

# **The Politics of Health Care Reform in Central and Eastern Europe: The Case of the Czech Republic**

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***...the democratic method produces legislation and administration  
as by-products of the struggle for political office.***

*Joseph Alois Schumpeter (1984[1942], p.286),  
Czech-born economist and political scientist*

## **Abstract**

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This thesis examines the political process of health care reform between 1989 and 1998 in the most advanced sizable political economy in Central and Eastern Europe (CEE) – the Czech Republic. Its aim is to explain the political process bringing about post-Communist health policy change and stimulate new debates on welfare state transformation in CEE. The thesis challenges the conventional view that post-Communist health care reform in CEE was designed and implemented to improve the health status of the people, as desired by the people themselves. I suggest that this is a dangerous over-rationalisation, and argue that post-Communist health care reform in the Czech Republic was the by-product of haphazard democratic political struggle between emerging elites for power and economic resources.

The thesis employs the analytical narrative method to describe and analyse the actors, institutions, ideas and history behind the health policy change. The analysis is informed by welfare state theory, elite theory, interest group politics theory, the assumptions of methodological individualism and rational choice theory, and Schumpeter's doctrine of democracy. Its focus is on the interests of health policy actors and how they interacted within an unhinged, but fast-consolidating, institutional framework. The results demonstrate that, while historical legacies and liberal ideas featured prominently in the rhetoric accompanying health policy change, in *Realpolitik*, these were merely the disposable, instrumental devices of opportunistic, self-interested elites. The resultant explanation of health policy change stresses the primacy of agency over structure and formulates four important mechanisms of health policy change: opportunism, tinkering, enterprise, and elitism. In conclusion, the relevance of major welfare state theories to the given case is assessed and implications for welfare state research in CEE are drawn.

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exceeded all expectations. I would encourage anyone interested in Central and Eastern Europe to study and visit the Czech Republic. I owe a special debt of gratitude to all those interviewees and correspondents who so generously offered me their time and tolerated my sometimes naïve questions. I list them in alphabetical order in the Appendix. I would like to thank, again in alphabetical order, Vlad'ka Bošková, Martin Dlouhý, Petr Háva, Jan Jaroš, Kamil Kalina, Petr Pasternak, Dagmar Pohunková, Martin Potůček, Jana Veselá, and Václav Žák for kindly sharing their personal documents and archives. I would also like to thank Jaroslav Bouček for allowing me to consult the Library of the Health Ministry, Tomáš Cikrt for enabling me to access Zdravotnické noviny electronically, and Karolina Kudynová for introducing me to the whole world of the Czech media. I am particularly thankful to Dita Pírková for greatly helping me to organise and conduct my research in the Czech Republic and for housing my fieldwork HQ in her flat in Modřany. Without her friendship and help I would have been lost in the Czech Republic.

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# INTRODUCTION: STUDYING HEALTH POLITICS

## ***The idea for the study***

The present study sets out to explain the political process which brought about post-Communist health policy change in the Czech Republic. The time span of the study is limited to the period 1989-1997, when most post-Communist health policy change occurred. During this period, the Czech Republic replaced a centralised, integrated state health service with a decentralised model of contracted social health insurance. It is particularly interesting to observe how policy change in the health sector took place in the context of an unprecedented transition from one-party rule, a highly centralised politico-administrative system, and a planned economy to democracy, decentralised government, and a market economy. These reforms have fundamentally changed the actors, institutional context, and political process of health policy-making. The introduction of market mechanisms in the health sector has created new incentive structures and crystallised economic interests around them. For example, fee-for-service reimbursement provided powerful incentives for the over-prescription of health care services and drugs. Furthermore, politico-administrative changes have created a new division of interests between different levels of government and its agencies and the newly-established democratic institutions have provided political arenas for various organised interests to exercise influence over health care reform. As a result, health policy change has been influenced by conflicts of interests involving doctors, trade unions, employers, medical and pharmaceutical industries, political parties, different levels of government and its agencies, and other health policy actors. It is, thus, imperative to study how the transitional changes have affected the system of health policy-making and its capacity to provide effective solutions to health policy problems.

The theoretical foundations for health policy study have been laid by scholars of economics, social policy, and public administration. Economists have elucidated theoretical concepts, devised analytical tools, and proposed indicators for health policy

planning and financing (e.g. Arrow 1963; Green 1992; e.g. Abel-Smith 1994; Kutzin 2001). Sociologists have explored the role of medical knowledge and the medical profession in modern society (e.g. Freidson 1970; Abbott 1988; Freddi *et al.* 1989; Gabe *et al.* 1991; Hafferty & McKinlay 1993). A great deal of theoretical and applied research has been done on the policy content of recent health care reforms (e.g. Mills *et al.* 1990; e.g. Saltman *et al.* 1998; Drache & Sullivan 1999; Mossialos & Le Grand 1999; Mossialos *et al.* 2002; Saltman *et al.* 2002). Applied health policy analysts and practitioners of the field have created a description of health policy change in the Czech Republic, assessed successes and failures in health care reform, and proposed strategies for further change (Saltman & Figueras 1997; Jaroš & Kalina 1998; Observatory 2000; Jaroš *et al.* 2005; Rokosová & Háva 2005). The current study owes much to this scholarship, and attempts to contribute one important perspective which has been rather inadequately treated.

Existing health policy literature has tended to neglect the process of reform, the context in which it occurs, the actors involved in it, and the distribution of power between them (Walt 1994; Figueras *et al.* 1997; Saltman & Figueras 1997). Instead, it has tended to produce an ideal image of health care systems and advocate ‘rational’ and ‘modern’ health plans. For example, although Abel-Smith’s classic textbook on health policy is intended to be ‘about how to improve health in a cost-effective and politically acceptable way’ (Abel-Smith 1994, p.vii), the issue of health politics is not addressed in this book. One might assume that the situation is different when it comes to practitioners’ literature; but, surprisingly, this is not the case. In the 1993 World Development Report (World Bank 1993), one finds seven chapters on the content of health sector reform, but only five paragraphs on the actual process of reform (Reich 1997). Similarly, the 2000 World Health Report (WHO 2000) ignores conflicts of interest between health policy actors, and the World Health Organisation (WHO) makes recommendations ‘as if health sector reform occurs in a political vacuum’ (Hsiao *et al.* 2001, p.70). In the real world, where changes are procedurally expensive and many health policy actors have conflicting interests, such literature runs the risk of advocating costly policy experiments or being received as a dead letter.

The idea behind the current study is neither to refine theoretical concepts and methodological approaches to the study of health care reform in CEE, nor to provide a comprehensive description and analysis of health policy change. This study does not set out to make policy recommendations for further change either. Other scholars have already done all this, and some very good textbooks, works of reference, and policy papers are available. However, there has so far been no study which deals with *health politics* in CEE. The current study attempts to compensate for this. It examines the political process of health care reform in one CEE country, the Czech Republic, through the theoretical-methodological lenses of political science, in order to explain health policy change.

### **The research question**

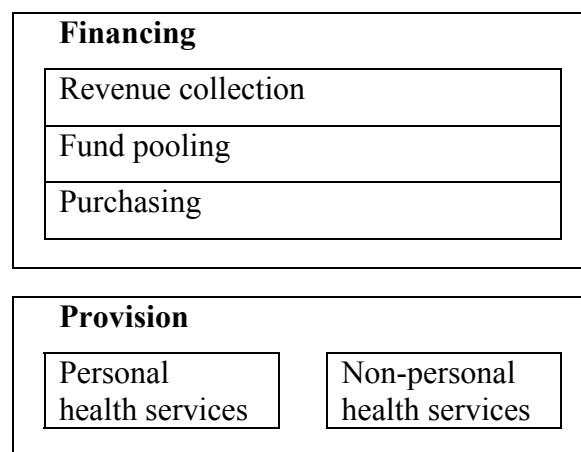
At the beginning of the 1990s, the Czech Republic shifted away from a centralised, integrated state model of health service to a decentralised and contracted social health insurance model. In 1991-1992, administrative and functional hierarchical systems of regional and district health authorities and health care facilities were abolished, and the medical profession won independence from the state. In 1992, mandatory social health insurance was introduced and then multiple independent health insurance funds were allowed to compete against the public General Health Insurance Fund. At the end of 1992, the privatisation of primary health care providers began. General Practitioners (GPs) became owners of their practices, and the outpatient specialists who wanted to establish their private practices were also able to do so. Policy-makers repeatedly attempted privatisation of secondary health care providers, but succeeded only marginally. Although some non-essential services and drugs were removed from social health insurance, the introduction of substantial patient co-payments failed in 1997 and has not succeeded until 2008. In tertiary healthcare, privatisation or other restructuring has never come on the agenda. What is more, in the mid-1990s, 'the reform of the reform' (Jaroš *et al.* 2005, p.201) was launched and many existing healthcare financing reforms were revised: the competition between insurance funds was abolished, two-thirds of them being merged or liquidated, and, in general practice and inpatient care, the fee-for-service reimbursement was abolished. The implemented, revised, and failed policy

changes have had far-reaching consequences for the configuration of the public-private mix in the financing and ownership of the health sector, for the access to health care services, and for the distribution of power and responsibility between the health policy actors. Therefore, it is imperative to know **how health policy change was initiated, what forces drove it, and why certain policy changes succeeded and others not.**

### **Health policy instruments**

If the aims of a health care system are efficiency and equity, it is puzzling why the aforementioned health policy change occurred. Insights from health policy literature suggest that health insurance, competition, decentralisation, and privatisation are positively associated with higher administrative costs and are negatively associated with equity of access to health care (Anderson 1997; Evans 1997; Wagstaff *et al.* 1999; Evans *et al.* 2001; Mossialos *et al.* 2002). Although these policies increase patient choice and may increase the quality of health care services, it is questionable to what extent losses in efficiency and equity are justifiable by gains in choice and quality. In order to understand the rationale of health policy change, it is helpful to distinguish between two major functions of a health care system (Figure 1), consider their components, and outline the advantages and disadvantages of related health policy instruments.

**Figure 1: Functions of health care systems**



Source: Mossialos *et al.* (2002, p.4)

The health care financing function can be broken down into three components: revenue collection, fund pooling, and purchasing (Murray & Frenk 2000; Kutzin 2001). During Communist rule, health care revenue was collected through taxes levied on firms. The advantages of taxation-based financing are a broad revenue base, low administrative costs, and flexibility in allocating resources to health care vis-à-vis other sectors of the economy (Mossialos *et al.* 2002). In the 1950s, taxation allowed for a significant increase of Czechoslovak health care expenditure but, later, health care expenditure growth became incremental, as industry and other public sectors gained a higher priority. In such circumstances, hypothecated, or earmarked, taxation was likely to protect the health care sector against competition with other sectors of the economy and to preserve the efficiency of revenue collection. Nonetheless, the Czech Republic opted for social health insurance in 1992. The latter shares with hypothecated taxation the advantages of a broad revenue base, but has higher administrative costs, and may be captured by vested interest groups (Preker *et al.* 2002). Moreover, patient co-payments negatively affect equity of access to health care. The introduction of social health insurance brought about changes on the level of pooling, i.e. ‘the accumulation of prepaid health care revenues on behalf of a population’ (Kutzin 2001, p.177). Although all health insurance funds were obliged to guarantee the same health care coverage, they were allowed to compete on the basis of additional health care services. If competition takes place without risk-adjustment, independent health insurance funds have incentives to cream-skim the population with a high-income and low health risks from their competitors (Beck & Zweifel 1998). In the Czech Republic, this contributed to a growing deficit of the social health insurance system and to emerging inequalities in access to health care. Lastly, the introduction of health insurance was accompanied by changes in the purchasing of health care services, i.e. ‘the transfer of pooled resources to service providers on behalf of the population for which the funds were pooled’ (Kutzin 2001, p.180). Fee-for-service reimbursement of providers does not result in substantial quality gains and usually leads to the excessive utilisation of health care services and drugs (Rosenberg *et al.* 1995; Evans 1997); but in the Czech Republic historical budgeting was replaced with fee-for-service reimbursement. Later, however, excessive utilisation prompted policy-makers to replace

fee-for-service reimbursement with more efficient forms of provider payments: capitation fees in general practice and budgets in inpatient care.

In health care provision, the main policy changes were focused on decentralisation. For analytical purposes, it is helpful to distinguish four types of decentralisation: deconcentration (transfer of decision-making to lower administrative levels), devolution (transfer of decision-making to lower political levels), delegation (transfer of decision-making to policy actors at lower organisational levels), and privatisation (transfer of decision-making and ownership to private firms) (Mills 1990). Advantages of decentralisation include: flexibility and a rapid response to the changing environment, greater effectiveness in identifying problems and opportunities, openness to innovation, and higher morale and productivity (Saltman & Figueras 1997, pp.52-53). Conversely, decentralisation can lead to the fragmentation of health services, weakening of central health departments, inequity, political manipulation in favour of particular vested interest groups, and a weakening of the public sector (ibid.).

In the Czech Republic, deconcentration was concerned with the abolition of hierarchical regional and district health authorities, along with the functional hierarchy of health care facilities. This allowed health care facilities to be contracted directly by health insurance funds. Moreover, to a great extent, patients became able to choose health care facilities, irrespective of their regional or functional level. Early plans for the devolution of health care governance to local Health Councils never materialised. Nonetheless, administrative reform in early 2000s transferred healthcare facilities to self-governing regional authorities which were established to meet EU accession terms. This created a new agenda for privatisation of healthcare facilities as regional authorities lacked sufficient funds to maintain their healthcare facilities; yet, apart from this, the impact of devolution on health care provision was limited. In addition to the delegation of health care financing to health insurance funds, self-governing bodies of the medical profession (medical chambers) were granted oversight over professional matters and standards of healthcare. Lastly, the Czech Republic attempted an ambitious programme of privatisation in healthcare. This programme succeeded in outpatient care, where GPs

became owners of their practices and gained opportunity to privatise their offices and equipment. Also, outpatient specialists and, to a small extent, inpatient specialists were able to do so. This led to significant fragmentation of the formerly integrated healthcare system, as large polyclinics, and even some hospitals, were divided into a great number of independent practices and health care facilities.

### ***Literature overview***

So far, there has been no comprehensive literature on health politics in CEE countries. Furthermore, the literature on health politics pertaining to other countries or regions is not abundant and, also, somewhat overlapping with the literature on the politics of the welfare state. As a result, the current study necessarily draws on the somewhat overlapping strands of literature on health politics and the politics of the welfare state from Western Europe and North America. In doing so, the current study attempts to cross-fertilise both strands of literature by examining health politics in the Czech Republic. The advantage of focusing on one welfare state sector in one CEE country is that this helps avoid the ‘ecological fallacy’ (Robinson 1950) of aggregating possibly opposite policy dynamics in different welfare state sectors of different countries (Seeleib-Kaiser 1995). Theoretical concepts and related categories developed in the context of Western Europe and North America may not fully apply to the Czech Republic. However, if treated as ‘sensitising concepts’, they can help reduce the complexity of the phenomena under investigation by setting parameters to data collection and the organisation of evidence (Ragin 1994, pp.87-89). In the course of research, it is expected that these ‘sensitising concepts’ will be clarified, and that some of them will even be abandoned. When these concepts are significantly altered, it will be possible to return to the data, which was initially discarded as irrelevant, and to use it in the formulation of new concepts.

### **Politics of the welfare state**

Health care is one of the most important forms of welfare in modern European societies. The health sector is a leading consumer of public funds and major employer. The public

provision of health care represented a significant step in welfare state expansion. Though this assumed different forms in different countries, in all countries with a mature welfare state, it took place within the framework of capitalism and democracy. The CEE welfare state, however, came into being under the diametrically opposite conditions of extended one-party rule and a planned economy. Again, recent major changes in mature welfare states have been taking place within a framework of well-established capitalism and democracy. In post-Communism CEE, it is rather democracy and capitalism that have been developing within the framework of the well-established welfare state. As such, the evolution of public health care provision in CEE reveals linkages between the welfare state, democracy, and capitalism. This exercise will connect the case in question to a wider body of welfare state literature in order to distil ‘sensitising concepts’ which can help guide investigation and answer research questions.

