been very thorough at explaining the status of the health care sector during the socialist years.
determined is what factors explain the difference in the post-transition performance between countries that were once in the same dire situation with respect to health care?

Table 2.2. Health care sector performance indicators in the 1980s.

<table>
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<td>USSR</td>
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<td>67.47</td>
<td>21(^1)</td>
<td>69.27</td>
</tr>
<tr>
<td>Yugoslavia</td>
<td>36(^1)</td>
<td>70.09</td>
<td>23(^1)</td>
<td>71.34</td>
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<td>Poland</td>
<td>21(^1)</td>
<td>70.77</td>
<td>16(^1)</td>
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<td>Hungary</td>
<td>20.5</td>
<td>69.09</td>
<td>16.5</td>
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<td>France</td>
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<td>7.78</td>
<td>76.23</td>
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<td>Japan</td>
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<td>4.8</td>
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<td>74.28</td>
<td>8.7</td>
<td>75.41</td>
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</table>

Source: World Development Indicators, World Bank (2005)

1. Data for 1980-1985 or 1986-1990 is not an average but for 1980 and 1990 respectively - the only figures reported for this period.

Two conditions characterized the health care system prior to the transition. First, the health care sectors of all CEEC experienced some degree of corruption in the pre-transition period, but this degree of corruption varied across the cases. Although the inefficiencies of the socialist economic system lead to the birth of corruption in all CEEC, the extent to which the corruption flourished differed because some CEEC had better overall economic conditions than others. For example, in 1986 Slovakia had per capita GDP of $7,688 compared with Bulgaria’s figure of $4,519.\(^1\) In some countries

\(^{18}\) The measures are adjusted for PPP in current international $.
gift giving (which is sometimes hard to distinguish from graft) was more socially acceptable than in others.

The second assumption is that the corrupt practices in the health care sector, such as out-of-pocket payments, were considered an acceptable practice by both recipients (doctors, nurses) and donors (patients), and such practices also went unpunished by the legal system. The motives, as mentioned earlier, were the low wages of the medical staff and shortage of personnel. Both of these conditions were consequences of the low budgetary priority status and lack of innovation in the health care system. Patients had no control over who to see or what kind of care they received. The only way to alleviate their defenselessness was to purchase some freedom of choice with side payments. Thus, side payments became one means of rationing a scarce commodity that was supposed to be equally accessible to all. While some other more important parts of the economy were changing, the health sector was not. Meanwhile, the health care system was inefficient through its exclusive use of costly inpatient services and long hospital stays. It was also deteriorating due to a lack of technological replacement and increased corruption. After the transition period, some countries were able to change this pattern.

These conditions arise in part because of institutional weakness. Like Kornai (2000), Lotspeich (2003) attributes the rise of corruption to the lack of sanctions within the institutions to punish corrupt behavior, which reflects the weakness of these institutions.¹⁹ Strong and effective institutions incorporate laws that effectively curb

¹⁹ They make the distinction between individual and organizational/bureaucratic corruption where the first one was punishable to set an example, but the latter one, much more pervasive in the system, was accepted. He defines organizational corruption as “actors within organization acting contrary to established rules of the organization” (77). This paper is concerned with both the
corrupt behavior. The laws not only exist on paper (which has sometimes not been the case in many CEECs such as the Russian Federation), but are also implemented consistently and effectively.

A general assumption is that all the CEE countries know that they have to improve the effectiveness of the health care sector in order to ensure its survival. The only alternative to reform is the gradual decay of the sector. Figure 2.1 illustrates how the interaction between the pre-transition level of corruption and the post-transitional institutional strength affect health care outcomes in the post transition period. More specifically, it shows how the implementation of more accountable and transparent institutions can benefit the health care sector in the long run, even in countries where the pre-transition corruption level was high.

In the pre-transition period institutions were ineffective and weak. Corruption in the health care sector was not recognized as illegal, and there were no formal laws that would punish corrupt behavior. The low priority status (reflected in low wages, and low government spending on health care) that was given to the health care sector during the pre-transition years led to dissatisfaction on the side of both recipients of the benefits (patients) as well as the providers (doctors). In countries with lower GDP per capita, governments were able to allocate even less of a portion of their total expenditures to health care, which made the health care sector more fertile for the birth of corruption. Corrupt behavior exacerbated the already ineffective health care sector. Furthermore, the weakness of government institutions during this period, reflected in the absence of mechanisms to monitor such behavior, also facilitated the growth of corrupt practices,

organizational/bureaucratic corruption of public enterprises as well as the individual level corruption that was common among the actors.
since activities such as side payments went unpunished and were slowly being accepted as part of the system. The reason for the lack of action by the government in punishing side payments was that corrupt practices boosted providers’ incomes without the State having to do major institutional reforms or even increase the sector’s budget. Corruption was a more cost effective alternative to formally increasing government spending on supply of health care services. Furthermore, enforcement of anti-corruption laws would have represented another cost that the government was not eager to take on. Side payments to the medical staff and hospitals also relieved social and economic pressures.

During the transition period, existing corruption was further exacerbated by the effects of economic liberalization and by the continued low priority attached to the health care sector. The economic effects of liberalization included hyperinflation and high unemployment. The fact that states were focused on achieving macroeconomic stabilization made it harder for the state to cope with destabilizing economic conditions such as hyperinflation. Harsh economic conditions such as hyperinflation and unemployment diminished the disposable income of people and created a greater need for corrupt practices as alternative sources of income. At the same time, new policy measures added to the growing need for the benefits derived from corrupt practices. One of the crucial issues of fiscal policy (a priority during the economic transition period) was the budget deficit and the state’s attempt to diminish it because it directly affected fiscal stability and growth as well as the ability of the state to invest in the social infrastructure (Sachs 1996). To this end, restructuring the taxation system was an important element because it is the greatest source of revenue for the state. The growth
of the GDP is the most important goal of the economies in transition and it is usually considered a reflection of general macroeconomic stability (Sachs 1996). The priority given to macro-stabilization policies, which inherently places the reforms of all other sectors in the background, comes from the influence of international organizations such as the International Monetary Fund or the World Bank, where economic growth is a prerequisite for eligibility to receive loans. These organizations support the shock therapy approach to reforms, where macroeconomic stabilization is the first step in the reform process. Thus, countries interested in being loan recipients focus on those measures that will achieve the desired preconditions the fastest. Most of the CEEC followed the shock therapy approach, neglecting the needed reforms of the social welfare sectors such as the pension system, unemployment insurance, and health care.

The health care sector was again placed at the end of the list of economic reforms. This was directly felt by the entire population in terms of decreasing quality of care and increasing mortality. At the same time, proportions of government budgets assigned to health care spending were getting smaller. Consequently, the increasing struggles felt by the people, including heath care workers and hospitals as well, were still a result of low wages, insufficient funds appropriated to the hospital maintenance, decreasing quality of health care services. This led to an increase in corruption as a mean to ensure survival. Where the supply is getting scarce, and the demand for free services is crowded out by side payments, those who want to climb on the waiting list for medical services or simply want the services they are entitled to in a timely manner are forced to pay up. Those who cannot afford it often get pushed down the list. In Croatia for example, after being diagnosed with a life threatening illness such as cancer,
a patient often awaits surgery for weeks in the hospital. This not only decreases his chances of being healed, but also makes for very inefficient use of scarce health care resources because he is occupying a hospital bed that could be used by another patient needing treatment.

Thus, the initial effect of shock therapy is likely to increase corruption levels. Economic hardships during the transition process contribute to the overall increase in the underground economic activity, including health care. A contributor to the rising underground activity is that during this time, the government is trying to, by increasing its taxation, reduce its budget deficits. The transition process was harsher than expected in most Central and European countries (Czech Republic and Slovenia are few exceptions), leading to political difficulties in implementing the austerity measures suggested by international lending organizations (Ellman, 1994). Ott (1999) states that the transition process contributed to a rise in corruption, given the very low wages of public servants. Since they have discretion over transitional processes such as the privatization of public institutions, they supplement their income though extortion. There is a discrepancy between the rise of wages of those who are able to take advantage of the liberalization process either by working for foreign firms or otherwise taking advantage of free trade benefits. The increased corruption is thus both an indirect effect of the increasing economic hardship as well as a direct consequence of the vacuum of lawlessness created in the first years of transition.

One of the most important economic consequences of corruption on efficiency is the fact that the money received by doctors can be used as a wage supplement.

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20 Of course, there are other forms of corruption in the health care sector that can be observed, such as the misallocation of funds, including those borrowed by the IBRD, or collusion (conflict of interest) where
this sense, it is not a negative phenomenon. It can in fact be positive factor insofar as it increases the purchasing power of the actors involved. A form of such supplemental wage creation can be observed in tipping a waiter. However, unlike the waiter, the employer of the physician (the hospital) does not account for such wage supplements when setting a wage for them (Kornai, 2001). The problem is that the money that the patient is giving to the doctor in order to receive preferential treatment should really benefit the hospital to replenish the equipment being used. From the physician’s side, since a large percentage of their monthly wage comes from the side payments that are untaxed, they have no incentive to change the system structure. In terms of equity, the consequence to patients is that they are paying for a service that is supposed to be provided by the state free of charge, although in many instances they pay for it through payroll deductions. Corruption in the post transition period is then likely to affect negatively the ability of the health care sector to preserve a healthy population.

**Hypothesis 3.1.** The higher the level of corruption, the lower the effectiveness of the health care system.

It means that the amount and quality of health care one gets is directly related to the ability to pay. In fact, many of those interviewed in Poland stated that they delay getting health care because they cannot afford to pay bribes (Shahriari, Belli, and Lewis, 2001).

Another form of inefficiency is that the private sector, instead of evolving as a healthy competitor to the public sector, exists in symbiosis with it: the private sector...
profits from the under-funding of the public one (Shahriari, Belli, and Lewis, 2001). Katarina Ott (1999) states that in the short run, if the growth of the underground economy is larger than in the official economy, true growth rates will be understated, which may lead to the inaccuracy of all relative indicators derived from it. This will lead the government to take expansionist policies to counter what is believed to be recession when there is recession. Thus, the persistence of corruption will lead to wrong policy choices, and the process becomes a vicious circle.

If all countries have some level of corruption present in their health care sector, how do some countries succeed at improving their health care effectiveness while other countries keep struggling? The difference in the success of some countries can be explained from an institutional perspective: countries that form strong government institutions in the transition period are able to create and enforce rules and laws that curb the corrupt behavior and reduce the underground economy. They do not directly solve the issue of supply shortage because that is a structural problem in the health care system that needs to be addressed through structural reforms. However, it changes the incentive system where bribing no longer pays off. Once the perverse incentive system is broken down, it opens up the stage for reforms to be implemented because more interest groups now have a clear need for reform of a system that is not benefiting anyone. Institutions are formal, written rules of behavior that constrain the behavior of individuals. In the sense in which O'Donnell (2004) presents it, strong institutions entail not only the existence of the rule of law that punishes illegal behavior in general but also the degree to which they are implemented equally across all actors. In a country where the democratic form of government is seen as the only option for
conflict resolution, the rule of law is applied more extensively, and thus the level of accountability is higher. Therefore, the creation of strong institutions depends upon the level of democratic consolidation the country has been able to achieve.\(^{21}\)

In the health care sector, strong institutions lead to lower corruption levels because they provide for a transparent method of exposing and punishing illegitimate behavior. This in turn increases the effectiveness of the health care sector because it changes the incentives of participants to where everyone would benefit from reforms. It also increases the benefit to patients who no longer have to pay up to get services they are entitled to for free. Where strong institutions are introduced in the post-transition period, they lower the level of corruption regardless of whether corruption was high or low prior to the transition. Changes in the institutional structure can affect accountability and corruption. Where governments showed credible commitment through changes in the formal institutions to address the issues of public concern, the institutions achieved the desired outcome through their impact on formal institutional change and public perceptions (North and Weingast 1989). This means that where governments are committed formally to anti-corruption measures in the health care sector, they are more likely to receive public support and commitment of the public to adhere to the policies.

Hypothesis 3.2. The higher the degree of democratic consolidation, the higher the effectiveness of the health care sector.

Hypothesis 3.3. The more effective the institutions, the higher the effectiveness of the health care system.

\(^{21}\) Under a democratic rule of law, O'Donnell claims, the agencies of electoral, societal and horizontal accountability function effectively without being obstructed by state actors. Furthermore, he claims that insofar as such laws are endorsed by and fairly applied to all relevant institutions can these institutions be deemed democratic. At the same time Diamond (1996) shows that the rule of law protecting citizens is one of the essential features of a liberal democracy, where not only vertical, but also horizontal accountability is assured.
Furthermore, when the public consistently experiences the presence and effectiveness of corruption-fighting institutions over time, they become more trusting of the government institutions because they experience first hand the results of effective institutions. The longer that experience is, the stronger their support for health care reforms will be.

Additionally, since the enforcement of rules cuts into the ability of people to supplement their incomes in a decaying health care system, the pressures coming from doctors and patients on the government to improve the system build up and force the government to improve the health care sector through reforms, which may involve not only higher spending, but restructuring. Higher social pressures for improvement lead to actual improvement. This is because the existence of strong institutions, which lead to higher social pressures to begin with, are also more likely to be formed in societies where governments are more accountable to the people. Thus, they are less likely to ignore their interests and instead crush popular pressures by force.

Thus, institutions have two effects on improving the health care sector: on one hand, they lower the level of corruption in the post-transition period; on the other hand, they increase social pressures on the governments to improve the health care sector. Figure 2.1 shows a matrix with four different possible outcomes of health care sector effectiveness, depending on the level of corruption prior to the transition and the strength of institutions after the transition.
In a country where the level of corruption was relatively low prior to the transition period, the creation of strong institutions leads to the almost complete eradication of corruption and the increased prospects of health care effectiveness. This is shown in the lower left hand box. By the same token, a health care system is relatively effective in countries that had high levels of corruption prior to the transition but were also able to create strong institutions. However, the high level of corruption in the pre-transition period may make it more difficult to achieve an effective health care sector, and this may be reflected in a longer period required to improve the sector. Nonetheless, the long-term efforts are likely to be successful. This outcome is displayed in the upper left hand corner. In the case where institutions are weak, or where the introduction of...
stronger institutions failed, regardless of the levels of corruption in the pre-transition period (upper and lower right hand boxes), the achievement of an effective health care sector is likely to be less successful than when the institutions are strong. This is because, even in countries where the pre-transitional corruption level was low, increased economic difficulties during the transition will likely increase the level of corruption. Where the level of corruption was high in the pre-transition period, the presence of weak institutions does nothing to curb it. The health care sector keeps decaying, mortality rates and disease keep rising unless the economic situation in the country drastically changes for the better. The level of corruption is expected to decrease in the long run, assuming the economic situation in the country improves in term of macroeconomic stability, growth, lower inflation and decreasing unemployment. Although the outcomes portrayed in the matrix are ideal types, the outcomes should be very close to the experiences of countries in Eastern and Central Europe. Changes in economic performance are expected to also affect the levels of corruption, but marginally so in the short run unless the changes are radical.

This chapter outlined the relationship between corruption and institutions and how they jointly affect the likelihood of achieving an effective health care sector in Central and Eastern Europe. Although the role of institutions has broad and multiple applications in the countries undergoing transitions because it affects long term support for the new regime, as is argued in the last chapter, they play a very specific role in

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22 Where institutions were weak, the process of economic liberalization was often perverse, lacking transparency and plagued with nepotism, which eventually led to the distrust in state institutions and fueled more corrupt behavior (Ott, 1999).
determining the success of World Bank funding of the health care sectors in Central and Eastern Europe.

4: International Funding and Health Care Sector Effectiveness

In the past thirteen years of the dual transition undertaken by the Central and Eastern European Countries (CEEC), most of the attention in the economic transition has been paid to the processes of price liberalization, macroeconomic stabilization, and privatization. This agenda was dictated by international organizations such as the International Monetary Fund and the World Bank\textsuperscript{23}, the most fervent supporters of rapid economic reforms in the post-communist countries. In light of the severe balance of payments problems and hyperinflation, the transitioning countries needed the monetary and technical support of countries and institutions to achieve stabilization and create post-transitional institutions to sustain a market economy. Historically, the World Bank and IMF have been the largest aid donors. In order to receive aid, countries are obliged to comply with austerity measures like the ones imposed in Central and Eastern Europe. In the research community, most deliberations have been between the advocates of fast versus gradual reforms, and partial versus complete privatization. The social welfare consequences of the transition process have been largely ignored. It is only in the past few years that researchers have focused their attention on insurance issues. With the advance of time, the deteriorating public health conditions in these countries have drawn the attention of the same international organizations and a few

\textsuperscript{23} The World Bank will be used interchangeably with IBRD (International Bank for Reconstruction and Development) throughout the paper.
Some of the CEE countries have been more successful at reforming their health care sector than others, as evidenced by less drastic declines in life expectancy, and improvements in other measurements of health care success. The question that this study seeks an answer is: Why were some CEE countries more successful in reforming their health care sector than others?

This chapter explores this question by looking at the impact of the World Bank support on the health care reforms in the CEEC. Besides the significant role the World Bank has played in the overall financial support of the region, it has been the only agency to make significant financial and technical assistance contributions to health reforms in particular. The timing of this study seems appropriate to explore whether and the extent to which the support from the World Bank has significantly contributed to the success of those reforms. The theory presented here proposes that the success of the health care reform, supported by the World Bank, depends not only on the timing and amount of aid provided by the World Bank, but also on the strength of the institutions in the particular country. I hypothesize that the sooner the country achieved economic stability, the less the health care system would deteriorate before reforms were implemented. Also, the more financial support was given by the World Bank, the better equipped the country would be to implement those reforms. Furthermore, the willingness of the World Bank to provide support depends on the agency’s evaluation of the country’s success at implementing first wave reforms such as macroeconomic stabilization and privatization. Thus, I plan to test whether a country that implemented

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24 Janos Kornai (2001), Christopher Davis (2000), and Paolo Belli are among the few who have produced viable research in the area of healthcare in transitional economies. Others have focused on the general role of international agencies on the transition process.
25 Among the most widely used measurements of health care system effectiveness is life expectancy, infant mortality, and birth weight.
its initial reforms rapidly and successfully was more likely to receive the World Bank support earlier and in a larger amount and whether the aid in turn made the health sector more effective, as indicated by increased life expectancy, and other indicators. Finally, I test whether the impact of the World Bank’s success in promoting reforms could be either promoted or inhibited by the institutions of the country. While strong institutions, which made the reform process transparent, would further the World Bank support by allocating the funds appropriately, weak institutions could inhibit the reform process by misallocating the funds, so that some share of them would never serve their initial purpose.

4.1: The World Bank and Institutional Effectiveness

The literature describing the impact of international organizations on health care reforms is scarce in general, and almost nonexistent with regards to transitional economies. This is due to the fact that the only international organization that has contributed significantly to health care reforms in the CEEC region, the World Bank, began its lending program for the purpose of health reforms only in the past ten years. The scarce attention paid by the international organizations to the health sector in the early transition years is attributable to the lack of knowledge about the social costs of economic transitions. Additionally, because health care systems vary so widely even among wealthy nations, there was no blueprint for a successful reform plan worth undertaking (Nelson, 2001). However, as the life expectancy in the CEE countries began declining rapidly, especially in Russia, the public outcry for health care reforms compelled governments and international agencies to move up health care reform on
the priority list. Nonetheless, there is some literature that has analyzed the process and impact of international organizations lending on the transitional economies, as well as the impact of the political transition on the health care sector of these economies.

The theory presented here proposes that the success of the health care reform, supported by the World Bank, depends not only on the amount of aid provided by the World Bank, but also on the strength of the institutions in the particular country. Figure 2.2 describes the relationship between World Bank financial support and success of health care reforms. First, the World Bank allocates funds based upon need as well upon their country evaluation, which indicates how likely a country is to repay its loans. Countries that are better off economically are more likely to repay the loans and are, thus, more likely to receive funds sooner and in larger amounts. However, money without oversight can be misused and not be directed to the proper recipients. Thus, the funds from the World Bank are a necessary but not sufficient condition for health care sector effectiveness. In addition to the amount and timing of funds, the institutional effectiveness at establishing and enforcing the rule of law so that the funds allocated for the health care sector are spent as intended is crucial in order to achieve an effective reform of the health care sector. The rule of law is essential to the success of reforms because it curbs corruption and ensures accountability and transparency.

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26 Life expectancy in Russia between 1985 and 1987 was 70 years, while it rapidly declined to 57.5 by 1995 (McKee and Leon, 1997).
4.1.1: The World Bank

Although most of the literature either entirely circumvents or minimally touches upon the World Bank assistance for the health care sector, it is still useful to examine both the principles used by the World Bank to allocate funding as well as the repercussions that it may have for the recipient countries. The World Bank has been the only agency to give loans and other types of support for the identified purpose of reforming the health care sector of these countries. Although the World Bank has been more aggressive in its participation in other social reforms, such as the pension system in Poland, it has been comparatively shy in its assistance to the health care sector. In the period between 1990 and 1993, the share of the World Bank lending that was dedicated to the health care sector was only three percent, and this measure included financing for nutrition and population sectors as well (Wallich, 1994). Nelson (2001)
identifies a few reasons for such behavior. While reform of the pension system had clear examples, such as affluent western countries, to model their systems after, the health care sectors of affluent countries vary significantly, and there is no consensus on a blueprint for reform of the health care sector. Thus, the first reason for the lack of participation of the World Bank was a lack of knowledge, or lack of consensus within this organization, on what model health care reform should follow. Second, as Nelson (2001) mentions, the political disagreements and conflicts of interest\textsuperscript{27} tend to be more frequent when it comes to healthcare issues. Coupled with the greater complexity of reforming a health care system (as opposed to a pension system), the IBRD chose not to get involved in reforms where success was not foreseeable.

Brada and Schönfeld (1995), Wallich (1995), and Zecchini (1995), among others, analyze the factors the World Bank takes into consideration when the organization decides to give support to countries to reform their health care sector. The process starts with the country requesting the needed assistance from the World Bank. Typically, countries have refrained from requesting assistance from the World Bank for health care sector reform. They have preferred to borrow for more traditional investments such as infrastructure development. The key factor in the decision on whether to borrow for social sector reforms has been the “economic efficiency of the investment” or economic returns. Health care reform projects do not yield direct financial returns (Wallich, 1994; p.74).\textsuperscript{28} Thus, it is harder to repay loans that do not yield direct financial return in terms of growth in income. Accordingly, a number of loans the World

\textsuperscript{27} In the case of Poland, the ministries of health tended to reflect the interests of particular groups of doctors, and there was tension between the ministry and the state health fund about who will manage the funds (Nelson, 2001).

\textsuperscript{28} Economic returns, as opposed to financial returns, incorporate both the social benefits, such as a healthier, better educated population, but also social costs, such as pollution (Wallich 1994).
Bank secured for the purpose of the health care sector were either mixed loans, or the scarcer sector reform loans where 100 percent of the funding was dedicated to the health sector reform. A mixed loan is a loan where a portion of the fund is given for the purpose of some macroeconomic stabilization or infrastructure growth while the remaining portion was for the health care sector.

When evaluating the request of a country for a loan, the World Bank uses data collected from the International Development Agency (IDA) Country Performance ratings, where the agency evaluates the country by a number of different factors. These ratings are based upon the Country Policy and Institutional Assessment Questionnaire (CPIA), which includes evaluations on the following areas: economic management, structural policies, policies for social inclusion/equity, and public sector management and institutions. The ability of a country to implement the economic and social policies that promote growth and poverty reduction gives the World Bank an assessment of the integration of aid into macroeconomic stabilization efforts already under way (Howell, 1998). The requests for assistance are screened selectively, given the observation that the impact of assistance on reforms and sector problems is most effective in countries that advance most rapidly in the economic transformations (Zecchini, 1995). This necessarily implies that countries that have achieved GDP growth and lowered inflation and unemployment, were more likely to receive World Bank support. Such an evaluation process does not come as a surprise, give that the IBRD is a bank and behaves so as to maximize its investment returns. Thus, where growth and reforms are not advancing rapidly, World Bank funding may be very limited.
This finding goes hand in hand with the literature on shock therapy reforms. The main promoters of the radical reforms of macroeconomic stabilization were and still are organizations such as the World Bank and IMF (Jones and Kummsa, 2000). In fact, according to Sachs (1991), the countries that undertake radical reforms are able to reverse the process of decline in production and growth much faster because, by implementing all reforms sooner, they are able to avoid the lengthy period of hyperinflation and negative growth. Moreover, they are also able to implement policies before existing political interests become mobilized to react against the costs of reform. In his 1996 study, Sachs found a positive and significant relationship between the economic growth and speedy reform progress. Thus, the sooner after the transition the countries achieve stability and growth through the implementation of reforms, the more funds they are likely to receive from the World Bank and the sooner they will receive them. International financial institutions’ financial assistance has rewarded mostly those countries that started their economic transformation earlier than others (Zecchini, 1994).

To summarize, the World Bank’s willingness to provide support depends on the agency’s evaluation of the country’s past economic performance (growth of GDP) and upon its successful implementation of other reforms such as macroeconomic stabilization, and privatization. Thus, a country that had implemented its initial reforms rapidly and successfully was more likely to receive World Bank support and to do so earlier rather than later. A country with good economic performance was also more likely to receive a larger amount of funding, given that such performance reflects the likelihood that the country will be able to take advantage of the loan effectively and be able to repay it as agreed.
Hypothesis 4.1: A country that is evaluated more favorably by the World Bank is likely to receive more funds and thus achieve a more effective health care sector.

The underlying argument states that when a country undertakes rapid and comprehensive reforms early (i.e., shock therapy), it achieves economic stability and growth early. This is because it is able to first implement all the necessary reforms, which initially led to an unstable situation (high inflation, negative growth, etc.), and then it implements stabilization procedures (fiscal rigidity, zero balance of payments, etc), which leads to a growing GDP. Given that the World Bank is one of the main supporters of such an approach to reforms, it evaluates the ability of a country to take on more assistance by measuring its success in the reforms implemented to date. The macroeconomic stability and reform implementation of the country indicates how well the country will be able to absorb the new assistance dedicated to sector reforms such as the health care sector.

Even though it has a different function than commercial banks, the World Bank still behaves according to the banking principles of returns on their investment and avoidance of high-risk loans. This means that the bank will steer clear of lending to countries that do not rank very high on their evaluation of past economic performance with respect to reform success. The World Bank and will be less willing to lend such nations any resources. Thus, when the bank lends resources for the purpose of the health care sector reform, it will be more likely to give less assistance to those countries that score lower on the evaluation list in order to minimize the Bank’s potential loss in case the country fails to implement the reforms successfully and/or defaults on the loan repayment. If that country experiences high growth and has achieved fiscal stability, it is
more likely to repay its debt to the World Bank than a country whose fiscal deficit is not under control and whose growth has been stalled by poor reforms (Howell, 1998). Furthermore, these types of loans, as opposed to loans meant for infrastructure development, do not bring financial returns to the borrower, and are thus harder to repay.

With respect to timing, the sooner a country receives support immediately after the transition, the less deterioration of health care would occur before reforms were implemented. Therefore, it should be easier to rehabilitate the performance of the health care sector. Here, the ability to reform the health care sector is a function of time because receiving funds sooner will stop the decay of the health care infrastructure, including the financing, management and functioning of both hospitals and the insurance system. The early availability of funds will result in lower mortality rates. In terms of the amount of the loan, the more financial support is given, the better equipped the country will be to implement those reforms faster and more comprehensively. In a country that has been undergoing economic reforms accompanied by initial economic decay (negative or slow growth, high unemployment, hyperinflation, poverty), timing of aid and reform is crucial to the country’s ability to reverse the decline in the health care sector (Davis, 2000). One of the reasons for an increase in mortality and decrease in life expectancy during the transition has been the fact that reform of the health care sector was placed on the backburner when the economic transition process started. This was partly due to the international pressures to reform other sectors, thereby neglecting the welfare sectors. In part it is also because of the secondary position that the health care sector occupied in the command economy, a status that continued into
the transition period. Thus, as Davis (2000) mentions, given that the effectiveness of
the health sector depends on the financing and effective management, the sooner the
financing is received, the better it will perform and recover from the shock effect of
transitions.

Hypothesis 4.2. The sooner a country undertakes economic reforms, the
more likely it is to achieve an effective health care sector.

This relationship follows from the previous hypothesis. Given that the World Bank
evaluates countries based upon past reform performance, the sooner the countries are
able to implement successful reforms and show macroeconomic stability and growth,
the sooner the World Bank be willing to lend them the necessary resources to
implement health care sector reforms.

Financing is one of the most important factors influencing the performance of the
health care sector (Davis, 2001). In developed capitalist economies the amount of
money spent per capita on health care is affects the quality of care. It has also been
found that an increase in medical care spending has a direct positive effect on health
outcomes, as is measured by infant mortality rate (Phelps, 2002). According to Janos
Kornai (2000), health care spending in former command economies was not unusually
high, as some have suggested (due to its inefficiency). Rather, it was not funded
properly in comparison to other sectors. Thus, the more financial assistance is
available for the purpose of reforming the sector, the more successful the health care
reform is likely to be, all other things being constant. The assistance is needed not only
for the renovation and technological update of hospitals, but also for the restructuring of
the wage system of health care employees and the reform of the underfunded health
insurance system.
Hypothesis 4.3: The larger the amount of assistance a country receives, the more effective its health care sector is.

