Health promotion in eastern Europe: a regional case study of economic reform and health development

Looking back at ‘the hard road to reform’ in eastern Europe since 1989, it is not easy to draw up a balance sheet. It is clear that important progress has been achieved in creating democratic institutions and transforming the centrally planned economies into market systems, but the economic and social cost of transition has been much higher than anticipated. A prolonged economic downturn, high levels of unemployment, sharply reduced social security, widening income and wealth differences, falling health standards and the rise of organized crime, have all contributed to frustration, disillusion and mounting political tensions. As a result, the current mood among the east European populations is very different from the enthusiasm and hope which were raised by the fall of the Berlin Wall in late 1989.

The dramatic divergence between expectations and reality has probably been the single most important factor behind the recent turnaround in the political and social climate in the region. Whether the transition could have been less costly in terms of economic losses and social welfare, and whether different policies could and should have been used to minimize these costs, remains, and probably will remain for some time, a hotly debated issue among economists and policy-makers. Nevertheless, there is an almost universal consensus that the recession has been much deeper and longer than initially expected, and that the transformation has not yet delivered on many of its explicit and implicit promises.

The initial reform programmes consisted of varying combinations of stabilization measures, institutional reforms and structural policies, including privatization. Monetary and fiscal restraint was aimed at reducing inflation, restoring financial equilibrium, and setting the stage for a stable macroeconomic environment. Liberalization of the external sector would help to establish correct relative prices and impose a desired measure of competition on the domestic market. Resources were expected to flow from loss-making firms into new, profitable activities, which would be undertaken and managed chiefly by newly emerging private entrepreneurs. The overall level of social welfare would rise, even though there would also be some ‘losers’, especially in the sectors which had enjoyed exceptional privileges under central planning, namely, heavy engineering, metallurgy, mining and the bureaucracy. However, the adjustment costs were expected to remain relatively limited, partly because of substantial foreign direct investments which were expected to flow into transition economies attracted by low manpower costs and ‘virgin’ markets.

The transformation was not expected to be completed quickly; it was clear—at least for a majority of policy-makers—that the creation of an efficient market system would take years. But it was also assumed that at least some of the benefits would materialize fairly quickly, especially the elimination of shortages, improved access to goods and services, and the liberalization of business activities. Although most reformist governments did not set precise dates, indirect evidence suggests that they all expected economic growth to resume after a relatively short adjustment period, perhaps within a year to two.

Popular expectations, on the other hand, were much more unrealistic. The massive critique of the inefficiencies and failures of central planning seemed to be perfectly consistent with the ‘demonstrating effect’ stemming from the affluent markets of Western economies: the result was a widely held popular assumption that the substitution of capitalism for communism would be a rather simple exercise, and that the shift would bring about a substantial and rapid improvement
in the long depressed standards of living of the east European populations.

The reality proved to be much harsher than the predictions of such rosy scenarios. Recession and unemployment hit all the countries in the region very hard. When the expected improvement was not quickly forthcoming, the reformist governments were accused of incompetence, wrongdoing and corruption; quite frequently, conspiracy theories were invoked to explain the lack of success. For many people, it was impossible to understand why the divorce from communism should be such a painful experience. This ‘reform fatigue’ spread, manifesting itself in frequent changes of government and in a shift of political support in favour of opposition, sometimes populist parties.

Economic performance improved markedly in the transition economies of eastern Europe since 1994. The recovery began in Poland in 1992 and has since spread to virtually all the economies of eastern Europe. Since 1994 there has been an increase in aggregate east European output—by just under 4%.

These developments in overall activity are most encouraging, at least for those who have suffered directly the considerable costs of transition to a market economy, but they need to be placed in perspective. After a decade of virtual stagnation, output in eastern Europe fell on average by more than 20% between 1989 and 1993. If the growth rate in 1995 of 4% is sustained, it will still take until virtually the turn of the century before the activity level of 1989 is equaled again. This of course is no more than arithmetic, but it illustrates the scale of the problem facing the governments of the transition economies as they try to grapple with the still considerable problems of transition, and at the same time try to maintain popular support for the entire process. Discontent with the economic and social costs of the transition is considerable. These high levels of dissatisfaction cannot be ignored by governments, and Western and international suppliers of aid and assistance might usefully help in easing some of the sources of social discontent, including health.

