



Policy Learning, Fast and Slow:
Market-Oriented Reforms of Czech and Polish
Healthcare Policy, 1989-2009

Tamara Popić

Thesis submitted for assessment with a view to
obtaining the degree of Doctor of Political and Social Sciences
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European University Institute
Department of Political and Social Sciences

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Abstract

What determines the pace of policy innovation and change? Why, in other words, do policy makers in some countries innovate faster than in others? This thesis challenges conventional explanations, according to which policy change occurs in response to class conflict, partisan preferences, power of professional groups, or institutional and policy legacies. The thesis instead argues that different paths of policy change can be best explained by the different learning processes by which policy makers develop ideas for new policies in reaction to old policies. The thesis draws upon both ideational and institutional streams of literature on policy change, and develops its argument that policy change, understood as a learning process, is a result of interactions between three different, yet interdependent factors – ideas, interests and institutions.

The thesis explores this argument by investigating in detail two radical cases of policy innovation – the introduction of market-oriented elements in Czech and Polish healthcare policy during the first two post-communist decades. The selection of the two cases is based on the methodological rationale of the ‘most similar system design’, given that the healthcare systems of the two countries were both state-dominated under communism, while in the post-communist period the governments of the two countries introduced market-oriented reforms that followed rather divergent policy paths. While Czech reforms were relatively consistent and comprehensive, those in Poland were fragmented, delayed and beset with reversals. The thesis looks at these two cases of healthcare reforms from a long-term historical perspective, covering the inter-war, the communist and, most thoroughly, the post-communist period. It draws upon the official documents, secondary literature and more than 40 interviews with policy making elites, and compares the two policy paths using small-N research design, causal analysis and process tracing techniques.

The main finding of the thesis is that the market-oriented ideas that occurred in healthcare policy circles during the 1970s and 1980s were crucial drivers of the post-communist reforms in the two countries. However, the capacity of these ideas to serve as a basis of policy change was dependent on two factors – on the existence of political actors who were willing to promote these ideas, and on the interaction of institutional veto points with the electoral and partisan dynamic. The findings of this thesis contribute to the better integration of the literatures on the role of ideational and institutional factors in policy change, and to the research on the causes and consequences of marketization in healthcare and, more broadly, in social policy.

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List of Abbreviations

- AWS: Akcja Wyborcza Solidarnosc (Solidarity Electoral Action)
- ČMKOS: Českomoravská konfederace odborových svazů (Czech-Moravian Confederation of Trade Unions)
- ČSSD: Česká strana sociálně demokratická (Czech Social Democratic Party)
- DEU: Demokratická unie (Democratic Union)
- KDS: Krěst'anskodemokratická strana (Christian Democratic Party)
- KDU- ČSL: Krěst'anská a demokratická unie – Československá strana lidová (Christian Democratic Union - Czechoslovak People Party)
- KSČM: Komunistická strana Čech a Moravy (Communist Party of Bohemia and Moravia)
- KSRM: Komitet Społecznego Rady Ministrow (Committee for Social Policy)
- LOK – SČL: Lékařský Odborový Klub - Svaz Českých Lékařů (Trade Union of Doctors in the Czech Republic)
- LPR: Liga Polskich Rodzin (League of Polish Families)
- NHS: National Health System
- NIF: National Insurance Fund
- NSZZ Solidarność: Niezależny Samorządny Związek Zawodowy 'Solidarność' (Independent Self-Governing Trade Union Solidarity)
- ODA: Občanska demokratická aliance (Civic Democratic Alliance)
- ODS: Občanska demokratická strana (Civic Democratic Party)
- OF: Občanske Forum (Civic Forum)
- OPZZ: Ogólnopolskie Porozumienie Związkow Zawodowych (All-Poland Alliance of Trade Unions)
- OSZSP: Odborový svaz zdravotnictví a sociální péče České republiky (Trade Union of Health and Social Care in the Czech Republic)
- PC: Porozumienie Centrum (Central Agreement)
- PiS: Prawo i Sprawiedliwość (Law and Justice)
- PO: Platforma Obywatelska (Civic Forum)
- POUZPČMS: Profesní odborová unie zdravotnických pracovníků Čech, Moravy a Slezka (Professional Trade Union of Medical Workers of Bohemia, Moravia and Silesia)
- PSL: Polskie Stronnictwo Ludowe (Polish People Party)
- RHSD ČR: Rada hospodářské a sociální dohody ČR (Council of Economic and Social Agreement)

SLD: Sojusz Lewicy Demokratycznej (Democratic Left Alliance)

SRP: Samoobrona Rzeczpospolitej Polskiej (Self-Defence Party)

SZ: Strana zelených (Green Party)

UP: Unia Pracy (Labour Union)

US: Unie svobody (Union of Freedom)

UW: Unia Wolności (Freedom Union)

ZOZ: Zespół Opieki Zdrowotnej (Area Health Complex)

ZUS: Zakład Ubezpieczeń Społecznych (Social Insurance Fund)

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Preface

This thesis studies the market-oriented healthcare reform of two post-communist countries. Market-oriented healthcare reforms were puzzling me because of the multiple market failures in the healthcare sector and the fact that even though the outcomes of these reforms are highly uncertain, more and more European countries are growing fond of markets in healthcare. Some of the post-communist countries that introduced markets in healthcare during the early transitional period were even more puzzling. At this time, they were very politically and economically fragile, but nevertheless engaged in the risky business of experimenting with new forms of healthcare financing and delivery that drew upon heavily on market instruments. It is with these two big puzzles that my research journey begun. In the search for the origins of these reforms, I quickly discovered that cognitive elements, ideas and learning, played a crucial role. The expert ideas that were emerging already under communism immediately became the main drivers of the process of policy change, which is best explained as a learning process, in the post-communist era. Nevertheless, by digging deeper into empirics, I realized that ideas alone could not explain why the two countries I decided to study, Poland and the Czech Republic, followed rather divergent reform paths. Discovering the links between ideas and other two elements, interests and institutions, I found that the learning process through which the policy change took place was shaped by the links between these three elements. In other words, what I found out at the end of my research journey was that while each of the three elements - ideas, interests and institutions – alone could not explain the whole process of policy change, it was the country-specific linking of these three elements that resulted in the divergent trajectories of policy change across the two countries.

Like every good journey, this one had its ‘partners in crime’. No matter how lonely writing of a PhD can be, and indeed often is in reality, it is the people in my professional and personal surrounding that made my PhD thesis writing a unique experience. First of all, I thank my supervisor, Professor Sven Steinmo, as without his guidance, intellectual stimulus and professional support this thesis and my overall PhD experience would not be the same. Sven pushed me to develop my own research ideas and interest, trusted my choices and provided me with the guidance I needed at the different stages of my PhD development. He patiently read and re-read my work, both when it was good and when it was bad, and helped me to refine my thoughts and writing until the very end. I am especially grateful to Sven because since the very beginning he showed strong interest and faith in my PhD project, which was extremely

motivating. I would also like to thank Professor Laszlo Bruszt and Professor Ellen Immergut for commenting on the very early versions of this thesis. Their comments were useful as they helped me refine my, at that time, very rudimentary research ideas, which enabled me to put my PhD project on a right track. Also, I am very grateful for the comments on the different written parts or presentations of this thesis provided by the late Professor Peter Mair, Professor Alex Trechsel and Professor Chris Reus-Smith and by my co-supervisees Emre Bayram, Johan Christensen, Furio Stamati and Josef Hien. I also thank my colleagues from the EUI Sophie, Višnja, Lorenzo, Lisa A., Jelena, Marina and Guilherme, who either read some parts of this thesis or with whom I had a chance to discuss my research plans, thoughts and ideas. Finally, I would also like to especially thank the participants of the Graduate Conference at the Max Planck Institute for the Study of Societies that took place in November 2013, where I had a chance to present some parts of this thesis and profit from their very enthusiastic and useful comments.

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Chapter One: Healthcare Marketization

Introduction

The last several decades have witnessed an increasing shift from state-dominated to market-oriented healthcare systems across Europe. By the time of the writing of this thesis, each European country with a traditionally strong role of the state in healthcare had already built some form of market instruments into its healthcare provision. The marketization of healthcare took different forms. In healthcare delivery, marketization mainly involved the privatization of formerly public provision of medical services and the introduction of competition among public, or between public and private healthcare providers. It also involved decentralization within the public sector, which increased autonomy and responsibilities of public providers and made them more independent from the state. In healthcare financing, marketization introduced competitive incentives, separating financing of services from their delivery, and decentralizing purchasing responsibilities. While many countries have also partly privatized their healthcare financing, introducing co-payments and user fees for healthcare services, in some countries private healthcare insurance has become either an alternative or a supplementary source of healthcare financing.

All these different kinds of market-oriented changes of the healthcare sector are puzzling for at least three reasons. First, healthcare is considered to be a welfare sector particularly prone to market failures, which occur due to information asymmetries and externalities that pervade healthcare provision. Second, reliance on market mechanisms in the delivery and financing of healthcare services has often been associated with inferior system performance, and the example of the extremely marketized healthcare system in the United States has often been used to illustrate this. Finally, healthcare in Europe has been traditionally provided by the state and states had crucial roles in the establishment of universal systems of healthcare provisions. This, however, cannot explain why European governments have been increasingly growing fond of markets in healthcare.

This thesis contributes to the literature on market-oriented reforms in the financing and delivery of healthcare services, with a comparative study of two cases of such reforms in two post-communist countries of Eastern Europe: Poland and the Czech Republic. These two countries radically broke-up the state-dominated model of healthcare after the fall of communism and introduced a set of market-oriented mechanisms in their healthcare systems,

and present an interesting topic for analysis for two reasons. One reason is that it involved a set of large-scale policy changes in particularly turbulent and uncertain times. In the whole Eastern European region, the period after the fall of communism in 1989 was a period of double transition, from communist dictatorship to multiparty democracy and from a centrally planned economy to capitalism. This double transition involved two parallel processes of institutional re-design of uncertain outcomes which Jon Elster and his colleagues metaphorically described as a process of “re-building the ship at the sea” (Elster et al. 1998). The double transitions in Poland and the Czech Republic involved ambitious reform projects, associated with intense, rapid and very often painful economic, political and social changes, which affected both the political fortune of the post-communist reformers and the well-being of their citizens. Changes in healthcare, which took place simultaneously with these intense transformations, were no less turbulent, as they involved an almost continuous process of radical and very innovative institutional and policy re-design that was set in motion in the early 1990s and is still not finished.

Another reason to analyse Polish and Czech reforms is that their healthcare systems in the immediate aftermath of the fall of communism faced a multiple set of challenges and were under enormous pressure of transformation. One of these challenges was similar to those faced by the healthcare policymakers in other countries across Europe, linked to the rapid trends of population ageing and growing costs of healthcare. Another type of challenge, more specific for these Eastern European countries, was related to their more recent, inglorious communist past. Under communism, Polish and Czech healthcare policy was extremely static: i.e. it involved very little change, so that at the end of the 1980s the two countries were still providing medical care following laws created in the late 1950s or early 1960s. More than three decades of policy stagnation created outdated healthcare systems, which were not only incapable of adapting to the changing healthcare needs of their populations but also, due to the neglect of healthcare under communism¹, became plagued by problems such as constant shortages, chronic underfunding and excessive corruption, that brought the healthcare sector almost to the verge of collapse. In response to these problems, the pressure for the transformation of the healthcare sector had already started to grow during the last years of communism and became especially strong after the political regime change in 1989, when the political barriers for the reforms weakened and opportunities for policy reform became more realistic.

¹ Under communism, healthcare was financed from the general budget and was a sector with low funding priority. High priority was given to the heavy industry sector, particularly the arms industry (see Kornai and Egelstone 2001: 136-7).

Given these specific features of the post-communist healthcare reforms, the particular context of double transition and the growing pressure for reforms in response to the multiple challenges, these reforms are interesting as they present an example of particularly deep-seated and innovative policy responses to the problems of healthcare provision that strongly relied on the use of market-mechanisms. Since the Polish and Czech cases of post-communist healthcare reform also present varying cases of these responses, they provide an excellent case for comparative analysis of factors that drive, enable or block market-oriented policy innovation in the healthcare sector as a specific sector of the welfare state.

The main aim of this thesis is to shed more light on the crucial episodes of Czech and Polish healthcare policymaking in the period between 1989 and 2009. The puzzle of the Czech and Polish reforms is that even though the healthcare systems of the two countries followed very similar historical developments, their post-communist policy paths have been significantly different. In terms of system similarities, Polish and Czech healthcare shared a number of common features throughout the twentieth century. During the interwar period, both countries introduced an insurance-based, so-called 'Bismarckian' system of healthcare. After the Second World War and with the arrival of communism, they both transformed the insurance systems into Soviet-style, state-dominated and centralized systems of healthcare. In the post-communist period, the third type of systemic change took place, as the two countries transformed their state-dominated system, introducing an insurance system with market-oriented elements. In spite of these considerable similarities in their healthcare system changes, both the trajectories and the outcomes of post-communist healthcare policy in the two countries were dramatically different. The Czech policy path was marked by significant continuity and witnessed comprehensive policy change already at the beginning of the post-communist period. In the very early 1990s, the government quickly marketized Czech healthcare and relatively successfully continued with market-oriented reforms throughout the two post-communist decades. In contrast, Polish healthcare policymaking was fragmented, marked with significant delays and large-scale policy reversal in the first half of the 2000s.

What explains these rather different policy paths? In this thesis, I argue that the difference in the processes of policy change, which I define as process of learning, best accounts for the divergence of the healthcare policy paths in the two countries. I define learning, drawing upon Hall, as "a deliberate attempt to adjust the goals or techniques of policy in response to past experiences and new information" (Hall 1993: 278)² and use this concept to explain why Polish

² This concept of learning corresponds most closely to the colloquial use of the term 'learning' that denotes "modification of a behavioural tendency by experience" rather than the other colloquial use according to which

and Czech transformations from state-dominated to market-oriented healthcare policy followed such different paths. Czechs, I argue, were ‘learning fast’ because they transformed their healthcare through series of relatively continuous and comprehensive pro-market reforms. Poles, instead, ‘learned slowly’, witnessing significant delays in policy change and much slower departure from the socialist state-dominated system of healthcare, through reforms that were both partial and beset by reversals. I also draw upon the idea of policy change as learning in order to stress the ideational elements of policymaking in the two countries. In both countries, as this thesis will show, the pro-market ideas that emerged under communism were the key drivers of the post-communist reforms, but interests of political actors and institutional arrangements also played a substantial role. I develop the theoretical framework of my argument in more details in the second chapter, where I explain how dynamic interplay of these three factors – ideas, interests and institutions – can lead to divergent policy outcomes.

The main purpose of this first chapter is to introduce the reader to the research journey of the thesis. Its first section provides details on the main topic of the thesis: post-communist healthcare reforms in Poland and the Czech Republic. The second section explains the variation between the Czech and Polish post-communist healthcare policies, specifies the key research question and elaborates the core argument of the thesis. It also shows how this argument challenges a set of alternative explanations available in the existing literature of welfare state and healthcare reforms. The third section is an overview of the context of the post-communist health reforms, and provides the reader with a better insight into the broader set of social, political and economic circumstances that surrounded the process of healthcare policymaking in the two countries. The fourth section sheds more light on the concept of healthcare markets by looking at the historical, theoretical, and practical dimension of markets in health. The last section specifies the research design and methodology used to conduct the theoretical part of the research project and collect and analyse the relevant empirical data. The chapter concludes with a short summary and a brief outline of the four subsequent chapters.

1. Czech and Polish Post-communist Healthcare Reforms

Czech and Polish post-communist healthcare reforms represent particularly interesting cases for analysis for two main reasons: they involved a systemic change of their healthcare sector and a radical change in healthcare policy goals and instruments. The systemic change

‘learning’ denotes “knowledge or skill acquired by instruction or study” (for different definitions of the concept of ‘learning’ see Merriam Webster dictionary, available online at www.Merriam-Webster.com). For a similar definition of the concept of learning, as modification of behavior by experience, please see Hecló’s (1974) definition in the footnote number 49 on page 54.

involved a shift from the so-called ‘Semashko system’³ to the specific insurance-based system of healthcare, also called a ‘Bismarck system’⁴. The shift from ‘Semashko’ to ‘Bismarck’ system was without precedence in Europe because it implied a large-scale organizational change from a National Health Service (NHS) system type to a system of a different, Social Health Insurance (SHI) type.⁵ As an extreme version of a NHS system, the ‘Semashko’ system represented a prototypical ‘command and control’ system of healthcare that fully integrated the two main system functions, delivery and financing of healthcare services, and gave the state an absolute role in both. In delivery, the state was the absolute owner of healthcare facilities, while in financing it centrally funded care from general taxation so that it was provided ‘for free’ at the point of delivery.⁶ With the shift to an SHI system type, Polish and Czech healthcare witnessed a major alteration, which involved not only a move away from the NHS-style integrated model of healthcare system organisation but also a series of policy changes that replaced the absolute role of state with a set of market-oriented instruments of healthcare financing and delivery. In what follows, I explain the range and importance of both the systemic and the policy changes that so radically transformed Polish and Czech healthcare during the post-communist period.

1.1. Systemic change: from ‘Semashko’ to ‘Bismarck’

During the first post-communist decade, the Czech and Polish ‘Semashko’ systems of healthcare were replaced with the ‘Bismarck’ system of healthcare provision. The shift to the SHI model of healthcare left one of the characteristics of the communist healthcare provision in place, namely universal access to healthcare, but changed its overall organizational logic. The most important organizational changes generated by this shift were the separation of the two previously integrated system functions, financing and delivery of healthcare services, and the introduction of new institutions responsible for healthcare funding: healthcare insurance funds.

³ The ‘Semashko’ model was named after its founding father, Nikolai Semashko, the People’s Commissar of Public Health in the Soviet Union. Introduced first in the USSR after the Second World War, the ‘Semashko’ model was implemented in the countries of Central Eastern Europe with to the Soviet occupation of the region. In terms of structure, the ‘Semashko model’ is very similar to the ‘Beveridge model’ (of which British NHS is a typical example), since in both models the healthcare system is centralized and funded by the state. Nevertheless, the ‘Beveridge model’ is considered to be far less regulated than the ‘Semashko model’, thereby leaving room for private services and private insurance (Marrée and Groenewegen 1997: 8).

⁴ Similarly, the ‘Bismarck’ model was named after its founder, the Prussian Chancellor Otto von Bismarck, who introduced the insurance-based system in the Prussian lands at the end of the 19 century.

⁵ Examples of systemic reforms in the opposite direction, from the SHI to the NHS system, are Italian (Ferrera 1995), Portuguese (Oliveira and Pinto 2005), Greek (Mossialos 1997) and Spanish (Guillén and Cabiedes 1997), through the healthcare reforms that took place in 1978, 1979, 1983, and 1986 respectively.

⁶ It is important to stress that even though healthcare was provided “for free”, the healthcare system under communism was not egalitarian. Most of the communist countries had a two-tiered system of healthcare, which implied that access to certain healthcare facilities, usually those offering the highest quality of care, was available only to specific parts of population, normally to the members of the communist party, the military elites and their families.

In healthcare financing, insurance contributions in the form of payroll taxes replaced general taxation as the main source of healthcare funding. These contributions became mandatory, based on employment, and defined as percentages of workers' salaries. Another novelty in financing was the introduction of health insurance funds, which were established as bodies responsible for the collection and administration of the insurance contributions and purchasing of medical services from healthcare providers. In healthcare delivery, organizational and institutional changes were equally wide-ranging. After the dissolution of the centralized and hierarchical system of healthcare facilities, the delivery system was transformed in such a way that healthcare facilities gained the status of individual entities responsible for the delivery of different types of care. As individual entities, facilities became independent from the state and were granted a considerable degree of administrative and financial autonomy.

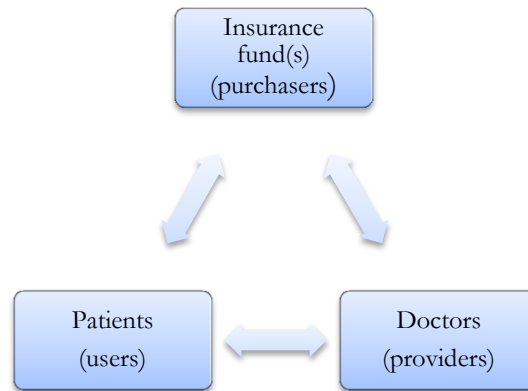
Table 2. Shift from the 'Semashko' (NHS) system to the 'Bismarckian' (SHI) system of healthcare.

Organisational Dimension/ System Type	'Semashko' (NHS) system	'Bismarckian' (SHI) system
General	Integrated financing and delivery of healthcare	Separated financing and delivery of healthcare
Healthcare financing	General taxation	Insurance contributions (payroll taxes)
Healthcare delivery	Owned and controlled by the state	Independent from the state

Source: own.

The shift from NHS to SHI (table 1) implied not only a shift to a new organization logic of the healthcare system; it also established a new functioning logic based on a new model of relationships between the system's main actors. Insurance funds, which were the completely new group of actors in the system, took over the active role of healthcare purchasers and became mediators in the relationship between doctors, as providers of care, and patients as its users. This new triangular relationship model, typical for the healthcare systems of the SHI type (figure 1), introduced genuinely new dynamic into the functioning logic of the healthcare system and offered multiple possibilities for the departure from the state-dominated healthcare system toward its market-oriented counterpart.

Figure 1. Main actors in the SHI system of healthcare.



1.2. Policy change: from state-dominated to market-oriented healthcare

Healthcare policy in Poland and the Czech Republic under communism provided care according to the ‘command-and-control’ model of healthcare provision, which implied that delivery and financing of healthcare services were state-dominated, centralized and hierarchical. This was due to the fact that the healthcare policy in these two countries, similar to the other communist countries of Eastern Europe, was an integral part of the socialist command economy (Kornai and Eggleston 2001). Healthcare in socialism was provided in line with the economic principles of state funding and centralized resource distribution, through the economic mechanism of ‘classical socialism’ and similar to the other policy sectors of the socialist state (ibid. p. 135). Resources dedicated to healthcare, which were rather meagre,⁷ were distributed according to a very centralized and hierarchical scheme that was fully controlled by the state, so that the governance of healthcare resources was based on a very strict top-down decision-making logic. Kornai and Egglestone (2001) describe this socialist model of healthcare provision in the following way:

“The healthcare sector is an integral part of the command economy. It does not differ in the least from the other sectors in its economic mechanism. All the sector’s activity is centrally controlled. At the peak is the health minister, who is in turn directed by his superiors in the communist party and the state. Orders filtered down from him through the bureaucratic hierarchy to the functionaries controlling the lowest-level organizations: hospitals, outpatient clinics, and district doctors’ offices providing primary health care.

⁷As mentioned earlier, healthcare was not considered an important part of the socialist economy, and was therefore given low priority (see Kornai and Egglestone 2011: 136-7).

They in turn direct the doctors, the nurses, and other medical personnel under their command ...” (ibid. pp. 135-6)

Polish and Czech healthcare under communism embodied all of the core elements of the socialist ‘command and control’ model of healthcare. It is interesting that in comparison to some of the other Eastern European countries,⁸ the two countries remained faithful to the ‘pure’ version of socialist healthcare provision during the entire communist period. In the course of almost five decades of communist rule, their healthcare systems witnessed very little change as the only ‘change’, which took place during the first post-war decades, involved further strengthening of the socialist model, through additional centralization and hierarchization.

The departure from this state-dominated healthcare policy model was initiated in the immediate aftermath of the fall of communism. The ‘Bismarckian’ system-specific separation of healthcare financing from delivery played an important role in this departure as it enabled policy makers to introduce a relatively broad range of market-oriented instruments in both dimensions of healthcare provision (table 2). In healthcare financing, markets were introduced through privatization of healthcare costs, which implied a breakup with the fully-funded public model of healthcare and partial transfer of healthcare costs onto patients through different forms of out-of-pocket payments. Marketization of financing also involved a breakup with the communist state-centred model of financing through decentralization⁹ of purchasing responsibilities and the creation of multiple independent insurance funds. Lastly, marketization involved a breakup with the hierarchical model of resource distribution, through the introduction of competitive healthcare insurance purchasing mechanisms and various forms of competitive compensation schemes for healthcare providers. Similarly, marketization took three different forms in healthcare delivery. It involved privatization of healthcare facilities, which implied transfer of healthcare facilities from state to private hands. It also involved decentralization that delegated responsibilities for healthcare delivery from the state to the regional or local level and granted greater autonomy to healthcare providers and facilities. Finally, marketization in delivery involved the departure from territorially determined access to healthcare, introducing competition through patients’ choice.

⁸ Hungary, for example, initiated some health reforms in the late 1980s, which allowed for emergence of private healthcare delivery (see Gáll and Rieseberg 2004: 7).

⁹ I define decentralization as “a transfer of responsibility for planning, decision making, resource generation and allocation, as well as administrative authority from the central government to the field units of central government, ministries and agencies, subordinate units of government, semi-autonomous public authorities or corporations, area wide regional functional authority and non-government private or voluntary organizations” (Rondinelli and Nellis. 1986: 5).

Table 2. Market instruments in healthcare delivery and financing.

Instrument/Organizational Dimension	Privatization	Decentralization	Competition
Healthcare Financing	Transfer of healthcare costs from public entities onto patients, through co-payments for healthcare goods and/or user fees for medical services.	Decentralization of purchasing responsibilities, through creation of multiple insurance funds.	Competitive purchasing of healthcare insurance through users' choice of insurance funds and variation of healthcare benefit packages.
Healthcare Delivery	Transfer of healthcare (outpatient and inpatient) facilities ownership from public to private hands.	Decentralization of delivery responsibility through greater autonomy of medical care providers and healthcare facilities.	Reimbursement of providers' services through competitive compensation schemes and selective contracting of healthcare providers.

Source: own.

Changes introduced through these market instruments were ground breaking for the post-communist healthcare system. The new model of healthcare provision was radically different from the socialist 'command and control' model in that it generated a radically new set of incentives that would shape the behaviour of the main three groups of actors within the healthcare system – doctors, patients and insurance funds.¹⁰ Doctors, as providers of care, were given through market instruments such as privatization incentives to 'exit' the public system,¹¹ become independent private providers of care and, in the case where competition was introduced as well, compete with other healthcare providers for patients through competitive compensation schemes and patient's choice. Patients, as users of healthcare services, through competition gained the possibility of choice, and could have the freedom to choose both their healthcare provider and insurance fund in charge of payment and administration of their healthcare costs. As the third largest group of actors in the health system, insurance fund(s), as purchasers of medical services, were given incentives to compete for clients, either by offering

¹⁰ I draw upon Gingrich's definition of markets in healthcare, which conceptualizes markets (in healthcare or other welfare sectors) in the following way: "The chief feature that distinguishes markets from other forms of organization is that they influence behaviour by manipulating incentives for consumers and producers of services" (Gingrich 2011: 7). Gingrich considers markets to be different from "hierarchical 'command and control' systems, where a central agency defines process and outcome, and from 'network systems' of management where users and providers operate on the basis of trust", because markets according to her "use competitive mechanisms to allocate scarce resources to producers and users" (ibid. p. 8).

¹¹ On doctors' "exit" to the private sector in healthcare see Klein (1989).

additional benefits in the insurance packages or through selective contracting of healthcare providers.

The new incentives scheme generated through market-oriented policies departed significantly from the socialist state-centred and hierarchical scheme of healthcare provision, not only because it used new policy instruments in healthcare, but also because it implied a substantial re-definition of healthcare policy goals. From the very beginning of the post-communist healthcare reforms in the two countries, terms such as ‘efficiency’, ‘responsibility’ and ‘choice’ started to dominate the policymaking discourse, quickly replacing the old socialist terminology, which put strong emphasis on ‘centralized’, ‘universal’ and ‘free’ healthcare provided by the state. This change in policy terminology indicated that marketization of healthcare policy in the two countries implied not only change in instruments and settings of healthcare policy but also the creation of new policy goals. Post-communist healthcare reforms were therefore an example of a ‘third-order policy change’ (Hall 1990, Hall 1993). According to Hall, a third-order policy change implies not only changes in instruments and settings of the healthcare policy, but also deeper, more significant, higher-order changes in the hierarchy of goals guiding specific policy sectors.¹² Exactly this was the case in the market-oriented Polish and Czech post-communist healthcare reforms. Through marketization, these reforms changed the organisational settings of the healthcare system, the mechanisms through which healthcare services were provided to the Polish and Czech populations, and, finally, the goals of Czech and Polish healthcare policy in the post-communist period.

These multiple levels of change in policy could also be understood as adaptive changes to the broader environment, if we look at Czech and Polish healthcare policy from a broader historical perspective. The Polish and Czech healthcare systems performed relatively well in the post-war period but started to gradually deteriorate from the late 1960s or early 1970s onwards, along with the worsening of the population health status. The post-socialist period of healthcare reforms that emerged in response to the failures of the socialist system initiated a process of reforms that could be described as institutional change through “displacement”¹³ (Streck and Thelen 2005), since the state instruments of healthcare provision were replaced with alternative market-oriented instruments, in the attempt to adjust the healthcare system to this new environment. The success of this attempt, as this thesis will show, was fundamentally dependent

¹² “Third-order policy change” implies change in all three elements of a policy – instruments, settings and goals – and is therefore the most comprehensive type of policy change (see Hall 1993: 281-7). Hall’s distinction between the first-, second- and third-order policy changes is explained in chapter 2.

¹³ According to Thelen and Streck (2005: 20), policy change through “displacement” occurs through the rediscovery or activation, and cultivation, of alternative institutional forms.

on yet another, even more important context: the political context of policymaking, which profoundly shaped the varied success of the paths of the market-oriented reform proposals in the two countries.¹⁴

1.3. Czech and Polish Policy Divergence

During the first two post-communist decades, Polish and Czech healthcare was marketized, witnessed a case of third-order policy change, but nevertheless followed different policy paths. The Czech path of healthcare marketization was relatively fast and continuous, characterized by a comprehensive set of reforms in both financing and delivery of healthcare services, introduced in the early 1990s. In contrast, Polish healthcare marketization during the 1990s was slow and fragmented. Once the country in 1999 finally managed to switch to a decentralized insurance system, this change was soon followed by a large-scale policy reversal that made the Polish post-communist healthcare system centralized and markedly different from the Czech system. The introduction of user fees in 2007 marked one step further in marketization that made the difference between Polish and Czech healthcare even more significant. This policy divergence between the two countries is puzzling, especially because comparison of the policymaking processes in the two countries reveals that both Polish and Czech policymakers were particularly keen on marketization. Market-oriented policy proposals emerged right after the fall of communism, in the very early 1990s, and in the subsequent two decades the healthcare policy arena witnessed a proliferation of policy proposals that, in one form or the other, relied on market instruments of healthcare provision. However, in the course of the reform process, the two countries made significantly different policy choices that shaped their healthcare systems, which are characterized with, as the reader will soon see, significant differences in performance.

In this section, I explain in more detail the divergence between Czech and Polish post-communist healthcare policy and outline my argument, which attributes this divergence to the differences in the process of policy change, understood as a learning processes, during which market-oriented ideas linked with interests of the political actors and followed paths that were shaped by political and institutional configurations in the two countries.

¹⁴ Please note that these ideas, on healthcare policy change as environmental adaptation, are further developed in Chapter 5, under section “Policy change as environmental adaptation”.

Divergence of policy paths

After the fall of communism in 1989, post-communist governments in Poland and the Czech Republic faced the same challenge of transforming dysfunctional and deteriorated socialist systems of healthcare characterized with almost forty years of policy stagnation. Pondering as to their possible points of departure from the socialist system, they considered the same reform options that were strongly inspired by market-oriented ideas. In the course of time, however, they made different choices that shaped their departures from socialism in a profoundly different way. Here is the story of healthcare reforms in the two countries.

In the Czech Republic, reforms of the healthcare sector started early, were very fast, comprehensive and relatively continuous. The first post-communist government initiated the reform round by passing two major healthcare law, the Law on General Health Insurance (Law No. 550/91) and the Law on the General Health Insurance Fund (Law No. 551/91), both in 1991. Two further laws, the Law on Branch, Local and other Health Insurance Funds (Law No. 280/92) and the Law on Healthcare in Non-State Healthcare Facilities (Law No. 160/92) were added in 1992. These four laws introduced an insurance-based 'Bismarckian' healthcare system with a comprehensive set of market-oriented mechanisms. In delivery, they introduced privatization allowing for transfer of healthcare facilities from public to private hands and the establishment of independent private medical practice by individual providers. They also introduced competition among the healthcare providers through competitive compensation schemes based on the fee-for-service (FFS) scheme.¹⁵ In financing, the laws allowed for the emergence of a decentralized structure based on the quasi-public, independent health insurance funds (HIFs) and generated competition in the health insurance market. Even though these HIFs would be publicly financed, they would be able to compete for their clients, offering services above the basic benefit package. To further spur competition in healthcare financing, citizens were allowed to switch funds every six months, choose the scope of services they would like to have covered and choose doctor or care facilities.¹⁶

The government's timetable for the implementation of these four laws was very ambitious. It was envisaged that the transformation to the new decentralized, competitive and privatized SHI system would take only two years. This highly ambitious plan envisaged a series of radical changes in a very short time-period and made the healthcare reforms similar to the

¹⁵ Fee-for-service (FFS) scheme is a payment model according to which medical services are unbundled and paid for separately, each service for a specific fee and a payment model which pays healthcare providers on their actual, service-based performance, rather than pre-determined budgets.

¹⁶ Under socialism, healthcare was provided on a strict territorial basis.

economic reforms, based on the “Shock Therapy” approach. Twenty-seven HIFs emerged on the insurance market, taking over a significant number of clients from the General Health Insurance Fund (GHIF).¹⁷ Privatization of healthcare delivery turned out to be particularly successful in primary care, as almost all physicians working in primary care became private providers. The providers’ compensation based on the FFS system became the main method of payment and, as expected, quickly generated competition for patients, especially among the primary care, predominantly private healthcare providers. The implementation process of the reform plan nevertheless quickly encountered a series of problems. A deep financial crisis swept the healthcare sector, involving a rocketing increase in healthcare costs that almost fully expanded the annual budget of the insurance sector in the first six months of the fiscal year. Out of the twenty-seven HIFs, only nine managed to survive on the health insurance market, while the other eighteen went bankrupt. The main cause of the crisis was traced to the demand-generating FFS scheme. The FFS system motivated private healthcare providers to stimulate demand for healthcare and overproduce services. The increase in healthcare consumption created enormous difficulties for both the GHIF and HIFs, which were not able to match the strong demand and quickly fell into financial trouble. These troubles were exacerbated by the tough competition between the insurance funds. The more successful HIFs, which profited from ‘cream skimming’ by attracting young clients,¹⁸ were in a much better situation than the less competitive HIFs and the GHIF, which due to their unfavourable demographic structure ended up in serious troubles.

In response to the crisis, the government initiated a new round of reforms that included revisions of the previous laws and the introduction of a new law. The Law on General Health Insurance was amended twice, in 1995 and 1996. The amendments introduced a risk adjustment scheme that would re-allocate contributions between the insurance funds in order to lower the potential for ‘cream skimming’ and other forms of risk selection, and in order to ease the financial difficulties of the insurance funds with adverse risk structures. The amendments also restricted the competition between the insurance funds, as funds were no longer allowed to compete for profit by offering services above the standard benefits package but rather by cutting their administrative costs. A new law passed in 1997, the Law on Public Health Insurance (Law No. 48/97), introduced changes in the providers’ compensation schemes limiting the use of the

¹⁷ These HIFs organized mainly around large employers or according to specific industries, and some of them quickly became particularly successful in attracting young clients by offering them extra services, such as spa treatment and travel health insurance.

¹⁸ ‘Cream skimming’ refers to the insurance fund’s practice of offering extra services particularly attractive to young, low-cost clients.

FFS system to specific provider groups, and replacing it with a capitation system.¹⁹ Implementation of this law left the existing system of multiple insurance funds, in the main, intact, and a second round of reforms led to the financial stabilization of the Czech healthcare system by the end of the 1990s. The 2000s were characterized by further stabilization of the insurance sector and the wearing-in of the new policies. The major reform of the second transitional decade took place in 2007, when the Law on Public Stabilization Budget (Law No. 261/07) introduced user fees for medical visits, further marketizing Czech healthcare in spite of strong public and political opposition.

The Polish policy path was similar to the Czech only to the extent that it also followed a reform-crisis-reform dynamic. However, in contrast to the Czech reforms, Polish post-communist healthcare reforms were much slower, fragmented and suffered from large-scale reversal that made the Polish healthcare policy path rather discontinuous. Post-communist transformation of the Polish healthcare sector started with partial marketization reforms, focused on only one aspects of healthcare provision, that of healthcare delivery. In 1991, the first post-communist government of Poland managed to pass only one law, Law on Healthcare Institutions (Law No. 91/408), which replaced the old socialist system of healthcare delivery, decentralizing responsibility for healthcare provision and granting independency to healthcare facilities. This law also allowed for privatization by stating that these newly independent facilities could be of either public or private ownership. In contrast to these early reforms of healthcare delivery, reforms of the financial sector took place much later. It was only the eighth Polish post-communist government that in 1997 managed to pass the Law on Universal Healthcare Insurance (Law No. 28/153). This law, amended in 1998 and prepared for implementation not earlier than 1999, introduced an insurance-based ‘Bismarckian’ system with a market-oriented financing structure.²⁰ The law decentralized purchasing responsibility and stated that Polish healthcare would be financed and purchased through a set of insurance funds which would be regionally based²¹ and given full freedom: to determine the contributions levels for their clients, to define services to be contracted with healthcare providers and, finally, to negotiate with providers prices of medical service.

¹⁹ In the capitation system, providers are paid according to the number of their patients, not like in the FFS system, according to the number of services they provide.

²⁰ Implementing the insurance system in 1999, Poland was the last country of the Eastern bloc to depart from the socialist model of financing based on the general budget.

²¹ Competition between these regional funds was planned to take place only two years after the implementation of the insurance system.

Implementation of the newly legalized SHI system in the Polish healthcare system started in the first days of 1999. Sixteen insurance funds were established according to the territorial division of the country into sixteen regional units, the voivodeships.²² These funds started contracting with the regional healthcare providers and purchasing their services according to the different, fund-specific compensation schemes. The schemes varied drastically across funds, ranging from the FFS system or capitation for providers of primary care, to budgets, *per diem* payments or diagnosis-related groups (DRG) for facilities providing secondary care. This newly established system of healthcare financing was quickly faced with a number of difficulties and generated high levels of public discontent in less than a year after its implementation. Some of the difficulties were linked to the above mentioned administrative problems, which created confusion and controversy not only among the insurance funds, but also among doctors and patients. Another type of difficulty was related to managerial problem, which caused significant delays in the collection of insurance contributions and payments of healthcare providers. Additionally, lack of spending discipline among the regional funds led to serious financial troubles, creating a debt spiral.

In the face of these multiple difficulties and growing public dissatisfaction with the reform, the Polish government initiated a new reform round which led to a major policy reversal. In 2003, the Law on Health Insurance with the National Health Fund (Law No. 45/391) abolished the decentralized system of regionally based insurance funds and replaced it with a centralized system with only one fund, the National Health Fund (NIF), which was put under the direct surveillance of the Ministry of Health. The introduction of the NIF was a major step back in the reforms of the Polish healthcare system (see Filinson et al. 2003), which through re-centralization of healthcare financing radically reversed the course of market-oriented healthcare reforms in this post-communist country.

²² There was also the seventeenth fund, which was not regional but professional, acted on the national level and insured representatives of the so-called 'uniformed services' such as policemen, fireman, soldiers etc.

Table 3. Difference in Polish and Czech healthcare policy choices, 1989-2009.

Country/Policy Choice	Czech Republic	Poland
Privatization of outpatient care	Yes (1992)	Yes (1991)
Privatization of inpatient care	No	No
Introduction of co-payments	Yes?	Yes?
Introduction of user fees	Yes (2007)	No
Decentralization of financing	Yes (1992)	Yes (1997), No (2003)
Decentralization of delivery	Yes (1992)	Yes (1991)
Competition between insurance funds	Yes (1992, revised in 1997)	Yes (1997), No (2003)
Competition between healthcare providers	Yes (1991, revised in 1997)	No

Source: own.

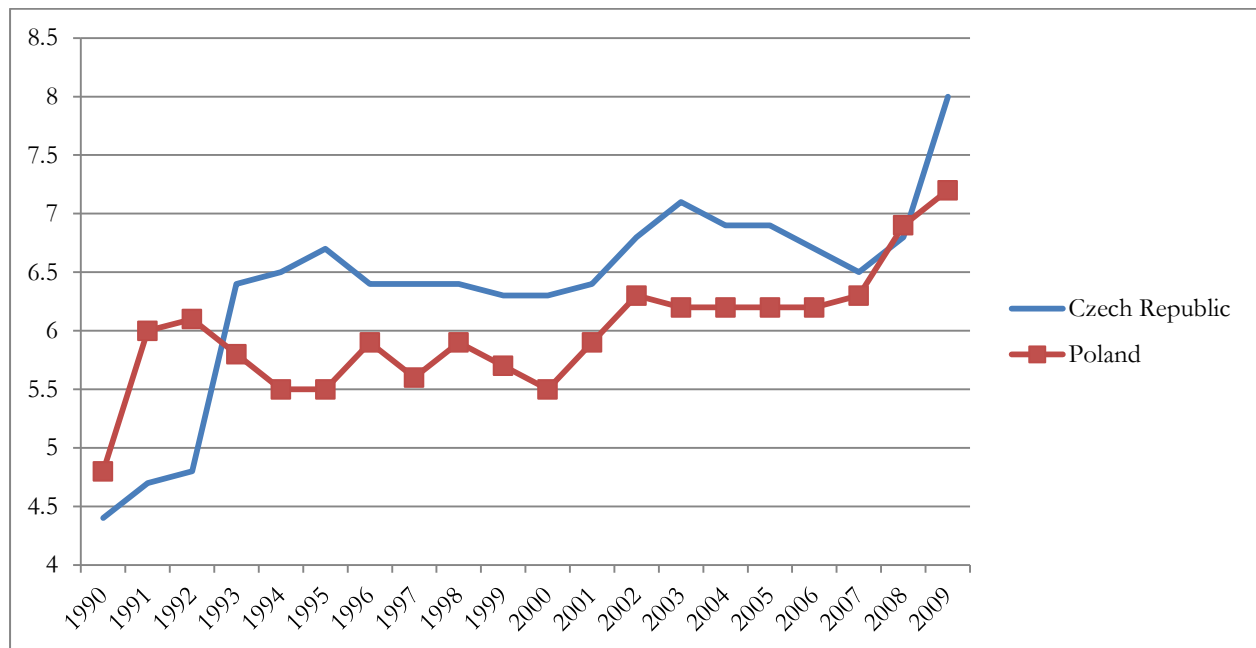
Divergence in policy outcomes

During the two decades of post-communist reforms, Polish and Czech healthcare experienced gradual but nevertheless significant improvements. In relative terms, healthcare spending in the two countries increased (figure 2) and some of the major health indicators witnessed major improvements. A close look at healthcare indicators data shows that from 1990 to 2009, life expectancy at birth was increased from 71.4 to 75.9 in the Czech Republic and from 71 to 75.9 in Poland. During the same period, mortality from circulatory diseases decreased from 157 to 79 cases in Polish and from 146 to 60 cases per 100 000 inhabitants in the Czech case.²³ While these positive results cannot be linked solely to the healthcare policy changes, they do suggest that the healthcare of the two countries in post-communism saw significant progress.²⁴

²³ These data are from the European Health For All Database, accessible at <http://data.euro.who.int/hfad/>.

²⁴ This shows that marketization was not coupled with retrenchment.

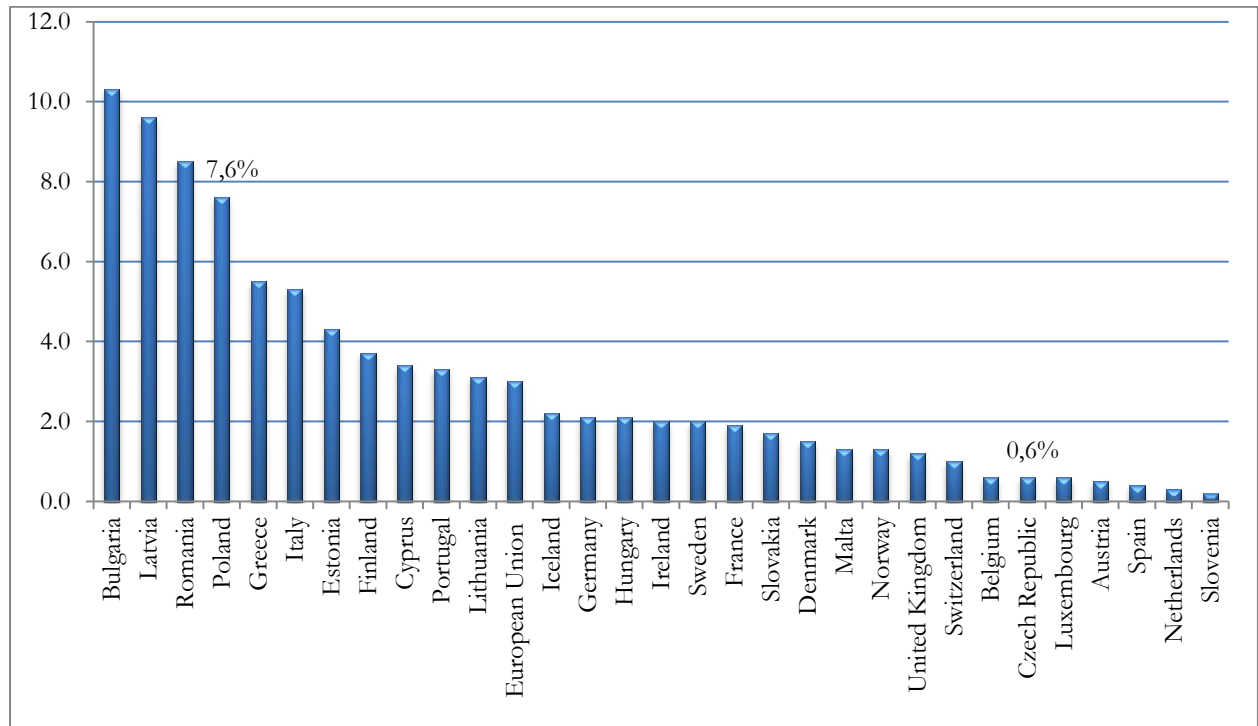
Figure 2. Health spending as percentage of the GDP, Poland and the Czech Republic, 1990-2009.



Source: European Health For All Database, data downloaded on 15.05. 2013 at <http://data.euro.who.int/hfad/>.

Yet, a closer look on the way citizens of the two countries perceive their healthcare systems reveals a dramatically different picture. A comparison of the performance of the healthcare sectors in these countries in two respect,; that of citizens' access to medical services and that of their perception of the quality of care in their country, reveals that the different policy paths of the two countries can be linked to the equally different policy outcomes. Comparison of the levels of unmet healthcare needs due to the barriers of access (figure 3), shows that the Polish and the Czech levels of unmet healthcare needs are significantly different. In contrast to 7.6% of Poles, who found it difficult to access the needed medical care due to the barriers in access, only 0.6% of Czechs experienced the same problem. From the broader international perspective, this difference looks even more striking, since Czechs are grouped with the citizens of Western European countries such as Austria, Switzerland and Belgium, while Poles are grouped with the citizens of Eastern or Southern European countries such as Latvia, Romania, Greece and Italy.

Figure 3. Percentage of survey respondents reporting unmet needs for medical examination for reasons of barriers of access in the OECD countries in 2009.²⁵

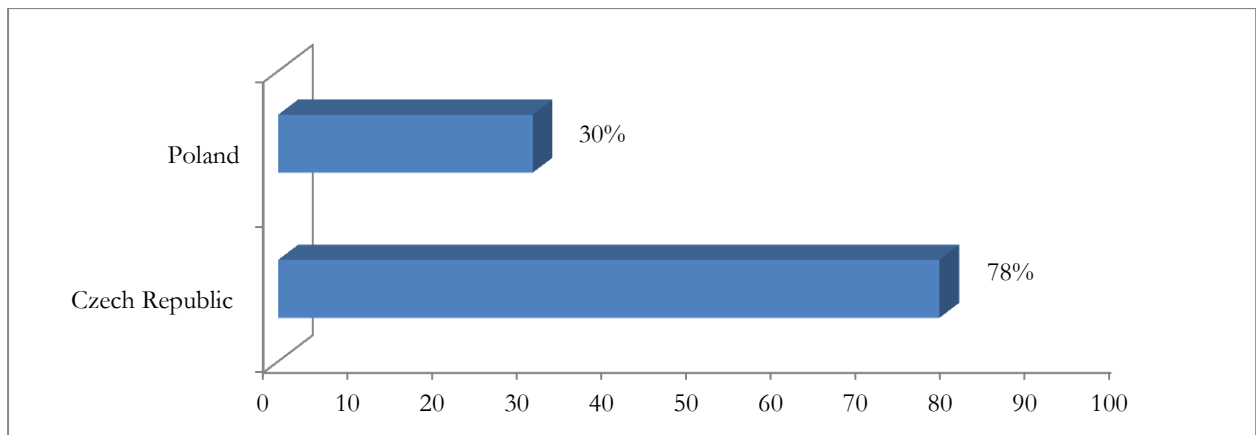


Source: EUROSTAT EU-SILC 2009 (data retrieved on 22.11.2013 from http://epp.eurostat.ec.europa.eu/portal/page/portal/microdata/eu_silc).

Another difference between the two countries lies in the opinion of Polish and Czech citizens about the quality of healthcare in their country. Comparison of the data from the Eurobarometer survey conducted in 2009, which measured citizens' perception of healthcare quality in their country (figure 4) shows that, unsurprisingly, a significantly lower percentage of Polish than Czech citizens evaluates the quality of their national healthcare as good.

²⁵ The most commonly mentioned barriers in access were: "too expensive", "too far to travel", or "waiting list" (EUROSTAT-EU SILC 2009, available at http://epp.eurostat.ec.europa.eu/portal/page/portal/microdata/eu_silc).

Figure 4. Percentage of survey respondents evaluating the quality of healthcare in their country as “good” in 2009.²⁶



Source: Eurobarometer 2010: 59.

This brief comparison of data on healthcare access and quality in the two countries shows strikingly different results. Two decades after the fall of communism and two decades of very intense reforms in the healthcare sector, significantly more Poles than Czechs experience barriers in the access to needed medical care and significantly more Poles perceive the quality of healthcare in their country in negative terms.

1.4. Explaining Policy Divergence: Argument in Brief

What explains the different policy paths of these two post-communist countries which, after two decades of reforms, feature healthcare systems with such strikingly different performance? This is the main question that motivates this doctoral thesis. The question can be broken down into several, more specific questions such as the following: Why were Czechs the pioneers and the Poles the laggards of healthcare reforms in post-communism? Why was the first round of Czech reforms so comprehensive while that in Poland was rather partial? Why, after the implementation problems emerged, did the Czechs keep the same structure of their insurance system in place, while the Poles decided to radically reshape it? Why, in sum, was the Polish post-communist healthcare reform so radically different in pace, design and comprehensiveness from that of the Czechs?

