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Review

Health policy in the Baltic countries since the beginning of the 1990s

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Abstract

The objective of this article is to compare the development of health policies in three Baltic countries, Estonia, Latvia and Lithuania in the period from 1992 to 2004 and reflect on whether key dimensions of these policies are developing in parallel, diverging or even converging in some respects. The paper identifies the similarity in the overall goals and compares the policy content in primary health care, the hospital sector and financing. We conclude that health policy in Estonia, Latvia and Lithuania has been progressing in parallel towards a Western European social insurance funding model, developing a primary care system anchored on a general practitioner service and lessening the hospital orientation of the pre-1990s system. There is evidence of both convergence and divergence across the three countries and of progress in the direction of EU15 in key health policy and outcome characteristics. These patterns are explained partly by differing starting points and partly by political and economic factors over the 1992–2004 period.

Keywords: Estonia; Latvia; Lithuania; Policy; Convergence; Health system; Health reform

Contents

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1. Introduction

Throughout the last two decades, health care reforms have attracted a high level of political attention in most European countries. Debate on the best path to reform has been particularly intense in former Soviet Union countries. These countries have been transforming their societies from a hierarchical structure to a market-oriented model and consequently have experienced even higher levels of radical social change than other European countries. Nowhere is this more evident than in the Baltic countries, which not only achieved political independence from the Soviet Union in the early 1990s but became members of the European Union in 2004.

Estonia, Latvia and Lithuania are situated on the northeast coast of the Baltic Sea and have about 7.5 millions inhabitants (1.4 million, 2.6 million and 3.5 million, respectively). Despite important differences in language (Estonian is a Finno-Ugric language while Latvian and Lithuanian belong to Baltic language group), religion (Estonia and Latvia are Lutheran and Lithuania is Catholic), traditions and culture, these countries are often viewed as one entity due to their small size, geographic location and recent history. Not surprisingly, they have all experienced rapid development and significant changes over the past decade and a half.

The Baltic countries inherited the Semashko model Soviet health care systems, characterized by centralized planning, inefficiency, hospital overcapacity, a poor quality of health care and universal access but as discussed below some significant differences in expenditure and deployment of personnel were already evident in 1992 [1–3]. Since political independence, the three countries have been in the process of reforming their health care systems. The objective of this article is to compare the development of key dimensions of their health policies in the period from 1992 to 2004 and reflect on whether they are developing in parallel, diverging or even converging in some respects and at some periods.

2. Methodology: analysis of convergence and divergence

The concept of convergence has a long history in policy analysis and is increasingly being used in studies of change in various aspects of policy in the European Union [4]. The common elements in all definitions of convergence and divergence are the concepts of similarity and difference and the measurement of change over time. Convergence is indicated if the differences between units in time t_2 is less than the difference in time t_1; divergence is indicated if the difference is greater. Synchronous or parallel development means that the differences are identical at both times [5]. Convergence is not a homogeneous process. It may reflect a decrease in variation across units due to all units becoming more similar – Sigma convergence – or a decrease in variation due to catch-up by laggards on leaders – Beta convergence. These are not the only types of convergence but they are the most frequently identified types [6]. These distinctions are important for interpretation of results of convergence analysis and particularly in making comparisons across studies. If we accept that convergence is an *overtime process effect*, specify the time over which it is measured and identify the type of convergence being demonstrated, we are still left with the issues of the element/s of policy that is/are being compared in policy convergence research. If cross-national equivalence is to be ensured in the study of policy convergence Bennett (1991) argued that it is 'crucial to be absolutely precise as to the aspects of policy being compared' [7]. He identified policy convergence as meaning one of five things: convergence of policy goals, of policy content, that is statutes or administrative rules, regulations, policy instruments or institutional tools, policy outcomes, that is the impacts or consequences, and policy