Traditionally, it was argued that the expansion of social rights follows the expansion of democracy through universal suffrage (Marshall 1950). Later, it was suggested that democracy did not automatically expand social rights, but created conditions for trade unions and Social Democratic parties to act together, against the interests of capital, to expand the welfare state (Korpi 1983; Shalev 1983; Korpi 1989). Further studies criticised the class-based perspective and formulated the interest group politics theory: ‘(1) economic and demographic changes affect the structure of group resources and demands for welfare spending, and (2) the existence of democratic political institutions facilitates the realization of group interests’ (Pampel & Williamson 1989, p.39). Lastly, it was argued that the dynamics of interest group formation affects politics, as the longer stable democracy exists the more interest groups emerge that tend to act in their own interests than in the interest of the whole of society (Olson 1992). It is intriguing to see whether the advent of democracy in post-Communist CEE triggered changes in public health care provision through universal suffrage, class-based politics or interest group politics defined by ascriptive characteristics such as occupation or age. If interest group politics mattered, it is important to see what the dynamics of group formation were and how this influenced health care coverage.

With regard to capitalism, it was first argued that the needs of the groups affected by industrialisation prompted the state (regardless of the economic system) to increase social welfare expenditure, to protect these groups and facilitate economic growth (Wilensky & Lebeaux 1965). Whereas the desirability of the welfare state for economic growth was couched in Keynesian terms, monetarist economics considered the welfare state as a burden on the economy and demanded economic austerity measures. These came as retrenchment – i.e. ‘policy changes that either cut social expenditure, restructure welfare state programs to conform more closely to the residual welfare state model, or alter the political environment in ways that enhance the probability of such outcomes in the future’ (Pierson 1994, p.17). However, the varieties of capitalism theory suggested that employers were interested in maintaining certain levels of the welfare state because it would allow them to have well-trained workforces who would not leave their industries due to contingencies of life (Ebbinghaus & Manow 2001; Estevez-Abe *et al.* 2001; Hicks & Kenworthy 2003). In post-Communist CEE, the trends towards industrialisation reversed as workers were leaving industry for services, but the aged urban population and their health care needs did not decline. Also, it is unclear whether retrenchment applied to the early stages of post-Communist economic transition and whether the new capitalists were interested in maintaining the welfare state.

State-centred theories emphasised state structure, corporatism, and the bureaucratic strength of state agencies (Wilensky 1975, 1976; Tufté 1978; Skocpol 1980; Evans *et al.* 1985). The centralised corporatist state and its tax structure allowed elites to reach a consensus on the introduction of the welfare state beneficial for the whole of society. Moreover, the bureaucratic strength of certain agencies can explain the growth of the welfare state in terms of the maximisation of their budgets and the expansion of their bureaucratic turf. Lastly, the electoral cycle may affect the allocation of funds to welfare state sectors on the face of upcoming elections. During Communist rule, the incorporation of the medical profession in the state and the unified state budget indeed helped the introduction of the integrated state-run health care systems. However, the bureaucratic strength of health agencies was low and the electoral cycle during extended one-party rule could not influence health care expenditure. Therefore, it is worthwhile

looking into how the evolution of the post-Communist state structure, the independence of the medical profession and social health insurance budgets from the state, and free elections influenced health policy.

Finally, it was noticed in early empirical research on social security adoption that social policy innovations could transcend national borders and drive policy change in other nations (Rys 1964). Collier and Messick (1975, p.1305) pointed out that national social policy development took place ‘within an international system of communication and influence’ and argued that social policy innovations can be subject to spatial diffusion (along the lines of spatial proximity or major lines of communication) or hierarchical diffusion (from one end of a hierarchy to another). In the case of spatial diffusion of health policy, mechanisms of policy learning were employed to explain why nations copy health policies enacted abroad (e.g. Ham 1997; Marmor 1997). In the case of hierarchical diffusion of social policy, the argument for ‘global social policy’ stressed the role of supranational organisations such as the IMF, World Bank, WHO, etc. in influencing national social policy (Deacon *et al.* 1997; Deacon 2007). It was shown that Washington-based supranational organisations acted to set a right-wing social policy agenda in Hungary, Bulgaria and the Ukraine (Deacon *et al.* 1997). Others became concerned with the possibilities of ‘social dumping’ (Ferrera *et al.* 2000) in CEE countries and argued that the so-called ‘European Social Model’ would impact their national welfare states through the process of the EU enlargement (Kittel 2002; Vaughan-Whitehead 2003). Thus, one major question is whether the spatial diffusion of health policy or supranational organisations actually influenced the Czech health policy agenda, and if so, how.

## **Health politics**

The history of public health care provision – successful in some nations and unsuccessful in others – is full of political conflicts. These involve the state and doctors, political parties and trade unions, various groups within the medical profession and managers of health care facilities, different levels of government and its agencies, medical and pharmaceutical industries, and private insurers and health care providers. Below, I

consider influential health politics studies with a view to borrowing valuable theoretical and methodological perspectives for the current study.

A good starting point for an overview of health politics literature is the treatment of the US case in *The Politics of Medicare* by the political scientist Theodore Marmor (1970). The study makes a strong case for the use of explicit analytical frameworks, arguing that only research guided by such frameworks can be comparable and cumulative. It draws on Allison's (1969) classic research on conceptual models of the US policy process. Thereby, Marmor consecutively employs three alternative models of policy process to explain different aspects of the legislative conflict over the 1965 Medicare bill. First, to explain policy formulation, the rational actor model is employed. Subsequent analysis is focused on a strategic political decision to adopt the Medicare strategy which was made by the state as a 'single rational actor'. The explanation given for the strategic choice involves a set of reasons showing why 'sensible men' (bureaucrats) agreed on this strategy. Second, to explain the pattern of policy debates over a prolonged period of time, the organisational process model is selected. Instead of concentrating on the decisions of specific individuals regarding certain policy proposals, analysis is carried out at the level of large organisations and their routine behaviour. It is argued that since organisational routines often determine the behaviour of individuals acting on behalf of their organisations, political debates are explained better by appeal to organisational rather than individual behaviour. Lastly, to explain the enactment of the bill, the bureaucratic politics model is adopted. According to this model, implementation of policy results from bargaining games arranged hierarchically within government and between agencies with unequal power and different policy preferences. Altogether, the study revolves around various political institutions and actors representing different branches of the government and interest groups. The study reveals pluralist strategies inside and outside Congress, but concludes that public opinion, ideology, and, allegedly, powerful interest groups have less influence on policy-making than the executive bureaucracy, which tacitly incorporates compromises between antagonistic interests into legislative proposals.

In another seminal study of the US case, *Health Politics*, the sociologist Robert Alford (1975) arrives at the opposite conclusion regarding the influence of interest groups and ideology. The study goes beyond a pluralist vision of the policy process concerned with bureaucrats and interest groups, to produce a more socially and historically determined image of the political process. This image is based on the analysis of structural interests and a symbolic understanding of politics. According to the latter, 'politics serves simultaneously to provide tangible benefits to various elites and symbolic benefits to mass publics, quieting potential unrest, deflecting potential demands, and blurring the true allocation of rewards' (ibid., p.x). As such, public opinion does not play an independent role in policy process, but is influenced and exploited by interest groups inside and outside the government in order to allocate resources according to their preferences. Unlike interest groups, structural interests either do not need to be organised to have their interest served, or cannot be organised easily. They are served or not served 'by the way they "fit" into the basic logic and principles by which the institutions of society operate' (ibid., p.14). Interest groups are based on structural interests, although there may well be antagonistic interest groups within a structural interest. Alford depicts the process of American health policy as a struggle between three structural interests. In this struggle, the role of ideology is extremely important but it does not act on its own: it is a function of structural interests. Alford conceives of ideology not as the abstract assertions of individuals, but as symbolic constructs made by structural interests to preserve their legitimate role and organisation. First, he identifies 'professional monopolists', which include physicians and other occupations with a monopoly over certain types of work. Monopolistic status allows them to set up their activities in a way that delivers real services to the population, but also provides a symbolic screen of legitimacy which preserves their activities, income, prestige, and power from the outside scrutiny and control. Secondly, Alford identifies 'corporate rationalizers' including hospital administrators, medical schools, government health planners, public health agencies, and researchers, all of which challenge the professional monopoly of the medical profession over the production and distribution of health care in order to make it more rational and responsive to changing technology and labour division in health care. Lastly, Alford identifies the 'community population' which include vulnerable ethnically,

socially, professionally, and geographically disadvantaged groups of the population which require better and more affordable health care. Sometimes, these structural interests can be organised into interest groups to demand a new hospital or a more comprehensive insurance coverage, but most often these structural interests are represented by ‘equal-health advocates’.

*The Politics of the NHS* and its update *The New Politics of the NHS* by the historian and social policy student Rudolf Klein (1983, 2001) offer an exemplary description and analysis of the policy process related to the establishment, development, and reform of the British National Health Service (NHS). Instead of providing a full historical account of events, the study focuses on chronologically selected topics that offer insight into the NHS policy process. The study analyses the constantly evolving nature of the health care policy arena as being determined by historically-specific sets of factors. In so doing, it employs a pluralist interest group approach and considers policies as results of consensus between various groups of actors, including the British Medical Association, Royal Colleges, and other interest groups within the medical profession; trade unions; political parties; and government agencies. In this regard, the study traces the evolution of actors, and examines power distribution within the health policy arena. The second set of factors, which are crucial for Klein’s analysis, encompasses policy ideas and ideology more broadly. These are treated as factors influencing both policy change and the context in which policy change occurs. Although the study focuses on Britain, the international context is taken into account; for example, the establishment of the NHS in 1948 is explained by both the Labour Party’s electoral victory and the international success of a managerial ideology. Similarly, the radical changes introduced in 1989 are explained by Conservative Party rule and an international shift in ideology towards restraining growth of public expenditure.

Another historical account of health politics, *Health Policies, Health Politics* by Daniel Fox (1986), takes a comparative view of Britain and the United States. The study describes policies adopted by the two nations, and explains their adoption by examining technocratic ideas behind policies. A peculiarity of the historical approach employed in

this study is that it is based on the assumption that the past does not unfold towards the present. Thus, the universal health care coverage is not considered to be a natural development of history. Moreover, it is assumed that the alleged 'progress of medicine' does not make certain policies desirable, because medicine changes and advances technologically, but it does not progress. Rather, the technological advances of medicine create imperatives for policy because they change the beliefs about the purpose and content of medicine. The study shows that such beliefs can transcend national borders, as happened in Britain and the US. Because of shared beliefs, these countries had similar ideas about organising health care which were based on the principle of hierarchical regionalism. Despite the similarity of British and American technocratic ideas about the organisation of health care, a difference in policies between the two nations occurred. This difference is explained by the fact that these ideas were 'refracted' by the different political culture in the US and Britain: a centralised polity in Britain versus a fragmented one in the US; a rigid versus a fluid class structure; and a wide versus a narrow range of ideological debate. In both countries, the role of public opinion and partisan politics in 'refracting' technocratic ideas is shown to be low.

*Health Politics*, by the political scientist Ellen Immergut (1992), is a comparative historical study investigating health policy change in Sweden, France, and Switzerland. The study focuses on formal political institutions, interest groups, and partisan politics. Comparisons between the nations reveal both unique and common factors influencing health policy processes and show that certain factors may be significant in one nation, but have little explanatory power others. The central claim of the study is that, although interest groups matter a great deal, it is neither their political resources nor the ideas they have at their disposal that determine the balance of power between policy actors, but the political institutions. Thus, political institutions are critical for the analysis of the policy process and its outcomes. Although the role of partisan politics and interest groups (above all, leftist parties and the medical profession) in the policy process is unquestionably high, it was a combination of their political resources and the opportunities provided by political institutions to influence political decisions that determined unique configurations of interest coalitions and accounted for different

outcomes of the political process in the three nations. The comparative perspective helps Immergut arrive at opposite conclusions about the role of the medical profession in the enactment of national health insurance legislation to Alford's argument that the medical profession can always veto enactment of national health insurance. Having analysed rich historical material, Immergut concludes that there are no veto groups in society, but there are veto points within the political system.

In his influential article *Path Dependency*, the political scientist David Wilsford (1994) compares health policy reform in Germany, France, Great Britain, and the United States, with a view to examining the role of history in health policy change and continuity. In doing so, Wilsford incorporates conjunctural elements into structural explanations. Conjunctures, or 'windows of exceptional opportunity', are the 'fleeting comings together of a number of diverse elements into a new, single combination' (ibid., p.254). Combined structural and conjunctural explanations overcome the inadequacy of purely structural explanations (e.g. Alford, 1975; Immergut, 1992) to deal with policy change. Wilsford attunes such combined explanations to a degree of history's salience: 'strong history', 'medium history', and 'weak history'. Naturally, history's salience accounts for the strength of a structure. The stronger the structure, the more powerful and compelling the conjunctures need to be in order to make it possible to depart from the well-established path. For example, in the American case, strong history has never been confronted with strong enough conjunctures, whereas in Germany the financial crisis of unification and a new health minister mitigated the effects of history and allowed major change to occur.

In *Boomerang*, the sociologist Theda Skocpol (1997) advances both a historical narrative and a structural explanation of the outcome of Clinton's health reform. The narrative offers a detailed description of the institutional context and principal actors' choices which contributed to the failure of the reform. Instead of focusing on personalities and unique events, an attempt is made to provide a more parsimonious explanation, which hinges on the strategic choices made by bureaucrats on the grounds of their institutional locations, political resources and ideas at their disposal. Another key factor in Skocpol's

explanation is past policy choices, namely the 1981 tax cut which brought about a federal deficit. The latter greatly influenced Clinton's choice of insurance instead of taxation as a means of revenue collection; a choice considered to be crucial to the reform's defeat. Another strategic choice contributing to the defeat of the reform was not to have put health care reform high on agenda in the first instance: it was only raised in the middle of Clinton's term in office. Altogether, this study's explanatory framework includes actors, institutions, ideas, and policy legacies, while such factors as ideology, public opinion, and national values also play a minor role.

In *Adapting the Welfare State*, the political scientists Susan Giaimo and Philip Manow (1999) compare patterns of health care reform in Britain, Germany, and the United States, to show that responses to the common challenges of the welfare state retrenchment differ across nations and that these responses have limited effects on social solidarity. Unlike previous studies, Giaimo and Manow do not focus predominantly on the legislative arena, but mainly examine the actors and institutions of the health sector. They conclude that the structure of the health sector significantly influences the policy preferences and reform strategies of key policy actors. For example, in structurally different health sectors, the state has a different degree of leverage over providers and payers and these, in turn, may define policy problems differently. In addition, the study recognises the importance of policy legacies and 'policy feedback' effects (Pierson 1993). Implementation of reform prompts policy feedbacks which can quicken, slow down, or alter reform. Therefore, if the analysis of the actors and institutions of the health sector does not accommodate 'policy feedbacks', it risks missing out important changes and transformations within the health sector.