I argue that the divergence of Czech and Polish post-communist healthcare policy paths represents a case of different patterns of policy learning²⁷ in which three factors – ideas, interests

²⁶ The precise survey question was: “How would you evaluate the overall quality of healthcare in your country?” (Eurobarometer 2010: 59). It is also interesting that the results of another question from the same survey shows that 63% of Poles perceives the quality of healthcare in their country as worse than in the other EU countries, in comparison to only 28% of Czech who have the same opinion (ibid. p. 62).

and institutions – play a crucial role. In these different patterns of learning, I argue, expert ideas were the main drivers of policy change. These ideas, which were emerging already under communism in their rudimentary form, were formulated by healthcare policy experts in reports that both criticized the socialist healthcare system and offered solutions to its problems. These ideas were not prominent under communism but became very influential in the policymaking circles after the political regime changed in 1989. They became influential because they provided the basis for the development of different reform proposals, some of which managed to successfully link with interests of the major political actors and reach the government agenda. Finally, the passing of these proposals into policy depended on the significantly different institutional structures and political circumstances of the two countries.

This understanding of policy change as a process in which ideas, interests and institutions together played a crucial part explains why the Czechs were fast and Poles slow policy learners in healthcare policy of the communist period. I elaborate this argument in the second chapter where I develop a theoretical framework which refines the causal processes through which ideas, interests and institutions jointly determine the pace of policy change. While my argument aims primarily to explain the divergent policy paths of the two post-communist countries, it is also linked to some of the big questions in political science and public policy analysis. What, for example, is the role of ideas in policymaking? Why do certain rather controversial ideas, such as those of markets in healthcare, become politically prominent? What is the role of interests in policy change? Why are some policy proposals more successful than the other? What, finally, is the role of institutions in the process of policy change? While these are definitely some of the biggest questions in political science, in this thesis comparing the two cases of Czech and Polish healthcare reforms I try to shed some more light on the role of interests and institutions in the process of policy change, as well as on the role of ideas as cognitive factors in this process. Because of the very radical transformation of the healthcare systems in the two countries, and their different healthcare policy choices, the comparison of Czech and Polish policy paths offers an ideal opportunity for the understanding of causal mechanisms through which ideas, interests and institutions shape different paths of policy change.

2. Polish and Czech Healthcare Reforms in Context

Post-communist healthcare reforms took place in the context of a double transition to capitalism in democracy. In 1989 the collapse of the Berlin Wall signalled not only the victory of democracy, but also of capitalism, as Eastern Europeans wanted to break free from the political and economic traditions of state socialism. After the fall of communism, there was no prominent

school of thought in the West that doubted that the dissolution of Communist power was part of a process of Westernization in which contemporary Western ideas and institutions could and would be successfully exported to the former communist societies (Gray 1993). Yet, many scholars remained sceptical about the long-term viability of the transitional project, and warned about the possible conflicts between the political and the economic goals of the transition (Offe 1991, Przeworski 1991, Elster et al. 1998, Offe 2004). Jon Elster (Elster 1990), for example, argued that capitalism and democracy are mutually incompatible, and that the creation of democratic capitalism in Eastern Europe would be fraught with difficulties, if not complete failures.²⁸ Claus Offe (Offe 1991) painted an equally pessimistic picture of transition, holding that these former communist countries would face an even harder problem, the ‘triple transformation’ to capitalism, democracy, and the nation state. Pointing to the necessity of the nation building process in some of the Eastern European countries, he warned against the overloaded transitional agenda that could generate a variety of social, economic and political conflict and failures, of which democratic breakdown, in his view, seemed to be the most likely.

In spite of these rather bleak predictions, after less than a decade of intense transitional transformations, Central Eastern European societies successfully established democratic institutions and achieved economic growth (Stark and Bruszt 1998). Studies evidencing a variety of Eastern European capitalist democracies (King 2004, Bohle and Greskovits 2007, Myant and Drahokoupil 2011, Bohle 2012) suggest that while the post-communist transitions were difficult, they were certainly not uniform, and showed that the forecasts of a homogenous process of Eastern Europe’s ‘Westernization’ were rather wrong. This section offers an overview of the Czech and Polish transition to capitalism, democracy and the welfare state, in order to shed more light on the broader context of the Polish and Czech post-communist healthcare reforms.

2.1. Transition to capitalism

The Polish and Czech transitions to capitalism were specific in that they were based on the radical and rapid approach to economic transformation, the so-called “Shock Therapy”. The “Shock therapy” approach was opposed to the more gradual approach to economic transformation and was authored by experts from the International Monetary Fund and the World Bank, who argued that the shift from socialism to market economy in Eastern Europe had to be radical and focused on rapid privatization, liberalization and stabilization (Lipton and

²⁸ Elster (1990) for example argued that ownership reform and democracy are incompatible because private ownership deals can lead to income inequalities opposed by the wider segment of the population. In a similar vein, he argued, the free price setting fused with the bargaining for the allocation of labour and capital ultimately dampens the impact of the market forces.

Sachs 1990, Sachs 1991).²⁹ The stress on rapid transformation, in the form of an economic shock, was justified by the fear of a possible return of the communist regime. Jeffrey Sachs, one of the key economic advisers on Poland's transformation, argued: "The need to accelerate privatization is the paramount economic policy issue facing Eastern Europe. If there is no breakthrough in the privatization of the large exercises in the near future, the entire process could be stalled for years to come. Privatization is urgent and politically vulnerable" (Sachs 1991: 4). The consensus about the need to make capitalism work through the market economy in Eastern Europe and through "Shock Therapy" became irreversible, and was surprisingly strong among economists.³⁰

Another similarity between the Polish and Czech transitions to capitalism was that in both countries the implementation of "Shock Therapy" was entrusted to a small group of technocrats, out of which two prominent figures appeared. Leszek Balcerowicz in Poland and Václav Klaus in the Czech Republic became Ministers of Finance and the transitional economic reforms leaders. As the first post-communist Finance Ministers, they had an unusual amount of power to push for their reform agendas and implement them within a short time period. Their policy strategy was based on the idea that the transformation from the planned socialist into the market economy required a radical shift that must include key stabilization and liberalization measures, carried out simultaneously, and followed by privatization. Stabilization and liberalization were considered as two closely intertwined and mutually supporting reform policy packages. The stabilization package had to bring a renewal of internal and external market equilibrium and help the economy cope with inflation. To this end, a strict monetary and fiscal policy with an austerity income policy were introduced, and followed by measures such as excessive devaluation of national currencies. In fiscal policy, stabilization aimed at balancing the public budget by substantially restricting the previous system of tax breaks and subsidies. The liberalization package focused on the opening of the economy to the world market, including measures such as trade liberalization, freeing of prices, and internal convertibility (Adam 1999, Myant 2003).

As a transformation strategy, the "Shock Therapy" did not contain any specific measure particularly focused on economic growth. Architects of the transition believed in the neo-liberal

²⁹ In the Czech Republic the macroeconomic shock was set for 1 January 1991, while exactly one year later, on 1 January 1992, the similar shock was implemented in Poland.

³⁰ According to Summers: "Despite economists' reputation for never being able to agree on anything, there is a striking degree of unanimity in the advice that has been provided to the nations of Eastern Europe and the former Soviet Union. The legions of economists who have descended on the formerly communist economies have provided advice very similar [...] The three 'ations' – privatization, stabilization, and liberalization – must be completed as soon as possible" (Summers 1994: 252-3).

market orthodoxy, based on the idea that the spontaneous operation of market forces will sooner or later bring growth (Adam 1999: 18). This strong belief in the power of the free market was extremely dominant during the early transitional phase, not only among the post-communist transitional elites, but also among the wider public. “Liberalism without a prefix” or “market economy without an adjective”, as the Czech Prime and Finance Minister Václav Klaus has called it, was considered the main ‘way out’ of socialism and was expected to be both the solution for the economic problems inherited from the communist past and the guarantee of prosperity in the post-socialist era. At the same time, a high degree of free market enthusiasm among the wider public³¹ was by large generated by the disenchantment with the socialist system of central planning, with all its defects.

2.2. Transition to democracy

In contrast to the economic transition, the Czech and Polish transitions to democracy were initiated through relatively different paths of extrication from communism. While Poland followed the path of negotiated compromise between the regime and the opposition, the Czech Republic witnessed the capitulation of the regime in the face of escalating public demonstrations (Stark and Bruszt 1998: 18).³² Despite the difference in their extrication path, the necessity for institution building that would secure the political transformation of these formerly communist countries into functioning democracies was strongly felt in both countries. Additionally, the need for democracy to accompany the transformation to capitalism was justified by the claim that capitalism as a new form of economic organization could not be successfully carried out without democratic leadership and wide public support. According to the optimistic transitologists, it had been historically proven that the two transformations can successfully go hand in hand (Centeno 1994). It was believed that the existing experience from Western Europe had shown that a market economy is necessary for democracy, as it is the only form of economic organization that provides a form of social differentiation which is both divisive enough to generate groups with different interests, and cohesive enough to make these interests reconcilable through democratic procedures. It was also believed that democracy is necessary for the market economy because democratic institutions render a more secure environment for the development of capitalism, by

³¹ In both countries, the popular support for the creation of market economy was strong. A public opinion survey conducted in 1990 showed that 61% and 68% of respondents in Poland and the Czechoslovak Republic respectively approved the creation of a market economy, in contrast to 13% of Poles and 13% of Czechoslovaks who opposed it (Hofrichter and Weller 1990: 15). In 1993, the support was still strong, with support at 56% in Poland and 55% in Czech Republic, respectively (ibid.).

³² Stark and Bruszt (1998) distinguish between four different paths of extrication from monocratic state socialism in Eastern Europe: “Capitulation” (Czechoslovakia), “Compromise” (Poland), “Restricted Electoral Competition” (Bulgaria, Romania and Albania) and “Unfettered electoral competition”. These authors argue that the different extrication paths have “yielded different transitional institutions in the new policies of the region” (ibid. p. 18-19).

granting property rights, which would not be the case in a dictatorship. Finally, the firm belief was that there was no inherent conflict between the two sets of transitional goals. As Jeffrey Sachs, the leading advocate of the “Shock Therapy” approach, concluded: democracy and the market are ‘inextricable’ (Passell 1993).

Yet, it is interesting that the rapid economic reforms based on the “Shock therapy” were considered preferential to the more gradualist approach because of their potential to take advantage of a period of “extraordinary politics”³³ which radically differed from periods of normal democratic politics (Balcerowicz 1995). The political regime transition, it was argued by the “Shock Therapists”, provided a unique opportunity for economic reformers to introduce radical change. In the early period of regime transition, the public was more likely to grant government room for reform, either because it was not very clear in its preferences or because the potential opposition to the changes was not organized enough to block the reform course. This situation, they claimed, opened windows of opportunities for the reformers that enabled them to introduce and implement profound changes, which would otherwise be extremely difficult to push through in a time of ordinary democratic politics.

Two decades of transition to democracy have shown that radicalism in economic restructuring would very often come at high political costs since rapid marketization often correlated with a relatively stunted development of an active democratic process (Rose et al. 1998). Featuring frequent government changes, lack of left-right political divisions, volatile electorates, and still unconsolidated party systems, the first transitional decade marked a very precarious phase of political development in Central Eastern Europe. While during this early period, the danger of a return to some form of authoritarianism or populism was often present, by the beginning of the second transitional decade, democracy had become ‘the only game in town’ (Linz 1996).

2.3. Welfare state transition

In addition to its political costs, the road to the market economy in Central Eastern Europe also entailed unexpectedly high social costs (Ferge 1997, Milanovic 1998, Standing 1996).

³³ According to Balcerowicz: “Extraordinary politics is a short period and gives way to ‘normal’ politics: politics of political parties and of interest groups, a sharply reduced willingness to think and act for the common good, and stronger institutional constraints with respect to the individual political actors. In the period of extraordinary politics, these constraints are fluid or loosely defined”(Balcerowicz 1995:312). The main argument of the post-communist reformers to push for rapid reforms during ‘extraordinary politics’ was that the reformers would be isolated from political pressures. This was necessary, they argued, because the interest groups linked to the old socialist system could use the democratic institutions to undermine the reform process (Balcerowicz 1995; see also Lipton and Sachs 1990; Klaus 1991; Balcerowicz and Gelb 1994).

In their effort to mitigate the socially adverse effects of economic reforms, the first post-communist governments often relied on *ad hoc* emergency measures aimed at the creation of early safety nets for those most seriously affected by the economic change (Haggard and Kaufman 2008, Inglot 2008). These measures were often quite generous and specific, as they put high priority on two policy areas: unemployment and pensions. The creation of the unemployment programmes and early retirement schemes was considered necessary because these social policy schemes were non-existent in the socialist era (in the case of unemployment programmes), or were used as effective additional means for managing the transitional collapse of labour caused by privatization (in case of early retirement schemes). These *ad hoc* emergency welfare reforms were to a large extent strategic, as they were driven by the immediate political needs of the ruling elites to secure political support for the reforms, by protecting citizens from the sometimes extremely high social costs of the market transition (Cerami and Vanhuyse 2009).

Analysing welfare state transition in Central Eastern Europe, Claus Offe (1993) identified a logical progression of different social policy stages that each of the post-communist countries had to go through: emergency measures, institution building, reform and adjustment within established social policy institutions. The three-stage process implied that only after emergence measures were addressed, would post-communist governments be able to construct new social policy institutions fitting to the demands of the new economic system. Once the process of institution building was relatively advanced, it would be possible to speak of ‘normal’ social policy, which would include an ongoing process of institutional reform and adaptation. However, constructing the new social policy institutions fitting to the Eastern European capitalisms was not an easy task due to the legacy of the socialist “premature welfare state” (Kornai 1992). Strong commitment to full employment, provision of cheap basic consumer goods and housing, universal and free access to healthcare, family care and education were the main tenets of the socialist welfare state.³⁴ Since socialist welfare provisions were excessively generous, they enabled the citizens of the socialist countries to live well beyond what their level of economic development would justify. Some of the legacies of this premature, socialist welfare state affected social policy making in the new democracies. They had an impact on political battles over the welfare state reform, mainly due to high public expectations about welfare provisions, which created significant hurdles for the retrenchments of the welfare programmes and hardening of social policy budget constraints (Cerami and Vanhuyse 2009). Faced with a

³⁴ Since the socialist social contract was by no means the result of democratic politics, or even bargaining with affected interests, some authors have asked whether the social policy formations of Eastern European countries under communism could even be even called ‘welfare states’ in the Western European sense of the word (see Szikra and Tomka 2009).

limited repertoire of actions that was determined both by the economic model of transition to capitalism and the socialist legacies of the premature welfare state, Central Eastern European reformers opted for country-specific welfare state developments. In line with their preferred model of capitalism, labelled as an ‘embedded neo-liberalism’ (Bohle and Greskovits 2007), Czech and Polish reformers developed an inclusive model of social protection, subordinated to the overriding objectives of the neo-liberal economic policies.³⁵

2.4. Impact of transition on healthcare reforms

Polish and Czech post-communist healthcare reforms took place in the context of the double transition to capitalism and democracy in which transformation of the welfare state was inextricably linked to extremely dynamic political and economic developments. Each of the two transitions had a specific and relatively separate impact on healthcare reforms. The transition to capitalism influenced healthcare reforms in two different ways. One, more indirect way, was through its impact on the population health status, through the “transitional mortality crisis” (Cornia and Pannicià 2000), which took place at the beginning of the 1990s across the whole of Eastern Europe. This crisis was signalled by a deterioration in healthcare indicators across the region, a dramatic decrease in life expectancies and a rapid rise in mortality rates, which were explained either by large-scale privatization (Stuckler 2009), or more generally, by psychosocial stress and impoverishment caused by the economic transition (Pannicià 1997, Cornia and Pannicià 2000). The “transitional mortality crisis” had an impact on the healthcare reforms to the extent that it contributed to an increasing salience of the problems in the healthcare sector, stressing the need for reforms that were very often not at the top of the government agenda. Another mode in which economic transformations influenced healthcare reforms was related to the ideological context of post-communist transition. Post-communist economic restructuring in Eastern Europe was strongly inspired by the neo-liberal ideology (Przeworski 1991), which was actively promoted by both foreign and domestic reform advisors and based on a set of belief in the limitless power of the market. According to these beliefs, markets are self-correcting and capable of allocating resources in such an efficient manner that they can also serve the public interest.³⁶ As the governing ideological framework of Polish and Czech transitions to capitalism, neo-liberalism influenced the post-communist healthcare reforms, providing an extremely fertile

³⁵ “Embedded neo-liberalism”, according to Bohle and Greskovitz, developed within the cluster of four Višegrad countries, including Poland, Czech Republic, Hungary and Slovakia. They distinguish “embedded neo-liberalism” from the simple “neo-liberalism” developed in the Baltic countries and “neo-corporatism”, which developed in Slovenia (Bohle and Greskovitz 2007, 2012).

³⁶ Stiglitz, Joseph *The End of Neo-liberalism*, Project Syndicate, July 7th, 2008 (available at <http://www.project-syndicate.org/commentary/the-end-of-neo-liberalism->). According to Amable (2010), neo-liberal ideology also carries a strong moral dimension.

intellectual ground for the growth of market-oriented ideas in the healthcare sector. Similar to the economic sector, in which neo-liberal views fostered privatization and competition as solutions for growth and economic recovery, the very same market instruments started to be seen as solutions for problems of healthcare provision.

Political transition to democracy also had a two-fold influence on Czech and Polish healthcare reforms. First, influence on the reforms was brought into play by a turbulent process of democratization. The transformation of the young and fragile Czech and Polish democracies into relatively mature and stable democratic political systems was characterized by frequent government changes, unstable party systems and volatile electorates, all of which had a very profound impact on the policymaking process in healthcare. Besides the wholesale government changes typically following elections, intra-governmental changes of healthcare minister presented another very common political phenomenon. From 1989 to 2009, Poland had no less than 17 healthcare ministers, 6 of whom were replaced through the intra-governmental re-arrangements. In the Czech Republic, 7 out of 16 ministers were the victims of intra-governmental rivalries. These frequent governmental and intra-governmental changes affected healthcare reforms, since hardly any of the major healthcare reforms in the two countries were prepared, enacted and implemented under the same governmental or ministerial constellation.

The second way in which political transformation influenced healthcare reforms was institutional. The Polish and Czech political transitions to democracy were marked by divergent paths of democratic institution building. These divergent paths had their origins in the countries' divergent models of extrication from communism (Stark and Bruszt 1998). Czech extrication, based on capitulation of the old regime, together with the breakup of the federal Czechoslovak state, led to the quick passing of the 1992 constitution that established the Czech Republic as a parliamentary democracy with a relatively light structure of institutional checks and balances. In contrast, Polish extrication, based on compromise, generated a protracted process of institutional design that delayed the passing of the new constitution until 1997. This new constitution created a relatively dense structure of institutional checks and balances. The impact of these different institutional configurations of post-communist healthcare policymaking in the two countries will be very profound.

3. Markets in Healthcare

The introduction of markets in healthcare was not a uniquely post-socialist phenomenon. As mentioned in the introduction, in the last several decades countries across Europe introduced

some sort of market mechanisms into the financing and delivery of medical services. This section shows that markets in healthcare represent rather complex policy phenomena with their own histories, theoretical and practical dimensions. Historically, the introduction of market policies in healthcare has been a relatively recent but increasingly dominant tendency of healthcare reforms across the modern industrialized world. The first examples of market mechanism in financing and delivery of health services emerged as a response to the welfare state crisis in the 1970s. In the two decades following this crisis, different types of market activities emerged surprisingly quickly in most of the European healthcare systems. From a theoretical point of view, the introduction of markets in healthcare is puzzling. Given the natural inclination of the healthcare sector toward market failures, the introduction of market-oriented policies of healthcare provision has often been considered with caution. In practice, market-oriented healthcare policies have taken a variety of forms across countries, and these various forms have produced a multitude of different outcomes. This section starts by discussing some conceptual issues surrounding markets in healthcare, and offers an overview of the three different dimensions of markets in healthcare: historical, theoretical and practical.

3.1. Conceptual issues

What are healthcare markets? How can we best define them? The existing literature offers different possibilities for the definition of markets in healthcare. Healthcare markets can be defined with reference to the broader phenomenon of markets in the welfare state. Frank Nullmeier (2001: 79), for example, defines welfare markets as ‘social and economic formations’ that satisfy three specific criteria. First, they imply some form of market-like structure that exchanges social goods and services. Second, they carry out activities that were formerly in the realm of the welfare state. Third, they are enacted through social policy laws. Jane Gingrich (Gingrich 2011: 7-8) offers a somewhat different definition of welfare markets, in which she stresses the behavioural dimension. “The chief feature that distinguishes markets from other forms of organization”, she argues, “is that they influence behaviour manipulating incentives for consumers and producers of services”. Gingrich’s definition is useful in that it distinguishes markets from both the hierarchical ‘command and control’ systems, in which a central agency defines processes and outcomes, and from the ‘network’ systems, in which users and providers operate on the basis of trust (ibid.).

Other authors provide more specific definitions of markets in the healthcare sector. Julian Le Grand, one of the founding fathers of the market-oriented reforms in the British NHS system under the Tony Blair government, defined market-oriented mechanism of healthcare

provision not as ‘pure’ markets but rather, as “quasi-markets” (Le Grand and Bartlett 1993, Le Grand 2007). These “quasi-markets”, according to Le Grand and Bartlett (Le Grand and Bartlett 1993), are markets in which the provision of a service is undertaken by competitive providers just as in pure markets, but where the purchasers of those services are financed from resources provided by the State instead of their own private resource. Le Grand argues that similar to “quasi-markets” in education, “quasi markets” in healthcare imply that the services are provided for free or largely free at the point of delivery, and unlike under most forms of State provision, that the user has a choice of provider and that the providers themselves operate in a competitive market (Le Grand 2011: 80-1). Tracking market-oriented changes in healthcare, other authors distinguished between ‘marketization’ and ‘economization’ of healthcare. Ewert (Ewert 2009), for example, argues that there is a significant difference between the two processes in respect to the degree in which they attach importance to the State. While ‘economized’ health policy depends on the strong and regulative State and involves elements of central steering, ‘marketization’ reduces the impact of the State by initiating competition between non-profit and for-profit providers, the contracting-out of certain services or the formation of new kinds of contracts between users and providers, and without the state (ibid. p. 24).

The different definitions of markets in healthcare or markets in welfare more generally, suggest that healthcare markets cannot be very easily classified according to the traditional ‘Private-Public’ or ‘State-Market’ dichotomies. Even the most market-oriented healthcare systems feature some role of the State and provide care with ‘quasi’ rather than ‘pure’ market instruments.³⁷ This is one of the reasons why healthcare markets represent a rather complex phenomenon. In the following three sections, I shed more light on three different aspects: the history, theory and practice of markets in healthcare.

3.2. History

While interest in healthcare markets can be traced back to the early developments of the European healthcare systems, it was in the 1970s that the interest in markets entered policymaking circles and took on a new energy (Callahan and Wasunna 2006). The emergence of markets in healthcare coincided with a period of economic crisis, when appeals for more prudent government spending started to be heard in a number of European countries. By the 1980s, the markets advocacy began to gain ground among policymakers across the European continent, but

³⁷ In 2010, public spending in the US health system, which is considered the most marketized healthcare system in the world, amounted to the 48% of the total healthcare spending (OECD Health Data). Most of this public spending is provided through Medicare and Medicaid, government-run programmes of healthcare financing for poor, old or some chronically ill parts of the American population.

it was particularly in the United Kingdom, through the approach of Margaret Thatcher's Conservative government, that the markets won their political battle. Thatcher's government opted for the transformation of the NHS through a series of reforms envisaging the introduction of 'internal markets' into the British healthcare system (Light 1997). Affection for markets spread quickly among policymakers in the rest of Western Europe. Governments gradually introduced markets as mechanisms of healthcare provision, resting on a belief that these new mechanisms would significantly improve the financial sustainability of the sector, which was becoming increasingly challenged by the growing costs of care and the changing healthcare needs of the population.

However, it was the period of the 1990s that witnessed a rather dramatic upsurge in the scale and character of market-oriented initiatives within healthcare systems across Europe. A wide variety of market inspired attempts to stimulate innovations in service provision, including increased quality and greater efficiency, have been launched within and outside of the public healthcare sector, as market mechanisms started to be used in the provision of core healthcare services, as well as ancillary services. What was particularly appealing was that the common orientation toward the market became evident in all European countries, and despite the peculiarity of the historical and structural differences between their healthcare systems. Not only the United Kingdom, but also the Nordic countries - Sweden, Norway and Denmark, all known for their strong tradition of NHS systems built during the post-war period, gradually introduced various forms of internal markets for publicly provided healthcare.³⁸ Similarly, in the Netherlands and Germany, where the SHI systems date back to the period before the World War I, markets became increasingly accepted tools of healthcare provision.³⁹ Finally, in the South European countries, such as Italy, Spain and Portugal, where universal SHI system were established much more recently, markets found their place in both healthcare financing and delivery.⁴⁰ Because of this pan-European move toward markets, the decade of 1990s represented a period of substantial re-configuration of the healthcare sector, strongly characterized with an increase of market-oriented activities in financing, organization, delivery and management of healthcare provision (Saltman and Figueras 1997, Saltman et al. 1998, Saltman et al. 2004).

³⁸ For an overview of the healthcare reforms in the UK see Klein 2010; in Denmark see Pedersen and Christiansen 2005; in Norway see Erichsen 1995; and in Sweden see Harrison and Calltorp 2000.

³⁹ For an overview of the reforms in the Netherlands, see Schut 1995, Helderma et al. 2005; in Germany see Brown and Amelung 1999, Altenstetter 1999.

⁴⁰ For an overview of the reforms in Italy see Ferrera 1995, in Spain see Guillén and Cabiedes 1997; and in Greece see Matsaganis 1998.

The introduction of markets in healthcare across Europe was accompanied by a profound change at the level of policy discourse. A new emphasis on terms such as ‘individual responsibility’ or ‘choice’ replaced the old policy rhetoric focused on universal, public and solidarity-based healthcare provision, even in those countries with a long tradition of healthcare provided through an NHS. In Sweden, the political parties in power in the 1990s called for a ‘freedom of choice revolution’ that would empower the dependent clients of state services by transforming them into self-confident customers (Rothstein 1998). Almost simultaneously, the Conservative government’s policy discourse in the United Kingdom challenged the entrenched, inefficient and unresponsive public services in healthcare, and re-conceptualized patients as consumers, encouraging them to be demanding (Light 2003). In other countries that also implemented market oriented changes, this change at the level of policy discourse became similarly evident.

3.3. Theoretical issues

In economic theory, the relationship between markets and healthcare is rather complicated because the healthcare and welfare sectors more generally are considered to be particularly prone to market failures (Arrow 1963, Arrow 1973, Barr 2004). Neo-classical economic theory argues that if markets are allowed to operate freely, they will optimally deliver goods and services to society, following price signals.⁴¹ If a commodity such as a loaf of bread is sold in the market with many sellers and buyers, homogenous products, free entry and exit and perfect knowledge, companies will be able to sell bread to individuals and individuals will be able to buy it following the price signals. This will ultimately lead to the Pareto efficient, i.e. socially desirable outcomes.⁴² The economics of the welfare state suggests that this neo-classical model does not work in the welfare domain, since some forms of market failures beset many public services (Barr 2004). These failures prevent market formations in the welfare sector to match, or even approximate, the neo-classical model of perfect competition, in which resources are allocated and produced efficiently on the basis of competition among equal participants.

Within the welfare state, healthcare figures as a sector particularly prone to market failures, because of the specific character of goods and services it provides. In his seminal article from 1963, the Nobel Laureate economist Kenneth Arrow (Arrow 1963) demonstrated that the

⁴¹ This is the so-called ‘First Fundamental Theorem of Welfare Economics’. The Theorem states that a perfectly competitive market will generate an allocation of resources that is efficient for society (Morris et al. 2007: 124).

⁴² Pareto or socially efficient outcomes cause a distribution in which it is impossible to improve the welfare of one or more individuals without simultaneously reducing the welfare of others. In other words, Pareto efficiency occurs when it is not possible to make someone in the society better off without making someone else worse off.

free market does not work in healthcare because the need for healthcare goods and services is unpredictable, and individuals face considerable difficulties in making decisions that are in their own interest, due to the specific character of these goods and services. Since the publication of Arrow's article, various studies on markets and healthcare have found multiple reasons why markets fail in delivering of healthcare (see Morris et al. 2007). One of the reasons why market failures arise in healthcare is that of externalities, i.e. spill-over effects incurred in the production and consumption of medical services in the market. These spill-over effects may be negative, when other members of society are adversely affected by the spill over effect, or positive, when other members are affected beneficially by these effects. An example of negative externality is the pollution of beaches by hospital waste, and a positive example is vaccination. Second, market failures in healthcare arise because of the asymmetries of market power, which can give rise to monopolies or imperfect competition, which result in healthcare markets providing less healthcare than is Pareto efficient. Third, market failures arise because most healthcare products are not public goods, since they are both rival and excludable. The receipt of healthcare by one person will usually prevent another person from consuming that same health care – for example, one person's admission to a hospital bed prevents another from using it. Finally, market failures in healthcare arise because of imperfect information (see Arrow 1963, Akerlof 1970, Rothschild and Stiglitz 1989). Imperfect information arises due to uncertainty and imperfect knowledge (Arrow 1963). Uncertainty pervades healthcare, since the principal characteristic of medical care is uncertainty. Individuals do not know when they will become ill, what kind of healthcare they will require and at what cost. Additionally, there is uncertainty about how any given state of ill health will respond to healthcare, since the recovery from the disease is as uncertain as its occurrence. The problem of uncertainty in healthcare can be addressed through the introduction of health insurance. However, this does not solve the problem, because healthcare insurance markets are also prone to market failures. Failures in the market for healthcare insurance occur in the form of adverse selection or moral hazard, which are both caused by information asymmetries. While adverse selection arises when only individuals with high risks decide to buy insurance (Cutler and Zechauser 1997); moral hazard is observed when individuals do not take on the full consequences and responsibilities of their actions, which results in the excessive use of healthcare services (Arrow 1968).

Failures of healthcare and healthcare insurance market to provide socially efficient allocation of medical goods and services call for a role of the State in healthcare.⁴³ There are

⁴³ A case for government involvement in healthcare was supported by some of the most liberal economists, such as Friedrich A. Hayek. According to Hayek: 'Where, as in the case of sickness and accident, neither the desire to avoid

different policy instruments governments can use in order to intervene in the provision of medical care. They can intervene directly, acting as funders and providers of healthcare, or indirectly, through taxes, subsidies, regulation or provision of information (Morris et al. 2007). The use of regulation, for example, implies that government establishes rules by prohibiting certain types of medical treatment because of its adverse consequences on health, while information provision implies supply of information to the general public about benefits of certain types of healthcare, such as MMR vaccine⁴⁴ for example. While government's interventions in healthcare can help correct market failures, they run the risk of generating an equivalently serious problem: government failures. Similar to market failures, government failures create a strong case for a limited government intervention in healthcare.

3.4. Healthcare markets in practice

In practice, markets introduced in healthcare take many forms. Following Gingrich's (Gingrich 2011) definition of markets as generators of competitive incentives, one could talk about family resemblance between different forms of markets in healthcare. All of these different forms use competitive mechanisms to allocate scarce resources, manipulating the behavioural incentives of the main actors in the system – patients as users, insurance funds as payers, and doctors as providers of care. At the same time, markets in healthcare differ depending on the aspect of behaviour and the dimensions of care provision they principally target.

Market mechanisms introduced in healthcare delivery involved privatization, which was expected to generate competitive provision of healthcare among public and private providers. Privatization in practice has taken many forms, as a shift of ownership and responsibilities from public to private agent operating on not-for-profit or for-profit base (Saltman et al. 2003, Maarse 2006). Countries that have gradually privatized their healthcare delivery have also often made moves toward decentralization, which implied different degrees of autonomy and financial responsibility given to the healthcare service providers (Saltman et al. 2007). Incentives for competition between providers have been created through performance-based compensation methods, such as fee-for-service (FFS) for outpatients, and diagnosis-related group (DRG)⁴⁵ for in-patient or hospital treatments (Thomson et al. 2009). The purpose of the performance-based

such calamities nor the efforts to overcome their consequences are as a rule weakened by the provision of assistance - where, in short, we deal with genuinely insurable risks – the case for the state's helping to organize a comprehensive system of social insurance is very strong' (Hayek 2007:148).

⁴⁴ Measles, mumps and rubella vaccine.

⁴⁵ Diagnosis-related group (DRG) is a system used to classify hospital cases into one of originally 467 groups. The main objective of the DRG compensation method was to develop a classification system that identified the 'products' that the patient received.

compensations was to make funding of healthcare more dependent on the productivity and actual, rather than predicted performance of the providers. In order to further stimulate competitiveness, many countries have been continuously working on patient empowerment, allowing free choice of primary care doctors and hospitals, and providing information that enables patients to make better choices (Saltman and Figueras 1997, Saltman et al. 1998). In healthcare financing, market practices have been principally focused on introducing competitive incentives for a more efficient and cost-conscious use of healthcare resources. With this objective in mind, many countries have gradually reduced public, and increased out-of-pocket payments for services, through the introduction of flat fees for doctor or hospital services, or co-payments for specific medical procedures and medicines (Mossialos et al. 2002). Some countries also introduced private health insurance as an either supplementary or complementary way of healthcare financing, alongside the existing public schemes (Preker and Scheffler 2006).

Despite their family resemblances, healthcare markets differ significantly in terms of their outcomes. The American system of healthcare, which relies heavily on market elements, has featured catastrophically high costs. In Europe, reforms focused on introducing markets in healthcare have had varying effects, as they sometimes increased and other times decreased costs. In terms of quality, evidence shows that market reforms in some countries improved doctors' attention to patients, while in others they worsened (see Ranade 1998; Freeman and Moran 2000). What is even more interesting is that markets have not uniformly limited the role of the state in healthcare (see Gingrich 2011). The existing studies shows that turning to markets in healthcare provision in many countries led to the strengthening of state control over budgets, hospital and physician payments, as well as quality and performance regulation (see Saltman and Figueras 1997).

4. Research Design and Methodology

Why did Polish and Czech post-socialist healthcare depart on different policymaking paths, which have given rise to such distinctive outcomes? This main research question of this thesis has directed the choice of research design and methodology, which is based on the comparative small-N approach. The small-N approach is the case-oriented research strategy focused upon a small number of cases, analysed with attention to each case as an interpretable whole (Ragin 2000). One of the main advantages of the small-N approach is that it is a method reflective of the specificity of each particular case, but nevertheless allows for identification of historically concrete generalizations (Della Porta and Keating 2008). The particular research technique used for the assessment of each selected case was process tracing. Process tracing

involves the procedure of identifying steps in the causal process leading to the outcome of a given dependent variable of a particular case, in a particular historical process (George and Bennett 2005). This research technique is considered suitable for intensive case studies because it allows for the identification of specific factors and causal mechanisms, and has been chosen because of its explorative character, which allows for identification of new explanatory elements in the course of the research process (Vennesson 2008).

4.1. Small-N research design

Small-N research design emerged as the most suitable approach to systematic analysis of post-communist health care reform because of its capacity to solve the problem of divergence of ontology and methodology in comparative politics (see Hall 2003).⁴⁶ According to Bennett and Elman, methodological choices must take into account the characteristic of the phenomena we seek to understand (Bennett and Elman 2006: 250). As my brief analysis of the Polish and Czech cases of healthcare reforms in this chapter has already suggested, these reforms were contextually embedded, complex processes and surrounded by a multiplicity of factors that influenced their course. Instead of treating the comparison of the cases primarily as an exercise in correlating a few independent variables with the dependent variable, the small-N approach allows one to conduct a causal analysis of each of the cases in a more sophisticated manner. Precisely because such research design covers a small number of cases, it allowed me to investigate particular causal processes that led to the difference in trajectories and outcomes of Czech and Polish healthcare reforms. This also allowed me to assess the explanatory power of each of the alternative theories and explanations against my main argument. The comparative method hence emerged as a distinctive and particularly suitable research approach that offered a much richer set of observations of the processes and outcomes than a large-N statistical analysis, thereby presenting the method more closely aligned with the ontological complexity of the phenomena at hand (see Hall 2003: 397).

4.2. Causal analysis

The focus of the research project investigating the post-communist healthcare reforms was on causal mechanisms. This meant that the emphasis was put on the chain of events that led

⁴⁶ According to Hall (Hall 2003: 374-5), this divergence occurred because there has been a post-war trend in comparative politics toward statistical methods, based pre-eminently on the standard regression model, while over the same period, the ontologies moved in the opposite direction – toward theories with conceptions of the causal structures at odds with the assumptions required for standard regression techniques. Comparative small-N research designs, in Hall's opinion, as intensive comparisons of a small number of cases can provide rigorous assessment of any kind of theory, and are indispensable for assessing theories of comparative politics whose ontologies specify complex causal structures incompatible with the assumptions required by regression analysis (ibid. p. 399-40).

to the specifically different policy paths of the two countries. The importance of causal analysis in social science was emphasized by Hedström and Swedberg (Hedström and Swedberg 1998), who argued that the advancement of social theory calls for an analytical approach that systematically seeks to explain observed associations between events. This emphasis on causation points to the intention of social science to be explanatory, i.e. to be able to explain why and how something happened, rather than just to describe, label or re-label the phenomena it deals with. Looking for mechanisms in the social world should therefore not be confused with a purely descriptive approach, which seeks to account for a chain of events that lead from one situation or event to another.

According to Yin (Yin 1994), all proper explanations explain the particular by reference to the general and while generalizations from empirical case studies and comparisons can of course be limited, they allow for analytical generalizations, which yield empirical findings that can be discussed and held against existing theories. Also, a focus on mechanisms, rather than laws, emphasizes that while laws are generally reserved for natural science such as physics, and represent explanations that allow for no significant exceptions, causal i.e. mechanistic, explanations follow a different logic. Explanation based on mechanisms, more frequently encountered in sciences such as biology, allows modifications of different components and adding of new mechanisms to the previously used ones. Finally, the last reason why the mechanism-based approach was chosen over the law-generating or variable-based approaches is that it does not base the understanding of the phenomena on the descriptive statistical models, but rather concentrates on the logic of the processes being analysed, in order to explore the generative mechanisms responsible for them (Hedström and Swedberg 1998).

4.3. Process tracing

Given the small-N research design and emphasis on causal mechanisms investigation, process tracing was used as the most suitable research technique. Process tracing provides an opportunity for combining positivist and interpretivist approaches in the making of the case studies (Vennesson 2008: 233-4). From a positivist's perspective, the main goal of process tracing is to establish and evaluate the link, or the absence of the link, between different factors. From an interpretivist's perspective, process tracing allows the researcher to look for the ways in which this link manifests itself in the context in which it happens. With an emphasis on both aspects of the given phenomena, the causation itself and the context in which it takes place are taken into consideration. For this purpose, the study relies on a strategy of thick historical descriptions based upon empirical materials for each particular case: historical data, academic

work, newspaper articles, statistical data, and interviews with policy makers, civil servants, journalists, union and professional associations' representatives, policy experts and medical professionals.

4.4. Case studies

Finally, case studies are used for their capacity to generate theoretical ideas, test theoretical propositions and offer persuasive causal explanations (Mahoney and Rueschemeyer 2003). Cases study selection has been guided by the strategy of the Most Similar System Design which means that the selection criteria relied on both inter-systemic similarities and inter-systemic differences of the cases in question (Przeworski and Teune 1970, Della Porta and Keating 2008). Similarities between the two cases refer to the corresponding 'command and control' system of healthcare Poles and Czechs implemented after the Second World War and kept in place until the fall of communism in 1989. They also refer to the similar sets of challenges faced by the Polish and Czech policymakers in post-communism and the similar institutional frameworks they introduced into their healthcare system in response to these challenges. Differences between the cases refer to the significantly distinct reform trajectories and healthcare system outcomes, generated by the different policy choices in the two countries.

4.5. Data collection

The empirical data used in the thesis were gathered over a period of four years. In order to access documents and carry out interviews with health care policy makers, I spent two periods of fieldwork in the Czech Republic (Prague, September-October 2010 and November-December 2011) and in Poland (Warsaw and Cracow, September-November 2011). During this period, I gathered policy-relevant data and documents, and conducted a series of semi-structured interviews. The aim of these interviews was to shed light on important episodes of healthcare policymaking in the period from 1989 to 2009. My interviewees' profiles ranged from journalists, civil servants, politicians, trade unionists, healthcare professionals to academics. I carried out forty-two interviews in both countries in total. A sample of the interview questions and the list of interviews conducted in each country are available in the appendix.

The interviews were semi-structured i.e. they were guided by a broad set of topics rather than a fixed list of questions. In some cases, questions were sent to the interviewee in advance, usually because he or she requested this. In all cases, the general pattern of the interview was adjusted to the profile of the person interviewed, which depended on his or her position and role in the healthcare policymaking process. Interviews were divided into three sets of questions. The

first set of questions normally focused on the history and characteristics of the country's healthcare system under communism. The second set of topics was more reform specific and usually referred to a particular policymaking episode in which the interviewee was a direct or indirect participant and was hence expected to have deeper knowledge and experience. The third set of questions was dedicated to more specific questions for each interviewee and thus ranged in issues. Overall, the questions focused on interviewee's views of the roles of different actors, their ideas and interests in the policymaking process, covering the most important episodes of healthcare policymaking during the two post-communist decades in each of the two countries. The duration of the interviews ranged from half an hour to three hours, with each interview on average lasting for about an hour. Thirty-six interviews were carried out in person, recorded and transcribed; five interviews were conducted through e-mail correspondence and one was conducted as a Skype interview. All of the interviewees were granted anonymity and have given their consent for the use of their interview statements for the purpose of this particular PhD thesis.

5. Summary

This chapter charted the path of this thesis focused on market-oriented healthcare reforms in two countries of post-communist Central Eastern Europe. Concentrating upon two particular cases of these reforms, Polish and Czech healthcare reforms, the chapter showed how these reforms were similar in some of the most general, systemic aspects but strikingly different in their respective policy trajectories and outcomes. The chapter also specified the main research question of the thesis, outlined its core argument in brief, explained the context of post-communist healthcare reforms, discussed different dimensions of markets in healthcare and described the methodology and research design.

The second chapter develops the theoretical framework of the main argument of this thesis and analyses four alternative explanations of post-communist policy change. The third and the fourth chapters are empirical and each chapter offers a detailed study of one of the reform cases. The third chapter sheds light on the Polish and the fourth on the Czech healthcare reforms in the period from 1989 to 2009. The fifth chapter, which concludes the thesis, summarizes its main findings and discusses some of its most relevant implications.

Chapter Two: Theoretical Framework

Introduction

What determines the pace of policy change and why do policy makers in some countries come up with new policies faster than in others? The previous chapter offered a brief overview of Czech and Polish health reforms, demonstrating radical divergence in the patterns of policy innovation across the two countries. In this chapter, I elaborate a theoretical framework that helps analysis of this divergence and which refines the main argument of this thesis. Let me remind the reader that my argument claims that the divergent paths of post-communist healthcare reforms are best explained by different learning processes that took place in the two countries. In this chapter I elaborate this main argument, focusing on the three elements that played a crucial role in this learning process – ideas, interests and institutions – and explain how these three elements jointly shaped the policymaking processes that led to the divergence of Czech and Polish post-communist healthcare reforms.

The existing literature on policy change can be broadly divided into three main theory streams. One is the ‘institutions stream’ which has its roots in the historical institutionalism branch of the neo-institutional theories of politics and stresses the role of institutions, understood as both formal and informal rules, in the shaping of policy paths and outcomes (Weir 1985, Immergut 1992a, 1992b Steinmo, Thelen et al. 1992, Steinmo and Watts 1995). Another is the ‘interest stream’ that emphasizes the role of individual and group interests in the process of policymaking (Downs 1957, Buchanan 1962, Ordeshook 1986). Finally, the third is the ‘ideas stream’, which assigns a crucial role to ideas and cognitive processes in bringing about policy change (Guillén and Vale 1990, Blyth 2002, Blyth 2003, Béland 2010, Steinmo 2010). The theoretical framework developed in this chapter brings together these three different theory streams, treating ideas, interest and institutions as three different yet strongly interdependent factors of policy change in the post-communist context. As such, this chapter has two main objectives. First, it aims to link the explanation of post-communist healthcare transformation to the broader discussion on the role of ideas, interests and institutions in the process of policy change. Existing studies of policy change in Eastern Europe have often tended to emphasize either the role of past institutions, in the form of old institutions and legacies from the communist, or even pre-communist period (e.g. Inglot 2008, Pop-Eleches and Tucker 2011), or the role of the interests of the post-communist economic and political elites (e.g. Hellman 1998,

Stark and Bruszt 1998), in order to explain policy change. My argument goes beyond these existing explanations in that it integrates institutions, interests and ideas into one theoretical framework, which enables us to understand and explain two cases of policy change in the post-communist context. Second and more specifically, this framework aims to contribute to the study of ideas and cognitive processes of policy change, which are understood as processes that shape and reshape the perceptions of and attitudes towards social problems and the way to tackle them (Guillén and Álvarez 2004: 286). Surprisingly, ideas have very rarely been used as important explanatory factors of the dramatic and large-scale policy changes that took place in the Eastern European part of the world after the fall of communism.⁴⁷ Surely, there are studies that stress the importance of neo-liberal ideology in the making of post-communist economic and social policy (e.g. Bohle and Greskovitz 2012) but no study so far, to my knowledge, has used ideas and cognitive processes such as learning to explain cases of post-communist policy change. Since my argument assigns ideas a rather crucial role in the process of policy change, it aims to contribute to the filling of this gap in the existing literature.

This chapter is divided into two main sections. The first section elaborates the theoretical framework of my argument, focusing on three of its main elements – ideas, interests and institutions. It introduces concepts of “social learning” and “paradigm change” (Hall 1990, 1993) which help explain how ideas drive change and determine the direction of policymaking in situations of uncertainty. It also looks more closely at interests and explains how through their links with identities (Hall 1993) and institutional roles (March and Olsen 1989, 2009) interests shape the preferences of policymakers. Finally, to account for the role of institutions in policy change, it introduces the concept of “veto points” (Immergut 1990, Immergut 1992a, 1992b), which helps explain how formal political institutions can either block new change or open windows of opportunity for change. The second section considers four alternative explanations that challenge the main argument of this thesis. It analyses four different theoretical approaches - Power Resource Theory, Partisanship Theory, Professional Dominance Theory and the Legacies approach - and discusses their potential to explain the two cases of post-communist healthcare reforms. In this section I explain why, in contrast to my argument, these alternative explanations fail to account for the divergence between the Czech and Polish healthcare policy paths.

⁴⁷ One of the notable exceptions here is an article by Bockman and Eyal (2002), which traces the roots of the neo-liberal ideas in the period before the actual fall of communism in 1989, and explains how these ideas emerged through transnational networks composed of both American and Eastern European economists.

1. Ideas, Interests and Institutions

How did market-oriented ideas emerge in Czech and Polish healthcare policy? How did these ideas become prominent in the post-communist political debates over healthcare reforms? What was the nature and role of interests in this process? How did institutions matter in the shaping of the divergent healthcare policy paths of these two countries? The first chapter outlined the main argument of this thesis: the claim that the divergence of post-communist healthcare policy paths is best explained by the different processes of policy learning. In this section, I elaborate this argument into a theoretical framework that explains the process of policy change, understood as learning, in which ideas influence change, interests shape policy preferences and institutions condition country-specific policy choices. This theoretical framework helps me to develop the argument that explains post-communist healthcare policy change that is based upon the following three claims. First, I argue that ideas, through the learning process, were the initial drivers of healthcare policy change in the two countries. Second, that in the process of policymaking, these ideas linked to interests, which were shaped by changing identities that determined actors' preferences for specific policy choices. Finally, I argue that this process of linking ideas and interests took place within extant institutions, which depending of political configurations either blocked or facilitated change, making the new policy ideas more or less viable. This linking of ideas with interests, within specific political and institutional contexts, explains the divergence of the healthcare policy paths in the two countries.

1.1. Ideas, learning and uncertainty

According to Heclo (Heclo 1974: 305-6), government affairs are not only about power but also about puzzle. "Politics", argues Heclo, "finds its sources not only in power but also in uncertainty – men collectively wondering what to do [...] Government's not only 'power' [...] they also puzzle. Policymaking is a form of collective puzzlement on society's behalf." Since Heclo's time, ideas have become increasingly present in studies of policy change that seek to explain policy processes as driven by ideas rather than self-interest (see Campbell 2002).⁴⁸ Several authors (Berman 1998, Hay 2001, Steinmo 2008) defined ideas as beliefs that help policymakers generate solutions for problems. Steinmo, for example, (Steinmo 2008) defines ideas as "creative solutions to collective action problems" (see also Lewis and Steinmo 2010) while Berman

⁴⁸ In his overview of the more recent literature on ideas and policymaking, Campbell (2002) identifies five different types i.e. definitions of ideas: cognitive paradigms and world views, normative frameworks, world culture, frames and programmatic ideas.

(Berman 1998) argues that ideas are “programmatically beliefs” that provide “guidelines for practical activity and for the formulation of solutions for everyday problems.” (ibid. p. 21).⁴⁹

If ideas are solutions to problems, how do they drive change? This question can be broken down into two more specific questions. First, how do ideas, as solutions for policy problems, emerge and drive change? Second, where do policy ideas come from? Hall’s (Hall 1989, 1990, 1992, 1993) account of policy change as a process of social learning helps provide answers to these questions.⁵⁰ Hall develops two concepts: the concept of social learning and the concept of policy paradigm, to explain the emergence and origins of new ideas in policymaking. He defines social learning as “a deliberate attempt to adjust the goals or techniques of policy in response to past experiences and new information” (Hall 1993: 278).⁵¹ An understanding of policy change as learning implies three core features. First, it implies that each new policy is always a consequence of the past policy, rather than a direct response to the external pressures of the social and economic context. Hall emphasizes the role of the past policy in the emergence of new policy ideas, arguing that the key factor affecting a policy at time-1 is a policy at time-0. New policies, he claims, always represent “meaningful reactions to previous policies” (Weir and Skocpol 1985: 119; quoted in Hall 1993: 277; see also Hecló 1974: 315). Second, social learning implies that the principal agents of change are experts in a given field of policy, who are able to influence policymaking either by working for the state or by advising it from their privileged positions at the interface between the bureaucracy and the intellectual enclaves of their society (Hall 1993: 277). Finally, social learning implies that policymakers have the capacity to act autonomously from societal pressures (ibid. p. 278).⁵²

According to Hall, policymaking as social learning process revolves around three central elements – policy goals, the instruments to attain these goals, and the settings of these instruments (Hall 1990, 1993). He argues that “policy makers customarily work with a framework of ideas and standards that specify not only the goals of policy, and the kind of

⁴⁹ Similarly, Dobbin (1993: 50) points to ideas as problem-solving beliefs arguing that “shared cultural meaning [...] influences the pragmatic solutions groups envision to such instrumental problems such as economic growth.”