4.1.2: Institutions

In the previous chapter I argued that effective institutions are crucial as a check on corruption. Here I address the role of effective institutions in attracting international funding for the improvement of the health care sector. The success of the financial support provided by the World Bank, is also affected by the type of the institutions present in the country. Ablo and Reinikka (1998) show how budgetary allocations for public spending, such as health care spending, can be inaccurate in the context of an ineffective institutional setting. Effective institutions provide for checks and balances in implementing the rule of law and create incentives not to cheat. Where institutions are ineffective, the policy implementation process breaks down, and in the case of resources delegated for public spending, the actual inputs do not reach the intended targets. This occurs in societies where the democratic process of transparency is lacking so that there is no accountability for government officials. Others, such as Svensson (2000), find that the control of public policy is less effective in highly polarized societies and where there is some degree of social conflict. Given that the process of democratization is a long-term process, for CEE countries the presence or absence of institutional effectiveness may play a significant role in the success of health reform implementation.

The World Bank’s support for reforms could be either promoted or inhibited by the institutions of the country. The institutions variable is an intervening variable. 29 Effective institutions could increase the benefit from World Bank support by holding the government accountable and making the process

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29 The institutions variable is an intervening variable.
more transparent. By allocating the funds inappropriately, ineffective institutions could inhibit the reform process by misallocating the funds because of corruption or lack of skills to implement it. Some of the funds might never serve their initial purpose or reach their intended target.

Hypothesis 4.4: The more effective the institutions are, the more effective the health care sector.

The success of policy (i.e., reform implementation), holding all the other factors constant, is dependent upon the ability of the government to translate the policy into actual effect (Ablo and Reinikka, 1998). In order for the implementation to be successful, the process must be transparent and there must be a structure of accountability for government officials. In other words, the institutions in place must be strong enough to implement the reforms fairly and effectively.

The following and final chapter of the theoretical framework ties together the issue of public opinion, public trust, corruption and institutions. The chapter introduces the notion of institutions in a different form from the ones used in the last few chapters. However, it ties it all together by showing how institutional designs can affect public trust and support. Public trust is closely related to the issues of corruption and trust in the new institutions. That is because where corruption is rampant and institutions weak, public trust is low. At the same time, where people perceive that their interests are not represented, their support for the regime is undermined.
Public support for the dual transition process and the post-transition government has a decisive impact on the ability of the government to successfully implement reforms in general and health care sector reforms in particular. The framework presented in the previous chapter suggests that public support for the transition is subject to change over time. In the case of Central and Eastern Europe, public support is likely to decline as the first wave of reforms is implemented and their negative consequences are felt both at the individual level (in the form of lower living standards, declining health, etc) as well as at the macroeconomic level (in the form of negative economic growth and high unemployment rates).

The case of Central and Eastern Europe is specific because public support of government institutions is impacted also by the performance of the previous, communist regime. In those countries where the memory of the communist past was very negative, the people are more likely to support the new democratic system. At the same time, public support of the new regime is also influenced by the recent experience with the new democratic system. Low levels of public support and trust in the new institutions are more pronounced in countries such as Russia and Romania, which experienced more traumatic transitions in both the political and economic realms. Other countries of CEE had a more satisfying experience with the transition process and its repercussions.

In addition to past and present experiences with the economic and political performance of two very different regimes, public support and trust are also affected by the type of institutions created in the post-transition period. Institutions that are more
representative are likely to be seen as more legitimate and thus increase public support for the incumbent government and the new regime. In the following section of this chapter, I develop a theory that explains how both public trust as well as institutional design can have a significant impact on the ability of countries to improve their health care sector.

5.1: Public Support, Legitimacy, and Health Care Sector Effectiveness

Public support for democratic institutions has been studied for decades, and one of the most distinguished works in this area is David Easton’s 1965 *A Systems Analysis of Political Life*. In this and subsequent works, he makes a distinction between support for the political community, regime and incumbent authorities. While the distinction between these is significant and important, in the case of Central and Eastern Europe, they have become one and the same because the introduction of a new regime and its institutions coincides with the election of a new government body. Thus, the dynamics of public support for a new democracy are potentially very different from that of an existing one. In a new democracy with no previous experience with democracy, the erosion of support for incumbent leaders can also erode support for democracy itself.

Democracy thrives on popular support and is threatened without it (Easton, 1965). High public support gives legitimacy to democratic institutions and enables elected government to perform more effectively (Mishler and Rose, 1999). If people support the government, they are more likely accept and obey its authorities and see its actions and rules as conforming to their own values and principles; that is, they see the government as legitimate (Easton, 1974). The notion of public support is very
important in the case of Central and Eastern European Countries, even more so than in other established democracies of Europe. While a drop in public support in established democracies does not undermine the fundamental belief in the democratic process (i.e. it has become “the only game in town”), the frequent identification of the incumbent government with governing system in a new democracy can lead to an erosion of support for both when an elected government’s performance does not meet expectations in newly democratizing countries. The performance of new governments is made all the more challenging because not only do they have to confront an unstable political environment, but they also lack the institutional capacity that enables established democracies to weather a crisis (Mishler and Rose, 1999).

How does public support and government legitimacy relate to health care sector effectiveness in Central and Eastern Europe? What Easton distinguishes as “diffuse” public support is a “reservoir of favorable attitudes or good will that helps members to accept or tolerate outputs (of the government) for which they are opposed or the effects of which they see as damaging to their wants” (1965). In other words, it is the public's willingness to take a leap of faith in the government, even in times when the outputs of that government are not favorable to their interests. In established democracies, because of their previous democratic experience, people may dislike government policy, but they still see it as legitimate because they believe in the fundamental process that brought it about.

For Central and Eastern Europeans, the experience with the democratic system is new, and it has not always been positive. In fact, the first wave of market reforms has brought widespread economic dislocations, lowered the standard of living of people and
increased stress, thereby threatening support for the new regimes (Kornai, 1992). Thus, the more negative experiences they lived through, the less support they had for the new regime. Even when the public cannot directly attribute a negative output to a government policy or action, there is evidence to suggest sociotropic voting occurs. This means that the public looks at the overall economic situation and is likely to believe that it is the government’s responsibility to deliver high economic performance (Mcallister, 1999). Thus, the volatility of public support for the new democracy increases because public support depends more heavily on the regime performance (both economic and political).

Given that health care sector reforms are usually pursued after the macro-stabilization policies have been implemented and brought about economic distress, public support for the government institutions is likely to be low at that point. When public support is strong, governments “are able to make new commitments on the basis of it and, if successful, increase support even more” (Gamson, 1958; p.45). Thus, the ability of the government to introduce and be successful at implementing the new health care reforms after pursuing the painful market reforms is likely to be low. This is even more pronounced if the country has not been able to rebound from the initial economic downturn.

Hypothesis 5.1. The higher the level of public support, the higher the health care sector effectiveness.

Mishler and Rose (1999) found that such public support in CEE is contingent upon the economic and political performance of the previous communist regime and the new democratic regime. Economic performance usually includes the performance of the national economy and the personal economic wellbeing of people, while the political
performance includes personal freedoms and rights. People with less negative experiences with the previous communist regime are less likely to support the new democratic regime when it faces difficulties (Mishler and Rose 1999). In other words, even if their support was initially high, they are quick to withdraw it if they long for the benefits they had under the communist regime. On the other hand, countries such as Romania, which had a more negative experience during the previous regime, are more likely to persist in their support of the new democratic regime even in the face of difficulty because the only alternative they know is not appealing.

Mishler and Rose (1999) also find that public support changes over time. As time goes by, the memories of the past regime fade and when faced with difficulties in the new regime, people are more likely withdraw support and consider other non-democratic alternatives. This would imply that countries that had a better experience under communism should ensure success in their immediate post-transition performance to secure public support in the long-run, since the presence of public support is crucial for their ability to introduce other reforms and policy commitments.

H 5.2a. The worse the experience with the previous regime, the greater the likelihood of a more effective health care sector.

H 5.2b. The better the experience with the new regime, the greater the likelihood of a more effective health care sector.

In more concrete terms, the political and economic system of communism often prevented the development of individual trust both in the government and in each other. With Stalin’s rise to power in the late 1920s, the destruction of all non-state social activities became the single most important goal of the revolutionary Soviet state (Fish 1995). The Stalinist state limited the rights of people to self-expression, thus making
them unable to express their individual interest through participation in voluntary association. Those groups of individuals who initiated underground movements in direct opposition to the state’s directives were in constant fear of being discovered and betrayed by individuals who reported to the state any suspected insurgent activity. Such behavior promoted deep attitudes of mistrust towards the government and its institutions, and eroded interpersonal trust.

However, not all communist countries are created equal. The level of state suppression of individual rights, self-expression, civil society institutions, and property ownership varied between countries of CEE. In states of the former Yugoslavia both the economic and political systems were more liberal. Yugoslavia practiced a more liberal form of communism that allowed for small private ownership, travel to both the eastern and western bloc without limits, and even access to radio and television transmission from west European countries. Because of their proximity to Italy and Austria, the northwestern coastal region of Croatia and parts of Slovenia regularly received transmitter signals from Italian television and radio stations. Furthermore, people from the western bloc regularly visited Yugoslavia as tourists, while those from the eastern bloc could do so as well, even though they were limited in the frequency of travel to this non-aligned country.\(^3\)

The economy of the former Yugoslavia was a prime example of a mixed economy. Limited trade was allowed with the western bloc. Although associations that directly challenged the government were still not allowed and the Communist Party was the only party allowed, church attendance and other non-

\(^3\) Even tough Yugoslavia was communist and socialist, citizens of the Warsaw Pact, and especially those of the former Soviet Union were severely limited as to how often they could visit Yugoslavia. This was in part due to the schism of 1947 between Stalin and Tito, and following the more liberal approach of the latter one to communism and foreign relations with the West.
political civic associations were allowed. This helped build a higher level of satisfaction
and interpersonal trust in these states than in those of the former Soviet Union. There
was also variation in the countries of the Warsaw Pact. Poland, Czechoslovakia and
Hungary were less oppressive than Romania or Bulgaria. In Poland, the Catholic
Church remained very active while Hungarians enjoyed some travel abroad after 1968.
Thus, there is variation between the countries in the pre-transitional level of economic
and political liberty, and this variation in the level of post-transition support for and
legitimacy of the new government and its institutions. It should also result in variation in
support for the dual transition and health care reform specifically.

The impact of public support and on health care sector effectiveness is of
particular importance because to people of the former Central and Eastern European
countries access to universal health care was a benefit they value highly along with the
right to work and be employed. In light of the severe unemployment that resulted from
the liberalization process, many have begun to yearn for the welfare states of the
communist period, with or without a repressive government (Mason, 2000). This trend is
attributable to the social costs of the transition (increased income inequality, lower living
standards), which have been very high, regardless of whether the transition has been
successful or not.\(^{31}\) Furthermore, the importance of the health care sector issue during
the transition period is accentuated not only because it is usually at the end of the
reform list (as explained in the previous chapters) but also because of the detrimental
effects that increasing inequality has on health care. Socialist states were known to be

\(^{31}\) An exception to this is the case of the Czech Republic. The economic disruption of the dual transition
was minimal and the country’s transition process was virtually undisputed and smooth. In fact in 1994, the
year after the formal transition occurred, the GDP growth rate was back to 2.6 up from –6.4 in 1992. At
the same time its unemployment rate never went above 3.5 percent (1996) (Mason 2000).
more egalitarian. Regardless of their level of economic development, they had much better overall health indicators than many non-socialist countries at similar levels of economic development. Increased inequality not only affects health directly but also affects “the social fabric and leads to increased violence (Mason, 2000). In order for the political institutions to be effective in advancing reforms of the health care sector, they must enjoy public trust and support, in light of the initial difficulties. Since public trust changes over time, the public support/trust developed during the pre-transition period has a significant impact on post-transition public support for the regime and support for the dual transition, which finally impacts the ability of government to implement second wave of reforms in which health care sector reforms fit.

5.2: Institutional Design and Health Care Sector Effectiveness

Public support for the dual transition is affected by the type of institutional system set in place in the post-transition period. The type of institutional design that is adopted can have an important effect on the public trust in the government, its effectiveness and its ability to improve health care sector effectiveness. Democratic institutions can either mitigate or enhance the effects of low public support, depending on the institutional design that is adopted. The critical element is whether Proportional Representation (PR) or Majoritarian/Pluralist electoral system is adopted for choosing the legislature.

There are both advantages and disadvantages that come with each system. The advantages of the a PR system have been defined in terms of its impact on the representativeness of the regime. Lijphart (1994) points out that in a PR system every new election does not bring a complete shift in the government makeup. Many of the
same members remain in the governing coalition from one government to the next. This makes policymaking more stable because the repeated interaction and anticipation of future interactions makes the representatives more likely to cooperate. Furthermore, in a PR system the government is better able to insulate itself from special interest group pressures and is more likely to listen to the interests of a larger range of constituencies (Rogowski, 1987). At the same time PR systems have been criticized as being less stable because they fragment the parliament among the multiple parties and encourage extreme parties to join the governing coalition. This can create instability marked by frequent confidence votes in policymaking (Rae, 1971). It can also lead to legislative immobility. Most agree that a PR system is better able to represent minority interest because it allows for smaller parties to win seats and have a chance to join the governing coalition (Sartori, 1994). On the other hand, some believe that it can bring to a legislative halt because of the multiple veto powers (Tsebelis 2000, Sartori 1994). Still, the fact that parties in a PR system have an incentive to cooperate, their number is less likely to create a legislative halt (Birchfield and Crepaz, 1998).

A majoritarian system has been highly criticized for giving more power to special interest groups, and for not allowing minorities to be adequately represented in the government. It is possible for a minority party or coalition to be voted in and pass policies that are not in line with their mandate, so that it does not represent the interests of most citizens (Powell 2000, Sartori 1994). That is because in a majoritarian system the winner takes all of the votes (whoever gets the majority of votes rules in the government). However, there are some advantages that Majoritarian systems enjoy. Clarity of responsibility is one. When policies are passed and implemented, it is easier
for the voters to attribute its success or failure to the responsible party. Where there are fewer parties in the government, voters know who is responsible for failed policy (Powell, 2000). However, the negative impact that the majoritarian system has on the degree of proportionality of the system is more important in the context of new democracies because it does not allow for equal representation of competing interests. In new democracies, the support of the new regime has is not consolidated and a perception of unequal representation can undermine the process towards consolidation.

The impact of institutional design on public support and health care sector effectiveness is related to by its impact on the degree of proportionality and representativeness in parliament. These are the two features that Lijphart (1999) claims can be used to assess how democratic a system is. These are also the main features that I will be focusing on in this chapter. A PR system is considered to be more representative and proportional because its electoral rules translate votes directly into seats. The PR system has low effective electoral threshold in that the proportion of votes that a party has to win in order to gain seats is very low. PR systems have a system of checks and balances between the executive and the legislature. On the other hand, a Majoritarian system is less representative because it involves an all or nothing approach to seat assignment where the candidate who gets the majority or plurality of the votes takes the seat. The remaining minority that did not vote for this candidate is not represented.32 What do the features of these two electoral system mean for newly democratizing countries?

An institutional design that is more proportional in its representation and that gives power to more groups is likely to be perceived as fairer by citizens in a new democracy because a large range of public opinion is represented in the governing coalition and in the legislature generally. The perception of the people that their vote counts is crucial in sustaining the new democratic regime by endowing it with a measure of popular legitimacy. What is more important is that a PR system increases the chance for a successful democratic consolidation in the long run (Przeworsk et al, 2000). The ethnic diversity of Central and Eastern European countries makes this issue even more significant as the ability of the diverse groups to be represented and have a say in the national government can build and enhance democratic values and mitigate ethnic conflict. Even among CEECs that are not ethnically heterogeneous, there are other advantages to having a more proportional system. The legitimacy of the new democratic regime is important in CEE because they have little or no prior experience with the democratic process and the market. Their democracy is not yet consolidated, and giving more people the chance to have their interests represented creates a sense of trust and allegiance to the democratic system of governance. Since economic crisis jeopardizes the survival of consolidate democracies and their legitimacy (Przeworski and Lemongi 1997) it is evident why newly democratizing countries are even more vulnerable to relapse into authoritarianism of some form. A legitimate government system enjoys higher support by the people, which makes it more effective at implementing necessary but often unpopular and painful reforms, such as the health care sector.

Hypothesis 5.3. The more proportional and representative the political institutions are, the more likely the health care sector is to be effective.
Although this study is not concerned with how and why different institutional setups are created in the post-transition period (rather, we are interested in the consequences of a certain institutional setup), it is likely that the institutional design was a reflection of the distribution of power among the groups at the time of the transition. Examples of different degrees of electoral proportionality and representativeness can be seen all throughout Central and Eastern Europe. Some countries adopted plurality setups while others have mixed systems. At the very beginning, when the communists still had significant power in the government and the negotiations about the new form of government were taking place, a majoritarian system with a strong presidency was the norm (ex. Croatia, Russia, Czech Republic, etc.). In all countries, Communist negotiators were in favor of a strong president since they expected to win in many cases (Geddes, 1996). At the same time, new smaller parties preferred proportional representation, given that they could not win the majority in the election. Unfortunately, opposition parties were often weak because they had no opportunity to organize under the old regime. Communists also preferred single member districts, since they still had patronage power at the local level that enhanced their prospects for victory (Geddes, 1996). The initial institutional setup emphasized a strong presidency because such a design suited those who had been in power before. Institutions are usually created to preserve a system that supports increasing marginal returns (marginal benefits) of those who had been reaping the benefits of the existing system. Thus, in the first elections after the transition, Poland, Hungary and Romania all had either majoritarian or semi-majoritarian systems.33

33 See Geddes (1997) for a more detailed explanation of events that lead to the vote on a Majoritarian
Some scholars have pointed out that because of multiple veto players PR systems are unstable because they result in legislative immobility and frequent no confidence votes (Tsebelis, 2000). More specifically, when there are more interest represented and all of them have veto power, it is more difficult to get any policies enacted. This feature of the PR system is likely to increase frustration on the part of the people because the process of policymaking is likely to be slow and incremental. It is likely to produce legislative immobility. This would imply less confidence on the part of the public. However, others such as Birchfield and Crepaz (1997) note that there is a distinction between veto points. In a majoritarian system where competition for the process itself is emphasized the veto points are competitive because it is seen as a zero sum game. One group’s win is another’s loss. It is an all or nothing process. The groups are focused on what they can gain without the consideration of other groups. On the other hand, collective veto points characterize PR systems where a philosophy of cooperation is present that ensures that the policy goals represent everyone’s interest.34 They are collective in that they work as a joint groups to achieve jointly agreed upon goals. That means that even though there are more diverging interests, what these multiple interest have in common is their desire to come to a common agreement and a result that everyone will be satisfied with. The process is seen as a positive sum game. Thus, their interactions are based on cooperation, not competition (Birchfield and Crepaz, 1997).

34 “Competitive veto points” are likely to produce pork barrel politics because the process is seen as a zero sum game. On the other hand, “collective veto points” see it as positive sum game where it is in the best interest for every party that all interest are satisfied.
In Central and Eastern Europe where the new democratic regime is new, the issue of institutional design and public perception of the new institutions is especially important. Public perception of the rules of the game and whether they give equal opportunity to all can determine the amount of support and legitimacy a government enjoys. If representative, institutions can increase public trust and thus increase support for institutions and reforms. At the simplest level "if we feel that the rules of the game allow the party we endorse to be elected to power, we are more likely to feel that representative institutions are responsive to our needs so that we can trust the political system" (Norris, 1999; p.219). In CEEC there is no evidence that the presidency is seen as "a cooperative solution among parties to a shared problem of uncertainty" (Geddes 1996; p.29). Strong presidencies are more likely in countries where the opposition in the legislature was very weak. Thus, there is a smaller likelihood to create a more transparent legislative process emerging where there is less discretionary power (Geddes, 1996). When high discretionary power is combined with the economic difficulties associated with the first wave of reform, public support is more likely to fade. Low public support then makes it more difficult to bring about the needed reforms, especially in the health care sector.

Finally, experiences with the previous and current regime's performance and institutional design can affect public trust, which in turn affects the likelihood of an effective health care sector. See the flowchart in Figure 2.3 for more clarity. Is shows that public support for the post-transition government is influenced not only by the performance of the post-transition regime, but also by the previous regime experience and the design of post-transition electoral institutions. Better performance of the current
Public support for the post-transition government institutions is crucial for the government in office to be effective at implementing the needed health care sector reforms. High public support gives the government legitimacy and enhances public trust. Public support of and trust in government institutions is especially needed to implement reforms that may cause some initial distress. When the public sees the government as legitimate and trusts its actions, then it is likely to obey the rules and policies even when the policies implemented are not most desirable, such as macroeconomic stabilization measures and later changes in the health care sector.

Public support for a government (in the case of Central and Eastern Europe this also affects support for democracy) is affected by three factors, as illustrated in Figure 2.3. First, a country that has had a negative experience with the past regime performance is

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**Figure 2.3: Effects of public trust and institutional design on health care sector effectiveness.**

Experience with Communist regime

Democratic performance

Post-Transition Institutional Design

Public Support for Post-Transition Government Institutions

Effectiveness of Government Institutions

Health Care Sector Effectiveness
more likely to support the new government, regardless of its current performance. At the same time, current government performance in both economic and political terms is very important in determining the current public support because people tend to attribute responsibility for the overall situation in the economy to the government (sociotropic evaluation). Since people do not have any previous democratic experience upon which to base their current evaluation, government performance in the post-transition period is crucial in determining support for the government and for democracy in general. In addition to performance, another factor affecting public support in the post-transition period is the proportionality and representativeness of the electoral system. When people have more parties to represent their interests (representation), and when the votes won by these parties are directly translated into seats in the legislature (proportionality), then they are more likely to see the system as fair in giving them the opportunity to have their interests voiced. This also increases public support for the government and for democracy since the public sees that they have reasonable opportunity of affecting policymaking.

Having seen the impact of both public trust and post-transition institutional design on the likelihood of achieving an effective health care sector, it is important to understand how these two factors interact, and what the product of their interaction is in terms of health care sector effectiveness. Figure 2.4 illustrates this relationship more clearly. The most successful outcome is likely to occur in countries that not only inherited higher levels of public trust but also created institutions that were proportionally representative and where the presidency was not as dominant (first
quadrant), at least not for long. The countries that had both of these factors should have an easier time attempting to improve the health care sector effectiveness. On the other hand, in countries where public trust in general was low (lower quadrant) in the pre-transition period (due to the system’s limitations on voluntary associations and the under-development of the social fabric of trust) the outlook for the health care sector is less than optimistic. However, even in countries that inherited lower levels of public trust, once more representative and democratic political institutions are introduced in the post-transition period (second quadrant), the likelihood of achieving a more effective health care sector improves. The creation of a more representative legislature that is more transparent is likely to inspire more trust over time, slowly but surely overpowering the negative effects of low public trust from the pre-transition period. By gaining trust in the political institutions, even when the economy is not performing well, the people are more likely to maintain their support for the institutions and see the economic downturn as a temporary drawback, rather than as a cause to abandon the dual transition process altogether.

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35 The reason for qualifying the degree of institutions representativeness is because most CEE countries’ very first elected government included the presidency because the communists still had a strong hand in the system. However, in many of these countries, as soon as the second round of election came about, the power shifted away from the executive toward the legislature.
Figure 2.4: The interaction between public support and institutions and their effect on health care sector effectiveness.

<table>
<thead>
<tr>
<th>Public Support</th>
<th>1. Health care sector effective relatively early in the transition process.</th>
<th>2. Health care sector outcome uncertain.</th>
<th>3. Health care sector effectiveness delayed, but successful in the long run.</th>
<th>4. Health care sector in decay; no promise of any positive changes in the near future.</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Ex. Slovenia</td>
<td>ex. Croatia</td>
<td>Ex. Slovenia</td>
<td>Ex. Russia</td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thus, in the short run, it may take some time for the institutions to start evoking trust from the people, but as time goes by, the government is likely to overcome the low public trust problem, thus providing public support for the transition process and eventually for the much needed reforms in the health care sector. Changes in health care sector policy are likely to be implemented later in the reform process in countries with high public trust. However, once the process is started, it is likely to be successful. From these two possible outcomes, it is evident that the post-transition institutional setup can have a significant impact on public trust and the ability to achieve an improved health care sector in the long run, regardless of the level of initial public support. This is in accord with the institutionalism arguments that formal institutions can affect informal ones over time. When a law is passed to create more accountable institutions that punish illegal behavior consistently, the people are likely to start trusting
the institutions and the government as well. They are also more likely to start obeying the rules.

The situation of countries where the post-transition institutional design is less representative is quite different. In a country with relatively high levels of public trust the likelihood of achieving a successful health care sector is high, since a trusting public is more likely to support the reforms necessary for a successful transition process. Since their belief in the new system of governance and its institutions is high at the beginning, they are willing to take on some cost in order to achieve long-term benefits. However, when the new institutional setup does not give equal representation to all groups (second quadrant), and where many feel excluded from the political process, even those who initially took a leap of faith start doubting the new system of governance and their trust is eroded over time. The disappointment with the initial period translates into future public mistrust and this represents an obstacle to second wave reforms, including health care sector reform. Even if the health care sector reforms are initiated, the process is slow and the outcome is uncertain because there is not a comprehensive plan and commitment by the government. Such is the case of Croatia, which inherited higher levels of public trust than most other Central and Eastern European countries due to the more liberal regime in the former Yugoslavia. At the beginning of the 1990s when the transition started, Croatia adopted a strong presidential system, in part because of the need to rally around the leadership for the upcoming civil war. Nonetheless, long after the war was over, Croatia retained a strong presidency until 2000, when the new government was modified to a semi-presidential system, where the office of the president was essentially symbolic. Its health care system has been
neglected, and the symbolic reforms and attempts to improve it have been slow coming and of dubious results.

Finally, the worst possible outlook is in store for a country where both public support was low at the transition point, and where the new institutions do not inspire trust in the public due to the lack of representativeness. Indeed, majoritarian institutions can further erode already low public trust. In a country such as Russia, public trust was very low at the time of the transition due to government restrictions on the type of associations that could be formed, as discussed earlier in the chapter. Even though an increase in freedom of association started in the mid 1980s, it was not long enough to reverse the negative effects of individual and public mistrust the Leninist regime had built over the previous seventy years. Though they were eager to experience the new freedoms, public opinion started turning away from the support for the transition as soon as the first negative effects of market reforms were felt. However, this is not unusual given that in most countries public support temporarily dropped as the first effects of economic downturn were felt. What was so different about Russia? First, it is the fact the public trust was already low, which fueled mistrust again once the economic downturn began. Second, and more important, is the fact that in addition to the dissatisfaction with the economic situation, the public could not express its dissatisfaction effectively through public policy making because the institutions that were set in place gave overwhelming power to the president. The legislature was not representative of many social and ethnic groups, many of which were completely neglected. The institutions also lacked transparency and were pervaded with nepotism and corruption. Given the low level of public trust in the government and its institutions,
any significant health care sector improvements are not likely to occur until the institutional setup, its transparency and effectiveness are improved. The consequences of such a state of health care are detrimental to the public health, as witnessed by increased mortality and substance abuse. The case study on Russia explores all these factors in more detail.

In this chapter I have explained how two important factors, public trust and institutional design affect public trust and support for new democratic institutions. Public trust, in turn, affects the ability of the government to improve the health care sector. The four quadrants represent ideal types, and most countries will not fall completely within one or the other, but will find themselves somewhere in between, often moving from one to another as time passes by and conditions change.

6: All Strings Attached: The Big Picture

The last four chapters spelled out how the dynamics of each individual relationship worked in advancing or hindering the promotion of an improved health care sector in post-transitional Central and Easter Europe. From this, it should be evident that there is a common thread that ties all these separate pieces together in order to provide a more coherent and organized story of health care sector success in CEE. Figure 2.5 the story told in the previous chapters.

The pre-transition period has left its legacy on the future of the newly democratizing Central and East European countries in terms of how it affected their ability to improve the health care sectors in the post-transition period. There are three main pre-transitional factors that have had a crucial impact: health care corruption, level
of public trust, and the experience with the market economy and political freedoms. The level of corruption in the pre-transitional period has affected the growth of future corruption in CEE. Assuming away the impact that effective institutions are likely to have on post-transitional corruption, high levels of corruption before the transition are likely to encourage more corruption in the post-transition period because such behavior establishes a system of incentives where corrupt practices remain unpunished and where some actors (doctors, nurses, etc) reaping rewards in terms of income from corrupt practices. On the other hand, the rule of law upheld through effective institutions can break such patterns by not only offering different incentives but also by punishing such behavior. Once it no longer pays to cheat, or where costs actually outweigh the benefits, corruption is likely to diminish. Lower corruption levels increase the likelihood of improving the health care sector because the rule of law creates an environment where people no longer benefit from corrupt practices. Thus, people begin supporting the needed improvements in the sector because, first, the funds are channeled to the appropriate destinations, and second, patients no longer have to pay out of pocket bribes to physicians for services they are already paying for.

Another pre-transition factor that impacts post-transitional health care sector effectiveness is the level of public support. The level of public support and trust in the government institutions are important for achieving health care sector effectiveness, especially when the early negative economic consequences of the transition process are felt. Even if people initially support the transition to democracy and the liberalization of the economy, the first effects that are felt are more often than not negative. For public support of the dual transition to stay relatively stable, the
underlying public trust in the institutions of the government has to be strong. Stable public support of the necessary reforms even in light of short-term setbacks enables the government to be more aggressive at pursuing reforms, including health care reforms.
Figure 2.5: Health care sector effectiveness in CEEC.
In countries where the regime performance was worse in the pre-transition period, public opinion and support for the dual transition tend to be higher at the beginning of the transition, but they can diminish over time if the performance of the new regime does not meet expectations. This means that the countries where the public support is higher are likely to achieve the needed reforms of the health care sector sooner. An example of this is Slovenia. Although Slovenia’s experience with communism was not as negative, it was able to overcome some of the early negative results of the economic liberalization and restore growth rapidly. Thus, its new regime performance has been good and stable. The country never wavered from the reform path because public support of the transition has always been strong.