Much of the current investment activity is likely to be focused on rationalization and modernization. This will lead to job creation in new, private enterprises but is unlikely to be sufficient to absorb the increase in unemployment due to the restructuring of agriculture and state-owned enterprises in industry, as well as increases in the population of working age. This means that current unemployment rates are unlikely to be reduced significantly for some time.

In fact, despite the recovery of output, employment continued to fall in eastern Europe in 1994–1996, although the rate of decline was moderated somewhat in those countries where the recovery had started in 1992 or 1993. Within this aggregate, however, private sector employment is rising rapidly, especially in the service sectors, but not yet by enough to absorb the losses in the state sectors.

Consequently, unemployment rates have remained high and ranged between 10 and 18% at the end of 1996 (with the notable exception of the Czech Republic). The level of unemployment in eastern Europe as a whole, however, appears to have peaked at about 7.5 million people in early 1994, but the fall in numbers over the year (about 4%) probably reflects for the most part a reduction in the labour force due to early retirements and the ‘discouraged worker effect’. Unemployment, with large and growing proportions of young people and long-term unemployed, is now one of the most pressing problems facing the governments of the transition economies.

Average economic wealth in a particular country can be approximated by using a per capita GNP indicator based on purchasing power parity (PPP). PPP takes into account the purchasing power of local currencies compared with what a dollar can buy in the United States. The World Bank has estimated GNP/head (PPP) for the majority of countries in the world and these can be used to make a rough comparison between countries, even though doubts can be expressed about specific cases. These World Bank estimates are in the range of $5000–$8000 for central Europe, $3000–$7000 in the Baltic states and between $1400 and $6000 in the newly industrialized states (NIS), although data are available only for a few countries. In western Europe GNP/head (PPP) is generally between $15 000 and $24 000, i.e. on average, about three times higher than in the central European countries.

In addition to the level of living standards, what may also be important for people’s sense of well-being is whether living standards are stable, improving or deteriorating. Official data indicate that real incomes have been declining in the early 1990s in most countries of central and eastern Europe. For example in 1994, inflation rates came down to between 10 and 35% per year, but these were still high compared with western Europe,
where the annual inflation rate was generally between 1 and 5%.

Even though these countries were experiencing economic crises in the early 1990s, declines in living standards were of manageable proportions and many people were able to maintain reasonable living standards. Profound political and economic reforms were initiated immediately following the disintegration of the previous regimes. Even after the initial euphoria withered away, many people continued to hope that living conditions were going to improve sooner rather than later. The macroeconomics performance of these countries generally started to improve in 1993 and 1994. But even before the macroeconomics indicators showed positive results, changes in the availability of consumer goods, in the retail distribution systems, in the possibilities of entrepreneurship and in the privatization of economic activity, were clearly visible. Also, political reforms were quite successful and the political atmosphere was calm. People continue to feel the improved milieu in respect for human and political rights, freedom of expression and freedom to travel abroad.

In the economic sphere the transition to market economies is only starting to bear fruit in some countries. For relatively small proportions of the populations, the historic changes of 1989–1991 have brought about tangible results in restoring or establishing democratic political principles and rights, as well as civil liberties in a number of countries. This does not imply that relative political stability has been achieved throughout central and eastern Europe—on the contrary, many countries in the region are experiencing political turmoil.

There is ample evidence that whereas morbidity and mortality trends in western and eastern Europe have differed considerably over the past three decades, the major unfavourable influences have been similar in all central and east European countries. In this respect the most striking tragic feature has been the decline of average life expectancy at birth and the deterioration of age-specific mortality rates for the middle-aged, especially men.

The deterioration in health status experienced by central and eastern Europe over the last three decades can only be corrected by a social policy that is based on an understanding and analysis of observed trends. We still do not have a conclusive differentiated picture of the causes. Professor Michael Marmot has recently embarked on a theoretical analysis in co-operation with eastern European experts to explore and explain socioeconomic variations in coronary heart disease across western and eastern European countries.