In *Accidental Logic*, Carolyn Tuohy (1999) develops both a historical narrative and theorisation of health policy formulation in the United States, Britain, and Canada. The study attempts to construct a conceptual framework for understanding the interplay between multiple factors which shape health policy-making, including legislators, health sector policy actors, political institutions, public opinion, political culture, historical legacies, policy ideas, and 'policy feedback' (Pierson, 1993). The framework draws on

historical institutionalism, rational choice, and path dependency. It holds that policy change occurs when primary policy actors have both political power and the political will to implement policy change. However, opportunities for change in the health policy arena stem from a broader political arena, and only periodically do policy actors in the broader political arena open windows of opportunity for health policy change. At all other times, health policy develops incrementally in accordance with the internal logic of the health policy arena. Although the rigour and usefulness of this model can be doubted, it stresses the importance of complex historical conjunctures or ‘accidents’. Furthermore, the descriptions and explanations of health policy change in each country are detailed and convincing, going beyond simplistic rational choice models to explore the unique historical contexts of policy episodes which set parameters within which rational actors make their choices. The dynamics of these parameters is rather path dependent, and they change only when a new window of opportunity emerges. The parameters are analysed within the dichotomy of structural and institutional dimensions. The latter refers to instruments of social control such as hierarchy, market and collegiality, while structure captures the balance of influence between key categories of health policy actors, i.e. the state, the medical profession and private finance. This study has profited from the use of a comparative perspective to distil common and particular features of the health policy arena in each nation to arrive at its main finding: that health care systems in the three nations have developed into what they are now ‘accidentally’ and that, if windows of opportunity had opened at other times, they might have evolved differently. Another important conclusion of the study is that, although all nations share a common logic of the health policy arena and face common challenges, this logic is mediated by the particularities of each nation so common challenges are experienced and responded to differently in the context of each nation. Thus, recognition of the tension between the common and the particular is indispensable for understanding policy process in each nation.

An important article by the health policy scholars Adam Oliver and Elias Mossialos (2005), *European Health Systems Reforms: Looking Backward to see Forward?*, reviews health policy change in Europe over the last three decades with a view to evaluating the

explanatory power of various political science variables and theories. The authors focus on the explanatory power of a great many variables including policy actors, institutions, ideas, history, and culture within the three branches of new institutionalism – rational choice, sociological, and historical institutionalism. Having reviewed research evidence from eleven European countries, the article stresses that the new institutionalist approaches can advance the understanding of health policy change in different countries, but questions the possibility of obtaining a satisfactory parsimonious explanation within one approach and cross-nationally, concluding that: ‘it is... reasonably clear that a single explanatory theory cannot account for all of the health sector developments that have occurred within any individual country, let alone across many countries with diverse cultures, histories, institutions, and interests’ (ibid., p.25). The authors call for the combined application of different theoretical approaches to the explanation of health policy change and continuity in individual countries.

# **PART I: METHODOLOGY AND METHODS**

# CHAPTER 1: AN ANALYTICAL FRAMEWORK

The reviewed studies have revealed a variety of explanatory factors, underlying theoretical concepts and assumptions. These provide a solid basis upon which to organise an analytical framework for the current study. The need to employ an analytical framework, instead of theory stems from the fact that, presently, there is no undisputed theory to explain the case under investigation. This chapter fleshes out an actor-centred institutionalism framework to be used in the current study and, within this framework, proposes to pay special attention to the effects of ideas and history on the health policy process. The chapter concludes by outlining the elements of the analytic narratives approach which are utilised in the current study, with a view to embedding the explanation of the case into a rich descriptive narrative.

## ***Theory versus an analytical framework***

Esping-Andersen (2000) rightly observed that, in today's fast-changing world of 'post-something', there is no 'real' theory to explain welfare state developments and advocated using theoretical concepts from previous research as 'suggestive *Leitmotifs*', in order to reduce the complexity of the phenomena under investigation and preserve a disciplinary coherence. The apparent absence of covering-law theory in my field prompts me to use theoretical concepts derived from relevant literature in a 'modular' way, that is, to devise explanations consisting of several theoretical modules linked by a partial theory or narrative (Scharpf 1997). In so doing, an analytical framework can fill the role of theory in guiding research and allow it to focus on the most important explanatory factors (ibid.). Since the analytical framework is employed to collect data and organise evidence, it should be as inclusive as possible.

The framework that I am going to use is based on the main tenets of 'actor-centred institutionalism': methodological individualism, rational choice theory, actor

constellations and modes of interaction between actors, and institutional settings (Scharpf 1997).

- Methodological individualism stresses that all social interactions are interactions among purposeful individuals and therefore prescribes to explain social interactions in terms of facts about individuals (Lukes 1968; Arrow 1994). Given that individuals have the ability to act in many capacities as representatives of composite actors, such as political parties, government agencies, interest groups, etc., I shall concentrate on the preferences of composite actors in whose interests individuals act; yet when necessary I shall zoom in to the level of individuals.
- Rational choice theory provides a useful set of assumptions about actors and their policy preferences, namely that they are self-interest seeking, means-end instrumental, and far-sighted. However, these assumptions are unrealistic as the actors' rationality is often bound by the existing institutions and actors often have incomplete information and limited computational abilities to process it, operate under short-term horizons and do not always anticipate the consequences of their actions. Therefore, the current study does not employ formal rational choice and game theory models. Though it starts with the basic assumptions of rational choice theory, alternative assumptions are used where those do not match reality.
- Actor constellations are central to the analysis of policy decision-making because this is usually carried out through the interaction of several actors with different capabilities, policy preferences and strategies to realise their policy preferences. The same policy problems may be tackled by the same actors differently in different actor constellations, and modes of interaction between actors affect decision-making too. The same actor constellation may produce different policies depending on whether actors choose their strategies in the situation of competition, negotiated agreement, voting, or hierarchical direction.
- Institutional settings play a paramount role in decision-making because they channel interaction of policy actors and give it meaning. Broadly, institutions are 'rules that structure the courses of actions that a set of actors may choose' (Scharpf, p.38). National and international law, parliamentary and administrative procedures, collective bargaining arrangements, and other formal and informal

rules not only enable or constrain choices of policy actors, but also define their legitimate scope of action and capabilities, and determine how their choices will be understood by other actors.

In what follows, I shall discuss explanatory factors deduced from the literature reviewed in relation to the analytical framework and the objectives of the study.

## **Actors**

### ***'The people' vs. elites***

According to what Schumpeter (1984) calls 'classical doctrine', democracy is the rule of 'the people' who have rational policy preferences on every issue (including health care) and select representatives who are to translate these preferences into policy. During Communist rule, CEE countries were not democracies: 'the people' did not have the freedom to choose their representatives or to stand for election. The Communist Party, as a vanguard of society, selected people's representatives and then 'the people' endorsed them through an unopposed vote. Given that the Communist Party was not open for everyone who wanted a political voice to join, nomination of candidates for people's representatives inside the party was not carried out through democratic procedures; moreover, 'membership in the party has generally required much more strenuous activity than most people in those countries were prepared to give [in order to have a political voice]' (Macpherson 1966, pp.21). It is, therefore, only fair to say these countries were 'vanguard states' rather than democracies (ibid.). As a result, during Communist rule, health policy was determined by homogeneous Communist elites. The latter are '*incumbents*: those who are collectively the influential figures in the governance of any sector of society' (Marvick 1977, p.111). It is interesting to examine whether, during post-Communist democratic transition, health policy change was initiated by 'the people', through their representatives, or by those elites autonomously. In doing so, I shall use two competing theories of democratic policy-making which both stem from Schumpeter's doctrine of democracy.

The economist Schumpeter disputed the ‘classical doctrine’ of democracy and stressed the role of elites in democratic decision-making. He showed that in reality ‘democracy is the rule of the politician’ – a type of the entrepreneur ‘dealing in votes’ – who on their initiative select issues and decide to compete for votes in order to win political office (Schumpeter 1984). Incumbent political leaders risk not being re-elected if they do not act in the interests of their constituents, but ‘the people’ do not control political leaders in office. Political parties further restrict the free selection of the people’s representatives because parties not ‘the people’ decide who appears on the party lists of electoral candidates. Thus, in democratic practice, the role of ‘the people’ is limited to accepting one of the competing candidates vetted by their parties in order to produce Parliament which, in turn, produces the government. Moreover, public choice theorists developed Schumpeter’s theory further and empirically demonstrated that self-interest seeking of elites can lead to the adoption of public policies which go against the interests of the general public (Downs 1957; Buchanan & Tullock 1965; Olson 1965).

Some modern theories of democracy accept the central role of elites in democratic policy-making, but diverge from Schumpeter in assessing the interests served by these elites. *Pluralist theory* (Truman 1951; Dahl 1967, 1971; Hirst 1989) maintains that there is more competition between elites than Schumpeter acknowledged. Competition between elites allows ‘the people’ to determine public policy, by electing elites who represent their interests and through participation in different organised groups which can put pressure on elected politicians. Pluralist theory assumes that there is a cross-membership of ‘the people’ in different organisations and a plurality of organised interests, so that power is widely dispersed in society. As a corollary, public policy is made through bargaining and conflict resolution between competing and frequently changing elites. In contrast, *elite theory* (Mills 1956; Domhoff 1967; Dye 2001) maintains that competition between elites is limited to a narrow range of issues, as elites agree on more issues than they disagree. Thus, ‘the people’ do not exercise real choice during elections and leaders of different organised groups act to preserve their leadership positions more than to advance the interests which they are supposed to represent. This creates homogeneous elites with a common interest in the preservation of power within

an existing institutional framework. Consequently, public policy is made through interest accommodation and conflict reduction by self-interested elites who disagree primarily on the means rather than the ends of public policy.

### ***Political parties***

The majority of the studies reviewed show that party politics was crucial for the enactment and further development of social health insurance programmes. To analyse the impact of party politics on health policy process, both class-based and interest group approaches can be employed. The ‘democratic class struggle’ (Korpi, 1983) or ‘power resource theory’ (Korpi 1985) approach argues that class-based partisan politics determine what input political parties contribute to social policy. This approach is based on the observation that resources in the market and politics are distributed according to different patterns. In the market, economic resources are distributed unevenly between different classes and interest groups. But in democratic politics such political resources as the right to vote and the right for collective action are distributed evenly among all citizens. Democratic politics, therefore, provides an opportunity for the majority with poor economic resources (the working class) to mobilise their political resources in order to alter the workings of the market for their benefit. When the working class succeeds in mobilising its political resources, usually through trade unions and leftist political parties, it can achieve sufficient political power to correct the uneven distribution of economic resources via social policies. Given that, in the beginning of the post-Communist transition, the class structure in CEE did not reflect the dualistic division between labour and capital, it is not implausible that the actual distributive conflict was likely to be couched in non-class terms. Interest group theory looks at the influence of economic and democratic changes on the structure of group resources and argues that party politics is driven by political struggle between various interest groups defined by ascriptive characteristics such as age, retirement status, occupation, and region (Pampel & Williamson 1988, 1989). As politicians seek the support of interest groups to win elections, interest groups convert their political resources into leverage on policy-making.

The explanatory power of either approach in CEE depends on whether party competition was programmatic. It was shown that, in mature democracies, party competition is programmatic and that there is a strong correlation between what parties stand for during elections and what they actually do when elected (Klingemann *et al.* 1994). The application of both approaches to the case in question may prove problematic if, in the aftermath of regime change, party competition was not programmatic and health policy change was not on the political agenda. It is argued that, during the first democratic elections (founding elections) in CEE, programmatic competition between political parties was limited (Evans & Whitefield 1993; Kitschelt 1995). Despite this, it was important for the electorate to learn about different parties, policies, and their impact on welfare. In line with the ‘political learning’ hypothesis, it is plausible that, as the electorate’s political sophistication and class awareness grew with every consecutive election, so did levels programmatic competition between parties (Evans 1999; Evans & Whitefield 1999). Given that health and health care are of concern to all citizens, one might expect that health policy generated public debate which impacted on the programmes of the contesting political parties and that office holders would implement health policies according to their electoral pledges.

### ***The state***

Previous studies have demonstrated both that a variety of actors participate in the health policy process and that the state is perhaps the most influential. As an actor, the state is associated with independent policy initiatives and responses to those of other actors. The state is conceptualised either as a single actor or a composite actor, comprised of Parliament and a number of government agencies. The single-actor view may be most relevant to my case, because CEE states inherited considerable administrative capacities from socialist times, strong political will to implement changes, and a limited time scale in which to do so. An architect of Polish economic reforms, Leszek Balcerowicz, describes the period of early post-Communist transformation as one of ‘extraordinary politics’ (Balcerowicz 1995). He argues that radical change was possible because, during this time, a spirit of revolutionary enthusiasm coupled with a readiness to make ‘sacrifices’ for a better future endowed reformers with the ‘political capital’ necessary to

carry out radical changes. Once this 'political capital' was exhausted, 'normal politics' returned and the opposition reduced the scope of further progress to incremental changes. It is possible that the early transitional period offered extraordinary opportunities to small groups of decision-makers in the government to initiate radical health policy changes.

Explanation of subsequent policy changes, i.e. when politics returned to normal, can profit from regarding the state as a composite actor. At this stage, enactment of certain policies can be conceptualised as the outcome of bargaining games arranged hierarchically within Parliament and the government, between agencies with different competencies, distinct policy preferences and unequal bargaining power. In light of pluralist theory, we can consider elected politicians, government officials and bureaucrats in various agencies as separate groups with their own interests and power resources. Alternatively, we can consider office holders as homogeneous elites acting to reduce conflicts in order to preserve their power. However, in the period immediately after regime change new elites might not have developed common interests to a sufficient level to reduce potential conflicts without taking these to the public domain. It is therefore interesting to investigate whether health policy change depended on conflict resolution between fluid elite coalitions or on conflict reduction between permanent, quickly-developed elites.

### ***Interest groups***

Different studies emphasised the pivotal role of interest groups in the health policy process. These included health care providers, health insurance funds, pharmaceutical and medical device industry, patient associations, and, above all, the medical profession. The influence of the medical profession can be explained by institutional and/or political variables. Firstly, institutional explanations stress the unique features of the medical profession, such as shared experience, collegiality, professional autonomy and even monopolistic position in the market. Because these features are institutionalised, the medical profession is theorised as a 'structural interest group' whose interests are served 'by the way they "fit" into the basic logic and principles by which the institutions of a society operate' (Alford, 1975, p.14). Secondly, political explanations focus on the power

resources of the medical profession and its ability to promote its interests through organised action. The success of this action depends on the political and economic resources available to the medical profession vis-à-vis other policy actors and on the ideology of dominant political parties. Thirdly, combined explanations suggest that a complex interplay of institutional structure and power resources of key policy actors during the health policy-making process determines whether the medical lobby succeeds or not.

In CEE, the power resources of the medical profession were dramatically lower than in the West. Officially, doctors did not enjoy professional monopoly because the medical profession was incorporated in the state and there was no market. In practice, however, doctors profited from under-the-table gratitude payments from patients and it was doctors working for state institutions who judged the conduct of and set routines for other doctors. Furthermore, doctors were well represented in both Parliament and government. Many MPs were doctors and often the Ministry of Health was the ‘ministry of the medical profession’ (Barr 1996, p.27). Nonetheless, the medical profession itself may still have been incapable of acting as a homogeneous interest group, since the interests of medical professionals varied according to organisation and medical specialisation. For example, there were divisions between different specialities and, even within the same speciality, there was differentiation between solely practising doctors, doctors combining practice and research, and doctors who had risen to the ranks of administrators; doctors in primary, secondary and tertiary health care; doctors in central and local health care organisations; as well as divisions between different age groups. After the collapse of Communist rule, divisions between different specialties were reinforced along lines of profitability. One issue worth investigating is how, during post-Communist transition, the medical profession established its autonomy from the state and whether new organisations of the medical profession managed to influence health policy change to their advantage. Also, it is important to explore whether health care providers, health insurance companies, and other organised interests influenced post-Communist health policy change.