However, there is another factor that influenced public opinion in Slovenia: their prior experience with the market economy and individual freedoms. Countries that have had prior experience with the market economy and individual freedoms are more likely to be supportive of the dual transition. Not only do they have prior knowledge of the new system, but they also have experienced the positive effects of it. When they are more aware of the long-term benefits of the new system, they are more likely to support it, in spite of the temporary setback. As mentioned earlier, when the public supports the government in its reform implementations, it makes the government more effective at improving the health care sector reforms as well.

A clear example of how public support is influenced by prior market experience and individual freedoms is the different experience between Slovenia and Croatia on one hand, and Russia on the other. When the major economic crises occurred in the first wave of reforms, Russians started having significant second thoughts on whether
the transition was a smart decision to begin with. In fact, the Communist party in Russia
gained significant public support from 14.22 percent seats in the Duma in 1993, to 44
percent seats in 1995 (Popescu and Hannavy, 2001). For a while there was fear from its
neighbors that the Russian transition to democracy would not end successfully and
would be reversed. At the same time there was never a question of whether the public
in Croatia and Slovenia wanted to remain communist. It is true that at the beginning of
the Yugoslav debate, Croats and Slovenes wanted to create a confederation of
Yugoslav states. Once the transition was under way, there was never the threat that
public pressure would stop supporting the dual transition process.

In addition to the influence that pre-transition factors can have on the likelihood of
achieving an effective health care sector, there are factors in the post-transition period
that can increase or diminish the impact of the factors just mentioned. One such factor
is institutional effectiveness. The meaning of institutional effectiveness in this paper is
the ability to implement and maintain the rule of law, accountability and transparency.
Effective institutions curtail the behavior of individuals and their choices to the extent
that it is considered the only game in town. The use of other non-democratic
alternatives is not a viable option.

The introduction of effective institutions has significant effects on health care
effectiveness through its effect on the level of corruption. Even when the pre-
transitional level of corruption is high, the introduction of effective institutions can lower
the corruption level significantly and in time improve the likelihood of achieving an
effective health care sector. This is because the new effective institutions change the
incentive system to where it no longer pays to engage in corrupt practices. Furthermore,
when the public perceives the institutions to be effective at implementing the rule of law, they become more trusting and supportive of the new institutions and are thus more likely to give more discretion to the government in its efforts to reform the health care sector. On the other hand, in countries where post-transitional institutions are weak and ineffective, corruption is not curtailed successfully, and people’s perceptions of the new system is that it is corrupt, ineffective and decaying. Thus, their outlook on the future and their trust in the government and its institutions are weak and they are less likely to empower the government to promote any kind of reforms. Additionally, a corrupt system reinforces activities detrimental to the future of the health care sector. Those achieving increasing marginal returns from such corrupt practices are not likely to promote changes. When this is coupled with a low public support, and a less representative electoral system, then the outlook for improving the health care sector is not very encouraging. Thus, one can observe how the degree to which institutions are effective has an impact on the overall effects of other pre- and post-transitional factors and their joint effect on the health care sector.

Country performance in terms of the economic and political success of reforms is also an important factor of the post-transition period. Country performance is used as evaluation criteria by international funding agencies, such as the World Bank, to evaluate whether they should lend funds to a country requesting them. If a country has performed well in its first wave reforms, then the World Bank is more likely to grant loan funds for the health care sector reform because the risk of the recipient defaulting on the loan is likely to be lower. Accordingly, a country that receives funds from the WB is more likely to improve their health care sector since the amount and timing of the loan
are also crucial. Those receiving larger funds earlier are more likely to have a more effective health care sector as well. Country performance also impacts the public perception of the situation, i.e. public support for the new regime. A country that has been successful in the first wave of reforms and is thus performing well economically and politically is more likely to inspire trust and support from the public because they have already enjoyed the positive experiences from the transition process. On the other hand, a country which has high unemployment rates, low economic growth, high levels of corruption and where people feel that they have no impact on the political process, public opinion will be negative and is not likely to support the government. The resulting governmental ineffectiveness is then likely to impact negatively the ability to improve the conditions of the health care sector.

The health care sector performance in the post-transition period is also impacted by the type of support or lack thereof that is present for these reforms in particular. More specifically, if a large portion of the population is comprised of senior citizens (that is, people who are retired or very close to it and who are reaping the benefits sponsored by the government), then the pressures against changing the current health care system are likely to be significant. This can sway public support against reforming the health care sector. Since politicians want to appease their constituents whose vote can decide the outcome of the next election, then the likelihood of improving the health care sector is lower. However, the outcome could vary depending upon how other independent factors are influencing public opinion. For example, in a country where the senior citizens’ vote is powerful and where they constitute a large group, their resistance to health care reform may not be as strong if the country’s economy is performing well,
and if they have found themselves in an advantageous position in the post-transition period. On the other hand, if their situation in the post-transitional period has deteriorated as a group condition because of insufficient attention by the policymakers, then their opposition is likely to be strong and influential as they try to hold on to the last bit of benefits promised to them during their pre-transition working years. Sometimes senior citizens do not support small increases in co-payments or administrative fees not because they do not want an improvement in the health care sector, but because they do not believe that the money that is being paid will actually find its way back into the health care sector. Thus, corruption and country performance can also have an impact on senior citizens and their support as well.

Finally, health care effectiveness in the post-transition period is also influenced by the institutional design adopted. In the midst of a dual transition and the uncertainties about the new regime, it is very important that the institutions set in place give the public a sense of participation in the political process. It is because this determines public trust and support for the new regime. Public support then affects the government’s effectiveness at implementing the needed health care sector reforms successfully. In a majoritarian system there is a significant amount of discretion that the president exercises. In addition, the minority of people who did not vote for the winning party are not represented. Coupled with a negative economic situation or a corrupt political structure, this produces a lack of trust from the people who feel that they have no participatory power in the political process. On the other hand, where people are better represented through a PR system, they can have more influence over the
legislative process even when there is an economic crisis, or when the inherited public trust has been low.

In order to understand how successful the countries undergoing dual transition are in improving their health care sector one has to take into consideration all the relevant factors that have played a part in its development, both directly and indirectly, coming from the pre and post-transitional period. Health care sector reform is a particularly difficult phenomenon to analyze due to the complexity of the processes involved in it, and the fact that it has been largely understudied. However, it is essential to shed some light on how the dual transition process has affected the diverse health care sector outcomes because this will have long term lasting effects on popular health, in light of the notion that the state has an obligation to provide its people with effective, reliable and readily available public health care. The success of a state in fulfilling this duty will affect the consolidation process in Central and Eastern Europe because of the particular position that health care held in these societies during the communist regime years.
The experience of 70 years of Soviet Communism was fundamentally different from that of the East-Central Europeans. Seventy years of totalitarian Communism destroyed the political elites, destroyed the cultural elites, destroyed the society, destroyed whatever markets existed, destroyed whatever civil society existed, and transformed whatever incipient political classes that these countries had into bureaucratic apparatchiks of the Communist party.

Alexander Motyl,

The Russian Federation is a case of public health care going from bad to worse. The failures in the health sector during the Soviet era can be traced to failures of the other sectors of the economy since central planning focused on quantity, without regard to quality or efficiency. Furthermore, since the country was separated from the capital and technological innovations occurring in the rest of the world (with the exception of the Eastern bloc countries) the technology used was often outdated. The post-transition period has not only dragged with it the negative conditions of this sector from the command economy era, but has added more oil to the fire through failed reforms, lack of financial support, corruption, low levels of public trust and inefficient institutions. This chapter provides a detailed analysis of health care sector in the former Soviet Union and the factors that have contributed to its further demise in the Russian Federation.

1: Health Care and Public Health before the Transition

The health care sector in Russia has not always been as low performing as in the last decade of the post-transition period. After the Second World War, the health care sector in Russia was designed on the principle of offering free and universal health care, and it was largely successful at doing so, at least through the early 1970s. The
system was based upon the socialist principle of equality and public responsibility that entitled all to free welfare benefits, such as unemployment benefits, pensions and health care. Thus, the institutionalization of universal and free health care was common throughout the countries of the Warsaw Pact in the post war period.

The greatest achievement of the system was its ability to deal both with communicable and non-communicable diseases. Through the effective childhood immunization programs, the USSR was able to improve life expectancy and achieve better health care outcomes than other countries with similar income levels (Belli, 2001). To illustrate, infant mortality in Russia in 1960 was 48 deaths per 1,000, while this number dropped to 28 per one thousand by 1980 and to 21 by 1990 (Table 3.1). These numbers should, however, be taken with caution since infant mortality rates tended to be underestimated under the Soviet counting method. One reason for this was the incentive to make the performance of clinics and hospital appear more successful since their financing was tied to their evaluation. Thus, if an infant died in the Soviet Union and there was doubt as to the criteria which would define it as still or live birth, “it would

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Aleshina and Redmond (2003) report that the Civil Acts Register where live births and stillbirths are registered accounts in infant mortality data only those infants of at least 1,000 grams or they must first survive for at least 7 days if they are underweight. They are also not eligible to receive medical aid within the first 7 days. Thus, if they are under 1,000 grams and die within 7 days, they are not considered live births.
have been to the benefit of the hospital or the clinic to err on the side of stating that the infant was extremely premature, or intentionally to misreport the birth as stillbirth, because infant mortality rates were one criterion used to evaluate hospitals and clinics” (Velkoff and Miller, 1995; p. 243). Mortality was still higher than in countries of the OECD region. Another positive change was the rise in life expectancy. With the exception to the period between the late 1970s and mid 1980s, life expectancy improved significantly overall, reaching its highest point of 64.87 years in 1987.

Although the health care system under the Soviet system was able to achieve some improvements in public health, it suffered from serious conditions of inefficiency, corruption, and the inability to sustain itself in the long run. The inefficiencies and lack of preventive care resulted in high deaths related to circulatory disease (664.2 per 100,000 as of 1989) and cancer (199.4 deaths per 100,000 as of 1989), compared to OECD countries. The widening health gap between Russia and West European countries was increasingly due to the deteriorating health of middle-aged adults in

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Table 3.1. Russia’s health sector indicators of performance from 1960-1990.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Infant mortality</th>
<th>Average life expectancy</th>
<th>Male life expectancy</th>
<th>Hospital beds per 1,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960</td>
<td>48.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1970</td>
<td>29.00</td>
<td>68.13</td>
<td>63.08</td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>28.00</td>
<td>67.03</td>
<td>61.39</td>
<td>12.98&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>1990</td>
<td>21.00</td>
<td>68.90</td>
<td>63.80</td>
<td>13.06</td>
</tr>
</tbody>
</table>

1. The data is for 1985.

Source: for infant mortality, life expectancy, hospital beds per 1,000: World Development Indicators (World Bank, 2005).
Russia, in particular due to cardiovascular and ischemic heart disease in middle-aged males (Preker and Feachem, 1994). The problem arose partially from the fact that during the communist years the national government advised the Russian people to consume three times the amount of protein from animal source that was recommended by the World Health Organization. Furthermore, unhealthy habits such as smoking and alcohol abuse were not sufficiently addressed until the Gorbachev years (1985-1992) when some anti-alcohol campaigns were introduced. However, the decline in the consumption of alcohol between 1985 and 1987 is now believed to be overstated since legal restrictions seem to have encouraged illegal distillation and alcohol poisoning (Belli, 2001). Mortality in Russia was further exacerbated by the high levels of pollution due to the use of chemicals such as DDT to increase agricultural production during the Cold War (Feshbach and Friendly, 1992). Although these were not direct consequences of the failings within the health care sector, they are a reflection of the government's lack of focus on public health.

The inefficiency of the health care sector was reflected in the overstaffing of hospitals, mismanagement of in-patient hospital stays, and emerging corruption. Overstaffing hospitals brought inefficiency, while the supply of hospital beds made Russia one of the countries with highest bed capacity in the world (World Bank, 1993). In fact while countries of the European Union had 674 beds per 100,000 people, the

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37 According to a survey conducted in 1993, over 80 percent of Russian men consumed alcohol and their consumption reached an average of 600 grams per day, roughly five vodka bottles per week (Eberstadt, 1999).

38 Based upon the marginal return of an additional worker, past a certain point, hiring a person beyond the point where marginal utility = marginal cost brings about inefficiency.
countries of western Commonwealth of Independent States (CIS)\textsuperscript{39} had 1,023 beds per 100,000 people as of 1999 (UNICEF, 2001). One reason for the high quantity of beds was the fact that hospitals were rewarded financially based upon the quantity of patients they treated, thus producing the incentive to add more inpatient capacities. The numbers are likely to have been much higher in the pre-transition years because some attempts at efficiency, such as cutting hospital beds, were introduced in the last part of the 1990s.

Outpatient hospital practices were virtually non-existent because all the technology was channeled to the large hospitals that based their business on inpatient admissions. Since they were rewarded based upon the number of patients they treated, hospitals had the incentive to take in as many patients as possible. This led to an overflow of patients and slow patient treatment time, resulting in patients spending an average of 16-17 days in the hospital (UNICEF, 2001). This in turn made them susceptible to other diseases sourcing from the hospital environment, which compromised their health further. It comes as no surprise that in most countries such as Russia or Croatia people believed that once confined to a hospital, you were not likely to come out alive. The problem of lengthy hospital stays also comes from the fact that in Russia there was not a general family doctor who would perform small procedures on an outpatient basis. Instead, the incentives in the system led physicians to choose narrow fields of specialization, which in turn resulted in more frequent specialist referrals (Twigg, 2000).

\textsuperscript{39} The CIS includes former Soviet Republics: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Moldova, Russia, Tajikistan, Ukraine, and Uzbekistan. Turkmenistan left the group in August 2005.
The system suffered also from a lack of financial support from the state budget as well as from questionable appropriations of the existing budget funds. The level of public spending on health care in Russia amounted to only 2.8 percent of the GDP in 1989 (UNICEF, 2001). In CEE countries where the health care sector was more effective, spending was much higher. Slovenia spend 5.6 percent and Poland 4.9 percent (UNICEF, 2001). The way the funding was generated also reflects the lack of importance given to this sector. Healthcare and education were financed according to the “residual principle” or what is called extra-budgetary funds. This means that they were financed with moneys left over after more important items such as defense and heavy industry were fully funded (Twigg, 2000). This practice is derived from the Marxist-Leninist principle that the services sector of the economy such as health care are non-productive sectors and thus are not given as much priority as more critical sectors such as metallurgy, industry, energy and defense. The lack of technological advances, which would have aided physicians in coping with non-communicable diseases, also contributed to higher morality rates. Even if there was new technology available, access to it varied greatly because access to health care resources varied depending on the geographic location and socio-economic rationing. Central urban areas or large industrialized cities would get more resources than smaller cities or rural areas (Davis, 1988). Thus, not all points of care were supplied with the appropriate qualified physicians or medical supplies.

Corruption permeated multiple aspects of the health care system, from bribing state school officials to get into medical school (which likely affected the qualifications of

---

40 Financing of the health care sector reached its peak in 1955 when it was about 20.8 percent, and it then kept plummeting down to about 5-6 percent from early 1960s to 1980s (Twigg, 2000).
the candidates who later become physicians) to the illicit diversion of funds appropriated for the health care sector to causes such as the war in Chechnya, to paying out of pocket bribes in order to push oneself to the front of the waiting list (Twigg, 2002). This last form of corruption was, and still is, the most significant form of corruption in the health care sector. Since the state had a constitutional commitment to give free health care for all, there was no method of ensuring better and faster care, other than through bribes. This was especially welcome, given that medical staff, both doctors and nurses, has always been grossly underpaid by the system, a condition that has continued in the post-transition period. Data from the command economy period on out of pocket patient payments does not exist, but data from the transition period indicates that as many as 74 percent of people in Russia made informal payments for health care services in 1997. Out of the total payments for health care costs 7.4 percent were made to hospitals unofficially, 1.6 percent unofficially for general care, 15.9 percent to physicians unofficially, and 6.6 percent to staff unofficially. This means that out of all health care payments 31.5 percent were due to corrupt practices (Lewis, 2001). The problem is that the paid services’ crowding out the free ones was not considered corruption in the pre-transition period; rather, a semi-legal market was somewhat tolerated by the state (Rybakov, 2005). In the post-transition period, the state indirectly benefited from these side payments to doctors since the state itself was not able to keep up with wage increases at the pace of price increases that resulted from economic liberalization. Corruption in the health care sector continued into the transition and post-transition period in Russia.

41 Feshbach and Friendly (1992) state that in 1990, two out of five young graduates of medical schools who entered service were unable to read an electrocardiogram and 50 percent of pediatricians were not familiar with sixteen widely used drugs.
During the economic downturn that occurred during the transition period, institutional weakness, social norms and continued lack of significant reforms in the health care sector exacerbated the deterioration of the health care sector even further. Evidence of a decaying health care sector is seen in dramatic drops in life expectancy, especially for middle aged males. In Russia, life expectancy at birth for men dropped to 57.5 years by 1994 (World Bank, 2005). According to a panel of Russian demographers, men in Russia live 15-17 years less than men in Western Europe, while women live 7-10 years less (Belli, 2001). Infant mortality also increased to 20 per 1,000 by 1998, which is several times higher than infant mortality in developed countries. Table 2.2 shows changes in medical sector performance indicators.

During the transition and post-transition period, there has been a sharp increase in the incidence of both communicable diseases that had previously been successfully controlled and non-communicable diseases. The increase in non-communicable diseases such as
### Table 3.2: Health Care sector performance indicators in the post-transition period.

<table>
<thead>
<tr>
<th>Year</th>
<th>Infant mortality</th>
<th>Life expectancy</th>
<th>Male life expectancy</th>
<th>Death rate from circulatory disease</th>
<th>Death rate from cancer</th>
<th>Public expenditure on health care (% of GDP)</th>
<th>Hospital beds per 1,000 people</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>21</td>
<td>68.9</td>
<td>63.8</td>
<td>668.7</td>
<td>201.5</td>
<td>2.7</td>
<td>13.05</td>
</tr>
<tr>
<td>1991</td>
<td>..</td>
<td>68.7</td>
<td>63.5</td>
<td>659.1</td>
<td>202.7</td>
<td>2.4</td>
<td>12.10</td>
</tr>
<tr>
<td>1992</td>
<td>..</td>
<td>66.8</td>
<td>62.0</td>
<td>676.5</td>
<td>204.4</td>
<td>2.5</td>
<td>12.23</td>
</tr>
<tr>
<td>1993</td>
<td>..</td>
<td>64.9</td>
<td>58.9</td>
<td>792.5</td>
<td>206.9</td>
<td>3.3</td>
<td>12.19</td>
</tr>
<tr>
<td>1994</td>
<td>..</td>
<td><strong>64.4</strong></td>
<td><strong>57.6</strong></td>
<td><strong>853.6</strong></td>
<td><strong>205.8</strong></td>
<td><strong>5.2</strong></td>
<td><strong>11.96</strong></td>
</tr>
<tr>
<td>1995</td>
<td>18</td>
<td>65.2</td>
<td>58.3</td>
<td>799.1</td>
<td>201.0</td>
<td>4.5</td>
<td>11.87</td>
</tr>
<tr>
<td>1996</td>
<td>..</td>
<td>66.1</td>
<td>59.8</td>
<td>756.0</td>
<td>196.0</td>
<td>4.2</td>
<td>11.63</td>
</tr>
<tr>
<td>1997</td>
<td>..</td>
<td>66.9</td>
<td>60.1</td>
<td>751.1</td>
<td>199.9</td>
<td>4.5</td>
<td>11.34</td>
</tr>
<tr>
<td>1998</td>
<td>..</td>
<td>66.7</td>
<td>61.3</td>
<td>748.8</td>
<td>202.5</td>
<td>3.4</td>
<td>11.10</td>
</tr>
<tr>
<td>1999</td>
<td>..</td>
<td>66.0</td>
<td>60.0</td>
<td>815.7</td>
<td>205.0</td>
<td>2.9</td>
<td>10.85</td>
</tr>
<tr>
<td>2000</td>
<td>18</td>
<td>65.3</td>
<td>59.00</td>
<td></td>
<td>3.2</td>
<td>10.89</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td></td>
<td>3.3</td>
<td>10.83</td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td>..</td>
<td>65.8</td>
<td>59.8</td>
<td></td>
<td>3.5</td>
<td>..</td>
<td></td>
</tr>
</tbody>
</table>


Cardiovascular illness and cancer has been impacted by the lifestyle factors of which alcohol and tobacco consumption and poor nutrition are the most significant. The increase in the abuse of these substances has been associated with the stress of daily life in a decaying economy where double-digit unemployment has been the norm. Between 1990 and 1995, 48.9 percent of the total deaths were due to circulatory disease, while 26 percent were due to accident and injuries (Brainerd, 2001). The incidence of the nervous system diseases and those of the sense organs have increased by seventy percent (Zbarskaya, 2002). Some of these habits were widespread before the transition and are thus not a new phenomenon. The fact that
Russian population’s health awareness is close to zero, as reported by Belli (2001) from his study, raises significant doubts about the ability of the government to improve public health unless it is done through the complete, large scale restructuring of the system. In addition to mortality, disability rates have increased from 76 to 91 per 10,000 population from 1992 to 1995 (Belli, 2001). This places additional stress on the economy as more people no longer contribute to the economic growth through work but at the same consume state resources. Some of this rise in disability is a direct consequence of the inability of the health care sector to prevent and treat circulatory disease and death (Belli, 2001). In part, the problems arise as a consequence of the lack focus on public health campaigns that would educate the general public on the consequences of alcohol or tobacco abuse.

In both men and women, the death rate from poisoning, accidents and injuries has accounted for more than two-thirds of the drop in life expectancy (Zbarskaya, 2002). Additionally, there have been some new trends in illness not observed previously, such as increases in HIV/AIDS and other sexually transmitted diseases. The Russian Federation and Bulgaria are among the CEE countries with the highest syphilis incidence in 1997. Most HIV/AIDS patients are intravenous drug users between the ages of 15 and 24, which points to the severity of the growing problem of hard drug consumption and the diseases associated with it (UNICEF, 1999). It also tells us something about the inability of the health care sector to deal with the multitude of public health issues that have emerged since the transition.

There has also been a reemergence of so called “poverty diseases” such as diphtheria and tuberculosis, which were virtually eradicated before the transition period.
The spread of diphtheria in the Russian Federation has been so large that the UNICEF defines it as being of epidemic proportions. By 1995 diphtheria has been found in all 89 regions of the Federation (UNICEF, 1999). Suicide rates have also increased, especially among middle aged males. Suicide accounts for 6.5 percent of all deaths among the employed population between 1990 and 1995 (UNICEF, 1999).

The high mortality rates and incidence of diseases and suicide rates are a reflection of the fact that the health care sector in the Russian Federation has not improved significantly to deal with the health consequences of the transition. Even though some of the increase in the morality and decrease in life expectancy is a consequence of the decline in quality of life rather than a direct consequence in bad health practices, some of it is a consequence of the inability of the medical sector to counter the effects of diseases, which is what scientists like Davis (1998) define to be health care sector effectiveness.

3: Changes in Health Care Financing

At the same time, there have been some changes in the national health insurance program. More specifically, in 1992 there were statutory changes that shifted the financing and control away from the federal governments and Ministry of Health, and moved it towards the local government. The underlying explanation is that the allocation of expenditures is best determined at the regional level and thus the financing should be as well. All of this was done in an effort by the state to preserve its constitutional obligation to offer free and universal health care coverage while shifting the administrative responsibility to the regional level with the expectation that it would be
more efficient. The new insurance system is mandatory and relies on an enterprise-based withholding tax augmented by federal funds. The mandatory enterprise tax for health insurance is 3.6 percent of the wages of employees, from which the majority (3.4 percent) is retained at the regional level while 0.2 percent is channeled to the Federal Mandatory Health Insurance Fund to provide coverage to the poorer regions and equalize the healthcare access throughout Russia (Burger, Field and Twigg, 1998). Even though there have been some improvements, the system has faced many challenges.

In addition to the fact that 3.6 percent is not sufficient to fund the kind of health care the Russian Federation wants to preserve (universal and free), many enterprises have defaulted on paying the tax. One reason is that many of them are struggling and on the verge of bankruptcy, while others refuse to pay it. Furthermore, municipal governments which are responsible for paying insurance for the unemployed are not doing so, and there is no legal recourse against them (only 50 out of 89 regions are currently making the payments). Since the introduction of the health insurance fund reforms there have also been cuts in the services that are considered to be free of charge, and the addition of visit co-payments and hospital co-payments. There is supplemental health insurance available for those who want to purchase it at an additional cost (Burger, Field and Twigg, 1998). In spite of these changes, the health care sector has not been able to move forward because of the lack of adequate funds and the manner in which these funds are spent.

Other crucial reforms that would improve efficiency and decrease costs have not been implemented, and the economic and political environment (corruption, lack of
accountability, economic decline) within which the health care system operates is not conducive to improvements. First, as mentioned earlier, the percentage of GDP that is being spent on the public health care in Russia is still much lower than that of other countries, both in East and West Europe. The second problem is that a great deal of the existing funds is not always reaching the designated destinations (hospitals, clinics, etc.). Third, the needed reforms that would restructure the insurance system, increase efficiency and change the incentive structure (co-payments, higher medical staff salaries) have not been implemented. Lastly, the economic situation has not improved since the economic shock occurred so that corruption is still widespread, serving as a “compensation plan” for the services the state is unable to provide. The public perception of a corrupt government does not inspire trust and support to improve the health care sector. The financial crisis is exacerbated further by overall morbidity of working age people which not only increases the costs of care, but depletes the workforce and its productivity. This also contributes to the overall decrease in employer contributions by decreasing the tax base. Twigg (2000) reports that there have been innovative improvements where some employers who are not able to pay their insurance taxes instead work out a kind of barter system where, for example, a coal mining company supplies heating to hospitals instead of contributing monetarily. But this is an exception rather than the rule. Lack of funds has increased the amount of corruption, where patients are expected to give out-of-pocket payments for services that are supposed to be provided free of charge. The government has been slow to crack down on such practices, since side payments relieve the government of its responsibility to find alternative sources of funding.
Why has the health care system in the Russian Federation kept deteriorating in spite of some changes that were made in the post-transition period? Why has the initial expected decline in economic well-being and public health not been followed by more positive changes fifteen years after the transition? The following explores the factors that have contributed to the continued demise of the Russian health care system and the changes that would need to occur in order for it to turn around.

4: Determining Factors

4.1: Country Performance during Transition

At the onset of the transition process Russia adopted the shock therapy approach of fast and early reform that would reform all the major sectors of the economy at once. In theory, because it is implemented quickly and early, and because the initial economic shock soon turns into steady economic growth, the shock therapy approach is supposed to give policymakers some room to implement policies without the negative pressures from the population. By the time the opposition to reform organizes and is able to turn against government-initiated reforms, the reform strategy is supposed to produce recovery from the initial losses and generate economic growth, declining unemployment, and balance of payments stabilization.

The Russian government adopted such a strategy in 1991, but the outcomes have not been as positive as they were for other countries such as Poland. There were some successes in Russia’s economic reforms, such as price liberalization that was completed by 1992 and the opening up to world markets. Exports nearly doubled in the period between 1992 and 1997, producing a trade surplus of $20 billion for the federal
budget (Schleifer and Treisman, 2000). However, the reforms hardly went beyond the initial shock to reach the therapy phase before they were rejected by society (Murrell, 1993). Macroeconomic stabilization in Russia did not occur in early 1992, but rather in 1995, long after the public trust in the Yeltsin’s government and their reforms had been eroded.

To illustrate how the economic transition was reflected in the economic indicators of performance, one needs only compare the situation shortly before the transition to the time period after the transition. In 1989 GDP per capita\(^{42}\) in Russia was $8,183. This number began decreasing in 1991 to $7,109 and to $5,758 by 1996, when the consequences of a mismanaged transition began being felt the most. Income inequality has risen as well. The transition from the socialist system to a market economy would naturally result in some increase in inequality due to differences in the supply and demand for different job skills. The growing disparity in income grew from a 0.271 GINI coefficient\(^{43}\) in 1989 to a 0.483 in 1996 has affected the quality of life in a society that was accustomed to rewards based upon need so that everyone had their primary needs satisfied. See Table 3.3 for more detail.

\(^{42}\) Source: World Bank (World Development Indicators). GDP per capita measure adopted is adjusted for PPP in current international dollars.