⁵⁰ Hall’s theory on the role of ideas in policy change was developed out of his analysis of the shift from Keynesianism to monetarism in the macroeconomic policy making in Britain between 1970 and 1989 (Hall 1989, 1990, 1992, 1993).

⁵¹ In Hall’s use of the term, ‘learning’ seems to denote “modification of a behavioural tendency by experience” rather than “knowledge or skill acquired by instruction or study” (these are definitions of ‘learning’ from the Merriam Webster dictionary, available online at www.Merriam-Webster.com). The understanding of learning as modification of behaviour by experience also seems to be the basis of Hecló’s (1974: 306) definition of learning, who argues that learning in the most general sense “can be taken to mean a relatively enduring alteration in behaviour that results from experience.”

⁵² Through focus on experts as ‘carriers’ of ideas and policymakers autonomy from social pressures Hall underlines the role of public officials and policy specialists in the process of policy change, emphasizing that the process of policy change is independent from, what he calls ‘external pressures’ - socioeconomic development, elections, political parties and organized interest (see Hall 1993: 277-278).

instruments that can be used to attain them, but also the very nature of the problems that they are meant to be addressing” (Hall 1993: 279). This comprehensive role of ideas – as not only solutions to problems, but also goals and instruments of policymaking – introduces the second key concept: that of the “policy paradigm”. Hall borrows the very concept of ‘paradigm’ from Thomas Kuhn’s (Kuhn 1962) theory on the development of scientific knowledge.⁵³ In analogy with Kuhn, he defines the policy paradigm as “the interpretative framework of policymakers” (Hall 1990: 7-8), and argues that a policy changes through the process of the ‘paradigm shift’. Like scientific paradigms, policy paradigms are normally stable, but at certain points in time, they became threatened by the appearance of anomalies: unusual developments that are not fully comprehensible to policy makers, even as puzzles, within the terms of the existing paradigm. As these anomalies accumulate, they gradually undermine the intellectual coherency and precision of the original paradigm, which leads to its re-consideration. The emergence of a new policy paradigm is triggered by the enduring apparent anomalies in an old paradigm that are leading to policy failures. The movement from one paradigm to another is likely to involve not only the accumulation of anomalies, but also experimentation with new forms of policy and policy failures that precipitate a shift in the locus of authority over policy and initiate a wider political contest between competing paradigms. The new paradigm is accepted if it is considered to have the ability to explain the persistent anomalies more accurately than the set of ideas and standards contained in the old paradigm (Hall 1993: 280-1).

While policies do change, for Hall they do not always change through a process as radical as a paradigm shift. The paradigm shift, in his view, is rather rare, as it is equivalent to what he calls the ‘third order policy change’. Hall distinguishes between the ‘first’, the ‘second’ and the ‘third’ order policy change, and argues that while the ‘first’ and the ‘second’ order changes imply changes in policy instruments and policy settings respectively, the ‘third order’ change involves all three: change in settings, in instruments and an overarching change of policy goals (ibid. p. 279).⁵⁴ The type of learning process that occurs in the case of Hall’s ‘third order’ change also seems to be quite different from the learning processes in the case of ‘first’ and ‘second’ order change (Berman 2013: 220). In contrast to these two smaller types of changes, policymaking in the ‘third order’ change is determined not merely by reaction to past policy but is instead heavily influenced by new ideas and broader societal conflicts and debates. Indeed, to stress this, Hall argues that the paradigm shift “is likely to be more sociological than scientific” (Hall 1993: 280)

⁵³ In Kuhn’s (1962) view, science or scientific knowledge develops through periodic ‘paradigm shifts’ rather than progressing in a linear and continuous way.

⁵⁴ Hall’s theory on the role of ideas in policy change was developed through his in-depth analysis of macroeconomic policy making in Britain between 1970 and 1989. He argues that the shift from Keynesianism to monetarism that took place during this period presented the case of ‘third order policy change’ (Hall 1990, 1992, 1993).

as it involves broader political struggle of the competing paradigms. This also suggests that in cases of ‘third order’ policy change, the new policy ideas are able to have the strongest influence on policymaking not only because of their ability to solve the problems that old policy could not solve, but also because they win the political battle within the broader social context (ibid. p. 288; see also Blyth 2013).⁵⁵

Another causal process at work is related to the spread of new policy ideas among policymakers and the broader public. Why do policy makers and stakeholders in certain policy fields accept expert ideas? Why do they perceive certain idea or sets of ideas as the solutions for a policy problem at hand? Blyth’s analysis on the role ideas play in times of crisis helps provide an answer to these questions.⁵⁶ Crises, according to Blyth, represent periods of unique events characterized by high degrees of uncertainty; by situations in which agents are “unsure as to what their interests actually are, let alone how to realize them” (Blyth 2002: 9). He uses the concept of “Knightian uncertainty”⁵⁷ to describe crisis-generated situations characterized by high levels of uncertainty, in which actors’ perceptions of their interests are fuzzy, unclear and problematic.⁵⁸ These periods of crisis, marked by uncertainty, are crucial for change because they unleash intense ideational conflicts among policymakers, during which advocates of new ideas struggle to provide compelling explanations in which old institutions and instruments of policymaking are diagnosed as “parts of the problem” not as “parts of the solutions” and are able to suggest reforms that are needed for the resolution of crisis (see ibid. 5; see also Hay 2004: 207-8). In other words, in the context of crisis and ideational struggle, new ideas gain prominence because they enable actors to reduce uncertainty about the future, help them understand their interests and provide them with a model of policy reform. Reducing uncertainty, ideas also act as key drivers of collective action. “Offering [these] actors a basic understanding of their interests, institutional opportunities, and the pressures that are at stake, the ideas help actors to coordinate their efforts and build coalitions around common objectives” (Blyth 2001: 3). Reducing uncertainty and building the base for coordination of actors on common interests, ideas enable actors to find the way out of the crisis, and in this way drive policy reform.

⁵⁵ In Blyth’s (2013: 3) words, “Policies fail because they do not serve the purpose for which they were designed.” “However”, he argues, “they also fail because they are ‘seen’ to fail, or also because failure is constructed despite the evidence” (ibid.). He argues that, while paradigms shift for reasons that are both scientific (failure) and sociological (perception of failure), the two reasons cannot matter at the same time. He calls this “policy paradigm paradox”.

⁵⁶ Blyth (2002) develops his approach on the role of ideas in policy making in his study of economic ideas in the context of the 1930s and the 1970s crisis.

⁵⁷ Blyth borrows this concept from economics. In economics, “Knightian uncertainty” refers to a risk that is immeasurable. This concept of uncertainty was developed by Frank Knight, who established important distinction between risk and uncertainty, arguing that while risk is something that can be calculated, uncertainty is something that cannot.

⁵⁸ Blyth (2001: 4) also draws upon Beckert (1996), describing uncertainty “as the character of situations in which agents cannot anticipate the outcome of a decision and cannot assign probabilities to the outcomes.”

Hall's and Blyth's approach to the study policy change offers a particularly fruitful theoretical framework that helps explain the origins of post-communist healthcare reforms. This thesis will demonstrate that the main drivers of Czech and Polish post-communist healthcare reforms were market-oriented ideas that emerged through processes of social learning and in response to the failure of socialist policy to solve the problems of the healthcare sector. As the empirical chapters will show, the socialist healthcare policy paradigm, based on the idea of centralized, hierarchical and state-dominated healthcare provision, in both countries performed relatively well during the early post-war decades. In this period, both countries significantly developed their healthcare systems in terms of coverage and system infrastructure, and witnessed impressive improvements in the health of their populations.

However, the first troubles started to emerge in the late 1960s and became evident over the 1970s, when anomalies such as constant shortages of materials, the corruption of doctors and medical staff and the gradual deterioration of population health became serious problems for the healthcare sectors in the two countries. First reactions to these problems emerged in the late 1970s and over the 1980s, in reports written by Polish and Czech healthcare experts, who were at that time working in the national institutes for healthcare service research. These reports pointed to the problem of scarce resources in the healthcare sector, but even more importantly, the authors of these reports argued that the main causes of the problems in the healthcare sector were wrong incentives generated by the overly hierarchical and centralized system of healthcare provision. The ideas developed in these reports, as the reader will see, later became crucial for the post-communist healthcare reforms as they provided the 'diagnosis' of the problems of socialist healthcare, suggesting that the state-dominated model of healthcare was a part of the problem rather than the solution. It is important to notice that these ideas emerged before the fall of communism in these two countries took place, and at a time when this was not even imaginable, which suggests that they originated independently of the process of political change.

The reader will also see that these reports became crucial for the formulation of post-socialist reform proposals, and in this way contributed to the process of change in which market ideas emerged in reaction to the failures of the stated-dominated socialist system and were seen as solutions for the problems at hand. The moment in which these reports, i.e. ideas developed by their authors, would start to play their role came after the political changes in 1989. In the Czech Republic, quickly after the Velvet Revolution, the Ministry of Health used these reports to develop several very concrete policy proposals, and a similar thing happened in Poland after the Round Table Talks . What was clear from these proposals is that what they proposed was a clear-

cut example of a ‘paradigm shift’ or ‘third order’ change in healthcare policy, which implied not only the departure from the ‘Semashko’ to the ‘Bismarckian’ system of healthcare, but also a dramatic shift from the State to market-oriented mechanisms, which would lead to dramatic changes in healthcare policy goals. In contrast to the socialist period, when healthcare resources were rather scarce and distributed according to the 5-year plan, more funding for healthcare and efficient distribution of healthcare resources became priorities of healthcare policy, which, it was believed, would be achieved through market-generated incentives.

There were three key factors that helped policymakers in the two countries generate broader support for market-oriented reforms. The first important factor was that during the very early post-communist period both the Czech and Polish healthcare sectors were facing deep crisis. This crisis was caused by legacies of communism such as underfunding, corruption and chronic shortages. Another cause of these crises was of post-communist origin, the “transitional mortality crisis” (Cornia and Pannicià 2000), which was signalled by the decline in overall population health and was generated by large-scale political and economic transformation.⁵⁹ The second factor was lack of policy advice. As mentioned in the first chapter, in contrast to other social policy sectors, healthcare was not the primary focus of the post-communist governments or external policy advisers. Governments placed healthcare not very high on their reform agenda and focused instead on unemployment benefits and pensions, which were used as cushions of economic restructuring, and were therefore seen as much more urgent transitional problems. External policy advice on healthcare reforms was also lacking partly because other, mainly economic reforms were considered to be more important, but also because the healthcare sectors of these countries were considered very country-specific, and this discouraged the development of foreign advice in the form of one-size-fits-all general reform plans.

This context of deep crisis in the healthcare sector and the lack of policy advice on how to reform made the future direction of healthcare policy unclear. It created a situation in which politicians, policymakers, doctors and citizens were very keen on reforms, but had no clear vision of what the future, post-communist system of healthcare should look like and what could be possible ways of reforming it. All this led to high levels of uncertainty and created a situation in which the interests of these actors became very problematic and the future of the healthcare systems was at stake. Expert ideas on market-oriented healthcare reforms offered a way out of this uncertainty. They provided guidance to actors in two crucial ways. First, they explained the causes of the problems in the healthcare sector, blaming the wrong incentives of the state-

⁵⁹ According to Moskalewicz et al. (2000: 99) the mortality crisis in Poland, which hit bottom in 1991, lasted longer than the mortality crisis in the Czech Republic, where it reached its peak a year earlier, in 1990.

centred, hierarchical socialist policy for failures and healthcare system deterioration. Second, they proposed a range of concrete solutions in the form of very concrete reform proposals. Fulfilling these two important tasks, these ideas offered actors possible ways out of the crisis and uncertainty, enabling them to think of where their own interests would lie in the new system of healthcare and, most importantly, provided them with a repertoire of models for policy change.

Finally, the last but certainly not the least important reason for the broad support of market-oriented reforms was the general political climate in the two countries after the communist regimes fall. The reader should remember that Poland and the Czech Republic were the only two Eastern European countries that very quickly after the fall of communism implemented a set of radical neo-liberal economic reforms, guided by the “Shock Therapy” approach. Fast and radical privatization, liberalization and stabilization were the main priorities of their first post-communist governments, which saw departure from the socialist model of central planning to free market economy as their key task. In this climate of general disenchantment with socialism and delight in neo-liberal reform, market-oriented ideas of healthcare found a very fertile soil.

1.2. Interests, identities and policy preferences

The previous section elaborated a theoretical framework in which ideas act as main drivers of policy change, by offering solutions to problems facing policy makers in the times of crisis and uncertainty. However, arguing that ideas act as important drivers of policy change does not explain how ideas enter the policymaking arena and actually change policy. This section introduces the concept of interests, in order to shed more light on the interaction of ideas with the interests of powerful political actors. It starts with the assumption that while ideas matter, politics is not only about puzzle but also about power (see Hecló 1974), and that in order to become influential in politics, ideas have to enter the policymaking arena by interacting with the interests of powerful political actors (Gourevitch 1989, Blyth 2002, Béland 2010).⁶⁰ Powerful actors such as elected officials, members of the political parties, or, in the healthcare context, doctors, are key agents in the propagation of specific ideas that, in turn, can serve some of their interests.

⁶⁰ In Gourevitch’s (1989) words: “To become policy, ideas must link up with politics - the mobilization of consent for policy. Politics involves power. Even a good idea cannot become policy if it meets certain kinds of opposition, and a bad idea can become policy if it is able to obtain support.” (ibid. pp. 87-8).

Interests, understood either as individual or as group interests of political actors, are certainly one of the most frequently used concepts in the political science literature.⁶¹ This wide focus on interests as core of politics has generated broad variety of understandings of what interests are and how they are formed. One of the dominant definitions of interests is the one offered by the theory of rational choice. According to this theory, individual interests are stable, self-centred and essentially calculable, allowing individuals to define their preferences according to the utility maximizing function. In this section, I elaborate a theoretical framework according to which interests do matter in politics, and therefore also in policymaking, because both individuals and groups involved in governmental affairs have certain wants, on the basis of which they act, and certain goals they wish to achieve in the political and policymaking arena. However, in contrast to the rational choice understanding of interests, this framework explains interests not as stable, self-centred calculations and individual utility maximizing functions, but rather as wants and goals which are defined by actors' perceptions as to which policy options are feasible, and, even more importantly, by their positions in the institutional context in which policy change is taking place. In other words, I argue that while interests do play an important role in policymaking, actors are not capable of knowing what their interests are without ideas about the possible policy options and the institutional context that shapes their roles and identities. In order to account for these specific features of interests, I focus on two main causal processes at work. One process explains how ideas shape interests and the other shows how interests, through their links with identities, give rise to actors' preferences for specific policy options.

The first process concerns the process of interest recognition, in which ideas play a decisive role. How do ideas help actors recognize what they want and what kind of goals they wish to pursue in a policy context such as, for example, healthcare? Drawing upon Blyth, the previous section explained how ideas can play a crucial role in the initial stages of the policy change process, a situation in which there is a significant amount of uncertainty about the future, especially in terms of the direction of a certain policy and its outcomes. Helping actors to make this situation comprehensible by clarifying the uncertainty of interests and by throwing some light on possible policy paths, ideas provide actors with guidelines for action. Blyth (Blyth 2002: 38) emphasizes this formative influence of ideas on interests also by arguing that during periods

⁶¹ Strong focus on interests was typical for the classical political science literature, which interprets politics as essentially interaction, struggle or reconciliation of interests (e.g. Lasswell 1958, Van Dyke 1962). This focus was mainly developed within Behaviourist approaches (e.g. Dahl 1961, Truman 1951) and Neo-Marxist theories of politics (e.g. Poulantzas 1973). Rational Choice Theory of politics (e.g. Downs 1957, Buchanan and Tullock 1962, Ordeshook 1986), which shifted the emphasis from group to individual interests, significantly contributed to this prolonged attention on interests as core drivers of politics.

of crisis, the way in which interests are constituted changes drastically. Drawing upon available ideas, actors are able to diagnose the crisis, and this enables them to understand the uncertain situations and to construct narratives that can help them re-constitute their interests (ibid.). For example, doctors who under communism considered their main interest to lie in implementing a centrally determined State plan and in delivering care in public institutions as public employees, in the context of crisis and uncertainty caused by the political regime change could use market ideas to re-constitute these interests. Seeing, for example, that expert ideas suggest departure from the socialist system through privatization, they could think of their main interests being in the exit from the public system of healthcare delivery, having better pay or in the strengthening of their professional autonomy.

What these examples suggest is that the main role of ideas in a crisis situation is to provide actors with cues about possible outcomes of the crisis, which in turn enables them to choose from the available policy alternatives. Outlining the direction of policy change and the range of its likely outcomes, ideas enable actors to understand what it is that they want in a new situation, and how they can achieve this. This implies that actors' interests cannot really be separated from their ideas, and that the concept of interests presupposes elements such as wants and beliefs, which are often unacknowledged, but important "cognates" of interests (Blyth 2003: 697). Furthermore, this constructivist interpretation of interests, based on the understanding of the interest formation process as a cognitive process and as an essentially context dependent process, challenges the view of interests as given, material facts (Blyth 2003). Developing an interpretation similar to Blyth's, Béland and Cox (Béland and Cox 2010: 10) stress this contextual character of interest formation, arguing that interests change as "actors alter their understanding of their changing world and re-calculate their changing priorities." In their view, interests are not objective facts, but also historical, social and political constructions (see also Hay 2010), which change in accordance with changes in their environments.

Ideas, as explained above, offer cognitive cues about the future directions of policy, and these cues provide actors with knowledge about what the new policy setting is going to look like. In this way, they provide actors with a notion of where their interests lie in this new setting and what could be possible ways to pursue these interests. However, while ideas help actors recognize and clarify their interests in a new policy setting, they do not tell them anything about preferences. Each political actor is nevertheless expected to define his or her interests by expressing his or her preference over the available policy alternatives. So, how do actors establish

their preferences for specific policies?⁶² According to Hall (2005; see also Hall 2009), the process of preference formation is closely linked to the process of forming and expressing identities. Individuals, he argues, have multiple interests which are associated with multiple identities, which implies that what actors prefer or consequently, what they choose will significantly depend on the way they perceive themselves and their identity in a given situation (Hall 2005: 132-3). There are many situations in which actor's multiple interests become closely associated with his or her multiple identities and make the process of preference formation rather difficult. Hall gives an example of a female voter who is asked to vote at the referendum about day care:

“When asked to vote in a referendum about day care, a voter has to decide how much weight to assign to interests that may evoke key aspects of her identity, whether as a woman, mother tax payer, republican, citizen or neighbour. Therefore, the process of forming preferences is intimately bound up with the process of forming and expressing identities. At such moments, the politics of interests and of identities come together in a single process.” (ibid. p. 133)

This link between individual interests and identities helps explain why preferences can be unstable. Political actors have multiple, interchangeable identities and these multiple identities enable them to change their preferences, depending on the situation and depending on which of their identities they give priority to, without making them inconsistent (see Steinmo 2013: 8).

Interests, deeply shaped by ideas and identities, played a crucial role in the process of post-socialist policymaking. Ideas of policy change, developed in the reform proposals of healthcare policy experts in the immediate aftermath of the fall of communism, quickly gained the support of powerful political actors in the healthcare arena, such as members of political parties and doctors. These ideas quickly gained their advocates among these actors, not only because they provided an explanation for the communist healthcare policy failures, but also because they suggested new policy models for the Czech and Polish healthcare sectors that enabled these actors to understand their interests. The new policy models provided them with clues about the possible direction of change and, even more importantly, narrowed down the spectrum of the available policy options. For example, different ideas concerning privatization or

⁶² There seems to be no agreement on the use of the terms ‘interest’ and ‘preferences’ in the existing literature. Hall (2005), for example, uses interests and preferences interchangeably, but distinguishes between “fundamental” and “strategic” preferences. Some other scholars, such as Vogel (1999: 202) for example, underline the difference between interests and preferences as the difference between “objective” and “subjective” values. Finally, Elster (1986) distinguished between preferences and choices, defining choices as “expressed preferences”. An attempt to distinguish between interests, preferences and choices was made by Immergut (1997; see also Immergut 1998). Here I treat preferences and interests as distinct, defining interests as wants and goals and policy preferences, following Woll, as “transitions from basic interests to political stances” (Woll 2005: 6).

decentralization of healthcare financing allowed doctors to understand the potential effect of the possible policy change on their own position within the healthcare system. Similarly, members of political parties used these ideas to develop their own stances on healthcare reforms and think about the goals they would like to achieve in the reform process.

As the reader will see in the empirical chapters, the process of interest recognition in which these actors clarified their goals was a rather gradual process, characterized by a considerable amount of uncertainty during the very early stage of the reforms, and gradual clarification of interests along with the development of these ideas into different policy proposals. Polish doctors, for example, at first had difficulties recognizing their own interests but as time went by, and more concrete policy proposals developed out of the general ideas about the shape of the healthcare system, they were able to develop a more explicit notion of their interests, and establish concrete preferences over different policy proposals. The opposite, however, was the case in the Czech Republic, where doctors managed to quickly recognize their ‘favourite’ proposal and supported it.

The empirical chapters will also show that policy preference formation did not always follow a very smooth path, because policy preferences of the political actors varied over time. Policy actors that most frequently changed their preferences over healthcare policy proposals were political parties and their members, and the reader will see that the ideological identities of the Czech and Polish parties were not always the best predictors of their policy preferences. The changes in policy preferences, which would often depend on the party’s position in the political landscape, i.e. whether the party was in government or in opposition, and therefore suggested that the split between the different party identities played a crucial role in the success and failure of specific proposals to reach the Government’s agenda.

1.3. Institutions, veto points and policy choices

The previous section pointed to the identity-based nature of preferences and explained why policy preferences of political actors can vary over time. Preferences, it explained, vary because actors have multiple identities and are able to shift between these different identities, preferring different policies at different times and in different situations. While the link between preferences and identities shed some important light on the origins of individual policy preferences, it did not provide an answer to the following crucial question: Why do actors *choose* a specific policy? In other words, why do actors decide to prioritize only one of their multiple identities and follow preferences that lead to a particular policy choice? Furthermore, the

previous section focused mainly on actors' preferences but did not explain the connection between individual and group preferences on the one hand and actual policy outcomes on the other. It remained therefore unclear whether policy outcomes should be considered as directly translated preferences of the main political actors, or whether they are, rather, more complex results of the policymaking process.

In order to answer these important questions, this section draws upon the literature on institutions and their role in policy change. The institutional approach to the study of politics builds upon the assumption that institutions are prerequisites for organized politics and that politics can exist only because there is an institutional context in which it takes place (see Steinmo 2002, 2003). This approach defines institutions as rules, formal or informal, that structure behaviour of political actors and its outcomes (Steinmo et al. 1992, Immergut 1998, Steinmo 2002). It also emphasizes that institutions are not simple but rather complex configurations of rules, which do not stand alone but are always embedded within the broader social, economic or political environment (Streeck and Thelen 2005, Lewis and Steinmo 2010). Building upon this basic view of institutions, this section develops a framework which explains *how* institutions influence behaviour and structure outcomes of the policymaking process. It singles out two main causal mechanisms which help account for the precise nature of institutional impact on policy change in the case of post-communist healthcare reforms. The first mechanism explains how institutions as rules shape policy choices, while the second clarifies how institutions through veto points structure policymaking procedures and shape their outcomes.

How do institutions shape policy choices? March and Olsen (March and Olsen 1989, 2009) explain the influence of institutions on individual preferences and choices through the concept of "appropriateness". In their view, when individuals, or groups, are supposed to act i.e. make decisions choosing among alternative courses of action, they get guidance for action by trying to answer the following three questions: "What kind of a situation is this? What kind of person am I (are we)? What does a person such as I (we) do in a situation such as this – what kind of behavioural prescriptions follow from matching the facts of the situation with the relevant rules." (March and Olsen 2009: 4; see also March and Olsen 1989). In this view, individual as well as group behaviour is profoundly shaped by rules that influence them to act "appropriately" i.e. in accordance with the prescribed practices attached to specific roles they play in particular situations.⁶³ This link between rules on the one hand and roles on the other implies that identities are institutionally created and that the multiplicity of institutions gives rise to the

⁶³ "To act appropriately", for March and Olsen (March and Olsen 2009: 4) is "to proceed according to the institutionalized practices of a collectivity and mutual understandings of what is true, natural, right, and good."

multiplicity of individual and group identities. Institutions, according to March and Olsen (March and Olsen 1995), matter because different institutionalized identities are able to create different individuals (and groups) - citizens, officials, engineers, doctors, spouses (ibid. p. 251). Establishing a kind of “pact”, or an implicit agreement to act appropriately in return for being treated appropriately, actors follow rules (ibid. pp. 251-2).⁶⁴ This tendency of institutions to link individuals with identities implies that choice made within a specific institutional framework is based more on the logic of appropriateness than on the logic of consequences and utility that underlie conceptions of rational action. It also implies that the process through which individuals or groups make decisions is cognitive, rather than a rational process, since the rules of action are derived from the individuals’ “reasoning about the self” (ibid. p. 252) i.e. from their understanding of their identities in a specific situation and institutional rules that are attached to these identities.⁶⁵

It is important to stress that the causal link that posits institutional rules as basis for action does not necessarily imply a deterministic view of human agency. Even though institutions through rules influence actors’ identities, preferences and, subsequently, their choices, this does not imply that they determine human action. There are two reasons why institutions cannot determine action. One is the variety of different identities i.e. institutional roles each individual can carry and the possibility that these identities i.e. roles can be mutually conflicting. As stressed earlier, each individual can have multiple identities on the basis of which they can act. An actor such as party member, for example, can act on the basis of his ideological identity or, if he or she is holding a public office, on the basis of his office holding identity; and he or she can also act on the basis of his or her professional identity, be it engineer, professor, or doctor.⁶⁶ Which of these identities he or she will decide to prioritize and act upon in situations in which they conflict with one another is very difficult to predict, and is up to both an individual and the specifics of the situation in which he or she is expected to act. The individual however can feel a ‘tension’ between alternative rules he or she is expected to follow and can experience significant difficulties in making choices (see Olsen 2007: 6-7).⁶⁷ Another reason why institutions

⁶⁴ March and Olsen (1995: 251-2) argue that it would be misleading to think about the relationship between institutions and identities in contractual terms. Because socialization into rules and their appropriateness is not a case of wilful entering into an explicit contract, they argue that it is better to think about the relationship between institutions and identities in terms of “pacts” rather than “contracts”.

⁶⁵ Cognitive psychology finds even deeper reasons in human rule-following behaviour, arguing that individuals follow rules rather than performing some kind of cost-benefit analysis of their prospective choices because following rules helps them satisfy their basic cognitive needs – need for accuracy, affiliation and self-esteem (see Steinmo 2013: 7).

⁶⁶ There are other identities that can be added to this list, such as citizen, taxpayer, father/mother identity etc.

⁶⁷ Olsen (2007) gives an example of a diplomat to point out that even the same institution can have mutually conflicting rules. Diplomats, he argues, face competing expectations because diplomacy as an institution involves

cannot be determinants of human action is that the clarity of rules, as well as identities and situations, can vary. Actors can often find themselves at odds trying to figure out what are the exact rules that they are supposed to follow, or what are the identities they would like to have or develop, just as they can also find themselves at odds with new or unexpected situations (March and Olsen 1995: 252).⁶⁸ Actors may also struggle in following rules by having problems in identifying and classifying themselves, defining who and what they are, and what this implies for their action in a specific situation. This explains why institutions can influence but do not determine political action, enabling individuals to act in a variety of possible ways.

Another causal mechanism that links institutions and policy change draws upon the capacity of institutions to regulate the process of policymaking and, in this way, structure its outcomes. Immergut (Immergut 1992) emphasized the capacity of institutions to regulate policymaking pointing to the important role of procedures. Policymaking procedures, she argued, “do not simply represent the views of interest groups. They select the groups whose views will be represented, and they shape demands by changing the strategic environment in which the demands of groups are formulated” (ibid. p. xiii). Accounting for the impact of institutional rules and procedures on policymaking, Immergut develops the concept of “veto points” (Immergut 1990, 1992a, 1992b).⁶⁹ She defines veto points in different ways, as “weak links” in the political decision making process (Immergut 1990: 396), as constitutionally defined rules or as “the political arenas in which government proposals may be blocked” (Immergut and Abou-Chadi 2010: 8). As constitutionally defined points of decision in different political arenas – executive, legislative, and electoral – veto points are crucial determinants of policy change. Each of these points is based on a constitutional rule that grants the power of veto to an actor or to a group of actors in the political system, which in turn enables them to block the departure from a *status quo*. While constitutionally established veto powers determine in which political arenas reforms could be blocked, their role is not only constraining. In a similar way to that by which they can block policy reforms, veto points can also facilitate them and open opportunities for policy change. The view of institutions i.e. veto points as Janus-faced elements of policymaking i.e. as being both constraining and facilitating factors of policy change, points to the fact that

tension between being the carrier of the interests of a specific state and being a defender of transnational principles, norms and rules maintained and enacted by representatives of the states in mutual interaction (ibid. p. 7).

⁶⁸ March and Olsen (1996: 252) suggest that the problem of clarity is due to the changing character of rules and situations and the matching of these two ‘moving targets’, arguing that: “Neither the definition of an identity nor its achievement is necessarily trivial. Fulfilling an identity through following appropriate rules involves matching a changing (and often ambiguous) set of contingent rules to a changing (and often ambiguous) set of situations.”

⁶⁹ Immergut (1990, 1992a, 1992b) develops the “veto points” approach explaining the differences in healthcare reforms across three countries - Sweden, Switzerland and Germany – during their attempts to introduce national health insurance.

while institutions do structure the policymaking process, the exact impact of institutions on policy outcomes is uncertain - at different points of the policymaking process, institutions can block but, depending on the circumstances, they can also facilitate change.⁷⁰

This brings us to another important characteristic of veto points. In order to understand the role of veto points in policy change, argues Immergut, it is important to look not only at the fixed constitutional rules that grant the powers of veto, but also at the political configurations (Immergut 1990, 1992a, 1992b; Immergut and Abou-Chadi 2010). Constitutional rules define where i.e. at which point in the policymaking procedure there is a possibility of veto, but they do not define who i.e. what kind of actors populate these locations. This, however, essentially depends on the dynamics of political competition, which generates specific political configurations through party competition and elections in modern democracies. Immergut (1992a) describes the combined impact of constitutional rules and the political competition dynamic on the policymaking process in the following way:

“Veto points depend both on constitutional rules and electoral results. These points are not physical entities but points of strategic uncertainty where decisions may be overturned; even a small shift in electoral results or constitutional provisions may change the location and strategic importance of such veto points. The political system taken as a whole, with all of its institutional provisions and a particular distribution of partisan representatives – which I call ‘institutional configuration’ – comprises an environment of conduct.” (ibid. pp. 27-8)

Results of political competition therefore matter as much as formal constitutional rules that define positions of the veto points in the policymaking process. In order to explain the importance of political competition for policy change, Immergut (1990) points to a different aspect of political competition dynamics or of a political system as a whole, that can be decisive for policy change. Stable party majorities and party discipline, for example, can play a crucial role in the process of policy change because in cases where the party system is fragmented and there is a lack of internal party discipline, it can be very difficult to form and to maintain decisive parliamentary majorities (ibid. p. 399).

There are at two main advantages of the veto points approach to policy analysis. First is its view of policymaking as a sequential process, which assigns high importance to timing. Understanding policymaking as a chain of decisions and veto points as a set of points distributed

⁷⁰ For this reason, veto points are also defined as “strategic points of uncertainty” where decisions may be overturned, that arise from the logic of the decision process itself (Immergut 1992b: 27-8).

along this chain, this approach emphasizes both the temporal and the dynamic dimension of policymaking. It stresses that each policy process is a decision-making process composed of not only one decision but rather a sequence of decisions, which have to be made both at different points in time and by different political actors. Comparing healthcare policy paths across different nations, Immergut (*ibid.* p. 396) stressed this with the following words: “Political decisions require agreement at several points along the chain of decisions made in different arenas. The fate of legislative proposals, such as those for national health insurance, depends upon the number and location of opportunities for veto along this chain”. This suggests that institutions as formal rules of politics define not only *who* can steer the policymaking process, but also *how many* veto points are there along the decision-making chain and, finally, *where* are those who can steer the policymaking by either blocking change or facilitating it.

Another advantage of the veto point approach lies in the interpretation of veto points as points that are interactions of constitutional rules with changeable political circumstances, these being generated through electoral results. The emphasis on both formal constitutional rules and changeable dynamics of political competition is crucial for the better understanding of the institutional role in policymaking. On the one hand, this emphasis points to the fact that the mode in which institutions as formal rules can influence the fate of policy is deeply conditioned by the specificities of a particular political situation. In other words, who wins the elections, with what majority and at which point in time, can all be crucial for policy change. On the other hand, the emphasis on the combination of formal rules and the dynamics of political competition also indicates that the capacity of institutions to influence policy change will vary in line with the development of a fairly unique set of political circumstances. Not only who wins elections, to what extent and at which point in time is important, but also who forms a party coalition. None of these, however, are fully predictable, because each depends on a complex set of factors, some of which can even be attributed to historical accidents or country-specific political characteristics.

The empirical chapters will show that combinations of formal constitutional rules and specific sets of political circumstances profoundly influenced healthcare policy outcomes in Poland and the Czech Republic. In Poland, a combination of semi-presidentialism and an extremely proportional electoral system, which gave rise to a strong presidency, high party fragmentation and low party discipline, created an institutional constellation with strong veto points in both the executive and legislative arena that made the passing of the comprehensive reform plan during the early post-communist period practically impossible. Two subsequent changes in the Polish institutional landscape – the change of the electoral rules and the changes in the Polish Constitution - gave rise to a new combination of rules and circumstances that

enabled the passing of this major reform at the end of the first post-communist decade. In contrast, a combination of parliamentarism and a moderately proportional electoral system that created relatively strong party discipline and low party proliferation, made the Czech departure from the old socialist model of healthcare both faster and smoother.

2. Alternative Explanations

The first part of this chapter focused on the elaboration of the ideas, interests and institutions centred explanation of post-communist healthcare policy change. This second part confronts this argument with four alternative answers to the main research question of the thesis: Why did Czech and Polish healthcare policy in post-communism follow such divergent paths? The four alternative explanations analysed in this section have two characteristics in common. First, each of them focuses on one single factor in its attempt to explain the variety of policy paths. As such, they all directly challenge my argument, which, in contrast, drew upon three different factors – ideas, interests and institutions. Second, each of the alternative explanations belongs to an influential theory or approach in the field of public policy research, or political science more broadly.

Indeed, these five theories or approaches were selected because they have already proven their capacity to explain either national policy paths or cross-national variation of policy outcomes. Power resource theory has been used for the last thirty years as a powerful explanatory tool of welfare state development in modern industrialized democracies. It was first formulated by Walter Korpi, back in 1983, and since then has been relatively successful in explaining the variety of policy outcomes across different welfare sectors, focusing on the role of labour movements (Korpi 1983, Huber and Stephens 2001, Korpi and Palme 2003). Similarly, partisanship theory has been used to explain welfare state development, concentrating more closely upon the role of political parties in this process of government policymaking (Hicks 1999, Iversen and Cusack 2000, Huber and Stephens 2001). Professional dominance theory, linked to the theory of professionalism (Johnson 1972), is more closely linked to the healthcare sector and was used to explain the special role of medical professionals in the health sector, or in society more broadly (Freidson 1970; Berlant 1975; Larson 1977; Starr 1982). The fourth approach, based on legacies, became particularly influential in the studies of post-socialist countries (Kitschelt et al. 1999; Pop-Eleches 2007; Kornai 1997; Cerami 2006; Inglot 2008), emphasizing the role of the communist or pre-communist past in the explanation of policy and institutional variations.

As each of the alternative explanations is tested in turn, each part of this section is structured in a similar way. I analyse each theory or approach, concentrating upon two main aspects: its main argument and a critical evaluation of the theory's capacity to explain Czech and Polish healthcare policy paths and their divergence.

2.1. Power Resource Theory

According to power resource theory, the variation in size, characteristics and the outcomes of the welfare state is best explained as a direct function of the political mobilization of the working class (Korpi 1983, Korpi and Palme 2003). Introducing political mobilization based on social class as the main explanatory variable for welfare state development, Korpi's argument was that the variations in welfare states developments reflect differences in class-related distributive conflicts (Korpi 1983: 168). The main assumption of this argument was that the splits in the employment situation, reflecting the class division, generate interaction between class, life-course risks and resources. Social classes with higher life-course risks tend to have lower individual resources to cope with these risks. This diversity in social risks generates a great potential for class-related collective action, which has a decisive impact on the shape of the welfare state and its policies. The more political resources the working class is able to gather, such as a strong and united labour movement providing electoral support to the parties of labour and social democratic orientation, the more extensive, comprehensive, universal and generous will be the welfare state provision (Esping-Andersen 1985, 1990). Drawing on this line of argument, power resource theory has been used to explain cross-national variations in policy outcomes by the variations, both in the strength of the countries' labour movements, and in the power of their parties with a social democratic orientation (Esping-Andersen 1990).⁷¹

There seems to be reason to think that power resource theory could be a useful tool in explaining the post-socialist healthcare reform paths. Both Poland and the Czech Republic after the fall of communism introduced the insurance model of healthcare provision, which in Western European countries has been known for its strong corporatist base. There are several studies (Altenstetter 2003; Altenstetter and Busse 2005; Hennock 2007), which showed that in countries such as Germany, where insurance based programmes of healthcare were introduced almost a century and a half ago, not only the initial success of these programmes but also their subsequent development was crucially dependent on the support of the working class and on the

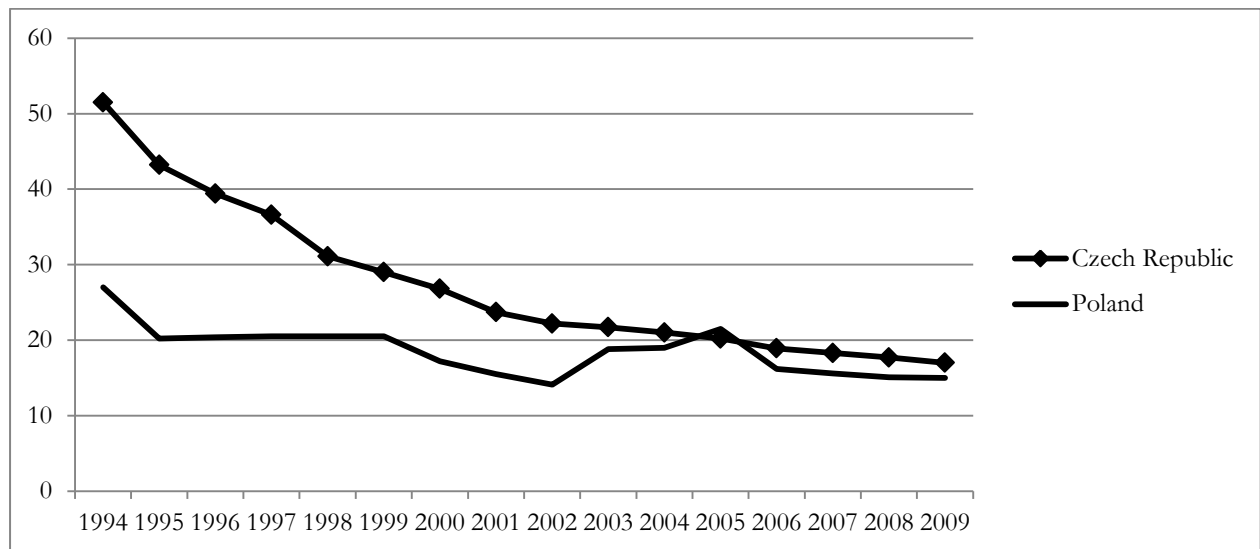
⁷¹ Commodification refers to the transformation of human needs and labour power into a commodity, which results in the workers being less autonomous and more dependent on the market. The Power resource approach explains the egalitarian welfare tradition and the high degree of de-commodification present in the Nordic countries by the political alliances between the social democratic parties and the strong labour unions (Esping-Andersen 1990).

corporatist governance structures. Following power resource theory, one would then expect that the radical healthcare reforms in these two former communist countries could be explained by strong working class power. Another reason to assume that working class power played a key role in these reforms is the strength of the labour movement. Particularly in Poland, a politically organized and strong labour movement, represented by the trade union Solidarity (*Solidarność*), played a key role in the fall of communism, enjoyed very wide popular support and ‘raised’ some of the key political figures of the post-communist period. The strength of trade unionism could, therefore, be taken as one of the crucial factors that could explain the divergence of the political process of healthcare policy change in the two countries.

There are, however, two major problems with the power resource approach to post-communist healthcare policy. The first problem is linked to the fact that the labour unions in these countries, similar to the rest of Eastern Europe, were generally weak and the second, related problem, to the fact that corporatism in Eastern Europe was different from corporatism in the West. Weak unionism in Eastern Europe (Pollert 1999, 2001; Ost 2001) has been explained by the fact that post-communist labour unions suffered a strong identity crisis during the early transitional years and often resorted to passivity and quiescence (Greskovitz 1998). This in turn enabled post-communist political elites to either marginalize their role in the policymaking process, or to use their consensual support for the painful transitional reforms. In both Poland and the Czech Republic, trade unions were also not capable of stabilizing their relationships with the social democratic parties, which further diminished their influence on the policymaking process. All of these factors contributed to a decline in union membership, evidenced in the drastically decreasing union density⁷² over the first two post-communist decades (figure 5).

⁷² Trade union density is defined as a measure of the membership of trade unions, calculated as the number currently enrolled as members as a proportion of all those employees potentially eligible to be members.

Figure 3. Trade union density in the Czech Republic and Poland, 1994-2009.



Source: OECD.

Furthermore, several authors (Iankova 1998; Kubicek 1999; Ost 2000; Kohl 2008; Myant 2010) emphasized that the genesis of corporatist institutions in Eastern Europe should not be confused with the development of the fully articulated corporatist society of the Western European style. According to Iankova (1998), Eastern European corporatism was substantially different from Western European corporatism, which was characterized by compromise between labour and capital in the formulation of government economic and social policy through centralized collective bargaining and monopoly of interest representation (*ibid.* pp. 232-3). Its Eastern European counterpart instead was characterized by a conflictual consensus; a strong cooperative-conflictual dynamic that “tempers policy concertation with higher levels of internally channelled, institutionalized conflict [...] in search of flexibility and adaptability in uncertain transitional times” (*ibid.* pp. 234-5). In her view, Eastern European corporatism was “transformative” and differed from its Western counterpart in that it emerged as a part of the state’s strategy to provide mechanisms for the concertation of interests during the very conflictual transition of post-communist countries toward capitalism (*ibid.* pp. 234-5). In Ost’s (2000) view, post-communist Eastern Europe is better described as a case of “illusory” rather than “transformative” corporatism. He claims that since in Eastern Europe the state kept its strong dominance in the institutions of labour interest’ representation, and trade unions were weak and employers’ organizations very fragmented, it would be rather inappropriate to call the post-communist societies “corporatist”. Tripartite procedures, in his view, instead of bringing about a politically stabilizing and economically inclusionary class served only as a façade for a

policy process that was deployed to introduce neoliberal, rather than social democratic outcomes (ibid. p. 504; see also Ost and Crowley 2001).

The role of labour unions in the shaping of the Czech and Polish post-communist health policy was a paradigmatic example of a weak unionism and an illusory corporatism, both characteristic for Eastern Europe. In the healthcare arena, this generally weak position of the Czech and Polish trade unions was further weakened by the deeply fragmented interest representation of healthcare workers across the labour movement. In both countries, there were several unions who claimed to represent the interests of the healthcare workers.⁷³ They did indeed represent different categories of medical staff, who very often expressed opposing demands in the reform process. One of the factors contributing to this fragmentation was the internal division of the labour movement, resulting in a plurality of unions. Another factor was divisions more specific for the healthcare sector, caused by market-oriented reforms, especially privatization and decentralization. Privatization created difficulties in the process of interest representation because healthcare workers from the private sector refused to join the unions dominated by public sector employees. Decentralization led to the transfer of healthcare delivery responsibilities to local and regional levels, which led to the emergence of a completely new set of employers and added to the confusion of interest representation. Due to the multiplicity of employment arrangements, the unions reported having difficulties identifying whom to negotiate with on behalf of their members (Healy and McKee 1997). Confronted with both weak unionism and lack of formal influence on government affairs and working conditions in the health sector, union members frequently resorted to militant strategies such as strikes and protest, which in most cases turned out to be short-lived and relatively ineffective.

2.2. Partisanship Theory

Another theory that could be more successful in the explanation of post-communist health policy paths concentrates on the role of political parties. Partisanship theory is often closely associated to power resource theory. The latter, in one of its more specific versions, emphasizes the role of political parties in generating working class power in the political arena through the parties of social-democratic orientation, or, more broadly understood, the parties of the Left (O'Connor and Olsen 1998). In Korpi's (1983) interpretation, the claim that political partisanship matters for shaping policy outcomes assumes three things. First, it assumes that socio-economic cleavage is the most important basis for social conflict and party system

⁷³ Unions attracted mainly healthcare workers, while doctors represented their interests through professional associations. There were some exception, however, and example is the Czech Trade Union of Doctors (*Lékařský Odborový Svaz Českých Lékařů*), which represented doctors working in the public hospitals.

structure. Second, it assumes that the working class and the capitalist class stand for these conflicting interests and; third, that there is no goal displacement between social class and organizational representatives i.e. parties and interest organizations. Social policy, within this framework, is understood in terms of the democratic class struggle in which parties of the working class have an interest in moving the struggle for social wealth distribution into the political arena, where their numerical strength can be used more effectively (ibid. p. 170).

The partisanship approach to social policy focuses on the policymaking process as a site of distributive conflict among political parties. Scholars working in the area of welfare state research in advanced industrial democracies (Esping Andersen 1985; Garrett 1998; Hicks 1999; Iversen and Cusack 2000) found convincing cross-national evidence that partisanship mattered significantly for the development of welfare state policies. They argued that the countries in which the parties of the Left were stronger managed to promote working class interests not only by expanding the welfare state and re-distributing income across social classes, but also by developing policies that are more egalitarian and de-commodifying. In contrast, those countries in which the parties of the Right were stronger produced social policies characterized by distinctive liberal orientation, which implied significantly limited welfare state development and commodification. Scholars focusing on the more recent periods of welfare state development (Hicks and Swank 1992; Franzese 2002; Huber and Stephens 2001) have offered additional evidence supporting the partisanship approach, assigning an important role to Right-wing parties in generating policies of marketization and welfare state retrenchment, and Left-wing parties in protecting the existing welfare entitlements.

Concentrating on political parties as main actors in the policy arena, partisanship theory suggests that the party dynamic would be particularly important for health policy outcomes. Healthcare reforms have often been seen by political parties as unique chances for the expression of their distinctive ideological profiles and, therefore, have been used by political parties as very effective means of getting partisan votes (see Immergut 1992a, see also Altenstetter and Haywood 1991). More specifically, partisanship theory would assume that health policy choices would be attributed to a considerable extent to the party composition and the ideological profile of the government. Governments dominated by the parties on the Left ideological spectrum would be expected to pursue egalitarian health policies in favour of low-income groups and state control over the health sector, while governments dominated by the Right ideological spectrum would opt for market-oriented policies in favour of high-income groups and restrictive welfare entitlements.

However, partisanship theory offers a rather limited explanation for post-communist healthcare policy paths. The main reason for this is linked to the fact that, similar to power resource theory, it developed through the analysis of welfare state development and party competition in Western democracies. The literature on political parties and party system development in the new Eastern European democracies (Mair 1998; Kitschelt 1999; Casal Bertóá and Mair 2010; Casal Bertóá 2011; Keman and Müller Rommel 2012) suggests that the party competition dynamic in post-communism differed from that found in the West. Post-communist politics displayed very unstable patterns of party competition and government formation, particularly during the early democratization phase, and one of the consequences of this instability was a high degree of party system fluidity (Kitschelt 1995; see also Markowski 1997; Rose et al. 2001).⁷⁴ This unconsolidated party system dynamic was characterized by two elements. One was the relatively high level of electoral volatility (Mair 1997; Rose and Munro 2003; Sikk 2005; Tavits 2008; Lane and Ersson 2007; Powell and Tucker 2014), evident in the strong tendency of Eastern European voters to shift their electoral preferences between successive elections.⁷⁵ Due to the very high electoral volatility, very few cabinets have managed to survive and complete their full term, making East governments unstable in comparison to the governments in the West. A high degree of electoral volatility was also crucial for the development of the specific post-communist party competition dynamic, as it forced almost all parties to engage in coalition building, often characterized by an ideologically mixed and innovative governing formula (see Casal Bertóá 2011). Another related factor that contributed to the unstable party system dynamic in Eastern European democracies was the unstable ideological profiles of Eastern European political parties (Evans and Whitefield 1993; Kostelecký 2002; Grzymała-Busse 2002). The changing ideological profile of the parties, according to Grzymała-Busse (Grzymała-Busse 2002), was most characteristic of the parties on the Left of the political spectrum, mainly represented by the communist successor parties. Studying the development of these parties, she found that the programmatic transformation of these formerly ruling parties was very context specific and that their success or failure differed across countries, depending on the extent to which these parties were ready to adapt their strategies and tactics to the changing political environment. The result of these adapting strategies, in her view, was that the divide

⁷⁴ Some of the more recent studies provide evidence of party system stabilization in Eastern Europe, particularly in Poland, Hungary and the Czech Republic (Bakke and Sitter 2005; Tavits 2008). However, other authors disagree with this assessment, arguing that the appearance of stability is a result of the cartelization of the party system which prevents 'genuinely new' parties from entering while levels of volatility within the system have remained relatively high (Sikk 2005).

⁷⁵ Electoral volatility reflects the fact that some voters, from one elections to the next, switch their votes among parties, or switch from voting to non-voting or vice versa. Commonly used measure of electoral volatility is the Pedersen Index (see Pedersen 1979).

between Left and Right in the post-communist political landscape was both less pronounced and universal than in consolidated party systems of Western Europe.

As the empirical chapters will show in more detail, neither Polish, nor Czech political parties consistently follow their ideological profiles throughout the first two post-communist decades. This explains why the Right-Left divisions of Czech and Polish political parties were rather poor predictors of healthcare policy choices in the two countries. Furthermore, closer comparison of the post-communist political dynamic in the two countries (table 4) reveals interesting country-specific characteristics. It shows that while in both countries there were relatively frequent government changes, these changes in Poland, much more often than in the Czech Republic, involved changes in the party composition of the government. In terms of government alternation, the two countries displayed relatively similar values, implying that in case of both more (Poland) and less (the Czech Republic) frequent changes in party composition of the government, these changes implied a relatively high degree of coalition changes. Finally, the level of electoral volatility shows that Polish voters were changing their electoral preferences much more frequently than their Czech counterparts.