### ***Supranational organisations***

In addition to domestic actors, supranational organisations might have influenced health policy change in CEE. Some argue that, in the 1990s, ‘global social policy’ became reality, as Washington-based supranational organisations set a right-wing social policy agenda in Hungary, Bulgaria and the Ukraine (Deacon *et al.* 1997). Conversely, some argue that, in the beginning of post-Communist transition, supranational organisations were not concerned with social policy and, therefore, domestic policy-makers were free to come up with new solutions for social services in ‘an idiosyncratic manner that reflected momentary alignments of intellectual and political recourses and historical conditions in a particular country’ (Orenstein & Haas 2002), p.14). However, even if free to set social policy, domestic policy-makers might still have been influenced by supranational organisations, for instance by new policy ideas (Walt 1994; Zarkovic & Satzinger 1997; De la Porte & Deacon 2002; Lee & Goodman 2002). Apart from Washington-based supranational organisations, the European Union (EU) may have influenced health policy change in CEE countries. This influence may have come in the form of the ‘soft regulations’ regarding EU accession, funding and technical assistance for certain programmes, and training of the state bureaucracy. Altogether, it is worthwhile to explore the role of supranational organisations in post-Communist health policy change.

### **Institutions**

The previous section outlined major health policy actors and how they can impact the health policy process. However, policy preferences of the actors alone do not fully explain the complexities of the process. A framework of institutions within which actors operate channels their interaction and gives it meaning. Examination of institutions and their effects on the policy process is, therefore, indispensable for the analysis of health politics. As the reviewed studies demonstrate, such an examination may involve three different approaches to institutions. First, Marmor (1970), Giaimo and Manow (1999), and Tuohy (1999) discuss how rules governing decision-making influence the strategic choices made by rational policy actors. Here, the decision-making rules represent institutions. Second, Marmor (1970), Alford (1975), and Klein (1983) focus on formal

organisations, administrative procedures, and shared codes of behaviour. In this case, information processing routines, or moral templates, represent institutions. Third, Immergut (1992), Skocpol (1997), and Tuohy (1999) examine the influence of historical institutions such as legacies, rules, and norms on the choices of policy actors. Below, I discuss different approaches to institutions and how they can elevate the understanding of the health policy process.

The idea of institutions is not new to political science. Even Plato and Aristotle dealt with institutions in their writings as they elaborated on justice, freedom and other values embedded in political institutions. Between then and the early 20<sup>th</sup> century, mainstream political science consisted of the appraisal and evaluation of political institutions against certain values. The behavioralist movement switched the attention of political scientists from ideal values to the preferences of real individuals. The behavioralists assumed that preferences were revealed through behaviour, and that the aggregation of interests through efficient summation led to an equilibrium. New institutionalism, which emerged in the 1970s, questioned these assumptions. The counter-assumptions were that institutions somehow channelled choices, interests could not be simply aggregated, and therefore that equilibrium was problematic (Immergut 1998). Table 1 outlines the concept of institutions, the ways of forming preferences, and the aggregation of choices made by behavioralism and the three branches of new institutionalism.

**Table 1: Behavioralism and three branches of new institutionalisms**

	<b>INSTITUTIONS</b>	<b>PREFERENCES</b>	<b>AGGREGATION</b>
<b>Behavioralism</b>	Arenas	Revealed through political behaviour	Efficient summation
<b>Rational Choice Institutionalism</b>	Decision rules	Strategic choice	Choice imposed by institutions
<b>Sociological Institutionalism/ Organisational Theory</b>	Information processing routines, cues and scripts, moral templates, cognitive paradigms	Bounded rationality, Interpretative frames	Standard operating procedures
<b>Historical Institutionalism</b>	Rules, norms, procedures, legacies	Alternative rationalities, Social construction of interests	Contextual logic of causality

Source: adapted from Hall & Taylor (1996) and Immergut (1998)

### ***Rational choice institutionalism and functionalist explanations***

Rational choice theory provides a consistent account of the human rationality, assuming that actors are self-interest seeking, means-end instrumental and far-sighted, and that policy results from the strategic choices of policy actors who try to maximise their benefits and minimise their costs. However, it is widely acknowledged that the assumptions of rational choice theory are too strict and often they do not match reality (Jones 2001; Schram & Caterino 2006). The rationality of policy actors is often constrained by existing institutions; moreover, actors have incomplete information and limited computational abilities to process it, operate under short-term horizons, and often fail to anticipate the consequences of their actions. Nonetheless, rational choice theory is still a useful starting point for formulating falsifiable hypotheses about political decision-making (Dunleavy 1991; Elster 2000), or as Pierson authoritatively argues:

- (1) Functionalist *premises* about institutional origins and change should be replaced by functionalist *hypotheses*; and (2) functionalist hypotheses should be supplemented and contrasted with hypotheses stressing the possible nonfunctionalist roots of institutions (Pierson 2000, p.493).

In a similar vein, Miller (2000) argued that, although functionalist premises about institutional origins and change are not defensible, an emphasis should be put on co-operation rather than competition between rational choice and other forms of explanation. Miller (*ibid.*) showed that the application of rational choice analysis to the policy arenas where it fails to provide satisfactory explanations can explain inefficient or 'dysfunctional' institutions through the inefficiencies of politics.

Within the assumptions of rational choice theory, there are two approaches to explaining the origins and change of institutions. Both suggest that explanations of institutional origins and change should be found in the functional consequences of institutions for those who created them at certain moments and under specific conditions, but they focus on different types of consequences. First, public choice theorists focus on the problems of collective action and co-operation between self-interested actors who are supposed to solve these problems (Downs 1957; Buchanan & Tullock 1965; Olson 1965). They explain public policies as solutions to collective action problems made jointly by self-interested policy actors and show that self-interested policy actors can produce public policies which suit their common interests but go against the interests of the general

public. According to this approach, new institutions can be created or old ones changed when the policy environment and conditions change with the effect that policy actors can increase their pay-offs through co-operation. Second, power resource theorists go beyond the problems of collective action and the aggregation of interests, focusing on the distributional effects of institutions. Power resource theorists show that trade unions and Social Democratic parties acted together against the interests of capital in order to expand the welfare state (Korpi 1983; Shalev 1983; Korpi 1989). According to this approach, new institutions can be created or old ones changed when there is change in the preferences of powerful policy actors or the balance of power between them.

When explaining early post-Communist health policy change in CEE, it is problematic to distinguish clearly between the two approaches because, after the collapse of Communist rule, the explanatory variables employed in both approaches changed. Furthermore, explanation of subsequent health policy change in terms of the changing policy environment/conditions is challenging because health policy-making institutions were in flux. Nonetheless, this approach may provide useful insights into the inefficiencies of politics, because early post-Communist health policy change was expensive and created a number of dysfunctional institutions. The second functionalist approach is particularly appealing for the current study because, in a relatively short period of time, there was a lot of change in the balance of power between policy actors and their policy preferences. Therefore, I shall start analysis with the functionalist assumptions; but, when these do not match reality, I shall use insights from other branches of institutionalism to identify political factors to explain why.

### ***Sociological institutionalism and ideational explanations***

The sociological branch of institutionalism emphasises that new institutional arrangements can be adopted, not because they provide efficient solutions, but because of ‘the role that collective processes of interpretation and concerns for social legitimacy play in the process [of adopting particular institutions]’ (Hall and Taylor, 1996, p. 20). Cognitive paradigms – i.e. ‘taken-for-granted descriptions and theoretical analyses that specify cause-and-effect relationships, that reside in the background of policy debates and

that limit the range of alternatives policy makers are likely to perceive as useful' (Campbell 2002, p.22) – may prompt policy makers to act according to the logic of what is 'appropriate' and how their actions will be interpreted, rather than the logic of efficiency and calculated self-interest seeking. However, the fallacy of the sociological approach to institutions is that, unlike rational choice institutionalism, it is 'bloodless' in the sense that it can miss 'a clash of power among actors with different competing interests' when new institutional practices are adopted (Hall and Taylor, 1996, p. 21).

Insights from the sociological approach can be useful for assessing the role of ideas in policy change (Blyth 1997; Campbell 1998; King 1999; Gottschalk 2000; Campbell 2002; Lieberman 2002; Bleses & Seeleib-Kaiser 2004; Beland 2005). Hall proposed to examine shifts in policy paradigms and associated with them changes in second- and first-order policy ideas, i.e. those related to the policy instruments and their precise settings used to attain goals specified by policy paradigms (Hall 1993, p.278). He argued that a new policy paradigm succeeds the old one when the state finds itself in a crisis and the old paradigm fails to explain it; the new paradigm provides both an explanation of the crisis and a way out (ibid.). The rational choice approach does not deny the impact of ideas on policy-making (e.g. Goldstein & Keohane 1993); both agree that, once policy paradigms become institutionalised, they impact policy-making by enabling or limiting certain policy options. However, while the rational choice approach argues that ideas are only instruments to mobilise collective action, the sociological approach maintains that ideas are also preconditions for it. The central argument against a purely rational choice approach is that ideas exist prior to individuals and, therefore, a flow of ideas determines policy at least as much as the choices of individuals (Blyth 1997).

After the collapse of Communist rule, the reduced role of the state and the introduction of market mechanisms in the health sector in CEE coincided with the same development in the West. Therefore, it is interesting to explore whether the same ideas influenced health policy change in the East and the West. If so, it is interesting to examine the logic behind the diffusion of Western reform patterns in the East. What role exactly did Western ideas

play in post-Communist policy change in the East, at what stage of policy-making were they introduced, who advocated these new ideas, and why?

### ***Historical institutionalism and historical explanations***

Historians argued that ‘the past... survives in the present’ and history provides knowledge of what can be done in the present, on the basis of what was achieved in the past (Collingwood 1961, pp.14, 256). While historians stress historical irregularities, historical institutionalists have developed an interest in historical institutions in order to find historical regularities in social change. Historical institutionalists do not necessarily disagree with the functionalist and sociological approaches to the explanation of institutional origins, but they stress a completely different logic of institutional change. The first two approaches explain institutional change in terms of the factors responsible for their origins, but the historical institutionalist approach draws a clear line between the factors behind institutional origins and those influencing institutional change. The central historical institutionalist argument is that the past influences the present. For analytical purposes, it is helpful to distinguish between two mechanisms of the past’s influence on institutional continuity and change.

First, it may be argued that, when Communist rule collapsed, policy actors realised that policies from the immediate past no longer suited the new circumstances. In searching for new policies, actors recalled the pre-Communist practices and for the most part borrowed health policies from the pre-Communist institutional template. Even before the post-Communist transition started, it was suggested that during hard-line Communist rule CEE countries had deviated from their historical path and thus sooner or later they would re-enter the same trajectory again but at a more advanced stage of development (Szelényi 1988).<sup>1</sup> In line with this argument, the introduction of health insurance in CEE countries was considered to be ‘path dependent’ (Mossialos & Dixon 2002, p.291). It was shown that, before Communist rule, CEE countries had Bismarckian health insurance systems, as in the rest of Europe, and that after the collapse of Communist rule they attempted to

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<sup>1</sup> In the case of the most liberal Communist CEE country, Hungary, it was plausibly argued that already in the 1980s she was returning to the trajectory it left after the Communist takeover (ibid.).

come ‘back to Bismarck’ (Marrée & Groenewegen 1997) and ‘back to Europe’ (Deppe & Oreskovic 1996). It is therefore interesting to examine empirically whether and to what extent post-Communist health insurance policies were in fact borrowed from the pre-Communist institutional template.

According to the path dependency argument, ‘actors are hemmed in by existing institutions and structures that channel them along established policy paths’ (Wilsford 1994). From this vantage point, obsolete pre-Communist institutions represented ‘weak history’ (ibid.), so post-Communist health policy should rather have been influenced by Communist institutions, thus in effect implying that policy change was unlikely. However, it was argued that post-Communist reforms in different CEE countries would not necessarily be influenced by Communist institutions, but rather by ‘the differing paths of extrication from state socialism that shape the possibility of transformation in the subsequent stage’ (Stark 1991, pp.20-21). Another part of this argument held ‘[c]apitalism cannot be introduced by design in a region where the lessons of forty years of experimentation by a rational hand have made the citizenry cautious about big experiments’ (Stark 1991, pp.19). The two parts of this argument can possibly hold true only if applied to formal institutions. If, in a sociological institutionalist fashion, we think of institutions as moral templates then post-Communist reformers, who were used to the Communist moral template, should have continued the rational hand experimentation after the collapse of Communist rule. Also, a snapshot view of enacted policies suggests that the path of extrication from state socialism was rather patchy and many early policy changes were reversed. Therefore, it is important to examine in detail whether post-Communist health policy change took a distinctive path immediately after 1989 and whether earlier policies determined subsequent ones.

### ***Analytic narratives***

The above section fleshed out an actor-centred institutionalism framework to be employed in the current study and, within this framework, proposed to pay special attention to the effects of ideas and history on the health policy process. The ambition of this study is to identify and explore the actors involved in the health policy process at

each given time, what interests they had, how they perceived health policy change, which policy options and preferences they held, what strategic choices they made, how policy actors interacted among themselves, and what institutions aided or limited their interaction and choices. The current study aspires to tell a story explaining health policy change and its driving forces. By embedding an explanation in a rich descriptive narrative, it shares a common ground with the ‘analytic narratives’ approach (Bates *et al.* 1998; Levi 2002, 2004).

There are crucial differences, but also similarities, between the current study and the analytic narratives approach. Both rely on the assumptions of rational choice theory and the theoretical concepts of new institutionalism. Likewise, I attempt to provide a rich historical account through an in-depth case study and the application of rigorous research methods. Both the analytic narratives approach and the current study are not concerned with testing theory in the first place, but interested in theory primarily to explain the case under investigation. By stating the assumptions and ways of reasoning, both the current study and the analytic narrative approach attempt to arrive at falsifiable explanations. Unlike the analytic narratives approach, however, the current study does not employ formal rational choice and game theory models. Instead, the current study aims to give a substantive treatment to health policy problems, ideational factors, and history. Also, whenever appropriate, the current study uses statistical data to analyse health policy problems. In the next chapter, I explain in detail the research design of the current study and the methods employed to build an analytic narrative.

## CHAPTER 2: RESEARCH DESIGN AND METHODS

The current study has a qualitative design with mixed ideographic and nomothetic objectives. The two major research methods employed here are case study and process-tracing. This chapter discusses the research design and research methods in relation to the objectives of the study, then details data collection strategies and methods of analysis, before addressing the limitations of the research design in terms of its validity and reliability. Finally, the chapter introduces validity and reliability checks to enhance the epistemological rigour of the study.

### ***Research design***

#### **Mixed ideographic and nomothetic case study**

The objectives of the current study are both ideographic, i.e. individualising and interpretative, and nomothetic, i.e. generalising and theory-seeking (Eckstein 1975). The core objective is to explain the case in question using explicit theory. In this respect, the current project is an ‘interpretative case study’ (Lijphart 1971), corresponding to Eckstein’s ‘disciplined-configurative case study’ (Eckstein 1975). Another objective is to generalise from the case under investigation, thereby contributing to theory-building. This can be done by: a) attempting to develop generalisations in areas where there is no major theory and b) using various theoretical insights from previous studies to confirm or falsify existing theories. From the strictly positivist perspective, the significance of such theory-seeking exercise is limited because it focuses on a single case. However, a single case should not be mistaken for a single observation (Rueschemeyer 2003, p.332). As the study explores many decision-making points over a prolonged period of time, it examines the explanatory value of a great many elements of the analytical framework in many instances. Furthermore, the small-N problem challenges the strictly positivist perspective that a single case study cannot generate theoretical insights. There are only a small number of comparable cases and, therefore, a positivist quest for universal theory is

problematic. The advantage of a single case study is that, instead of concentrating on only a few explanatory variables in a large number of poorly comparable cases, it is possible to investigate many variables related to the explanatory framework in a rich context. Investigating the explanatory power of the analytical framework is valuable because it helps to identify a number of casual mechanisms and specify conditions under which they operate. Therefore, a single case study can capture complex non-linear logics, which may plausibly apply to other cases, or within-case observations under certain specifiable conditions.