\(^{43}\) The Gini coefficient is a measure of inequality of income distribution, defined as the ratio of area between the Lorenz curve of the distribution and the curve of the uniform distribution, to the area under the uniform distribution. It is a number between 0 and 1, where 0 corresponds to perfect equality (e.g. everyone has the same income) and 1 corresponds to perfect inequality (e.g. one person has all the income, and everyone else has zero income).
Table 3.3: Economic performance indicators in the post-transition period.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>GDP per capita (% change)</th>
<th>Inflation</th>
<th>Government expenditure (% change)</th>
<th>Unemployment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>-3.37</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>-5.26</td>
<td></td>
<td>-11.3</td>
<td>0.08</td>
</tr>
<tr>
<td>1992</td>
<td>-14.57</td>
<td>1,589.58</td>
<td>-11.8</td>
<td>5.2</td>
</tr>
<tr>
<td>1993</td>
<td>-8.56</td>
<td>891.98</td>
<td>-6.4</td>
<td>5.9</td>
</tr>
<tr>
<td>1994</td>
<td>-12.46</td>
<td>301.77</td>
<td>-2.9</td>
<td>8.1</td>
</tr>
<tr>
<td>1995</td>
<td>-4.02</td>
<td>213.30</td>
<td>-1.1</td>
<td>9.5</td>
</tr>
<tr>
<td>1996</td>
<td>-3.34</td>
<td>36.10</td>
<td>3.1</td>
<td>9.7</td>
</tr>
<tr>
<td>1997</td>
<td>1.69</td>
<td>12.75</td>
<td>-2.4</td>
<td>11.8</td>
</tr>
<tr>
<td>1998</td>
<td>-5.04</td>
<td>27.27</td>
<td>1</td>
<td>13.3</td>
</tr>
<tr>
<td>1999</td>
<td>6.83</td>
<td>96.64</td>
<td>3.1</td>
<td>12.6</td>
</tr>
<tr>
<td>2000</td>
<td>10.57</td>
<td>17.50</td>
<td>2</td>
<td>9.8</td>
</tr>
<tr>
<td>2001</td>
<td>5.67</td>
<td>21.28</td>
<td>-0.8</td>
<td>8.9</td>
</tr>
<tr>
<td>2002</td>
<td>5.17</td>
<td>12.18</td>
<td>2.6</td>
<td>8.6</td>
</tr>
<tr>
<td>2003</td>
<td>7.83</td>
<td>11.21</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: World Bank (World Development Indicators), 2005.

Other economic performance indicators paint a similarly grim picture. Inflation in food prices, the most basic need for survival, has grown by 1,589 percent since 1992 (World Bank, 2005). This was expected at the onset of price liberalization since food prices were kept artificially low during the Soviet era. What evokes concern and has dampened people’s ability to acquire basic foodstuffs is the fact that the growth of inflation has persisted: in 1994 it was still about 301 percent annually and in 2001 it was 21 percent. Since then, food price inflation has slowly dropped but still in the double digits.

Along with the economic downturn, Russia had to reduce government spending as part of the program of shock therapy. The total fiscal spending dropped by 11 percent in 1991 and it continued to drop at a slower rate until 1996. Spending began growing gradually in 1998 by only one percent annually. However, the increase in government spending remained very low and often negative over the past five years.
The cut in government spending affected largely the welfare system and in particular
the health care system. The lack of proper financing was soon reflected in rising infant
and maternal mortality rates, increase in STDs, tuberculosis and HIV/AIDS (UNICEF,
1999).

The reasons for the largely failed economic transition in the Russian Federation
are multiple. They include lack of preparation, both technical and human, for the
transition, a lack of political power to implement the needed reforms, and no knowledge
or understanding of the reform process. Reforms of the market system of former
command economies are not necessarily bad for the public health sector in general.
Rather, it is bad reforms or good reforms implemented badly that lead to a decaying
public health care system (Gross and Suhrcke, 2000). Such was the case of Russia.
The lack of knowledge about how reforms should be implemented coupled with lack of
oversight of the process resulted in bad reforms. First, the Russian economy had no
experience with the market economy that would have provided an institutional or legal
framework to guide the transition. Furthermore, the economic situation prior to the
transition was experiencing some difficulties the form of budget deficits that started in
1985 (World Bank, 2005). Large budget deficits required action to cut government
spending, which was not immediately done. As a consequence, when the economic
liberalization started, the economy was already predisposed for even greater
vulnerability that would come with the 1991 transition.

The lack of knowledge on how to implement reforms and what it takes to
successfully recover the economy after the centralized system was dismantled also
contributed to the failed reforms. For other countries in Central and Eastern Europe
exchanges with the West and market reforms were not completely banned during the communist era. By contrast, the top policymakers in Russia did not have the technical understanding nor tradition “of an active monetary policy to limit credit growth... The idea that bank credit should be limited to restrict the overall growth of money supply simply did not exist until 1992” (Lipton and Sachs 1992, 227). Thus, the dissolution of the state apparatus did not include a plan for what kind of new institutional measures should be used to remedy the declining economy. At the same time, the advice and support of the international community to implement shock therapy reforms included an outline of things that needed to be done, but no clear instruction or guidance on how to implement these changes a day-to-day basis.

In order to succeed, policymakers knew that they would need public support. This is where a large part of the problems began. In Russia the reformers had no successful political strategies to circumvent the main anti-reform pressures coming from the pro-communist wing. Schleifer and Treisman (2000) conclude that Russia’s reforms were relatively successful when one looks at the number of political obstacles the pro-reform governments had to face during the 1990s. They claim that it is not only a matter of choosing the correct reforms that matters for them to be successful, but also the conditions that may affect the realization of reforms.

Russian policymakers faced opposition from anti-reform factions in the parliament and private interests (such as foreign banks and businesses) that wanted to profit from the opening of Russia’s economy. The anti-reform interests in Russia came from those who benefited from the old system and wanted to keep it that way. While the old communist interests were not in favor of reforms, they lacked the political
strength to mount any significant opposition. It was the early beneficiaries of reforms that represented the greatest obstacles to additional reforms. Partial reforms and the vacuum of undefined or nonexistent rules in which they are introduced give profit opportunities for those who can take advantage of them. Many “newly rich” in Russia did so in the privatization process that lacked transparency by taking over state assets in a system without proper laws to protect private property (Schleifer and Treisman, 2000). Those who enriched themselves in the vacuum of lawlessness between when the old institutions were dismantled and the new ones were constructed opposed changes that would take away their opportunities. These were the regional leaders in the government, owners of newly privatized companies that were able to take advantage of the large profits at the onset of free trade, and new private banks that were created from the decentralization of large state banks. In the government, the parliament could pass the budget and other laws affecting the economy and thus had a large influence on the reform process. The central bank could issue credit at its own discretion until 1993 so that it had a great influence on the success or failure of reforms. Even if the reforms were passed, they also had to be effectively implemented. This was problematic since reforms were sometimes disregarded outright and other times evaded by the same government bodies to which they applied. Because the economic situation was not improving for the average Russian worker, waves of protests and demonstrations occurred. This made it even harder to implement further reforms. Thus, Russia has had a difficult time improving its economic and political situation so far. Its inability to achieve macroeconomic stability has also affected its rating by international
financial institutions. They use such information to decide whether to lend the funds to help nations recover from the transition process.

4.2: Corruption

In the post-transition period the health care system did not improve. Some attempts were made to reform parts of the system, including the changes to the health care financing system and the slow shift towards in-patient care. Despite these reforms, indicators continued to deteriorate. As described in the previous section, the general health of the people declined in virtually every aspect, from the spread of communicable disease by epidemic proportions to increases in stress and lifestyle related non-communicable diseases such as cardiovascular illnesses. One factor that has had a strong influence on the further deterioration of the Russian health care sector is the persistence of corruption. When the transition to the new political and economic regime occurred in 1989, the vacuum of lawlessness that was created led to new opportunities for the growth of corrupt practices in different areas: from perverse privatization practices, to corrupt election practices. The health care sector has not been spared from this trend and the inherited practices from the command period have grown to become more deliberate and pervasive.

Corruption in the health care system, as described in the theoretical section, comes in two forms: micro level or what Levin and Satarov (2000) call “grassroots” corruption and macro level of institutional corruption. Both forms of corruption existed before the transition, but the post-transition economic crisis increased the incidence of corruption as a mean of survival. An example of corrupt practices at the institutional
level is the fact that regional funds have occasionally been victims of “coffer raids”. For example, in 1994-95 an undetermined amount of funds budgeted for the health care sector were diverted for use in the Chechen war (Twigg, 2000). Institutional corruption in the health care sector has also entailed the practice of public servants stripping off public assets in order to “transform entire public institutions to private fiefdoms” (Karklins 2001, 117). An example is clinic administrators who deliberately bankrupt hospitals in order to privatize it to an in-group (Karklins, 2001). In the health care sector, corruption affects not only hospitals and the medical staff directly, but also universities and programs training future medical workers. This involves practices such as selling admissions to medical schools, higher grades or fake diplomas. The reason for this is the same as the motive for in other forms of corruption in the health care sector: high demand for admission and small number of placements available. Furthermore, because medical school professors are paid inadequately (and they are university physicians) they “suffer from the same syndrome” as regular physicians do (Karklins, 2001). They have the same incentives as practicing physicians to extract side payments for their services. Other corrupt practices in the health care sector have involved the conflict of interest of a physician employed at the hospital who sends his/her patients to his private clinic to get services faster, for a fee, than they would get them at a state hospital for free.

The inefficiency of state institutions is the key cause of corrupt practices that involve extracting bribes to ration scarce services. Grassroots corruption has in fact increased dramatically in the post-transition period, especially in terms of the share of physicians’ income that comes from bribes. In Russia, as in many other CEE
countries, the most prevalent form of bribe is the one given to the medical staff and hospitals. In 1998, 31 percent of all informal payments were made to general hospitals, 21 percent to physicians, and 7 percent to nurses (Lewis, 2000). This numbers were up from 1997 when 7.4 percent of all informal payments were made to hospitals and 15.9 to physicians (Feeley, Sheiman, and Shiskin, 1999). In 1998, 3.5 percent of the household spending in Russia went to informal health care payments. In addition to bribes given to the medical staff, patients now have to give informal payments for drugs. This is a new phenomenon because during the command economy period all drugs were paid for by the federal government.44

These are disturbing trends because corruption exacerbates the inequality in health care access brought on by the transition in terms of the ability of people to make informal payments. Many people choose not to seek medical care because of their inability to pay for services that they are constitutionally entitled to for free. In fact, in December 1997, more than 45 percent of households in Russia were unable to pay for health services due to lack of income (Feeley, Boikov and Sheiman, 1998). Rybakov found that there is a discrepancy between the claims of the Ministry of Health that they are able to meet all of the maximal allowed amounts of healthcare services and still have a balanced budget, given that the level of health care financing provided is not sufficient for the maximal allowed services. The discrepancy comes between the claim that all of the planned health care services have been utilized without incurring a budget deficit. This claim does not add up, since the amount of spending needed to provide the

44 In fact the percentage of the average per capita income spent on drugs in the Russian Federation in 1997 was 2.61, while the average income was 472 US Dollars (Lewis, 2000). This is a still, however, a relatively low amount when compared to other CEEC such as Poland (9.67% of 765USD) and the Kyrgyz Republic (28.64% of 127USD) (Lewis, 2000).
provided health care services is not being met by the government financing, and yet there is not a deficit. The difference between what is financially provided by the Ministry and what is actually spent has been met through informal out of pocket payments where some can pay and many cannot. The government claims that the willingness of some to pay guarantees them better service quality, which is legitimate, and at the same time serves a source of revenue. However, if that is the case, then not all of the services provided are financed through the Ministry, as claimed (Rybakov, 2005). This implies that a crowding out of free services has occurred where those who are willing to pay undermine the ability of others to get free services. Thus, side payments decrease patient surplus by taking away free services they are entitled to, and undermine the desire to enact and commit to other needed reforms because it uses corrupt practices to supplement the loopholes in the system. To summarize, it is not reforms per se, but bad reforms and lack of them that have fueled the growth of corruption in the Russian health care system and undermines the ability of the government to achieve an effective health care system.

4.3: Public Support

Public support of the government and the transition process was very high at the eve of the dual transition. This is to be expected since without public support the transition would have been an unlikely occurrence. The experience of the Russians with the communist regime has not been as positive in the last couple of decades of its existence, because of the declining standard of living and economic downfall. Thus, at the beginning of the transition, public support for the transition was high because the
people’s most recent experience with the performance of the Soviet regime had been largely negative.

The government instilled a sense of fear and distrust in people through periodic purges of elites (such as those of Stalin) and by rewarding loyalty to the State through the betrayal of those who were critical of it. In addition to banning personal freedoms of expression, the communist system also forbade any type of voluntary associations that were not directly affiliated with the State (Fish, 1995). Thus, people did not trust each other or the state institutions. Starting from the Stalin’s rise to power, the destruction of all non-state societal activity became the goal of the revolutionary State. Until the Gorbachev period, there was virtually no independent organization that had any relevance in the public sphere. In addition to having no freedom of assembly (unless it was State organized), there was no freedom to travel to the West, and there was an almost total ban on trade with non-communist European countries (Fish, 1995).

During the first Gorbachev years, the ban on organizational activity was relaxed, and some organizations were unofficially tolerated, though not officially legalized. Glasnost was an attempt to stimulate the reconstruction of the public sphere by controlling it from above by civil servants who were to be allied with the reforms from above (perestroika) (Arato, 2000). Glasnost gave the permission to the media to expose the truth about the past communist governments and the facts they hid from the public (the truth about the 1986 Chernobyl accident was critical in this revelation). Soon, however, the free media also turned against the leader of this new policy, Gorbachev. The first organizations that formed after 1985 were ecological groups or groups for the preservation of historic monuments. By 1987, some groups with defined
political agendas started emerging in line with the Perestroika movement. Though the size of the groups and movements was not revolutionary, the fact that small organizations that were not state affiliated were tolerated signified the beginning of the formation of an independent popular sphere (Fish, 1995). In 1988, the Soviet Union witnessed the expansion of independent groups, street demonstrations organized by independent groups. They started pushing their demands beyond what was tolerable by the state. Organizations promoting political discussion were organized and membership in these was often fluid and overlapping (Fish, 1995).

In economic terms, the performance of the communist regime was also not stellar. At the beginning of the arms race, the USSR was able to compete with the United States, but at the expense of the consumer. A disproportionate share of national resources was diverted towards military industry. Several decades of underinvestment in other sectors and new technologies led the economy to reach its limits of extensive growth. Additionally, the socialist system started experiencing the limits of trading only with other socialist countries that were suffering from many of the same inefficiencies as the USSR. Thus, there was growing dissatisfaction with the economic conditions in the USSR, which finally culminated in perestroika in 1986. Thus, the inefficiencies and stagnation of the late Brezhnev era led Russians to look forward to the new democratic system and to be more likely to support it even when the initial negative consequences were felt.

However, the economic and political performance of the post-transition Russian regime was worse than anyone imagined. Initially, in the first rounds of the democratic elections, the public was not particularly keen on voting for communist parties.
However, as soon as the economic difficulties begun, people started yearning for the security of the communist era welfare state. A temporary setback in popular support is to be expected even in consolidated democracies when there is a major economic crisis. However, the expectations of economic welfare and their eventual achievement usually mitigate the negative consequences quickly and restore public support and trust in the government during the dual transition. This is not quite what happened in the Russia Federation. The social costs of the dual transition have been high, especially in countries such as Russia where economic growth took more than six years to be restored (GDP growth was -14.5 in 1992, -12.6 in 1994 and -5 in 1996) (World Bank, 2005).

The growing inequalities had an impact on the health of the population and the initially supportive popular attitudes started dwindling. The state did not deliver on the promises of economic prosperity and growth, which diminished any trust in the intentions and abilities of the corrupt and inefficient state apparatus. In light of the failure of the State to achieve economic prosperity and become consolidated, and the growing problem of corruption, the Russian people are still weary and distrustful of the state and society. The impoverishment of the population and the inability of the state to ensure a decent existence to civil servants has encouraged corruption in the government, made people lose confidence in public officials at different levels, and alienated them from the authorities even further (Levin and Satarov, 2000).

Opinion studies found that in the early period of democratization Russia enjoyed substantial popular support for democratic values and the emergence of a democratic culture (Gibson, 2003). Even though Russians placed little value on their political rights
(as opposed to personal freedoms and social rights), they showed very little political trust in their leaders and institutions (Levashov, 1995). While early surveys found that Russians did not place so much value on political rights (an indication of low level of civic culture) in the democratic process, they attached the greatest importance to economic prosperity that the new democratic government would bring. Thus, they defined democracy in economic terms (Mason and Kluegel, 2000) and viewed democracy with respect to how much economic benefit it could bring them. Other surveys such as the ones from the International Social Justice Project found that Russians, as well as other Eastern Europeans, preferred a system with a strong state presence in the economy, which provides social safety nets and social services and that "the government should provide jobs for everyone who wanted one" (Mason and Kluegel 2000, 13). Thus, they want a free democratic system but more just and equal than those of some other developed countries.

As the economic decline of Russia continued well into the mid to late 1990s, public support for the government started declining. When asked in 1996 what the most important political goals should be, 17.5 percent said that they wanted to have more say in the government while 58.9 said that the state needed to maintain order and 20.4 percent mentioned the need to fight inflation (Mason and Kluegel, 2003). This indicates that seven years after the transition, the Russian government was still unable to fulfill some of its basic obligations, nor to involve the citizens in the political process from which they felt excluded. Mason and Kluegel (2003) also found that in 1996 only 23.4 percent of individuals in Russia said that they were satisfied with the life in Russia, and only 15.5 percent were satisfied with their standards of living. The majority of people
also believed that the income inequalities are too large and unjust (92.2 percent in 1996).

In addition to the general decline in popular support, there was another factor that made it more politically risky to start radical reforms of the health care sector: the proportion of the population that is made up of people 65 years of age and older has doubled in Russia from 6.2 percent in 1960 to 13.5 percent in 2004 (World Bank, 2005). In 1996 seventeen percent of respondents of the ISJP surveys also said that they very often experienced injustice due to their age, which indicates that they perceived the negative impact that the new system has had on older population. The older people have not been in favor of welfare reforms, including health care, which would strip them of universal and mostly free coverage. While the notion of paying for some services is generally accepted by people if the payments are accounted for, results from such practice can be directly felt in terms of better health care. At the same time, older generations seem to be less prone to accept such changes, given that their income is limited and not enough to cover basic living expenses.

Another form of resistance to health care reforms comes from the medical workers. They are in most part reluctant to exchange a guaranteed wage for the uncertainty of a system that gives rewards based upon merit (Twigg, 2000). They are part of the entrenched interests inherited from the Soviet era that make it hard for policymakers to initiate any significant health care reforms (Cook, 2005). Changing the laws that govern the provision of health care services would come at the cost to some group and would need to be approved by the legislature that has been reluctant to change the provisions until now. Cook notes that despite the general political weakness of the Russian
population, veterans and pensioners have been able to mobilize successfully to lobby, protest and sue in court in order to keep their current benefits (2005).

Public support is also influenced by the popular perception of how effective the governmental institutions are at promoting their interest and protecting their rights. The following section addresses the situation of institutions in the Russian Federation.

4.4: Institutions: The Rule of Law and Degree of Representativeness

One of the characteristics of consolidated democracies is that the rule of law regulates the behavior of individuals by protecting their rights and holding them accountable for their actions. Absence of the rule of law and lack of its proper enforcement leads to the flourishing of corruption, lack of government legitimacy, and a threat to democratic survival. In the post-transition period in the Russian Federation, as in other countries such as Croatia and Slovakia, the temporary vacuum created at the breakdown of the old system and the creation of the new one has created a system without legal norms regulating new activity. Such a situation has been the breeding ground for corruption. There are many levels at which the lack of institutional strength is present: from the weak legislative system and absence of laws, to the lack of implementation of the laws created by a corrupt law enforcement system (Levin and Satarov, 2000). This created a situation where the old institutions and methods of doing business have combined with the idea of a free market economy in Russia to take advantage of a weak state for private profit (Levin and Satarov, 2000).

First, there were many loopholes the privatization process, especially with regard to the illegal sale of land (Levin and Satarov, 2000). One such loophole is the lack of
oversight on property estimation (cost of privatized property is underestimated) and collusion laws (where public servants engage in mass buying of enterprises through trustees). Other illegal activity was pronounced in the privatization process. Large state owned companies were run into bankruptcy only to be then sold for a small fraction of their original value to the newly rich Russian business class under questionable circumstances (Levin and Satarov, 2000). The public viewed such government practices as corrupt and distrusted the government in further reform policies, such as those of the welfare services. This situation opens the laws up for interpretation by the individual authorities without effective oversight to ensure its consistency. With respect to the judiciary, even when the rules are enforced by the courts, their decisions are often not implemented because there is no effective enforcement mechanism. The low effectiveness of the judiciary process caused by a complex bureaucracy is reflected in the long delays in case processing and stalling of economic activity. Thus, the lower courts are not an effective way to battle corruption. There is a general perception by the people of the legal immunity of public officials. This further undermines the power of the law and the need by the public to obey by it since they perceive that the law does not apply equally to all. Thus, the lack of the rule of law has produced negative consequences at both the state and individual level. At the same time, many of those laws such as those governing tax collection and budget disbursement are very complex and easily abused by government officials. According to the law enforcement agencies, in the first stage of privatization, about 30 percent of all decrees already had violations of existing laws (Levin and Satarov, 2000). That indicates that there was no supervision or implementation of the rule of law during this process. If that is the case, why does law
enforcement not use the existing laws that are being broken in order to prevent illegal practices both by individual and by the state?

The reason for the lack of enforcement of laws that would fight corruption is that the problem is not only present at the individual level where it can be criminalized, but also at the systemic level. In other words, the institutions of the government do not punish the individuals because that would give permission to others to apply the same corruption fighting mechanism on the corrupt government officials. Furthermore, because the law enforcement organizations have been themselves pervaded with corruption, their work is of dubious quality (Levin and Satarov, 2000). Even though the government has declared the fight against corruption on numerous occasions and in particular on the corruption of public officials in taking bribes and embezzlement, they have only been able to get rid of corrupt elites and replace them with others. However, they have not been able to get rid of corruption in this process (Coulloudon, 2002). That is because the appeals to fight corruption were more of a strategic move during new government inauguration, rather than a firm commitment. There have been non-government efforts to fight corruption. For example, some groups within the civil society in the cities of Samara and Tomsk have organized as citizens’ advocacy offices to provide support for victims of corruption by expressing grievances and filing appeal procedures and other legal steps (Karklins, 2005).

The weak rule of law and the continuation of corruption have both eroded state legitimacy in the public eyes. This has been coupled with the non-representative institutions in the Russian Federation. Russia has a history of strong executives in its lifetime, starting with Peter the Great, through the communist regime to the post-
transitional period. Despite the fundamental transformations, the post-Soviet Russian government has maintained an overly powerful executive branch and a decision making process that has remained highly secretive (Coulloudon, 2002). At the beginning of Yeltsin’s presidency the decision making process was retained within the Kremlin, starting from the appointment of regional governors (which is currently the power that Putin executes). Yeltsin and the Congress reached an impasse when in 1994 they could not agree on the share of power between the central government and the representative constituent units. He dissolved the parliament. In 1995, by presidential decree he instituted electoral laws governing parliamentary elections (Smith and Remington, 2001). This decree included the following rules: 5 percent threshold, which is not as high as some other countries have had but is higher than many others; and a mixed PR/Single member district (SMD). Half of the representatives would be chosen on the proportional representation basis and the other half by single member district where the winner would be the one who was first past the post. Clearly, single member districts are less representative than the multiple member districts. The mixed system that some call Presidential-Parliamentary system has been considered by some to be prone to stalemates, as the government has to answer to both the president and the parliament (Smith and Remington, 2001). Many felt that a strong president was needed in order to enforce the democratic rule. Oddly, the same power structure is at odds with democratic principles of checks and balances and representativeness according to scholars such as Lijphart (1994).

Coulloudon claims that Yeltsin’s reforms were determined by a policy implemented from above without consideration of any other social, financial or industrial
bodies. This invariably led to special consideration of some groups and involved insider dealings, misallocation of public funds and gift giving. The executive was catering to the private groups because their funding, support and government influences would help him stay in office. In exchange, Yeltsin would dispose of publicly owned capital and hand it over to the newly rich class for cents on the dollar. The lack of policymaking based on consensus alienated the state from society and part of the industrial and financial elite and reproduced a Soviet pattern of governance (Coulloudon, 2002). One example of the non-transparent policymaking in privatization in illustrated in the case of the Railroad Minister Anatoly Chubais. In 1997, he was presented with a detailed proposal from the industrial managers and Russian investors on how to privatize the railroads. This included keeping a tighter control over the finances of the Ministry. Initially, the Minister agreed but then without an explanation changed his mind. The perception of the business group was that the ministry and other high-ranking officials saw them as a destabilizing force in their corrupt privatization practices (Coulloudon, 2002). The perception of the press that the ruling elite during Yeltsin has favored special interests has been translated to the public as well. In 1997, a leading Russian newspaper disclosed that the Railroad Ministry had signed contracts with private enterprises owned by their relatives. Similar events occurred in 1999 with the Energy Ministry and crude oil pipeline monopoly.

This makes the public less supportive of the regime and less likely to trust and support the government’s attempt to change the universal health care system if a significant attempt is ever made. Putin’s presidency has further placed a tighter control of the president over the government.
4.5: Government Effectiveness

The ability of the government to implement the needed economic and political reforms effectively and in timely manner has also proven to be challenging in Russia. It has also affected the public trust in the government and its inability to make any significant changes to the health care sector.

There are two main factors that have affected the current ineffectiveness of the governmental institutions in Russia: inheritance of the inefficient administration of the Soviet period, which stimulated the growth of corruption, and the institutional embeddedness, which is preventing any changes from occurring. Some reformists believe that the post-transition period and the dissolution of the communist power has created a *tabula rasa* on which new laws and institutions can be created from scratch. However, there is a path-dependency inherent in the transition process because the institutions that have maintained and guided a system (no matter how inefficient) for so many years cannot simply be forgotten or destroyed. For one, they leave a standing legacy because they affect social norms and political culture. In other words, institutions have been socially embedded in Russia. Some institutions of the previous regime (such as price controls) have been easy to change, while others, such as the notion of free and universal health care and guaranteed job security, have been accepted as an entitlement by the people. It has been very hard to change those because interests that have been experiencing marginal benefit from such arrangements exert pressures against institutional change. It is these less flexible institutions that keep creating more inefficiency and ineffectiveness in the post-transition period.
A general example of institutional ineffectiveness has been the complex system of state management. Levin and Satarov (2000) show that the more radical the attempts at changes there are, the more the bureaucratic structures attempt to resist it. In general, they lag behind other economic changes that occur so that most of the privatization process in Russia occurred in the absence of any legal regulations (Levin and Satarov, 2000). As a consequence of the red tape and confusing procedures to get things like private property ownership (especially land distribution) corrupt practices started flourishing at a growing pace. It has been estimated that some 10 percent of total revenues in small- and medium-sized businesses are give away through bribes to officials (Levin and Satarov, 2000). Since corrupt practices favor those in the government who benefit from them, there has not been an incentive to reform the inefficient institutions.

The path-dependency of inefficient institutions can also be seen in the health care sector. By the mid 1990s, reformists were proposing social welfare plans that would shift how health care was financed. However, the Communist Party (KPRF) gain enough support in the Duma to block any kind of liberal reforms (Cook, 2002). The legacy of the Soviet state is further exemplified in the resistance from medical workers to a proposed change to a merit based system. They preferred a secure salary. Because of resistance to any move towards a more efficient institutional setup, especially in the health care sector, highly inefficient practices continue to deplete the already low level of health care financing. On the one hand, special interests block the reform of the system. On the other hand, the perpetuation of this same ineffective and
corruption-ridden system is what is inspiring a growing sense of distrust in the government’s capacity to achieve any success with health care reforms.

4.6: Market Experience

The Russian Federation falls within the group of countries in the Central and Eastern Europe with the least amount of experience with the market economy. After the ousting of the Tsar and the ending of feudalism, Lenin instituted a communist regime with the socialist economic system. While other countries of CEE had the chance to experiment with some form of the market economy until the end of World War II, Russia never got its chance. Thus, people never learned the skills required to create a business or the rights and responsibilities involved in owning private property. The laws of supply and demand did not create free competition for jobs since nearly everyone was guaranteed a job by the constitutional provisions of the Soviet regime. “The late and partial development of Russian capitalism, the weakness of pre-Revolutionary middle class, and the indoctrination and atomization of seventy years of Soviet rule, ….have left citizens distrustful, cautious, insufficiently individualistic, unconcerned with profit, hostile toward private initiative, and generally poorly equipped for life in a modern market economy” (Schleifer and Treisman, 2000). Thus, the lack of experience with the market economy made it a foreign and threatening experience when market reforms were abruptly introduced in the 1990s. The temporary economic downturn was the most dominant and negative experience with the market economy for the Russians. Since they did not have any previous experience to compare it to, they soon started turning against it. In other words, while there were historical precedents for countries making
the transition from authoritarianism to pluralism, there were no such models for countries moving from socialism to capitalism (Mason and Kluegel, 2000). Unlike some other systems such as that of the former Yugoslavia where a mixed economy was present, the Russian case involved more radical changes in transitioning to capitalism such as stimulating competition by ending government subsidies for state-owned firms, creating a new legal structure and privatizing state firms. The mismanagement and lack of transparency in the privatization process mentioned earlier made the transition process worse.

Seventy years of state-dependency also affected the inherited legal structure, which did not have any provisions for private property ownership. This has had two consequences. First, it has made it harder to privatize successfully the large state owned companies without becoming susceptible to perverse privatization schemes involving private interest of some public officials. The privatization process was only guided loosely by the newly created rules since there was no prior experience and knowledge of potential loopholes that allowed the corrupt privatization practices. One such practice is running down a state owned enterprise, such as dairy factory. When its value is low, and in many instances upside down on its loans, the factory is sold for a small fraction of the value it had when it was initially eligible for privatization. The public officials involved are usually compensated informally for this service. Furthermore, the absence of prior market experience in Russia made it harder to create laws from scratch that would establish the basis of and protect effectively private property.