Table 1. Number of changes in the party composition of the government, government alternation level and electoral volatility in Poland and the Czech Republic, 1989-2009.

	Poland	Czech Republic
Number of changes in party composition of government⁷⁶	11	3
Government alternation level⁷⁷	60.7	72.6
Electoral volatility⁷⁸	46	27

Sources: Number of changes in the party composition of the government: Casal Bertóia and Mair (2010: 8). Government alternation level: Casal Bertóia and Mair (2010: 8). Electoral volatility: Powell and Tucker (2014: 9).

⁷⁶ This measurement includes only changes of government (between 1990 and 2008) that entail a modification in the partisan composition of government i.e. it excludes all changes in government due to an intervening elections or a change of prime minister, which do not entail a partisan change of the cabinet itself (see Casal Bertóia and Mair 2010: 4-5).

⁷⁷ These values represent means for the index of government alternation (IGA), which measures the degree to which party composition of successive governing coalitions changes at each new period of government formation (see Casal Bertóia and Mair 2010: 3-5).

⁷⁸ Powell and Tucker (2014) disaggregate the Pedersen Index into two measurements: type A volatility, due to the new party entry and exit, and type B volatility, due to shifts in votes between the existing parties. These values represent mean values for total volatility for the period between 1989 and 2009 (ibid. p. 9).

These differences in the party competition dynamic of the two countries were certainly important for the policy dynamic in the healthcare sector. However, as this thesis will demonstrate, parties and party dynamic did not matter per se, but only in combination with country-specific constitutional rules i.e. in combination with the veto point structure of each country, which created a very specific political-institutional combination that shaped Czech and Polish healthcare policy paths. In other words, it was not the parties or party composition of governments themselves that determined policy outcomes but rather the interaction with the institutional structures that made these outcomes possible.

2.3. Professional Dominance Theory

Professional dominance theory differs from the previous two theories in that it draws upon a very distinctive element of the healthcare sector – the power of the medical profession. This theory was first formulated by Freidson (1970), as part of a broader theory of professionalism, later developed by Johnson (1972).⁷⁹ Freidson argued that the theory of professionalism applies specifically well to medicine, since the medical profession distinguishes itself from other professions due to the monopoly it has managed to achieve, thanks to its technical expertise, in the healthcare sector. As the only truly autonomous profession, he argued, medicine achieved its independence gradually in the process of a division of labour, gaining the exclusive right to technical autonomy in all spheres of medical practice, as well as the exclusive right to issue legal licenses for this practice (Freidson 1970). Even though some of the subordinated i.e. paramedical professions also tried to claim their professional status, they lacked professional autonomy, and this placed them in an entirely different structural position in the hierarchical division of labour in the medical sector (ibid. pp. 47-70).⁸⁰ A somewhat different view on the origins of medical autonomy, which focuses more narrowly on medical licensing, was offered by Berlant (1975). According to Berlant, it was not the technical expertise but rather the market monopoly that was crucial for the establishment of the medical profession in such a commanding position in modern capitalist societies. Once medical professionals started to control entry into the profession through licensing, doctors became able to use their monopoly position to corporately dominate the healthcare sector.

⁷⁹ Johnson (1972) defined a profession as a method of controlling work, one in which an occupation, rather than consumers, or an agent or agency mediating between occupation and consumer, exercises control over its work. Similarly, Freidson (1970) argued that an essential feature of a profession is the possession of something of a monopoly over the exercise of its work.

⁸⁰ As Immergut (1991: 3) notes, in Freidson's understanding of professional power, this power is based on "defining the 'cognitive' boundaries of the profession by defining medicine as unique branch of knowledge and protecting the exercise of medicine against competing therapeutic ideas as well as competing practitioners".

These two different versions of professional dominance theory vary in their explanations of the origins of professional autonomy, i.e. technical expertise or market monopoly, but nevertheless agree about its implications. Once established, the autonomy of the medical profession would place doctors in a special position from which they would be able to act as a powerful lobby group. The idea that this professional power would translate into political power is based on the assumption that cooperation with doctors, as the only professional group officially qualified to carry out medical treatments, would be necessary for the passing of healthcare reforms. Doctors' professional power, in other words, would place them in a very privileged political position, from which they would be able to successfully bargain different aspects of government healthcare policy, such as working conditions or pay (see Immergut 1991: 4-5).

To what extent can professional dominance theory be applied to Eastern Europe? The historical development of the medical profession and its autonomy in the West differed from its development in the East. Under socialism, medical professionals went through the process of “taming”, which implied a change from a small, elite and prestigious profession working in private practice for the rich, to a large, publicly employed mass profession (Field 1991). This process of “taming” was part of the project of medicine “socialization”, initiated in the early post-war years in the Eastern European countries that were under the pervasive influence of the Soviet Union (Weinerman and Weinerman 1969; Field 1991). The result of this “socialization” project was that in respect of their professional autonomy, socialist doctors enjoyed a rather hybrid status (Field 1991). In decisions concerning clinical matters i.e. in the technological side of their work, they enjoyed almost complete independence, possessing a tremendous amount of power to dictate their terms to the other healthcare occupations and remained usually unchallenged by the patients. In economic and political matters, however, doctors were completely powerless and dependent on the state (ibid. p. 54; see also Freidson 1970).⁸¹ They were incapable of affecting their working conditions, such as hours of work or rates of pay, since these conditions were determined bureaucratically or set by a decree.⁸²

Finally, in socio-political terms, socialist doctors were also “creatures of the state” (Freidson 1970: 41) since they were not allowed to organize politically and independently of the

⁸¹ According to Freidson (1970), even though doctors in the Soviet Union had no secure economic position independent of the State, they nevertheless had professional autonomy due to fact that the heart of professional autonomy; their technical expertise and judgement was unquestioned (ibid. p. 42-3).

⁸² In the Soviet Union, doctors' working hours were generally six and a half hours per day. The tempo of work was also dictated by bureaucratic norms, as in 1960, a paediatrician in the Soviet Union was expected to see an average of five patients per outpatient clinic hour (Freidson 1970: 41).

state.⁸³ While under socialism the medical profession enjoyed a rather hybrid status, the post-communist period across Eastern Europe was definitely a period of professional revival. In Poland and the Czech Republic, the main sign of this revival was the re-establishment of professional medical chambers, after almost forty years of inactivity. The Polish Chamber of Physicians and Dentists (*Naczelna Izba Lekarska*) was re-established as a professional self-governing body of doctors and dental practitioners as early as in 1989. Similarly, the Czech Chamber of Physicians (*Česká Lékařská Komora*) was re-established in 1991. Through the recovery of their legal status, the medical chambers in both countries quickly achieved an important position within the health sector and took over tasks which included licensing of healthcare professionals, enforcement of ethical standards of medical practice, and guarantee of the quality of delivered care. This professional role of the chambers was additionally strengthened by the introduction of obligatory membership for all practicing physicians in the two countries, which also enabled these chambers to monopolize the interest representation of the medical profession.

Given these post-socialist trends, it would be reasonable to expect that the revival of professional medical associations in Eastern Europe would be matched by a strong professional influence on the policymaking process and its outcomes. Being finally capable of organizing independently from the state and having their say in government healthcare policy, the doctors, it could be expected, would use this as an excellent opportunity to influence the policymaking process. However, as the empirical analysis will show in more detail, the post-socialist revival of the medical profession did not translate into an organized political influence of doctors on the policymaking process. Indeed, a closer look at the Polish and Czech healthcare reforms suggests that professional dominance theory could be rather wrong in its predictions. Namely, in terms of doctors' distribution in the overall population, it would be expected that Polish doctors would be more powerful in getting their own way in policymaking than Czech doctors, because the former were in significantly shorter supply (table 5a) and could thereby exert stronger pressure on the government (see Immergut 1992a: 7). With a distribution of only 208 physicians for every 100 000 inhabitants in 1989, and just a slightly higher number in 2009, Polish doctors would be expected to have more influence in determining the conditions of professional practice and the level of pay than their Czech colleagues.

⁸³ Elston (1991) distinguished between three different aspects of medical autonomy. One is economic autonomy, which implies the right of doctors to determine their remuneration. Another is political autonomy, which implies the right of doctors to make policy decisions as the legitimate experts on health matters. Finally, there is the clinical and technical autonomy, which implies the right of doctors to set their own standards and control clinical performance. Following Elston's division, one could say that medical professionals under socialism enjoyed only clinical and technical autonomy, while they were deprived of both economic and political autonomy.

Table 2. Czech and Polish doctors in the population, in the Government and in the Parliament.

	Poland	Czech Republic
a) Doctors per 10 000 population⁸⁴		
1989	20.8	27.2
2009	21.7	35.6
b) Doctors as health ministers (out of total number)		
1989- 2009	16/18	11/14
c) Doctors in the parliament		
1996	3%	9%
2006	5%	4%

Sources: Doctors per 100 000 inhabitants: WHO European Health For All Database (<http://data.euro.who.int/hfadb>), accessed on 01/05/2012. Doctors as health ministers: own calculation based on data available at the websites of the Czech (www.mzcr.cz) and Polish (www.mz.gov.pl) Ministry of Health. Doctors in the parliament: own calculation based on data from the website of the Czech (www.psp.cz) and the Polish (www.sejm.gov.pl) parliament, accessed on 01/05/2012.

The main reasons why the professional revival could not translate into the professionals' control over the policymaking process was the fragmentation of interest representation within the medical profession. In spite of the obligatory membership in the chambers, in both Poland and the Czech Republic, professional interest representation was distorted because the medical profession was divided along different lines. Apart from the old divisions, which existed in socialist times, such as those between doctors working in preventive and curative care, new and even more explicit divisions emerged along the lines of profitability of particular medical specialties and new approaches to health care administration and funding (Healy and McKee 1997). These multiple dividing lines were one of the core obstacles to the interest organisation of medical professionals. They led to the burgeoning of a variety of professional associations, each of which claimed to represent different professional groups and very often expressed mutually opposing demands in the policymaking process. Another consequence of these multiple divisions among medical professionals was that the chambers' monopoly of interest representation, established through obligatory membership, was quickly broken. One

⁸⁴ The ratio of general practitioners (all of which are private practitioners in both countries) to specialists is almost the same in the two countries. There are 20% (head counts) doctors in Poland and 20% of doctors in the Czech Republic who are general practitioners, while 79% and 80% of doctors are specialist in the two countries, respectively (OECD Health Data 2014).

consequence of this was that both Polish and Czech medical chambers and professional associations failed in establishing adequate relationships with government, and became poor, marked by conflict and, at times, even personal animosity (ibid. p. 292). It is, therefore, not surprising that the strikes led by the professional associations were one of the typical ways in which professional associations expressed their discontent with government healthcare policies.

As the empirical chapters will show, one of the consequences of the fragmentation was that the main channel through which Czech and Polish doctors could influence the policymaking process was through their individual access to one of the political decision-making arenas. There were two main ways in which individual doctors could gain access to these arenas. One was through doctors' positions in the government. Their entry to the government was enabled by the fact that, in contrast to most Western European countries, Polish and Czech ministers of health were, in most cases, doctors (table 5b). Another common method of access to the decision-making arena was through the doctors' position as members of the national parliaments (table 5c), which enabled them to exercise their influence in the legislative arena. The individual mode of access to the policymaking arenas, however, made doctors' influence highly dependent on individual policy preferences, which made the pattern of doctors' influence on the policymaking process discontinuous and often unpredictable.

2.4. Legacies

The last alternative account of the post-communist healthcare policy paths is that based on legacies. Legacies based explanations have been particularly prominent in studies of the different aspects of post-socialist transitions (e.g. Barany and Völgyes 1995; Kitschelt 1999; Ekiert and Hanson 2003; Pop-Eleches 2007) and more specifically, in studies of the post-socialist welfare state (e.g. Kornai 1997; Haggard and Kaufman 2008; Kovács 2002; Tomka 2007; Inglot 2008).⁸⁵ Understanding the political processes of policy transformation as strongly influenced by the social, cultural and institutional structures created in the past, different legacy-based approaches have one important element in common. They stress the important role of history and historical causation in generating the stickiness of political choices.

⁸⁵ Legacies-based explanations are common not only in studies of post-communist transitions or welfare state development. One variant of legacy-based explanations are studies of the historical neo-institutionalists that draw upon the role of history and institutions from the past in the shaping of the divergent policy paths. A classic example of these is Weir and Skocpol's (Weir and Skocpol 1985) study of the different Keynesian responses to the Great Depression in three nations, which these authors explain by the difference in the state structures and policy legacies.

In post-communist welfare state research, the legacy approach was often used to underline the specific character of the post-socialist welfare states. Advocates of this approach have argued that because of their communist or even pre-communist past, the welfare states in Eastern Europe created structures that made them follow paths that deviate from those followed by the welfare states in Western Europe. Janos Kornai, famous Hungarian economist, analysing patterns of welfare spending in Eastern Europe, argued that the legacy of the “prematurely born” communist welfare state was the major obstacle of welfare state development in post-socialism (Kornai 1992, 1997).⁸⁶ This very specific legacy of the communist welfare system, in Kornai’s view, seriously impeded the development of the welfare state in East Central Europe in the communist aftermath, generating high expectations about the future of welfare provision. These expectations, in turn, influenced welfare politics in such a way that they significantly curtailed the policy choices of post-communist elites and slowed down the reform process. As a result, post-socialist welfare became one of the few relics of the command economy, with all its dominant features such as over-centralization, waste, rationing, shortage, paternalism, rent seeking and corruption (Kornai 1997). Similarly to Kornai, Haggard and Kaufman (Haggard and Kaufman 2008) argued that the legacies of the very generous social expenditure under communism provide the best explanation for the very unusual development of social spending in the post-communist countries, which stands in stark contrast to the social spending in Latin American or East Asian countries, which have a very similar level of economic development.

Some authors went even further back in history and argued that post-socialist policy choices are best explained by the pre-communist welfare legacies. Inglot (Inglot 2008), for example, drew upon the institutional welfare legacies of the interwar period in order to explain the divergence of policy choices in Central Eastern Europe in the post-communist era. Defining institutional legacies as “structures and norms that are firmly embedded in the process of state-building and re-building during different historical periods” (ibid. p. 41), Inglot emphasizes that each of the countries from the region, before communism, had a lengthy history of social security programmes that developed during both the Bismarckian period and the period of Austro-Hungarian rule. These pre-communist institutional legacies, in his view, were crucial in the shaping of the post-communist social policy developments that gave rise to the divergent welfare paths across the region.

⁸⁶ Kornai (Kornai 1992, 1997) shows that the communist welfare states were far more generous than the welfare states in the non-communist countries with a similar level of economic development. He argued that under communism Eastern European countries ignored the criterion of affordability and granted universal social entitlements, which were out of proportion to these countries’ resources and fiscal capacities of the state. This, in turn, gave rise to the communist “prematurely” born welfare state.

The legacy approach to policy change has one important advantage – it emphasizes the role of the past in the explanation of present policy choices. Arguing that ‘history matters’, the approach enables us to put the present events we seek to understand into a broader historical perspective. The legacy-based argument for post-communist health reforms could, for example, refer to the pre-communist i.e. inter-war period, when Polish and Czech lands implemented compulsory healthcare insurance based on the ‘Bismarckian’ model of healthcare, which involved the introduction of self-governing sickness funds and obligatory contributions as the main source of public healthcare financing. This historical fact could suggest that the shift to the insurance system was simply a continuation of the old healthcare policy path, which had been temporarily broken by the introduction of the communist ‘Semashko’ system of healthcare. The Czech and Polish post-communist healthcare systems, certainly, resemble the system of healthcare these two countries implemented during the inter-war period. However, it would be very difficult to track the origins of the post-communist reforms in the inter-war period without accounting for the causal mechanisms of change. This, nevertheless, is one of the three typical problems of legacy-based approaches to policy change. The first is that they are overly deterministic. Legacy explanations point to the path-dependent character of policy choices and stress the need for a recursive reference to the past in the attempt to explain the present. In this way, legacy-based approaches leave no space for surprises, which makes them incapable of explaining any significant deviations from the beaten path. These deviations, however, are necessary for the emergence of policy change. The problem of legacy-based explanations, in other words, is that their deterministic outlook implies not that history matters, but rather, that it matters too much, and this leaves no space for developments that go against the beaten path. The second problem refers to the tendency of legacy-based explanations of policy change to perceive history as a passive rather than an active driver of the policymaking process. Arguing that history matters not as a driving force of transformation, innovation and change, but rather as a reproductive mechanism through which past policy choices are translated into new political contexts, legacy-based arguments of policy change consider change to be nothing more than a translation of the past into the present.

Finally, the problem of the legacy approach is its understanding of new policies as translations of past policies. The shorter historical distance of the socialist legacies of healthcare seem to make the task of the legacy-based explanations of the post-communist policy choices somewhat easier. However, the potential accounts of the role of the communist legacies in the shaping of the post-communist policy choices seem to face the same kind of issues faced by the pre-socialist legacy explanations. The issues facing socialist and post-socialist policymaking were

drastically different, so it would be rather difficult to explain how they could draw upon the old socialist policies to solve these problems. What is more, we have seen that the socialist way of healthcare provision was considered the main source of the problems facing the healthcare sector, so it would be difficult to understand why post-communist reforms should be seen as a reproduction of the old institutional structures of socialism. The challenge, then, in accounting for the role of socialist healthcare in post-communism policy choices, as my argument has already shown, is to explain exactly how, when and why post-socialist policies emerged in response to the institutional structures of socialist healthcare. Focusing on the understanding of new policies not as ‘translations of’, but rather as ‘reactions to’ old policies, the argument offered an account of the powerful role of the past in policymaking which is contrary to that offered by the legacy approach. The empirical analysis in the chapters that follow will show that market ideas were radically new to the Polish and Czech healthcare sectors and that healthcare policy change involved experimentation and innovation that was driven by ideas rather than past structures and policies.

3. Summary

The first part of this chapter developed a theoretical framework which explained how ideas, interests and institutions jointly shaped the process of post-communist healthcare policy change. Departing from the thesis main argument, which claims that the process of post-communist health policy changes is best described as a process of social learning characterized by a divergent cross-country dynamic, the chapter explained how market oriented ideas as the core drivers of the social learning process created the impetus for change. It also discussed the role of the ‘usual suspects’ of policy change, namely interests, arguing that while interests did matter in post-communist healthcare policymaking, they needed ideas in order to play their role, and often gave rise to preferences that were closely linked to identities, and therefore turned out to be often unstable and very context dependent. Finally, the role of institutions was analysed through the veto point approach, according to which policy change is profoundly shaped by political-institutional configurations that combine formal institutions with unpredictable outcomes of the political dynamic. The second part of the chapter discussed four alternative explanations, and the potential of each of these explanations to account for the Czech and Polish healthcare policy paths. The four sections showed that those explanations focusing on the role of the unions, political parties, healthcare professionals and, finally, historical legacies cannot account for Czech and Polish healthcare policy paths and their divergence. The unions-based explanation failed to account for the divergence because trade unions in both countries were

weak, characterised by the fragmented union movement, low union density and illusory corporatism, all of which resulted in the unions not playing an important role in the policymaking process. Similarly, I also showed that the explanation that draws upon the role of professional power cannot fully account for the divergence of the post-communist policy paths, because professional influence was not organized and depended on the individual access of doctors to the policymaking arenas and their different preferences. The explanation that emphasized the role of the political parties was also unsuccessful in explaining the policy divergence, because in both countries ideologies of the political parties were poor predictors of their policy choices. Finally, the legacy-based approach lacked a causal mechanism that could explain how new policies emerge as ‘responses to’ rather than ‘translations of’ old policies. The two chapters that follow provide empirical support for specific elements of the theoretical framework developed in this chapter. Each tells the country-specific story of post-communist healthcare reforms and sheds more light on the role of ideas, interests and institutions in the process policy change.

Chapter Three: Poland

Introduction

Poland was not able to introduce a comprehensive reform of its healthcare system right after the fall of communism. Its healthcare policymaking process during the post-communist period was fragmented, delayed and suffered from a major reversal. While privatization of healthcare delivery had started already in the early 1990s, it took Poland a full decade after the fall of communism to depart from the old socialist model of healthcare financing and switch to an insurance system with market-oriented elements. When in 1999 the government managed to replace the centralized and hierarchical structure of the Polish healthcare system with its more liberal counterpart, the system quickly fell into trouble. Several years later, in 2003, the new Polish government introduced another major reform. This new reform, however, took a major step back in the policymaking process, so that the ultimate outcome of the two decades of Polish post-communist reforms was an insurance system with limited market elements.

What stands out in the process of healthcare policy making in post-communist Poland is its slow and protracted character. The empirical analysis shows that market-oriented ideas of healthcare were emerging among Polish healthcare policy experts already in the 1970s, and in the 1980s gained prominence in policymaking circles. After the fall of communism, these ideas became crucial in two respects. First, they enabled the establishment of a general consensus in the policymaking circles that a departure from the old socialist model of healthcare was needed. Second, they served as a basis for the formulation of the first reform proposals. The period of the early 1990s was however characterized by an intense political struggle between the competing reform proposals presented by the strongest political blocks in Polish transitional politics. Political instability, preference shifting among the major political actors, factionalism and the coalitional character of Poland's post-communist governments continuously hindered the ability of the policy makers to form a consensus over the complex issues of healthcare reform. These reforms efforts were further hampered by the dense network of veto points generated by the Polish semi-presidential constitutional system. All of these factors help explain why healthcare policy marketization in Poland followed such a slow, protracted and, ultimately, reversible policy path.

From a comparative perspective, Polish post-communist healthcare reforms are similar to those of the Czech Republic in two significant respects. First, during the last decades of

socialist rule health care in both countries underwent a period of deep crisis. Due to the low priority of the health sector within the socialist economy, both the Polish and Czech healthcare systems became seriously underfunded, featuring constant shortages, low salaries of health care personnel, high corruption and dissatisfied patients. Second, in both countries, the communist governments were looking for possible solutions to this crisis, and evidence shows that both Polish and Czech healthcare policy experts over the 1970s and 1980s started to develop market ideas. These experts believed that replacing the hierarchical and strictly controlled socialist system of health care with a system with market-oriented incentives would be the best remedy for the socialist system's inefficiencies. After the regime change in 1989, in both countries these ideas became the basis for healthcare reform plans. The actual course of Polish and Czech healthcare reforms in the post-communist period nevertheless differed, in respect of timing, policy trajectories and their outcomes.

The empirical evidence used in this chapter is collected from various sources. It is based on a comprehensive review of the literature on the Polish healthcare system and policy reforms, analysis of media reports, including Polish and foreign newspapers and magazines, analysis of the reform proposals and draft bills presented in the Polish parliament, healthcare related laws, statistical data and finally, twenty one in-depth interviews conducted with Polish healthcare experts, policy makers, politicians, journalists and doctors in Warsaw and Krakow in Autumn 2011.⁸⁷

This chapter is divided into three main sections. The first section offers a brief overview of the history of Polish healthcare policy during the inter-war and the-post war, i.e. communist period. The second section moves to post-communism and describes the main characteristics of the context in which the post-communist healthcare reforms took place. This section reviews the main developments in the realm of politics, economic and social reforms, and also looks at interest group representation in post-communist Poland. The third section analyses the post-communist healthcare reforms, describing the main episodes of healthcare policy change in the period from 1989 to 2009. The main aim of this chapter is to show how market ideas of healthcare, which were emerging already under communism, became the basis for the formation of reform proposals in the turbulent context of the Polish post-communist transition. The passing of these proposals into policy was however significantly hampered by the country-specific arrangements of the political institutions and the dynamic character of Polish political competition.

⁸⁷ A list of these interviews is available in the appendix.

1. Polish Healthcare: Historical Overview

The historical overview of Polish healthcare focuses on two periods, the inter-war period and the communist period, and its main objective is twofold. First, the overview aims to show the gradual development of Polish healthcare throughout the 20th century. During this period, Polish healthcare policy witnessed some of its most important moments, such as the introduction of the insurance system after World War II and the development of universal access to healthcare under communist rule. Second, by shedding more light on Polish healthcare policy under communism, this section shows how the last two decades of socialism, when Polish healthcare was in a dire condition, were crucial for the development of the market ideas that would become the key drivers of the post-communism reforms. Offering solutions for the anomalies of the socialist healthcare system, these ideas developed in the attempt to not only explain the core problems of the socialist healthcare system but also to offer suggestions for change that, as it would later turn out, would become the main inspiration of the post-socialist policy makers.

1.1. The inter-war period

When Poland gained its independence in 1918 and proclaimed the Second Polish Republic, its welfare system was territorially split.⁸⁸ The biggest and the most immediate challenge for social policy makers was to try to diminish a huge gap that existed both in the scope and quality of welfare state development across the territories now constituting the new Polish state. In the former German territories, all major groups of hired employees had access to a complete range of sickness, maternity, disability and old age protection. In the Austrian part of the country, workers had limited sickness and work injury coverage, and relatively well-developed pensions for salaried employees. In the Russian part of Poland, however, there was only a rudimentary protection in a few large enterprises. The first step in bringing these different territories under a common welfare structure of healthcare was taken in 1918. The Ministry of Labour, Health and Social Welfare was established and given responsibility over health issues. Its main activity focused on fighting infectious diseases and promoting hygiene among the population. In 1919, the Polish provisional government announced the introduction of compulsory sickness insurance, based on the Bismarckian model,⁸⁹ for the whole the country

⁸⁸ This was the consequence of the fact that, before gaining independence in 1918, Poland for more than a century was divided in three parts, ruled by the Austria-Hungarian, the German and the Russian Empire.

⁸⁹ Inglot (2008: 81) explains this government move in the following words: “Experience with the advanced and well-functioning programs in the western part of Poland (ruled by imperial Germany until World War I) inspired

(Inglot 2008). The Law on Health Insurance came into force in May 1920, establishing the system of sickness funds (*kaszy choroby*). While many of the funds were direct successors of the German *Krankenkasse*, in contrast to the original German model, the Polish insurance model put more emphasis on the territorial structure of the sickness funds and on their self-governance (Sadowska 1993). The new system of healthcare was funded through contributions i.e. payroll taxes, which were paid jointly by employee and employer. According to the law, the funds had to maintain balanced budgets, and while the state was not directly responsible for the financing of the health insurance programme, its task was to guarantee the system's financial stability.

The establishment of the insurance system in the inter-war Poland was an incomplete success. On the one hand, the achievement of the newly founded Polish state in building a national social security system was impressive. Introducing a modern and relatively efficient social insurance administration in a largely impoverished and mostly rural country, with extreme social and economic diversity, has been considered a significant achievement (Davies 1982). On the other hand, however, the Polish inter-war health care system was far from perfect. One of its flaws was a very low coverage. Funded from contributions, the insurance scheme was created to cover only salaried and manual wage-earners and their families, and this resulted in only 7% of the whole Polish population being covered by public health insurance (Kuszeński et al. 2005). At that time the vast majority of the Polish population were peasants, working in agriculture, and therefore were not eligible for public health insurance.⁹⁰ This also explains why the majority of medical care before World War II in Poland was obtained privately. In some industries, such as mining, salaried doctors in organized dispensaries provided healthcare services, but most insured, as well as uninsured persons, received services from private practitioners who were paid by the fee-for-service. Another deficiency, related to the former, was that the delivery of medical care was particularly strong in the cities and very weak in the rural areas, which were inhabited by the two thirds of the Polish population (Roemer and Roemer 1981). The result of this uneven coverage was that even in case of service improvements, the delivery of care was unequally distributed across the regions, with Warsaw and Cracow representing over-concentrated centres of medical care.⁹¹

government leaders to draft ambitious plan for a comprehensive national social insurance system that could match or even surpass countries with more developed safety nets, such Weimar Germany and Czechoslovakia.”

⁹⁰ According to the 1921 census, the occupation structure of Poland was the following: 64% peasants; 10% agricultural labourers; 17% industrial proletariat; 5% professions and intelligentsia; 2% entrepreneurs; and 1% landowners (Davies 1982: 406).

⁹¹ The number of hospitals beds in 1918 was 44 250; in 1938 it reached 75 000, in 677 hospitals. Similarly, from 1923 to 1938 the number of physicians almost doubled, rising from 6 850 to 12 917 (Kaser 1976: 199).

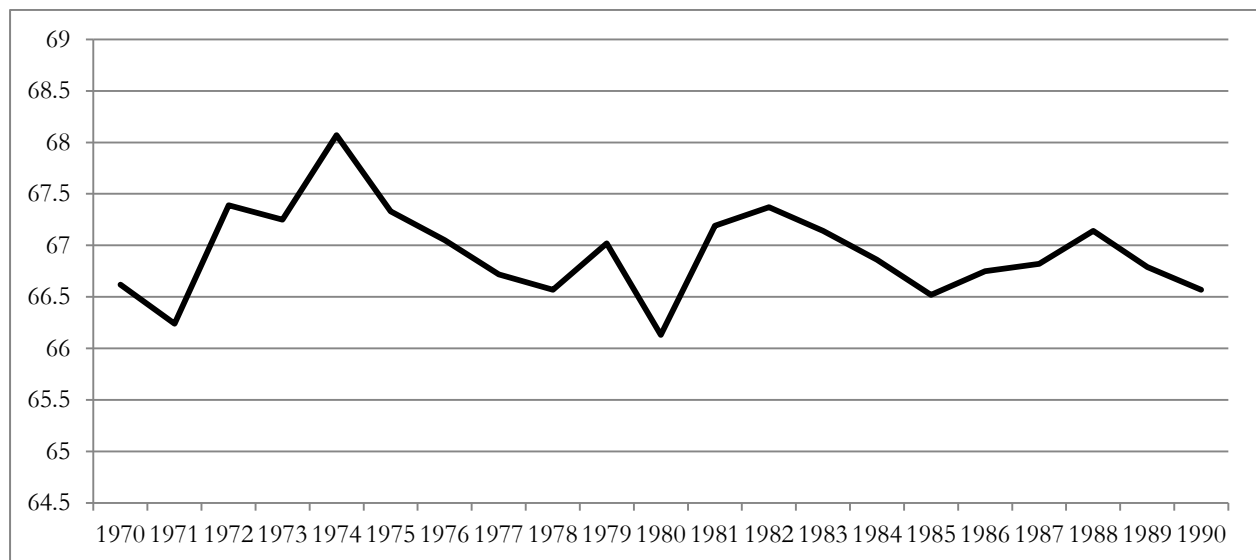
1.2. The communist period

Poland emerged from World War II devastated, losing almost 6 million of its citizens and a huge proportion of its national wealth. The war also destroyed most of the Polish health care infrastructure, hospitals and other health care facilities, and the country suffered a loss of nearly 50% of its medical professionals (Roemer and Roemer 1981: 4; Weinerman and Weinerman 1969: 117-118). The liberation of the country by the USSR, the subsequent occupation and the elections in 1947 resulted in the introduction of the socialist political system and the official proclamation of the People's Republic of Poland in 1952. Changes in the health sector took place quickly, already during the first post-war years. Soviet leaders had a clear intention to replace the insurance system with one modelled after the Soviet, 'Semashko' system of healthcare (Poland 2011: 16). The initial steps were taken in 1945, when the government established the Ministry of Health, withdrawing the responsibility for health care issues from the Ministry of Labour, Health and Social Welfare. The same year, a government decree shifted the burden of health insurance contributions, changing contributions from the previous payroll system, equally shared by employer and employee, to the tax system paid by employers only. The government also worked on a gradual integration of healthcare facilities, in order to put them under the direct control of the Ministry. The final step was taken in 1951 when sickness funds were incorporated into the general budget and health care financing switched from contributions to general taxation (Roemer and Roemer 1981).

The first post-war years featured evident progress in the healthcare sector in several respects. One of them was the education of professional healthcare workforce. Already by 1950, the proportion of doctors in Poland had reached its pre-war level of 3.7 doctors per 10.000 inhabitants. In 1955, this ratio had risen to 6.7. A similar improvement was witnessed in the education of healthcare staff. Whereas in 1938, the nursing profession was almost not existent, by 1955 there were 17.9 nurses per 10 000 inhabitants (Millard 1982). Another aspect of the post-war progress was improvement of the medical infrastructure and geographical distribution of health care services. Finally, the post-war progress was also evident in the improved health status of the Polish population. In the 1950s and early 1960s, mainly due to compulsory programmes of medical treatment and mandatory immunization, the Polish population experienced significant improvements in the treatment of infectious diseases and increases in values of some of the main health indicators, such as life expectancy and infant mortality (Golinowska and Sowa 2006).

This period of the ‘golden age’ of Polish healthcare ended in the late early 1970s, when the healthcare system started to show some of its first anomalies. The stagnation period had started already in the mid-1960s (ibid. p. 7), when some of the main health indicators, such as adult men’s life expectancy, started to decrease and mortality rate rose. Over the 1970s and 1980s, the situation continued to deteriorate (figure 6). By the 1980s, constant underfunding, shortages, low salaries and high levels of corruption became ubiquitous characteristics of the Polish healthcare sector. Corruption in particular became so rooted that it became a regular element both of individual health care expenditure and of physicians’ incomes.⁹²

Figure 4. Male life expectancy at birth in Poland, 1970-1990.



Source: WHO Health For All Database.

In the attempt to solve these problems, the new Polish communist party leader Edward Gierek introduced a series of reform during the 1970s. These reforms focused on the expansion of healthcare coverage and the reorganization of healthcare delivery in line with the socialist model of healthcare provision. In 1972, the last group of previously excluded citizens, some 6.5 million agricultural workers who were predominantly private farmers, was granted free access to public healthcare (Roemer and Roemer 1981). In 1973, the parliament adopted a long-term programme for the healthcare sector, entitled “Programme for the Development of Healthcare and Social Welfare until 1990”⁹³, which aimed to ensure comprehensive and free provision of care to all, in line with the principles of the socialist medicine. The programme implied

⁹² While it was difficult to estimate the degree of corruption, Tymowska (1987) argued that 0.5% of GDP should be added to the official records of the total healthcare spending in order to account for the scope of the informal payments. Another study on health care financing in Poland (Chawla et al. 1998) shows that in the post-communist period corruption still formed an important source of earning for Polish physicians, as in 1994 informal payments made by patients to physicians were almost doubling physicians’ salaries.

⁹³ *Program Rozwoju Ochrony Zdrowia i Opieki Społecznej do 1990.*

functional integration of all forms of health and social care into single management units, the ZOZs (*Zespół Opieki Zdrawotnej - ZOZ*), which would locally integrate services of primary care, hospital, emergency and specialist care, and even welfare assistance at the county (*powiat*) level (Kuszeński et al. 2005: 7).⁹⁴ The ZOZs were seen as a symbol of the bureaucratic style of healthcare services management (Włodarczyk and Karkowska 2000: 380). From a political respect, the introduction of this programme represented an attempt by the new communist party leader Gierek to convince Polish society of the sincerity and depth of the government's commitment to the principles established at the Sixth Party Congress (Millard 1982).

In spite of these significant organizational changes, the problems of Polish health care remained. The situation in the healthcare sector in the second half of the 1970s became so alarming that in June 1980 the Central Committee of the Polish Communist Party⁹⁵ decided to hold, for the first time, a plenary session devoted exclusively to the problems of the healthcare sector. At this session, the Minister of Health Marian Sliwinski confessed that despite considerable effort, the desired rate of progress in the healthcare sector had not been achieved.⁹⁶ In spite of the minister's confession,⁹⁷ the new party leadership in 1983 issued the Parliamentary Resolution on Health Care and Social Welfare,⁹⁸ which declared that the health status of the Polish population was satisfactory and that the health sector, in spite of the extremely difficult economic situation, was performing well. Poland's health care problems, in other words, were swept under the carpet.

In the meantime, the situation in the healthcare sector was deteriorating. In the 1980s, this prompted the emergence of reports that analysed the problems of the sector and suggested possible solutions. The first of these reports⁹⁹ was published in April 1981, by a group called "Experience and Future" (*Doświadczenie i Przyszłość*), which was composed of independent healthcare experts. The report argued that the Polish healthcare system was substantially under-financed, resulting in tragic situations in Polish hospitals, because of the increasing lack of medicines, and serious undersupply of medical equipment and materials. The report stated:

⁹⁴ When ZOZs were initially established, there were 392 districts and 33 urban districts with an average of 85 000 inhabitants in each. In the second step of the reform, the counties (*powiaty*) were abolished as administrative units, but ZOZs remained responsible for the health care provision to the inhabitants. At the upper administrative level, 17 voivodeships were restructured into 49 and they took over the obligation of taking over referral institutions (Włodarczyk and Karkowska 2000: 380).

⁹⁵ Polish United Workers' Party (*Polska Zjednoczona Partia Robotnicza*).

⁹⁶ Sliwinski's speech on the third plenary session of the Central Committee. In *Służba Zdrowia*, July 4, 1980, p. 5.

⁹⁷ Sliwinski resigned in November 1980, when the new party leadership, led by Stanisław Kania, took power. Kania was replaced in 1981 by General Wojciech Jaruzelski.

⁹⁸ *Uchwała Sejmu Polskiej Rzeczypospolitej Ludowej z dnia 29. Września 1983 r.w. sprawie ochrony zdrowia i opieki społecznej, Dziennik Sejmowy nr. 10/83.*

⁹⁹ *Raport Konwersatorium "Doświadczenie i Przyszłość"*, *Zycie i Nowoczesność*, 02. April 1981.

“There is a shortage of everything. There is neither sophisticated diagnostic equipment nor the simplest drugs and detergents. Neither artificial kidneys nor disposable syringes and needles are available in the system”. The authors of the report claimed that due to the deficient resources, it had become impossible for the system to meet even the already diagnosed health needs. They calculated that, given that in 1980 there were as many as 10 000 people waiting for artificial valve implantation and that only 400 operations could be carried out per year, more than a quarter of the century would be necessary to satisfy the actual need for this type of medical treatment.

The authors of the report further suggested that these and similar problems emerging in the healthcare sector were not just local, but rather systemic in nature. The malfunctioning of the health service, they stated, might be seen as a result of poor management of the healthcare system itself. The authors pointed to the problem in the supposedly flawless system of healthcare distribution using the analogy of a reversed pyramid: a bulk of resources is spent to meet special needs of a proportionally small fraction of the population. Meeting the prevailing burden of health needs, they argued, should be the strongest part of the pyramid, but this actually was its weakest section. The report finished with the authors’ conclusion that the existing management model of the health care system would be completely ineffective in the attempt to distribute healthcare resources in a more rational way. Taking its cue from this report, another report advised regionalization and greater flexibility of the healthcare system’s organizational structure as the solution for the managerial problems. It argued that the main source of the problem was that managers’ performance had been evaluated on the base of formal criteria, while these should be replaced by the criteria of substantial efficiency (Interview Włodarczyk).

These two independent reports prompted the Polish communist party leadership to officially offer solutions for the problems of the healthcare sector. In 1988, the Ministry of Health published the High Commission Report titled “Draft Reform of the Health and Social Care”¹⁰⁰. This report was based upon the commissioned opinion of healthcare experts and was the first official document openly suggesting the introduction of an insurance system in Polish healthcare. The High Commission Report argued that the insurance system would be the best solution for the existing problems of the healthcare sector, not only because it would be able to raise money, through insurance contributions, but even more importantly, because it would introduce rationality in the distribution of healthcare resources. This, according to the report,

¹⁰⁰ *Projekt reformy systemu ochrony zdrowia i opieki społecznej. Tezy, komisja Partyjno-Rządowa Przegądu i Unowocześniania Struktur Organizacyjnych Gospodarki i Państwa, Ministerstwo Zdrowia i Opieki Społecznej, Warszawa, styczeń 1988.*

could be done through a system of incentives in which the insurance funds would be paying the healthcare providers on the basis of their productivity.¹⁰¹

In sum, the Polish healthcare system during the last communist decade, due to the lack of political will for change, remained almost unchanged.¹⁰² The period of the 1980s witnessed the emergence of very interesting and stimulating concepts and ideas, but was also the period of extreme scarcity of decisions (Indulski and Włodarczyk 1989: 19). However, the emergence of new policy ideas demonstrates that ideas played a crucial role in the preparation of the process of policy change. As it will become evident from the further analysis, the ideas and concepts that developed under communism, even though they were presented in a somewhat rudimentary form, were crucial for the post-communist reforms in two main respects. On the one hand, they helped policy makers to formulate a ‘diagnosis’ of the problems plaguing Polish healthcare. Pointing not only on the lack of medical resources, but also to the misplaced distribution system of these resources, they suggested that the real cause of the problems lay not in the lack of resources but in the management structure of the socialist healthcare system itself. On the other hand, these ideas also offered a ‘cure’ for the diagnosed problems, suggesting that an insurance system with more liberal incentives should work better and could be a possible way out of the system’s crisis.

2. The Post-communist Context

During the communist period, the disproportion between the growing policy ideas and the poverty of final decisions was striking. Once the political regime change finally took place in 1989, the major hopes for reform were transferred to the new political situation, based on the expectation that the political change would pave the way for the needed transformation of the healthcare sector. After the fall of communism, however, the plans for the comprehensive reform of the healthcare sector would quickly become entangled with the turbulent dynamic of the Polish post-communist transitions. As the reader will soon see, the transition to democracy in a country in which the breakup with the communist regime was based on a compromise

¹⁰¹ According to the authors of the report, this would imply that the healthcare providers would be supplied not with pre-determined resources, but with the resources according to the amount of services they have actually provided. While this remark might seem logical from today’s perspective, in the communist system where resources were distributed centrally and according to a five-years plan, this was a quite radical idea.

¹⁰² The only two changes introduced in Polish healthcare in the late 1980s were a small degree of flexibility in healthcare organization and the free choice of physicians, limited to the personnel attached to one urban health centre. These two changes were minor, but their symbolic importance should not be underestimated because they undermined the idea of the extremely rigid control-and-command logic of the socialist healthcare management.

(Bruszt and Stark 1998) faced many difficulties, especially during the early transitional phase. These political difficulties were exacerbated by the economic and social reform that added to the ‘ups and downs’ of the Polish transition. Unconsolidated division of powers, a highly polarized party system and riotous and over politicized trade unions, which turned out to be incapable of playing their traditional corporatist roles, became some of the main characteristics of the early period of the Polish democratic transition, and these would have a profound effect on the post-communist healthcare policy trajectories.

This section offers an overview of the three main transformations of Polish transition - political, economic and social – which created the context of the healthcare reforms. Its main objective is to ‘set the scene’ for the major episodes of Polish healthcare reforms by introducing the reader to the unsettled political dynamic, and changing process of economic and social transition that marked the first two decades of Poland’s post-communist history.

2.1. Extrication from Communism

Poland had a long history of opposition to the communist regime and its breakup with communism was an end of an almost a decade long struggle. By the spring of 1989, the country was in the midst of an immense crisis – economic, social, political and moral. The Martial Law introduced in December 1981 by General Jaruzelski intended to crush the Solidarity trade union, but instead generated an even greater opposition.¹⁰³ Strikes organized by Solidarity, which started in the shipyards of Gdańsk, had spread all over the country by the end of the 1980s. They forced the government to start negotiations with the opposition and the Round Table Talks were held in April 1989, with the communist government and the Solidarity leaders as the main participants. The talks were organized into three working groups, which examined issues of political reforms, the economy and social policy, and the status of trade unions (Elster 1996). After two month of negotiations, the participants signed an agreement which laid the basis for the establishment of the new democratic state which was constitutionally established as the Third Polish Republic.

It is important to note that the Polish extrication from communism, unlike the Czechoslovakian, was based on a compromise (Elster 1996, Stark and Bruszt 1998). This compromise did not match the expectations of the Solidarity leaders, since it was particularly favourable to the leaders of the communist party. The latter were guaranteed partial but

¹⁰³ Martial law was implemented in the period from December 13th 1981 to July 22nd 1983. This was a period in which the Polish communist party drastically restricted normal life in the attempt to crush its political opposition. During martial law, police arrested thousands of opposition activists without charge and as many as 100 people were killed. Although martial law was lifted in 1983, many of the political prisoners were not released until the general amnesty in 1986.

nevertheless continued control over the country's main political institutions, without being exposed to the uncertainties of electoral competition.¹⁰⁴ This specific character of Polish extrication from communism, as it would soon turn out, became an important source of difficulties during the country's first transitional years.

2.2. Political transition

Evolving from a negotiated transition between the leadership of the communist regime and the Solidarity opposition movement, Poland emerged from the Round Table Talks as a country with an undefined institutional system. Since during the negotiations over the regime change the position of the Polish communist party was still strong, Solidarity had to make a pragmatic compromise, agreeing to give the presidency to the communist party, while getting in exchange the leadership of the Government.¹⁰⁵ In order to provide a guarantee of continued communist power, it was also agreed that General Wojciech Jaruzelski, the leader of the Polish Communist Party, would be elected as President (Pelczynski and Kowalski 1990). Nevertheless, the governing of the Third Polish Republic turned out being a rather difficult task, mainly due to rather vague regulations and indistinct delimitation of competencies between the Government and the President, within the still active Polish constitution from 1952 (Fijalkowski 2010: 123; McMenamin 2008). This lack of clarity in governing rules, however, also allowed the first democratically elected Polish president, Lech Wałęsa,¹⁰⁶ to exercise an extremely strong and independent presidency during the early transitional period. In October 1992, Prime Minister Hanna Suchocka tried to temper Wałęsa's authoritarian tendencies by passing the provisional "Small Constitution" (*Mała Konstytucja*), which mainly addressed the conflict between the President and the *Sejm* over their respective scope of powers (ibid.). While it was successful in annulling some of the outdated parts of the old communist constitution from 1952, the "Small Constitution" neither extended nor limited the presidential powers, and therefore was rather inadequate in resolving the institutional tension.

The new constitution

It was only five years later, in 1997, that the coalitional government of the two parties, Democratic Left Alliance (*Sojusz Lewicy Demokratycznej* - SLD) and the Polish People Party (*Polskie*

¹⁰⁴ The centrepiece of the Round Table Talks was the agreement that there would be parliamentary election held on the basis of a unique system of 'compartmentalised competition'. This implied that 65% of the seats in the lower house of the Polish Parliament (the *Sejm*) would be reserved for the communist party and its satellites, while only 35% of the seats would be open for competition among the opposition (Olson 1993).

¹⁰⁵ This pragmatic compromise was laconically described by Adam Michnik, one of the communist dissidents, with the following words: "Your President, our Premier" (Stone 2002: 90).

¹⁰⁶ Wałęsa won the presidential election on 9th of December 1990, defeating Prime Minister Mazowiecki and other candidates to become the first democratically elected president of Poland.

Stronnictwo Ludowe - PSL), managed to formally proclaim the new Polish constitution, replacing the former communist one from 1952. The new constitution was inspired by the constitution of the Fifth French Republic (Pelczynski and Kowalski 1990), and even though it reduced the President's power to the benefit of the Prime Minister, it confirmed the semi-presidential system (McMenamin 2008: 5; Tatham 2013: 57). The new constitution was strongly criticised by the political opposition, by the Solidarity trade union and by the now already former President Wałęsa, who saw in it the continuation of the communist state (Cole 1998).

Table 6. Political institutions in Poland after the 1997 Constitution.

	Actors	Election, accountability and dissolution	Rights and jurisdictions
Legislative	House of Representatives (<i>Sejm</i>)	Elected for a 4-year term, 460 members; two-thirds of the votes of the majority of members dissolve both the <i>Sejm</i> and the Senate; the president calls the elections.	Three readings of the draft bills; the Council of Ministers may initiate an urgent legislative procedure, for which the <i>Sejm's</i> committees have to accomplish their work in one month.
	Senate (<i>Senat</i>)	Elected for 4-year term, 100 members; plurality block voting with two to four senator elected in each district.	Right to initiate legislation; may request changes to or move for rejection of a bill (the <i>Sejm</i> overrules by absolute majority of its members).
Executive	President	Elected for a 5-years term; if no candidate receives 50% of votes then second ballot; only one re-election; held accountable before the Tribunal of State for any violation of the Constitution.	Selects the Prime Minister; initiates legislation; issues regulations and executive orders; can veto legislation (the <i>Sejm</i> overrules with three-fifths of the vote of half of its members) and submit it to the Constitutional Tribunal; dissolves the Parliament when it fails to nominate the council of Ministers to pass the budget.
	Prime Minister	Nominated by the President, proposes the composition of the Council of the Ministers; this is confirmed by a vote of confidence in the <i>Sejm</i> ; the Prime Minister and individual Ministers are held accountable by votes of no confidence (constructive for the Premier) in the <i>Sejm</i> ; held accountable before the Tribunal of the State	Right to issue legislation, introduce and propose legislation, adopt a draft state budget and ensure the implementation of statutes.

Judiciary	Constitutional Tribunal	Elected for a 9-years term, 15 judges elected by the <i>Sejm</i> ; elects its president for a 3-years term; the President and the Vice-President are selected by the President of the Republic.	Judicial review and broad supervisory rights.
	Tribunal of the State	Elected for a 4-years term (coinciding with that of the <i>Sejm</i>), 1 chairperson (the First President of the Supreme Court, appointed by the President for 6 years, is the chairperson), 2 deputy chairperson and 16 members.	Rules on the constitutional liability of the highest offices of state: the President, the Prime Minister, members of the Council of the ministers etc.; broad prosecutorial rights.
Electoral	Referendum	Compulsory to delegate sovereignty to supranational institutions; ordered by majority of half of the <i>Sejm</i> members or by the President with the consent of the Senate.	Binding if more than a majority of voters participate.

Source: Polish 1997 Constitution (available at <http://www.sejm.gov.pl/prawo/konst/angielski/kon1.htm>).

The 1997 Constitution was crucial for the design of the Polish post-communist system of political institutions and for a clear definition of its veto points structure (table 6). In the legislative, the bi-cameral Parliament constituted the first veto points arena. Decisions of the *Sejm*, as the Parliament's lower house, could be vetoed by the upper house, the Senate, but the *Sejm* could nevertheless overrule this veto by the absolute majority of its votes. In the executive, the President as head of state was given a power to veto the legislation passed by the Parliament. This veto however could be overruled by the *Sejm*, with three fifths of its votes, and in the presence of at least half of the *Sejm*'s members. As the head of state, the President was also in charge of directing draft laws to the Constitutional Tribunal, which implied that he could use his decision-making powers to verify the compatibility of the laws with the Constitution. The Tribunal's veto position however was strengthened through a clause which stated that once the draft laws were approved by the Tribunal, they could no longer be vetoed by the President. As a judicial body established to resolve disputes on constitutionality, the Constitutional Tribunal hence acquired a very influential role in policymaking procedure. Finally, in the electoral arena the electorate, with the power to overthrow or accept government's decisions through a referendum, constituted the last element of the Polish post-communist system's veto points structure. This network of checks and balances of the Polish political institutions gave rise to a dense veto points' structure, which played a very significant role in the process of healthcare reform. As it will be shown later, in combination with the specific dynamic of Polish post-communist politics, this veto points structure gave rise to specific institutional-political configurations that would play a decisive role in the healthcare policymaking process.