The qualitative case study method is used, instead of quantitative statistical methods, because the former is able to capture the types of the causal process occurring in policy-making better than statistical methods. The latter are indispensable to explaining linear causality, i.e. causality where one event causes another one in a chain of events similar to falling dominoes. In policy-making, however, linear causality is seldom observed. Policy-making outcomes are usually products of complex interaction between a number of converging causal chains with many, often interdependent, variables working together. Therefore, to capture such complex interaction, extremely advanced statistical models are required. Moreover, statistical models currently available to social scientists are based on linear cross-tabulation; even if they were advanced enough, it would be difficult to collect all the required quantifiable data. Contrary to that, qualitative methods for data collection and analysis are well-established and accessible. Furthermore, a qualitative design is more advantageous because of an apparent lack of covering-law theory in the field of health politics. Quantitative research methods are characterised by deductive reasoning based on theory, which is required to generate explicit and testable hypotheses. Conversely, the case study method employed here proceeds by inductive reasoning based on a detailed historical narrative. This is also better to capture another type of causality common in policy-making, i.e. path dependency. Qualitative research methods allow one to analyse inductively to what extent policy choices are restricted by previous decisions; whereas statistical methods cannot really offer this kind of analysis.

### **Crucial case study**

The mixed epistemological objectives are not unique to the current study. However, unlike other researchers with similar objectives, I was not ‘fascinated’ by particular cases in the first instance and, thus, did not let the case under investigation select me, as Bates *et al.* (1998, p.13) claim their cases selected them. Rather, I became fascinated by the case in question only after selecting and studying it. The main reason for selecting the Czech Republic is that it is a ‘crucial case’ for the study of health politics in CEE. As proposed by Verba (1967) and popularised by Eckstein (1975), ‘crucial cases’ are ones that are extreme on pertinent measures and either closely fit or completely do not fit tested theories. Thus, the case of the Czech Republic is selected chiefly because it witnessed more successful, failed and reversed health policy change than any other CEE country. The time period of the current study is limited to 1989-1997 because most post-Communist reforms were attempted and enacted during this period. Although Hungary was the first CEE country to launch social health insurance, the Czech Republic was the first country in the region to introduce multiple competitive health insurance funds. Furthermore, the Czech Republic experienced the highest degree of deregulation and decentralisation in health care (Jaroš *et al.* 2005). Lastly, the Czech Republic drew up the most ambitious plans for health care privatisation in the region and started implementing them before other countries.

Besides the amount and magnitude of health policy change, the Czech Republic is the most advanced sizeable political economy in the CEE region. After Slovenia, the Czech Republic has the second most developed economy in terms of GDP per capita (IMF 2007) and the second highest public health expenditure per capita (Waters *et al.* 2008). It can be assumed that a high level of development justifies the application of theoretical insights from Western literature to the Czech Republic, which may not apply to less economically developed countries. Also, it can be assumed that a very small size of the population and health care sector accounts for a low variation of political and economic interests in health politics. Therefore, the Czech health politics is more representative of CEE, because Slovenia’s population (2m versus 10.3m in the Czech Republic versus 14.7m CEE average) and health sector (18,000 doctors and nurses versus 130,000 in the

Czech Republic versus 121,000 CEE average) are among the smallest in the region (Albreht *et al.* 2002).<sup>2</sup> Thus, just as the most economically developed Western European nation, Luxembourg, is not representative of Western Europe, Slovenia is not representative of the most advanced CEE political economies or CEE generally. Moreover, the case of Slovenia is complicated by the violent dissolution of Yugoslavia and the establishment of the national Slovene state for the first time.

### **Process-tracing method**

The process-tracing method is employed to describe and explain the health policy-making process. This ‘attempts to identify the intervening causal process – the causal chain and causal mechanism – between an independent variable (or variables) and the outcome of the dependent variable’ (George & Bennett 2005, p.206). As the present study concentrates on a series of policy-making outcomes over an extended period of time, this requires a broad range of empirical within-case observations. Therefore, the process-tracing method not only helps one formulate causal explanations of policy-making outcomes, but also creates a ‘thick description’ (Geertz 1973) of the policy-making process.<sup>3</sup> The current study does not attempt to follow the exact prescriptions of this famous anthropological method, but nonetheless every attempt is made to create a description of the policy-making process as comprehensive and relevant to the objectives of the current study as possible.

Process-tracing can be done in many ways, depending on how general or detailed, and analytic or descriptive, a narrative is. The aim of the current study is to create a historical account of how events unfolded and decision-making took place that is as complete as the collected data allowed. This is necessary for two reasons. First, by giving the reader an appreciation of the collected data in a ‘raw’ form, my analysis is made more transparent

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<sup>2</sup> Here, I employ WHO data for around 2000 and the WHO grouping of CEE countries, which includes Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Federal Republic of Yugoslavia, Hungary, Latvia, Lithuania, Macedonia, Poland, Romania, Slovakia, and Slovenia (Albreht *et al.* 2002).

<sup>3</sup> Geertz (1973) uses an example of a person who rapidly opens and closes his eye to argue that a ‘thin description’ of this process that just states that an eye is opened and then closed is not enough. What is needed is a ‘thick description’ that interprets this eye movement, depending on its specific context, as either an involuntary twitch, a conspiratorial wink, or a parody of a conspiratorial wink.

and, hence, the whole study more objective. Second, a detailed historical account is important for generating hypotheses about possible causal mechanisms and, therefore, for developing a more analytic form of process-tracing. This is achieved through use of the analytic narratives approach, with its explicit emphasis on deductive theory and underlying assumptions. Consequently, the initial detailed historical narrative makes it possible to derive hypotheses inductively, paving the way to an analytical causal explanation. To a certain degree, however, the resultant explanation is only partial. The collected data is not comprehensive and, even if it was, it is not possible to ground data analysis fully upon available theory. The current state of theory in the field of health politics is not adequate enough to cover the whole policy-making process over the period under investigation. I discuss the limitations of the research design of the current study in terms of its validity and reliability and how to enhance its rigour later in this chapter.

The process-tracing method has at least two advantages over statistical methods in contributing to nomothetic studies. First, process-tracing can reduce the problem of *indeterminacy*, specifically in cases where, due to the intervening variables, there can be many explanations but no fact-of-the-matter determining a correct explanation (George & Bennett 2005, p.207). Whereas statistical analysis does not explain how explanatory variables are linked to each other, in a process-tracing case study data are collected and analysed in a way that shows how variables interact. Although the development of data-processing techniques has encouraged a kind of research in which ‘anything one can think of is cross-tabulated and correlated with just about everything else’ (Eckstein, 1975, p.83), the formal procedures of statistical analysis justify only premises derived from this analysis. The researcher still needs to explain the results of the analysis and put them in a causal chain leading to an explanation, but this is done best using the process-tracing method. Thus, the current study employs statistical data analysis only to substantiate the analysis of health policy problems, rather than to make causal inferences. Another advantage of process-tracing is concerned with the *equifinality* (or multiple convergence) problem, i.e. the case when there are many causal paths leading to the same outcome (George & Bennett 2005, p.215). Large-N statistical analysis tends to overlook this

problem and to settle for one most probable path, whereas process-tracing is capable of identifying more than one causal path (ibid.).

## ***Data collection and analysis***

### **Written sources**

Data for the current study has been collected from both written sources and qualitative interviews. Written sources include:

- 1) academic journals and books;
- 2) reports and research evidence compiled by international organisations;
- 3) independent research reports;
- 4) current affairs reports, quality newspapers, and periodicals;
- 5) trade publications;
- 6) parliamentary records and legislation;
- 7) official government documents and policy papers;
- 8) policy statements of health policy actors; and
- 9) programmatic statements of political parties.

As described below, different types of written sources were used for specific purposes at different stages of the study. I attempted to review as much data related to failed or enacted policy change and the variables of the analytic framework as was available. I found a substantial number of secondary sources describing and analysing health policy change, but only a few containing data relevant to the analytical framework. Therefore, my data collection strategy largely depended on the review of primary sources. I employed keyword search techniques and extensive use of online data-retrieval interfaces of the relevant primary sources, integrated social science archives, and Internet search engines as recommended by Hewson *et al.* (2003). As described above, the period under investigation was limited to 1989-1997, i.e. when key post-Communist policy change was accomplished or failed. Consequently, I arrived at a researchable number of instances of health policy change and the depth of the investigation was limited by the availability of data in the public domain. Altogether, I had no problem deciding which sources to include in (and exclude from) analysis because of the paucity of data and the

defined period under investigation. For the analysis of written sources, basic techniques of content analysis were used. These are described in the next section.

My data collection strategy was influenced by what I call '*the ignorant foreigner approach*', which rested on the assumption that nobody knew Czech health politics better than the Czechs themselves. As a corollary, in order to maximise the quality of the collected data, and not to fall victim to someone else's possibly uninformed interpretation, I relied on Czech sources as much as possible. A number of secondary sources were originally published by Czech authors in English and were available in England either in libraries or over the Internet. However, the primary sources were available only in their original language and were based in the Czech Republic. In addition to desk research, this study inevitably required extensive fieldwork. In the course of research, I learnt basic Czech and made four research visits to the Czech Republic, lasting 145 days in total.<sup>4</sup>

I started research by reading academic publications and various research reports to familiarise myself with the Czech health care system and how it had changed over time. For this purpose, reports compiled by the leading Czech health policy experts for the WHO and the OECD proved extremely helpful because they provided an authoritative description of the Czech health care system. After that, exploratory interviews were conducted, with a view to filling gaps in my reading and checking it against the opinion of country experts. Then, current affairs reports, quality newspapers and periodicals, and trade publications were studied to gain in-depth understanding of the conditions for policy change, its content, and timeline. Because health policy change proved so dynamic and multidimensional, only current affairs reports were able to capture its riches and complexity. Also current affairs reports were useful because failed attempts at policy change are not adequately treated in post-hoc publications, and enacted policy change is

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<sup>4</sup> Although I have studied Czech specifically in order to accomplish the necessary fieldwork, my knowledge of Czech is limited. This would have seriously constrained my research if I had not received generous help with translation, and sometimes interpretation, from my Czech friends and colleagues, especially, Dita Pirková and Tara Pober-Thomson.

often subject to post-hoc glorification or critique. Similarly to Larson (2001, pp.345-48), I found insights from current affairs reports essential in order to:

- recapture the perspective of policy-makers, by showing what information they had and what events they regarded as important, because policy-makers often rely more on newspapers for information than on classified reports;
- to infer policy-makers' goals, by reconstructing the environment in which policy documents were written;
- to decipher the meaning of documents by providing journalistic analyses and interpretations of speeches;
- to develop a chronology of important events that is unbiased by hindsight or interpretation.

The analysis of current affairs demanded substantial effort. Altogether, more than 500 electronic pages of current affairs reports were closely analysed, and this was only approximately one-tenth of what was reviewed in search of relevant information. My ambition was to review all the available information in order to collect comprehensive data. This strategy was guided by the analytical framework, which was operationalised with the keywords related to the instances of health policy change under investigation and the names of major health policy actors and institutions. Most of these are mentioned throughout the study and detailed in the glossary of Czech acronyms and abbreviations and in the example interview schedule given in the Appendix. The broad-scale data search and collection was worthwhile because it significantly broadened my understanding of the timeline and causal mechanisms behind policy change. The principal source of current affairs reports was the Czech national news and information agency (ČTK). The main reasons for relying extensively on ČTK were its objectivity, scope of information and speed of data retrieval. Unlike partisan newspapers and periodicals, ČTK provides relatively objective information because it is a politically and economically independent public agency. Furthermore, ČTK is the largest and the most comprehensive information provider in the Czech Republic. In addition to its own reports, ČTK reviews current affairs reports compiled by other media and compiles briefings of the information from the mass media. Lastly, ČTK has an efficient online data retrieval interface which streamlines information search and reduces its costs.

The next step was to study legislation, government documents, policy statements of health policy actors, and programmatic statements of political parties to understand the precise content of health policy change, interests of policy actors and health policy options available to them. I reviewed all failed and enacted health care legislation, but analysed only substantive successful and failed policy changes. These exclude technical changes in the related legislation, but I did not analyse these because they were redundant to the analysis of health policy change. Unfortunately, I could not access internal documents of the Health Ministry because, at the time fieldwork was conducted, these were not yet accessible to the public in the National Archive; yet I managed to collect non-classified documents published by the Health Ministry from its library and members of the health policy community and included these documents in analysis.<sup>5</sup> In contrast to the documents produced by the Health Ministry, it was possible to fully analyse the directives and decisions of the government because they are freely available online. I also analysed policy statements of policy actors which I obtained from their personal or organisational archives. In assessing the role of political parties and impact of ideas on the policy process, I analysed three types of documents – electoral manifestos, coalition agreements, and government declarations – as recommended in the political parties literature (Klingemann *et al.* 1994; Thesing & Hofmeister 1995; Klingemann *et al.* 2006). A detailed account of health policy pledges from electoral manifestos is given in the Appendix. Lastly, I examined parliamentary records to analyse parliamentary debates, patterns of voting behaviour, the role of the Parliamentary Health and Social Policy Committee and, when relevant, the role of other Parliamentary Committees. Parliamentary records were available online, so I was able to review all parliamentary sessions where issues of health policy change were discussed and voted.

## **Interviews**

The data gathered from written sources was supplemented with information derived from interviews with health policy-makers and other members of the health policy community.

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<sup>5</sup> The archive of the Health Ministry (1991-2002) was kept in the Department 5 of the National Archive as Deposit no.1533 and was not accessible to the public according to §37, Part 1, Act no. 499/2004 (Kalina email 2006).

As recommended by Dexter (1970, p.11), I employed interviews as part of my data collection strategy when they provided i) better data, ii) more data, or iii) data at less cost. Given the relative scarcity of health policy literature and the elitist nature of health policy-making, very often interviews were able to provide more informative data than could have been obtained elsewhere. Even when data on certain political events existed in written sources, in many cases these reflected a very limited number of perspectives, whereas interviews allowed me to cover diverse perspectives. However, many interviews that covered a broad range of issues over a long period of time, or provided leads to valuable information, proved a rather cost-effective strategy for data collection.

The main criterion in the selection of respondents was their ability to contribute towards the understanding of certain policies or events, either in depth or in breadth. Interviews were conducted in two waves: exploratory and investigative. The exploratory wave was designed to a) fill gaps and resolve contradictions in written sources, b) identify interesting topics and puzzling events for further investigation, and c) generate contacts for the subsequent interviews. To meet these goals, I interviewed knowledgeable informants, such as journalists, academics and health policy experts. Analysis of the data from exploratory interviews and relevant written sources served as a basis for designing the investigative wave of interviews. This was designed to obtain both unique in-depth data on health policy-making and its various interpretations. I assumed that the interviewees who represented key players in the health policy arena and those who were close to decision-making would be best suited for this purpose and attempted to interview Health Ministers, senior civil servants in the Health Ministry, other government departments and MPs. I also interviewed people outside the government, including leaders of the medical profession, directors of health insurance companies, health managers, representatives of pharmaceutical and medical device industry, patient associations and other interest groups. I was genuinely impressed by the openness and eagerness with which Czech policy-makers granted me interviews; for example, among five Health Ministers who served in the period under investigation I was able to interview four, the fifth being now deceased.

Both waves of interviews were comprised of semi-structured interviews organised mainly around an interview schedule/topic guide rather than a rigid questionnaire. This ensured both a systematic coverage of the relevant issues throughout all interviews and flexibility in pursuing information specific to each respondent (Artur & Nazroo 2003). However, when my respondents did not speak English, I supplied each of them with a very detailed and customised interview schedule in Czech beforehand, which was effectively a questionnaire (see Appendix V for an example). Although I structured both waves of interviews around interview schedules, these were less rigid in the second wave, which consisted of interviews with top decision-making elites.

Elite interviewing is characterised by a special, non-standardised treatment of the interviewee, such as (Dexter 1970, p.5):

- stressing the interviewee's definition of the situation,
- encouraging the interviewee to structure the account of the situation,
- letting the interviewee introduce, to a considerable extent, his or her notion of what he or she regards as relevant.