Russia’s past strongly affected the emergence of independent organizations in the post-transition period because it restricted their ability to obtain needed resources without
being dependent on the government (Fish, 1995). In turn, the problem of resources acquisition for these organizations rendered them powerless and anemic in their ability to represent interests and play a vital role in the civil society of the new Russian Federation.

4.7: International Funding

Funding from international organizations such as the World Bank has to be requested by the country in order to it to be considered as recipient. Russia has received increasing amounts of money in the 1990s from the IBRD and IDA. Russia has promised, though not always followed through, by the Bank's fiscal austerity criteria, especially in the health care sector. The first structural adjustment loans (SALs) started coming in the early 1990s as the side effects of economic liberalization began manifesting themselves through hyperinflation, high unemployment and negative economic growth. Although the per capita amount of the all World Bank loans to the Russian Federation has grown over time from 2.46 US Dollars in 1993 to 34.3 in 1997 and 45.8 in 2002, the amount of these funds actually directed for the purpose of the health care sector restructuring has been very small. In fact, in 1992 the portion of the SALs that were appropriated for health care sector use was only 0.69 US Dollars per capita, and this amount grew to 2.29 in 1996, only to fall to 0.41 in 1997. Thus, at it highest in 1997, only about 13 percent of the total IDA loan lent to Russia was actually used for health care sector purposes (World Bank, 2005). Part of the amount that is lent is based on need as well as the ability of a country to repay the loan. Since SALs are installment loans, they are disbursed upon evidence from a country that it has
preformed well towards the set economic goals. Thus, the fact that Russia has done so poorly in the economic transition and in the health care sector in particular has made international funding agencies reluctant to continue financial support. Only recently have they also begun assisting the restructuring of the health care sector in non-monetary ways.

The World Bank has recently started implementing some pilot programs in the Russian Federation. One of them has been the recent spending of 270 million US dollars to develop the polyclinic network designed to shift the majority of care from in-patient care, which is expensive and inefficient, to outpatient care. This restructuring would also involve cutting the number of beds in hospitals by 15 percent and transferring them to outpatient facilities (Twigg, 2000). Similar projects are going on in other parts of the Russian Federation, though they are limited to urban centers.

Some technical assistance to the health care sector has been also provided by the United States. In addition to the initial humanitarian aid after the transition, a series of programs were organized such, as the hospital Partnership Program where doctors from Russian hospitals would collaborate with their colleagues from U.S. hospitals on things such as education and training. The goal and the hope was that the newly trained physicians in Russia would then train others. Anther effort from the U.S. government came in terms of sponsoring a Health Care Finance and Service Delivery Reform Project, whose goal was to restructure the health financing institutions in Russia and other states of the former Soviet Union. The program was largely intended to achieve efficiency in the delivery in the quality health care in Russia. However, the heavy reliance of the program on American principle of market forces and competition
threatened the traditional Russian arrangements and personnel and the program was soon ended without much success (Burger, 2000).

5: Conclusion

The ability to achieve a health care sector that is able to provide services to the public effectively is a complex task that depends on multiple factors. Russian Federation was unprepared at the beginning of the transition process both in terms of their social capital and technical knowledge of what the transition to the market economy would entail. As a consequence, a declining economy, rising corruption and declining trust has made it even harder for the government to implement the badly needed reforms, especially in the health care sector. The unsuccessful reforms, including the privatization process have depleted public trust, which has made the government inefficient and powerless in its ability to implement health care sector reforms.

In order to break the cycle the keeps feeding on its weaknesses to produce new ones, some factors seem to be more easily altered than others. While memory of previous regime performance cannot be altered, the ability to establish and enforce the rule of law has a long lasting effect. Effective institutions can have a significant effect not only on the public trust and corruption, but also on the ability to reform and sustain an effective health care sector that will preserve its commitment to provide for the poor and needy, while still offering the basic protection for all its citizens.
CHAPTER IV
CASE STUDY: HUNGARY

1: Health Care and Public Health before the Transition

Hungary has a long history of providing health care services. This tradition dates back to the 11th century in form of infirmaries in monasteries. The first evidence of the state mandated care came in 1752, when the state established a requirement that there be provision of health care for the poor. Officially, the first public health care act in Hungary was passed in 1876. A Social Insurance Institute at the national level was created in 1927, and by 1930, about one third of the population was insured. Still, until the 1940s, health care services were mainly delivered through the private sector and some state owned hospitals (European Observatory on Health Care Systems, 1999).

When the communist government took power in 1948, the health care system in Hungary was socialized. This meant that all the private provisions of health care, including medical services and insurance providers, were dismantled. Subsequently, the planning, financing and organization of the sector came under central State management. In 1949, the new Constitution in Hungary declared health to be the fundamental right of citizens for which the state would be responsible. This was the beginning of the paternalistic state in Hungary where the major role of the state was to increase the economic and social well-being of its people by boosting consumption and taking care of welfare needs. The Ministry of Health had the exclusive responsibility over financing and delivery decisions. This left the local authorities and health care providers with little or no influence in the decision making process. In the 1950s the public health care services were also covered by local medical centers that supervised
the population and dealt with hygiene and communicable disease issues. Extensive public campaigns and monitoring of sanitation and hygiene standards resulted in positive outcomes in terms of limiting the spread of disease (European Observatory on Health Care Systems, 1999). During the 1950s, the administration of child immunizations promoted by international organizations, such as the World Health Organization, helped lower infant and child mortality to where the numbers dropped by more than half between 1960 and 1985 (Table 4.1).

Table 4.1: Health indicators, 1949-1985.

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<tr>
<td>Deaths per 1,000 inhabitants</td>
<td>11.4</td>
<td>10.2</td>
<td>10.6</td>
<td>11.6</td>
<td>12.4</td>
<td>13.6</td>
<td>13.9</td>
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<tr>
<td>Male life expectancy at birth (years)</td>
<td>59.3</td>
<td>65.9</td>
<td>66.7</td>
<td>66.3</td>
<td>66.2</td>
<td>65.5</td>
<td>65.0</td>
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<tr>
<td>Infant mortality</td>
<td>91.0</td>
<td>46.4</td>
<td>38.8</td>
<td>35.9</td>
<td>32.8</td>
<td>23.1</td>
<td>20.4</td>
</tr>
<tr>
<td>Mortality under 5 (per 1,000)</td>
<td>-</td>
<td>52.9</td>
<td>43.8</td>
<td>39.2</td>
<td>36.1</td>
<td>24.4</td>
<td>22.8</td>
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<tr>
<td>Communicable diseases mortality (per 1,000)</td>
<td>1.3</td>
<td>-</td>
<td>-</td>
<td>0.27</td>
<td>-</td>
<td>0.14</td>
<td>-</td>
</tr>
<tr>
<td>Number of hospital beds (per 1,000)</td>
<td>-</td>
<td>6.9</td>
<td>-</td>
<td>7.9</td>
<td>-</td>
<td>9.1</td>
<td>9.7</td>
</tr>
<tr>
<td>Standard Death Rate malignant neoplasms/1000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2.2</td>
<td>-</td>
<td>2.4</td>
<td>-</td>
</tr>
</tbody>
</table>

Source: population deaths (Hungarian Central Statistical Office; World Bank, *World Development Indicators*); Infant mortality (Hungarian Central Statistical Office; World Bank, *World Development Indicators*); Mortality under 5 (World Bank); Male life expectancy (Hungarian Central Statistical Office; World Bank); number of hospital beds (World Bank); Communicable diseases mortality (Hungarian Central Statistical Office).
Furthermore, the principle of universal coverage had resulted in significant positive outcomes during the first phase of the communist regime. Infant mortality and maternal mortality were brought down significantly, as was the incidence of communicable disease. For example, infant mortality dropped from 91 per 1,000 in 1949 down to 35.9 per 1,000 by 1970. Table 1 provides more information on the health of the population during the communist regime.

However, as life expectancy increased due to the control over communicable diseases, the system failed to adjust to new public health demands as early as the 1960s. While the incidence of communicable disease was largely eradicated or brought under control, the mortality caused by non-communicable disease started increasing. The drop in communicable diseases were largely due to the introduction of vaccinations on one hand and introduction of improved sanitary measures through campaigns of international organizations such as the WHO. Male life expectancy increased initially from 59.3 in 1949 to 66.3 in 1970, only to start dropping thereafter. It did not return to the 1970 level until 1997 (European Observatory on Health Care Systems, 1999). UNICEF reports that between 1965 and 1985, death rate for men between 45 and 49 had increased by 118 percent, higher than USSR (1999). The gap in mortality rate between Hungary and developed countries in Europe had been shrinking until the mid 1960s. After that, the developed countries improved their population’s health significantly while that of Hungary worsened considerably among young males (Lakatos, 2002).

The decline in health care indicators was in part a function of the lifestyle issues, which contributed to the increase in cardiovascular diseases and cancer. One such life
style factor has been nutrition. The data collected from the 1960s on from the Food and Agriculture Organization of the United Nations suggests that Hungary has traditionally followed a northern European dietary pattern, which is full of saturated fats and low in fruits and vegetables. Furthermore, tobacco and alcohol consumption have been on the rise in Hungary since the 1960s and 1970s, and is well above the average for Central and Eastern European countries for that period. The incidence of cardiovascular diseases and cancer in Hungary increased rapidly in the late 1970s (WHO, 2000).

The fact that the financing and management of the health care services was centrally managed on the Soviet principle of strict population planning norms without input from local authorities made the system inflexible and unable to deal with the changes confronting the health care system. The state concentrated instead on achieving quantitative goals such as increases in hospital beds. For example, the number of hospital beds in 1960 was 7 per 1,000 and it increased to almost 10 by 1985 (World Bank, 2005). In comparison to other CEE countries like the Soviet Union, the number is much lower, but it is higher than non-communist European countries. Table 4.2 illustrates more information on Hungary in a comparative context.

Thus, the discrepancy between what was supplied and what was really needed brought about inefficiencies that were also felt in the quality of services. For instance, while the number of in-patient hospital beds exceeded the real needs, there was a lack of investment in technology, which would make the health care sector more efficient, and could perhaps help cut down on the amount of inpatient hospital stay (EOHCS, 1999). Universal coverage increased inefficiency due to overspending in some areas such as utilization of specialist services and hospital services, and under-spending on
other resources such as outpatient facilities. The fact that the health care budget was kept outside of the

Table 4.2: Comparative health indicators for 1970.

<table>
<thead>
<tr>
<th>Country</th>
<th>Hungary</th>
<th>Russia</th>
<th>France</th>
<th>Germany</th>
</tr>
</thead>
<tbody>
<tr>
<td>GDP per capita</td>
<td>3,210(^1)</td>
<td>7,837</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Life expectancy at birth or males</td>
<td>66.72</td>
<td>65.06</td>
<td>63.08(^2)</td>
<td>62.73</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>38.8</td>
<td>20.4</td>
<td>29(^2)</td>
<td>28(^3)</td>
</tr>
<tr>
<td>Number of hospital beds per 1,000</td>
<td>7.9(^2)</td>
<td>9.7</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>Death rate (per 1,000)</td>
<td>10.6</td>
<td>13.9</td>
<td>-</td>
<td>11.3</td>
</tr>
</tbody>
</table>

1. Indicator is for 1975 because of lack of data availability.
2. Indicator is for 1970 because of lack of data availability.
3. Indicator is for 1980 because of lack of data availability.

regular budget allocation shows the lack of priority given to this sector. While spending on the military and other sectors was planned in the national budget, health care spending was funded with extra budgetary funds. One of the consequences of the discrepancy between real needs and the uncoordinated supply that would address these needs adequately was the high demand for services that could not be met within the system. One of the ways in which the excess demand was satisfied was through informal payments. As mentioned earlier, other consequences of the inefficient health care sector resulted in rising mortality rates, especially among men. Even though poor habits, including the abuse of tobacco, were not a direct result of health care sector maladies, the fact that mortality rates due to cancer were so high indicates weaknesses
in the sector. Most notably, while schoolchildren were subject to regular preventive checkups, preventive care for the adult population was inadequate.

The need for health care reforms became increasingly apparent in the 1980s. The deteriorating health care status of the population, the high health care costs because of reliance on in-patient hospital services, low socio-economic status of health care practitioners and poor working conditions prompted a response in 1987. The Ministry of Social Affairs and Health established a body that produced policies such as establishment of the Social Insurance Fund and the allowance of limited private practitioners (Chinitz, et. al., 1998). This was the beginning of the introduction of policies that would eventually help improve the health care sector in the post-transition period. This system continued into the transition period so that there was some degree of continuity in the health care sector policy administration.

2: Health Care and Public Health after the Transition

The reform of 1987 was soon followed by other reforms. In 1990, an Act on Local Governments assigned the responsibility for local health services to the local governments, but they were allowed to contract out the provision of services to private providers. This was an improvement over the old system because the local government could assess the real needs of the local community. The relaxation of the centralized hold on health care has provided an opportunity for the growth of the private sector, but so far it has been limited to primary care providers, dentists, pharmacies, and clinics. Most hospitals have remained in the hands of the local governments. Thus, in terms of management, the health care sector has been changed to a split-provider contract
model (EOHCS, 1999). This means that the administration and organizational structure of the system has been placed in the hands of the Health Insurance Fund and the local government. However, the significant reforms made between 1990 and 1994 stalled significantly thereafter due to the Hungary’s initiation of overdue economic restructuring to address its external debt problems. The second wave of health care reforms was introduced in 1997, but at a much slower pace.

The Ministry of Health, however, still regulates and controls the sector. Until 1998, the Ministry was responsible for other social issues as well. Thereafter, it was given exclusive responsibility for management of the health care sector. The Ministry of Health was given oversight of multiple organizations such as the National Public Health and Medical Officer Service. This organization became responsible for public hygiene and infectious disease control, and the licensing of health care providers. The Ministry also provides tertiary care services through national institutes and university hospitals that engage in scientific research, clinical work, and other services. They are financed through the Health Insurance Fund. Finally, the Ministry also runs the state hospitals that are partly funded by the Health Insurance Fund and partly by the government (EOHCS, 1999).

Thus, health care sector management has remained largely centralized, with the exception of some privatization. However, the main steps forward have been made in terms of separating health care sector management and financing from other welfare sectors, and the management of local hospitals has been assigned to local authorities. Furthermore, a number of regulatory bodies have been created to control the quality of care, such as the already mentioned Medical Officer Service as well as the Health Care
Specialist Training and Continuing Education Council, and National Institute of Pharmacy, among others (EOHCS, 1999).

In terms of the financing of health care services, some improvement has been made. In 1992 the Health Insurance Fund has been separated from the joint Social Insurance fund that financed both the social insurance as well as the health care sector (EOHCS, 1999). Given the initial deficits in the fund, there has been a movement back towards a more centralized system, where the Ministry of Finance now oversees the financing of the health care sector. Whereas under the previous system the health care services were financed from the government budget, now the Finance Ministry is responsible for the fiscal policy and macro-economic dimensions of health care financing. The ministry determines the health care budget and that of the Health Insurance Fund. The collection of health insurance contributions to the Fund has been moved to the tax department. The Fund collects revenue through payroll premiums. The positive impact of separating the Health Insurance Fund from the government is that the government cannot use any surplus for other purposes but it is still obligated to cover any the deficit in the Fund. That diminishes the possibility of health care sector funds being misused for political gain by the government. To summarize, the organization and financing of the health care sector has changed considerably since the 1980s. Decentralization has been the main object of the restructuring of the system. While the health services are still publicly financed and provided, the role of the central government has diminished significantly. Figure 4.1 depicts the organizational structure of the Hungarian decentralization of the health care sector.
Physicians are still mostly public employees (with the exception of the ones that entered private practice) and are paid on a patient capitation basis. Even though their pay is based upon qualifications and years of experience, physicians working in the public sector are still underpaid, receiving a wage that is below the national average. This is a continuation of the pre-transition situation of inadequate compensation of health care workers. It also reinforces the practice of soliciting informal payments, which still constitute a considerable portion of physicians’ income. Kornai (2000) estimates that informal payments amount to sixty percent of the physicians’ income on average. The low paying jobs in the health care sector seem to be deterring entrance into the service since the number of physicians and nurses per 1,000 population is well
below that of west and east European countries. The average number of physicians per
1,000 in Hungary is 3.6 while that of Norway is Italy is 5.5 and Belarus 4.4 (WHO,
1999). The spending on the health care sector in the post-transition period is still
lower than the CEE countries that have been the most successful at improving their
health care sector (Slovenia), and much lower than the EMU average (Table 4.3)

Table 4.3: Spending on health care as percentage of GDP (1998-2002).

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Russian</td>
<td>6.1</td>
<td>5.2</td>
<td>5.7</td>
<td>6</td>
<td>6.2</td>
</tr>
<tr>
<td>Federation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hungary</td>
<td>7.3</td>
<td>7.4</td>
<td>7.1</td>
<td>7.4</td>
<td>7.8</td>
</tr>
<tr>
<td>Slovenia</td>
<td>7.8</td>
<td>7.7</td>
<td>8</td>
<td>8.3</td>
<td>8.3</td>
</tr>
<tr>
<td>EMU</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9.2</td>
<td>9.4</td>
</tr>
</tbody>
</table>

Sources: World Development Indicators (World Bank, 2005).

What do the changes of the health care sector in the post-transition period mean
in terms of their effect on public health? Standard health care indicators of the post-
transition period indicate that the public health has deteriorated generally in the 1990s.
Most notably, the trend of increasing mortality due to non-communicable disease of the
1970s and 1980s has continued, but at an accelerated rate. The incidence of
cardiovascular disease and cancer has been very high in comparison to the pre-
transition period. Figure 4.2 shows how Hungary compares to other countries of
Central and Eastern Europe (WHO, 2002). The ten reference countries that are
compared to Hungary include Bulgaria, Czech Republic, Estonia, Hungary, Latvia,
Lithuania, Poland, Romania, Slovakia and Slovenia.
Figure 4.2: Hungary relative to reference countries in 1985 (●) and in 1996 (1998) ☐.

<table>
<thead>
<tr>
<th>BEST</th>
<th>WORST</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSITION</td>
<td>1</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>☐</td>
</tr>
<tr>
<td>Male versus female difference in life expectancy at birth (years)</td>
<td>☐</td>
</tr>
<tr>
<td>Infant mortality per 1000 live births</td>
<td>☐</td>
</tr>
<tr>
<td>Maternal mortality from all causes (per 100,000(^1))</td>
<td>☐</td>
</tr>
<tr>
<td>SDR(^2) from cardiovascular disease (0-64 age)</td>
<td>☐</td>
</tr>
<tr>
<td>SDR from cancer</td>
<td>☐</td>
</tr>
<tr>
<td>SDR from trachea/bronchus/lung cancer (0-64 age)</td>
<td>☐</td>
</tr>
<tr>
<td>SDR from cancer of the cervix among females aged 0-64</td>
<td>☐</td>
</tr>
<tr>
<td>SDR from suicide and self-inflicted injury</td>
<td>☐</td>
</tr>
</tbody>
</table>

Position Improved 5 (indicators)
Position unchanged 1 (indicator)
Position deteriorated 3 (indicators)

1. Three-year averages
2. SDR: Standardized death rate
3. Lowest value observed among 10 reference countries
4. Highest value observed among 10 reference countries

Sources: The table is in part reproduced from the “Highlights on Health in Hungary” (Health Information Unit of the WHO Regional Office for Europe, 2000)

The overall health of the public in Hungary has deteriorated in the post-transition period, especially when one considers the fact that Hungary has increased its GDP per capita, which is supposed to improve the quality of life for people. While total life expectancy at birth has increased, the discrepancy between male and female life expectancy has increased as well. Female life expectancy has continued to rise at a pace faster than the decrease in male life expectancy so that overall life expectancy is higher than in 1985, but still lower than the country group average. As in many other CEEC, the increased mortality of males is a symptom of the post-transitional stress
brought on by economic decline (WHO, 2000). The longevity of women has increase also in part because the mortality from cervical and breast cancer (not shown here) has decreased due to the world improvements in detection and treatment of these types of cancer. At the same time, the overall standardized death rate (SDR) from cancer has increased significantly in the post-transition period. Among the ten countries compared, Hungary has the highest SDR of cancer in general and of lung and respiratory organ cancer in particular. This is an indication of the worsening of the pre-transitional situation where the environment of alcohol and tobacco abuse plays a large role in rising deaths. The inability of the health care sector to detect such diseases through preventive services before the disease becomes fatal contributes further to the high rate of death. In addition, the worsening economic situation has led many to find an escape in unhealthy life styles. WHO reports that by 1998, the rate of chronic liver disease and cirrhosis had increased to the highest among the reference countries, a rate that is more than double the average of the CEEC and three times that of the European Union (EU) average (2000). The post-transition period has also brought new diseases such as AIDS, and the rate in Hungary is higher than the median of the reference countries, though still lower than that of the EU (WHO, 2000). The surprising fact is that the number of intravenous drug users is much lower than most other European countries, though it has increased since the pre-transition period.

At the same time, some practices that were successful in the pre-transition period have continued into the post-transition period. These include a high rate of child immunizations where Hungary is among the most successful. In addition, SDR from
cerebrovascular diseases has decreased, in addition to the already mentioned decrease in cervical cancer (WHO, 2000).

Hungary is a case of mixed success in terms of the health care sector. The reforms that have been implemented were done so successfully, such as the decentralization, and separation of the Health Insurance Fund. However, the reforms that have been implemented have not been sufficient and have had a limited impact. In particular, after 1994 when Hungary was advised to implement austerity reforms to achieve structural adjustment, the reforms were stalled and then picked up at a much slower pace after 1998. Thus, Hungary is an example of a country that has been more successful then others such as The Russian Federation, but not as successful as others such as Slovenia. Overall, the situation is considered to be relatively poor in both in 1985 and 1998. The following section offers a detailed account of the factors that have contributed to the current health care sector status in Hungary.

3: Determining Factors

3.1: Country Performance during Transition

Hungary is among the countries that have made a relatively successful transition both to a new political and economic system. The political transition started in 1989 when political parties were allowed to form. The country made the transition to democracy in 1990. In economic terms, the government had initiated a series of reforms starting in 1968 with the New Economic Movement (NEM). Hungary had been forcefully placed under the communist rule in 1948 by the USSR. Opposition to the new economic and political system had come to surface in the uprising of 1956 that was
brutally suppressed by the USSR. The brutal suppression led the Kadar regime to accept the influence of the Soviets. Implicit in the new relationship was the regime’s willingness to accept the society’s withdrawal from active politics in return for the state’s promise to supply Hungarians with a higher standard of living. Thus, consumerism was initiated. One way to support a higher standard of living was through international borrowing, which eventually put the country in a precarious financial situation by the early 1990s because of balance of payments problems and the inability to repay the loans (Brown, 1988).

By the time the transition period arrived in 1990s, Hungary had a relatively high standard of living and an economy that was already set up for a smooth transition to the market economy. In fact, the GDP per capita in Hungary in 1989 was 9,622 US dollars, among the highest of all CEEC. Along with the domestic reforms, the country had started opening up to western influence. In a sense, they tried to marry the wealth from the West and the Eastern system on which their power was built (Kornai, 1996). See Table 4.4 for more information on Hungary’s pre- and post-transition economic performance indicators.
By the early 1990s the Hungarian economy already had many elements in place for the development of the market economy. The government did not face the urgency to adopt shock therapy transition to the market economy, as was the case in some other countries such as Poland and Russia. This slow and delayed liberalization resulted in what Janos Kornai calls a “half-ready” market economy that has taken years to mature and is not yet fully developed (1996). By the mid 1990s, however, international organizations such as the World Bank and the IMF started urging the Hungarian government to implement Structural Adjustment Loans because the country had rising external debt with which they had financed the consumerism of the 1970 and 1980s.
Hungary had been one of the first communist countries of Europe to gain World Bank and IMF membership in 1982.

Hungary also performed well in the privatization sphere. Although some privatization had occurred prior to 1990, by 1994 roughly half of the state enterprises had been privatized (Kornai, 1996). As compared to the privatization in the Russian Federation, privatization in Hungary was more transparent and less pervaded with corrupt practices. The process had stopped for a year and then resumed with the privatization of large state-owned electricity, oil and gas corporations. Because the macroeconomic stabilization reforms were delayed for the first few years of transition, the government had the opportunity to address needed reforms in some sectors of the economy usually considered to belong to the second wave of reforms. The health care sector and the pension system were reformed partially. Although there was a slow down in the reform process between 1995 and 1997, the initial reforms made it easier to implement additional reforms later.

As was the case with other CEEC, Hungary experienced some economic downturn in the early 1990s, but was able to resume economic growth and lower inflation and unemployment fast. Its highest unemployment rate was 12.1% in 1993. By 2000 the unemployment rate had dropped by nearly half and was comparable to other developed democracies in Europe. During this period, most other similarly well performing CEEC had much higher unemployment rates (Latvia, 14.4 percent; Poland, 16.1 percent, and Slovenia 7.2). The highest inflation in consumer prices was experienced in 1990 and then again in 1995 when macro stabilization measures were introduced. But inflation but never rose beyond 28.3 percent (World Bank, 2005).
Income inequality is higher than what it was during the command economy period, and it is still comparable to that of other former communist countries such as Slovenia, Russia and Germany. Hungary’s GDP per capita kept rising over the years regardless of the shocks of the transition period. GDP growth fell in the 1990s but soon recuperated. Hungary has had one of the highest output levels along with Slovenia, Czech Republic and Poland (UNICEF, 1999). This is a remarkable success given that other countries average economic performance during this period was noticeably worse. However, there have been some negative repercussions in this period. TARKI (a sociological research association) found that the period between 1987 and 1992 was characterized by an increase in income inequality and the emergence of an upper stratum of society (Lakatos, 2002). The middle class kept falling behind in its growth between 1993 and 1996 but this trend was reversed after 1997 when most of the economy was stabilized.

3.2: Corruption

The case of the bartender: To wit, in a factory cafeteria it is forbidden to sell alcoholic beverages to the workers and employees. Nevertheless, the bartender sells alcoholic drinks, but she also reports the names of her buyers to the manager of the factory. In return, the manager closes his eyes on her selling the alcoholic beverages in the cafeteria.

Elemer Hankis

As in most other Central and Eastern European countries, corruption in the health care sector has existed in Hungary since the communist period. It was a response to the disjunction between demand for health care services on one hand and the supply of them on the other. The misallocation of resources in the health care
sector was endemic to the strict central planning and management of the sector. Local health care authorities were powerless over that process. Although they were most familiar with the situation in the field, they had little or no input in the decision-making about the sector. In addition the low compensation of the health care sector employees contributed to the rise in side payments to health care providers, which was the most common form of bribery in the health care sector of Central and Eastern Europe. While the Kadar government introduced mixed economy principles into industry, agriculture and commerce, the same did not apply to the health care sector (Kornai, 2000).

Hungary’s economy was organized as a kind of “hybrid” market marked by the coexistence of centralized political, social and economic redistribution on one hand and the principles of the market economy in the business sphere. This kind of a dual economy situation creates a situation where no one exactly knows what is legal and what is not, especially when offenders are not punished because of loopholes (Hankiss, 2002). It also creates opportunities for corruption at the boundaries between the two sectors. The corrupt practices in Hungary flourished in the 1960s and 1970s when the government introduced the consumerist economy as a means to means to purchase political quiescence among the population. Citizens bribed government officials into closing one eye to the expansion of the underground economy (which improved their living standards) while renouncing their rights to express dissatisfaction with the political system (Hankiss, 2002). Hankiss also notes that by the time the communist regime was able to successfully impose power in the country, there was already a “chaotic interaction of a great number of heterogeneous economic and social mechanisms, and this chaos was, understandably, a hotbed of corruption” (2002; 247). Although corrupt
practices in the Hungarian economy may have served as a temporary relief from having to live under the communist boot, over time such practices eroded social trust and undermined the rule of law, even if they did contribute to a rising standard of living. When the transition period arrived and new rules were established to guide the economy, the corrupt practices persisted and even increased as a means to alleviate economic hardship associated with the initial shocks of market transitions. In the health care sector, physicians employed in the public health care sector kept accepting side payments from patients as a way of supplementing their regular incomes. What gratitude payments did for patients is buy them a little freedom of choice in an increasingly inefficient health system.

Although Hungary recovered from the economic shock faster than most other Central and Eastern European countries, there was still an initial negative economic shock reflected in rising unemployment and income inequality. These effects lowered the living standards of the people. The transition process also introduced many grey areas in the process of privatization and coordination between state bureaucracy and market institutions in which gratitude payments fit quite easily. One way in which senior doctors assured the collection of side payments was by limiting access to hospital equipment such as ultrasound machines and CT scanners to those who could pay a tip. Kornai (2000) estimates that the informal payments constitute as much as 60 percent of a public sector physician’s salary in Hungary. Therefore, there is little incentive for medical staff to change this payment structure, especially since this income is unreported and therefore untaxed. From surveys conducted by TARKI in 2000, it is evident that side payments have a negative moral effect in the health care sector. From
the people surveyed, a large 58 percent of physicians and 52 percent of the public surveyed agree wholly that side payments are a necessary evil. What is even more worrisome is that 82 percent of physicians surveyed believe, wholly or in part, that it is right for them to accept money so long as the state does not pay them adequately (Kornai, 2000).

Hankiss (2002) calls this a “neurosis” of corruption. Once the system is pervaded with corrupt practices, even the fight against corruption can generate more corrupt behavior. In Hungary, the media has saturated the people with news and rumors of corruption so that it has created a myth of the universality of corruption. It is counterproductive because it may further undermine the social trust in public institutions and democracy. When people suffer from a “neurosis of corruption”, they believe that the corrupt practices cannot be restricted or controlled. Thus, they become less willing to fight corruption (Hankiss, 2002). A case was reported in the 2004 Financial Times articles where a computer programmer from Budapest set up a web site to raise awareness and invite complaints about side payments to doctors, but the web site was shut down after he received complaints and threats of lawsuits by physicians named on his web site.