Parties¹⁰⁷ and Elections

For the 1991 elections, there was a minimum national vote threshold of 5%, only for 69 seats awarded at the national level. The remaining 391 seats in the *Sejm* had no threshold requirement, which implied that any party could take one of these seats, no matter what its percentage of the national vote, as long as it had sufficient votes concentrated in one constituency to qualify for office (Keefer and Shirley 2001). This was the consequence of Poland's first post-communist electoral law, passed in 1991, which introduced proportional representation, tabulating votes according to the Hare-Niemayer formula from 37 districts. The most significant characteristic of this first electoral law was that it introduced proportional representation in its extreme form, since it stipulated a 5% threshold only for the national list and included no thresholds for districts. This enabled each party with sufficient votes in the constituency to qualify for one of the 391 seats in the *Sejm*, creating opportunities for very small parties to obtain parliamentary representation. This was changed by the second electoral law passed in 1993, which established barriers for parliament entry stipulating 5% and 8% thresholds for parties at the district level and a 7% threshold for parties for the national lists. The law also introduced tabulation after the d'Hondt formula from 52 districts.

The first, semi-free elections took place quickly after the Round Table Talks, in June 1989. The communists were stunned by Solidarity's victory, since it managed to get all but one of the available parliamentary seats.¹⁰⁸ The next elections were fully free and held in October 1991. Their results clearly displayed the strong effect delivered by the Polish extreme version of the proportional representation system. Only nine parties gained more than 5% of the seats in the *Sejm*, the largest of which won only 13.5% of votes, while the additional twenty smaller parties gained entry into the Parliament.¹⁰⁹ This led to a high level of fragmentation and the period after elections was characterized by battles, splits and forging of coalitions among the different Solidarity factions, mainly divided over issues such as post-communist lustration and economic reform. The Freedom Union (*Unia Wolności - UW*) emerged as one of the strongest parties, defining itself ideologically as a centre-right party and presenting liberal views on both economic and social reforms. The Central Agreement (*Porozumienie Centrum - PC*), formed by Jarosław Kaczyński, became another quite influential party on the political scene. This party put forward a

¹⁰⁷ A list of Polish political parties with their ideological orientation is provided in the appendix.

¹⁰⁸ In these first, semi-free elections, only 35% of the *Sejm*'s seats were open for competition.

¹⁰⁹ Commenting on the results of the Polish 1991 parliamentary elections, the Warsaw correspondent for *Newsweek* spoke of the Polish electoral system rules as "leading to bizarre" results, and described these results as "a laboratory demonstration of proportional representation gone wild" ("Politics of the Bizarre: Democracy Is Running Wild in the Polish Elections", *Newsweek*, 28th October 1991).

less liberal social programme, protesting against the tight budget constraints and supporting the role of the trade unions in the transition process.

The situation changed in 1993, when the successfully reformed former communists, now proclaimed left-wing parties, after the collapse of the Suchocka government, won the September elections, taking power from the Solidarity coalition. A group of parties, in which post-communists prevailed, formed the Democratic Left Alliance (*Sojusz Lewicy Demokratycznej - SLD*) which declared its commitment to a more gradual pace of transitional reforms. From 1993 to 1997, *SLD* formed the coalition with the Polish People's Party (*Polskie Stronnictwo Ludowe - PSL*), which was more conservative, but managed to gain dominance, especially after 1995 when Aleksander Kwaśniewski, one of the founders of the *SLD* was elected as President. Notwithstanding the success of the former communists, the scandals related to the political past of the *SLD*'s and the *PSL*'s leaders significantly eroded both parties' electoral support.

In the 1997 elections, the *SLD* lost power and the post-Solidarity alliance, Solidarity Electoral Action (*Akcja Wyborcza Solidarnosc - AWS*) formed the governing coalition with the *UW*.¹¹⁰ The *AWS - UW* government was characterized by weakened liberal tendencies and a conservative stance. It was nevertheless a proactive government as during its term, in 1999, Poland witnessed the introduction of four major policy reforms - administrative, education, pension and health reform. Although Jerzy Buzek was the first Prime Minister to serve a full term in office, this government was marked by internal disputes. Friction between the parties constituting the *AWS*, and Prime Minister Buzek's non-confrontational stance were both interpreted as incompetence. Deep disagreement over the finance minister Balcerowicz aggravated relationships in the coalition. The issues of NATO membership and EU accession created even more divisions and the coalition collapsed in 2000, leaving Buzek as the head of a minority government. Significant number of the *AWS*'s parliament members left for three other parties: the liberal Civic Platform (*Platforma Obywatelska - PO*), the conservative Law and Justice Party (*Prawo i Sprawiedliwość - PiS*) and the Euro-sceptic movement to rebuild Poland. In the meantime, the *SLD* was in disciplined opposition under Leszek Miller. The party embraced the pro-market reforms, managed to distance itself from the socialist past and showed willingness to compromise with the Catholic Church, all of which was important for the establishment of its new identity. It was therefore not surprising that in the next elections, in 2001, the *SLD* successfully returned to power in a coalition with the Labour Union (*Unia Pracy - UP*), and the

¹¹⁰ The *AWS* and the *UW* held 261 of 460 seats in the *Sejm* (Nohlen and Stöver 2010: 1513).

PSL.¹¹¹ The four years in government however turned out to be particularly difficult for the *SLD-UP-PSL* coalition, and this resulted in the *PSL* leaving the government in 2004.

In the next elections, which took place in 2005, there were new parties participating, formed out of the old ones, and the government for the first time was formed by parties with a strong populist tendency: the Self-Defence Party (*Samoobrona Rzeczypospolitej Polskiej - SRP*) and the League of Polish Families (*Liga Polskich Rodzin – LPR*). These two parties, even though they received only a small percentage of votes, formed a coalition with the conservative *PiS*.¹¹² Led by the two Kaczynski brothers, the *PiS* was regarded as a right-wing party, which nevertheless embraced a programme of social and economic policies that could even be regarded as rather leftist, since its political platform was based on the rejection of the liberal track sustained by the previous governments. The main opponent of the *PiS*, the *PO*, shifted from opposition to power in 2007, with a stunning win in the early elections, with more than 41% of the popular vote. As a centre-right party, the *PO* established a coalition with the *PSL*, forming a government with a liberal attitude toward the economy and social policy in particular.¹¹³

Table 3. Polish political composition and main healthcare reforms, 1989-2009.

Period	Party composition of the Government Prime Minister President	Health Minister	Healthcare reform
10/1989 – 12/1990	Solidarity, Tadeusz Mazowiecki Wojciech Jaruzelski	Andrzej Kosiniak-Kamysz	
1/1991 – 12/1991	Post-Solidarity parties Jan Krzysztof Bielecki Lech Wałęsa	Władysław Sidorowicz	Law on Health Care Institutions
12/1991 – 6/1992	PC + 3 other Jan Olszewski Lech Wałęsa	Marian Miśkiewicz	
6/1992 – 7/1992	<i>PSL</i> + 4 other Waldemar Pawlak Lech Wałęsa	/	
7/1992 – 5/1993	UD + 6 other Hanna Suchocka Lech Wałęsa	Andrzej Wojtyła	

¹¹¹ The *SLD-UP* and the *PSL* held 258 seats in the *Sejm* (ibid.).

¹¹² The *SLP*, the *LPR* and the *PiS* held together 245 seats in the *Sejm* (ibid.).

¹¹³ The *PO* and the *PSL* held together 240 seats in the *Sejm* (ibid.).

5/1993 – 10/1997	SLD + PSL Waldemar Pawlak, Janusz Olesky, Włodzimierz Cimoszewicz Lech Wałęsa, Aleksander Kwaśniewski	Ryszard Żochowski, Krzysztof Kuszewski	Law on Healthcare Insurance
10/1997 – 10/2001	AWS + UW Jerzy Buzek Aleksander Kwaśniewski	Wojciech Maksymowicz, Franciszka Cegielska, Grzegorz Opala	Amendments to the Law on Healthcare Insurance
10/2001 – 5/2004	SLD-UP + PSL Leszek Miller Aleksander Kwaśniewski	Mariusz Łapinski, Marek Balicki, Leszek Sikorski, Wojciech Rudnicki	Law on Healthcare Insurance with National Health Insurance Fund
5/2004 – 5/2005	SLD-UP Marek Belka Aleksander Kwaśniewski, Lech Kaczyński	Marian Czakański, Jerzy Hausner	Law on Health Care Services Financed from Public Sources
5/2005 – 11/2007	PiS + SRP + LPR Kazmierz Marckiewicz, Jaroslaw Kaczynski Lech Kaczyński	Zbigniew Religa	
11/2007 –	PO + PSL Donald Tusk Lech Kaczyński	Ewa Kopacz	Amendment on the Law on Health Care Services Financed from Public Sources

Frequent changes of governments, wholesale changes of parties in the government after elections and partially also between elections, as well as sometimes very innovative government formulae have been some of the main characteristics of the Polish post-communist party system (table 7). These characteristics have prompted some party scholars such as Millard to define the Polish party system as highly unstable and under-institutionalized (Millard 1999, 2009, 2010). In Millard's view, the development of the Polish party system failed to match expectations created by the 1993 electoral law reform - that the new rules of political competition would lead parties to stabilize and form more predictable patterns of interaction (Millard 2009).¹¹⁴ Even though the 1993 electoral law limited the degree of party system fragmentation, Polish political parties failed to cohere, with elite defections providing the main impetus for either party collapse or for the emergence of new parties on the political landscape (ibid.).¹¹⁵ Simultaneously, high levels of electoral volatility generated dramatic shifts in the relative strength of the parties and led to the

¹¹⁴ Another important institutional arrangement aiming on reduced fragmentation was specification in the 1997 Constitution, claiming that only political parties and citizens grouped in election committees could stand for election. This removed the numerous trade unions (including Solidarity), pressure groups, local and regional organisations, and *ad hoc* civic groups that had contested elections in 1991 and 1993 (Millard 2009: 785).

¹¹⁵ According to Millard (2009), Polish semi-presidentialism was particularly damaging for the party system stabilisation because compositions of the electoral alliances were determined by the patterns of interparty collaboration established at the time of presidential elections.

defeat of incumbent governments at every single election during the whole period from 1991 to 2007. Party replacement in the Parliament also implied the re-building of the relationships between parties, often causing party re-alignments and sometimes leading to very innovative coalition formulas.

Poland's poorly institutionalized and highly fragmented party system had significant effects on the political dynamic of the post-communist transition. The first two decades of Poland's democratic governance witnessed significant institutional reforms, but its political landscape was nevertheless characterized by continuous political instability, due to both unpolarised party competition and to the electoral system contributing to the fragmentation of Polish party politics. The country started with a strong, uncontrollable presidency, but gradually turned into a semi-parliamentary democracy with clearly defined constitutional powers in the 1997 Constitution. The electoral reform of 1993 introduced significant limitations to any party's entry to the Parliament but the existing proportional electoral system continued to render the coalition governments fragile and unstable.

In combination with Polish semi-presidentialism, the turbulent dynamic of Polish post-communist politics gave rise to country-specific policymaking trajectories. Especially during the early transitional years, political instability, factionalism and an undefined institutional system continuously hindered the country's governability and negatively contributed to the ability of the Polish policy makers to form consensus around a comprehensive reform plan. The changes introduced in the electoral system in 1993 and the new Polish constitution passed in 1997 did not significantly improve the situation. Poland's turbulent politics, and a political system characterized by a dense network of veto powers, including the veto powers of the Senate and the President, explain why often unilateral decision-making was an unavailable option. As it will soon be shown, most of the healthcare reforms Poland managed to pass during the two first post-communist decades required an extensive dialogue between the main participating sides. This was often additionally complicated by the over-politicized trade unions, all of which resulted in a very slow and protracted path for Polish healthcare policymaking.

Another important factor that contributed to Poland's slow path of healthcare policy making was the specific character of policy preferences. The unstable and highly fragmented Polish party system, especially during the early post-communist period, was perfectly reflected in the healthcare policy arena, characterized by frequent changes in reform proposals and changing policy preferences of political parties and their members. One of the reasons for these changing preferences was the fact that Polish political parties very rarely defined themselves clearly on

healthcare issues. Instead, the party preferences developed within the institutional context and were shaped mainly by the interactions of the individual party members and healthcare policy experts who participated in the development of reform proposals, but also in response to the counter-proposals. Another reason was that some of the parties, in particular the post-communist ones such as the Democratic Left Alliance (*Sojusz Lewicy Demokratycznej – SLD*),¹¹⁶ were very often torn between their different identities – ideological, electoral or office holding identities. All this explains why the preferences of the political parties and their members in the course of the reform process were not always fixed. It also explains why the proclaimed ideological orientations of the Polish political parties turned out to be rather poor predictors of the actual positioning of the parties and their members in the policy debate.

2.3. Economic and social transition

Polish economic and social transition was characterized by the neo-liberal “Shock Therapy” approach and by a lack of clearly formulated strategy for the development of the welfare state. During the first transitional years, the Ministry of Labour and Social Policy remained focused on the preservation of the old communist entitlement schemes, which also included a universal guarantee of healthcare benefits. However, the State’s capability to actually provide these benefits was seriously threatened by the fiscal vulnerabilities generated in the course of economic transition.¹¹⁷ The healthcare sector was not only extremely sensitive to the fiscal shocks, but also prone to frequent crowding outs, because the Polish government often focused its spending attention on social emergency measures in the pension¹¹⁸ and the unemployment sectors. The first time the healthcare sector seriously fell prey to the country’s fiscal crisis was during the first transitional recession, from 1990 to 1992, when health expenditure in real terms dropped by 16%, and wages in the health sector fell to the level of 9% below the average wage level. Without a stable source of funding, the Polish healthcare sector began to develop a two-tiered scheme in which one part of healthcare became available through cash payments to private physicians, while access to public healthcare services became increasingly restricted.¹¹⁹ This further aggravated the already critical situation in the sector, but

¹¹⁶ The SLD was the biggest communist successor party on the Polish post-communist political scene. It was formed in 1991 as a coalition of centre-left parties but became a single party in 1999.

¹¹⁷ Until the shift to insurance system in 1999, healthcare was financed from the general budget.

¹¹⁸ In 1991, the *Sejm* passed five pension laws, of which two dealt with laid-off workers who were allowed to retire, irrespective of age, if they a sufficient contribution record. The result of this measure was that in 1991, 497 thousands of new old-age pensioners and 319 thousands new disabled pensioners entered the Polish pension system (Guardiancich 2009: 138).

¹¹⁹ Marek Balicki, an employee in the Ministry of Health and Social Care at that time, described the situation in the following way: “In the situation of disequilibrium between the obligations of the state and the possibility of their realization, there have arisen different informal methods of regulating access, often unopened, together with the

nevertheless led to no radical policy change. It was only at the end of the 1990s, when the political-institutional configuration became more favourable, that this change could take place.

Economic transition

Poland was the first country of the whole Communist block that undertook comprehensive economic reforms designed to dismantle the remnants of the socialist command economy (Kochanowicz et al. 2005). In October 1989, the government presented a programme of rapid and deep economic transformation towards a market economy, based on the “Shock Therapy” approach. The Polish version of the “Shock Therapy” was named the “Balcerowicz plan”, after the leader of the transitional reform team, Leszek Balcerowicz,¹²⁰ the first Polish post-communist Finance Minister and Deputy Prime Minister. Similar to the Czech programme of economic transition, the Polish reform programme was designed by a small group of reform minded mainstream economists, which was gathered by the Prime Minister Mazowiecki and enjoyed technical support from foreign economic advisors of the International Monetary Fund (Stone 2002; Sachs 1993; Slay 2000). The “Balcerowicz plan” received parliamentary approval as a package of ten laws in December 1989 and its implementation started in January 1990. The plan contained a very radical reform package, aimed to drastically limit the state's influence over the economy. The fact that it gathered support and was introduced in such a short period of time was attributed by Balcerowicz (Balcerowicz and Gelb 1994) himself to the period of “extraordinary politics”, which gave way to “normal politics” and enabled the introduction of a radical economic programme without much public opposition (ibid. pp. 84-6).

Just as in the Czech Republic, the economic transition in Poland implied a series of measures focused on the macro-economic stabilisation and liberalisation of the country's economy, accompanied by re-structuring measures needed for the building of the institutions necessary for the functioning of the market economy. In contrast to the Czech transition, however, the focus of Polish economic reforms was not on privatization but rather on stabilization. Balcerowicz's team put its highest priority on privatization in their theoretical papers written as preparation for the reform. However, the team members changed their opinion, as they believed that the galloping inflation that emerged in the second half of 1989 threatened to make economic transition much more protracted and costly, and they quickly became convinced that their first task was to stabilize the economy by taming inflation (Stone

privileging of certain groups of patients [...] This situation is particularly disadvantageous for economically weaker groups, to whom access to number of services has lately become limited, despite the still existing provision in the constitution guaranteeing free care” (Balicki 1994: 157).

¹²⁰ Balcerowicz was the Finance Minister and the Deputy Prime Minister of Poland from September 1989 to December 1991.

2002: 90).¹²¹ The main instrument of the economic policy became a special tax imposed on wage increases, called *popiwek*, aimed at fighting hyperinflation. *Popiwek* quickly became the most unpopular element of the Balcerowicz programme and was controversial even among the team of economic advisers.¹²² As an additional measure aimed on controlling inflation, Balcerowicz's plan set the normative wage increase at 70% of monthly inflation (ibid. p. 94). In addition to these stabilization measures, in 1990s the economic reformers emphasized internal and external liberalization. Some 90% of Polish prices became completely liberalized in early 1990, so that the endless queues that had been an endemic feature of Polish socialism disappeared in a matter of weeks. The major devaluation in January 1990 furthered the expansion of the *złoty* convertibility, and was followed by the liberalization of foreign trade and the deregulation of private and state enterprise activities (Slay 2000: 54).

Mass privatization in Poland was not as important as it was in the Czech Republic. The privatization programme of state owned enterprises (SEOs) did not begin until the second half of 1995 (Slay 2000). The central element of the Polish mass privatization programme was the universal citizenship grant, in the form of state vouchers, which were issued to every Pole. No registration fee was required for participation and the vouchers were not exchanged for shares in a privatized enterprise, but rather for shares in one of the asset managers, which would in turn exchange vouchers for shares in the transformed enterprises that it chooses to manage.¹²³ With its unrestrictive access, Polish privatization was inclusive but resulted in a very passive citizens' participation (Bruszt and Stark 1998: 94-6). Consequently, the outcomes of the Polish privatization process were significantly less remarkable than the Czech, since by 1997, around 6 000 Polish firms could still be classified as SOEs and only about 2 500 firms were privatized (Slay 2000: 60).

¹²¹ According to Slay (2000), this explains why in addition to the heterodox nominal anchors of interest and exchange rate policies, the Polish stabilization programme relied heavily on incomes policies based on prohibitive taxation of excessive state enterprise wage growth (ibid. p. 59).

¹²² Balcerowicz argued for *popiwek* on the grounds that state owned enterprises lacked owners who had an interest in enforcing wage discipline, and that the immature credit and banking system was not yet ready to bear the full brunt of applying the brakes to aggregate demand. By forcing wages to grow more slowly, *popiwek* would turn inflation into a self-restraining process, because price rises would undermine the basis for demand (Stone 2002: 94).

¹²³ According to Bruszt and Stark (1998), this sent a clear message that vouchers are a free gift from the state (ibid. 95).

Table 4. Main economic indicators, Poland, 1991-2009.

Indicator/Year	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
GDP growth rate (annual %)	-7.0	2.5	3.7	5.3	7.0	6.2	7.1	5.0	4.5	4.3	1.2	1.4	3.9	5.3	3.6	6.2	6.8	5.1	1.6
Inflation rate (annual %)	76.8	46.1	37.0	33.0	28.0	19.8	14.9	11.6	7.2	9.9	5.4	1.9	0.7	3.4	2.2	1.3	2.4	4.2	3.8
Unemployment rate (annual %)	12.2	14.3	16.4	16.0	14.9	13.2	10.3	9.6	12.0	16.1	18.3	20.0	19.8	19.1	17.9	13.9	9.6	7.0	8.1
FDI inward stock as % of GDP	0.5	1.5	2.5	3.5	5.6	7.3	9.3	13.0	15.5	20.0	21.7	24.4	26.7	34.3	29.9	36.8	42.0	31.0	43.0

Source: OECD (available at <http://www.oecd.org/statistics>). Data for unemployment rate from 1991 to 2000 are from the Polish Central Statistical Office (*Główny Urząd Statystyczny* - GUS).

According to the architects of the Polish economic transition, during its first year the “Shock Therapy” approach was supposed to generate a short-term crisis, a painful recession with higher prices and single-digit unemployment. In its second year, however, it would lead to lower inflation and fast recovery (Balcerowicz et al. 1992). The actual course of Polish economic transition showed that the reform architects misjudged the scale, the nature and the impact of “Shock therapy” on the Polish economy. In 1991, Poland’s GDP declined by 7% in comparison to the previous year; the inflation rate rocketed to 77% and unemployment started to grow (table 8).¹²⁴ The first Polish post-communist recession¹²⁵ was, nevertheless, short and was followed by a quick recovery in the second half of the 1990s, with GDP growth of more than 7%, and this, together with reduced inflation and unemployment, granted Poland the label of “the soaring eagle” of East Central Europe (De Broeck and Koen 2001). Because of these positive

¹²⁴ It was only in 1997 that the government managed to meet the inflation targets (Slay 2000: 55).

¹²⁵ Poland, in fact, had the shortest transitional recession among all transitional countries. According to Kolodko, this was not really a consequence of the “Shock Therapy”, but rather a positive effect of the market reforms implemented at the end of socialism (Kolodko 2005: xvii).

developments, Polish economic transition in the 1990s was considered as one of the biggest transitional success stories, especially by some of the country's foreign economic advisors (see Sachs 1993). This fame however faded away quickly at the beginning of the new millennium, when the country plunged into its second recession, with a drop in GDP and a new wave of unemployment expansion. In the second half of the 2000s, an increased inflow of foreign direct investment (FDI) and restored GDP growth managed to bring Poland back on track.

Social transition

The shift from socialist central planning to the market economy, despite the cyclical growth-recession pattern, undoubtedly brought recovery to the Polish economy as a whole, but also produced substantial social costs. However, in contrast to the carefully planned and elaborated economic transition, programme for comprehensive social policy reform was lacking. During the first two transitional years, the issue of social policy was very confused and the government gave an impression that it was not sufficiently prepared to redefine welfare goals within the context of economic transition. The Solidarity backed government clearly kept social policy in the background, putting the focus on political and economic reforms. Although from the very beginning Prime Minister Mazowiecki introduced the term “social market economy” in order to emphasize the importance of social issues, the term was not clearly defined and was used mostly at the rhetorical level (Książopolski 1993: 179).

Lack of any particular long or even short-term strategy stood in stark contrast to the proactive social policy of the government in the Czech Republic and turned Polish post-communist social policy into a series of reactive, emergency and *ad hoc* responses to the fiscal crises of the state (Książopolski 1993; Orenstein 1995; Inglot 2008). Moreover, some of these emergency measures turned out to be very badly planned, and this additionally frustrated development of long-term solutions. The most notable cases of badly planned emergency measures were related to unemployment and pension benefits, both of which relied on a dangerous relaxation of eligibility criteria. The increase of cash benefits for pensioners expanded dramatically during the first transitional years and made the payment of benefits a significant burden for the state budget (Inglot 2008; Guardiancich 2009).¹²⁶ Writing about his time in office as the first post-communist

¹²⁶ Extremely liberal policy was introduced for farmers' pensions but also across the board in all categories, including most prominent disability benefits, early retirement regulations, and loose employment rules for current pensioners, benefiting largely high-earning groups with added bonuses, such as the miners, police, fireman, and railroad and steel workers. Newly introduced disability pensions jumped by almost half a million in 1990, and in 1991, young pensioners flooded the system at a time when unemployment also climbed to double digits. Subsequently, within just three years overall pension spending doubled in size in relation to the GDP, from barely 7 % to over 13 % of the GDP, as the Social Insurance Fund (*Zakład Ubezpieczeń Społecznych - ZUS*) had to pay benefits for almost two millions of new beneficiaries (Inglot 2008: 267; see also Guardiancich 2009: 138-9).

Minister of Labour and Social Policy, Jacek Kurón admitted that Polish early transitional social policy had many shortcomings and explained this by Solidarity's unpreparedness to take power after the victory in June 1989 elections (Kurón 1991).

The lack of a comprehensive social policy programme that would be able to match the programme of economic transition met with strong criticism, both from trade unions and from different political groups and parties. This criticism resulted in the preparation of several programme documents by the Ministry of Labour and Social Policy (Książopolski 1993: 180). The first two documents were drafted in 1990, and argued that Polish social policy should be organized according to the subsidiarity principle. This would imply withdrawal of the State as provider of social services and its replacement with individual and family responsibility, new social initiatives and charitable activities. Another document was prepared in 1991, with the title "Problems and Dilemmas of Social Policy". It stated that in the present situation social policy should be concentrated on minimizing the social policy costs of transition, counteracting unemployment, poverty and other problems generated by economic restructuring. While it stressed that the new social policy model should be based on coordination between economic and social policy, reshaping the income distribution system and the establishment of appropriate machinery for negotiations at all levels of social organization, the document offered no plan of how this could be achieved.

After the presidential elections of December 1990 and the parliamentary elections of October 1991, the newly emerged parties had a chance to present their strategy of welfare state reform. Unfortunately, the party elites turned out to be incapable of preparing any coherent vision (Książopolski 1993: 180). When the next government, led by the ex-communists and their coalition allies, took power after the September 1993 parliamentary elections, the new Polish Prime Minister Waldemar Pawlak blamed the former Solidarity-based government for the lack of progress in social policy reforms and announced that his government "will not treat social expenditure as burden on the budget" (*Ludzki rząd* 1993: 10-11). However, by that time it had already become clear that any proposal to change the existing social security system would not only carry serious political and economic risk, but would also face major structural constraints (Inglot 2008: 262). Yet in 1997, by the end of the next electoral cycle and under the Buzek government, Poland's policymakers finally managed to pass three major welfare reforms – of healthcare, education and pensions – all at once.

2.4. Interest groups

Poland's history of trade unionism dates back to the period well before 1989. During the last decades of socialism, Poland developed a bi-polar model of unionism in which Solidarity as the anti-communist workers union, established in 1980, stood in opposition to the communist Polish Confederation of Trade Unions (*Ogólnopolskie Porozumienie Związków Zawodowych - OPZZ*). At the beginning of transition, the scene was still dominated by the cleavage between Solidarity and the *OPZZ*. The new Solidarity was much smaller than that of the past (Ost 2001)¹²⁷ and its members found themselves in a particularly difficult situation. Confronted with radical market reforms, which generated high social costs for the workers and their families, they faced a dilemma as to whether to continue their protest against a government that was now composed of people from their own ranks. This explains why in the 1990s Polish trade unions became increasingly politicized, developing strong links with the political parties,¹²⁸ and this significantly contributed to the strengthening of political paternalism over the labour movement (Avdagic 2005). Another dominant trend was gradually increasing fragmentation, over the years, within the labour movement. As a result, in 2009 the trade union sector was comprised of three big trade union confederations,¹²⁹ almost 600 nationwide unions and federations, and 24 000 regional labour organizations. Despite these large numbers, the gradual weakening of Polish labour strength was also evident from the progressive decline in union density.¹³⁰

Why was labour so weak in transitional Poland? The labour weakness is puzzling because of the contrast between the enormously powerful labour movement of the 1980s, which played the crucial role in initiating both economic and political change, and the almost complete impotence of Polish trade unions in shaping the country's transition to democracy and a market economy in the 1990s. Ost (2001) suggested that the explanation for the labour weakness could be found in the specific character of Polish unionism. During the early transitional period, Polish union leaders and their activists, just like the government, believed that institutionalization of industrial relations in a country where capitalism was still in its infancy, and where trade unions were still too weak to stand up to private employers, would weaken the tempo of the reforms and reduce the chances of Poland's modernization (ibid. p. 81-2). This belief was clearly expressed by Lech Walesa, the former Solidarity leader and the first President of the Third

¹²⁷ According to Ost (2001: 82), Solidarity membership shrank for three reasons: a changing political environment, a changing intellectual consensus, and an unwillingness of unionists to recruit.

¹²⁸ Solidarity was part of the Solidarity Electoral Action (*UW*), and *OPZZ* was an instrument for the creation of the Democratic Left Alliance (*SLD*). In 1993, one fourth of the *SLD*'s deputies were members of the *OPZZ* (Ost 2001: 87).

¹²⁹ The three main trade union confederations in Poland are: Solidarity, *OPZZ* and Trade Union Forum (*Forum Związków Zawodowych - FZZ*).

¹³⁰ In 2008, union density in Poland was just 11-13% (European Commission 2009: 107-8).

Republic, who already in October 1989 explicitly appealed against the rebuilding of a strong labour movement in Poland, arguing that strong unions would oppose reform and that, for this reason, Poland could not have strong trade unions until it had a strong economy.¹³¹ This prompted the leadership of the new Solidarity union to offer political acquiescence of the labour movement to government reforms. They not only saw no need for union activity in monitoring Poland's path to market economy, but became government's committed partner, helping it bring about social and economic change. This double role of the Polish trade unions, as formally opposing but practically quiescent on government's transitional choices, led to the development of a "divided personality" identity among union members (ibid. p. 87).¹³²

This explains why, in contrast to the immediate post-1989 period in other Eastern European countries, the development of social dialogue in Poland was not immediate. The coming to power of Solidarity meant that its activists were placed in the position of state power, and they saw no need to formally negotiate with unions, whose interests they considered themselves to be representing. Walesa committed Solidarity to support government policy, while the *OPZZ*, anxious to demonstrate its new credentials, followed suit. This situation in which unions had no say in the decision-making process changed in 1994. After a wave of strikes in 1992, and on the initiative of the Ministry of Labour and Social Policy, a tripartite instrument of social dialogue was established in 1994, called the Tripartite Commission for Social and Political Issues, whose main task was to resolve basic social issues, especially wage conflict. The first meetings of the Commission were characterised by inconclusiveness and lack of union coordination, but the initial years of social dialogue nevertheless managed to limit labour unrest (ibid. p 91).¹³³ However, the initial success of Polish tripartitism soon became ephemeral. Due to the Commission's very limited decision-making powers, it became obvious that the government was using it as a tool to secure labour consent, instead of increasing labour power. The situation became even worse in 1999 when, due to the *OPZZ*'s boycott, the Commission underwent a thorough reform. The following period featured simultaneous abandonment of political activism by both labour unions and expansion of the catalogue of issues examined by the Commission. During the second transitional decade, additional difficulties emerged so that the social dialogue could not reach its aim mainly because of the progressive weakening of the trade unions, increased inter-union competition and their confrontation with the emerging employers' unions.

¹³¹ Interview in *Gazeta Wyborcza*, cited in *Tygodnik Solidarnosc*, October 20th 1989.

¹³² In Ost's (2001: 87) words: "Solidarity was guided not just by ideological enmity but by simple electoral logic."

¹³³ There was a dramatic drop in the number of strikes, from 7 443 in 1993, and 429 in 1994, to 42 in 1995 (Ost 2001: 91).

In the healthcare sector, two major interest group organisations became the providers' professional associations and the unions of healthcare workers. The first professional associations, the Chamber of Physicians and Dentists (*Naczelna Izba Lekarska*) and the Chamber of Nurses and Midwives (*Naczelna Izba Pielęgniarek i Położnych*) were established in 1989, gaining a legal right to issue licences for professional practice and express their opinions on behalf of medical professionals.¹³⁴ These organisations joined the developing trade union movement, which had already been fragmented so that there were five main unions established within the health care sector (table 9). One of them represented only the interests of Polish doctors, mainly those working in the public sector, while the other four represented the interests of different groups of healthcare workers and were affiliated with one of the nationally representative trade union confederations.¹³⁵

Table 5. Main healthcare unions in Poland.

Name	Affiliation	Membership (approximately)
All-Poland Union of Nurses and Midwives (<i>Ogólnopolski Związek Zawodowy Pielęgniarek i Położnych -OZZPiP</i>)	Trade Unions Forum (<i>Forum Związków Zawodowych – FZZ</i>)	79 000
Health Care Secretariat of the Independent and Self-Governing Trade Union 'Solidarity' (<i>Sekretariat Ochrony Zdrowia Niezależny Samorządny Związek Zawodowy 'Solidarność' - SOZ NSZZ Solidarność</i>)	Independent and Self-Governing Trade Union 'Solidarity' (NSZZ Solidarność)	45 000
Federation of Health Care and Social Care Employee Unions (<i>Federacja Związków Zawodowych Pracowników Ochrony Zdrowia i Pomocy Społecznej – FZZPOZiPS</i>)	All-Poland Alliance of Trade Unions (<i>Ogólnopolskie Porozumienie Związków Zawodowych - OPZZ</i>)	20 500
National Trade Union of Doctors (<i>Ogólnopolski Związek Zawodowy Lekarzy – OZZL</i>)	No affiliation.	14 000
All-Poland Union of Operating Block, Anaesthesiology, and Intensive Therapy Employees (<i>Ogólnopolski Związek Zawodowy Pracowników Bloku Operacyjnego Anestezjologii i Intensywnej Terapii - OZZPBOAiIT</i>)	Trade Unions Forum (<i>Forum Związków Zawodowych – FZZ</i>)	1 680

Sources: own and Eironline 2010 (<http://www.eurofound.europa.eu/eiro/eirobserver.htm>).

¹³⁴ Beside these two main chambers, today there is a number of smaller professional associations representing physicians of different specialities that emerged over time.

¹³⁵ There are also numerous small autonomous trade unions of health care workers whose number and coverage is difficult to estimate. All trade unions represent doctors and health care workers employed in the public sector.

As the following sections will show, Polish trade unions and professional associations of doctors and health care workers did try to play a role in the process of healthcare reforms. However, due to the general weakness of Polish unionism, fragmentation, divided identities and lack of social dialogue, their role in the reform was not organized but rather mediated, either through individual influence of their members in the politics of the reform process or through non-institutional means such as protests and strikes. As will be soon shown in the next section, government coalitions used both unions' and professional associations' support in the preparation of their healthcare reform proposals. The political parties, however, due to either their divided identities or to the turbulent dynamic of political competition, were often characterized by changing preferences, which in turn modified professionals' and unions' influence on the reform process.

3. Post-communist Healthcare Reforms

As one of the previous sections has shown, the first ideas about the possible directions of Polish healthcare reform had begun to develop already in the 1980s, through the experts' reports that criticized the communist system of healthcare for its inefficiencies, and suggested the introduction of insurance system with market-like elements. It was however only in the post-communist period, after the political regime change in 1989 that these ideas managed to reach the main actors in the policy making arena and generate plans for the comprehensive reform of Polish healthcare. This section offers a chronological overview of the policymaking dynamic through which these experts' ideas reached out to the political circles and served as a basis for a set of reform proposals, only one of which would be successfully passed into policy, together with the other three major welfare reforms, under the Buzek's government in 1997. The course of the pro-market policy would nevertheless be blocked just a few years after this major reform, in 2003, when under the new government of Leszek Miller Poland decided to re-centralize its insurance system, clearly signalling a step back from the earlier liberal and market-oriented policy course.

The section aims to shed more light on the main episodes of the Polish healthcare policymaking process during the two post-communist decades, in order to show how ideas, interests and institutions interacted in a process that brought about healthcare policy change. As the reader will see, in a stark contrast to that of the Czechs, the Polish process of policy change took place through a learning process that was rather slow, protracted and discontinuous.

3.1. The Round Table Talks and the first post-Solidarity proposals

During the Round Table Talks in 1989, healthcare reforms were not a major issue, since the core of the Solidarity and government debates focused mainly on issues of the institutional design of Poland's Third Republic. However, the ideas generated in the experts' reports from the late 1980s were present in the Talks, since one of the sessions discussed the replacement of the centralized system of healthcare financing with its insurance based counterpart. These ideas were then included into the part of the Round Table Agreement dedicated to healthcare, which articulated a vision of reform towards an insurance system, in which all citizens would be entitled to services and contributions would be paid by a tax on the wealthy and by employers.

The first attempt to develop more concrete reform proposals took place during the first post-communist government. Under the formal coalition agreement of the Mazowiecki's government, a member of the *PSL*, Andrzej Kosiniak-Kamysz, became Minister of Health and Social Welfare. However, since the *PSL* had no articulated position on healthcare reform, a Solidarity-based group of healthcare experts positioned within the Ministry was able to take over control of the situation. There were two draft proposals that emerged during this period. One was the Ministry's official proposal,¹³⁶ co-authored by a team of experts within the Ministry, who were working on the implementation of the Round Table Agreement, and another, which was prepared by a team of experts outside the Ministry, and therefore called the "Independent proposal"¹³⁷. These two proposals were remarkably similar, suggesting that the present system of healthcare should be replaced with a universal and centralized national system of health insurance. The Ministry's proposal envisaged the creation of an independent and central health insurance fund with separate branches, funded by employers' premiums and public funds. It stressed public provision of healthcare but also considered alternative forms of ownership. The proposal also envisaged that the reimbursement of healthcare services would be based not on the fee-for-service system but on types and quantities of services. The "Independent Proposal" also envisioned a central insurance fund but suggested that this fund would be dependent on the Ministry, and also stressed public provision. It planned that contributions would be paid by both employers and employees, while the insurance fund would be partially financed from the state budget. Payments to the providers would be by an ex-ante global budget covering all expenses in the coming year, rather than payment by type and quantity of service. Neither of the proposals envisioned a significant role of competition among providers, or private participation.

¹³⁶ *Projekt Reformy, Zespół do spraw reformy opieki zdrowotnej i pomocy społecznej, Ministerstwo Zdrowia i Opieki Społecznej, W. Majewska, J. Starega-Piasek, K. Opolski, E. Wnuk-Lipinski, Warszawa, listopad 1989.*

¹³⁷ *W Interésie Zdrowia Społeczeństwa, S. Golinowska, K. Tymowska, C. Włodarczyk, Warszawa, listopad 1989.*

Despite the similarities between the two proposals, there was considerable emotional conflict among the authors of the proposals, together with conflict over the exact roles of the expert groups. The Ministry appeared to favour the “Independent Proposal” but felt bound to respect the formal process of the Round Table Agreement, which obliged it to support the official proposal drafted by the Ministry-based team (Bossert and Włodarczyk 1999: 9). This confusion resulted in no clear decision to follow either proposal and prompted the Ministry to try to resolve the conflict between the two groups by organizing a conference with the assistance of international organisations and foreign experts.

3.2. The Law on Healthcare Institutions

The reform drafts produced under Mazowiecki’s government opted for an insurance system, but they were not radical, as they favoured centralization and clearly lacked market elements. The change in government after the first Polish post-communist fully free elections created a new government configuration, characterized by a much stronger pro-reform impetus. This happened as the second and the third post-Solidarity governments replaced the members of the Ministry of Health and Social Welfare with significantly more pro-reform oriented experts and political figures. The proposal for this law was drafted by a small team of experts and a lawyer from the Ministry of Health and Social Welfare, who used the British Hospital Trust as a model. Surprisingly, there was almost no public debate about this major reform, since the status of healthcare providers was presented as a management issue, rather than a major restructuring (Interview Włodarczyk). Evidently following the protected pattern of policymaking in the time of “extraordinary politics” (Balcerowicz 1994), the government managed to successfully pass its proposal in the *Sejm* on July 30th1991, in the form of the Law on Healthcare Institutions (Law No. 91/408).

The most important elements of the Law on Healthcare Institutions was that it abandoned the strictly unified system of healthcare facilities organization, introduced the basis for the purchaser-provider split and authorized new and independent forms of healthcare providers (Włodarczyk and Karkowska 2005). The law also allowed contracting between local governments, as payers for healthcare services and healthcare facilities, different forms of ownership for providers’ institutions, and different levels of autonomy for public healthcare facilities. In terms of ownership, the law allowed for different forms, including central, provincial and local authorities, the voluntary (non-profit) and private ‘for-profit’ ownership (Poland 1999: 11). The law’s provisions were important as they significantly increased the scope of financial independence for healthcare providers, allowing them, as self-managed independent structure, to

raise their own revenues, sign contracts and sell services. One of the law's provisions, for example, was that even the providers that were still operating under budgetary rules were allowed to retain up to 80% of their annual savings and spend it at their own discretion. This greater financial independence was also coupled with greater responsibility, as the providers became accountable for their actual balance of payments, which implied that they could be required to pay their debts from their own assets.

Taken together, these provisions of the Law on Healthcare Institutions represented the first market-oriented move in Polish post-communist healthcare policy, enabling the break away from the state monopoly over healthcare delivery. Implementation of the law was quickly followed by the gradual privatization of healthcare delivery, mainly in primary and ambulatory care, and this gradually developed over the 1990s and led to almost complete privatization of this sector of Polish healthcare.¹³⁸

3.3. The World Bank proposal

While the Law on Healthcare Facilities introduced significant market-oriented changes in healthcare delivery, Polish healthcare financing remained untouched. The financial situation of the healthcare sector was however becoming worse, also because Poland soon entered into its first transitional recession. International experts from the World Bank added to the reform dynamic by preparing a series of preparatory proposals for Polish health reform, which resulted in a report published by the Bank in 1992.¹³⁹ The preparation of this report was linked to the loan agreement between the Polish government and the World Bank,¹⁴⁰ and the proposal itself was developed in collaboration with the National Centre for Health System Management and a few Ministry officials.

The recommendations given in this official World Bank report were remarkable in that they did not follow the usual Bank's promotion of radical market solutions. The report instead suggested that the present system of healthcare should be more focused on coordination and planning rather than insurance and competition. It envisaged preservation of the integrated system of healthcare delivery in the form of ZOZs and argued that Polish policy should focus on centralized approaches in order to reduce duplicated services among different healthcare providers. In sharp contrast to the proposals developed by the Polish experts, the Bank proposal also expressed a significant dose of scepticism toward the idea of an insurance system. It

¹³⁸ In 2000, 90% of primary care in Poland was private (Kuszeński et al. 2005: 90).

¹³⁹ Poland: Health System Reform, The World Bank, Washington D.C. 1992.

¹⁴⁰ The loan, signed on July 17th 1992 between the Ministry of Health and Social Welfare, was worth 130 million dollars.

proposed that Polish healthcare should retain central budgetary funding, adding new taxes, local government contributions and co-payments, and suggested that healthcare providers should be paid through budgetary transfers rather than capitation or a fee-for-service remuneration system.

Both the preparatory proposals and the World Bank report were rejected in the next phases of the healthcare reform process. The government rejected the Bank's ideas by saying that they would not manage to attract political support. The Polish experts, who preferred their own proposals to those of the Bank, judged the Bank's ideas as too similar to the old socialist system (Interview Włodarczyk). When the government signed the loan agreement with the Bank, its recommendations for health reform were thoroughly ignored and were quickly replaced by a set of competing proposals from the last post-Solidarity government, which emerged just before the post-communists' return to power.

3.4. Competing Proposals of the Suchocka's government

It was under the government of Hanna Suchocka, which was formed in July 1992, that Poland witnessed the emergence of more radical reform plans focused on healthcare financing. Suchocka's government was formed by the coalitional agreement between the *UD* and six smaller parties. The diversified structure of the coalition government however turned out to be the major source of government discord that would evolve into competing healthcare policy preferences of the Ministry's officials.

There were four reform proposals presented under Suchocka's government (Włodarczyk and Karkowska 2000: 385), which reflected divisions within political parties and between the competing visions of different groups within the governing coalition. The first proposal¹⁴¹ was prepared in 1992 on behalf of the government body responsible for the coordination of social policy, the Committee for Social Policy (*Komitet Społecznego Rady Ministrów - KSRM*), whose main task was to assure compatibility of social with economic policy. The second proposal¹⁴² was prepared in 1993 by the influential Solidarity group within the coalition, which initially supported the government but, as it would turn out later, became the main cause of its collapse. The Solidarity proposal was developed by a group of experts drawn from the trade union movement, including Teresa Kaminska, a chairperson of Solidarity's Health Committee, who would later play a crucial role in the policy process during the second post-Solidarity period.

¹⁴¹ *Ubezpieczenia zdrowotne. Założenia z dnia 30 grudnia 1992, Zespół d/s Przygotowania Projektu Założeń Ubezpieczeń Zdrowotnych Komitetu Społecznego Rady Ministrów, Warszawa.*

¹⁴² *Założenia Ubezpieczeń Zdrowotnych w Polsce, Parlamentarno-Związkowy Zespół Ubezpieczeń Zdrowotnych NSZZ Solidarność, styczeń 1993.*

These two proposals, the *KSRM* and the Solidarity proposal, were similar and enjoyed the support of both the major part of the government and the trade union base of the coalition. They envisaged the creation of a large number of small independent insurance funds and healthcare delivery through private service provision. They also focused on strengthening physicians decision-making powers, especially of those working in outpatient care, and divided hospital from ambulatory care.¹⁴³ In terms of reimbursement methods, they envisaged the introduction of fee-for-service system for outpatient services. Overall, the two proposals were clearly market-oriented and consistent with Solidarity's orientation toward privatization and competition, and with the anti-bureaucratic orientation of the post-Solidarity governing coalition. Surprisingly, the medical interest groups did not immediately support the joint proposal of the *KSRM* and Solidarity even though these were clearly favouring their interests. This was explained partly by confusion among professionals and partly by the conflict of interests between the different professional groups (Interview Romaniuk). The Chamber of Physicians and major professional associations however soon realized that the *KSRM* and Solidarity proposal were in their interest and decided to support them.

A team composed of representatives of the Ministry of Health and Social Welfare, the Ministry of Labour, and the Ministry of Finance, who were directly responsible for both the development of the vision of social policy and its implementation, prepared the third proposal.¹⁴⁴ All the members of the inter-ministerial team were from the *UD*. The Ministry of Health and Social Welfare took the leadership and drew support from experts from the National Centre for Health System Management, in particular from Andrzej Koronkiewicz, who would later re-emerge and play an important role in the process. The proposal of the inter-ministerial team stood in stark contrast to the first two proposals. It proposed regional health care planning and financing systems, maintaining public institutions, especially in the hospital sector. It introduced the concept of regional insurance mechanisms and payment through contracting. Although it emphasized integrated care and public provision, it also opened the way for private provision of outpatient care. Overall, the inter-Ministerial proposal, even though it contained market elements, was dominated by a more social-democratic approach. As it will soon become clear, this proposal would eventually emerge, with significant modifications, as the successful proposal under the Buzek's government.

¹⁴³ This stood in clear contrast to the idea of integrated care supported by the World Bank proposal.

¹⁴⁴ *Założenia Ogólne Ubezpieczeń zdrowotnych, Międzyresortowy Zespół do Spraw Reform zabezpieczenia Społecznego i Systemu Świadczeń Zdrowotnych, grudzień 1992.*

Finally, the fourth proposal¹⁴⁵ was presented on behalf of a team from the Government Representative Office, which at that time was one of the most active parts of the government working on strategic public administration reform. This team was also dominated by members of the *UD*, but by the wing that was not associated with social democracy but rather favoured decentralization. The proposal itself was very closely linked to the proposals for public administration reform. It involved the creation of the counties (*powiaty*) and was primarily interested in defining their role in healthcare organization and financing. It did not really address the insurance issues and argued for the preservation of public responsibility for both financing and delivery of healthcare through the county governments.

Two of these proposals, the *KSRM/Solidarity* proposal and the proposal of the inter-Ministerial team, were submitted to the *Sejm's* Health Committee. During the discussion in the Committee, the inter-ministerial proposal did not receive a single vote and was rejected on the basis of the argument that it did not reflect public expectations for a far-reaching health reform that had been promised in the Round Table Agreement. The proposal was criticized as simply supporting the existing *status quo* in the healthcare sector and not being in favour of major healthcare reform, which was considered necessary. In the *Sejm*, the majority of the parties' parliament members, even those from the left-wing oriented opposition, the *PSL* and the *SLD*, supported the *KSRM/Solidarity* proposal, but the *UD*, the biggest party of the governing coalition, stayed reserved. In the meantime, the divisions in the governing coalitions became exaggerated, mainly because of the inter-coalitional conflict between the *UD* on the one side and the rest of the coalition parties on the other. The *UD* was accused by the coalition parties as attempting to take control of the government, and this also caused delays in the formal government ratification of the *KSRM/Solidarity* proposal, shortly before the unsurprising government collapse in May 1993.

3.5. The Law on Health Insurance

Healthcare reform entered a new phase when, after the new elections, Poland's first left-oriented post-communist government took power under Waldemar Pawlak as Prime Minister, in December 1993. The electoral success of the post-communist *SLD*, which formed the government in coalition with the *PSL*, resulted from their success in convincing the Polish electorate that they were not the old communists. This explains why the party, once in government, focused on continuing many of the reforms of the post-Solidarity period and

¹⁴⁵ *Raport dla Pełnomocnika Rządu d/s reformy Administracji Publicznej, przygotował zespół pod kierunkiem J. Ruszkowskiego, Warszawa, 21 marca 1993.*

assuring the public that the changes that were to be made would be more in line with their recently acquired social democratic views. In healthcare, the post-communists therefore rejected the *KSRM/Solidarity* proposals and decided to embrace the one prepared by the inter-ministerial team, as they saw in it a better expression of their new political orientation. In the meantime, the Ministry of Health and Social Welfare took charge of the reform process, building on previous proposals and organizing a set of conferences in order to create political consensus and to develop a technical review of the proposal that was lacking in the post-Solidarity period. This initiative resulted in the quick transformation of the inter-ministerial proposal into a draft bill that was to be presented to the *Sejm*. The Centre for Health System Management re-emerged in this period as one of the government's important collaborators in the draft preparation. The leader of the team was now Andrzej Koronkiewicz, who was part of the original team that authored the inter-ministerial proposal in the previous post-Solidarity government (Interview Romaniuk).

In early 1994, the government organized several conferences in order to establish general agreement on the basic principles of healthcare reform. These conferences resulted in a consensus that there was a need to establish an insurance system that would be based on sixteen large, regionally-based insurance funds. These funds would be in charge of directly negotiating contracts with both public and private healthcare providers, through professional associations. This implied that the providers would contract with regional insurance funds as independent units, which was important as it meant that the role of municipal governments in the provider-purchaser relationship would be eliminated. The insurance system itself would be funded by contributions paid by both employers and employees at a rate set annually by the *Sejm*. The government would be in charge of providing coverage for the retired and the unemployed.

By December the same year, a bill drawing upon the main elements of this agreement was presented to the *Sejm*, but with two important changes. The first was more of a technical issue, as the bill claimed that instead of the shared employer-employee responsibility, the employee would be fully responsible for the contribution payment. The second change allowed additional insurance funds to be established, as branch funds of separate industries, in order to allow greater choice and break the regional insurance monopoly. In early 1995, the Council of Ministers approved the bill and returned it to the ministries for consultation, so that its final draft was prepared and submitted to the *Sejm* in July the same year.