This kind of treatment is most often given to elites, i.e. '*incumbents*: those who are collectively the influential figures in the governance of any sector of society' (Marvick 1977, p.111), rather than the general population. This is justified on the grounds that elite interviewees can help with the interpretation of documents and personalities, and provide access to unique information and other potential interviewees (Richards 1996). Elite interviewing does not require a statistically representative sample because it is assumed that 'potential respondents differ in how much they can contribute to the study and that each respondent has something unique to offer' (Manheim & Rich 1995, p.164).

Three non-probabilistic approaches were employed to choose respondents: 1) criterion-based or purposive sampling, 2) snowballing or chain sampling, and 3) opportunistic sampling (Ritchie *et al.* 2003). First, I selected a number of government agencies, organisations and interest groups that played key roles in the health policy arena and tried to arrange interviews with their representatives. Although this approach yielded many interesting interviews, it did not always work. Therefore, I enhanced purposive sampling with the snowballing or chain sampling approach, asking the people already interviewed

to recommend other people they knew who would fit the selection criteria. Because the health policy community is rather close-knit, its members knew each other personally and were able to recommend people who fitted my selection criteria and would be willing to grant me an interview. Finally, I took advantage of unforeseen opportunities that arose during the early stages of fieldwork, including personal encounters with the people from the health policy community or those who could recommend such people, to a certain degree letting them shape my sampling. As part of the sampling strategy, to maximise such opportunities, I participated in conferences and other events that potential interviewees attended. In line with Strauss and Corbin's (1998) suggestion that different sampling strategies are to be adopted at different stages of research, my sampling strategy evolved accordingly. In the early exploratory stage of my fieldwork, I was particularly keen on opportunistic sampling, the respondents then allowed me to benefit from snowballing sampling, while, at the final investigative stage, my approach became more purposive.

The number of interviews was determined by the desire to achieve a diverse but balanced sample of key policy actors over the period of study. For the following three reasons, my sample did not turn out to be large:

1. the population of key policy actors was small;
2. even though additional representatives of the same agency or organisation could have provided more detailed information, there was a point of diminishing return where additional interviewees were no longer able to contribute new information or the cost of conducting and analysing additional interviews outweighed the significance of additional information;
3. I did not have access to everyone I wanted to interview.

Altogether, I conducted 45 in-depth interviews, all lasting between 30 and 150 minutes (most commonly, one hour).<sup>6</sup> I used email correspondence to clarify certain points raised

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<sup>6</sup> Interview data was collected through digital audio-recording and pencil and paper note-taking. Although most of the interviews were conducted in English, a few interviews were solely conducted in Czech. Furthermore, a number of interviews slipped from English into Czech because the Czech terminology demanded so.

by the respondents, or to ask them new questions which arose after the interview, and also used email or telephone interviewing when I could not meet interviewees in person.

During the interviews, the interviewer decides whether to remain silent or ask a question and, when he does ask a question, he chooses what and when to ask. Therefore, in semi-structured interviewing, important analytic decisions are made both while the data are being collected and after (Gomm 2004). However, it was my experience that elite interviewees tended to talk more about what they deemed necessary rather than answering precise questions. Because they provided extremely valuable data and it was often difficult to interrupt their train of thought, most elite interviews did not involve much decision-making in the process of interviewing. Therefore, the main analytic tasks were carried out after the data had been collected. Among the three main methods to analyse such data – linguistic analysis, thematic or content analysis, and ‘as a set of reports about states of affairs and matters of facts’ (Gomm 2004, pp.184-215) – I used the last two.

First, I treated interview transcripts as textual data and analysed them in order to derive facts and interviewees’ accounts of various policy events. These included some which could be potentially verified (corrigibles), and some which were matters of self-knowledge and could not be verified (incorrigibles) (Gomm 2004). I tended to limit the use of incorrigibles in my research in favour of corrigibles. When analysing these, I took into consideration that my data was susceptible to various biases such as retrospective or recall bias and biases caused by the demand characteristics of the interview (ibid.). The latter occurred when the interviewees might have attempted to change or interpret facts in a way that suited what they thought was the purpose of the interview. Also, they might have unintentionally provided inaccurate facts due to the imperfection of human memory. I tried to minimise the effects of these biases through triangulation and member validation.

Second, I employed basic techniques of content analysis (Holsti 1969; Prior 2003; Krippendorff 2004). In order to make interviews accessible and comparable, I coded their

transcripts thematically with a binary code, i.e. whether a certain theme occurred or not without measuring the significance of its occurrence. I identified themes and indexed them by putting their names on the transcripts' margins. On the left hand-side margin, I indexed themes related to the dependent variables, i.e. health insurance, decentralisation, privatisation, and other instances of health policy change. On the right hand-side margin, I indexed themes related to the independent variables, i.e. specific actors, institutions, ideas, and historical influences. Such indexing proved particularly helpful for the analysis of elite interviews. When respondents did not follow my interview schedule or substantially deviated from it, indexing reflected the real structure of the interview.

### ***Reliability and validity***

In collecting and analysing data, my goal was to produce an objective piece of research. Given the qualitative nature of my research, it was not easy to implement the checks and balances of objectivity. Similar to natural science, objectivity in qualitative social science can be evaluated in terms of the reliability and validity of its observations (Kirk & Miller 1986). Usually, reliability is understood as the extent to which research findings can be replicated if another similar study is carried out. LeCompte and Goetz (1982) distinguished between 'internal' and 'external' reliability, where the latter concerns the replicability of the entire study and the former concerns only the degree to which other researchers would arrive at the same conclusions using the same data and methods. It is impossible, in qualitative social science, to replicate fully identical social circumstances in another study, because some social phenomena are exclusive to the given settings. Nor is it possible to find a researcher who would fully resemble the scholarship and skills of the original researcher. Therefore, full external reliability is not achievable in qualitative social science. Nonetheless, it is possible to enhance external validity through giving the reader as much detail as possible of the background assumptions and procedures used in the research (Seale 1999). The previous and current chapters of the thesis serve precisely this purpose.

Internal reliability is more feasible to achieve. LeCompte and Goetz (1982) propose five methods to enhance internal reliability. Three of these methods were subsequently

employed in the current study: 1) low-inference descriptors, 2) mechanical data records, 3) peer examination.<sup>7</sup> When collecting data, I tried to capture and describe it in a way that would reduce inference about its potential meaning in the first place. My aim was to generate ‘raw’ data, free from any superimposed meaning or biased selection. To this effect, I clearly separated data collection from data analysis during fieldwork. I recorded interview data electronically, using a digital dictation method, instead of just taking notes instantly to outline the general sense of what interviewees said. Likewise, when possible, I photocopied archival materials. I kept the original Czech versions of documents and interviews, along with their translation.<sup>8</sup> My commitment to low-inference descriptors is also reflected in the extensive referencing of sources and effective use of citations. At different stages of research, the adequacy of my research procedures has been scrutinised by both my supervisor and peer graduate students.<sup>9</sup>

Another component of objectivity in qualitative social research is validity, usually understood as the extent to which research findings are correct when research is replicated. Lewis and Ritchie (2003, p.274) describe it as the extent to which research findings ‘accurately [reflect] the phenomena under study as perceived by the study population’. To ensure validity in a qualitative study would require fully replicating it, which as shown earlier is impossible. To overcome this, social scientists have developed two main alternative methods of validation: triangulation and member validation.

As far as triangulation is concerned, Denzin (1970) distinguishes between combination or triangulation of different data sources, research strategies (methods), investigators and theories. Validity is claimed on the grounds that such combinations reduce various biases. In the current study, I used the triangulation of sources, i.e. complementing and

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<sup>7</sup> Two other methods, multiple researchers and participant researchers, have not been used for obvious reasons.

<sup>8</sup> This has proved very helpful because my ideas, interpretative abilities, and Czech language skills have evolved over the course of research and if I had not kept the data in its original format, I would not have been able to return to it when it was necessary.

<sup>9</sup> I am indebted to participants of the Politics of Social Policy Graduate Research Group at the Department of Social Policy and Social Work for their valuable input. In particular, I would like to thank Almuth Wietholtz and Timo Fleckenstein for extremely helpful comments and suggestions. The remaining methodological flaws are entirely mine.

comparing data gathered from one source with data gathered from other sources (Patton 2002, p.331). Whenever possible, I compared oral evidence gathered from people with different points of view. Furthermore, I compared government programme documents and other written evidence with interview data gathered from the people who were responsible for them. This was not only to cross-check what people write and what they actually think, but also to check the consistency of their reasoning over time. Lastly, I complemented analysis of oral evidence with analysis of official documents and data from newspapers, periodicals or other secondary accounts, as recommended by Lilleker (2003).

I employed member validation whenever possible and appropriate. I took my research findings back to the members of the Czech health policy community and asked them to confirm or infirm my findings. On many occasions, I checked my reading of written sources and understanding of oral evidence with the people who had contributed to them in the first place. Also, I discussed the descriptive part of my research with members of the health policy community to see if they accepted it as accurate. Lastly, I asked several members of the community to comment on earlier drafts of my research and judge the adequacy of my analysis from their perspective.

The procedures of triangulation and member validation aim at enhancing the objectivity of research, but it is important to realise that the epistemological value of these procedures is limited. Although they are designed to guard against the socially-constructed biases of qualitative research, they themselves have this kind of bias because all validating procedures are social products (Bloor 1997, pp.48-49). Therefore, although I hope that these procedures enhance the objectivity of the present research, I do not expect them to be strict objectivity tests.<sup>10</sup> Rather, I expect them to contribute towards greater objectivity of my research, through making it more accessible, generating additional material for analysis, fostering awareness of possible methodological biases

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<sup>10</sup> Bloor (1999, p.50) rightly argues that bounds of the analytic task are not set by validation procedures, but 'a mix of relevances stretching from the researcher's own intellectual curiosity and scrupulousness to external conditions such as funding limits, supervisory stipulations and (not least!) publishing deadlines.'

(Bloor 1997), and providing opportunities for ‘reflexive elaboration’ (Emerson 1981, p.362).

Even if these procedures significantly enhance the objectivity of my research, they do not give it the status of indisputable truth. The concepts of reliability and validity on which these procedures are based are developed in the tradition of positivist social science. However, not only have the concepts of reliability and validity been criticised by the followers of different positivist schools, but the entire positivist social science enterprise has been questioned by new, post-positivist approaches. Moreover, by the time this thesis finds its place in the Bodleian Library, the post-positivist approaches will probably have been challenged by new ‘post-something’ approaches.<sup>11</sup> In the current circumstances, when no agreement in social science prevails on which approach maximises the truth, my reliability and validity checks are aimed at readers receptive to the ‘subtle realist’ tradition (Seale 1999), to which I hope my research belongs epistemologically. Thereby, the reliability and validity checks are employed to ensure the ‘sophisticated rigour’ (Patton 2002) of the story being told through my research, without claiming that it is the only possible truthful interpretation of the collected data.

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<sup>11</sup> This term belongs to Esping-Andersen (2000).

## **PART II: A HISTORICAL BACKGROUND**

# CHAPTER 3: PRE-COMMUNIST HEALTH CARE REFORM

## *Austro-Hungarian Empire*

### **'The Empire strikes back' with hospitals and health insurance**

In the Czech Lands (Bohemia, Moravia, and Silesia) – which were part of the Austro-Hungarian Empire – the development of public health care was associated with the Empire's military needs. Reports of Maria Teresa's War Council on the poor state of military recruits in 1771 prompted the establishment of the first public hospitals, including VFN Hospital in 1790 in Prague (Papeš 2005, p.22). Similar reports in the second half of the 19<sup>th</sup> century led to the 1870 Public Health Act, which introduced the institution of the official (state) doctor in political districts and in specially defined health districts (Zákon č. 68/1870 ř. z.). The Act aimed to make health care accessible in every part of the Empire, especially for the poorer classes. However, 'political obstruction on the part of Czech politicians and doctors, who were at loggerheads with their German-speaking equivalents, meant that the appropriate provincial health laws (for Bohemia, Moravia and Silesia) were only accepted after some delay (1880/1890s)' (Svobodný *et al.* 2002). In the late 1880s, Eduard von Taaffe's government, known as the 'Iron Ring'<sup>12</sup> (Jenks 1965), complemented the suspension of civil liberties and persecution of the Socialists with the introduction of health insurance and other social legislation for workers, following in the footsteps of Germany's 'Iron Chancellor', Otto von Bismarck; with the important difference that Taaffe could not compete with Bismarck, either in the brutality of persecution or generosity of social legislation.

Mandatory health insurance for industrial workers was introduced only in 1888 (Zákon č. 33/1888 ř.z.) because the Austrian-Hungarian legislators waited until Bismarck enacted

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<sup>12</sup> Grandner (1994) characterises the ideology of the 'Iron Ring' as 'anti-liberalism, anti-capitalism, anti-socialism, and anti-centralism', or, in positive terms, 'a comprehensive backward-looking conservatism with a distinct touch of catholicism'.

his social legislation, using its popular appeal to overcome resistance within their own ranks (Grandner 1994). In the 19<sup>th</sup> century, large industrial works and associations of various enterprises had their own sickness funds (health insurance funds in modern terms), which provided workers with some cash benefits and free health care by an in-house doctor. The 1888 Act made provisions for establishing new district health insurance funds covering workers from enterprises which did not have their own health insurance funds, and specified the terms of health insurance coverage. The Act focused on the description of seven different organisational forms of health insurance funds and the provision of benefits was dealt with only in a few brief paragraphs. Health insurance contributions were split between workers (2/3<sup>rds</sup>) and employers (1/3<sup>rd</sup>). The insured were reimbursed for medical treatment and drugs; provided with a work incapacity benefit of 60% of the average daily wage for up to twenty weeks of sickness and four weeks of childbirth; and received a lump sum burial benefit (Zákon č. 33/1888 ř.z.). In addition to insuring industrial workers against sickness and injury, Austro-Hungary also had, far less generous, ‘fraternal insurance’ for miners and old-age insurance (pensions) for the higher classes of private salaried employees. However, the functioning of health insurance was limited because employers tended to bypass the law (ČSSZ 2004). With the exception of allowing voluntary health insurance for the family members of the insured workers, in 1917, promises to extend health insurance coverage were never fulfilled. Altogether, in 1916, there were 1,992 health insurance funds which covered approximately one million (Sociální revue 1922) of the ten-million people of the Czech Lands.<sup>13</sup>

### **Doctors versus the state and health insurance funds**

The introduction of health insurance prompted the state to seek the doctors’ co-operation and doctors to organise themselves to defend their interests.<sup>14</sup> In 1888, the Central Association of Czech Doctors (ÚJČL) was established as an umbrella organisation for various specialties and groups of the medical profession. In 1891, the state legislated for

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<sup>13</sup> Out of 1,992 health insurance funds, statistics was available only for 1,728 health insurance funds which had 913,332 members (Sociální revue 1922, p.195). On average, one health insurance fund had 529 members.

<sup>14</sup> The Society of Czech Doctors (SČL) established in 1862 by J.E. Purkyně was a purely professional organisation.

the creation of the Medical Chambers in Bohemia, Moravia, and Silesia<sup>15</sup> because it needed an institution to represent the liberal profession (which medicine was at that time) and to serve as an advisory body to the state in the matters of people's health and medical care (Pelc 1937, p.51; cited in Niklíček 1991). Soon it became clear that the Medical Chambers failed to promote effectively the interests of doctors against health insurance funds. For this purpose, in 1906, a designated section of the Central Association of Czech Doctors was founded – the Association of Doctors of Health Insurance Funds (SPL) (Tesařík 2001). It was modelled after trade unions in industry to fulfil what was viewed as the main task of the medical profession at that time – to fight against health insurance funds (Niklíček 1991), which were regarded by doctors as greedy middlemen profiting at the expense of both doctors and patients:

What for does a worker pay to health insurance funds? Not for a doctor, but for political agitators, marginally educated workers, for whom their trade has started to stink and it is more appealing for them to become a 'governor', a 'controller' or an 'officer' of a health insurance fund for a hefty salary. What is saved on the sick and doctors will be eaten up by the clerks (Kotýnka 1906; cited in Sojka 2000).