Table 4.5 shows the development of the Corruption Perception Index for Hungary over the 1990s. Hungary’s Corruption Perception Index (CPI) has improved over the past 10 years, but not significantly.\footnote{The CPI index ranges from 0 to 10, 10 being the score assigned to the least corrupt state.} Although its score has improved by no more than one point, its placement in the international CPI ranking has deteriorated as more countries have been added to the surveyed group and as their index improved over the same time. For example, Italy had a lower CPI score than Hungary in 1997. However,
while Italy rose from 5.03 to 5.2 for the same years, Hungary remained at essentially the same, somewhat lower score (5.18 vs. 4.9). In 2002, Slovenia’s score was 6.0. Thus, Hungary fell behind one of the most corrupt, developed European democracies, Italy. For 2005, Slovenia improved its score to 6.1, while Hungary shares its position with Italy.

Table 4.5. Perceptions of corruption in Hungary, 1995-2005.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CPI score</td>
<td>4.12</td>
<td>4.86</td>
<td>5.18</td>
<td>5.0</td>
<td>5.2</td>
<td>5.2</td>
<td>5.3</td>
<td>4.9</td>
<td>4.8</td>
<td>4.8</td>
<td>5.0</td>
</tr>
<tr>
<td>World ranking</td>
<td>28</td>
<td>31</td>
<td>28</td>
<td>33</td>
<td>31</td>
<td>32</td>
<td>31</td>
<td>33</td>
<td>40</td>
<td>42</td>
<td>40</td>
</tr>
<tr>
<td>No. of surveys used</td>
<td>6</td>
<td>9</td>
<td>13</td>
<td>10</td>
<td>10</td>
<td>11</td>
<td>13</td>
<td>12</td>
<td>11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Standard Deviation reported because data on confidence interval is not available.


Gaal (2002) estimates that while formal out-of-pocket (OOP) expenditures are the highest for pharmaceutical purchases (46.3 percent of total formal OOP) a whopping 52.2 percent of all informal OOPs is given as informal payments to physicians for surgery and 33.2 percent for informal consultation. Because the requirement of informal payments affects the worst those on the low end of the income scale, the persistence of this practice raises issues of equity. Finally, as long as the health care sector reforms, including increasing spending on health care and raising wages of the medical staff, are not brought up to speed with other reforms, the practice is likely to continue and further undermine process of democratic consolidation.
3.3: Public Support

Hungary’s dual transition was introduced in a top-down method so that there was little input from the population on the transition process. Thus, Hungary never experienced the kind of popular uprising and street demonstrations that were seen in Romania or Poland. The Hungarian experience with communist rule was not so negative in economic terms because, compared to many other communist countries, the government emphasized a policy of consumerism in order to preserve high living standards. In political terms, Hungarians lived with a sense of apathy towards politics and its implications, in part from the learning experience of 1956 when an attempt to overthrow the imposed communist regime was crushed. Thus, Hungary transitioned into the new political and economic order with popular support, but it was not nearly as pronounced as in other countries of Eastern and Central Europe.

The experience with the new democratic government in Hungary was mixed. The first government in power between 1990 and 1994 was able to established its legitimacy through the introduction of democratic institutions and procedures. However, the same government compromised its popular support and legitimacy in a number of ways. First, it was the government that had to introduce the painful and unpopular economic shock therapy measures, and it failed to achieve the expected rapid economic recovery. Furthermore, the emergent political rivalry between opposition parties at a time when the need for coalition and compromise were greatest in order to solve common problems undermined support for democratization. The great coalition of the three parties that emerged from civil society was naturally expected to form, but it failed to do so for reasons not clear to the public (Arato, 2000). In other words, instead
of ending political rivalry and forming a government that would address issues of concern in the transition process, the parties remained divided. The public expected those who led the democratization movement to create a government coalition that would lead the country successfully through political and economic reforms. Furthermore, as the privatization of enterprises and the creation of private property laws proceeded, the public perceived them to be purposefully designed to benefit business groups at the expense of the workers. One of the main reasons is because the general population and even organized groups and institutions such as local government, labor unions, and professional organizations were excluded from the privatization process. They neither were involved directly in the proceedings nor were their interests represented. This eroded public support even further (Arato, 2000). In general, the exclusion of emergent civil society organizations and local government organizations from the policymaking process on crucial issues affecting them has been particularly disliked. Thus, the existing political apathy that had existed during the communist period has carried forward into the new period (Mason and Kluegel, 2000). Citizens perceive that they have no input in the policymaking process, regardless of which regime they live under. The emphasis thus continued on the regime performance in the economic sector.

Overall, the public remained relatively content with the government’s economic performance in the post-transition period. On the positive note, the government has been able to achieve good macroeconomic results. The gradual nature of Hungary’s economic reform process has contributed to the comparatively low levels of perceived political and economic injustice present in the first six years of the transition (Mason and
Kluegel, 2000). On the other hand, people feel that they have been abandoned by the political and business classes, and thus breaking the rules and undermining the new regime has become justifiable (Hankiss, 2002). Furthermore, given the singular emphasis on the standard of living in terms of performance, those whose living standards have not improved significantly over the past fifteen years see themselves on the losing side (Mason and Kluegel, 2000). In the past decades the emphasis in Hungary has been on increasing consumption and maintaining socioeconomic security. The transition to the market economy has diminished the latter without properly compensating for the former, and so the increasing emphasis has been on economic performance as a method of evaluating regime performance and the value of the dual transition (Kornai, 1997).

Public support of the reforms has remained stable over the period. There is still great opposition to radical changes in the pension and health care systems, and the large majority are still in favor of government intervention in these sectors, especially in light of growing income inequalities. In an ISJP survey administered to different CEEC countries in 1991 and again in 1996, 64.8 and then 66 percent of those surveyed in Hungary showed support for the principle that people ought to get what they need (Mason and Kluegel, 2000). The government has thus maintained continuity with the socialist practices of a paternalistic welfare state by providing the key elements of pension and health care. This is especially supported by a growing population of retirees in Hungary, many of whom retired under the early retirement encouraged during the transition period as a way to minimize the rise in unemployment. The coalition between the Socialists and the Free Democrats in the 1994 election campaign
had enabled them to gain support both from the rent seeking left groups (those who opposed reforms that would take away government programs and subsidies) and the pro-reform right. In health care, there has been widespread rejection of some proposed reforms such as the one in 1995 that attempted to reduce the number of hospital beds and close some clinics (Nelson, 2001). The attempt to dismantle the Health Insurance Fund proved impossible when it was met by the opposition from health service organizations who had control in the fund. Some had been involved in bribing government officials (Haggard, Kaufmann, and Shugart, 2000). The importance of dismantling the Fund was because of its large discretionary policies over health care financing. This increased the public perception of corrupt and non-transparent practices at all levels (government, and patient-physician) in the health care sector.

Overall, the public support for health care reform in Hungary and the legitimacy the government has enjoyed with the public have been mixed, and have changed over time. The overall good experience with government performance in the economic sector has been compromised by the narrow inclusion of only a few group participants in the policymaking process, and by the perception of pervasive corruption in the privatization process and the public health care sector.

3.4: Institutions: The Rule of Law and Degree of Representativeness

3.4.1: The Rule of Law

Hungary has achieved relatively high levels of success in dual transition. The exception of the welfare system and in particular, the health care sector, which have declined as a result of economic liberalization. Hungary has produced a stable political
and economic environment and is making progress towards a sustainable economic development and democratic consolidation. It is now member of the European Union and the North Atlantic Treaty Organization. However, in order to assess the ability of Hungary to improve its health care sector, it is necessary to assess the extent to which the rule of law has been established in the everyday life of citizens.

The attempt to apply the rule of law to the underground economy in general and the practice of side payment to doctors in particular has not been very successful in Hungary over the past fifteen years. In the instance of side payments to doctors, the practice is deeply embedded in the society and culture (EOHCC, 1999). Because gift giving is part of the culture in Hungary, it is difficult to implement a law that will distinguish the legal from the illegal and punish that type of activity. Furthermore, there are other features of the health care sector itself that need to be addressed for the rule of law to have an effect on corrupt practices. Reforms should be designed to remove the need for side payments in the first place. In Hungary, the low salaries of medical doctors and health care workers, compared to other sectors of the economy, are a major contributor to the problem. Still, increasing salaries will not by itself solve the problem. The elimination of side payment requires a coordinated effort aimed to restore confidence that a person can get quality health care service without side payments (EOHCC, 1999). The only action on this problem has been an attempt by the Minister of Health to set up a committee that would look into the problem.

In general, the fight against corruption has been tough because of the government’s belief that it would lead to political repercussions of losing votes in elections. For example, almost the entire Hungarian population takes part in tax
evasion, according to Kornai (1996). Although it would be popular for the tax police to go after a few rich individuals for tax fraud, it would not be popular if it was methodically applied to the entire population (Kornai, 1996). An example of where this is applied more consistently in other countries of CEE is Croatia, where the financial police randomly audit small private businesses a few times per year.\textsuperscript{46} Thus, it would be a risky and unpopular thing for an elected government to undertake, if it wishes to stay in power. In 2001, a Government Resolution on the anticorruption strategy was passed, but it has not had a significant impact in the fight against corruption (Transparency International, 2005).

In a GALLUP survey administered to people in Hungary the respondents stated that the laws in Hungary are “flexible”, meaning that they can be bent to different purposes. Furthermore, they state that the bills proposed by the government end up losing their initial purpose through parliamentary debates (Hankiss, 2002). The encroachment of business on government has been large and attempts at dividing the two spheres have proved impossible. More specifically, large business influence on the government though benefits paid out to government officials and through the placement of “business friendly” officers in government has created a form of collusion that results in weak legal consequences of illegal business behavior. Even when consistent laws are passed, the institutional machinery of the state is too weak and disorganized to be able to implement the laws consistently. Part of the problem is that the social and economic wellbeing of the citizens has not been secured across the board. Where

\textsuperscript{46} Still, some believe that random and persistent tax audits are more of a form of personal revenge by someone who is in or has connections in the financial police.
people struggle with the problems of everyday survival, they are not bound to have much respect for the law (Hankiss, 2002).

The very institutions that are supposed to implement the laws are the hotbeds of corruption. The legal system is over-bureaucratized. For example, the paperwork and time that it takes to open a business is costly and lengthy and has an effect of discouraging the flourishing of business enterprises. Because of that, people often give bribes to expedite the process. One of the solutions proposed is to deregulate the legal system. Other forms of the lack of law implementation is the government members’ ignoring of rulings by the Supreme Court. For example, the Constitutional Court has found the Parliament guilty of not passing certain laws by constitutional deadlines but that has been ignored. In another example, the Government has refused to pay its debt to the City of Budapest (Hankiss, 2002). All of this has contributed to the erosion of the respect for the Law in the minds of the people.

3.4.2: Degree of Representativeness

In Hungary the constitutional changes that would decentralize the communist government began prior to the actual transition in 1988 and 1989. The old system was peacefully transformed into one with two political arenas. One was the existing institutional setting of the socialist Parliament and government, and the other involved the introduction of the civic movements into the political sphere, including the reestablishment of new parties. While old socialist and new emerging parties had a key role in defining the nature and pace of the transition, the civil society had less of a formal influence on its course. Thus, a multiparty system was created well before the
actual transition took place. There was an inherent passivity in the public, carried over from the decades of non-involvement in the political life.

Hungary has had a longer history of parliamentarism than most other countries of Europe. From 1848 until 1949, Hungary had a parliamentary government where, at least formally, the government was responsible to the parliament (Szoboszlay, 1996). The degree to which the parliament was truly representative varied during this time period, but it was formally a system where the parliament played a large role. In 1989, the Constitutional changes gave more power to the Parliament, with the Ministers and the President accountable to it. However, the Parliament’s powers were limited because it was subject to the rulings of the Constitutional Court designed to guard the new democracies against dictatorial inclinations (Szoboszlay, 1996).

With respect to the electoral system, in Hungary system chosen was a mixed majoritarian-PR electoral system. The national representative body is unicameral and elected for four years by a single member system combined with the PR system based on territoriality, with PR at the national level. Because the rules of election are highly selective it eliminates much of the competition. For example, in order to establish lists, at least 750 citizens must back up the candidates on the petition list. In order to participate in the national representation, they have to have at least seven of such lists from different territories (i.e. 750 x 7 = 5,250 people minimum in total). As a consequence, in the 1990 election, only twelve parties were eligible to compete in the national election and only six parties reached the required 5 percent threshold to gain seats. Compensation seats are given to less represented parties to gain more proportionality in representation. This system worked in the 1994 election, where fifteen
parties were eligible to run, but only the same 6 gained sufficient votes to earn a seat. The initial threshold for representation was set at 4 percent, but was raised in 1993 to 5, in order to limit the number of parties who could enter the national legislative body and thus limit the competitors for power. The higher the threshold is set, the less representative is the system (Szoboszlai, 1996).

The Hungarian mixed system is disproportional because of the majoritarian nature of the single member district system, which represent 45.6 percent of all seats, and by the disproportional territorial lists. Even tough the majority of the seats are assigned according to the PR system, the list requirement to run in the elections and the threshold makes it harder for small parties to be represented in the territorial lists. For example, in 1990, the leading conservative party (HDF) obtained 42.5 percent seats even though it won only 23.7 percent seats. Szoboszlai states that if the system were fully proportional in its representation, the three party coalition would have obtained 43 instead of the 52.8 percent seats it actually received. At the same time, the PR seats that are given to less represented parties compensate for the lack of proportionality.

The benefits of a mixed-PR system is that it makes coalitions easier to form and hold together and increases the degree of governability, but it decreases the degree to which it can represent a wider number of interests by excluding smaller parties. In 1990, 15 percent of voters remained unrepresented, and this number fell to 12.6 in the 1994 election. Given that the public has been discouraged to participate in it for decades now, the perception can affect public support for the democratic system that has been established. Loss of public support could hinder the government’s ability to introduce
new, needed reforms and in that way sabotage the consolidation of democracy and the success of reforms such as those in the health care sector.

3.5: Government Effectiveness

Government effectiveness is greatly affected by public support, which grants it legitimacy. However, in the case of Hungary there are other factors that have affected the effectiveness of the government at bringing health care reforms. Among these are corruption, and unresolved socio-economic needs of the citizens who oppose the possibility of the government taking social safety nets away from them.

The government in Hungary has been able to achieve a comparatively successful dual transition. In particular, it has been effective at recovering from the economic downturn that occurred at the beginning of the transition. It has also successfully and effectively implemented structural adjustments, including macroeconomic reforms as well as the privatization of large state enterprises. As mentioned earlier, part of this success is credited to the Hungary’s tradition of reforms through the last thirty years, which made the final complete transition to the market economy smoother.

At the same time, however, the government has been less effective at improving the health care sector. It is true that its health care sector is in a much better position than those of some other countries such as Croatia, Russia or Romania. But in comparison to other sectors of the economy, it has lagged behind. One of the reasons is that there was lack of public support in promoting health care reforms. Hungary has been historically a paternalistic state, where the welfare guarantees were provided by
the state. Removing such provisions in the face of economic crisis has not been a popular idea. Though the government has not lost legitimacy in terms of performance satisfaction, the sole fact that the country has transitioned into market economy has introduced some inherent shocks (unemployment, inflation) through the elimination of the old system's inefficiencies (over-employment, wage controls, etc.). Thus, even though the economy has performed relatively well overall, many have experienced a decline in the living standards compared to the communist era.

In addition to health care reforms, there was a lack of support to create and support stronger legal institutions that would fight corrupt practices, as described in the section on institutional effectiveness. This is not because corruption is seen as a good thing, but because it compensates for certain inadequacies that the state has not been able to provide, such as higher wages for health care workers and more funding for the health care sector in general.

3.6: Market Experience

Hungary’s experience with the market economy, along with Yugoslavia, has been more extensive than that of other CEEC. The process of economic transformation in Hungary began in the 1960s. Kornai (1996) describes these initial changes as the beginning of a “Hungarian style gradualism” towards the market economy, similarly witnessed only in Slovenia. The Hungarian government married communist-style politics with a market-oriented mixed economy in an attempt to keep political calm after the suppression of the anti-communist uprising in 1956. In that year, an armed rebellion broke out against the prevailing political order. The result was Soviet military
occupation, the only incident of this kind in the history of the socialist world, in addition to the 1968 case of Czechoslovakia (Kornai, 1996). In the few days that “freedom” lasted, a multi-party government was formed, but a few weeks later the revolution was crushed by the Soviet troops. Janos Kadar was imposed as the new leader in Hungary.

During the Kadar period, the New Economy Movement (NEM) was introduced on January 1, 1968, which officially started the government policy of consumerism by increasing the consumption power of the citizens. Fears that the trend of Polish workers toppling the Communist Party would become contagious, and with the past attempts in mind, the Hungarian government focused on achieving higher living standards (Brown, 1988). The priority of this program was to preserve economic wellbeing, security and political calm. This often required acquiring loans from international organizations in order to finance the program. At the same time, because the NEM allowed some private property and foreign travel, the communist regime took the form of a more moderate “soft dictatorship”. The NEM involved the abolition of many of the former central planning indicators and the shift of many management responsibilities from the central government to the enterprises. In the price system, 50 percent of all prices were determined by the market forces and a semi-free market guided the industrial sector (Brown, 1988). A few years after the system was in place, the Soviets introduced a series of policies that started reversing the initial intentions of the NEM. They believed that Kadar was too liberal. One of the policies introduced that went directly against the NEM was an across the board increase in blue-collar workers wages. Economically it would have a detrimental effect to the market based policies, but it was politically popular, so that it provided a setback to the reform
movement (Brown, 1988). This set back increased the level of the informal economy and encouraged a system of bribing public officials in order to be able to continue with private economic activities.

The consumerist years between 1966 and 1975 proved to be the golden age of economic policy. Reforms became an ongoing feature of public life (Brown, 1996). Household consumption was high and rising through years, without economic recessions or stagnations. From Table 4.6 it is obvious that the Hungarian economy was growing steadily until the late 1970s, when the first ailments of this system started to be felt both in terms of GDP growth as well as consumption growth. The growth of production started falling and reached near stagnation conditions (Kornai, 1996).

Table 4.6: Selected economic indicators for Hungary, 1961-1989.

<table>
<thead>
<tr>
<th>Period</th>
<th>GDP growth</th>
<th>Final consumption (% of GDP)</th>
<th>Final Consumption growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961-1965</td>
<td>7.71</td>
<td>75.21$^1$</td>
<td>3.7</td>
</tr>
<tr>
<td>1966-1971</td>
<td>5.17</td>
<td>69.80</td>
<td>5.5$^2$</td>
</tr>
<tr>
<td>1972-1977</td>
<td>6.18</td>
<td>67.74</td>
<td>3.83</td>
</tr>
<tr>
<td>1978-1983</td>
<td>2.21</td>
<td>70.36</td>
<td>2.25</td>
</tr>
<tr>
<td>1984-1989</td>
<td>1.44</td>
<td>72.40</td>
<td>1.33</td>
</tr>
</tbody>
</table>

1. The data is for 1965 only.
2. The data is for 1971 only.


In 1978 when the slowdown in the economy started to be felt, another wave of reforms introduced more structural changes towards the market economy than any other prior reform. Some large state monopolies in the industrial sector were divided into smaller units in order to encourage competition. This made the enterprises less
dependent on the central government. Also, the “second economy” now became legalized. Private agricultural plots were distributed again. The following year small purely private firms that engaged in purely economic activity were allowed to operate, in addition to cooperatives of workers and professionals, though their membership was mostly limited to the Budapest geographical area. The cooperatives never employed more than 140,000 people total. During this period the underground economy continued to flourish in light of the economic setbacks of the 1980s.

Hungary has had an extensive experience with the market economy when compared to other CEEC. In addition to the states of the former Yugoslavia that broke off from the Soviet style communism in the late 1940s, it had one of the longest and most extensive experiences with a mixed economy, which set it apart and facilitated the transition to a full market economy by the 1990s. The public experience with private ownership and the repercussions of the market economy (both positive and negative) made the people more familiar and supportive of the new economic transition when it arrived.

3.7: International Funding

Hungary was among the first CEEC to become a member of the IMF and the World Bank in 1982. Once a member, it was able to enjoy the benefits of membership in the form of loans. Hungary had borrowed extensively during the communist period in order to finance its consumerist program. When the external debt reached high proportions and the macroeconomic reforms were long overdue, the IMF and the World Bank urged Hungary to introduce stabilization measures in the pre-transition period.
The World Bank has played the leading role in addressing broader health care strategies and policies, but its actions have not been sharply focused on the health care sector (Nelson, 2001). Part of the reason is the lack of a clear blueprint on what an effective and efficient health care sector should be. The financial assistance has come through Structural Adjustment Loans dedicated to the public sector in general. In 1993, the per capita funding received for the health care sector was 8.81 US Dollars, which is more than the combined average for other CEEC. However, these loans come in installments depending on the country performance. The Bank’s frustration with inefficient policies which prompted them to take out the portion of the loan dedicated to the health care sector in 1996. Thus, Hungary enjoyed some of the financial support from the World Bank but has not been able to retain it for very long because of its inability to show any progress in the use of these funds to improve the health care sector.

4: Conclusion

There are multiple factors contributing to the effectiveness of the health care sector in countries that have undergone the dual transformation of the kind that CEEC have. Hungary is an example of a country that had a large portion of the preparation for the dual transition in place well before the actual transition in 1990. That made the dual transition much smoother and achievable in a successful manner, which had implications for the health care sector.

First, Hungary had been reforming its economy gradually since 1968 by introducing partial market reforms such as partial price liberalization, the formation of
small business cooperatives, and the dismantling of large state owned enterprises in order to foster competition. This, and the focus on high living standards, has created a mixed economy which was institutionally more ready to accept the complete transition in the 1990s. Even though there was some economic slowdown and problems in stabilizing the economy, Hungary has had good economic performance in the post-transition period, despite the introduction of some less desirable market characteristics such as increasing inequality.

Positive economic experiences in the post-transition period has contributed to sustained public support for the new democratic government, even though Hungary’s communist period experience was more positive than that of most other CEEC. Still, the fact that political participation in the post-transition period was a partial continuation of the passivity of the communist period, indifference and lack of public involvement in the most crucial policy decision undermined public support for the health care sector reforms. The electoral system that gives more power to large parties has also not helped with increasing public participation and popular support for the government. However, regime legitimacy was never in question to the point where there was fear of reversal to some form of non-democratic regime, as was the case of Russia.

Continued corruption, especially in the health care sector, has undermined the belief of the people that the government will be able to get rid of corruption and improve the health care sector significantly. This is partially because of the failure of the government to address early on some key features of the sector, such as medical staff wages. Consequently, major reforms that would take the state out of the health care sector and compromise the principle of universal and free coverage have been opposed
by both the older generations as well as the medical sector employees who have strong lobbies in the Medical Fund.

Having received mixed reviews, the Hungarian government was not very effective at pushing through the most painful reforms in the health care sector yet. Some reforms were completed in the late 1980s and first few years of the transition, but they stalled and then picked up at a much slower pace in the late 1990s. There is still much work that needs to be done, but Hungary finds itself somewhere in the middle of the success ladder and it still needs some steps to climb to be among the top performers in the health care sector performance.
CHAPTER V
RESEARCH DESIGN

This chapter presents the tests of the hypotheses developed in the previous chapters using data from a sample of all twenty-six countries of the Central and Eastern Europe. The unit of analysis is country-year. The criteria for selecting the countries is that prior to 1989 they were Leninist regimes in Eastern and Central Europe. Annual data on each country was collected for the time period between 1980 until 2003. The starting point was chosen in order to account for the difference in the state of health care before and after the transition. The time frame has been extended back to 1980 rather than some year close to the transition because in the mid to late 1980s some of the countries under question started market economic reforms, and these reforms may have had an impact on factors such as corruption and economic growth. Using 1980 allows us to estimate more accurately the pre-reform status quo on most of our variables. Thus, there should be 598 country-years in the sample. However, because of missing data, the sample size is smaller. The summary statistics are presented in Table 5.1.
Table 5.1: Summary statistics.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Observations</th>
<th>Mean</th>
<th>Std. Dev.</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy</td>
<td>414</td>
<td>70.33</td>
<td>2.42</td>
<td>60.98</td>
<td>76.49</td>
</tr>
<tr>
<td>Cancer SDR</td>
<td>414</td>
<td>182.97</td>
<td>38.91</td>
<td>85.86</td>
<td>277.98</td>
</tr>
<tr>
<td>Infant mortality</td>
<td>414</td>
<td>25.72</td>
<td>23.03</td>
<td>3.9</td>
<td>110.49</td>
</tr>
<tr>
<td>Corruption</td>
<td>414</td>
<td>4.64</td>
<td>4.32</td>
<td>0.02</td>
<td>34.88</td>
</tr>
<tr>
<td>Corruption (CPI index)</td>
<td>101</td>
<td>3.65</td>
<td>1.20</td>
<td>1.3</td>
<td>6</td>
</tr>
<tr>
<td>Institutional effectiveness (Governance)</td>
<td>142</td>
<td>-0.15</td>
<td>0.62</td>
<td>-1.06</td>
<td>1.1</td>
</tr>
<tr>
<td>World Bank funds</td>
<td>414</td>
<td>.23</td>
<td>1.05</td>
<td>0</td>
<td>8.84</td>
</tr>
<tr>
<td>Public support current regime (political)</td>
<td>136</td>
<td>1.21</td>
<td>18.652</td>
<td>-43.62</td>
<td>33.25</td>
</tr>
<tr>
<td>Public support current regime (economic)</td>
<td>136</td>
<td>-18.59</td>
<td>22.58</td>
<td>-59.8</td>
<td>23.87</td>
</tr>
<tr>
<td>Public support (past regime)</td>
<td>152</td>
<td>2.05</td>
<td>18.27</td>
<td>-36.95</td>
<td>39.21</td>
</tr>
<tr>
<td>Institutional Effectiveness</td>
<td>134</td>
<td>-0.12</td>
<td>0.59</td>
<td>-1.2</td>
<td>1.06</td>
</tr>
<tr>
<td>Market economy strength</td>
<td>119</td>
<td>61.94</td>
<td>15.69</td>
<td>2</td>
<td>78.2</td>
</tr>
<tr>
<td>Market economy strength (2)</td>
<td>414</td>
<td>2.17</td>
<td>0.91</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Economic performance (CPI)</td>
<td>414</td>
<td>48.98</td>
<td>43.28</td>
<td>0</td>
<td>294.9</td>
</tr>
<tr>
<td>Political performance</td>
<td>414</td>
<td>4.30</td>
<td>1.99</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Senior population</td>
<td>414</td>
<td>10.71</td>
<td>3.09</td>
<td>3.78</td>
<td>16.41</td>
</tr>
<tr>
<td>Electoral system proportionality</td>
<td>414</td>
<td>52.75</td>
<td>43.08</td>
<td>0.1</td>
<td>100</td>
</tr>
<tr>
<td>Civil War</td>
<td>414</td>
<td>0.028</td>
<td>0.16</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
1: Dependent Variables

The dependent variable is health care system effectiveness, which is the performance of the health care service in offsetting the negative effects of illnesses (Davis 2001). Here, the concept is measured in with three different variables: life expectancy at birth, infant mortality rates, and cancer mortality. Other measures commonly used in other studies include birth weight, perinatal weight, invalidity rate, and others. Using exclusively any one of the measures may be more straightforward, but it may also overlook the effect of certain case specific factors. For example, birth weight has been used to measure health care effectiveness in developing countries where malnutrition is an issue. The measure correctly captures the health care given to the mother and the newborn, but it also captures some effects such as the level of economic development and cultural influences, which are not necessarily of relevance in CEEC.

Each of the three distinct variables (infant mortality, total life expectancy at birth, and mortality due to malignant disease) measures some aspect of the health care system. Infant mortality is the number of infants per thousand that die in the first year after birth. Infant mortality is taken from the United States Census Bureau. Infant mortality captures health care effectiveness in caring for newborns in their first year of life. By itself, this may not be a good measure of health care sector effectiveness since basic care was well developed within the socialized medicine of pre-transition CEEC.

47 He expresses this relationship by the function $H = f(T, M)$, where the production of health ($H$) is a function of disease ($T$) and medical system success ($M$). Thus, the relationship between $H$ and $T$ is negative, while that between $H$ and $M$ is positive.
Total life expectancy at birth is the average age that both men and women are expected to reach, provided they did not die in the first year (infant mortality), or first 5 years (child mortality). Life expectancy at birth is available from the *World Development indicators*, the *World Health Organization Health For All* dataset (WHO HFA), and from the *United States Census Bureau*. The potential problems with this measure is that there are exogenous factors, such as nutrition and pollution that also affect life expectancy.

Mortality due to malignant disease is the proportion of total deaths per 100,000 that are a direct consequence of malignant growths. This measure is important because the CEEC’s health care sector had a relatively well developed system of basic preventive care. However, diagnostic care such as cancer screening was seen as expensive. Ultimately, cost cutting in this care led to higher costs because more invasive and costly interventions were needed to treat cancer that was not detected until it was in an advanced stage. Cancer mortality is measured as the Standard Death Rate (number of malignant neoplasm deaths per 100,000) and is taken from the WHO HFA database.