In the meantime, the opposition prepared a competing proposal. This proposal was based on the earlier *KSRM/Solidarity* proposals and was submitted to the *Sejm* by the President

Lech Wałęsa in August 1995. This proposal re-introduced the idea of a competitive insurance market based on independent funds, which significantly differed from the government's proposal of regional insurance funds. Looking for a compromise, an Extraordinary Committee of the *Sejm* was appointed to find an agreement by November 1995. However, it was only after a year that a new draft bill emerged, retaining the original ideas from the inter-ministerial proposal, but also opening more room for competition, which was in line with the *KSRM/Solidarity* proposals. The bill was passed to the Senate, which supported it, and then returned to the *Sejm* where it was finally approved on the 6th of February 1997 as the Law on Healthcare Insurance (Law. No. 28/153). Wałęsa as the President ratified the law since it satisfied some of the important provisions of the Solidarity proposal. The implementation of the law was scheduled in two years, for January 1999, since this should leave enough time for the preparation of the detailed regulation and for the development of the institutional infrastructure needed for the establishment of the regional insurance funds.^{146 147}

The passing of the Law on Health Insurance was a major step in the comprehensive reform of the Polish healthcare system and its departure from the socialist state-dominated model. In terms of policy change dynamic, this episode demonstrates that the path from the first market-oriented reform ideas, which in their rudimentary form emerged already under communism, until actual reform that would turn these ideas into reality was fundamentally shaped by the political and institutional configurations of post-communist Poland. While frequent changes of government generated very unstable political circumstances, which often made the linking of expert ideas with political interests rather difficult and discontinuous, the passing of the 1997 reform itself was evidently a result of the political compromise developed in the shadow of Polish semi-presidentialism.

3.6. Amendments to the Law on Healthcare Insurance

In October 1997, the right-wing liberal coalition between the *AWS* and the *UW* returned to power under Jerzy Buzek as Prime Minister. The first document issued by the new government repeated the general principles of the Solidarity proposal, suggesting the

¹⁴⁶ Given that the insurance system would be based on regionally established insurance funds, its implementation also depended on the implementation of the public administration reform, also passed in February 1997. The administration reform envisaged administrative division of Poland on three levels. The country would be divided into *voivodeships* (states), which would be further divided into *powiats* (counties), which would then be divided into *gminas* (communes or municipalities). Since 1999, when this reform was implemented, Poland is divided into 16 *voivodeships*, 379 *powiats* (including 65 cities with the status of *powiats*) and 2 479 *gminas*.

¹⁴⁷ The Law on Healthcare Insurance was one element of the big reform package passed under the Buzek's government. This package apart from healthcare contained reforms for other three crucial sectors: public administration, education and pensions.

replacement of the Law on Health Insurance. Within the Ministry of Health, the *AWS* appeared to dominate over the *UW* and its power was additionally strengthened by appointing its affiliate Teresa Kaminska,¹⁴⁸ the co-author of the original Solidarity proposal from 1993, as the minister in charge of social policy coordination. The *UW* however retained significant power in the government by appointing Leszek Balcerowicz as Deputy Prime Minister. While the *AWS* came up with a revised version of the 1993 Solidarity proposal, despite its weakness within the Ministry, the *UW*, through Balcerowicz, was able to modify it.

The bill that emerged in April 1998 introduced only limited modifications to the Health Insurance Act and significant modifications to the Solidarity proposal. One modification was that the board of regional insurance funds was to be elected by newly established *voivodeship* parliaments, instead of the general ballot, and another that contributions were to be collected not by local governments, but by the state agency responsible for social insurance, the Social Insurance Fund (*Zakład Ubezpieczeń Społecznych - ZUS*) and then from there transferred to the insurance funds. The contribution level was to be reduced from 10 to 7.5% of worker's income. The reduction of the insurance contributions, as the most significant change, was considered a major defeat of the *AWS* who had promised to increase the contribution level during their election campaign. The change in the contribution level resulted from pressures coming from the Deputy Prime Minister. In the meantime Balcerowicz became primarily concerned with the balancing the healthcare budget and combating the healthcare sector's financial deficit. He thought that strong pro-market measures, such as the introduction of the fee-for-service system, which was suggested in the early post-Solidarity proposals, could potentially cause additional financial problems.

Being in favour of all solutions that would increase control over spending, Balcerowicz demonstrated that he was ready to give up his deep pro-market convictions by not advocating strongly for private insurance and unregulated physicians' fees (Bossert and Włodarczyk 1999: 16). Greater control and reduction of physicians' decision making power was also evident from the decision to eliminate direct negotiations between professional associations and insurance funds, and replace them with negotiations between the funds and the local governments. Finally, it was also decided that the management members of the funds would be appointed by the regional assemblies. In the form of amendments to the law from 1997, the President approved these modifications and ratified them in August 1998.

¹⁴⁸ Kaminska was also a member of the Health Council (*Rad Ochrony Zdrowia*) during Walesa's presidency.

Polish medical professionals, unsurprisingly, did not support the outcomes of this very long process of healthcare reforms. The physicians expressed their opposition to the reforms publicly, arguing that the idea of the management of the insurance funds being appointed by the regional assemblies was a sign of political influence and control over financial decisions in the healthcare sector. They also criticized the low contribution levels, the lack of guaranteed contracting for service providers and the elimination of direct negotiations with the professional associations.¹⁴⁹ Having no direct access to the reforms decision making process, physicians backed their demands with strong protest and a refusal to fill out the required forms for the insurance funds.¹⁵⁰ However, after the approval of the amendments, they fell silent and accepted the new version of the law with moderate support.

3.7. Implementation problems

On January 1st 1999, four big Polish policy reforms came into effect - the reform of public administration, the reform of the pension sector, the education reform and the healthcare sector reform. Of the four, the prospects of the health reform were the gloomiest, even before its start date, since the Buzek's government had managed to pass the amendments to the Law on Health Insurance just some months before the scheduled implementation and the law therefore still required significant clarifying regulations (Interview Góra). It was therefore not surprising that the implementation process immediately witnessed three different sorts of problem.

The first sort of problem was administrative. These administrative problems emerged because the implementation of the Law on Healthcare Insurance depended partly on the parallel adoption and implementation of the Law on Public Administration. The latter was supposed to formally establish a new territorial division into sixteen regions and initiate the administrative and electoral process necessary for the regional insurance plans to be put in place. Although formally coordinated, the two laws were not consistent with one another and this meant that some of the major issues would have to be resolved by additional regulations, which were however missing (Bossert and Włodarczyk 1999: 17). Another problem was that the Law on Healthcare Insurance negated the Law on Large Cities, passed in 1995. The Law on Large Cities gave some municipalities a strong role in ownership and management of local healthcare provision, allowing cities to decide whether to manage the provider services through public or private providers. The Law on Healthcare Insurance significantly limited the role of the cities, since it introduced insurance funds as payers for services, so that the cities' role became limited to the ownership of

¹⁴⁹ *Gazeta Lekarska* 1998 No. 4.

¹⁵⁰ *Gazeta Lekarska* 1998 No. 9.

public facilities and participation in the governance of the insurance funds (ibid. p. 15). These administrative issues created confusion and controversy among patients at the initial stages of reform since they were unsure which hospital and health centres they could visit and how their healthcare bills were going to be paid.

The second sorts of problems were managerial problems. The provision of the 1997 law was that the contributions would be collected by the government, transferred to the *ZUS* and then from the *ZUS* transferred to the sixteen regional health funds and one ‘branch’ fund.¹⁵¹ This new system of financing began in chaos, partly generated through the emergence of different, regionally defined reimbursement schemes. The *ZUS* turned out to be incapable of tracking the different regional reimbursement systems and distributing the insurance contributions accordingly (Interview Strzalkowska). This created delays in money transfers, because of which the government had to break the law by giving loans to the regional insurance funds in order to keep the system going. The insurance funds at the same time started to overspend, not respecting the hard budget constraints envisioned by the architects of the reform (McMenamin and Timonen 2002). In order to prevent the system from running into serious financial difficulties, in 2000 the *Sejm* passed an additional amendment to the 1997 law, raising the contribution level from 7.5% to 7.75% and scheduling an annual increase in the contribution rate by 0.25 percentage points, which would imply that by 2007 the contribution level would reach 9% (Kuszeowski et al. 2005: 25-6).

Finally, the third sorts of problem were political. According to the 1998 amendments, local governments were in charge of providing the majority of personnel in the regional healthcare funds, and at the same time owned most of the public healthcare facilities. This was the main reason why the funds soon became subject to political interests. Local governments were seen as a vital source of “jobs for the boys” by the Polish political parties, which were weakly institutionalized, had little else to offer their members in terms of material incentives and support (Filinson et al. 2003: 111). Because of these political appointees, the funds became primarily interested in satisfying their constituents rather than implementing the intended reform goals.

Unsurprisingly, the healthcare reform became deeply unpopular during its first year of implementation. A public opinion survey carried out in January 2000 showed that 76% of the respondents agreed that the situation in the healthcare sector was worse than before the reform, whereas only a small percentage evaluated the operation of the Polish healthcare system as

¹⁵¹ The branch fund was nationwide and covered those employed in the defence, interior, justice and the railway sectors.

“good” (CBOS 2000a). In December the same year, another public opinion survey showed that Poles were more dissatisfied with the healthcare reforms than they were with the government or with any of the other three individual reforms initiated in 1999 (CBOS 2000b).

3.8. The Law on Healthcare Insurance with the National Health Fund

The strong negative public perception of the healthcare reforms caused the emergence of new reform proposals during the pre-election period. The *SLD*, building upon this negative perception, as a part of its electoral platform proposed abolition of the sixteen regional insurance funds and their replacement by fewer bigger funds. This proposal became one of the core parts of the party’s election campaign and was considered one of the key factors in the *SLD*’s persuasive electoral victory in September 2001. After the elections, a government was formed by the *SLD* and a small left-oriented party, the *UP*. The Prime Minister Leszek Miller appointed a *SLD* member, Marius Łapinski, as the Minister of Health. The minister on his own behalf quickly proposed an alternative solution – replacement of the regional insurance system with a single, centrally governed health insurance fund (Interview Hausner). His proposal envisioned that this fund, which would be called the National Insurance Fund (*Narodowy Fundus Zdrowia - NFZ*) would have its regional branches, but that these branches would be given only a limited range of organisational functions. The range of choice for the local decision makers was also to be limited, especially when it came to the preparation of healthcare plans, which served as a basis for healthcare services contracting, as this responsibility was instead given to the Ministry of Health (Interview Włodarczyk). The proposal also envisaged that the *NFZ* would be supervised by the Fund Council, which would consist of nine members appointed by the Prime Minister for a five-year period (see Kuszewski at al. 2005: 11). The need to centralize the insurance system and put it under state control was justified by strongly ideological arguments. Minister Łapinski claimed that the changes implemented in 1999 resulted in the Ministry of Health’s incapacity to create state healthcare policy, and that the central financing of healthcare services would be much better in ensuring efficiency and equality of access than the previously instituted competitive system of multiple health insurance funds (Krajewski-Siuda and Romaniuk 2008: 69).

The proposal to abolish the existing system of regional funds and replace it with one central fund was heavily criticized by healthcare experts, professionals and by the post-Solidarity parties now forming the political opposition (Interview Hausner). Among the public, the idea of a centralized system also seemed to attract relatively low support, with more than 30% of the respondents in a 2001 public opinion survey thinking that establishing the *NFZ* would not be

the solution for the present problems of the healthcare sector (CBOS 2001b). Despite this public, professional and political opposition, the government of Leszek Miller decided to approve the Łapinski proposal as it hoped that the new reform could help reduce dissatisfaction with the very dysfunctional healthcare system (Interview Hausner). With the minister Łapinski's intensive commitment to the new reform project, the Law on Health Insurance with the National Health Fund was passed in the *Sejm* on January 23rd 2003 (Law. No. 45/391).

The introduction of the *NFZ*, as yet another comprehensive reform of the Polish healthcare sector since the fall of communism, was certainly met with less enthusiasm than the 1999 reform and was described as a step "back to the future" (Filinson et al. 2003). As a specific policy episode, however, the introduction of the *NFZ* demonstrated one important thing. It demonstrated that innovative policy ideas, despite the political support they might get in policy circles, could also experience serious hurdles in the policy making process, impeding their success on the government agenda. The reasons for this, as the Polish case has shown, can lie both in the character of political support given to these ideas and in the institutional setting in which this support is granted. Unstable politics, factionalism and frequent shifting of policy preferences among the main political actors, as the Polish case has shown, can generate an unstable pattern of political support for innovative ideas that can seriously impede their success in bringing about policy change. The case has also shown that an institutional system with a thick network of checks and balances, such as Polish semi-presidentialism, can create additional hindrances in the decision-making process that block the introduction of innovative policies or create reversals to the old ones. This, yet again, confirms the crucial role played by political-institutional configurations in the process of policy change.

3.9. The Law on Health Care Services Financed from Public Sources

There were many anomalies in the functioning of the *NFZ* that emerged during its first few months of existence, and which resulted in the continuation of general public discontent. Re-organization of the insurance system, introduced by the new law, did not seem to have significant influence on its functioning, since inefficiency and improper allocation of healthcare resources continued to plague the Polish healthcare sector. Another important consequence of the new reform was the instability of the personnel working in the *NFZ*, which became significantly susceptible to political influence, so that during the first 18 months of the fund's existence, there were several changes of the *NFZ*'s President (Krajewski-Siuda and Romaniuk 2004: 69). In the meantime, support for the *SLD* shrunk dramatically, in line with decreased public support for the government. In January 2003, Minister Łapinski was removed from office

and replaced by Marek Balicki.¹⁵² The strongest opposition to the new law came from the Polish primary care physicians, who organised a large protest that caused an almost complete collapse of the healthcare system (Pilonis 2004).¹⁵³ In order to attract support from medical professionals, the Ministry of Health initiated a Round Table on Health Care in June 2003. By then, however, it was already too late to secure professional support for the reforms that were barely supported in the medical circles.

The overall discontent with the new law culminated in January 2004, when the Polish Constitutional Tribunal ruled that some of the key regulations of the 2003 law were ‘unconstitutional’ and gave the government twelve months, i.e. until the end of 2004, to amend the law in conformity with the constitution. The Tribunal’s claim for the unconstitutionality of the law was mainly focused on the lack of clear regulation in respect of the services funded by the *NFZ*. In order to resolve the issue with the Tribunal, the government introduced a new law, the Law on Health Care Services Financed from Public Sources, passed by the *Sejm* passed on August 27th 2004. The law introduced few changes compared to the law from 2003. The first, most important, was that the law met the Tribunal’s requirement concerning the list of healthcare services financed by the *NFZ*, introducing a ‘negative’ list of services, which were not financed by the *NFZ*.¹⁵⁴ It also introduced transparent regulations for the management of waiting lists for scheduled interventions and hospitalizations and managed to reduce political influence over the *NFZs* by abolishing the Fund Board. The new law however did not increase the independence of the regional *NFZ* branches, which implied that the Polish healthcare insurance system kept its centralized form (Kuszeński et al. 2005: 13).¹⁵⁵

Another change of government after the September 2005 elections led to a new round of reform dynamic. The governing coalition composed of three parties, the *PiS*, the *SRP* and the *LPR*, presented a proposal that clearly recalled the post-Solidarity reform proposals. The proposal claimed that the stabilisation of the existing healthcare system and its effective functioning could be achieved only through decentralization i.e. replacement of the *NFZ* with multiple, nation-wide, competitive health insurance funds. In the *Sejm*, even though it was not supported by the members of the two governing parties, the *SRP* and the *LPR*, the proposal had a chance to succeed because the largest governing party, the *PiS* and the largest opposition party,

¹⁵² Balicki was replaced by Leszek Sikorski in April 2003, who in May 2004 was replaced by Wojciech Rudnicki. After just 17 days, Marian Czakański replaced Rudnicki.

¹⁵³ The main reason for these protest were contract conditions of the *NFZ* which turned out being extremely unfavourable for primary healthcare providers (*Służba Zdrowia* No. 77, 2004).

¹⁵⁴ Because of the short time period taken to prepare the law, the Ministry did not manage to prepare a ‘positive’ list, the list of services financed from public sources, as originally planned. Instead, the new law contained a ‘negative’ list of services (Kuszeński et al. 2005: 13).

¹⁵⁵ The law also clarified the question of healthcare costs for the homeless and the uninsured (*ibid.*).

the *PO*, declared that they would support it. The *PiS*, however, decided to follow the coalition agreement. Nevertheless, the three governing parties soon got involved in a series of political conflicts causing the collapse of the coalition and the fall of government, after the *Sejm* voted for its own dissolution in September 2007.

The new government established after the 2007 elections, formed through the coalition of the *PO* and the *PSL* under Donald Tusk as the Prime Minister, took office in December the same year. The Tusk government initiated discussion on several issues, one of which was discussion on hospital autonomy and their transformation into commercial, ‘for-profit’ companies, and another was the strengthening of patients’ rights and the establishing of a patients’ rights Ombudsman. The idea of hospital commercialization attracted much attention because of the poor financial situation of the Polish hospital sector, organized in Autonomous Public Healthcare Units (*Samodzielny publiczny zakład opieki zdrowotnej – SPZOZ*). In order to improve hospital finances, in 2008 the government proposed a bill introducing the obligatory transformation of all *SPZOZs* into limited liability joint-stock companies governed by commercial law (Poland 2011: 157-8). The idea of hospital commercialization was however not favoured by the President, Lech Kaczyński, who decided to veto the bill after its passing in the *Sejm*.¹⁵⁶ After the President's veto, the transformation of hospitals was left to the discretion of the local governments. After the notion of compulsory transformation failed, the government proposed another reform plan in April 2009, titled “Save Polish Hospitals”. This plan offered state assistance to territorial self-governments that decided to transform hospitals into commercial companies. The success of this alternative plan was, however, limited since the local adopted it rather reluctantly (Poland 2011: 157-8).¹⁵⁷ Thwarted in its attempt to comprehensively reform the hospitals sector, the Tusk government by the end of 2009 managed to leave its last print on healthcare policy only by amending the 2004 law, replacing the existing ‘negative’ with a ‘positive’ list of healthcare service financed by the *NFZ*.

This final policy episode of Polish healthcare reforms, yet again, demonstrated the importance of political-institutional configurations for policy change. In spite of the significant effort of the Tusk government to push for comprehensive market-oriented reform of the hospital sector, the specific structure of institutional checks and balances of Polish semi-presidentialism had the last word, and hindered its ultimate success.

¹⁵⁶ Tusk argued that the healthcare and other reforms of his government had been "sabotaged" by the opposition and President Lech Kaczyński, whose brother Jarosław headed the *PiS* (*The Warsaw Voice*, November 16th 2008).

¹⁵⁷ There were 212 hospitals transformed into joint-stock companies in 2010.

4. Summary

After this two-decade long process of policy change, Poland showed mixed marketization results. While the majority of outpatient care had been privatized and hospitals' privatization was on the way, the centralized system of healthcare financing, established through a large scale policy reversal in 2003, created a monopsonistic insurance market. In this chapter I showed that these mixed results of Polish healthcare sector marketization were results of the process of policy change dominated by ideas, interests and institutions. The first traces of ideas about market-oriented healthcare reforms emerged early, already under the communist regime in Poland of the 1970s. After 1989, when political events finally created opportunities for policy change, these ideas developed into a set of different proposals for the comprehensive transformation of the Polish healthcare sector. However, the turning of these proposals into policy would turn out to be a rather hard row to hoe. As this chapter has shown, the Polish policymaking process was protracted and turbulent because of the unstable links created between ideas and interests, the dense institutional structure of checks and balances created through Polish semi-presidentialism and because of unstable political configurations. These three factors were the main reasons why Polish post-communist healthcare reform, in contrast to the Czech, was first significantly delayed and then followed a path beset by reversals.

Chapter Four: The Czech Republic

Introduction

The first market-oriented policies in Czech healthcare emerged quickly after the country's extrication from communism through the Velvet Revolution. A set of laws passed in the period from 1991 to 1993 created the framework for a new insurance, market-oriented system of healthcare based on privatized, competitively provided and decentralized delivery and financing of medical services. The implementation process followed within a short period, and quickly created a number of difficulties that seriously threatened the financial sustainability of the health sector as a whole. Through a new set of reforms, the government managed to save the insurance sector from serious crisis, but nevertheless continued its market-oriented reform zeal. Comprehensive reform plans for further marketization of the Czech healthcare sector emerged again, several times, during the late 1990s and the 2000s but were only partly successful, resulting in the introduction of user fees as the main market-oriented measure.

A distinguishing feature of the early period of the Czech policymaking process is its fast, comprehensive and radical character. The empirical analysis shows that the first market ideas emerged in Czech expert circles relatively late, in the mid- and late-1980s. These ideas, turned into concrete reform proposals, were nevertheless quickly accepted among policy makers after the fall of communism and helped establish a consensus that the departure from the old socialist model and the shift to market oriented healthcare provision was what was necessary for the solution of the persistent healthcare crisis. The range of market-oriented instruments introduced in Czech healthcare during this early transitional period was dramatic, and led to a series of textbook examples of market failures in the health sector. Introducing remedies for these failures, the government managed to restrict the adverse effects of marketization, but nevertheless during the subsequent reform episodes continued to pursue market-oriented policy choices.

Characterized by comprehensive reform plans and quick and decisive political moves taken right after the communist fall to turn these plans into policy reality; the Czech healthcare reforms were clearly different from the Polish. The Czech healthcare reforms were also much more continuous than those of the Polish, as they did not experience such a drastic policy reversal as the one that took place in Poland in 2003. In terms of marketization, the two countries also stand at opposing poles, since Poland's 2003 re-centralization and failure to

privatize its hospital sector can be easily contrasted with the Czech ultimate success in introducing user fees in 2008. In spite of these differences, however, the Polish and Czech healthcare reforms also have a lot in common. As this chapter will show, the first traces of the post-communist health reforms emerged in the Czech Republic, like in Poland, already under communism. These ideas served as a basis for the development of the post-communist reform proposals that, as this chapter will show, were fascinatingly similar in the two countries. However, due to the radically different policymaking dynamic, in which interests and institutions played a decisive role, the two countries witnessed healthcare policy developments along divergent paths.

The empirical resources used in this chapter are based on a comprehensive review of the literature and data on the Czech healthcare system and its reforms. This included analysis of media reports including Czech newspapers and magazines, analysis of the reform proposals and draft bills presented in the Czech parliament, healthcare related laws, statistical data and finally, the twenty one in-depth interviews that the author conducted with Czech healthcare policy experts, politicians, policymakers, journalists and medical professionals in Prague in the autumns of 2010 and 2011.

Similar to the previous chapter, this chapter is divided into three main sections. The first section offers an overview of the Czech healthcare system during the inter-war and the communist period and accounts for the emergence of the first reform ideas emerging in response to the problems of the socialist healthcare sector. The second section is a description of the political, economic and social context of the Czech post-communist transition, which builds links between the healthcare reforms and some of the key aspects of political, economic and social change that took place during this period. The second section therefore ‘sets the scene’ for the last section, which gives a detailed account of the most important policymaking episodes in the first two decades of Czech post-communist healthcare.

1. Czech Healthcare: Historical Overview

This section offers a historical overview of Czech healthcare that focuses on two periods, the inter-war period and the communist period. Depicting early development of the insurance system in the Czech lands during the Austro-Hungarian rule, healthcare policy during the First Republic and the subsequent development of Czechoslovak healthcare policy under the Communist regime, the section has two main aims. First, it shows the gradual development of Czech healthcare policy in the 20th century during which, similar to Polish healthcare policy, it

witnessed some of its most successful and most tragic moments. Second, by shedding more light on Czech healthcare policy under communism, this section shows that the 1980s were crucial for the development of the first reform ideas that would become key drivers of the post-communism healthcare policy dynamic. Offering solutions for the anomalies of the socialist healthcare system, these ideas developed in the attempt to not only explain the core problems of the socialist healthcare system but also to offer suggestions for change that, as it would later turn out, would re-emerge in the post-communist period.

1.1. The inter-war period

The first social insurance laws introduced in the Czech lands date back to 1887, when the Austro-Hungarian government introduced compulsory accident insurance for manual workers, followed a year later by a mandatory sickness insurance scheme (Inglot 2009: 63). This law was incorporated into the legal framework of the First Czechoslovak Republic, established in 1918 after the First World War. The same year, the Czechoslovak Ministry of Public Health and Physical Education replaced the Austrian Ministry of National Health. This new ministry assumed the responsibility for the functioning of healthcare facilities and took care of public health measures such as sanitation and epidemiology, co-ordinating with voluntary organisations and initiating necessary legislative changes. A series of incremental improvements in healthcare financing and provision took place during this period. In financing, the legislation passed expanded health insurance coverage, rationalized the network of health insurance funds, and increased the role of the state in health insurance. The Law on Mandatory Insurance, from 1919, extended the maximum duration of sickness benefits to 39 weeks. It also extended health insurance coverage to all wage-earning employees and members of their families, as well as to agrarian and forestry workers (Jaroš et al. 2005: 198). In 1924, the Law on Health and Social Insurance for Industrial Workers redefined certain sickness benefits, created a common social insurance framework for health insurance, invalidity insurance and pensions for workers and low-wage employees, and established the Central Social Insurance Fund (*Ústřední Sociální Pojišťovna - ÚSP*), which was designed to co-ordinate the network of health insurance funds. In healthcare delivery, improvements were most evident in the increased number of state health facilities and medical staff (Svobodný et al. 2002). In 1920, a law was passed nationalizing public hospitals, allowing the state to take over and improve large hospitals formerly run by local authorities.

Despite these improvements, healthcare during the First Republic suffered from similar problems as its Austro-Hungarian predecessor - low insurance coverage and excessive

fragmentation. In terms of coverage, the insurance system covered 3.3 million workers in 1938, amounting to 73% of the Czechoslovakian labour force (Korbel 1977: 80). While this was a considerable success, the existing coverage was far from perfect. There were inequalities in coverage within the system that not only cut across occupational groups but also reinforced differentiation in the level of protection in various categories of risk.¹⁵⁸ Furthermore, lack of unemployment insurance excluded from the healthcare system those without work and their dependents, while the coverage for industrial accidents and occupational sickness remained low (Inglot 2009: 68).¹⁵⁹ Fragmentation was another major problem. In 1927, the *ÚSP* supervised 307 health insurance funds, including 190 district health insurance funds. In addition, there were three health insurance funds supervised by the Ministry of Social Security, and a number of independent insurance funds: 19 health insurance funds of tobacco companies, 8 fraternal funds of coalminers, and 58 funds for farmers (Deyl 1985: 84-5). An additional problem was that the different funds supervised by the *ÚSP* would often be covering the same district, creating complications in administration, leading to enormous administrative expenses (De Deken 1995: 229), and making the management of the healthcare system a rather difficult task. In the area of healthcare delivery, the biggest problem remained uneven territorial distribution of healthcare facilities, since the majority of facilities were located in the big cities.

1.2. The communist period

The communist period brought significant improvements in the Czechoslovak health sector, mainly visible in the integration of healthcare financing, the extension of coverage and an increase in the number of healthcare facilities (Interview Hava 2010). The first important healthcare legislation after the Communist party electoral victory in post-war Czechoslovakia was the Law on National Insurance from 1948. This law abolished the numerous public health insurance funds,¹⁶⁰ and established one central fund, the Central National Insurance Fund with district branches (Jaroš and Kalina 1998: 2).¹⁶¹ It also expanded health insurance coverage and abolished the differences between employment categories (Inglot 2008: 72). As a result, by 1950 mandatory health insurance covered 92.7% of all Czechoslovakians (Štich 1950: 202). Thanks to the process of nationalisation and centralisation in the industrial sector, the Communists were also able to increase the number of healthcare facilities in industrial enterprises. While in 1938

¹⁵⁸ Selected occupations had access to supplemental private and company plans, often subsidized by the government (Inglot 2008: 68).

¹⁵⁹ Of the 73% of the labour force with sickness insurance, only 44% had protection against industrial accidents (Korbel 1977: 80).

¹⁶⁰ Nationalization of private funds took place earlier, in 1945.

¹⁶¹ Through the establishment of the Central National Insurance Fund, health services were separated from temporary cash assistance in cases of illness i.e. sickness benefits (Inglot 2008: 125).

only 15 industrial enterprises had health facilities, in 1948 their number increased to 475, in 1955 to 1, 691, and in 1959 to an impressive 1, 935 (Šourek 1960: 22). In 1951, the Central National Insurance Fund was abolished and healthcare was incorporated into the state budget.¹⁶² All healthcare providers were nationalized and subsequently incorporated in the Regional and District Institutes of National Health. The result was that in the Czech part of Czechoslovakia there were 8 Regional Institutes of National Health and 76 District Institutes of National Health (Jaroš and Kalina 1998).¹⁶³ Finally, the peak of the Communists' early post-war achievement was a very modern law, the Law on Health Care and Population in 1966, which stipulated that access to healthcare was to be provided by the state, free of charge, and universally to all citizens (den Exter 2002: 166).¹⁶⁴

These post-war changes clearly indicated that the Czechoslovak healthcare system was being modelled in accordance with to the Soviet 'Semashko'. This implied several important changes. The main change was that healthcare governance became more centralized, hierarchical and bureaucratic. This implied the full integration of healthcare professionals into the state, turning them into state employees.¹⁶⁵ The State Planning Commission became responsible for the planning of healthcare expenditure and the preparation of a normative Five-Year Plan. The Ministry of Finance developed an annual state budget, according to the Commission's Plan, and through the Ministry of the Interior, allocated funds to local authorities – the Regional and District National Committees, which then distributed the relevant funds to the District and Regional Institutes under their jurisdiction. The Committees also formulated local health policies, participated in the planning and administration of local health services, and were responsible for local health promotion and disease prevention, health education and public health programmes. The Ministry of Health was also in charge of regulating wages and salaries in the health sector,¹⁶⁶

¹⁶² In this way, it became easier to divert money from the welfare state to investment into the industrial sector, i.e. to subordinate social planning to economic planning (see Ingot 2008: 134).

¹⁶³ Every district had one District Institute of National Health, and every region had one Regional Institute of National Health, so that each healthcare organization corresponded to only one administrative unit, either a district or a region. District Institutes consisted of medium or small hospitals, large divisions for ambulatory care, polyclinics with general practitioners and ambulatory specialists, healthcare centres, pharmacies, emergency and first aid services, hygienic stations, enterprise healthcare centres, nursing schools etc. The average number of employees in the District Institute was 2 690, of which an average of 390 were doctors. Directors of Regional and District Institutes were appointed by the heads of the Regional and District Committees, after receiving approval by the Communist Party (Jaroš and Kalina 1998: 2-3; Jaroš et al. 2005: 198-9).

¹⁶⁴ This law is still valid, in spite of the various amendments. As it will be shown later, the provision of this law will be stressed in the context of post-communist healthcare reform that introduced user-fees.

¹⁶⁵ This excluded any possibility for doctors to offer their services outside of the state-owned facilities. According to Potůček, in contrast to the other socialist countries, such as East Germany, where GPs were allowed to run private practice, this was not the case in Czechoslovakia (Interview Potůček 2010). Healthcare expert Hava also confirms that in contrast to Poland, there was no private care delivery in communist Czechoslovakia (Interview Hava 2010).

¹⁶⁶ The work force of the District and Regional Institutes, from manual labourers to top specialists, received fixed salaries without regard to their education level, or to the quality of their work (Jaroš and Kalina 1998: 3).

setting prices for drugs, and controlling the allocation of medical equipment to healthcare institutions. Finally, health services were delivered according to strictly defined territorial rules, as citizens were allotted a specific general practitioner, polyclinic with ambulatory specialist, hospital and other similar services, according to their residence (Jaroš and Kalina 1998: 3).

When in 1968 the progressive part of the Communist Party, led by Alexander Dubček, attempted far-reaching reforms in order to build “Socialism with a human face” (Williams 1997), healthcare was not very high on the reform agenda. The Action Programme of the Prague Spring focused on economic and social reforms, and mentioned healthcare just briefly. It suggested that salaries in healthcare should increase and become equal to those in the industrial sector, and stated that there were some “unexploited opportunities” to improve healthcare organisation and the working conditions of healthcare professionals (*ibid.*). Despite the Programme’s sparse reference to healthcare, the events of the Prague Spring had some significant implications. One of these was that as the unitary Czechoslovakia was federalized in the form of the Czech Socialist and the Slovak Socialist Republic, the responsibility for healthcare was devolved to the level of the republics, and was delegated to the newly established Czech and Slovak Health Ministries. Another, more important implication was the establishment of the Czech Union of Doctors in 1968, with around 27 000 members. Even though the Union was outlawed as quickly as in 1970, and its activists prosecuted, its establishment indicated that Czech doctors used the Prague Spring as an opportunity to voice their dissatisfaction with the situation in the socialist healthcare sector and that, by that time, something was ‘rotten’ in Czech healthcare.

In the early 1950s, the Czechoslovak healthcare system proved reasonably effective in dealing with post-war problems. During that time, malnutrition, the high infant mortality rates, and the incidence of serious infections such as tuberculosis diminished rapidly. By the beginning of the 1960s, Czechoslovakia had very good health status in international terms. In fact, the 1960s were considered as ‘the golden age’ of the Czechoslovak health sector. The 47% decline in infant mortality from 1955 to 1964, for instance, was the largest recorded by the World Health Organization, among the 15 nations of the world with the best rates. The 1964 rate of 21.7 deaths per 1 000 live births placed Czechoslovakia tenth, just below England and France. This general progress in health status was also reflected in the shift of the disease pattern, since the major causes of death became cardio-vascular diseases, cancers, and accidents, which at that time was a familiar pattern of diseases in “advanced” and “developed” countries (Weinerman and Weinerman 1969: 44-5). Another important achievement of the 1960s period was a significant increase in government healthcare spending. From 1960 to 1970, government expenditure for health increased from 6,900 to 14,700 million Czechoslovak crowns, which represented an

impressive growth of 113%. In relative terms, health spending reached 14.5% of the Social Product,¹⁶⁷ and amounted to one quarter of social insurance spending.¹⁶⁸

This 'golden age' of Czechoslovak healthcare came to an end when at the end of the 1960s the positive trends reached their turning point. Health status indicators started to stagnate from the late 1960s onwards (Rokosová et al. 2005: 12). By the 1980s, the situation had become alarming. Standardized mortality rates reached around 1 300 deaths per 100 000 inhabitants, which was two times higher than the rates in Western Europe (Jaroš and Kalina 1998: 4). It was therefore not surprising that during the 1980s the Czechoslovak healthcare sector witnessed the emergence of new policy ideas that tried to suggest solutions to the emerging problems. These ideas came from two main sources. The first source was the dissident movement Charter 77 (*Charta 77*).¹⁶⁹ In 1984, Charter issued a document¹⁷⁰ that critically examined the deteriorating state of the population's health and of the healthcare sector and provided a liberal and democratic critique of the socialist healthcare system. The document attributed the causes of the problem to the fundamental principles of the socialist healthcare system, such as its totalitarian character and state organisation. It argued that health was part of the right to life and that, therefore, the State had a duty to guarantee provision of health services adequate to meet this right. It further pointed out that the situation in the health sector was deteriorating due to insufficient financing, lack of drugs, medical equipment and healthcare material, and blamed this deterioration on ineffective and disproportionate allocation of healthcare resources. The cause of the allocation problems was traced to the State monopoly over healthcare provision, excessive bureaucratisation, and the reimbursement of doctors according to the salary tariffs, rather than the costs and quality of performed procedures. While the document did not make specific reform recommendations, it suggested that liberal and democratic reforms could be a starting point for the improvements in the healthcare sector.

The second source of new ideas came from the small community of experts from the Institute of Social Medicine and Organisation of Health Services. Over the 1980s, the experts

¹⁶⁷ Instead of the GDP, communist statistics used the Social Product as macroeconomic indicator.

¹⁶⁸ These calculations are based on data published by the Czechoslovak Ministry of Finance in 1990 (*Dlouhodobý vývoj finančních ukazatelů ČSFR do roku 1990. Praha : Federální ministerstvo financí, 1991. XII*).

¹⁶⁹ "Charter 77" was a document published in January 1977, which accused the Czechoslovak socialist government of a systematic discrimination in education, employment and other areas of society against citizens critical of its policies. The charter was inspired by Czechoslovakia's acceptance of the human rights provisions of the Helsinki agreements, and was initially signed by 300 Czechoslovak intellectuals, led by Václav Havel. From 1977 until the Velvet Revolution in 1989 the Charter was signed by only 1, 900 people, which suggests an extremely high level of political repression in Czechoslovakia in the 1970s and 1980s. There were several means of retaliation used against the signatories, including dismissal from work, denial of education opportunities for children, suspension of driving licence, forced exile and loss of citizenship, detention, trial and imprisonment.

¹⁷⁰ Pohunkova D, Freiova S. 1984 *Zdraví je součástí práva na život*. Praha, *Charta 77, dok. č.14/84* z 15. srpna 1984.

from this Institute developed a series of reports that analysed the situation in the health sector. The government gave additional encouragement to these experts in 1985, when the Minister of Health Jaroslav Prokopec asked them to write a report in which they would analyse the healthcare sector's main problems and suggest possible solutions (Interview Jaroš). The resulting report was published the same year and criticized low system performance, deterioration of health status and other problems such as inequalities in healthcare financing and provision across the regions. In terms of solutions, the report was not very explicit, suggesting that the government had to find ways to introduce new financial resources into the system.¹⁷¹

The fact that the report was rather hesitant to propose change, according to one of its authors, was explained by the fact that Czechoslovak healthcare policy experts in the 1980s simply did not think that any change that would involve a departure from the socialist 'Semashko' model would be even possible (*ibid.*). They were aware that the authorities needed suggestions that would stay within the limits of the Communist' framework and knew that proposing something "not fitting to this framework" would simply be too risky. In addition, it is important to stress that none of the researchers involved in the writing of this and other 1980s reports was prepared for the dramatic and sweeping political changes that took place in Czechoslovakia in November 1989, and therefore they were not working on a radical plan of healthcare reforms. This explains why in most of their work socialist healthcare experts focused mainly on criticism of the existing system, as they were more concerned to develop a general critique of the socialist healthcare rather than to set out an immediate and radical reform proposal.

These reports nevertheless showed one important thing. They showed that the emergence of criticism and new ideas in healthcare policy took place in the context of a real crisis in the health sector, in which there was a great deal of uncertainty about what could be done to solve this crisis. In this context of deep uncertainty, expert ideas played a crucial role, since they provided initial cues about the possible outcomes of the crisis (Blyth 2002, 2003). These reports also showed that there was a considerable consensus among experts about the anomalies of socialist healthcare, in both financing and delivery of healthcare services, and an agreement that there could be alternatives to the existing system. At the same time however, seeking for these alternatives was significantly hindered by the fact that there was a complete lack of public debate on healthcare issues, which prevented both any discussion about the existing problems, or wider

¹⁷¹ This however, was just the official version of the experts' view, since according to one of the authors of this report, they were aware that offering the government solutions such as privatisation, or suggesting some other radical change would be considered "a heresy" and would carry a significant threat of losing one's job (Interview Jaroš).

collaboration between the experts. The result of all this was that, when the Communist system collapsed, even though there were some ideas of reform developed in a relatively narrow circle, there was no coherent programme and no widespread understanding of what healthcare reform in the post-communism would entail (Interview Jaroš).

That the top communist authorities were also worried about the situation in the healthcare sector became clear to the public just at the very end of the 1980s. In this period, the government started officially discussing the problems of the health sector and asked the Ministry of Health to prepare a plan for some moderate changes and improvements (Jaroš et al. 2005: 200). In an interview given on June 1989, Minister Prokopec argued that while Czech healthcare had been experiencing insufficient funding since the late 1970s, the present situation was creating a serious case of a financial crisis, the worst during his 19 year long mandate.¹⁷² He also argued that “until the federal government adopts the principle of allocating resources to healthcare directly in the plan and according to the needs, such crisis will persist” (ČTK 1989). Another proposal for change came from the Parliament, which proposed strengthening the role of the Health Ministry. The proposal argued that there was a suboptimal dualism in the existing system of healthcare provision: the Ministry had overall responsibility for healthcare, but the network of healthcare facilities was administered by regional and district health authorities (Domas 1988).

The proposals for healthcare reforms formulated under the last communist government in Czechoslovakia did not translate into laws. What they, nevertheless, demonstrated was that the crisis of the healthcare sector in the 1980s was acknowledged by both the communist government and the healthcare experts, the latter being actually mandated to identify problems and search for their solutions. However, in contrast to experts who were keen on criticizing the socialist system, government suggestions were clearly confined within the existing paradigm of centralized, hierarchical and bureaucratic healthcare provision. Summarizing his view on the healthcare reform potential during this period, one of the health experts described the situation in the following words: “During the 1980s, there were no considerable changes even though there was large amount of deep research conducted about the situation in the healthcare sector. None of the research results however ended on the table of the decision makers, because the party structure was too frightened to change things.” (Interview Potůček).

This shows that, in striking similarity to Poland’s healthcare under communism, despite very vibrant activities within the expert community, the connection between the ideas and policy change in the Czechoslovak healthcare policy of the 1980s was missing. This incapacity of ideas

¹⁷² Public opinion survey released just before the collapse of the communist regime revealed that healthcare and environment were two principal areas of public dissatisfaction (Jaroš et al. 2005: 204).

alone to generate policy change can be explained by two factors. First is the fact that under communism there were no actors i.e. interests that would be willing or could make these experts' ideas politically powerful, and develop them into more concrete policy proposals. On the one hand, the Czechoslovak communist regime was not willing to consider these ideas while, on the other hand, actors who could support these ideas and act as potential advocates of change, such as doctors, were politically powerless. The second reason for the lack of change was the fact that, in the context of a monolithic one-party system, there was no institutional setting in place that would enable their passing into policies. Political change in 1989 would, however, open the window of opportunity for change, bringing these three crucial elements of policy change, interests and institutions, into play.

2. The Post-communist Context

Healthcare reforms of the post-communist period took place in the dynamic context of triple transition. This section is an overview of the main aspects of the political, economic and social transition that characterized this context. Its main aim is to show that while the context of Czech healthcare reforms was significantly different from the Polish, the dynamics of the triple transition to capitalism, democracy and the new model of the welfare state were equally important for the emergence of the country-specific transitional and, more particularly, healthcare policy paths.

2.1. Extrication from Communism

Some of the first anti-regime sentiment in the Czechoslovak Socialist Republic occurred as early as the early 1960s. Pressure for change reached a climax in January 1968, when the new communist party chief Alexander Dubček tried to liberalize the political system through a series of moves popularly known as the “Prague Spring”. The Soviet leaders, unsurprisingly, fiercely rejected the “Prague Spring”. In fear of losing political control over the country, they crushed the opposition by occupying Czechoslovakia in August the same year. The post-1968 period was characterized by orthodox, dogmatic, and conservative socialism, described by the Soviets as the period of ‘normalization’. While public expression of anti-regime sentiment throughout the 1970s and the 1980s remained suppressed, with an exception of the “Charter 77”, the opposition remained relatively silent until the very end of the 1980s. The path toward the Velvet Revolution was paved by the foundation of Civic Forum (*Občanské Forum- OF*), led by Václav Havel, and the subsequent escalation of non-violent demonstrations of opposition in November and December of 1989. These events initiated a series of Round Table Talks between the opposition

and the government, which ultimately led to the capitulation of the Czechoslovak socialist leadership.

The Czechoslovak breakup with state socialism stands in contrast to the Polish compromise-based extrication (see Stark and Bruszt 1998). Built upon the unexpected collapse of the socialist leadership after the peaceful mass protests on the streets of Prague, the capitulation came as surprise to the opposition leaders who, unlike the Solidarity members in Poland, were not organized on a unified front, under a strong trade union movement. The unpreparedness of the opposition for negotiations with the regime was obvious during the Round Table Talks and led the opposition to underestimate the actual weakness of the regime and make several unnecessary concessions (Calda 1996). The outcomes of the ten rounds of negotiations held from November 26th to December 9th of 1989 were nevertheless momentous, as they resulted in agreement over the formation of the government coalition and the renewal of Parliament that would involve the replacement of the most offensive communist deputies by co-opted members of the opposition (Elster 1996).

2.2. Political transition

The beginning of the Czech political transition from communism to democracy was marked by two important events. The first one was extrication from communism through capitulation, while the second was the breakup of the federal Czechoslovak state in late 1992. These two events, as the following sections will show, were important in that they accelerated the process of institutional design that would establish the new Czech state as a parliamentary democracy and also in that they had significant influence on the development of the Czech post-communist party system dynamic. Strong parliamentarism, in combination with a stable and relatively strongly institutionalized party system, as the next sections will show, also played a crucial role in the policymaking dynamic of the healthcare reforms.

The new constitution

The Round Table Talks did not discuss the constitutional issues, but the political configurations produced through the process of extrication through capitulation helped Czechoslovakia pass through a relatively rapid process of institutional reconstruction. One of the main obstacles in the making of the new Czechoslovak constitution was not the presence of the Communists in the Parliament, but rather the conflict between the two federal republics (Elster 1996: 12). An intensive struggle between the Czech and Slovak political elites over the nature of the federation eventually led to the peaceful breakup of the Czechoslovak federation on

November 25th of 1992. This breakup accelerated the process of constitution making in the Czech Republic, the necessary legislation being passed less than a month after. The process of constitution making was marked by intensive bargaining over the role of the President in the new constitution. This bargaining took place between the two strongest political figures, the Prime Minister Václav Klaus and the federal President Václav Havel,¹⁷³ as the latter expressed a preference for investing the President office with more than symbolic power and wanted to introduce direct election of the President through popular vote (ibid. p. 73).¹⁷⁴ However, Havel's wishes were not fulfilled, as the new constitution granted relatively weak formal power to the President. Replacing the old communist constitution of Czechoslovakia from 1960, the new constitution was adopted on December 16th 1992, establishing the Czech Republic as a parliamentary democracy.¹⁷⁵

Table 6. Political institutions in the Czech Republic after the 1992 Constitution.

	Actors	Election, Accountability and Dissolution	Rights and Jurisdictions
Legislative	Chamber of Deputies (<i>Poslanecká sněmovna</i>)	Elected for a 4-years term; 200 members, elected by secret ballot on the basis of general, equal and direct voting, and proportional representation; may be dissolved by the President under conditions specified by the Constitution Art. 35.	Three readings of the draft bills; absolute majority is needed for the passing of the legislation; can override the President's veto by absolute majority of the votes of all of its members.
	Senate	Elected for 6-year term; 81 members; elected by secret ballot by majority vote; one third of the Senate members are elected every two years; cannot be dissolved.	Can either directly reject bills or propose amendments, which the Chamber of Deputies can override by the absolute majority vote.

¹⁷³ Both Havel and Klaus had a history of political involvement during of the communist period. Havel had been a communist dissident ever since the Soviet occupation of Czechoslovakia. He was one of the authors of the "Charter 77" and the leader of the Civic Forum. After the regime change, he was elected the President of the federal state. Klaus was an economic advisor to the Civic Forum from 1986 and in 1989 became the first Czechoslovak post-communist Minister of Finance.

¹⁷⁴ Havel repeatedly asked the Parliament to increase the powers of the President. His draft of the constitution presented on March 5th 1991, for example, gave the President the right to declare a state of emergency, to dissolve the Parliament and to call referendums (Elster 1996: 73).

¹⁷⁵ However, the stature of the first Czech president, Václav Havel, was such that the presidential office acquired greater influence than the one outlined by constitutional design. This was mainly due to Havel's personality, but also his democratic legitimacy and great prestige which gave him the status of a "moral authority" (Elster 1996: 76; Lijphart 1992: 212). This explains why Lijphart qualified Czechoslovakia, in the period when Havel was the federal President, as basically parliamentary democracy, but in comparison to the other parliamentary democracies, as "slightly more presidential" (Lijphart 1992: 212-13).

Executive	President	Elected for a 5 years term by a joint session of both chambers of the Parliament; if no candidate receives absolute majority of votes then second ballot; only one re-election; held accountable before the Constitutional Court.	Nominates the Prime Minister; has a right to veto legislation (but the Chamber of Deputies can overrule by the absolute majority of votes) and submit it to the Constitutional Court; may dissolve the Chamber of Deputies under specific conditions, specified by the Constitution Art. 35.
	Prime Minister	Nominated by the President; proposes the composition of the Government; this is confirmed by the vote of confidence or rejected by the vote of no confidence in the Chamber of Deputies.	Has a right to propose and issue legislation, adopt and draft the state budget.
Judiciary	Constitutional Court	Elected for 10-years term; 15 judges; appointed by the President and confirmed by the Senate; the chair and the vice-chair are appointed by the President.	Judicial review.
	Supreme Court	Unlimited term; consists of the president, the vice-president, heads of divisions, chairmen of panel and other judges; the chair and the vice-chair are appointed by the President; also consists of 2 divisions and a plenum.	Has the highest judicial authority in both civil and criminal matters, excluding issues dealt with by the Constitutional Court and the Supreme Administrative Court.
Electoral	Referendum	Call for referendum is implied by the Constitution Art. 10a.	Passing a constitutional act the Parliament can define the rules of the referendum.

Source: Czech 1992 Constitution (available at <http://www.psp.cz/cgi-bin/eng/docs/laws/1993/1.html>).

The new Czech constitution set up a relatively light system of checks and balances that defined the positions of the main institutional veto points, characteristic for a parliamentary system (table 10). Within the legislative, the Chamber of Deputies as the Parliament's lower house enjoys the right to prepare and pass the legislation. The right given to the upper house, the Senate, to reject bills passed by the Chamber establishes the right of veto within the Parliament's bicameral structure. The President as the head of State has mainly a ceremonial role, and his prerogatives are rather limited. He enjoys the right of veto over bills passed by the Parliament but this veto power is rather weak as it depends on the support of more than the majority of the votes in the Parliament's lower house. This gives the Chamber of Deputies the right to suspend the President's veto. Within the executive, the relationship between the President and the Prime Minister is characterized by a lack of significant tension, given that the President's powers are rather limited.¹⁷⁶ Decision-making powers of the judiciary are vested with the Constitutional

¹⁷⁶ According to Kopecký (2001), there was a substantial tension between the President and the Government at the start of the Havel's term in 1993, but this tension smoothed during the 1992-1996 term, to the extent that Havel's influence to day-to-day governmental process was practically marginal (ibid. 146).

Court, a judicial body in charge of resolving disputes on constitutionality. The Court possesses a right to veto laws that it considers not compatible with the Czech Constitution. The electorate, with the power to either accept or reject government's decisions by voting against or for them in a public referendum, constitutes the last element of the institutional veto structure.¹⁷⁷

The effects of this first post-communist decade were characterized by the contentious relationship between the two most prominent figures on the Czech political scene – Václav Havel and Václav Klaus - who held opposing views on the direction of Czech post-communist transition. Havel's influence on the Czech transition, despite his revolutionary charisma and political importance, was however diminished by the fact that the system established after the Czech 1992 constitution did not give a significant role to the president. It rather established a parliamentary system in which the policymaking dynamic developed in the government, the country's bi-cameral parliament and, sometimes, the judiciary all played the crucial role. As it will later become clear, in combination with the changing political arrangements, this constitutional structure and its system of veto points was to be crucial in shaping the strategies necessary for both failures and successes of the post-communist reform proposals.