One of the basic problems is the lack of a holistic theoretical framework to help formulate detailed arguments. The mortality and morbidity trends of the last three decades illustrate the limits of traditional epidemiological study that cannot go beyond the level of the individual. Without doubting the validity of positive factual results, it is absurd to reduce eastern European trends simply to smoking, nutrition and blood pressure without even discussing the possibility that risk factors are inherent in our specific social situation just as much as they are causal agents. It must be evident that the causal agents cannot be examined purely on an individualistic level. The roles of the power structure and macropolitical elements in the decline of health status must also be analysed.

Unfavourable morbidity and mortality trends cannot be traced back primarily to the socialist health care system itself. Prevention and health promotion have been in a disadvantageous position even within the health sector. Diminishing financial resources, dysfunctional organizational frameworks, inadequate and unfit personnel, outdated methods and the low esteem of prevention were also responsible for the population’s deteriorating state of health. The notion of prevention and health promotion have been reduced to a rhetorical stock-phrase. All this has induced deep distrust and suspicion towards any real initiative in the field of prevention. Traditional public health was not capable of responding to the challenges of the new epidemiological era. The existing Soviet-type network was not prepared to take the lead in managing the primary prevention of chronic non-communicable diseases whose incidence was growing, nor to adopt the ideas of health promotion. The political establishment and health policy that played second fiddle to it, completely disregarded prevention and social considerations and suppressed initiatives. Consequently, prevention was pushed into the background in the hierarchy of power in the health sector, in medical education and research.

Was it realistically possible during the seventies and eighties that the State-socialist eastern European countries could have faced and met the health challenges? It cannot be disputed that even given the political system and the level of
development, better health policy practices could have taken place than actually did. This is evidenced by the non-negligible differences in health status apparent among the formerly communist countries.

As already mentioned, the deteriorating trends in the health status of the population, that took place during the last three decades, were caused by factors that are outside of the health care systems (although we cannot say that health services were innocent). No significant change could have been achieved in these negative trends purely by the tools available to health policy. This could have only been done by comprehensive societal policy (healthy public policy) capable of affecting lifestyles and the psychosocial environment. But government policy can only have limited influence on lifestyle, quality of life, social structure and the psychosocial environment within any given historical period. Even in a socialist state bent on purification, harmful habits could not have been banned (indeed the attempt at prohibition in the Soviet Union had a boomerang effect). Had the socialist politicians recognized those economic and social circumstances that are harmful to health, they would have had to question their own legitimacy. The governmental apparatus would have been incapable of taking effective action. The socialist political system was organized on the sectoral principle and was incapable of intersectoral co-ordination and co-operation. Owing to the denial of social and environmental problems, social and environmental policy was underdeveloped and deformed. Partly inherited from previous historical traditions’ wishful thinking, victimization and a patronizing attitude were factors in dealing with problems. In these circumstances even the few specially supported health education campaigns were doomed to fail. People depended on the omnipotent central state in vain to solve their problems so the practice of health promotion based on the community and self-empowerment did not develop.

It was WHO that disseminated the Western experience. The dynamism of WHO’s European Regional Office greatly contributed to the spread of health promotion and, from the mid-eighties, the introduction of political initiatives. However, even in 1986 the Soviet leadership received the ‘bourgeois’ concept of health promotion with mistrust and hostility and was against sending high-level delegates to the Ottawa Conference on Health Promotion. During the beginning of the nineties in eastern and central Europe no all-road political strategies or programmes were initiated or launched to combat the alarming mortality and morbidity trends.

The economic and social prerequisites of long-term gradual improvement in the health status were missing. A significant drop in GNP or lowering standards of living due to recession, growing deprivation, poverty, unemployment, migration were all unfavourable to improvements in health.

The conflict between the long-term investment nature of health promotion and the short-term interests of the governmental parties, planning only for 4 years, remains sharper than ever. In addition, in a period of economic crisis and the difficulties embodied in political transition, it is not surprising that for the new governments of eastern Europe improving the health status of the population is only a token priority.