Although, by the early 1900s, doctors largely did not oppose health insurance, because it provided them with a certain income, the relationship between doctors and health insurance funds was rather hostile. Doctors fought for fixed and higher salaries, control over patient numbers, abolition of prescription limitations, simplification of paperwork, and the right to participate in the governance of health insurance funds (Niklíček 1991).

## ***First Czechoslovak Republic: 1918-38***

### **A liberal-democratic layout but not-so-liberal-democratic practices**

Thanks to the opportunity to create a nation-state provided by Austro-Hungary's defeat in WWI and subsequent collapse, the Czech and Slovak nationalist elites proclaimed independence and established Czechoslovakia in 1918. The new state consisted of the Czech Lands, Slovakia and Subcarpathian Ruthenia. In the Czech Lands, one-third of the population were German, while the Czechs in Bohemia and Moravia spoke different

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<sup>15</sup> In Bohemia and Moravia, the Medical Chambers were split into the Czech and German sections which rotated presidency between each other on the yearly basis.

dialects of the Czech language. In addition to ethnic differences, there were huge economic differences between the various parts of the new state. Most Austro-Hungarian industry was concentrated in the Czech Lands, making them the most developed part of Czechoslovakia. In stark contrast to monarchies and military dictatorships in other CEE countries, Czechoslovakia became a democracy. The Russian Revolution thwarted the early attempts of nationalistic Czech elites to export a European or Russian monarchy.<sup>16</sup> Due to the ‘benevolent dictatorship’ of Czechoslovakia’s founding fathers, especially Tomáš Masaryk,<sup>17</sup> democracy was installed against the monarchic feelings of the majority of the Czechoslovaks:

Before the war our constitutional programme was monarchical. ... But, in my memorandum to the French Government and to the Allies in February 1916, I declared officially in favour of a Republic... (Masaryk 1927, p.353).

Although Czechoslovakia had a liberal-democratic layout, based on a market economy and proportional representation, free market competition and democratic rule were limited by economic and political cartels. Czechoslovakia had a highly-fragmented political system and was ruled by a succession of fragile coalition governments. In 1920, in order to assist the weak cabinet of Jan Černý with decision-making, a political cartel known as the Committee of Five (Pětka) was established. This was a non-constitutional body of representatives of the five political parties, who brokered compromises in Parliament and made decisions for the government when it could not reach an agreement (Mamatey & Luža 1973). The Committee of Five survived throughout the First Republic, serving as its ‘real government’ (Crampton 1997, p.63) because elected governments were based on weak multi-party coalitions. Regardless of elections, more or less the same parties and people governed the country, either overtly through the government or

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<sup>16</sup> The strongest proponent of the Russian dynasty for the would-be Czech throne was the most influential Czech politician of that time Karel Kramář, who went on to become the Chairman of the Czech National Council and then the first Czechoslovak Prime Minister. Although Masaryk enjoyed less support at home than his rival Kramář, Masaryk made his reputation on leading negotiations with the Allies and upon his return to Czechoslovakia his popularity surpassed that of Kramář. Interestingly enough, the ideas and success of Masaryk as a politician and diplomat might have been influenced by his marriage to an American woman while Kramář’s predisposition towards the Russian monarchy might have been due to his marriage to a Russian aristocrat.

<sup>17</sup> The idea of the benevolent dictator can be traced back to Plato’s philosopher-king (Plato, Republic 473d-e). Given his all-round education and zeal to lecture his fellow citizens on all sorts of subjects ranging from democracy to alcoholism, Professor Masaryk comes close to Plato’s philosopher-king.

covertly through the Committee of Five. Just as the Czechoslovak economy was dominated by cartels, designed to maximise the profits of their members by reducing competition, Czechoslovak politics was dominated by a cartel of five political parties which maximised time in office for their members. If Czechoslovakia had been a majoritarian parliamentary democracy, then it is quite possible that the governing bourgeois and nationalist elites would have lost their position of power. The Communist Party came second in the 1925 election, by only a 0.5% margin of the vote, and the Sudetenland German Party topped the polls in 1935 (ČSÚ 2006); but these parties were excluded from government because bourgeois and nationalist elites deemed them extremist. At the same time, the founder of Czechoslovakia Tomáš Masaryk enjoyed the office of President from 1918 until 1935. His entourage created a cult of him as ‘President-Liberator’ and ‘Father [of the nation]’.<sup>18</sup> When ‘Father’ Masaryk resigned at the age of 85 due to poor health ‘...he made a personal appeal, that his pupil and friend, his political brother-in-arms might be elected as his successor. His people obeyed this simple request of their Father and four days later Dr. Edvard Beneš became President’ (Cohen 1941, pp.250-51). Before taking over Presidency, Dr Beneš had been Foreign Minister since 1918 uninterruptedly.

The important ministerial portfolios, with significant powers and budgets, like Foreign Affairs or Finance, changed hands less frequently than unimportant ones, like Public Health. The first Austrian Ministry of National Health was established in 1918 and, shortly afterwards, was succeeded by the Czechoslovak Ministry of Public Health and Physical Education. It assumed responsibilities for overseeing the functioning of health care facilities, sanitation, epidemiology and other public health measures, co-ordination of voluntary organisations in the related fields, and initiating necessary legislative changes. However, the Ministry of Public Health fared low among other branches of state administration, was strapped for cash, and had no influence on health insurance, which was supervised by the Ministry of Social Security. Furthermore, frequent changes of

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<sup>18</sup> It is disputable whether President Masaryk had been occupying his office for so long simply because he liked power. For example, a period publication suggests that ‘He remained the most democratic President of a democratic people. Ceaselessly he looked forward to the future of his people and he was afraid to lay down the staff of office till he was assured of their political health’ (Cohen 1941, p.248).

Health Minister reduced the administrative efficiency of the Ministry. Due to frequent changes of government, caused by the fragility of coalitions and corruption scandals, unimportant and low-budget portfolios were reshuffled fairly frequently. An average time in office for Health Minister in the First Republic was approximately 23 months.<sup>19</sup> In addition to the frequent changes of the Health Minister, the political system impacted on health care reform in two other ways: 1) radical reforms were impossible because fragile government coalitions could hardly agree on anything radical; 2) the Committee of Five provided a framework for accommodating interests between elites, thereby facilitating agreements on incremental improvements.

### **Radical reform fails while incremental improvements succeed**

During the First Republic, radical health policy change failed, but incremental improvements in health care financing and provision succeeded more than anywhere else in CEE. Also, Czechoslovakia improved her social legislation more significantly than Austria.<sup>20</sup> To allay working-class discontents, the Czechoslovak government considered introducing comprehensive national insurance. In 1920, the Social Security Ministry set up a committee of experts to explore the possibilities of transforming the fragmented and incomplete Austro-Hungarian social insurance into comprehensive national insurance. However, the committee and Social Security Minister Jozef Gruber concluded that '[o]wing to fiscal reasons... a general system of national insurance [was deemed] not being feasible' and that 'the introduction of unemployment insurance must be postponed for the present and the Ghent system subsisted' (Gruber *et al.* 1924, p.219).<sup>21</sup>

### ***Improvements in health care financing***

The legislation passed in the early years of Czechoslovakia expanded health insurance coverage, rationalised the network of health insurance funds, and increased the role of the state in health insurance. The Social Democrats initiated the Mandatory Health Insurance

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<sup>19</sup> 11 permanent Health Ministers changed between 14.11.1918 and 4.10.1938 (own analysis based on Churaň 1998).

<sup>20</sup> Old-age insurance for workers in Austria came only in 1938, thanks to the Nazi Anschluss.

<sup>21</sup> The Ghent system refers to the practice when government provides trade organisations with subsidised funding to administer voluntary unemployment insurance schemes.

Act (Zákon č. 268/1919 Sb.), which extended the maximum duration for which sickness benefits could be received from 26 to 39 weeks, expanded health insurance coverage on the basis of payment to all wage-earning employees and members of their families, and allowed health insurance to agrarian and forestry workers. This Act also attempted to consolidate health insurance through state supervision and reduction of the number of health insurance funds. Seven organisational forms of health insurance funds were reduced to three, to the effect that 708 factory, 549 company, 90 mutual aid and 1 building works health insurance funds were enlisted for voluntary merger or liquidation (Musil 1995). Moreover, in 1924, the Committee of Five supported and guided through Parliament (Mamatey & Luža 1973) the Act on Health and Social Insurance for Industrial Workers (Zákon č. 221/1924 Sb.) initially proposed by the Social Democrats and National Socialists.<sup>22</sup> This Act redefined certain sickness benefits and created a common social insurance framework for health insurance, invalidity insurance and old age insurance (pensions) for workers and low-wage employees. A year later, a similar act was adopted for privileged groups of employees: independent health insurance funds were created for civil servants, clergy, mail, railway and tobacco company employees to provide them with better cash and in-kind benefits.

According to the 1924 Act, the Central Social Insurance Fund (ÚSP) was established to co-ordinate the network of health insurance funds. This consisted of the two-level (administrative district and farming area) territorial health insurance funds and the associated non-territorial health insurance funds of factories, companies, trade associations and mutual aid societies. The Central Social Insurance Fund gained the right to appoint its representatives on the executive boards of health insurance funds, but these remained self-governing bodies. Most members of the executive and supervisory boards of health insurance funds were elected to represent evenly the employers and the insured, but the democratic provisions of the 1924 Act were not realised: '[t]he last election to the organs of health insurance funds was held as far ago as in the Austrian times' (Pelc 1937, p.252; cited in Niklíček 1991).

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<sup>22</sup> The Czechoslovak National Socialist Party (ČNSS) was a nationalist, but not fascist, party.

In 1927, the Central Social Insurance Fund supervised 307 health insurance funds, including 190 district health insurance funds (1,989,126 members) and 117 other health insurance funds (504,892 members) (Deyl 1985, pp.84-85). In addition, there were 3 health insurance funds supervised by the Ministry of Social Security (124,498 members in 1927) and a number of independent health insurance funds: 19 health insurance funds of tobacco companies (11,440 members in 1929), 8 fraternal funds of coalminers (143,977 members in 1929), and 58 insurance funds of farmers organised into the Association of Farmers' Health Insurance Funds (168,409 members in 1931) (Deyl 1985, pp.84-85). The apparent fragmentation of health insurance makes it difficult to calculate precisely the numbers insured in a given year, but we can estimate that at the end of the 1920s there were about three million insured individuals; two-thirds of whom were insured by district health insurance funds created by the state according to the 1888 Act. There is no data on the family members of the insured, but Niklíček (1991) estimates that, including the family members of the insured, about seven million of the Czechoslovak population, or half its total, had health insurance. Because the Czech Lands were far more industrially developed than other parts of Czechoslovakia, it is reasonable to assume that more than half of the Czech population were insured.

In the early 1920s, doctors frequently went on strike against health insurance funds for higher pay. For example, in 1921, Prague doctors went on strike demanding a 30% pay-rise and fixed salary instead of performance-based reimbursement (Senát NSRČ 1921). By the late 1920s, the financial capacity of health insurance funds increased and their previously hostile relationship with doctors became more co-operative, as doctors had to negotiate framework agreements with health insurance funds. Nonetheless, reimbursement rates for working-class patients were low and doctors tended to increase the number of patients and drop the quality of care in order to maximise their income (Šourek 1966). Also, doctors continued fighting for their clinical freedoms to prescribe drugs and treatments without limitations and criticised health insurance funds for incompetence and high administrative costs. The former Health Minister Ladislav Procházka (1920-21) argued:

The state, poor and saving, could have been building a simple office instead of a palace and spending the saved tens of millions on making sure that a thousand of people do not die unnecessarily every year without help. ...it is more important to provide and invest in improved medical treatment than to splash out on the palace-like offices for health insurance funds (Procházka 1927, p.205; cited in Niklíček 1991).

It is difficult to estimate the administrative costs of health insurance funds, but they must have been significant. In 1927, 307 health insurance funds, supervised by the Central Social Insurance Fund, employed 5,401 people, including 2,930 health insurance officers (Deyl 1985). If we compare this figure against 8,919 doctors, as in 1930 (SSÚ 1968), then there was at least one health insurance officer per three doctors. If we take into account 85 independent health insurance funds, then the proportion of health insurance officers to doctors could have been as high as one officer per two doctors.<sup>23</sup> Such a high number of health insurance officers can be explained by the high status of the bureaucratic jobs inherited by Czechoslovakia from the Austrian times: 'In the Austrian Empire the lowest of the State Railway officials lorded it over the public, as though to serve them were an act of grace' (Masaryk 1927, p.393).

### ***Improvements in health care provision***

In spite of being 'poor and saving', the state managed to implement a number of important incremental improvements in health care provision. Most significantly, the number of state health care facilities and staff increased and they reached out to the less developed areas (Svobodný *et al.* 2002). In more developed regions, such as Western Bohemia, however, the network of hospitals did not increase at all (Paichl 1993). In 1920, a law was passed nationalising public hospitals, to allow the state to take over and improve large hospitals formerly run by local authorities (Zákon č. 242/1920 Sb.). However, there were just eight such hospitals in the whole of Czechoslovakia and plans to establish district state hospitals failed (Paichl 1993). State hospitals and subventions to local authorities towards new health care facilities and public health programmes were

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<sup>23</sup> Statistics is not available for 85 independent health insurance funds, but if we assume that they employed the same number of health insurance officers as those supervised by the Central Social Insurance Fund (2,930/307=9.5) then there were about 800 health insurance officers more. Given that the annual increase in the number of doctors in the early 1930s was 500 doctors per year, in 1927 there were about 3,700 health insurance officers per about 7,400 doctors or one health insurance officer per two doctors.

financed through a 7% surcharge on direct taxes (Zákon č. 477/1921 Sb.).<sup>24</sup> There was also an increase in voluntary social health care organisations in the field of public health and preventive social care, such as sanatoria and dispensaries for tuberculosis, maternity consultation clinics, etc.

In the 1920s, the young doctors' association Young Generation of Doctors (MGL) led a growing movement for social medicine. This movement emerged as a reaction to the inability of the old German and Austrian tradition of curative health care to tackle the most wide-spread disease in post-WWI Czechoslovakia, tuberculosis. The young doctors looked beyond traditional curative care and promoted social hygiene, epidemiology, and preventive health care, as well as hospital management, rationalisation in health care organisation, new developments in clinical medicine, technology, etc. The young doctors championed educational efforts that resulted in the establishment of the Departments of Social Medicine at Czechoslovak universities in the 1930s (Niklíček 1991). As the social medicine agenda resonated with the social reform agenda of left-wing political parties, many young doctors swung towards the political left.

In 1925, the government responded to the growing movement for social medicine by launching the National Institute of Public Health (SZÚ), responsible for providing state health agencies with scientific and research expertise, education in preventive medicine, and practical education of health professionals (Zákon č. 218/1925 Sb., §2). Given the scarcity of state resources, an overseas charity, the International Health Commission of the Rockefeller Foundation, provided the Health Ministry with the majority of the funds required to build offices for the Institute (SZÚ 2003). The Rockefeller Foundation also financed the Masaryk State School of Health and Social Care (Šlapák 1936b). This suggests both that Czechoslovak public health depended on overseas charity and that there was a sizeable public health knowledge transfer from the USA.

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<sup>24</sup> This surcharge was initially introduced as a temporary measure to even public health care capacities in different regions but, with some adjustments, it stayed throughout the First Republic.