Parties¹⁷⁸ and Elections

The electoral law passed in the post-socialist era established a moderate proportional representation system (see Lijphart 1992),¹⁷⁹ dividing the Czech Republic into 14 multi-member constituencies, and tabulating votes using the D'Hondt method.¹⁸⁰ One of the main characteristics of the Czech electoral rules was that they tempered party proliferation by creating relatively strong party discipline and low incentives for smaller parties to form (Keefer and Shirley 2001). Significant disincentives for party members to defect from a position taken by their party leaders were assured through electoral rules which established a weak form of individual preference voting. The rules prescribe that a candidate has to obtain more than 5% of

¹⁷⁷ The Czech Republic has no general law on referendum, even though the call for referendum is implied in Constitution Art. 10a. The Parliament can define the rules for public referendum, such as in the case of passing Constitutional Act 515/2002, which defined the rules for the referendum on the Czech Republic's accession to the European Union.

¹⁷⁸ A list of the main Czech political parties and their ideological orientations is available in the appendix.

¹⁷⁹ According to Lijphart (1992), the adoption of the PR model, instead of majoritarian, during the Round Table Talks was decisively influenced by the fact that Czechoslovakia was a deeply divided bi-national state. He argues that the PR model was a deliberate choice and a part of comprehensive package of measures designed to alleviate ethnic pluralism and facilitate minority representation. This, in Lijphart's view, confirms Rokkan's hypothesis, according to which PR models are adopted as guarantees of minority representation in countries with ethnic and religious problems, which could act as potential threats to national unity and political stability (Rokkan 1970).

¹⁸⁰ The first two post-socialist elections, held in 1990 and in 1992, were held under the Czechoslovakian electoral system rules, which divided the Czech Republic into 9 constituencies, and specified 5% for 1, 7% for 2, 9% for 3 and 11% for 4 or more parties' threshold in order to gain seats in the National Council. The new electoral law for the Czech Republic was passed in 1995, and the first elections according to these new rules were held in 1997.

the vote cast in order to displace a candidate higher up on the party list. In this way, party leaders gain greater positional advantage over the party members, the outcome of which was a relatively strong discipline within the party. The electoral law also generated low incentives for the formation of smaller parties through the introduction of voting thresholds, which discouraged parties with low popular support to run for elections. These thresholds were set at 5% for single parties and were even higher for coalitions, since 2 parties had to achieve a 10% threshold, 3 parties a 15% threshold, and 4 or more parties a 20 percent threshold, in order to be able to gain seats in the Parliament.

The effects of these electoral rules on party competition were already visible in the outcomes of the first post-socialist Czechoslovakian elections. The first free democratic elections took place in June 1990. These elections were considered by society to be a plebiscite on the relation of the Czechoslovak public to communist rule (Fiala et al 1998: 107). With the Civic Forum (*Občanské Forum – OF*) winning almost 50% of the votes, there were only another 3 other parties that managed to pass the 5% threshold and win parliamentary seats. In the next elections that took place in June 1992,¹⁸¹ still held within the federalist framework, the number of parties passing the threshold rose to 8, with the Civic Forum's successor, coalition of Civic Democratic Party and Christian Democratic Party (*Občanská demokratická strana – ODS, Křesťanskodemokratická strana - KDS*), winning almost 30 percent of the votes. A government was formed between the *ODS-KDS* coalition and three other parties, Civic Democratic Alliance (*Občanská demokratická aliance – ODA*), Christian and Democratic Union- Czechoslovak People Party (*Křesťanská a demokratická unie – Československá strana lidová - KDU- ČSL*).¹⁸²

The protracted struggle between the Czech and the Slovak political elites dominated the first two Czechoslovak post-socialist parliaments, as they sought to define the division of powers between the federation and the two constituent republics (Elster et al. 1998). In the Czech part of the country, this early period witnessed the foundation of a party that would significantly shape the Czech post-socialist political landscape. The Civic Democratic Party (*Občanská demokratická strana - ODS*), founded in 1991 under the leadership of Václav Klaus, became the country's strongest right-wing party and the driving force behind the country's economic transition. Another element was the long-lasting complicated relationship between Václav Klaus, who acted first as the Minister of Finance, and later as Prime Minister for two consecutive terms, and Václav Havel, who was both the Czechoslovakian and subsequently the Czech President

¹⁸¹ Both the 1990 and the 1992 elections were elections for the National Council in the Czech part of Czechoslovakia. After the breakup of the federal state, the National Council was transformed into the Czech Parliament.

¹⁸² The three parties held 99 seats in the Chamber of Deputies.

from 1993 to 2003. Throughout the 1990s, the relationship between the two Václavs, Klaus and Havel became a source of constant tension, and mainly focused on issues related to the Czech transition toward market economy.¹⁸³

In the first Czech elections held after the breakup of Czechoslovakia, in June 1996, out of 16 parties and movements, only 6 passed the threshold for entry to Parliament. The 3 strongest parties - *ODS*, *KDU-ČSL* and *ODA* – formed the governing coalition, obtaining 99 seats in the Chamber of Deputies and 52 seats in the Senate. This distribution of parliamentary seats vested the governing parties with significant legislative power. However, in December 1997 the coalition parties were forced to resign from power due to the collapse of the coalition, which was mainly caused by long term inter-coalitional disagreements, several scandals related to the financing of the *ODS* and the worsening economic performance of the country as a whole.

After the temporary government led by Tošovský, elections in June 1998 resulted in a majority of votes being gained for the first time by the left-wing party, the Czech Social Democratic Party¹⁸⁴ (*Česka strana sociálně demokratická - ČSSD*) and in 5 other parties passing the electoral threshold. After weeks of negotiations with potential coalition partners, the *ČSSD* decided to form a minority government with only 74 parliamentary seats, striking a surprising ‘opposition agreement’ with the *ODS*.¹⁸⁵ While this unusual agreement between two parties of a very different ideological orientation was much criticized by some politicians and by President Havel, it was for the first time after the Velvet Revolution that a left-oriented party ruled the country. The following, June 2002 elections lowered the number of parliamentary parties to 4, and brought another electoral victory to the Czech Social Democratic Party, which won around 30% of votes and this time formed a government with the *KDU-ČSL*, and a coalition of Union of Freedom and Democratic Union (*Unie svobody - US, Demokratická unie- DEU*). This government saw three changes of three Prime Ministers - after Vladimír Špidla resigned from his

¹⁸³ While Klaus was the author of the much disputed voucher privatization scheme as a means of transforming large state-owned industrial companies into private enterprises, Havel was opposed to it, describing Klaus economic policy as ‘gangster capitalism’.

¹⁸⁴ The Czech Social Democratic Party, unlike the Polish social democratic *SLD*, was not created by the transformation of the old ruling Communist Party. Instead, the *ČSSD* claimed continuity from the foundation of a first Social Democratic Party from 1874 and was reformed in 1989 by returning political exiles and former dissident politicians. A congress resolution of 1995 ruled out *ČSSD*’s cooperation at government level with the Communist Party (Myant 2010: 12)

¹⁸⁵ During the ‘opposition agreement’, the *ČSSD* and the *ODS* attempted to change the electoral law increasing the majority elements by changing the system parameters (smaller district, using d’Hondt method). This was vehemently opposed by smaller parties and blocked by the Constitutional Court since it was considered as going too much against the proportionality principle stated in the Constitution. The outcome was that only a moderate form was adopted. This however, led to a stalemate in the 2006 elections since both the left and the right gained exactly 100 seats, while the earlier system would have given the right a 3-4 seats majority.

position due to the ČSSD's loss in the 2004 European Parliamentary Elections, he was followed by Stanislav Gross and Jiří Paroubek.

The period of social democratic rule ended by electoral victory and the comeback on the political stage of their main opponent, the ODS, in the elections held in June 2006. While these elections produced an almost evenly balanced distribution of seats in terms of potential right- or left-wing coalitions, the ODS turned out to be more successful than the ČSSD, gaining a vote of confidence in the Parliament together with the KDU-ČSL and the Green Party (*Strana zelených - SZ*), taking exactly half of the seats. The government was led by Topolánek, and managed to stay in power for almost 3 years when, after losing the vote of confidence, it was replaced by the caretaker government of Jan Fischer in May 2009.

Table 7. Czech political compositions and main healthcare reforms, 1989-2009.

Period	Party composition of the Government Prime Minister President	Minister of Health	Healthcare reform
02/1990 - 07/1992	OF Petr Pithart	Martin Bojar	The Law on General Health Insurance The Law on the General Health Insurance Funds
07/1992 – 01/1993	ODS-KDS+ODA+KDU+ČSL Václav Klaus Václav Havel	Petr Lom	The Law on Departmental, Professional, Corporate, and other Health Insurance Funds The Law on Healthcare in Non-State Healthcare Facilities
01/1993 – 12/1997	ODS+KDU-ČSL+ ODA Václav Klaus Václav Havel	Petr Lom, Ludek Rubaš, Jan Stráský	The Law on Public Health Insurance
12/1997 – 07/1998	Josef Tošovský (caretaker)	Jan Stráský	
07/1998 – 07/2002	ČSSD Miloš Zeman Václav Havel	Zuzana Roithová, Ivan David, Bohumil Fišer	
07/2002 – 08/2006	ČSSD+KDU-ČSL+US-DEU Vladimír Špidla, Stanislav Gross, Jiří Paroubek Václav Havel, Václav Klaus	Marie Součková, Jozef Kubinyi, Milada Emmerová, David Rath	
08/2006 - 05/2009	ODS ODS+KDU-ČSL+SZ Mirek Topolánek Václav Klaus	Tomaš Julínek, Daniela Filipiova	Law on Public Budget Stabilization (user fees)

Source: various.

This brief overview of the electoral dynamic and the post-electoral process of government formation shows that the Czech party system displayed relative stability already by the end of the first post-socialist decade (see Toole 2000). Among the party systems of post-socialist democracies, the Czech system earned a reputation as one of the most consolidated party systems, characterized by a high level of institutionalization (Casal Bértoa and Mair 2010; Casal Bértoa 2011). One of the elements that contributed to the system's fast consolidation is said to be the specific role played on the political scene by the communist successor party, the Communist Party of Bohemia and Moravia (*Komunistická strana Čech a Moravy – KSČM*) (Eibl and Chytilík 2007). Even though all parties had an agreement to exclude the *KSČM* from coalitions,

and the party itself experienced fluctuating electoral success, the party's presence on the Czech political scene had a significant effect on the logic of electoral competition and post-electoral negotiations, since the convention to exclude the *KSČM* significantly limited the manoeuvrability of the other parties. In this way, the restricted space available for designing majority governments offered limited possibilities for government alteration (ibid. p. 175).

The relatively consolidated and institutionalized Czech party system had a significant effect on the transformation of the healthcare sector. The capitulation of the communist Czechoslovakian regime created conditions for an undisturbed transition to democracy, while the rather peaceful breakup of the Czechoslovak federation and the passing of the 1992 Constitution led to the establishment of strong parliamentarism with rather limited presidential powers. There was a fast stabilization of the country's party system, and its patterns of political competition were strengthened through a proportional but cohesive electoral system. Electoral rules tempered party proliferation by creating relatively strong party discipline and low incentives for the formation of smaller parties, so that the dynamics of party competition and coalition forming followed an established pattern, with not much innovation, but which significantly contributed to the stability of government. Furthermore, the relatively quick 'freezing' of one dominant cleavage of political competition, focused on socio-economic issues, contributed to the parties, in general, defining themselves clearly on the issues of healthcare reforms. As the reader will soon see, these political and institutional dynamics significantly facilitated the process of policy change, especially during the early transitional period, making Czech healthcare reforms an example of a joint effect of ideas, interests and institutions. Political stability enabled relatively stable linking of expert ideas with political interests, which in turn enabled the development of more concrete reform proposals. At the same time, strong parliamentarism created institutional conditions that enabled the passing of the comprehensive reform plan that would dramatically change the Czech healthcare sector.

2.3. Economic and social transition

In contrast to the Polish, the Czech socio-economic transition was characterized by careful planning of economic reforms, matched with both short- and long-term measures of welfare state transformation. Relatively favourable economic conditions and decisive neo-liberal guidance for the Czech economic transition under Finance Minister Klaus protected the country from the pressures of international organizations. This made possible the design of the country's own economic policy, in which privatisation played a crucial role, and which tried to establish unique "Czech capitalism". The welfare state policy, in contrast, followed a social democratic

project, which had been initiated by the Ministry of Labour and Social Affairs already during the federal period. Coupled with the neo-liberal reforms in the economy, the political success of the Czech ‘social-liberal hybrid’ developed the image of a successful transition, which in turn created a positive, market-oriented climate and boosted government confidence in the introduction of wide-ranging reforms, one of which was the comprehensive healthcare reform of the early 1990s.¹⁸⁶

Economic transition

As in Poland, the approach to economic transition in the Czech Republic was based on “Shock Therapy”. One of the most ardent supporters of the fast neo-liberal economic reforms in the country was Václav Klaus, a former research economist, who after the Velvet Revolution became the Minister of Finance in the federal government, and later the Czech Prime Minister. Klaus’ approach to the Czech economic transition was extremely neo-liberal, and he proclaimed that his plan was to introduce a “market economy without an adjective”.¹⁸⁷ The fundamental principles of the transformation strategy, prepared by Klaus and his team, were presented in a document published on April 20th 1990 by the federal Ministry of Finance, entitled “Strategy for Economic Reform”. After several months of parliamentary discussion, this strategy was approved on September 17th 1990 as “The Scenario for Economic Reform” (Myant 2003: 17-8).¹⁸⁸ The fundamental reform principles stated in this document followed closely the prescriptions of the Washington Consensus, as they emphasized the necessity of a “Shock Therapy” approach to the Czech economy, i.e. rapid reforms focused on the achievement of the macroeconomic balance. The scenario therefore included measures such as deregulation, price liberalization and foreign trade liberalization, privatization and support of private sector development, as well as a restrictive stabilization policy. Even though the reform scenario followed the general prescriptions of foreign economic advisors, what was very specific about it was that it also included some important elements of innovation, such as voucher privatization and the endeavour to create a strong national capital, both of which were supposed to lead to the creation of a specific “Czech capitalism” (Sojka 2000: 234).

¹⁸⁶ The early introduction of the insurance system, as it will later turn out, was crucial as it protected the healthcare sector from the direct impacts of the fiscal crisis of the State that ensued in cycles after the implementation of the radical economic reforms.

¹⁸⁷ Klaus’ attitude was also described as “narrow and dogmatic, defended by an arrogance that ruled out receptiveness to alternative views” (Myant 2003: 2).

¹⁸⁸ According to Myant (2003: 18), the initial plan of the Klaus team was approved quickly in the Parliament since he “had no interest in accepting any changes when all the criticism was coming from a more ‘gradualist’ approach”.

The voucher privatization became the flagship policy of the Klaus reform team, as it stood at the heart of their hopes of creating a dynamic and vibrant “Czech capitalism” (Myant 2003: 114). The main institutional innovation of the privatization programme was the use of citizen vouchers in public auctions selling shares of large state-owned enterprises (SEOs). The programme involved the distribution of over 50% of equity of more than 1 000 SEOs.¹⁸⁹ Since the actual process of exchanging vouchers for shares was complex, the government undertook a major project in the attempt to educate the public about its basic principles and logic (Bruszt and Stark 1998: 91-2). The privatization programme was implemented in two waves, the first wave starting in 1992 and the second wave completed by the end of 1994. As a whole, the programme was essentially based on the neo-liberal idea that the process of property distribution should be market-mediated and that the process of share distribution to the population would guarantee that distribution with the greatest speed and certainty (Drahokupil 2009: 66). Citizens’ participation in the voucher schemes turned out to be quite high, since 78% of the adult Czech population in the first, and 81% in the second wave took part in the programme (Appel 2004: 60). The dominant owners after the two waves became Privatization Investment Funds (*Investiční privatizační fond*), which concentrated individuals’ voucher points (Myant 2003: 117-20). In the eyes of the public, voucher privatization was initially perceived quite positively, since the majority of Czechs became enthusiastically involved in bidding for shares, seeing them as free gifts of individual wealth.¹⁹⁰ However, its popularity significantly decreased by the end of the 1990s, when as a consequence of individual transactions, shares became concentrated in the hands of a few consolidated institutional investors, and the remaining individual share owners experienced a lack of control over management of the privatized companies (Večerník and Matějů 1999: 74).

The voucher privatization was part of a national economic strategy of the neoliberal reformers to create Czech national capital in the early 1990s (Drahokupil 2009).¹⁹¹ As an internally oriented project, based on a mix of domestic neoliberal and nationalist economic ideas, this strategy formed a clear preference for the creation of a domestic capitalist class, instead of opening the doors for the participation of foreign investors. The strategy was based on a firm belief in the enormous economic potential for building a strong Czech capitalism, and had a

¹⁸⁹ Each Czech citizen over 18 years of age received vouchers equal to 1000 investment points. These investment points could be exchanged for shares in the enterprises designated for privatization through the voucher programme. In order to be able to use the vouchers, citizens had to pay a registration fee of 1000 Czech crowns (Bruszt and Stark 1998: 91)

¹⁹⁰ Thanks to the voucher privatization, for a short period of time the Czech Republic occupied the top position in the number of shareholders per inhabitant, worldwide (Večerník and Matějů 1999: 72).

¹⁹¹ Based on the ‘hands-off’ model, it was incompatible with the entry of foreign direct investment, which demanded an active approach by the state to secure contractual commitments required by the investors (Drahokupil 2009: 60-61).

strong political rationale, since the flagship policy of the reform team, the rapid implementation of the voucher privatization, was considered crucial for the creation of a stable social support for capitalism, both on the popular and on the level of class formation (Appel 2004; Drahokoupil 2009).¹⁹² This early attempt at creating a specific “Czech capitalism”, however, soon turned out to be a failure, and was even considered as the key factor behind the transitional depression of the early 1990s (Myant 2003). Luckily, the failure of this attempt was not too detrimental for the country’s economy, since through a “trial and error” pattern, Czech policymakers managed to re-orient their neoliberal policy. They started to consider other factors as basis for renewed growth, the most important of which were foreign direct investments (FDIs) in parts of the manufacturing industry (Zemplerová and Benáček 1997; Drahokoupil 2009). The final outcome of this economic engineering was that successful capitalism in the Czech Republic, by the beginning of the 2000s, became increasingly foreign rather than Czech-owned (Myant 2003).

Table 8. Main economic indicators, Czech Republic, 1993-2009.

Indicator/ Year	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
GDP growth rate	0.1	2.9	6.2	4.5	-0.9	-0.2	1.7	4.2	3.1	2.1	3.8	4.7	6.8	7.0	5.7	3.1	-4.5
Inflation rate*	20.8	10.0	9.1	8.8	8.5	10.7	2.1	3.9	4.7	1.8	0.1	2.8	1.9	2.6	3.0	6.3	1.0
Unemployment rate	4.3	4.3	3.0	3.9	4.8	6.5	8.7	8.8	8.1	7.3	7.8	8.3	7.9	7.1	5.3	4.4	6.7
FDI inward stock as % of GDP	8.8	10.0	12.7	13.2	15.5	22.5	28.2	36.8	42.1	49.4	47.5	50.2	46.6	53.8	62.3	50.2	64.1

Source: OECD (available at <http://www.oecd.org/statistics>).

The Czech economy during transition witnessed relatively smooth and positive developments. The first transitional crisis, the so-called “transformation depression,” was most visible in the GDP decline of 22% from 1990 to 1993. The decline was nevertheless followed by a considerable GDP growth and reduction in inflation and unemployment, in the period from 1994 to 1996, which was labelled as the “golden age” of early Czech capitalism (Myant 2003: 51).

¹⁹² The method was expected to perform a long-term ideological and socializing function. Karel Dyba, Minister of Economic Policy and Development (1990-1992), explained that the Czech, in contrast to the Poles, had no experience with the market economy. Therefore, the purpose of the reform was to change people’s minds with respect to their understanding of economics and politics (Drahokoupil 2009: 68).

Two other important indicators, inflation and unemployment, became the most outstanding features of the Czech economy (table 12). A very low inflation rate in the period of radical economic restructuring was considered by international economic experts to be the most impressive Czech transitional achievement (Aghevli et al. 1992). Another accomplishment was a remarkably low rate of unemployment, well below the expected level. The impressive achievements of the “golden age” notwithstanding, the first signs of a slowdown were occurring already in 1996. By 1997, the country plunged into its second transitional crisis, mainly caused by an enormous increase in the external imbalance (Myant 2003). The same year, two emergency packages were passed involving budget cuts of 25.5 and 20 billion Czech crowns, equivalent to 3% of the GDP (ibid. p. 52). This helped the economy to recuperate, and the crisis was displaced by another period of growth. The new growth phase was mainly stimulated by an accelerated inflow of FDIs, which in the early 2000s increased so dramatically that they amounted to half of the country’s annual GDP. Apart from the significant FDI growth, macroeconomic developments of the second post-socialist decade were comparably stable, with low unemployment levels and significantly decreased inflation.

Social transition

The last two years of the Czechoslovak federal state, 1990-1992, presented the crucial period for post-socialist welfare state building, since they witnessed the emergence of a plan for social policy reform. This plan was based on a compromise of social democratic and liberal forces in the country (Orenstein 1995; Potůček and Radičova 1997; Potůček 1999). While the team dealing with economic policy, led by the Finance Minister Klaus, focused on neo-liberal solutions and paid little attention to social policy, a team of social policy experts led by Petr Miller, Minister of Labour and Social Affairs, and his Deputy Minister Igor Tomeš prepared a plan for social policy reform with a strong social democratic orientation (Inglot 2008). Because of their diverging visions, the two teams nevertheless entered an intense debate that eventually led to a compromise, incorporated into the “Radical Strategy of Economic Reforms”. This document contained the plan for social reform which was entirely designed by the Ministry of Labour and Social Affairs and based on a political pact.¹⁹³ The result of this compromise was a “social-liberal hybrid” that envisaged the construction of the basic institutions of a new welfare state that would be concurrent with the neo-liberal economic reform (Inglot 2008: 180).

¹⁹³ According to Myant (2003: 177), the social policy reform plan had the character of a political pact since Klaus needed the votes of some social democrats to get his programme of economic reform passed through the Government, so he integrated into his own economic programme a social policy section drafted entirely by Petr Miller and his team.

This social-liberal hybrid had both a short-term and a long-term component (Orenstein 1995). The short-term policies, also labelled as “emergency policies”, aimed to provide a reliable safety net for the most vulnerable social groups, on the path toward the market transition (ibid. p. 194). Some of the most important measures included policies focused on citizens’ protection from the vast increase in food prices caused by price liberalization, through compensation payments and changes in food taxation.¹⁹⁴ Other policies focused on the provision of government subsidies for basic consumer costs, such as rent, heat, electricity and transport (ibid. p. 182). While these short-term policies were clearly intended to compensate for the social costs of economic transition, the long-term measures were aimed at a lasting reconstruction of the social security net. They contained strong social democratic components, such as policies focused on the introduction of a ‘living minimum’, which defined the lowest guaranteed level of social income by providing a universal standard for minimum pensions, social benefits, unemployment benefits, as well as wages. Another important element of the long-term measures was the tax reform that instituted separate payroll taxes for social security benefits, pensions and sickness insurance, unemployment benefits, and health insurance. The introduction of the payroll tax was a major step in the reform of the social sectors since it made them independent from the state budget, safeguarding them from budget cuts (ibid. p. 185).¹⁹⁵

The social-liberal welfare model conceived during the early transitional years created the basis for the development of the post-socialist welfare state in the Czech Republic (Inglo 2008). After 1993, the Czech government continued to promote this model, combining social democratic entitlements, in the sphere of pensions and family protection, with the liberal incentives for the middle class, such as voluntary private pensions and tax breaks. The widespread popularity of this welfare model has been explained by its relative success in the attempt to reconstruct previous social policy settlements. This implied not only the perpetuation of the universalistic goals of the National Social Insurance Act from 1948, but also the maintenance of a balanced mix of cash benefits and social services developed during the socialist era, along with the better integration of the social policy laws with the labour market and the changing economic system of the country (ibid. p. 77). The success of the social-liberal model

¹⁹⁴ The government transferred 56 million Czech crowns from price subsidies to cash supplements paid to all wage earners and recipients of social benefits. Planned for three years, the State Compensation Allowance Act in 1991 instituted a monthly cash allowance of 140 crowns per household as compensation for increases in food prices (Inglo 2008: 222).

¹⁹⁵ In fact, pension and sickness benefits were not fully separated from the state budget, and this became a source of dispute between the government and the trade unions. Government’s unwillingness to create an independent fund was explained by the fear that the state would have to surrender the possibility of not only formulating, but also directly pursuing particular social policy goals (interview with the Minister of Labour and Social Affairs, Jindoich Vodicka, in *Ekonom* 41: 1993).

has also been attributed to a skilful combination of pro-market rhetoric with active welfare policies by the Czech government (Sirovátka and Rákoczyová 2009),¹⁹⁶ as well as to the powerful welfare ministry with a highly disciplined and administrative apparatus (Inglot 2008).

2.4. Interest groups

After the regime change in 1989, the Czech trade unions, similar to the trade unions in other countries across CEE, suffered from a post-communist crisis of identity. One of the main causes of this crisis was the unions' legitimacy. Given that under socialism trade unions enjoyed close connections with the regime, in the new democratic setting they were not perceived as legitimate social actors (Pollert 2001). Despite institutional reform in the major union organizations, including the break-up with the political parties and replacement of their leaders, Czech unions received very unfavourable coverage by the media, which portrayed them as essentially communist and anti-democratic organizations (Appel 2004: 136-7). The consequence of this identity crisis was that the Czech unions and their members resorted to passivity and quiescence (see Greskovits 1998). This explains why in the early 1990s, union representatives agreed with many of the Klaus neo-liberal reform policies, including those focused on the cutting of real wages. During the privatization process, the unions lobbied unsuccessfully for an increase in the ownership share of employees in private enterprises. They also failed to acquire the shares allotted to them in the original reform programme, "Scenario of the Economic Reforms" (Drahokoupil 2009: 64). The outcome of these multiple incapacities was that the perspective of the unions, and of their members in particular, largely overlapped with that of radical reformers. This led some critics to conclude that organized labour's failure to adapt to new economic and political conditions had rendered Czech unions "emasculated" or "politically feeble" (Orenstein and Hale 2001: 259).¹⁹⁷

If during the early transition the quiescence strategy was by some perceived as a signal of relative union strength, by the end of 1990s it became clear that the remaining Czech trade unions' advantages had gradually dissolved (Ost 2001). Unions started to significantly lose influence over policy process after 1994, when the Klaus government stopped signing even the

¹⁹⁶ Vanhuyse (2006) writes about the Czech brand of social and economic "exceptionalism" within the CEE region, showing that throughout the 1990s Klaus' governments were *de facto* proactively social democratic in their social policies, and only rhetorically neo-liberal (ibid. 1125-9).

¹⁹⁷ One of the symptomatic cases of Czech trade unions' quiescence with the programme of neo-liberal reforms is that in April 1990, at the constitutive meeting of the Czechoslovakian Confederation of Trade Unions, later named Czech-Moravian Confederation of Trade Unions (*Českomoravská konfederace odborových svazů - ČMKOS*), the elected chairman was Vladimír Petrus, who later became a member of the Klaus Civic Democratic Party (Drahokoupil 2009).

weak annual agreements that had been earlier negotiated with the union federation (ibid. p. 87). Another indicator of significantly weakened union influence on the early process of socio-economic reform was a progressive dissolution of union membership during the early transition. The most progressive loss of trade union membership happened during the early transition. From 1990 to 1995, union density halved (Ost 2001). The reasons for such a drastic membership loss were twofold - the end of compulsory union affiliation characteristic for socialism and the privatization process, which led to the restructuring of the labour force (Orenstein and Hale 2001). A continued reduction in trade union density resulted in a meagre 17.3% in 2009 (OECD 2012).

At the same time, the country witnessed a rebirth of national corporatist institutions. The Council of Economic and Social Agreement (*Rada hospodářské a sociální dohody ČR*,) was created in October 1990, following a voluntary agreement established between the government, the unions and business associations. With the establishment of the Council as the country's main tripartite institution, the *ČMKOS*, the strongest trade union confederation representing around 30 different unions, quickly emerged as a key government partner. While this early development of instruments of social dialogue was supposed to become a cornerstone of Czech corporatism, it was qualified as rather "illusionary" (Ost 2000). Czech corporatism reflected the government's transitional strategy to incorporate organized labour in the policy discourse, at a time when liberalizing economic reforms were taking a heavy toll on the interests of labour (Kubicek 1999, Ost 2000). This explains why in practice the early activities of the Council and its efforts to construct social dialogue were characterized by fragile compromises and constant tensions. The situation was slightly improved when the government allowed the continuation of the corporative, branching system of industrial relations at central, sectorial, and enterprise levels. In exchange, it expected unions to respect the tripartite structure, not to mobilize their members, and to come to terms with their inferior position in negotiations on fundamental issues of salaries and social policy (Potůček and Radičova 1997: 6). Hence, while unions continued to maintain some influence through their bargaining position, their role in social dialogue was continuously on the wane until the mid-1990s (Orenstein 1995). The rise of social democrats in power in 1998 improved the social dialogue, since the *ČMKOS*, had managed in the meantime to develop closer affiliation with the Social Democratic Party. During the 2000s, even though union structure stabilized and a decentralized bargaining structure was strengthened through EU

accession, the unions' role in the policymaking process depended on the political orientation of the government.¹⁹⁸

Similarly to Czech industrial relations, low union density and decentralized bargaining stand out as distinguishing features of interest group representation in the healthcare sector. There were three main trade unions that emerged in the sector (table 13). The first two were the Trade Union of Health Service and Social Care of the Czech Republic (*Odborový svaz zdravotnictví a sociální péče České republiky - OSZSP*) and the Professional Trade Union of Medical Workers of Bohemia, Moravia and Silesia (*Profesní odborová unie zdravotnických pracovníků Čech, Moravy a Slezka - POUZPČMS*). While the former represents the biggest trade union in the sector, affiliated with the ČMKOS, involved in tripartite bargaining on both the national and company level, the latter is smaller and participates only in company level bargaining. The third important union to emerge was the Trade Union of Doctors in the Czech Republic (*Lékařský Odborový Klub - Svaz Českých Lékařů - LOK – SČL*), which represents the interests of those doctors that are mostly hospital employees. The main subject matter of collective bargaining, which is held exclusively at company-level, has been the working conditions and pay of doctors and healthcare workers (Veverkova 2012).¹⁹⁹ Of all the unions, only the OSZSP, which is able to participate in the tripartite meetings of the Council for Social and Economic Agreement through its membership of the ČMKOS, has been involved in the negotiations over policy reforms with the Government since the early transition.

¹⁹⁸ The collective bargaining coverage in 2008 was 47% of all employer contracts, while the company level bargaining became the most important form of collective bargaining (Myant 2010).

¹⁹⁹ The reason why there are only company-level collective agreements in the health sector is that even though there are several employer organizations that operate in the sector, they do not participate in the collective bargaining process. Higher-level collective agreements therefore cannot be concluded because a contractual partner – employer organisation – is missing (see Veverkova 2012).

Table 9. Main healthcare unions in the Czech Republic.

Name	Affiliation	Membership
Trade Union of the Health Service and Social Care of the Czech Republic (<i>Odborový svaz zdravotnictví a sociální péče České republiky - OSZSP</i>)	Czech-Moravian Confederation of Trade Unions (<i>Českomoravská konfederace odborových svazů - ČMKOS</i>)	30.000
Professional and Trade Union of Medical Workers of Bohemia, Moravia and Silesia (<i>Profesní odborová unie zdravotnických pracovníků Čech, Moravy a Slezska - POUZPČMS</i>)	No affiliation.	n.a.
Trade Union of Doctors in the Czech Republic (<i>Lékařský Odborový Klub - Svaz Českých Lékařů</i>)	No affiliation.	n.a.

Source: Eironline 2010.

The Czech chamber of physicians was established in 1992. The Medical Chamber Law, as it will later be shown, was a matter of discussion between the government and parliament, the former arguing that the law gave a monopoly of power to the Chamber, without clear responsibility. However, some doctors who were members of the Parliament Health Committee managed to persuade some parliamentarians to vote in favour of the Chamber law. This led to a lasting tension between the Chamber and the Government. The Chamber was mandated to exercise professional control over the profession, to guarantee a high quality of care, and to provide licences for medical practice. However, this professional responsibility was not very visible, since the Chamber became more active in the advocacy of professional interests, and often seemed to behave like a trade union rather than professional association (Jaroš et al. 2005: 220). In Parliament, doctors were concentrated in the Health Committee, which tried to promote the policy preferences of healthcare professionals. Through this Committee, Parliament became an active health policy actor because the number of doctors with parliamentary positions significantly increased right after the political change in 1989. The growth of doctors' participation in politics, both as parliamentarians and as healthcare ministers, significantly increased their influence on the policy making process. At the same time, however, frequent clashes between the three most important channels of professional participation in the policy

process – the Ministry of Health, the Medical Chamber and the parliamentary Health Committee – suggested that professional interests were far from homogenous.

3. Post-Communist Healthcare Reforms

Immediately after the Velvet Revolution, Czech policymakers started to work on reform proposals that would lay the ground for sweeping changes in the healthcare sector. An organisation which was a part of the Civic Forum, called the Civic Forum of Health Professionals (*Občanské fórum zdravotníků - OFZ*), became one of the main reform actors during the first several weeks following the Velvet Revolution of November 1989. The *OFZ*'s Prague branch quickly published a document in the medical newspaper *Zdravotnické noviny*, entitled “The Principles of Healthcare Reform in Czechoslovakia”.²⁰⁰ This document was clearly in line with the expert reports from the 1980s, as it was highly critical of the socialist system of healthcare organization and argued that there was a need for major reform (Interview Potůček). While it offered some rather rudimentary reform ideas, this document, as it would soon transpire, was important, as it stimulated the debate on the future of healthcare and the development of different reform proposals for change.

3.1. The first ministerial proposal

The first post-communist Minister of Health, Pavel Klener, who was appointed Minister in the temporary cabinet with mandate until the first free elections in June 1990, was open to reform ideas and initiated an official preparation for healthcare reform. Even though Klener's time in office was limited to only six months, he appointed an external multi-disciplinary team of experts to work on the reform plan. This team was headed by a researcher from the Institute of Social Medicine and Organisation of Health Care, Martin Potůček,²⁰¹ and in several months elaborated the first official post-communist proposal for health reform. Minister Klener, according to one of the experts from this team, recognized the need for comprehensive reform and became interested in collaborating with his external team as “he was clever enough to learn

²⁰⁰ *Teze k programu zdravotní. Praha, Programová skupina Občanského fóra zdravotníků, Svazových lékařů a Zvázu slovenských lékařov. Zdravotnické noviny 1990.*

²⁰¹ Potůček was one of the authors of the reports that emerged in the 1980s.

soon that he cannot learn much from the old bureaucrats” (Interview Potůček).²⁰² The proposal of the Potůček’s team was published in May 1990 as “Proposal for Health Care Reform”.²⁰³

This proposal put forward two alternative options for the reform, with an implementation timeline of four to five years. Both alternatives entailed the dissolution of the existing Regional and District Institutes for National Health, and a bottom-up formation of the new organisational structure of healthcare delivery. According to the first alternative, healthcare facilities would become independent public institutions, which would organize themselves into Associations of Health Care Facilities, in order to optimise healthcare provision within a given area. The existing health authorities would be replaced by Health Councils, which would develop the overall health policy for a given area, approve the budgets of the Associations and nominate candidates for the administration. Health Councils would be made up of local councillors, health professionals and representatives of health organisations. The second alternative envisaged that municipalities and local communities would assume the ownership and administration of healthcare facilities on their territory. In respect of financing, the proposal advocated the introduction of both mandatory and voluntary health insurance and the creation of multiple health insurance funds. Beside insurance contributions, it also suggested multiple sources for the financing of healthcare, including the state budget, the budgets of local authorities, voluntary donations and patient co-payments. Finally, it recommended devolving oversight of the medical profession from the State to an autonomous chamber of physicians.

3.2. Reform proposal under Pithart’s Government

After the first free parliamentary elections in June 1990, the Ministry of Health and Social Affairs became divided into two separate institutions: the Ministry of Health and the Ministry of Labour and Social Affairs (Jaroš et al. 2005). This enabled the new Health Ministry to pursue the reform agenda relatively independently of the rest of the social policy team in the Labour Ministry, headed by Tomeš and his colleagues. After the elections, the winning party, the Civic Forum, appointed Martin Bojar, one of the leaders of the *OFZ*, as the Minister of Health. Minister Bojar was a member of Potůček’s reform team and he appointed others of his team members to senior posts in the Ministry. The Deputy Health Minister and the Director of the Health Policy Department, for example, was Kamil Kalina, who would quickly emerge as the

²⁰² According to this expert, at the beginning the bureaucrats working in the Ministry wanted to launch a proposal that would be alternative to the proposal of Potůček’s team, but they soon turned out to be “not able to produce it so that, after some months, some of them decided to join our team” (Interview Potůček).

²⁰³ *Návrh reformy zdravotnictví, Ministerstvo zdravotnictví, květen 1990.*

leader of the Ministry's reform team (Interview Potůček).²⁰⁴ Some positions in the Ministry were also offered to old 1968 activists of the "Prague Spring", such as Zbyněk Novotný, who became the advisor to Minister Bojar.

The drafting of the new reform proposal began in the context of a significant lack of administrative and legislative capacity, and its development was significantly inspired by foreign healthcare legislation (Interview Volf). Nevertheless, within the first six months of its existence, Kalina's reform team managed to prepare a new reform draft and in October 1990, the Ministry managed to publish "The Proposal for a New Health Care System".²⁰⁵ This new reform plan drew upon the previous proposals of the Potůček team, but advocated a much more liberal-minded, market-oriented approach and, instead of offering alternatives, made definitive policy choices. Similarly to the previous proposal, it advocated the dissolution of the Regional and District Institutes for National Health and a bottom-up formation of the new local government structure for healthcare facilities. It too did not make specific provisions in respect of ownership arrangements, stating that most healthcare facilities should be retained in public ownership, but also outlining the possibility that facilities could be transferred to local authorities, which would then be free to decide whether to privatize them or not. In contrast to the previous proposal, this proposal envisaged the introduction of mandatory healthcare insurance that would be administered by one public healthcare insurance fund, but also considered the possibility of establishing additional private health insurance funds. It also envisaged competition among healthcare providers according to the 'money follows patient' principle, which would be created through a fee-for-service (FFS) remuneration method. In terms of implementation, this proposal was more ambitious, arguing that the implementation process would take just two years (Interview Potůček).

Since views as to the exact shape of the insurance system within the Ministry differed, this led to the development of another, much less market-oriented reform proposal (Burda et al. 1991). This proposal was prepared by a group of healthcare professionals and experts from the Institute for Social Medicine and Healthcare Organisation. It replaced the competitive insurance system with a system of territorially based insurance funds and argued not for the very liberal FFS, but rather for a mix of remuneration methods that would be based on salaries, capitation fees and FFS.

²⁰⁴ Kalina advocated quite radical and liberal approach to reforms, which would soon prompt several members of his reform team to leave the Ministry (Interview Potůček).

²⁰⁵ *Návrh nového systému zdravotní péče, Ministerstvo zdravotnictví, říjen 1990.*

In the meantime, large Czech hospitals had already started experimenting with the FFS system. Favouring the reform proposal of Kalina's team, many medical professionals openly expressed their preference for the introduction of its plan for reforms. During and after the Velvet Revolution, the public popularity of medical professionals actually increased, due to the activism of many healthcare professionals within the Civic Forum. What was very interesting is that the Ministry's proposal drew upon this popularity and stressed the important role of the medical profession (Jaroš et al. 2005: 204). The proposal, for example, stated:

“If [the system of healthcare] has not yet collapsed, this is only due to the moral motivation of the greater part of healthcare workers, to which they adhered even under such unfavourable conditions and exerted considerable efforts to benefit patients and maintain their professional standard. Thanks to this motivation, the majority of medical branches have not lost complete touch of world medicine, in spite of all the barriers that separated us from the international medical community. However, in the last few years, the moral reserves of our health services have been exhausted.” (Kalina et al. 1991).

Doctors in particular managed to gain notable political influence during this early period, mainly through their individual involvement in the government, in parliament and in numerous local councils (Jaroš et al. 2005: 205). They believed that the introduction of a competitive health insurance system with an FFS reimbursement method would significantly help them to improve their position. After four decades of communist suppression of professional independence and of low pay, these doctors were looking at neighbouring countries such as Germany and Austria, where their colleagues were well off and enjoyed a high degree of professional independence, coupled with high social and economic prestige, and wanted something of that status for themselves. The views about the benefits of the insurance system for healthcare professionals were also promoted by Czech doctors who during communism left the country and were in exile but with the political change of 1989, came back to give their colleagues a hand in the reform process (Interview Potůček). All of these factors resulted in the strong support of healthcare professionals for the Ministry's reform plan.

As it will soon become clear, the development of healthcare reform proposals during Pithart's government was crucial in the preparation for the sweeping change that would take place in the Czech healthcare sector quickly after the fall of communism. The specific dynamic that developed between, on the one hand, the reform proposals built on expert ideas initially developed under communism and now formulated as more concrete reform plans, and on the other hand, the interests of the political parties and healthcare professionals, suggests that the

linking of ideas with interests was one of the crucial factors of policy change. Indeed, the fact that experts were so closely collaborating with the government, which included special reference to healthcare professional in their reform plan, suggests that they were quite aware of the necessity of getting political and professional support for their ideas. That this dynamic was very strong and one of the crucial factors of the incoming healthcare reform would also become clear from the rejection of the World Bank reform proposal.

3.3. The World Bank proposal

While the proposals presented under Pithart's government evidenced a lively policy dynamic between ideas and interests of Czech experts and medical professionals, the international expert community was simultaneously actively trying to offer consultancy for Czech healthcare reform, and formulate their own scenarios. One of the most interested in giving a hand to Czech policy makers was the World Bank, whose experts published a study dedicated to the issues and reform priorities in the Czech health sector (World Bank 1991). Despite the close collaboration of Czech experts with their international colleagues, the Bank proposals were faced with a predominantly negative attitude of government officials toward the recommendations from international organisations. A signal of this reluctance to accept international advice was sent immediately, when in 1991 the government rejected the Bank's loan for the health sector, offered in exchange for oversight of the reform process. As reason for the rejection, the Government stated its firm belief that prudent financial policy should be focused on avoiding loans and approaching debts cautiously, mistrusting views from abroad and consequently not accepting international expert intervention in national policy.²⁰⁶

3.4. Comprehensive reform in 1991 and 1992

In the meantime, the proposal of the Kalina Ministry team, which was more liberal and market-oriented than the alternative proposal of the external experts' team, achieved more success. The Ministry's proposal was more favoured by the federal Minister of Finance, Klaus, whose strong neo-liberal leaning made the passing of the proposal through the hands of the Finance Minister rather easy, so that just two months after its publication, in December 1990, the proposal of the Ministry's team was approved by the government as the official programme for healthcare reform (Jaroš et al. 2005). Following the acceptance of the Ministry's proposal, the team prepared a set of bills that Parliament, dominated by the Civic Forum, quickly approved,

²⁰⁶ Finance Minister Klaus rejected the Bank's consultancy saying that he is not ready to pay hard money for soft advice (Interview Volf).

passing a set of laws that would comprehensively reform Czech healthcare. The first two laws from this set were introduced in June 1991; the Law on General Health Insurance (Law No. 550/1991) and the Law on the General Health Insurance Fund (Law No. 551/1991). To these, two other laws were added in April 1992 - the Law on Departmental, Professional, Corporate, and other Health Insurance Funds (Law No. 280/1992) and the Law on Healthcare in Non-State Healthcare Facilities (Law No. 160/1992).

The first law introduced a mandatory insurance system of healthcare based on payroll contributions which amounted to 13.5% of workers' wages, 4.5% of which would be paid by the employee and 9% by the employer.²⁰⁷ It also specified FFS as the main reimbursement method for services provided by both private and public healthcare providers. The second law established the General Insurance Fund (GHIF), while the third allowed for the establishment of additional health insurance funds (HIFs).²⁰⁸ It envisaged that any population group of 50 000, and different occupational profiles such as miners, teachers, transportation workers, could set up their own insurance fund. The fund would be required to cover the government's list of health benefits and to pay for services using the legal remuneration schemes. In order to spur competition, the law also envisaged that the clients of the funds would be able to change them, if they wish so, every six months and also allowed HIFs to offer services in addition to the basic benefit package. The law on non-state healthcare facilities envisaged decentralization and allowed for private forms of ownership of healthcare facilities.

While none of these laws was opposed in parliament, the Law on Medical Chambers that had been passed with the other two laws in 1992 turned out to be the most contentious. This law envisaged obligatory membership in the Chamber for all Czech physicians, and Prime Minister Klaus was against this, arguing that it would create a monopoly of professional interests' representation. The law was nevertheless passed, since it was strongly supported by the parliamentary Social Policy and Health Policy Committee, and the Chairman of the Committee, Petr Lom, who would later also become Health Minister, was successful in persuading Members of Parliament as to the necessity of professional independence and the importance this independence would have in the new privatized and competitive insurance system (PP CTK 1992).

²⁰⁷ The law also stated that the government would pay contributions for workers' dependents and the unemployed, while the self-employed would be obliged to pay the entire premium, calculated as 13.5% of 35% of their income before taxation.

²⁰⁸ Competition between these private funds and GHIF would be in quality of services and perhaps additional services, if they could find the way to provide them with the same funds. The funds were supposed to derive savings by negotiating lower point prices within the FFS scheme with physicians and hospitals (Scheffler 1999).

The passing of these comprehensive reforms, which would dramatically change the structure and the working logic of the Czech healthcare system, demonstrates the crucial role played by political dynamic in the process of healthcare policy change. The decisive extrication of the country from communism through the capitulation of the old regime immediately created favourable political conditions for the formulation of radical market-oriented reform proposals, in which no negotiation with the Communists was needed. The electoral victory of the anti-communist parties at the 1990 Czechoslovak elections and the subsequent creation of a government with a strong majority in the legislature was another crucial factor in the comprehensive transformation of the socialist ‘Semashko’ system into its market-oriented ‘Bismarkian’ counterpart.

3.5. Implementation problems

The Government’s timetable for the implementation of the four laws was very ambitious - it envisaged that the shift to the new insurance system would take only two years and could be roughly completed by 1993. Within this short period, healthcare provision witnessed radical changes. In financing, the introduction of insurance contribution significantly increased resources, as between 1990 and 1995 the total health expenditure rose from 4.7 to 7% of the GDP. During 1991 and 1992 these contributions were initially collected only by the GHIF, but after the passing of the 1992 law on multiple insurance funds, there were 27 HIFs that emerged in the insurance market, taking over a significant part of the GHIF’s clients (Bryndova and Gaskins 2009: 90). The competition between the GHIF and HIFs developed quickly.

Changes in healthcare delivery involved decentralization and privatization. Decentralization was divided into two phases and started with the dissolution of the District and Regional Institutes for National Health, which resulted in a high degree of legal and economic autonomy for healthcare facilities. During the second period, from 1993 until 1996 the decentralization was focused mainly on ambulatory services and was closely linked with privatization (Jaroš et al. 2005). One method of privatization was that former polyclinics were first transferred to communities or towns, or still state-owned, and then divided into single practices so that they became available for renting to private physicians. Another method of privatization, mainly of ambulatory care, was through direct privatization of the polyclinics’ buildings, which would then be available for rent by a group of physicians or another party.²⁰⁹ Privatization of primary and ambulatory care turned out to be quite successful since already by the mid-1990s, 95% of Czech physicians working in primary care were private (Scheffler 1998:

²⁰⁹ There were cases of physicians opening private practice even in their family homes.

4). While there was also a strong political attempt to privatize hospitals, their privatization was much less successful. There were various obstacles for hospital privatization. One was that even though various routes for privatization of facilities were extensively debated, the actual process pursued by the government lacked clear, established guidelines or principles (Háva and Kružík 1995). Another was that the majority of hospitals were in financial difficulties, so that private investors were not very interested in taking them over (Interview Dlouhy). Finally, political opposition to hospital privatization by the trade unions was very strong (Interview Potůček). The problem was that some of the hospitals were teaching hospitals that trained physicians and other health professionals, while many were involved in clinical and biomedical research. These public functions were not fit for privatization, so these hospitals were taken off the list (Schaffer 1998: 4). As a result, the hospital privatization process was undercut and by the end of the 1990s, it resulted in only about 10 small private, church or NGO owned hospitals, with less than 2 000 beds, which amounted to just 3% of total hospital capacity in the country (Jaroš et al. 2005: 223).

Soon after the implementation began, the new Czech insurance system fell into a serious crisis. The main issue became the problem of spiralling costs. The open-ended FFS remuneration method motivated private healthcare providers to overproduce services, i.e. stimulated supply-induced demand, which drained resources from the insurance funds.²¹⁰ As later analysis revealed, under the FFS scheme it was common for private physicians to bill for more than 100 hours per week: obviously not a very realistic work schedule. Private surgeons also billed for over 25% more points than those in the public hospitals.²¹¹ This resulted in an almost complete spending of the annual budget of the GHIF in the first six months of the fiscal year (Scheffler 1998: 10). Many of the private funds had even more severe financial problems, as they fell into insolvency and were declared bankrupt, so that their clients had to be taken over by the GHIF. Besides the FFS, the cause of the failure of the insurance system was open competition, characterized by a complete lack of any risk adjustment scheme within the insurance system. This allowed some text-book examples of market failure in healthcare, in the form of adverse selection and cream skimming, to emerge. Some of the HIFs created special insurance packages attractive to young and healthy citizens. This left the GHIF with an ever smaller number of

²¹⁰ The FFS was based on the point system, which implied that the price of services would be based on its provision costs. The value of the billing point was then subject to budgetary limits, since the funds available in the insurance companies were divided by the total points billed for physicians to calculate the value of each point. In this way, point values were subject to change in volume of service points billed for. This strategy however proved untenable, because the value of the point at the very beginning was set very low and continued to decline as the number of points billed increased dramatically (Scheffler 1999).