The reason I have chosen to keep the three measures separate rather than combining them into an index that it allows us the opportunity to distinguish the different features of a health care system’s effectiveness. For example, while infant mortality may be very low, cancer mortality and life expectancy may be high, in which case it would imply something about the health care sector’s weaknesses and strengths. The frequency distribution of the three health care effectiveness measures in the pre- and post-transition period is presented in Appendix A in Figures A.1 – A.6.
2: Independent Variables

2.1: Level of Health Care Corruption

One way in which health care corruption manifests itself is in the state budget. The misallocation of public funds in the government budget occurs when budget allocations for health care spending are not expended according to the stated plan but instead are diverted to some other purpose (Reinikka and Svensson 2003a). This becomes evident in lower spending at the facility level when the sum of all facility spending is less than the total budget for that item. Because the formally committed budgetary allocations are diverted to other purposes or appropriated by corrupt public officials, even funding dedicated to health care sector reform from international organizations such as the World Bank is likely to be misallocated and not to produce the expected outcomes in terms of the three performance measures.

Another form of corruption that has pervaded the health care sector is informal payments to medical staff. Informal payments are defined as payments (in cash or in kind) made to service providers (persons or institutions) by patients who are already entitled to the services. The services are already paid for from the national budget under the provisions of universal health care program (Central and Eastern European Health Network 2002).

The measurement of corruption at the government level represents a measurement challenge. In the private sector, corporations have to justify their actions on a regular basis to the shareholders. Government agencies, though responsible to the voters, are not as transparent. This is partially due to the large size and complexity of the government and its programs. The situation is even more extreme in CEEC
where the democratic system has not consolidated and does not provide a clear and transparent process of oversight of the policy making and governance processes. In this study I adopt a proxy measure for health care sector corruption by measuring the level of the underground activity. I explain this later after outlining other commonly used measures and their drawbacks or reasons for not using them in this study.

One of the most widely adopted measures of government level corruption in the health care as well as education system is the Public Expenditure Tracking Surveys (PETS). The PETS are used to track the leakage of funds from the budget allocation point to the outputs; that is, they measure the share of budgeted funds that actually reach their target goals. The problem is that the number of surveys done in this way is limited, both with respect to the number of countries where they have been implemented and the number of years.

Another measure that has been widely used to measure corruption is the Transparency International Corruption Perception Index (CPI). The purpose of CPI is to provide data on the perception of corruption within countries. The data have been collected annually since 1994 and by 2002 encompassed 102 countries. The score a country receives for each year ranges from 1 (worst) to 10 (best). The issue with the CPI measure concerns its content validity. It is a multiple scores composite index that uses nine sources of data, among which are those that tap into the private sector. The result is a measure that includes some phenomenon that are not related to health care corruption and that therefore may bias the findings.

Finally, the World Bank Governance Indicators are also measures that could be used to measure government level health care corruption. They measure aspects of
the quality of governance, including the severity of corruption, the extent of civil liberties, bureaucratic efficiency, the rule of law, and the predictability of policymaking. These data are available only from 1996 and the data are biennial.

While government level corruption is difficult to observe directly due to the lack of transparency and accountability of fund allocation, individual level corruption is difficult to account for due to the fact that it is illegitimate activity. This leads those involved in it to conceal it. One measure of individual level corruption is from Living Standard Measurement Surveys (LSMS). They are household surveys implemented by the World Bank that measure household expenditures. The surveys are constructed to capture formal, in-kind, and informal earnings. The drawback in these surveys is that the data on household surveys only encompass ten out of twenty-six countries of Central and Eastern Europe, and are not comparable across countries. Country Specific Surveys have been implemented by different research groups and range from 1993 (Kyrgyz Republic) until 1999 (Georgia, Armenia, Moldova, Poland, Slovak Republic, Tajikistan, Ukraine). Even though all of these surveys were designed to measure specifically micro level corruption, they vary widely in their design and the type of informal payments they capture.

Because of the drawbacks and inappropriateness of the measures mentioned above. In this study, corruption is measured by using multiple variables, including some of the ones mentioned above. The first measure, and the one most widely available, is the extent of the shadow economy as percentage of GDP. This measure is used for several reasons: first, as a number of authors (Kornai, 2000; Lewis, 2000) have noted, hidden payments were not considered illegal since there were no provisions for
punishment of such behavior under the old regime. In some cases such behavior borders on legality and falls into the grey (shadow) area, given that it is not always easy to distinguish gifts from bribes. In many of the CEECs the line between gift giving and bribe is a fine one that varies across cultures. Furthermore, since it is considered bordering on legality, any change in it will also reflect the general impact that institutions or the rule of law have on such practices. Thus, while this measure is not a direct measure of corruption in the health care sector, it offers an approximation. Even thought this method measures the level of unofficial economic activity (shadow economy), rather than the direct amount of bribes given in the health care sector, it is still a useful proxy that will allow me to study a larger number of countries for a more extensive time period.

The size of the unofficial economy is measured by using the electricity utilization rates. Electricity consumption offers a rough measure of the overall economic activity, while the GDP measures the official economic activity. Because the two measures are in different forms (Kilowatt-hours vs. US Dollars), I compare them in terms of their percentage change. Then, the measure is constructed by subtracting the percentage change in electricity consumption (total economic activity) from the percentage change in GDP growth (official economic activity). The difference between the two is an estimate of unofficial economic activity. The reasoning behind this is the expectation that a change in GDP growth should be reflected in a proportionate change in electricity consumption rate. Where this is not the case, the difference is used as a proxy for the size of the unofficial economy. The resulting values may be positive or negative, but what matters is the distance from the value of 0 (which indicates no corruption). In
order to facilitate interpretation, the numbers are then transformed to positive values and the resulting variable will vary from values of 0 (no corruption) to potentially 100 (perfect corruption). Economists such as in Johnson, Kaufmann, and Schleifer (1997) have used this method of estimating the unofficial economy. They argue that the unit electricity-to-GDP elasticity assumption may lead to a small underestimation of total economic activity in some energy efficient countries such as CEEC. However, the difference is not significant.\textsuperscript{48} The data on GDP growth are from the World Development Indicators and the United Nations Statistics Office, while the electricity consumption data are from the National Electricity Information Agency. The variable is measured in the following manner: the percentage change of electricity consumption is subtracted from the percentage change in GDP growth, and the final number is used to measure the level of corruption. The representation of the frequency distribution of pre- and post-transition corruption is illustrated in Figure 7 and Figure 8 in Appendix A.

In addition to these measures that allows us to test the hypotheses for the entire time period, I use other supplemental measures that are more specific. I use the World Bank Governance Indicators, more specifically the Control of Corruption indicator, where a country can range between -2.5 (worst) to 2.5 (best) score. Since the data are biennial, the same score is assigned to the year following the year for which the score exists. I also use the Corruption Perception Index to complement my primary measure. The score a country receives for each year ranges from 1 (worst) to 10 (best).

\textsuperscript{48} CEEC are considered to be energy efficient countries because there energy price adjustments started earlier and have been more significant.
2.2: Market Experience/Personal Freedoms

The extent of a nation’s market economy experience is measured in terms of the percentage of the total labor force employed in the private sector. The data comes from the International Labour Organization LABORSTA Labour Statistics Database (1985-2004). Since the data provided are in absolute numbers (number of people employed in the private sector), I divided these numbers by the total employment to express the variable as percentages. Some countries have separate values for men and women employed in the private sector, and these were added together to obtain the total number of people employed.

2.3: Communist Regime Performance

The economic and political performance of the previous communist regime affects public support for new democratic regimes. This is important because the worse the former regime’s performance, the stronger the support for democracy will be, even in light of economic or political crises the new government may face. In order to measure performance of the communist regime, I use multiple measures. For economic performance, I use standard macroeconomic indicators of inflation measured by the Consumer Price Index. The data are taken from the World Development Indicators and the United States Development Agency databank Unemployment is not used because it does not reflect economic performance since unemployment rates were kept artificially low (through over-employment) during the communist period. Thus, the standard assumptions of free market economics about the meaning of unemployment rates are not applicable. For political performance, I use Freedom House data.
Although these data have a built-in bias toward democratic regimes, they are more complete than any other comparable NEB surveys. The values range from 1 (best) to 7 (worst) in increments of 0.5 point, and they measure both political freedoms and civil liberties. In order to get one score for each country, the two values have been averaged.

2.4: Post-Transition Regime Performance

Country performance in the post-transition period is measured by looking both at its economic and political performance. Economic performance is measured in terms of macroeconomic indicators. The reason for selecting macroeconomic indicators versus some indicators of individual experience is the notion that people evaluate the government in a sociotropic manner, i.e., by blaming the government for the general economic situation in the country. Two indicators of economic performance are used: GDP growth, and inflation (Consumer Price Index with baseline year 2000). The data are taken from the World Development Indicators and the United States Development Agency databank. Give this study’s theoretical argument that country performance influences World Bank loans, I will use a variable that measures the degree of economic liberalization in addition to standard macroeconomic indicators. The economic liberalization score is collected by the Heritage Foundation. I will use it to test the hypothesis that more economically liberal countries should experience more health care success.

Political performance is evaluated in terms of political and individual and political freedoms in a country. When people perceive that their personal and political freedoms
are being honored and protected, they see the performance of the democratic government as more successful. Thus, Freedom House scores are used to measure the post-transition political performance of the regime.

2.5: Institutional Effectiveness

The ability of a government to fight corruption and instill public trust in government institutions is affected by the institutionalization of the rule of law. Thus, institutional effectiveness is measured as the existence and effective implementation of rules by the government. This measure comes from the World Bank Governance Indicators. More specifically, the Rule of Law measure includes several indicators which measure the extent to which people have confidence in and abide by the rules of society. These include perceptions of the incidence of crime, the effectiveness and predictability of the judiciary, and the enforceability of contracts. The values range from -2.5 to 2.5 with higher scores corresponding to better outcomes. Since the data are biennial from 1996 to 2004, the same score is given for year following as the one for which a score is available.

2.6: Senior Population

The size of the senior population can have a significant impact on the support the government receives to undertake needed market reforms in the health care sector. The senior population is measured as the percentage of the total population who are 65 and older. I use the standard retirement age for two reasons: first, it is people who retire that become the most dependant on welfare services, including health care, and they
are least willing to give it up. Second, although many CEEC encouraged early retirement after the transition in order to eliminate structural unemployment, it is safer to err on the side of underestimating their size by including only those over 65 (even tough actual early retirement can take place before. If findings support the theoretical grounds laid out, the implications will be that much stronger. The data come from the World Bank’s World Development Indicators.

2.7: Institutional Design

The hypotheses in this study assert that the proportional representation is more supportive of reform than the majoritarian or the pluralist election system. In order to compare the effects of the two systems, Lijphart’s (1994) measure of the degree of proportionality is adopted. The degrees of proportionality measure represents a uniform and simple way of measuring the proportionality of an electoral system by calculating the difference between the percentage of votes won by the two major parties in a parliamentary election and the percentage of seats won by the same parties. The values are measured in absolute terms, as the point of reference of absolute proportionality is the value of zero. Mackie and Rose (1991), the Popescu and Hannavy (2002) database of elections in Eastern Europe (2002) as well as Nordsieck (2005) have been used as sources for the election results data, as there is no one database that contains the data on all of the countries and years in the analysis.
2.8: Public Support

The degree of satisfaction with regime performance affects the public support for
the current regime. The level of support a regime enjoys affects its ability to create a
more efficient health care sector. If people are satisfied with government performance,
they will be more likely to support even those changes that are not necessarily popular.
Even though reforms such as those in the health care sector may be painful, people
believe they are in their best interest if they trust the regime based upon the regime’s
good performance history.

In this paper public support is measured using different variables. Two
measures of public support for economic and political regime performance are used and
they come from the New Europe Barometer (NEB) surveys, where participants are
asked to rate the current economic and political system performance, with values
ranging from -100 (worst) to 100 (best) for each measure. Those who view the
performance of the regime more favorably are also more likely to be the winners in the
system and are more likely to support the same system (Norris, 1999). Thus,
satisfaction of the regime has been used as a measure of public support in other
research (Anderson and Guillory 1997, Norris 1999). The two measures are kept
separate so that one measures public attitudes toward political performance and the
other towards economic performance of the current regime. Since all the data from the
NEB surveys, the answers of all the respondents for each year had to be averaged.
The missing data or non-responses were not taken into consideration for aggregation
purposes, since we are only interested the average level of public support. The
individual level data have been aggregated by adding them and using their mean as the
country score for every year. This method has been already used by Muller and Seligson (1994). The data comes from the NEB surveys and cover the time period from 1992 to 2001. For a more detailed description of the questions asked and the explanation of ratings see Appendix B.

2.9: World Bank Health Care Sector Funding

Prior studies show that World Bank funding of health care sector reforms in some CEEC has had a positive impact on health care sector effectiveness. More specifically, it has been shown to have a significant effect in countries that have also performed well in macroeconomic terms. Since the World Bank has been the only international agency to give significant and measurable support to transitioning countries of CEE, it is appropriate to measure the dollar amount per capita disbursed to each country by the World Bank. The amount of assistance measures the amount of World Bank assistance given to the country. It is a U.S. dollar per capita measure. Since the assistance data is usually given in a package with resources intended for other sectors, the exact amount for health care was calculated by multiplying it by the total dollar amount of the loan by the percentage of the loan allocated to the health care sector. Then, in order to account for the population size, the real dollar amount is divided by the population size. The data has been collected from the International Development Agency (part of the World Bank) web site.
3: Method

The method of analysis used here is OLS regression. Since I have time series cross sectional data I had to concern myself with issues of both time series data, such as serial correlation, and those of panel data, such as heteroskedasticity. I chose to use a linear autoregressive distributed lags (ADL) model, with the panel corrected standard errors linear regression model, in order to deal with panel heteroskedasticity. An extensive debate exists in the literature about which model to use and what kind of restrictions to place on the parameters, given the nature of TSCS and panel data (see Garrett and Mitchell 2001, Kittel and Winner 2001, Beck and Katz, 2004, Plümper, Troeger, and Manow, 2004, DeBoef and Keele, 2005). Most recently, authors have agreed this to be an appropriate way to deal with the possibility that observations with higher values also may have a higher error variance. Using a panel corrected standard error model corrects this violation of the OLS standard assumption for panel data (Beck and Katz, 2004; Plümper, Troeger, and Manow, 2004).

For this analysis, the data are pooled and this offers two main advantages: it increases the number of observations and the degrees of freedom, which makes it possible to estimate efficient specified models (Plümper, Troeger, and Manow, 2004). The second advantage is that it makes it possible to generalize the results across countries. In order to eliminate serial correlation of errors, I add to the model a lagged dependent variable as suggested by Beck and Katz (2004).

Following these theoretical arguments, at least one of the independent variables included has level effects so that, for example, a change in the senior population from 8-9% in one country has a different effect on the health care sector effectiveness than a
change from 13-15% in a different country. Thus, I do not impose country and time dummies usually associated with control of unit fixed effects. In fact, when there is at least one variable believed to have level effects, and the country and time dummy variables are included, it can lead to an omitted variable bias because the level effects are suppressed (Plümper, Troeger, and Manow, 2004).

Finally, the theoretical framework describing what variables influence health care sector effectiveness imply that there are lasting effects of some of the independent variables that go beyond the time period \( t \) under study and that these effects may be spread over future time periods \( t+1, t+2, \ldots \). One example of such a variable is institutional effectiveness. In the theory, the effects of institutions are such that effective institutions that uphold the rule of the law lower corruption and build popular trust and support for these institutions. The effect is likely to persist over future time periods since the longer the institutions are present, the more trust is built up people over time. Thus, these theoretical implications require that dynamic effects be specified in the model so that they can be accounted for and interpreted. Following suggestions by DeBoef and Keele (2005), dynamic effects of independent variables are easily specified in the ADLs. A general ADL model is presented in equation 1.

\[
Y_{t+1} = \alpha_0 + \alpha_1 Y_{t-1} + \beta_0 X_{t-1} + \beta_1 X_{t-1} + \epsilon_{t+1} \tag{1}
\]

In this time-series model, there may be two effects that an independent variable can have on the dependent variable. First, it can have a short term effect which may occur at any lag, but its effects do not persist over future time periods. The effect of high popular support can influence government decisions today, but not tomorrow. In the general model this effect is given by \( X_t \) on \( Y_t \) and it has no memory. The same variable
may also have a long term effect on the dependent variable. That is, changes in $X_{t-1}$ affects $Y_t$ and that effect is distributed over several future time periods (DeBoef and Keele, 2005). There are four exogenous variables that are hypothesized to have a long term effect on health care sector effectiveness. They are: institutional effectiveness, economic performance of the regime, political performance of the regime, and World Bank funding.
CHAPTER VI

ANALYSIS

The results from the regression analysis have yielded interesting results. In this analysis, health care sector effectiveness is measured using three variables in order to account for multiple dimensions of the health care sector: infant mortality, life expectancy, and cancer mortality. The models presented in this chapter are organized by dependent variables. In addition to the short run effects presented by the autoregressive distributed lags (ADL) models, I also present the long run multipliers. These multipliers represent the total, cumulative effect that the selected independent variables have on the dependent variables, over future time periods. The average number of time periods (years) over which an effect takes place is calculated from the estimates of the ADL models. Finally, I present the average number of future years that the effects of the independent variables have on the three dependent variables.

1: Dependent Variable: Infant Mortality

The first model in Table 6.1 uses infant mortality as a dependent variable. An increase in infant mortality indicates the inability of the health care sector to effectively deal with the consequences of the decline in the general quality of life. As hypothesized, short run increases in corruption lead to statistically significant increases in the rate of infant mortality. The independent impact of corruption on infant mortality by itself does not tell us much because the short run impact of corruption on infant mortality also depends upon the degree of institutional effectiveness. That is because the presence of effective institutions alters the effect corruption has on infant mortality.
When the interaction between institutional effectiveness and corruption is taken into account, the impact of corruption on infant mortality is still present. A one percentage point increase in corruption increases infant mortality by $(0.1076 + 0.1736 \times -0.472 \text{ (institutions mean) } ) = 0.0257$ deaths per 1,000 when the effect of institutional effectiveness is included, as hypothesized. However, when institutions are the least effective (minimum value = -1.41), corruption decreases infant mortality by $(0.1076 + 0.1736 \times -1.41=) -0.1372$ infant deaths per 1,000. On the other hand, when the institutions present are the most effective (maximum value = 1.06), the short run effect of corruption is positive (increase in infant mortality by 0.2916 deaths per 1,000). This last result is counter to the ones hypothesized.

These results can be interpreted in the following manner. Where the institutional effectiveness is very low corruption serves as a temporary vehicle to circumvent the inefficient health care system to get timely care. As long as there is no impediment to corrupt practices, the ability to get care faster through bribes has a negative, although small impact on infant mortality in the short run. In other words, corruption ameliorates the negative consequences of an inefficient system. However, once effective institutions are implemented (starting at their average value), the immediate effect on infant mortality is positive (0.0257) because the ability of patients to get preferred treatment by the doctors is taken away. Strict rules have an immediate effect on the patients’ ability to get better care faster by slowing down the process, increasing the waiting lines and lowering the quality of care. Furthermore, the physicians and medical staff may not have a (monetary) incentive to perform as well or provide timely care, which can jeopardize the infant health and chances of survival.
Considering that in many countries in the sample corruption rose sharply in the post-transition years, this impact can be quite large. As an example, consider that in Macedonia corruption increased by 2.5 percentage points between 2002 and 2003. This has repercussions for infant mortality since a one percentage point increase in corruption (given average institutional effectiveness) would increase infant mortality in Macedonia by \((2.5 \times 0.0257 =)\) 0.062 deaths per 1,000 over two years. The impact of corruption on infant mortality is even more telling when one considers the fact that corruption has risen dramatically in the years after the transition. This rise was due to the liberalization of the economy and the resulting fall in living standards among other things. Additionally, infant mortality had fallen dramatically during the four decades prior to the transition, mainly because of the improvements in health care treatments and immunization campaigns sponsored by the World Health Organization and the UNICEF. Thus, initiating policy measures to curb corruption in the health care sector of Central and Eastern European countries promises to yield significant results from in the form of lower infant mortality. The independent effect of corruption, and its joint effect with institutions on infant mortality are illustrated in the Figure 6.3(a-c). Figure 6.3(a) in this set shows that the relationship between corruption and infant mortality is upward sloping, while that of institutional effectiveness and infant mortality is downward sloping (Figure 6.3(b)). However, when the interaction between corruption and institutions is accounted for, there is an overall declining trend in infant mortality, as represented in Figure 6.3(c).

Institutions and corruption have a significant impact on infant mortality in the short run. Independently, institutions have a significant short run effect on infant
mortality, and their impact continues to be significant when the interaction with corruption is considered. A one point increase in institutional effectiveness decreases infant mortality by \((6.762 - 9.4803 + 0.1736 \times 5.734 \text{ (corruption mean)} =) - 7.645\) deaths per 1,000.\(^{49}\) The negative effect of institutions on infant mortality indicates that when the effectiveness of institutions improves, while holding the corruption level at its average value, the impact of infant mortality is immediate and significant. On the other hand, if corruption were rampant (maximum value = 85.28), then the impact of institutions would be positive, i.e. increasing infant mortality by \((6.762 - 9.4803 + 0.1736 \times 85.28 =) 12.04\) deaths per 1,000. However, the impact of institutional effectiveness on infant mortality is actually much smaller since the average change in institutional effectiveness is 0.003.\(^{50}\) Thus, for an average change in institutional effectiveness, the negative effect on infant mortality (given the average level of corruption) would be \((-7.645 \times 0.003 =) - 0.023\) infant deaths per 1,000. These results support the hypothesis that the implementation of effective institutions has an immediate payoff towards decreasing infant mortality, although their effectiveness is limited in cases where corruption is very high.

In addition to the short run, immediate effects of the covariates, they also have significant long run effects on infant mortality. The significant long run effects (multipliers) for infant mortality are reported in Table 6.2. The \(k_1\) multiplier is calculated from the ADL model by dividing the sum of the lagged and non-lagged coefficient of a covariate and then dividing them by the lagged dependent coefficient that has been

\(^{49}\) Joint \(\chi^2\) test of all institutional variables was performed to determine its joint significance.

\(^{50}\) The size of the average change in institutional effectiveness is lowered by the fact that there are numerous years for which the change is zero (0). This is because the data on institutional effectiveness is collected biennially, so for the years in which no data is collected the previous year's values are assigned by the author.
subtracted from 1 or \((\beta_0 + \beta_1)/(1-\alpha_1)\). The calculation of the multiplier and its standard error is important in order to determine whether a long term effect of a variable is significant. The mean lag length is the average number of time units (years) over which the long run effect takes place. It is calculated in the following manner: first, divide the lagged coefficient by the sum of the lagged and non-lagged coefficient. Second, divide the value of the coefficient of the lagged dependent variable after subtracting it from 1 with its negative value. Finally the value from the second calculation is subtracted from that of the first and the result is the mean lag length: \((\beta_1)/(\beta_0 + \beta_1) - (-\alpha_1)/(1-\alpha_1)\).^{51}

In the long run, the interaction between institutions and corruption has a significant effect as well. Similar to the short run effect, institutions have a negative long run effect on infant mortality that is even stronger than their short run effect. The result indicates that over the long run a 1 point increase in effective institutions and their effect on corruption decreases infant mortality by a total of \((-7.645/1-0.8531=)\) -1.17 deaths per 1000 (Table 6.2). The effect lasts on the average for 9.54 years. Thus, effective institutions have a negative effect on infant mortality, and its effect is present immediately although it is larger over the long run.

The short run effect of World Bank funding is also significant. A one US dollar per capita increase in World Bank funding increases infant mortality by 0.3323 deaths per 1,000, contrary to the hypothesized effect. One possible reason for this is the nature of the measure, infant mortality. Funding that is given to countries to help improve the health care sector usually takes some time to reach the intended targets, and the ones who are most likely to feel its effects are the ones who live long enough to

^{51} The long term multiplier and mean lag length calculation are adopted from De Boef and Keele (2005). The \(k_1\) is calculated from the ADL model: \((\beta_0 + \beta_1)/(1-\alpha_1)\); the mean lag length calculation: \((\beta_1)/(\beta_0 + \beta_1) - (-\alpha_1)/(1-\alpha_1)\).
enjoy the benefits. Infants are not targets of the World Bank funding. Furthermore, World Bank’s health care loans sometimes come in a package with other structural adjustment loans that require the adoption of austerity measures. This means that at the same time that they are receiving funds, countries are having to cut down on government spending (including social services and other types of assistance for pregnant women or new mothers) which may affect infant health adversely. More specifically, rapid economic liberalization, according to many observers, forces loan recipient states to reduce or even stop making efforts to help the people through health care, education, food, and other services because structural adjustment conditions almost always require reductions in government spending for social programs (Chipeta 1993; Fields 2003; Handa and King 1997; Sowa 1993; Meyer 1998; World Bank 1992; Zack-Williams 2000). Thus, World Bank funding actually increases infant mortality in the short term.

Similarly, in the long run an increase in the per capita amount of World Bank funding has a significant effect on infant mortality. More specifically, the long run multiplier \(k_1\) of World Bank loans on infant mortality, which indicates the total effect that a one dollar increase per capita in World Bank funding has on the infant mortality over future time period, is 2.5 increase in infant deaths per 1,000. This full effect of World Bank loans on infant mortality takes an average of 5.9 years to be completely felt and full 55 percent of the total effect takes place in the first three years. One competing explanation for the opposite effect of World Bank funds is that the degree of corruption in a country undermines any potential positive effect of World Bank funding because of the misallocation of funds for other purposes. Another one is that, as explained earlier,
the austerity measures imposed by the World Bank and their negative repercussions on the welfare programs may actually outweigh the total positive effect the loans are designed to have.

In addition to the significant effect of corruption, institutions, and World Bank funding, economic performance also has a significant short run effect on infant mortality. A one percentage increase in the Consumer Price Index, decreases infant mortality by 
\[(0.0402 - 0.0557 =) \cdot 0.0155 \text{ deaths per 1,000.}\] This result is in the opposite direction of the one hypothesized. Economic performance also has a significant long run effect on infant mortality. In the long run the total effect of a one percent increase in the Consumer Price Index decreases infant mortality by 
\[(-0.0155 / 1 - 0.8531 =) \cdot 0.1055 \text{ deaths per 1,000.}\] This effect lasts an average of 9.4 years. One explanation for both the unexpected short and long run effects is that, a general increase in consumer prices may, x \(x\), also be an indication of the general rise in the standards of living, including higher wages.\(^{52}\) The explanation could be that the rise in prices has a long run effect that improves infant survival because higher prices (including wages) increase production and thus supply, which stimulates economic growth. Thus, this measure may not be capturing economic crisis as intended. Figure 1 at the end of the chapter illustrates the change in CPI over time, while Figure 2 illustrates the change in GDP growth over the same period. GDP growth is a measure of economic hardship, though I am unable to use it directly in this model.\(^{53}\) I use it here for illustrative purposes to show how CPI does not capture the same trends as GDP growth does. There is a significant

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\(^{52}\) The Consumer Price Index (CPI) program produces monthly data on changes in the prices paid by urban consumers for a representative basket of goods and services (US Department of Labor).

\(^{53}\) Although a valid and available measure of economic hardship, I could not use change in GDP because of its close correlation with the measure of corruption (which incorporates change in GDP).
drop in GDP growth for a few years at the beginning of transition. However, the CPI does not follow a similar pattern. In other words, there is a continuous and steady increase in CPI over time, which suggests that the measure is capturing other economic phenomena, and may not be adequate at measuring economic hardship.\textsuperscript{54}

Political performance has a short-term negative impact on infant mortality, as hypothesized. A one point increase in political performance decreases infant mortality by $(-0.5522 + 0.0447 =) - 0.5075$.\textsuperscript{55}

Public support based upon economic performance has a significant effect on infant mortality and a one percentage point increase in public economic support increases infant mortality by 0.0447 infants per 1,000. At the same time, public political support is not significant, but it is in the expected direction (negative). There is a reason for which an increase in public support based on economic performance reduces infant mortality. While good economic performance may increase support for the government in any given year, that increase in public support may not last long enough to empower the government to makes changes in the health care sector, if the good economic performance does not last the next year. So, if in the next year public support is low due to low economic performance of the regime, then there will be no chance for the government to initiate any health care sector improvements since its support by the public is not lasting.

\textsuperscript{54} I have also used the unemployment rate as an alternative measure to the CPI of economic hardship. The only significant short run and long run effect is when the dependent variable is life expectancy. In this case a rise in the unemployment rate increased infant mortality, as expected. The drawback of this measure is that its availability is limited in terms of countries and years.

\textsuperscript{55} A $\chi^2$ test was performed to determine whether $\beta_i$ and $\beta_{i-1}$ for political performance are jointly insignificant in ($H_0 = 0$).
The proportion of seniors in the population also has a significant effect on infant mortality. A one percentage point increase in the population of seniors increases infant mortality by 0.1835 per 1,000. Since the proportion of seniors in a population grows slowly (about 0.5 percent per year) the effect on infant mortality is not very large, although it is consistent because the growth of the senior population has been steadily increasing over the years included in the analysis. Seniors, as hypothesized, are less likely to be supportive of changes in the universal and free coverage of the health care sector inherited from the command economy period because that usually implies a greater out of pocket cost for them. Given that they have been contributing to the social services fund all of their life so that others can receive benefits, they now expect the same benefits. Additionally, those who are seniors in the new market economy are the ones who have spent most of their life under the socialist economy and were, most of the time, the least successful at adapting to the new system and gained the least benefits from economic liberalization. For that reason, they are even less likely to support a government that changes their social safety nets.