On the other hand the new, more democratic conditions mean a number of chances for health promotion such as the growing role of voluntary organizations and community-based action for local societies. Harmonization within the European legal system is also a step forward. Today it would be impossible to keep the data and the figures in secret and to ignore the tragic situation. But this is not enough.

The health situation in eastern Europe currently has the following characteristics:

- deteriorating health status
- increasing gaps in health status between east and west, between east European countries and within individual countries
- return of old infectious diseases, including tuberculosis, some of which are affected by a reduction in immunization rates
- new emerging problems, such as AIDS and drug abuse.

The safety net has collapsed and the role of the state and other partners is changing radically. Medical domination is very strong and there is some resistance to interdisciplinary approaches. Ministries of Health are facing health-care reforms in extremely difficult circumstances.

International activities in the region have increased considerably and in addition to the WHO, organizations such as the European Union (EU), Council of Europe and the World Bank are active. In 1991 the European Regional Office of the WHO modified its argot-system in accord with the new realities and created an
organizational department to support the health policy of the central and eastern European countries. The EU has secured special finances for cooperation with the region and the TEMPUS programme was of significant help in the modernization of the public health training system. The World Bank plays a major part in financing the developmental programmes.

Despite such advances, all in all international agencies are not very effective. The really significant financial tools are still missing for the enhancement of capacity building programmes. The activities of international organizations are uncoordinated and in some cases they can even be described as competitive, which can be self-defeating. Health problems dominant in eastern Europe cannot be solved by Western help. But strengthening co-operation does contribute. There are good European programmes, e.g. the Health Promoting Schools Project in which the international organizations co-operate. Recently, eastern European health policy experts show more and more willingness to co-operate with each other.

Since the early nineties, all central and eastern-European countries have policy documents which include health promotion targets. These strategies often lack coherence and are far from implementation. It is not clear how health promotion strategies harmonize with the ongoing health-care reforms, to the extent that there are some countries in the region where health promotion agencies and activities are even marginalized by new health service development, e.g. the Czech Republic and Hungary. There is a clear development of health promotion infrastructure in central and eastern European countries with identifiable national agencies (with the exception of Slovenia). A critical mass of experts has developed and there are increasing graduate and postgraduate training opportunities.

In central and eastern Europe settings-based approaches offer real success stories. Indeed Health Promoting Schools and Healthy Cities are flourishing activities in most of the countries. Also more and more district- and region-based approaches can be observed. These are run in parallel with an increase in the number of disease-focused programmes, e.g. AIDS, drug abuse, tobacco, nutrition.

In some of the countries health promotion has clearly identifiable financial resources. However, neither the level nor the allocation mechanisms and the accountability are satisfactory. In a few nations there are organizational frameworks of intersectoral co-operation at central governmental level, e.g. Hungary. However, healthy public policy needs further development and more effective tools of implementation.

Community action is one of the most positive aspects of central and eastern European health promotion development in recent years. This is reflected in the rapidly increasing number of NGOs and their role in everyday life at the grass roots level. Traditional risk factor health education methods focusing on individual development, knowledge and attitude change are still strongly surviving. But encouragingly these are reflecting an emergence of new approaches in the spirit of the Ottawa Charter.

Indeed the concepts of health promotion based on the Ottawa Charter are well known within the region. This includes countries with a longer tradition and better developed infrastructures like Poland and Hungary as well as others with more recently developed fragile structures like Romania and Bulgaria. The Hungarian National Institute for Health Promotion was designated in 1996 as a WHO Collaborating Centre for Health Promotion Development in central and eastern Europe. This clearly illustrates the willingness, observable in recent years, of health promotion experts and field workers to work together more within the region.

What then are the prospects for eastern Europe to formulate and implement health promotion strategies that could meet the new health challenges? Progress over the last 10 years indicates that the chances to do this are greater than before—but of course there are no short-term solutions. Hopefully, the second generation of democratic governments that will emerge at the end of the century will have the energy to move forwards. They need not only the capacity to develop their own strategies but also the commitment to start implementing them. Such leadership together with economic and social stabilization could stop the deteriorating health status and provide the conditions for sustainable health improvements. Such is our common interest.

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