²¹¹ A similar pattern was also found in the supplies of healthcare goods. Orthopaedists, for example, billed over twice as much for supplies when they were in private practice (Scheffler 1999: 10).

insured individuals and a disproportionate share of older persons with more complex healthcare needs (Bryndova and Gaskins 2009: 90).²¹²

3.6. Amendments to the 1991 and 1992 laws

The crisis in the insurance system stimulated response by the Government, which after the 1992 elections was now led by Klaus as Prime Minister. The new Minister of Health Rubaš, appointed in June 1993, proposed several emergency cost-saving measures that were passed in the Parliament as amendments to the existing laws. One of these was the introduction of co-payments. These were very limited, as they affected non-essential services such as some dental services, cosmetic treatments and provision of vitamins.²¹³ The second, more important measure was the regulation of the insurance market. Regulatory measures included the merging or liquidation of small and inefficient funds, stricter control of insurance benefits offered by the funds, and the introduction of government supervision over the funds, which became obliged to provide financial reports. The new measures nevertheless brought significant improvement in the insurance sector. By 1997 the number of insurance funds decreased to 11, through either liquidation or a range of mergers between several smaller funds. Other measures included the establishment of the Securing Fund²¹⁴ and a risk adjustment scheme created to re-distribute the remaining funds' resources according to the age structure of their clients. Interestingly, even though the Parliament accepted these measures, with the strong support of the Ministry of Finance, the Social Democrats opposed the measures, arguing that the regulation of competition would lead to the monopoly of the public GHIF (ČTK 1993a). The regulatory measures introduced by the neo-liberal *ODS*, and opposition to them by the social democratic *ČSSD*, suggested that ideology was a rather secondary concern in this situation.

In the meantime, a division within the medical professions took place. The division was signalled by the establishment of the Doctors' Trade Union Club (*LOK*) in January 1995. The *LOK* positioned itself as an association representing hospital physicians, who felt that the existing Medical Chamber was not representing their interests. The first chairman of the *LOK* was David Rath, who quickly became Minister Rubaš's partner in negotiations over the central

²¹² Some of the extra benefits of their insurance package included free travel insurance or subsidies for wellness activities (Bryndova and Gaskins 2009: 90), which clearly revealed the intentions of the funds to attract younger and healthier clients.

²¹³ Minister Rubaš intended to introduce a small user fee for specialist visits without GPs referral. This idea was not welcomed by the specialists who preferred to maximise their FFS scheme.

²¹⁴ The role of the Securing Fund is to settle outstanding payables in the case of bankruptcies among health insurance funds. With the exception of the GHIF, all insurance companies also became obliged to make annual contributions to their 'rainy day' accounts, based on their average yearly healthcare expenditure. While this obligation was withdrawn in 2006, the Security Fund still exists (Bryndova and Gaskins 2009: 90).

topic - increase in pay for hospital physicians. Negotiations with the *LOK* enabled the Minister to ignore the Medical Chamber, which strongly protested against the replacement of salary tariffs with a performance based contractual system (ČTK 1993b). Minister Rubaš however in the meantime had become very unpopular,²¹⁵ causing unrest in professional circles, and Prime Minister Klaus in October 1995 decided to replace him with Jan Stráský.

3.7. The Law on Public Health Insurance

Stráský, though not a doctor himself, was considered to be a diplomatic problem-solver and was expected to solve the unrest in the health sector.²¹⁶ Right after his appointment, the new Minister published a report on the situation in the sector and launched an extensive plan that called for the “reform of the reform” (Jaroš and Kalina 1998; Jaroš et al. 2005). “There's no sense in trying to deny the crisis”, said the Deputy Minister Maček, speaking on the day of the report's release, “The figures speak for themselves.” According to the Ministry's statistics, insurance companies had reported a collective loss of around 5 billion Czech crowns (equivalent to \$185 million at that time), while in 1995 alone, hospitals lost 1.3 billion (Jaroš and Kalina 1998).

Minister Stráský's plan contained two parts, a short-term and a long-term programme of reforms.²¹⁷ The short-term programme focused on financial measures that were supposed to stop spiralling costs and implied an injection of 1.4 billion Czech crowns into the insurance sector. It also focused on the introduction of a cost-containment mechanism that would involve the introduction of selective contracting between the insurance funds and the providers. It envisaged changes in remuneration methods, in the introduction of capitation payments for GPs, and service-based functional budgets for hospitals, while FFS would be kept only for ambulatory specialists. Other important measures included defining the gate-keeping position of GPs and the introduction of co-payments and user fees, as well as rationalization of the network of insurance funds. The long-term programme involved other changes in the remuneration scheme, which would implement case-based payment for hospitals and ambulatory specialists. The long-term programme also envisaged replacement of the insurance system with several alternatives, such as a variety of insurance plans, optional private insurance, medical savings accounts, pre-paid care, or co-existence of all the three models (Jaroš et al. 2005).

²¹⁵ A petition for Rubaš's resignation was supported by the *LOK*, as well as by the Labour Union for Healthcare and Social Policy. The Health Care and Social Policy Committee also severely criticized him in the Parliament.

²¹⁶ Stráský was the first Minister of Health after 1989 who was not a doctor.

²¹⁷ *Krátkodobý program Ministerstva zdravotnictví, Ministerstvo zdravotnictví. Dlouhodobý program Ministerstva zdravotnictví, Ministerstvo zdravotnictví, 27.10.1995.*

Stráský's plan was ambitious and comprehensive, and quickly became controversial mainly because of two of its elements - co-payments and user fees. For co-payments, his plan envisaged a significant increase from 8 to 10% of treatment costs (*ibid.*). Even though this measure was favoured by the *LOK*, it nevertheless caused a prolonged parliamentary controversy between the *ODS* and the *ČSSD*. This dispute even resulted in the Constitutional Court ruling (PI.ÚS 35/95), which claimed that in their present form, the co-payments violated the constitutional right to healthcare, and should therefore be improved (den Exter 2002: 168). The plan to introduce flat user fees that would require patients to pay 50 Czech crowns (equivalent to \$1.50 at that time) for a day in hospital, 100 crowns for an ambulance ride and up to 800 crowns per year for outpatient and specialist treatment was also controversial. The *ODS*'s coalition partners, the Christian Democratic *KDU-ČSL*, was strongly against it. Consequently, Stráský's Ministry succeeded in implementing only a part of its extensive reform plan. The Law on Public Health Insurance (Law No. 48/1997), passed on March 7th 1997, replaced the Law on General Health Insurance, introducing three important changes. The first of these was selective contracting between healthcare providers and insurance funds. Secondly, a new reimbursement scheme replaced the exclusively FFS-based scheme with a mix of capitation and the FFS scheme for ambulatory services, and with budget-based payment for hospital services. Lastly, there was an increase in co-payments that excluded emergency cases and economically disadvantaged citizens (Jaroš and Kalina 1998: 9).

Stráský's ambitious reform project thus remained uncompleted and chances for another reform attempt were stalled due to frequent medical strikes²¹⁸ and the political crisis in the autumn of 1997. However, the reform attempts of both the previous ministers, Rubaš and his successor Stráský, showed that the turbulent coalition dynamic could be the major factor preventing healthcare reform plans from success. Additionally, the way in which the Czech Republic coped with the financial crisis of the healthcare sector in mid-1995 suggests that political parties' ideological identities did not always guide policy choices. The regulatory measures introduced in the insurance sector by the neo-liberal *ODS*, and the opposition to these measures by the social democratic *ČSSD*, strongly suggested that while ideological identities of these party members were rather of secondary concern, other identities, such as that of public office holder, played a more important role.

²¹⁸ The *LOK* organized one of the biggest strikes, which was also joined by the nurses, in March 1996. This strike was nation-wide, lasted for two days and was followed by another strike in May 1996, called "Campaign Titanic", organized by the Health and Social Care Union. This strike was followed by another small strike by the *LOK*. The main purpose of these strikes was to protest against the government's idea to abolish salary tariffs for healthcare professionals working in hospitals (ČTK 1996a; ČTK 1996b).

The fall of the *ODS*'s coalition government and pre-term parliamentary elections in 1998 witnessed the victory of the *ČSSD*. Disinterest in reform at the beginning of the *ČSSD*'s coalition government was so strong that the word “reform” disappeared from the coalition discourse (Jaroš et al. 2005: 201). One of the Ministry's officials working with the Minister of Health, Fišer, described his Minister as a person who was “not a friend of strong reforms”. He suggested that the lack of reform initiative could be explained by the fact that the situation in the insurance sector was “cultivated” and that the Ministry was intensely involved in large scale reform of public administration (Interview Malina).²¹⁹ Even when David Rath, the charismatic former Chairman of the *LOK* and the President of the Medical Chamber, took over the position of Health Minister in 2005, his Ministry did not envisage radical reforms in health service provision, but rather focused on the pharmaceutical sector.²²⁰ The main measures of Rath's Ministry in healthcare provision focused on the refinement of the risk adjustment scheme and changes in insurance contributions for the unemployed (Jaroš et al. 2005).

3.8. Introduction of the user fees

The last attempt to comprehensively reform the Czech health sector took place under the Government of Mirek Topolánek, who took office after the June 2006 elections. Even before the elections, the *ODS*'s electoral campaign stressed the need for health reforms, and the party's successful come-back to power on September 4th 2006 signalled that the new government was ready to push for a new wave of radical changes. Topolánek's first cabinet, formed by the *ODS* and non-partisans, showed strong interest in reform, an interest that was also confirmed by the appointment of Tomáš Julínek as the new Minister of Health. Julínek was an *ODS*'s member who acted as shadow-minister during Rath's term and was the only candidate for the Minister's position who had an already prepared reform plan (Interview Macháček).

After taking over his ministerial position, Julínek presented his reform plan, which had been prepared two years earlier by his reform team.²²¹ The plan envisaged three major reform measures. The first one was related to a change of the legal status of hospitals, as the plan envisaged that hospitals would be privatized through transformation into joint-stock companies. The second was the introduction of managed competition in the insurance sector, which would be coupled with the privatization of insurance funds. The third measure was focused on the

²¹⁹ Reform of public administration did not have significant impact on the healthcare sector (Jaroš et al. 2005: 216).

²²⁰ Rath's appointment by Prime Minister Paroubek was problematic. Václav Klaus, who in the meantime became the President, opposed it, arguing that if Rath suspended his presidency of the Medical Chamber, it would be pretty much “like suspending pregnancy” (PP 2005). During his only 7 months long term Rath initiated and passed a very important law that introduced limitation in drug spending, causing rage in the pharmaceutical industry (ibid.).

²²¹ *Reforma zdravotnictví pro ČR v Evropě 21. století, Pavel Hroboň, Tomáš Macháček, Tomáš Julínek, 2004.*

introduction of user fees for medical services. Of the three measures, the one focused on the introduction of the user fees was chosen to be at the forefront of the reform plan. This was a strategic decision; Julínek's team believed that introducing the fees first would create financial stability, and that would in turn enable the implementation of the other two big reform measures. The introduction of fees was also given priority for practical legal reasons, since it did not require too many legal changes and was also considered the "least complex of all measures" (Interview Macháček).

However, the lack of political support within the governing coalition soon turned out to be a major obstacle for the reform. Topolánek's second cabinet was in the meantime formed by the *ODS* and other two parties, the Christian Democratic *KDU-ČSL* and the Green Party. The *KDU-ČSL*, immediately after the coalition was formed, started to criticize the Ministry's proposal and the Greens, as the third coalition partner, followed suit. This significantly weakened the chances that the proposal would get support in the Parliament, since the *ODS* needed the votes of the coalition partners.²²² Trying to build consensus for the reform, the Ministry of Health initiated a discussion about the future of the Czech healthcare system, organizing Round Table that included parties both from the government and the opposition. According to one of the organizers of this Round Table, even though the participants of this Table did not openly debate Julínek's reform plan, it was clear that the main aim of the discussion was to win political support for it (Interview Matl). This initiative nevertheless failed, when the former Minister David Rath, who participated as the *ČSSD* i.e. opposition representative, decided to leave the discussion (*ibid.*).

After the failure of the Round Table discussion, Julínek and his team found an alternative solution which they hoped would be more successful in getting political support. They decided to include the fees into a bigger Government reform package aimed at the stabilization of public finances. This package was passed on September 19th 2007 as the Law on Public Budget Stabilization (Law No. 261/2007). The law envisaged the introduction of flat user fees for a set of healthcare services: 30 crowns (equivalent to €1.20) for a doctor's visit, 60 crowns (€2.40) for a day in hospital, 90 crowns (€3.60) for a visit by ambulatory services outside of their office hours, and 90 crowns (€3.60) for an emergency treatment. It also granted exemptions from fees for specific population groups, such as those living below the poverty line, neonates, pregnant women, and patients with infectious diseases. Moreover, it introduced an annual ceiling of 5 000

²²² In the Chamber of Deputies, the *ODS* had 81 seats, and the *KDU-ČSL* and the Greens 4 and 5 seats respectively. This implied that the *ODS* needed support of both coalition partners and a minimum of additional 11 votes in order to pass the healthcare reform plan.

crowns (€200) per insured individual, which excluded fees for hospital stays and fees for the use of ambulatory services outside of office hours.²²³ It was envisaged that above this limit, further user fees would be reimbursed by the insurance funds (Bryndová et al. 2009: 50).

In both public and political debates, however, the user fees emerged as a very controversial issue. The fees became so controversial that the ČSSD decided to use them as the main focus of their campaign for the regional elections in 2008, promising that they would abolish the fees in those regions where they gained power.²²⁴ Not even the doctors, somewhat surprisingly, were in favour of the user fees. This, however, was explained by the fact that they feared patients' perception of them and thought that their taking of the fee payments at the point of service delivery could potentially threaten their relationship with their patients (Interview Frydecka).²²⁵ The opposition to the user fees peaked in 2008, when the ČSSD decided to take the issue to the Constitutional Court, arguing that they were against the constitutional principle of free healthcare provision, and posed a major threat to access. The Court however ruled (Pl.ÚS 1/08) that user fees should be retained, stating that, among other reasons, they represented an integral component of the public budget stabilization plan and that, in the opinion of the Court, they did not represent a real danger of making Czech healthcare inaccessible. The fees hence stayed in place and even managed to survive Minister Julínek, who in January 2009, because of the user fees controversy, was replaced by the new Minister of Health, Daniela Filipiová.

In sum, this last reform episode demonstrated, once again, that political-institutional configurations played a fundamental role in the success of policy change. It shows that while the coalitional dynamic of Topolánek's second cabinet turned out to be the major obstacles for the consensus over Julínek's comprehensive reform plan, it was through the political manoeuvring of the Ministry's reform team that user fees were successfully integrated into the framework of Czech healthcare policy. This episode also shows that beside the political dynamic, institutional configurations, i.e. the institutionally determined structure of veto points, mattered for the final success of this specific case of policy change. Besides the parliamentary approval of user fees through the Public Stabilization Law, it was the 2008 Constitutional Court ruling that prevented their removal from the Czech healthcare system, giving it yet another market touch.

²²³ This ceiling was later lowered to 2500 Crowns (€100) for children and adolescents up to the age of 18, and for people older than 65 (Bryndová and Gaskins 2009: 41).

²²⁴ In the elections, the ČSSD persuasively won in all regions.

²²⁵ According to one of the journalists actively following the issue of user fees for the Czech daily newspaper *Dnes*, doctors found the idea of user fees' payments "dirty" and instead preferred that the Government increased the level of the existing insurance funds' reimbursements (Interview Frydecka).

4. Summary

This chapter demonstrated that, in striking similarity to the Polish post-communist healthcare reforms, Czech post-communist healthcare reforms developed through a process of learning, in which ideas, interests and institutions played a crucial role. Expert ideas about the reform of the healthcare system emerged already under communist rule, in response to the failures of the Czech socialist healthcare system. As in Poland, these ideas criticized the socialist system for its centralized and hierarchical model of healthcare provision and suggested that the government should consider other, alternative ways in which it could finance and deliver medical care. In the post-socialist period, after the political regime change through the 1989 Velvet Revolution, these ideas developed into competitive reform proposals advocated by some of the major political forces. However, in contrast to the Polish experience, the relatively stable dynamic of the Czech post-communist political and institutional landscape, characterized by a significantly lighter structure of institutional checks and balances, facilitated the passing of some of these proposals into concrete policies. As a result, healthcare delivery and financing were marketized simultaneously, and, thanks to the introduction of user fees in the 2000s, a gradual but nevertheless steady pace of marketization was maintained, until the end of the second post-communist decade.

Chapter Five: Conclusion

Introduction

Why do some countries introduce new policies faster than others? Why do countries, in other words, follow divergent paths of policy innovation? In this thesis, I compared and analysed two cases of innovative policy change in post-communist Eastern Europe, in which after 1989 divergent paths of market-oriented healthcare reforms were followed. I have presented the argument that these divergent paths are best explained by a process of policy learning in which three elements - ideas, interests and institutions - played a crucial role. With the understanding of policy change as a learning process, through which new policies emerge in response to old policies and are driven by cognitive elements such as ideas, I developed a theoretical framework that links these cognitive elements with interests, and considers political-institutional configurations to be the main factors determining the ultimate success or failure of reform proposals. I then used this framework in the two empirical chapters of this thesis to account for specific episodes of policy change in both Polish and Czech healthcare reforms of the post-communist era.

In this last chapter I summarize my main findings, discuss to what extent they can be generalized and reflect upon the concept of policy change as environmental adaptation. Discussing to what extent the findings of this thesis, based on the two cases of Czech and Polish post-communist healthcare reforms, can be generalized, I ask whether my findings can be useful for the analysis of the other cases of market-oriented policy change or, more broadly, neo-liberal public policy change. In my reflections on the concept of policy change as environmental adaptation, I try to apply this concept to the two cases of Czech and Polish healthcare reforms and analyse some of its main implications. I conclude this chapter with a brief discussion on the policy relevance of my findings and a section on the directions of future research.

1. Policy change as learning process

The argument that the process of healthcare policy change in Eastern Europe is best explained as a learning process has four main characteristics. First, it argues that policy change implies a process which is essentially continuous. Each new policy, according to the 'policy change as learning' view, grows out of, or in other words, is born from the previous policy. While at first sight this stress on continuity might seem superfluous, it is nevertheless important

for two reasons. One is that the understanding of each new policy as an outcome of a previous one allows us to look at the very early phases of policy development, at those moments when the ideas of policy change have just been conceived and develop into rather rudimentary forms, which nevertheless reveal the first traces of reformative thought. Another reason why continuity adds to the understanding of policy change is that it situates policy development in its own *habitat* i.e. in the policymaking context itself, in which the community of policymakers and experts on specific policies work together on finding solutions to policy problems.

Even though the ‘policy change as learning’ view stresses the continuity of policymaking, it does not argue that policymaking is cumulative. New policies, rather than following old ones, emerge in response to the incapacity of old policies to solve social problems. These responses to old policies, according to the ‘policy change as learning’ view, can sometimes be so dramatic that they lead to the radical, “paradigm change” of policy. In the previous two empirical chapters I have shown that Polish and Czech healthcare policy change was both continuous and non-cumulative, witnessing a radical shift from a state to a market-oriented policy model that would change the underlying logic of healthcare provision. I showed that the beginnings of this process could be traced back to the communist period, to the 1980s, or even earlier, to the 1970s, when policy experts in the two countries started to analyse the problems of the socialist system of healthcare. Their analyses were prompted by the growing incapacity of the system to provide healthcare to their populations and, especially in the late 1980s, by concern of the communist elites about the situation in the healthcare sector. The experts’ reports published during this period demonstrated that their criticism of the existing system which, and this was very important, was not focused on the anomalous epiphenomena of the healthcare crisis, such as corruption and shortages, but rather on the character of the system itself, which was centralized, hierarchical and bureaucratic. This clearly demonstrates that the first reform ideas developed in reaction to the old socialist policy of healthcare in these two countries.

With the view of ‘policy change as learning’ I also argue that policymaking is an autonomous process. The empirical analysis has shown that the development of the first rudimentary ideas of policy change under communism and the development of different proposals for policy change in the post-communist period both took place within the domestic policymaking circles of the two countries. The case of the rejection of the World Bank’s reform proposal is the best illustration of this autonomous character of policymaking in post-communist healthcare policymaking. The Polish reaction to the Bank’s proposal, which suggested that the country should opt for a less radical and a less market-oriented change in the healthcare sector, one strikingly similar to the Czech system, demonstrated that Czech and Polish healthcare

reform proposals were home-grown. Even though they sometimes drew their inspiration from healthcare policies in other countries, these proposals were developed by the very vibrant communities of healthcare experts working either inside or outside of the Ministry of Health, and who had their own, often competing visions of future directions of healthcare policy.

Finally, by arguing that policy change takes place through learning, I claimed that such radical changes in policy direction as those which took place in my two cases were an essentially cognitive process. Explaining change as a learning process that starts with a “puzzle” rather than “power” was developed by Hecló (Hecló 1957) and implies that, while interests and the respective powers of these interests, and actors who carry them, do matter in policymaking, the change itself can be initiated in a context that lacks the dynamic of competing interests and unbalances of power, characteristic for policy dynamic in democracies. The two cases of post-communist health reform perfectly illustrate this. Under communism, the first ideas of healthcare reform developed in a context that was characterized by the absolute power of the regime and the political powerlessness of potential opponents of the regime’s health policy, such as healthcare professionals. Instead of interest groups, these ideas were formulated by the policy experts who in the late 1980s were asked by the communist elites to ‘puzzle out’ the main causes of the healthcare crisis. These ideas were therefore developed in a context in which the “power” dimension was lacking and, even more importantly, in the context in which political change which would lead to a new balance of power did not even seem likely.

2. Ideas, interests and institutions

How does policy change through learning takes place? I have argued that ‘policy change as learning’ cannot be properly understood without three of its essential elements – ideas, interests and institutions. Expert ideas that emerged in the two countries under communism were the initial drivers of policy change because they both explained the problems of socialist healthcare and suggested solutions from them. In the post-communist period, these ideas continued to drive policy change, allowing consensus that healthcare reform was necessary and being the basis for the formulation of the competing policy proposals developed in the new policymaking context. In both Poland and the Czech Republic ideas thus initiated change and were the crucial factor that launched the departure from the socialist state-centred ‘Semashko’ system of healthcare to its market-oriented ‘Bismarckian’ counterpart.

While ideas were important, they were not the only factor necessary for healthcare policy change to take place. I have argued that one of the main reasons that ideas alone cannot bring about policy change is that policy ideas are politically powerless. Ideas such as those proposing

healthcare delivery privatization, decentralization of insurance funds or competition between healthcare providers, apart from their very often complex technical character, by themselves do not carry significant political power. Instead, they rather represent beliefs about the ways in which healthcare provision should be organized and how the healthcare system should function in order to perform its task. This explains why, in order to become politically powerful, ideas have to enter the realm of politics, where they can gain the needed support of actors with interests and influence over the policymaking process. The analyses of the Czech and Polish reforms, especially the episodes that took place during the early 1990s, demonstrated how reform proposals that managed to successfully link with the interests of prominent figures, such as politicians and, more markedly in the Czech case, also physicians, became more successful in reaching the Government's agenda. These analyses also showed that, while these interests were sometimes not clear enough, or very often not even stable, the linking of ideas with interests nevertheless played a crucial role in the process of policy change.

Finally, I have shown how ideas can be successfully linked with interests and lead to policy change only in the context of specific political and institutional arrangements. The two empirical chapters analysed the different processes of constitution making in the two countries during the early phases of the post-communist transition, which generated institutional arrangements with significantly different structures of veto points. Poland's 'delayed' semi-presidentialism and the Czech Republic's quickly established parliamentarism created significantly different institutional arrangements of checks and balances, which involved different structures of veto points in the executive and legislative decision-making arena. In combination with the changing political configurations of the post-communist transition, these structures shaped strategies of policy change in different ways, and, consequently, determined the fate of the healthcare reform proposals based on market ideas.

3. Can these findings be generalized?

In the previous two sections, I summarized my argument that the process of post-communist healthcare policy change is best explained as process of learning, in which different links between experts' ideas and interests in different political-institutional arrangements led to divergent paths of policy development. Can these findings be generalized? There are three specific features of the post-communist healthcare reforms that could limit the application of my findings to other cases of healthcare, or more broadly, public policy reforms.

The first feature is related to the specific ideational context of Czech and Polish healthcare reforms. In 1989, both countries witnessed a crucial historical event, the fall of Communism, which marked a turning point in their political, economic and social policy paths. During the first decade of post-communism and, most specifically, in the early 1990s, both in the eyes of the elites and of citizens in these two countries, the fall of Communism was identified as a failure of the State and its capacity to deliver any kind of socially or economically beneficial results. The decade of the 1990s was therefore the period of the ‘grand delusion’ with the socialist way of policymaking, and this created a very specific context that allowed market-oriented, neo-liberal ideas to ‘rise and shine’ in policymaking circles. This explains why the core neo-liberal idea that the State was not the solution, but rather the main source of social and economic problems, found in these two countries very fertile ground. The idea of a market economy ‘without an adjective’ or ‘liberalism without prefix’ was signalled as a radically new approach to not only economic but also social problems, such as that facing the healthcare sector, since it was believed that only liberated market forces would be able to put their societies and their economies back on their feet. This drastic change from the state-dominated to the market-oriented approach signalled that while the ‘socialist experiment’ was over, the ‘neo-liberal experiment’ had just begun.

However, while the shift from socialism to neo-liberalism in post-communism was specific, it was not too specific to make these countries solitary cases of idea-driven policy changes. Analysing the historical development of neo-liberal ideas in the West, Steinmo (2008: 172) argues that “The neo-liberal ideas grew in popularity in the later decades of the 20th century because more and more people (especially the rich and powerful) came to *share the belief* that ‘government was not the answer, but the problem’, to quote Ronald Reagan’s famous phrase.” He finds that pro-market, neo-liberal policies became increasingly persuasive because an increasing number of people, both elites and average citizens, were convinced by the logic of the neo-liberal argument; even though there was no proof that neo-liberal policies would address the problems these countries were facing at that time. If we consider Steinmo’s view, acceptance of neo-liberal ideas in Eastern Europe does not seem to be remarkably different from the rise of these ideas in the West. Because of the ‘grand delusion’ with the socialist way of policymaking, one could say that even though the specific post-communist context maybe witnessed a more dramatic ‘clash of ideas’, the cognitive processes that led to the acceptance of market-oriented policies seem to be the same.

The second reason that the generalization of my findings could be limited lies in the complex institutional and political dynamic that surrounded post-communist healthcare reforms. In both countries I analysed, the process of healthcare policymaking coincided with periods of dramatic institutional change. The empirical analysis, for example, showed how a protracted process of constitutional design, affected by Poland's specific path of extrication from communism, saw the period of the 1990s dominated by heated discussions over institutional divisions of power, and left the Polish political institutional structure undefined during the first transitional years. Furthermore, both Poland and the Czech Republic in the 1990s were starting their processes of democratisation, and in the 2000s these processes were still, in some respects, not completed. All this contributed to the fact that some of the 'taken for granted' characteristics of mature democratic systems in the West, such as party system institutionalization or electoral systems capable of producing relatively stable political configurations, were not fully realized in these first two post-communist decades in Poland and the Czech Republic.

Finally, the last reason for difficulty in generalizing the findings of this thesis and applying it to other cases of public policy change lies in the specific character of healthcare policy. As a policy area, especially in the last several decades, healthcare provision has been increasingly considered a highly technical issue. This could be partly explained by the growing pressures that demographic changes and the growing costs of healthcare technologies put on the national healthcare systems of modern states. It can also be partly explained by political factors, given that the universal systems of healthcare of advanced capitalist democracies, because of the above mentioned challenges, have been 'under threat', and their governments are trying to find ways to please their constituents by continuing to provide healthcare universally, but at lower costs. Additionally, healthcare as a policy area has been characterized by relative isolation. Healthcare policymaking, mainly because of the national healthcare systems' complexity but also because of its politically sensitive character, has often been confined within the borders of national states. This, for example, explains why in the EU's *acquis communautaire* policies of healthcare remain within the sphere of exclusive competence of national governments. It also explains why, in contrast to other social policy sectors such as pensions, healthcare policy advice by international organisations is often missing. This both 'technical' and 'sheltered' character of healthcare policy could help explain why domestic policy experts, as in the case of post-communist healthcare reform, are able to gain such an important role. This does not necessarily imply that healthcare is drastically different from other policy sectors, since some of the more recent studies of, for example, tax policy in small open economies (Christensen 2012) assign an important role to expert ideas in the process of policy change. This suggests that even though

healthcare is special, it is not so special as to make the findings of this thesis applicable only to the field of healthcare policy.

4. Policy change as environmental adaptation

In this last section, I would like to reflect upon the view of policy change as environmental adaptation. The core argument of this thesis was that policy change is best explained as learning, but did not tackle the broader picture, which would allow me grasp the exact nature of these learning processes from a broader institutional perspective. Do countries and policies, for example, through learning adapt to their environments, or is the process of policy change rather independent of the environment in which change takes place? Over the last several years, the view of institutional or policy change as an incremental, evolutionary process, in which policies and institutions adapt to their environments through a gradual process of change, has become increasingly prominent among scholars studying policy and institutional formations in modern democracies (Streeck and Thelen 2005, Lewis and Steinmo 2010, Mahoney and Thelen 2010, Steinmo 2010). This view developed out of the need to cope with the challenge of explaining institutional stability and change, but also with an intention to ‘think big’ about either single or comparative cases of policy change, and understand their meaning in the broader context.

Streeck and Thelen (Streeck and Thelen 2005, see also Thelen 2004, Thelen and Mahoney 2010) argued that institutional change is incremental and can take different modes. They distinguished between five different modes of change, which they labelled as “drift”, “displacement”, “layering”, “conversion” and “exhaustion” (Thelen and Streeck 2005). Institutional change through “drift” stands for degenerative processes of erosion or atrophy, which may be masked by stability but nevertheless imply change (ibid. p. 24). “Drift” occurs when, despite changes in the economic and social environment in which they are embedded, institutions remain static. Instead of being reset or refocused or, even more fundamentally, recalibrated and renegotiated, through “drift” institutions ‘ignore’ the changes that surround them and develop in disjuncture with the ‘natural trends’ in their environment.²²⁶ In contrast to “drift”, change through “displacement” occurs when new institutional models emerge and diffuse by calling into question existing, previously taken-for-granted organizational forms and practices. This, obviously, is a different kind of change from “drift”, because “traditional arrangements are discredited or pushed to the side in favour of new institutions and associated

²²⁶ For ‘natural trends’ Thelen and Streeck (2005: 25) give an example of slow changes in family structure that alter the composition of social risks and, consequently, de facto welfare state coverage.

behavioural logic”. Change through “displacement”, according to Thelen and Streeck, often occurs through the rediscovery or activation, and cultivation, of alternative institutional forms (ibid. p. 20). “Layering” is the third type of change and involves processes in which “innovators accommodate and in many ways adapt the logic of the pre-existing systems, working around those elements they could not change” (Thelen 2004: 226). “Conversion” on the other hand describes change in which institutions designed with one set of goals in mind are re-directed to different ends (ibid. p. 228). Finally, “exhaustion” involves a process of change that gradually leads to institutional breakdown (Thelen and Streeck 2005: 29)

Lewis and Steinmo (Lewis and Steinmo 2010) also understand policy change as a gradual process. Replacing a rather superficial understanding of the term ‘evolution’ as a historical path in which different events are simply related to one other over time, they develop an ‘evolutionary’ approach to institutional analysis that is both innovative and structured. Using the analogy of political processes with evolutionary processes in biology, Lewis and Steinmo draw upon some of the key elements of Darwin’s theory of evolution. According to Darwin, populations are composed of individuals, some of which have special traits that give them an advantage in their environment. Over time, those individuals with advantageous traits become more successful in competition for resources and mates, and have more offspring than other members of the population, and this in turn increases the presence of their traits within that given population. This is one of the key mechanisms of evolutionary theory, known as the mechanism of ‘natural selection’, according to which certain traits are selected because they are successful in a given environment. Darwin argued that the natural selection process enables different species to evolve over time, and to have different traits which they change in response to their environments (ibid. p. 3). Lewis and Steinmo extend this theory of evolution to social phenomena, using Darwin’s theory to explain institutional developments in our man-made world. Institutional change, they argue, can be understood as process based upon the following evolutionary algorithm: variation, selection and retention. The process of change begins by a variation of ideas. Throughout their institutional history, humans have developed different sorts of ideas that propose and aim to introduce innovative changes in their institutional settings. Some of these ideas are unsuccessful, as they are tested and tried but fail to adapt to their environments, and are therefore never repeated or copied. Some ideas, however, are selected, copied and retained. The reasons why individuals or entire populations accept and copy certain idea, according to Lewis and Steinmo, can vary. In some cases, populations adopt innovations because they are literally conquered by other populations or groups, who impose their institutions and on them. In other cases, groups decide to voluntarily copy ideas which they see

as successful innovations by other groups, in their attempt to adjust their institutions to changing environments (ibid. p. 13).

The two modes of incremental change described by Thelen and Streeck as “drift” and “displacement”, and the Lewis and Steinmo’s view of institutional change as an evolutionary process of variation, selection and retention, could be applied to the cases of post-communist health reform. The departure from the socialist ‘Semashko’ model of healthcare, after a long period of policy stagnation in which the system was gradually deteriorating, could be explained as a process of change through “drift”, in which the main institutional structure of the health system atrophied, resisting change in its environment. As the empirical chapters have shown, the Polish and Czech healthcare systems performed relatively well in the post-war period but started to gradually deteriorate from the late 1960s or early 1970s onwards. This could be explained by the fact that these systems were not able to adjust to the changes caused by the “epidemiological transition” (Omran 1971).²²⁷ The post-socialist period of healthcare reforms that emerged in response to the failures of the socialist system, initiated a process that could be described as “displacement”, since the socialist model of healthcare was replaced with alternative market-oriented institutional structures, in the attempt to adjust the healthcare system to this new environment. Lewis and Steinmo’s work adds to this view of adaptive change through “displacement” by suggesting that the different policy paths of Czech and Polish healthcare could be best understood as a set of different adaptations or, better, as a set of different adaptation attempts, through which policymakers tried to adjust their healthcare systems to the changing environment. As the empirical chapters have shown, market-oriented ideas of healthcare represented attempts by policy experts to displace the centralized, hierarchical and state-dominated system of healthcare by innovative, market-oriented policies which, they believed, would be able to solve problems, i.e. to adapt the healthcare systems better to their environment. The empirical chapters have, however, also shown that the success of these attempts was fundamentally dependent on yet another, even more important context: the political context of policymaking, which ultimately determined the varied success of market-oriented reform proposals in the two countries.

²²⁷ According to the Abdel Omran’s (1971) theory of epidemiological transition, there are three stages societies pass in the process of modernization. The first is the stage of “pestilence and famine”, during which mortality is high and fluctuating, with an average life expectancy less than 30 years. The second stage is the stage of “receding pandemic”, a period in which life expectancy considerably rises, reaching levels from 30 to over 50 years. The last, third stage, is the one of degenerative and man-made diseases, during which the pace of mortality decreases, but the disappearance of infectious diseases increases the visibility of degenerative diseases, and man-made diseases become more and more frequent.

There are several important implications of the gradual, evolutionary approach to institutional and policy change. The first is that systems of institutions such as healthcare systems, and the policies that guide them, are never perfect, but rather more or less successful, or more or less adapted to their environments. The second, related implication is that not all institutional and policy changes are efficient or even likely to lead to improvements in the compatibility between institutions and their environments. Some changes succeed and some don't. Some of those that are successful improve the compatibility of policies and institutions with their environments, while others don't. Finally, the last significant implication of the evolutionary approach to institutional analysis is that the 'fitness' of a certain institution to its environment is not a static characteristic. Institutions differ in that they are more or less fit for their environment, but the degree of this fitness varies both across and within institutions. This degree can vary across institutions, since institutions in one country can be more adapted to the broader environment than the same kind of institution in another country. The degree of fitness can also vary within the same institution or institutional configuration, over time. Some innovations can initially grant institutions competitive advantage but as these innovations become outdated, they can be replaced by new ideas that lead to a higher level of fitness between environments and institutions.

The evolutionary approach, as this section has just suggested, could contribute to a better understanding of policy change but would also require further theoretical elaboration. One of its advantages would certainly be its perception of policymaking as developing through a continuous and dynamic process, in which change rather than stasis is the dominant trend, and in which context plays an important role. The flux between the multiple contexts of policy on the one hand, and the ideas and policies that respond to these contexts on the other hand, implies that while contexts are changing over time, ideas are changing as well, and that policies that are innovative today, tomorrow may simply be outdated. This parallel dynamic between ideas and environments, and the somewhat ephemeral character of policy change in the broader historical perspective, suggests the co-evolving nature of institutional and social, economic and political change.

5. Policy Implications

What are the main policy implications of my findings? In other words, to what extent are these findings relevant for policy-makers who are actually reforming healthcare systems or other welfare state structures around the world? A reference to policy implications seems inevitable in

the context of burgeoning healthcare reforms across Europe and in the United States. Rapid and radical changes in the healthcare systems of some Southern European countries strongly affected by the global financial crisis, and the comprehensive health insurance reforms taking place in the United States suggest that healthcare reforms stand quite high on the government agenda around the world, and that policy-makers, now more than ever, could be in need of policy advice.

While the findings of this thesis are clearly limited in their capacity to offer concrete advice to policy makers, there are nevertheless two main aspects of them that could be relevant for healthcare or, more broadly, public policy makers. One aspect refers to the evidence related to the actual success and failure of the post-communist health reforms, which points to the fact that policy reforms are often characterized by rather mixed results and do not always have the anticipated impact. This thesis showed that, overall, the market-oriented reforms of health policy introduced in the two post-communist countries did lead to some very significant improvements in the health sector, such as for example healthcare financing, and have certainly contributed to the increase in the overall quality of delivered care. However, these reforms in both countries also led to serious crises that threatened the financial stability of the health sector as a whole and created problems in access to medical services. Furthermore, the reforms had mixed results and did not always have the expected impact in terms of their distributive outcomes, since they did not always favour those that they were supposed to favour the most – citizens. As illustrated by the Polish case, two decades of intense and radical healthcare reforms produced outcomes that were unpopular among the Poles.

Another related implication refers to the finding that the degree of success of reforms can depend on various factors. Some of these factors lie in the characteristics of the reforms themselves such as, for example, the degree of marketization they introduce. As the Czech case of the introduction of a fully liberalized insurance market in the early 1990s clearly demonstrates, extremely marketized modes of healthcare provision can lead to textbook examples of market failures, such as adverse selection, which can have profoundly damaging consequences for the policy sector as a whole, and for its financial stability. Another related factor that determines the success of these reforms can be the coherence of the specific set of reforms, i.e. the successful combination of different market instruments with one another or the combination of market instruments with state ones. As the case of the Polish reforms has suggested, extreme cases of market- and state-dominated policies can have equally negative outcomes. In contrast, a more balanced combination of market and state mechanisms, i.e. a regulated market for healthcare services like the one implemented in the Czech Republic, can be more successful. This suggests that the biggest challenge facing policymakers should not be boiled down to the dilemma ‘state *or*

market?', but rather to that of finding the right balance between the two, i.e. the right *degree* of state *and* market elements that could be combined within a specific welfare sector in order to help governments solve social problems.

Last, but certainly not the least relevant policy implication of my findings is related to policy advocacy and the capacity of policy makers to generate support for welfare state reforms. As my research on post-communist healthcare reforms shows, generating support for reforms can be much more difficult for policy makers than expected. Specific actors or interests groups, despite their obvious interests in a particular policy, might not be ready to publicly support this policy, because of their multiple identities that might shift their preferences in the opposite direction. An example of this was the introduction of user fees in Czech healthcare: a move which was not publicly supported by doctors. This policy episode showed that, for some policy actors, identities can sometimes be more important than interests and, consequently, can in turn make support for specific reforms and their ultimate success highly unpredictable.

6. Directions of Future Research

There are several interesting research themes which were not covered in this thesis, but which could be worthwhile investigating in the near future. One is the extended comparison of the two cases of health reform investigated here with other cases of health reforms in Eastern Europe, or, from a cross-regional perspective, reforms in Southern or Western Europe. Extending the existing East-East comparison would be interesting in the light of the most recent literature on the post-communist varieties of capitalism. It would be interesting for example to analyse how far the differences in the healthcare policy paths might correspond or be linked to the characteristics of the three country clusters – neoliberal, embedded neoliberal and neo-corporatist – that are said to divide the post-communist Eastern European space (Bohle and Greskovitz 2012). The East-South comparison, on the other hand, could shed more light on the role of politics in policymaking. As this thesis has shown, politics matter for the realization of policy ideas, allowing these ideas to link with interests in the political arena and translate into policies under specific institutional arrangements. It would therefore be interesting to compare the political dynamic of healthcare policy in the other countries of Europe's periphery that also relatively recently experienced political transition, and joined the club of advanced European democracies. Finally, the East-West comparison would be interesting, not only as a challenge to the traditional East-West divides but also because this comparison would allow research focused on Eastern Europe to play a part in the broader debate on welfare state development.

Another interesting research theme would be comparative analysis of the impact of healthcare marketization policies on medical professionals. This theme, to my knowledge, has been relatively poorly researched in the more recent academic literature and could link very well, both with the sociological literature on the role of professionals and professional groups in politics and public policy and with the literature on markets in the welfare state. While in this thesis I have offered an account of the roles of healthcare professionals that focused closely on marketization policies in two post-communist cases, I think it would be interesting to compare these roles across Europe. As I have become aware in my own research so far, there are some very interesting and unexplored aspects of healthcare professionals' roles in healthcare marketization policies, and variations thereof, which could make this theme a very fruitful avenue for future research.

Finally, certainly one of the timeliest directions for further research would be analysis of healthcare reforms in the context of the global economic crisis. The timeframe of this study was limited to the first two post-communist decades, and analysis of the healthcare reforms in the two countries ended precisely at the outbreak of the global financial crisis. In some European countries, the crisis was shattering for healthcare in as much it was shattering for the welfare state and its advocates. It brought the issue of healthcare governance and spending to national and even international scrutiny and, in the context of austerity, led to changes, the consequences of which still have to be measured, compared and critically evaluated. In this context, it would be interesting to analyse the extent to which the changes in healthcare generated by crisis and austerity have been successful in changing the balance between state and market instruments of healthcare provision. In other words, is it more market or maybe, contrary to the expectations, more state provision that we see in European healthcare sectors in the context of crisis and austerity? Another equally interesting research project could focus more closely on the healthcare sector in the countries of Europe's periphery, which were significantly affected by the crisis and in which, consequently, the healthcare systems were most seriously exposed to fiscal pressure. This project could analyse for example whether, and, if so, to what extent, the role played by external actors such as the EU in the healthcare policy of these countries has changed, in the context of strong and explicit international pressure for major adjustments of their public and healthcare finances.

Appendix

Interview Sample (Czech Republic)

First group: Healthcare policymaking in the Czech Republic (general questions)

- Why has health reform been such a salient issue in public ever since 1989?
- What formal and informal groups have been actively involved in pursuing their interests in healthcare policy making?
- Why did the health ministers change so frequently?
- How often do policy makers express an ideological stance in the debates over policy proposals?
- How consequentially have political parties followed their pre-election promises in respect to health?
- In how far has healthcare policy making in the Czech Republic been the matter of political entrepreneurship?
- What has been the role (if any) of the following international/supranational institutions in the policy making process:
 - › European Union
 - › World Bank and International Monetary Fund
 - › International experts/International consultancy agencies

Second group: 1991 and 1992 reforms

- Were there any significant reforms in Czech healthcare under communism?
- What happened with the former/communist Ministry staff after 1989? Were there any purges in the Ministry?
- What/Who was the main driver of these reforms?
- Why did these reforms start so quickly after the regime fall in 1989? Did the health sector have a priority for some reason?
- What was the role of doctors or healthcare professionals in general in this reform?
- Was there any resistance on the side of the bureaucracy during this early reform period?
- What was public reaction to these reforms?

Third group: Healthcare professionals

- Were healthcare workers organized during communism?

- What are the main channels through which healthcare professionals try or have tried to influence the policy making process? Is it through the Chambers? Through the Union? In the Parliament through the doctors MPs?
- Most of the Health Ministers since 1989 were doctors. Do you think this has influenced the reform process in some way?
- What are the main cleavages in the medical profession:
 - › General practitioners versus specialist?
 - › Specialists versus specialists?
 - › Private doctors versus state doctors?
 - › Any other?
- How frequent were/are the medical workers strikes in the country? Apart from strikes, were there any other ways in which medical professionals expressed their discontent with some aspects of government reforms?
- How do doctors MPs behave when the main debates over healthcare reforms in the Parliament are taking place? Are they supporting the interests of the profession or rather of the parties they are affiliated to?
- What is the relation of the Medical Chambers with the Unions representing healthcare workers? Which of the two organizations has been collaborating more closely with the Ministry?
- How serious is the brain drain problem in health profession?

List of interviews conducted in Poland

- Michal Marek, Ministry of Health, Department of Health Insurance, September 27th
Warsaw
- Marczisko Wojciech, Ministry of Health, Department of Health Insurance, November 4th
2011, Warsaw
- Maria Swidrek, National Health Fund, Chief Specialist, September 23th 2011, Warsaw
- Katarzyna Klonowska, National Health Fund, Chief Specialist, September 23th 2011,
Warsaw
- Iga Magda, Institute for Structural Research, September 21st 2011, Warsaw
- Barbara Wieckowska, Warsaw School of Economics, October 13th 2011, Warsaw
- Marek Gora, Warsaw School of Economics, October 18th 2011, Warsaw
- Jerzy Hausner, Faculty of Economics, October 25th 2011, Cracow
- Cezary Włodarczyk, Institute of Public Health, Jagiellonian University, October 20th
2011, Cracow
- Krzysztof Krajewski-Siuda, Institute of Public Health, Jagiellonian University, October
21th 2011, Cracow
- Christoph Sowada, Institute of Public Health, Jagiellonian University, October 21th 2011,
Cracow
- Piotr Romaniuk, Silesian University, Bytom, October 21st 2011, Bytom, Konstantin
Radziwill
Polish Chamber of Physicians and Dentists, October 24th 2011, Warsaw
- Stanisława Golinowska, Institute of Public Health, Jagiellonian University, November 5th
2011, Warsaw
- Bartłomiej Osieka, manager, Better Government Programme, Ernst and Young,
September 20th 2011, Warsaw
- Katarzyna Strzałkowska, Polish Chamber of Physicians, September 28th 2011, Warsaw
- Krzysztof Bukiel, National Association of Medical Professionals, November 22nd 2011,
Warsaw
- Renata Gorna, All Poland Alliance of Trade Unions, e-mail correspondence
- Katarzyna Drabczyk, Trade Union Solidarity, e-mail correspondence
- Jacek Grabowski, Medical University Lodz, e-mail correspondence
- Wacława Wojtala, Deputy Minister of Health (2001-2007), e-mail correspondence
- Anna Knysok, Ministry of Health, e-mail correspondence

Table 10. Political parties groupings in Poland according to their ideological orientation (major parties in government from 1989 to 2009).

Party family	Acronym	Party Name	Ideological orientation	Foundation
Right-wing	LPR	League of Polish Families (<i>Liga Polskich Rodzin</i>)	Eurosceptic, radical nationalists	2001
	SRP	Self-defence of the Republic of Poland (<i>Samoobrona RP</i>)	Agrarian populist, christian socialist	1992
Centre-right	UW	Freedom Union (<i>Unia Wolności</i>)	Liberal	1994
	AWS	Solidarity Electoral Action (<i>Akcja Wyborcza Solidarność</i>)	Liberal, conservative, christian democratic	1996
	UD	Democratic Union (<i>Unia Demokratyczna</i>)	Liberal, christian-democratic	1990
	PiS	Law and Justice (<i>Prawo i Sprawiedliwość</i>)	Conservative	2001
	PO	Civic Platform (<i>Platforma Obywatelska</i>)	Christian democratic, liberal conservative	2001
Centre	PC	Central Agreement (<i>Porozumienie Centrum</i>)	Christian democratic	1990
	PSL	Polish People Party (<i>Polskie Stronnictwo Ludowe</i>)	Agrarian, christian democratic	1989
Centre-left	SLD	Democratic Left Alliance (<i>Sojusz Lewicy Demokratycznej</i>)	Anti-clerical, social-democratic	1991
	UP	Labor Union (<i>Unia Pracy</i>)	Social-democratic	1992

Source: various.

List of interviews conducted in the Czech Republic

- Veprek Pavel, Ministry of Health, Insurance Department, November 24th 2011, Prague
- Tomas Roubal, Ministry of Health, Insurance Department, September 18th 2010, Prague
- Tomas Machacek, doctor and healthcare expert, Coalition for Health, September 20th 2010, Prague
- Petr Hava, doctor and healthcare expert, Faculty of Social Science, Charles University, September 22nd 2010, Prague
- Jan Richter, journalist *Radio Prague*, September 23rd 2010, Prague
- Lucie Frydecka, journalist *Dnes*, September 25th 2010, Prague
- Moravcova Karolina, Czech Nursing Association, September 19th 2010, Prague
- Pavloková Katerina, Ministry of Health, September 20th 2010, Prague
- Mrazek Jozef, Czech Association of Patients, September 17th 2010, Prague
- Martin Potuček, healthcare expert, Center for Economic Research and Graduate Education, Economics Institute, September 18th 2010 and November 22nd 2011, Prague
- Jaroš Jan, healthcare expert, Czech Association for Health Service Research, November 20th 2011 and December 15th 2010 (Skype interview), Prague
- Jaroslav Volf, National Institute for Public Health, November 9th 2011, Prague
- Martin Dlouhy, healthcare expert, Faculty of Economics, Charles University, November 9th 2011, Prague
- Jan Alexa, Ministry of Health, November 10th 2011, Prague
- Ondrej Matl, Ministry of Health, November 11th 2011, Prague
- Henrieta Madarova, Advance Institute for Healthcare Management, November 18th 2011, Prague
- Pavel Kožený, National Reference Centre, September 20th 2010, Prague
- Schlanger Jiri, Trade Union of the Health Service and Social Care, September 25th 2010 and November 18th 2011, Prague
- Marek Šnajdr, politician, Deputy Minister of Health (2006-2010), September 25th 2010, Prague
- Antonin Malina, Institute for Postgraduate Medical Education, November 23rd 2011, Prague
- Terezie Písarova, Trade Union for Health Service and Social Care, November 23rd 2011, Prague

Table 11. Political parties groupings in the Czech Republic according to their ideological orientation (major parties in government from 1989 to 2009).

Party family	Acronym	Party Name	Ideological orientation	Foundation
Centre-right	ODS	Civic Democratic Party (<i>Občanská Demokratická Strana</i>)	Eurosceptic, liberal-conservative	1991
	US- DEU	Union of Freedom-Democratic Union (<i>Unie Svobody-Demokratická Unie</i>)	Liberal	1998
	ODA	Civic Democratic Alliance (<i>Občanská Demokratická Aliance</i>)	Liberal-conservative	1989
	KDS	Christian Democratic Party (<i>Křesťansko Demokratická Strana</i>)	Christian democratic	1990
Centre	KDU-ČSL	Christian Democratic Union - Czechoslovak People Party (<i>Křesťanská a Demokratická Unie – Československá Strana Lidová</i>)	Christian democratic	1992
	SZ	Green Party (<i>Strana Zelených</i>)	Green politics, social liberalism	1990
Centre-left	ČSSD	Czech Social Democratic Party (<i>Česka Strana Sociálně Demokratická</i>)	Social-democratic	1993
Left-wing	KSCM	Communist Party of Bohemia and Moravia (<i>Komunistická Strana Čech a Moravy</i>)	Communist	1989

Source: various.

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