The other two variables, electoral proportionality and prior market experience do not yield significant short-term results in Model 1, although they are both in the expected direction. Greater prior experience with the market economy and a more proportional electoral system decrease infant mortality.

To summarize the results, corruption, institutions, World Bank loans, economic and political performance, public economic support and the proportion of the senior population all have significant short run effects on infant mortality. On the other hand, prior market experience, electoral proportionality and public support based on political
performance do not yield any significant short run result for Model 1. In the long run, economic performance, World Bank loans, and institutions all have significant effects on infant mortality.

2: Dependent Variable: Life Expectancy

Life expectancy is also considered one of the important measures of health care sector effectiveness. Where infant mortality captures the effectiveness of the health care sector at early stages in life, life expectancy accounts for the health care sector's adequacy at promoting the health and providing care to human throughout their entire life. Model 2 in Table 6.1 at the end of the chapter presents regression results with life expectancy as the dependent variable. Life expectancy is a less direct measure of health care sector effectiveness because there are other significant factors that affect it such as diet/nutrition, lifestyle choices (smoking and drug use), and environmental hazards.

The theory presented here predicts that corruption in the health care sector has detrimental effects on life expectancy. Table 6.1 reveals that. While the isolated effect of corruption on life expectancy is negative but insignificant, when the interaction effect of corruption and institutions is considered, it has a significant positive effect on life expectancy in the short run. A one percentage point increase in corruption, with an average level of institutional effectiveness, decreases life expectancy by \((-0.0316-0.06\times(-0.472)\) =) -0.00328 years in the short run. When the level of institutional effectiveness is held at its minimum value (minimum value= -1.41), corruption has a positive effect on life expectancy of \((-0.0316-0.06\times(-1.41)\) =) 0.053 years, and when it
is held at its maximum (maximum value = 1.06) the impact on life expectancy is
negative (decline in -0.0955 years in the short run). Similar to the effects on infant
mortality, when institutions are the most ineffective, corruption serves as a mean to
getting around the inefficiencies of the health care system to obtain better care. Once
effective institutions are implemented, they prevent the ability to gain access to timely
care through bribes, and there is a temporary negative effect on life expectancy. What
does that mean in actual terms? If corruption in Bosnia and Herzegovina increased by
64 percentage points between 1995 and 1996, then the increase in life expectancy for
that year would be approximately (0.053 x 64 =) 3.39 years, given the low institutional
effectiveness. That is quite a significant short run increase in average life expectancy
that can be attributed to the effect of corruption in the short run.

Institutions also have both a short and long run significant effect on life
expectancy. In the short run, a 1 point increase in institutional effectiveness increases
average life expectancy by ((-0.3035 + 1.1114) - 0.06 x 5.74 =) 0.4635 years for the first
two years. In the long run, institutions have an independent effect of increasing life
expectancy by 3.939 years for every 1 point increase in institutional effectiveness, but it
is its interactive effect with corruption that matters. Thus, the total effect of institutions
(with corruption) is an increase of (0.4635/1-0.7949 =) 2.26 years in average life
expectancy (see Table 3). This effect lasts for average of 5.25 years and 47 percent of
it takes place in the first four years. This effect is hypothesized in the long run where
effective institutions are expected to lower the effect of corruption over time keeps
having a negative effect on life expectancy.
Another significant short run effect on life expectancy comes from World Bank funding. Similar to the effect that it had on infant mortality, increases in World Bank funding have a negative short run effect on life expectancy. More specifically, for every dollar per capita increase in funding, life expectancy decreases by \((-0.0771 + 0.0489 =\) -0.0282 years. Again, one of the reasons for this counterintuitive effect is that the austerity measures imposed by the World Bank have initially very strong negative effects on the health care system. These effects are a consequence of the austerity driven cuts in government spending on social welfare benefits, or what have been called economic human rights, including the right to effective and reliable health care. These policies cause hardships, especially among the poorest citizens, who are most dependent upon social programs (Vreeland 2002). Thus, the results in Table 6.1 capture the stronger short run effect of the World Bank loans, which is negative.

Two more covariates have a significant short run effect on life expectancy: the percentage of the senior population and prior market experience. As hypothesized, a one percentage point increase in the senior population decreases life expectancy by 0.1867 years or 68 days. Given that the proportion of seniors for the countries in the sample increases by about 0.5 percentage points per year, the effect is a 34 days decrease in average life expectancy. The impact of the prior market experience is also in the expected direction where a one percentage point increase in the labor force employed in the private sector increases life expectancy by 0.0126 years or 4.6 days.

Economic performance and political performance, as well as degree of proportionality of the electoral system do not have a significant effect on life expectancy. Similarly, public support based upon political performance has a positive short run effect
on life expectancy but its significance level for a one tailed tests is limited ($p = 0.148$). Public support based upon economic performance was also not significant.

In addition to the short run effects, there are also covariates that have significant long run effects on life expectancy presented in Table 6.2. Political performance of the regime also has significant long run effects, and in the expected direction. A one point increase in political performance increases life expectancy by a total of 1.256 years. This effect lasts an average of 4 years and over half of the total effect is distributed in the first 3 years. Similarly, economic performance also has a long run effect on life expectancy, even though its effect is in the direction opposite from the one hypothesized. A one percent increase in the CPI index (an indication economic decline) increases life expectancy by 0.069 years. This effect is similar to the one this covariate has on infant mortality. The likely explanation for this counterintuitive result is that the rise in price of goods and services over a long time period may also be an indication of economic growth and higher living standards (because it also includes wages). Thus, this may not be an accurate measure for long run economic decline. If it were an accurate measure of economic hardship, it would follow sharp patterns of increase and then decrease during the years of the transition, which is not the case from what can be observed in Figure 1 at the end of this chapter. In fact, the progressive linear increase over time indicates that its movement increases over time.

In conclusion, the results in this model with average life expectancy as dependent variable, are supportive of the hypotheses. Corruption lowers life expectancy in the short run when effective institutions are implemented, while institutions help to increase it in the long run by cracking down on corruption. World
Bank funding is significant in the short run, although it reduces life expectancy, which is the opposite from what was hypothesized. World Bank funding effect is similar in the case of infant mortality (short run increase). Thus, it is likely that World Bank funding effect manifests itself over the long run, but is not captured by life expectancy because there are other competing factors that affect life expectancy (such as environment, unhealthy habits, etc.). Economic and political performance as well as public support, are not significant in the short run, but prior market experience and size of the senior population are. In the long run, however, both political and economic performance have a significant and positive effect on life expectancy.

3: Dependent Variable: Cancer Mortality

The last model uses cancer mortality as dependent variable. Cancer mortality measures an aspect of the health care sector, which the other two measures do not: since cancer mortality is higher when the detection is late, this measure is an indicator of the preventive and diagnostic services of the health care sector. It is also less affected by factors exogenous to the health care sector. This implies a measure of the system’s efficiency as well, given that preventive and diagnostic care is less costly and more effective than palliative care. Incorporated in this measure is also the capacity of the health care system to extend the survival of those diagnosed with cancer. Finally, as opposed to the other two measures where other factors such as diet can be of influence in life expectancy and infant mortality, this is less of case with cancer mortality.
Results for the short run effects are presented in Table 6.1 under Model 3. In the short run, the independent effect of corruption is that a one percentage point increase decreases cancer mortality by 1.0689 deaths per 100,000, but the interactive effect between corruption and institutions has a positive effect on cancer mortality. More specifically, one percentage point increase in corruption with the average level of institutional effectiveness increases cancer mortality by (-1.0689 - 2.3457 x (-0.472) =) 0.038 deaths per 100,000. When institutions are ineffective (minimum = -1.41) that effect increases even more, so that the effect is (-1.0689 – 2.3457 x (-1.41) =) 2.24 deaths per 100,000. However, if institutions are effective (maximum = 1.06) then the effect of corruption in the short run is dominated by strong institutions and it decreases cancer mortality by (-1.0689 – 2.3457 x (1.06) =) -3.56 deaths per 100,000. If there is a 2.5 percentage point increase in corruption such as that in Macedonia between 2002 and 2003, then cancer mortality would increase by (2.5 x 2.24 =) 5.6 deaths per 100,000 when institutional effectiveness is at its lowest. On the other hand, when institutional effectiveness is high, it would decrease cancer mortality by (2.5 x -3.56 =) -8.9 deaths per 100,000 in the short run. This is quite a large impact. That means that the effect of institutions and corruption has an immediate expected effect on cancer mortality.

Institutions also have a significant short run effect. A 1 point increase in institutional effectiveness, given the average level of corruption, decreases cancer mortality by ((-63.5942 – 2.3457 x 5.734 =) -77.05 deaths per 100,000, as hypothesized. In the long run, however, institutions do not have a significant effect.

56 The lagged coefficient of institutional effectiveness is not included in the short run effect calculation because its joint effect with the non-lagged coefficient is not significant.
World Bank funding has a significant negative short run effect on cancer mortality. This is the only model in which World Bank funding has an immediate effect on the dependent variable in the hypothesized direction. A one dollar per capita increase in World Bank funding decreases cancer mortality by \((-3.0314 - 7.694 =)\) - 10.7254 deaths per 100,000 in the short run. This covariate has the largest short run effect on the dependent variable in Model 3. Unlike the other two models in which the negative side effects of the loan outweigh the intended positive ones, in this model World Bank funding has the intended effect of lowering cancer mortality. However, its effect is not significant over the long run.

Political performance is also significant in the short run, where a one point increase in the score indicating a decrease in political performance increases cancer mortality by 1.148 cases per 100,000. Thus, the effect is in the hypothesized direction. The only other significant short run effect in this model is the degree of prior market experience. A one percentage point increase in the amount of the labor employed in the private sector decreases cancer mortality by 0.3411 cases per 100,000. This result is opposite from the one hypothesized, and I am not convinced to what this effect should be attributed.

In the long run, only economic performance has a significant and negative effect on cancer mortality, even though its effect was not significant in the short run (Table 6.2). In the long run, a percentage increase in the CPI decreases cancer mortality by 0.571 cases per 100,000. This effect lasts over 1.2 years. Similarly to the effect found in the previous two models, the long run effect is in the opposite direction because CPI may be a measure of economic growth in the long run. This is possible in the case of
Central and Eastern Europe where there was a rise in prices of goods and services simply because of the liberalization of the economy, and these prices never back down to the pre-transition period when the price levels were kept artificially low.

To summarize, in Model 3, five factors have a significant short run effect on cancer mortality: institutional effectiveness, corruption, World Bank loans, political performance, and prior market experience. In the long run, only economic performance has a significant and negative effect on cancer mortality.

4: Conclusion

In this chapter I analyzed the results of the regression analysis to determine whether I found support for the hypotheses that explain why some Central and East European countries have been more successful at creating a better health care sector while others left it in decay. I used three measures as proxies for health care sector effectiveness: infant mortality, life expectancy, and cancer mortality. First, infant mortality captures the effectiveness of the health care sector in pre-natal care, and infant care. Therefore, this measure captures both the care of the infant and the mother before birth (through motherhood counseling, testing for congenital diseases, etc), as well the care the infant receives in its first year of life with respect to immunizations and frequent check ups to monitor infant development in the first year when their immune systems are just developing. Second, the measure of life expectancy was used to assess the care a person receives through their lifetime, which is likely to increase their longevity. These can include yearly physical exams, which are usually the best tool to asses one’s general health, anti smoking, and anti drug campaigns directed towards the
general public. Finally, cancer mortality captures the effectiveness of preventive services, treatment effectiveness, and it is less susceptible to spurious effects.

The reason I kept them as three separate measures rather than combining them into a single index variable is because of the initially difficult choice to assess the degree to which each one of them would capture the different aspects of health care sector effectiveness. Even though I have a good argument as to why the three measures would be adequate prior to the analysis, analyzing them in models as individual measures allowed me to assess their adequacy as a health care sector effectiveness proxy.

The results from the analysis show that the effect of corruption has been gauged adequately all of the three measures of infant mortality, life expectancy, and cancer mortality. However, its effect with the influence of institutions seems to have different short term effects on the three dependent variables. First, corruption increases infant mortality and life expectancy in the short run when institutional effectiveness is low because it ameliorates the negative effects of the ineffective health care sector by giving access to timely care. However, if the institutions implemented are very effective, in the short run corruption increases infant mortality because of the initial bans on bribes and extortions that then prevent access to adequate care. In the long run, the effect of corruption and institutions improves life expectancy and lowers infant mortality, as hypothesized. On the other hand, their effect on cancer mortality seems to be immediate, while the long run effect is insignificant. Thus, the three measures gauge different effects of the exogenous variables.
World Bank funding has both a short and long run effect on the dependent variables. It has a significant short run effect in all three models, but in the long run its significance persists only in Model 1. The short run and long run effect is in the opposite direction from the one hypothesized because of the austerity measures imposed by the Bank that have an opposite and stronger effect in the short run than the loans themselves (due to economic hardship). Economic performance seems to be an adequate measure of short run economic hardship but its long run effect suggests that the measure may actually be measuring other phenomena.

Finally, the effect of the proportional of seniors, as well as prior market experience have expected significant short run effects, while degree of proportionality of a representative system does not.
Table 6.1: Regression results.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1 (Infant mortality)</th>
<th>Model 2 (Life expectancy)</th>
<th>Model 3 (Cancer mortality)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Mortality t-1</td>
<td>0.8531</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Life Expectancy t-1</td>
<td>-</td>
<td>0.7949</td>
<td>(0.0798)</td>
</tr>
<tr>
<td>Cancer Mortality t-1</td>
<td>-</td>
<td>-</td>
<td>0.6621</td>
</tr>
<tr>
<td>Correlation</td>
<td>0.1076</td>
<td>-0.0316</td>
<td>-1.0689</td>
</tr>
<tr>
<td>Corruption*Institutional Effectiveness</td>
<td>0.1736</td>
<td>-0.0600</td>
<td>-2.3457</td>
</tr>
<tr>
<td>World Bank Funding</td>
<td>0.3323</td>
<td>-0.0771</td>
<td>-3.0314</td>
</tr>
<tr>
<td>World Bank Funding t-1</td>
<td>0.0354</td>
<td>0.0489</td>
<td>-7.6940</td>
</tr>
<tr>
<td>Institutional Effectiveness t</td>
<td>6.7621</td>
<td>-0.3035</td>
<td>-33.1117</td>
</tr>
<tr>
<td>Institutional Effectiveness t-1</td>
<td>-9.4803</td>
<td>1.1114</td>
<td>63.5942</td>
</tr>
<tr>
<td>Economic Performance t</td>
<td>0.0402</td>
<td>0.0095</td>
<td>0.1430</td>
</tr>
<tr>
<td>Economic Performance t-1</td>
<td>-0.0557</td>
<td>0.0048</td>
<td>-0.0639</td>
</tr>
<tr>
<td>Political Performance t</td>
<td>0.1105</td>
<td>0.2245</td>
<td>-8.3960</td>
</tr>
<tr>
<td>Political Performance t-1</td>
<td>-0.5522</td>
<td>0.0332</td>
<td>9.5444</td>
</tr>
<tr>
<td>Public support (Economic)</td>
<td>0.0447</td>
<td>-0.0049</td>
<td>-0.1613</td>
</tr>
<tr>
<td>Public support (Politics)</td>
<td>-0.0174</td>
<td>0.0129</td>
<td>0.1440</td>
</tr>
<tr>
<td>Senior Population</td>
<td>0.1835</td>
<td>-0.1867</td>
<td>-0.5885</td>
</tr>
<tr>
<td>Electoral Proportionality</td>
<td>0.0015</td>
<td>-0.0042</td>
<td>0.0552</td>
</tr>
<tr>
<td>Prior Market Experience</td>
<td>-0.0008</td>
<td>0.0126</td>
<td>-0.3411</td>
</tr>
<tr>
<td>Constant</td>
<td>1.1484</td>
<td>14.8781</td>
<td>89.6147</td>
</tr>
<tr>
<td>Residual SE</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>66</td>
<td>66</td>
<td>66</td>
</tr>
</tbody>
</table>
Table 6.2: Long term multiplier values.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1 DV=infant mortality</th>
<th>Bewley</th>
<th>Model 2 DV=life expectancy</th>
<th>Bewley</th>
<th>Model 3 DV=cancer mortality</th>
<th>Bewley</th>
</tr>
</thead>
<tbody>
<tr>
<td>( k_1 \text{Corr X institutional} )</td>
<td>-1.17 (0.088)</td>
<td>0.162</td>
<td>0.395</td>
<td>-0.200 (0.042)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>( k_1 \text{institutional} )</td>
<td></td>
<td>3.939</td>
<td>2.525</td>
<td>2.525 (1.353)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>( k_1 \text{WB loans} )</td>
<td>2.5 (0.138)</td>
<td>0.195</td>
<td>0.399</td>
<td>-0.052 (0.061)</td>
<td>31.74 (2.897)</td>
<td>0.407</td>
</tr>
<tr>
<td>( k_1 \text{political perf.} )</td>
<td>-</td>
<td>-</td>
<td>1.256</td>
<td>-3.005 (0.835)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>( k_1 \text{economic perf.} )</td>
<td>-0.1055 (0.009)</td>
<td>-0.057 (0.004)</td>
<td>0.069</td>
<td>0.035 (0.004)</td>
<td>-0.583 (0.159)</td>
<td>-0.571 (0.159)</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>66</td>
<td>66</td>
<td>66</td>
<td>66</td>
<td>66</td>
<td>66</td>
</tr>
</tbody>
</table>


Figure 6.1: Consumer Price Index over time.

Figure 6.2: GDP growth over time.
Figure 6.3(a): Corruption and infant mortality over time.

Figure 6.3(b): Institutional effectiveness and infant mortality over time.
Figure 6.3(c): Corruption, institutional effectiveness and infant mortality over time.

Figure 6.4(a): Corruption, institutional effectiveness and life expectancy over time.
Figure 6.4(b): Institutional effectiveness and life expectancy over time.

Figure 6.4(c): Corruption, institutional effectiveness and life expectancy over time.
Figure 6.5(a): Corruption and cancer mortality over time.

Figure 6.5(b): Institutional effectiveness and cancer, mortality over time.
Figure 6.5(c): Corruption, institutional effectiveness and cancer mortality over time.
CHAPTER VII
CONCLUSION

Sixteen years after the beginning of the dual transition to democracy and to the market economy, some countries of Central and Eastern Europe still find themselves unable to improve their ineffective health care systems while others successfully improved theirs. In countries where the health care sector is ineffective and continues to decay, death rates from cancer and life expectancy indicators are deteriorating, and are above the average for the CEEC group (ex. Russian Federation and Moldova). Even though all of the countries started undergoing the dual transition at the same time in the early 1990s, some have advanced much further than others when it comes to the health care sector performance. In this paper, I addressed factors that have a significant impact on the health care sector outcomes in Central and Eastern Europe. Understanding the impact of these factors on public health care may provide insight into what factors the less successful CEEC should address in order to achieve a better health care sector. It may, therefore, have tangible public policy implications for these countries.

First, it is interesting to notice just by looking at a few examples such as Slovenia, the Czech Republic, Russian Federation and Croatia, that those countries with the best overall (both political and economic) performance during the transition process also have the most effective health care sector. Countries that have been able to get on with the initial reforms (Slovenia and the Czech Republic), and bring about macroeconomic stability, conduct a transparent privatization process and increase employment, were also able to secure public support for the new democratic
regime. Having secured a degree of public support and trust, their governments were able to get onto the more painful, but necessary reforms of the social welfare system inherited from the communist era. These countries also have the best performing health care sector in the region. Political performance (the protection of rights and liberties) of these countries in the post-transition period has secured the support of the people even further. On the other hand, countries in which the initial transition process was pervaded by political instability (Croatia's civil war) and corrupt privatization process (Russian Federation and Croatia) have had a faltering public support for the new political regime. They also have ineffective health care sectors and have been unable to address its inefficiencies adequately.

The presence of corruption in the health care sector, but also in society in general, also has significant multiple effects. This is supported by the empirical evidence. First, corruption in the health care sector has a direct negative effect on the welfare of patients because it imposes fees (bribes) for services that are supposed to be paid for. Those who cannot afford to pay the bribe are pushed to the end of the line and do not receive the same quality of care as those who pay the bribe. Additionally, the money collected through bribes is not reinvested into the health care sector directly to maintain or supplement the resources of the hospital. Rather, the money is paid out to the medical staff and is unaccounted for both in terms of reinvestment and as tax base. Bribes also undermine prospects for future reforms in the health care sector because they reinforce an incentive system where those who receive the bribes do not want to surrender the income benefits.
Corruption was present in all CEEC in the pre-transition period and the transition process is likely to have exacerbated the incidence of bribes that serve as a supplementary form of income. However, some countries have been able to address the issue of corruption by instituting strong and effective institutions to combat corruption. In other countries, the practice of bribing medical staff is accepted as a part of system, and only recently has there been recognition of corruption as a problem in health care. Such is the case of Croatia, where a law that was drafted in 2001 was introduced on the floor of the legislature only in March 2006. Empirical evidence shows that where there are no anticorruption laws or no enforcement of those laws because effective institutions are lacking, increasing corruption serves as a way to circumvent the inefficiencies of the health care sector in order to get better quality care. On the other hand, where institutions are effective and anti-corruption laws are enforced, corruption has a negative effect on health care sector effectiveness indicators such as infant mortality and cancer mortality.

The introduction of effective institutions is important in the fight against corruption. The implementation of effective institutions also creates public trust in government institutions because they recognize the consistent enforcement of the law to fight corruption. After the recognition that corruption is a contributing factor to the detriment of the health care sector, the implementation of effective institutions is important to address the perverse incentive system in which taking bribes pays. As supported by evidence, the more effective the institutions are, the better the health care sector outcomes will be, as evidenced through lower cancer mortality rates, higher life expectancy and lower infant mortality rates. Thus, introducing strong institutions ends
the negative effects of corruption on the health care sector, even though institutions do not directly address the primary cause of corruption (i.e., the need for structural reforms to end inefficiencies). However, institutions do represent part of the equation in addressing problems with the health care sectors in CEEC. Still, institutions are not omnipotent. Where corruption is very high, reflecting complete disregard for the rule of law, the introduction of effective institutions is not able to reverse the negative effect of corruption on health care in the short run. However, the consistent implementation of the law over time is likely to succeed. The consistent implementation of effective institutions over time, in a country where bribery in health care is accepted as part of life, may also raise public awareness of the problem. The implementation of the rule of law will also result in a better country evaluation by international financial institutions such as the World Bank, whose funding for health care is based upon such evaluations.

However, what empirical evidence shows, and contrary to the hypotheses in this study, is that World Bank funding has a negative effect on health care sector performance, both in the short and the long run. The more funding per capita for health care a country receives, the shorter their life expectancy is. The effect of World Bank funding on health care sectors in these countries is probably not anticipated nor desired either by the recipient country or the Bank, but the explanation is very simple. In order for the Bank to disburse the entire SAL package that health care funding is part of, the countries have to abide by the Bank imposed austerity measures. However, these austerity measures make the health care sector situation even worse because they require that governments cut down on spending, including welfare spending. Thus, the initial effects of the loan are negative. The positive effects of SALs may be felt many
years later, and most governments and people are not willing to pay the short run price. At the same time, the loans are needed in order to implement a smooth structural adjustment program. Thus, it is a tough choice for a country between receiving SALs and experiencing a public health downfall on the one hand, and not receiving the SALs and struggling with reforms. However, one thing is certain: receiving SALs is not a single ticket to solving the health care sector problems in CEEC.

The proportion of the senior population in the country is also a debilitating factor in improving the health care sector because seniors oppose the changes from a universal and free system to one where they have to pay for health services. One reason is because they have paid into the system all their life and now they want to reap the benefits, as it was promised to them. Another reason is that they are the most health wise and financially vulnerable sector of the population as they are retired and their incomes are limited, while at the same time they are in need of medical care. Empirical evidence shows that the higher the percentage of seniors in society, the less effective the health care system is, though the effect is very small. However, the senior population has been growing across most of the CEEC. Why then have some countries been able to improve the sector and others have not? First, it is not the voting and lobby of the senior population exclusively that have hindered health care reform. As mentioned, the size of the effect is very small, though significant. It is also safe to assume that countries that performed better during the transition also have a more content population, including seniors. Thus, it is feasible to conclude that it is the dissatisfied senior population, with a sense of entitlement to the benefits promised to them that represents a significant impediment to health care sector reform. Some
countries such as the Czech Republic and Slovakia have been able to appease the seniors through a gradual shift in the health care sector where seniors are still given full coverage and benefits, while younger generations are starting to partially pay for some services. Perhaps they represent a model to follow for other CEEC.

Although prior market experience is not a factor that countries can change, since it has been determined by pre-transition experiences, it explains some variation in the differences in health care sector outcomes. Evidence supports this. Countries that had a mixed economy, such as Slovenia and Hungary, also have a health care system that performance better than most other CEEC (Croatia and Bosnia and Herzegovina are an exception because of the civil war that last the first five years of the transition period). Empirical evidence also shows that the greater the experience of a country with the market economy the more effective is their health care sector. In countries where people had the opportunity to earn their living owning some private property and profiting from their business operations (even though the extent of private property ownership was limited to small businesses, and real estate), they were more supportive of the reform process even when they faced initial downturns. Furthermore, having had some laws on private ownership in existence, the final transition to the market economy in the early 1990s was smoother and the adjustment process was less painful in countries with prior market experience. Thus, these countries had more public support for reforms, including health care sector reforms, since they saw value in the market economy operations. Though this factor is impossible to change, it does have implications for the future of CEEC, even for those which did not have pre-transition market experience. It implies that the longer and better performing their post-transition
market economies are, the more likely they are to not only profit from it, but to be supportive of some needed and painful health care sector reforms in the near future.

Finally, the situation of the health care sector in many CEEC is so negative that they are likely to have to implement some significant changes in the near future. One of the first steps, in addition to actual structural reforms of the sector in terms of resource allocation, management and funding, is to address corruption. Part of addressing corruption is not only the official government recognition of the problem, but also the creation and consistent implementation of effective institutions to deter the payment of bribes and misallocation of funds. Addressing corruption in other sectors of society, such as more transparent privatization issues and government contract bids by private companies to minimize chances of corrupt practices, is likely to solidify public trust in the new regime and economy. Positive experiences and trust in government institutions are then likely to make them supportive of the need to change the ineffective health care sector, even if the short run costs are higher than desired. There is no blueprint for creating a successful health care sector, and this study does not make pretenses to have created one, but it points out to the factors that need to be addressed in order to create and implement successfully the reforms of the health care sector in CEEC.
APPENDIX A

PRE- AND POST-TRANSITION HEALTH CARE SECTOR EFFECTIVENESS
Figure A.1
Pre-transition health care sector effectiveness (life expectancy).

Figure A.2
Pre-transition health care sector effectiveness (cancer mortality).
Figure A.3
Pre-transition health care sector effectiveness (infant mortality).

Figure A.4
Post-transition health care sector effectiveness (life expectancy).
Figure A.5
Post-transition health care sector effectiveness (cancer mortality).

Figure A.6
Post-transition health care sector effectiveness (infant mortality).
Figure A.7
Pre-transition corruption.

Figure A.8
Post-transition corruption.
APPENDIX B
SURVEY QUESTIONS, YEARS, AND HYPOTHESES
1. The New Europe Barometer (NEB) Survey Questions

**Public Support based upon Economic Performance**

Q. Here is the scale for ranking how the economy works. (Show scale for Approval/Disapproval running from +100 at top to -100).

   a) Where on this scale would you put the socialist economy before the revolution?
   b) Where on this scale would you put the present economic system?
   c) Where on this scale would you put the economic system in five years time?

**Public Support based upon Political Performance**

Q. Here is a scale for ranking how our system of government works. (Show scale for Approval/Disapproval running from +100 at top to -100).

   a) Where on this scale would you put the former communist regime?
   b) Where on this scale would you put the present system with free elections and many parties?
   c) Where on this scale would you put our system of governing in five years time?
Table B.1. Countries and years of NEB Survey Administration.

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Table B.2. List of Hypotheses.

<table>
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<tr>
<th>Hypothesis 2.1:</th>
<th>The larger the number of senior voters, the larger the decline of in health care sector performance.</th>
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<tr>
<td>Hypothesis 2.2:</td>
<td>The greater the prior experience with the market economy and individual freedom, the more effective the health care sector.</td>
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<td>Hypothesis 2.3:</td>
<td>The more successful the first wave reforms, the more effective the health care sector.</td>
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<td>Hypothesis 3.1:</td>
<td>The higher the level of corruption, the lower the effectiveness of the health care system.</td>
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<td>Hypothesis 3.2:</td>
<td>The higher the degree of democratic consolidation, the higher the effectiveness of the health care sector.</td>
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<td>Hypothesis 3.3:</td>
<td>The more effective the institutions, the higher the effectiveness of the health care system.</td>
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<td>Hypothesis 4.1:</td>
<td>A country that is evaluated more favorably by the World Bank is likely to receive more funds and thus achieve a more effective health care sector.</td>
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<td>Hypothesis 4.4:</td>
<td>The larger the amount of assistance a country receives, the more effective its health care sector is.</td>
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<td>Hypothesis 5.1:</td>
<td>The higher the level of public support, the higher the health care sector effectiveness.</td>
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<td>Hypothesis 5.2:</td>
<td>The worse the experience with the previous regime, the greater the likelihood of a more effective health care sector.</td>
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<td>Hypothesis 5.3:</td>
<td>The better the experience with the new regime, the greater the likelihood of a more effective health care sector.</td>
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<tr>
<td>Hypothesis 5.4:</td>
<td>The more proportional and representative the political institutions are, the more likely the health care sector is to be effective.</td>
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