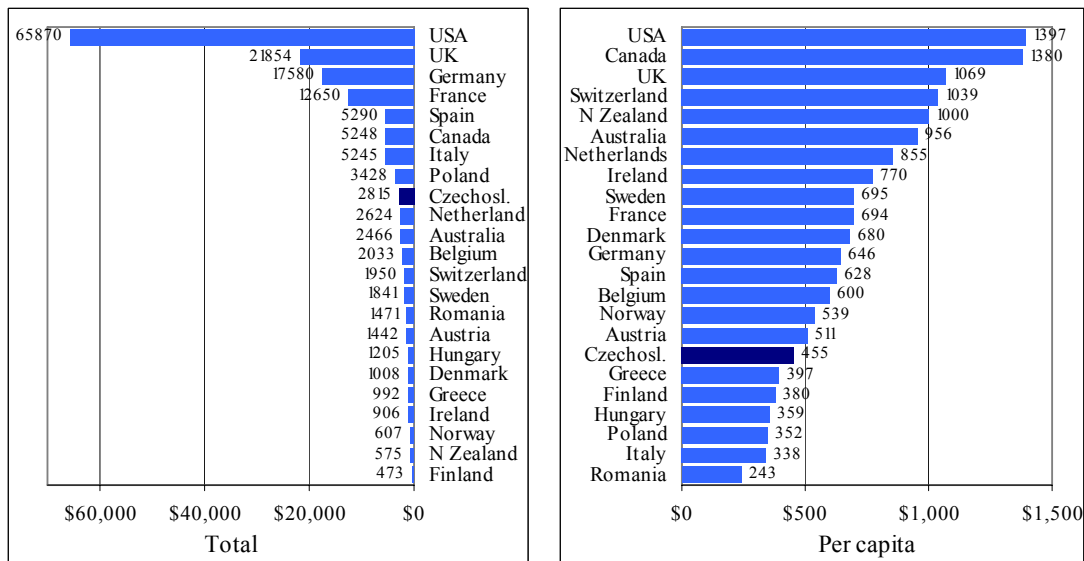
## Economic depression undermines health insurance

### *Not-so-advanced economy causes protracted unemployment*

A digression is in order here to explain the general economic conditions in the late 1920s. Today, it is commonly believed by the Czech people that inter-war Czechoslovakia was among the ten most economically developed countries in the world, but this was not the case:

...actual economic life and the level of its development in the inter-war Czechoslovak Republic were simply more prosaic and complicated than what was commonly believed, and altogether did not match the romantic image painted by the sense of national pride and vainglory... (Kubů and Pátek 2000, p.5)

**Figure 2: National income in selected countries, 1925-1934 average, US\$**

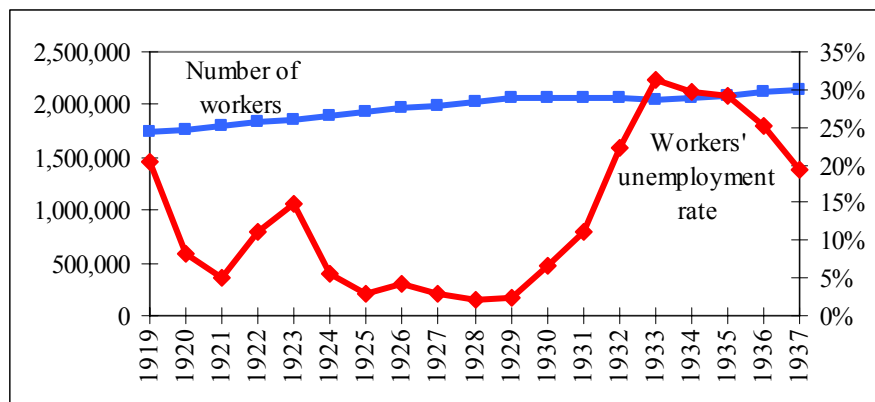


Source: Kubů & Pátek (2000, p.367)

After overcoming the economic recession of the early 1920s, Czechoslovakia enjoyed an economic boom until 1930. During this period, Czechoslovakia increased her industrial output which, in quantitative terms, became comparable to some of the world's most developed economies (Figure 2). In qualitative terms, however, most of the Czechoslovak economy lagged behind leading economies, the large number of international and domestic cartels curbing adoption of modern technologies and management techniques by Czechoslovak firms (Kubů & Pátek 2000).

As Czechoslovakia was an export–manufacturing state *par excellence*, the Great Depression hit her hard, especially the most industrialised Czech Lands. In order to recover from depression Czechoslovakia had to modernise her industry, which involved structural unemployment. The daily wages of workers, in nominal terms, decreased by 20% between 1928 and 1935 (Sociální revue 1948, p.271) and workers’ unemployment skyrocketed from 2% in 1928 to a record high of 31% in 1933 (Figure 3). In 1932-1935, when the economic depression was at its worst, the proportion of the unemployed, partially-employed, and their dependents varied between one-quarter and one-third of the population (Sociální revue 1948, p.270).

**Figure 3: Workers’ number and unemployment rate, Czechoslovakia, 1919-37**



Source: Deyl (1985), p.43

### ***Health insurance benefits reduced***

Economic depression exacerbated the deficit of health insurance funds, which arose due to the introduction of the 1924 Act on Health and Social Insurance for Industrial Workers. This Act came in force in July 1926 and by 1927 most health insurance funds were in the red (Deyl 1985, p.157-158). They responded by reducing activities and benefits not stipulated by law, such as those aimed at disease prevention and health promotion. This failed to bring the expected financial stabilisation, because the depression meant that wages plummeted, so the employed were paying lower contributions, and the deficit of health insurance funds grew higher. As a solution, Parliament supported a government proposal to reduce sickness benefits and limit health insurance coverage for family members of insured workers. As this did not solve the

problem of access to health care for the unemployed, the Communists opposed the government's proposal; proposing instead to 1) introduce general social insurance for both the employed and unemployed, 2) provide free health care for the whole duration of work incapacity, 3) make employers pay social insurance contributions instead of employees, 4) transfer the administration of social insurance to workers and call for immediate elections to the boards of social insurance companies (Deyl 1985, p.158-159), but Parliament rejected these proposals.

### *State failure in health care*

Unemployment made access to health care for the unemployed and their dependents problematic. The unemployed lost both health insurance and income, because the Czechoslovak social insurance system did not provide insurance against unemployment.<sup>25</sup> Normally, public doctors, appointed by the state and local authorities, were obliged to examine the sick unemployed and their dependents, local authorities had to pay for medicines, and public hospitals had to provide free care. However, due to protracted mass unemployment, the local authorities ran out of funds, the limited capacities of public health care facilities were insufficient, and the sick unemployed could hardly afford to travel to distant public hospitals (Šlapák 1933). In such circumstances, the Ministry of Social Security and Ministry of Public Health led charitable action, issuing a directive calling for the 'voluntary collaboration of all the officials in health and social care' to ensure provision of health care for the unemployed (Šlapák 1933, p.22). The two Ministries established the Central Advisory Board, involving officials from state administration, health and social insurance funds, local authorities, professional and voluntary organisations, to discuss ways of collaboration. Also, the Ministry of Public Health pledged some limited resources towards the treatment of the unemployed, as did the Central Social Insurance Fund (Šlapák 1933, p.28). However, these limited resources and charity work could not safeguard the health of the nation because of the systemic failure of Czechoslovak social insurance, i.e. the absence of insurance against unemployment. Only a few large industrial works, trade associations and coalmines had

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<sup>25</sup> There was a possibility for the unemployed to continue health insurance contracts on a voluntary basis, but most of them could not afford it because they did not have a stable income.

voluntary unemployment insurance schemes and the state's sponsorship of such schemes through the Ghent system was limited. Inevitably, poverty undermined the health of the nation: a survey of 1,393 healthy children in the industrial areas affected by unemployment found that 80.8% of them suffered from malnutrition, 86.8% – anaemia, 10.6% – skeletal disorders, 10.7% – lung problems, 11.6% – heart problems (Šlapák 1936a, p.683).

**Table 2: Infant mortality\* in selected countries, 1921-38**

	Czecho-slovakia	Hungary	Poland	USSR	Belgium	France	Italy	West Germany†	Austria	UK	USA
1921- 1925	155	187	...	...	100	95	126	...	136	78	74
1930	137	152	...	173	93	78	106	...	104	63	65
1937	117	133	136	170	83	65	109	...	92	61	54
1938	110	131	140	161	81	66	106	59	80	56	51

\* died before one year of age per 1,000 live births; †lands corresponding to future West Germany  
Source: SSÚ (1968)

Overall, during the First Republic Czechoslovakia improved health care outcomes better than other CEE nations, but still lagged behind more developed Western nations (Table 2). As Health Minister Ludwig Czech sarcastically described the high incidence of infant mortality: ‘we [Czechoslovakia] have a steady lead over other civilised nations’ (Šlapák 1936b, p.14). The infant mortality rate is a good indicator of the country's development level, medical technology, accessibility of health care, and therefore is argued to be a predictor of good governance or, vice versa, ‘state failure’ (King & Zeng 2001). It is thus fair to conclude that, in terms of health care, the Czechoslovak state was a failure compared to developed Western nations.

## **Proposals for comprehensive health care reform**

### ***Health Minister Czech's proposal for planned and integrated health and social care***

Given the social determinants of the nation's deteriorating health, the cause of social medicine became the official programme of the Health Ministry, under the leadership of

Ludwig Czech (1935-1938). He was a long-standing leader of the German Social Democratic Workers' Party (DSDAP)<sup>26</sup> and served in the previous government as Social Security Minister (1929-1935). He argued for a planned and integrated approach to the administration of the two 'sister' departments – public health and social security – and formulated their joint aim as 'prevention and social-health care' (Šlapák 1936a, p.687). In 1936, he put forward an Action Programme (Šlapák 1936b, 1936a) to:

- consolidate and improve child and youth care;
- educate doctors in social hygiene and social medicine;
- strengthen health and safety and promote occupational health;
- set up preventive health screening of the healthy population;
- campaign against alcoholism;
- organise systematic health statistics;
- provide health care for the unemployed;
- improve sanitation;
- launch the Masaryk State School of Health and Social Care, with the financial assistance of the Rockefeller Foundation;
- increase the remuneration of hospital doctors by reducing their tax burden;
- modernise the ambulance service;
- ensure that even the poorest can access spa treatment;
- re-organise and consolidate preventive and curative health care on a new legal basis.

Minister Czech argued for a new comprehensive Health Care Act to piece together highly-fragmented legislation with a view to 'uniting all parts [of social-health care], which until now have been separate, in one tightly-bound unit' (Šlapák 1936b, p.15). He proposed uniting all public hospitals and nursing care facilities, private clinics, and public and charitable institutions of preventive and social-health care into an integrated network, while preserving their self-administration. Furthermore, he proposed revising the 1920 Hospitals Act to create easier ways for local authorities to invest in public health care. To a large extent, his proposal was based on the Albert-Trapl Plan which originated in the Association of Czechoslovak Hospitals.<sup>27</sup>

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<sup>26</sup> In Czechoslovakia, there were two Social Democratic Parties: the Czechoslovak Social Democratic Workers' Party (ČSDSD) and the German Social Democratic Workers' Party (DSDAP).

<sup>27</sup> The Association of Czechoslovak Hospitals was founded in 1931 and distinguished itself by promoting US-style hospital management, rationalisation, planning and modern technology (Mášová 2005).

### *The Albert-Trapl Plan for rationalised and integrated health care*

In 1933, Bohuslav Albert proposed a number of measures to rationalise Czechoslovak health care, which were gradually developed into a comprehensive reform proposal known as Albert-Trapl Plan (Mášová 2005). Albert was a founding member of the Association of Czechoslovak Hospitals and director of the hospital of industrial magnate Tomáš Baťa. He was also an associate of the famous Czech surgeon Rudolf Jedlička, who established a modern clinic near Prague, modelled after Mayo Clinic in Rochester. Therefore, the Albert-Trapl Plan was inspired by the US tradition of hospital management and rationalisation. Firstly, it envisaged organising all hospitals into a hierarchical network of two types of hospitals: Type 1 (large specialised state-of-the-art regional hospitals, built by merging small hospitals) and Type 2 (first-aid centres, built by restructuring remaining small local hospitals). Secondly, it was proposed that GPs team up with hospital doctors and organise themselves into co-operatives. Thirdly, the new network of hospitals was envisaged to be integrated with health and social insurance. Lastly, hospitals were to assume the function of preventive care and consultative public health centres.

The Ministry of Public Health supported the Albert-Trapl Plan, using it as a basis for new health care legislation put before Parliament in 1937. However, this legislation was never properly discussed, let alone adopted, because the Czechoslovak political system was destabilised by the growing demands of ethnic Germans for autonomy and matters of national security, which took precedence over health care reform. Moreover, the public health budget suffered due to escalating military expenditure.<sup>28</sup> Following the Austrian Anschluss, the ethnic Germans were perceived as a threat to Czechoslovak statehood and Minister Czech – ethnic German and Chairman of the German Social Democratic Party – was forced to resign from government.<sup>29</sup>

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<sup>28</sup> An MP remarked: ‘the fact that the [yesteryear] budget was the budget of state defence manifested itself not only through the accounts of the Ministry of National Defence but also through the accounts of the Ministries of Social Security, Public Health, and Education’ (Jurnečková-Vorlová 1937).

<sup>29</sup> After the fall of Czechoslovakia, Ludwig Czech was executed by the Nazi in a concentration camp.

Shortly after that, the First Czechoslovak Republic fell as the Western democracies granted part of the Czech Lands populated by ethnic Germans (Sudetenland) to Nazi Germany. Without even consulting Czechoslovakia, Chamberlain and Daladier signed the Munich Agreement with Hitler and Mussolini, ordering Czechoslovakia to surrender Sudetenland to Germany. Reflecting the way that Czechoslovakia's fate was decided by Western democracies, this agreement became known in Czechoslovakia as the 'Munich Diktat' and 'Munich Betrayal'. As Abrams (2004, p.25) concluded, '[Western] democracies looked, at best, weak and fearful in the face of the Nazi threat or, at worst, like imperfectly self-interested collaborators with Hitler'. In addition to the West's self-interest, this agreement reflected the failure of Czechoslovak diplomacy produced by the First Republic. Although President Masaryk argued that '[t]he old diplomacy was dynastic and there is an insistent demand for a new diplomacy' (Masaryk 1927, p.393), he appointed his son, Jan Masaryk, as Ambassador to the UK in 1925. Before taking over Presidency in 1935, Masaryk senior's 'pupil and friend, his political brother-in-arms' Edvard Beneš (Cohen 1941, pp.250-51) had been Foreign Minister since 1918 uninterruptedly. Chamberlain's justification of the Munich Agreement in the House of Commons shows that Masaryk's 'new' diplomats simply failed to make the existence of Czechoslovakia known in the UK:

How horrible, fantastic, incredible it is that we should be digging trenches and trying on gas masks here because of a quarrel in a far-away country between people of whom we know nothing (Chamberlain [1938]1939, p.393).

The fall of the First Republic gave way to the Second Czechoslovak Republic – a military dictatorship which collapsed in just six months as Czechoslovakia disintegrated (Kuklík & Gebhart 2004).

Nazi Germany was not interested in Slovakia because, unlike the Czech Lands, Slovakia had little industry or natural resources. Under the threat of Hungary and Poland occupying Slovakia completely, Germany persuaded Slovakia to proclaim independence from Prague. The so-called First Slovak Republic adopted a pro-Nazi regime, under self-styled *Vodca (Fuehrer)*, Jozef Tiso – former Czechoslovak Health Minister (1927-29). Thanks to Tiso, Slovakia avoided German occupation for most WWII, though Hungary annexed a region populated by ethnic Hungarians. However, Nazi Germany occupied the

Czech Lands, establishing the Reich Protectorate of Bohemia and Moravia. The first months of Nazi occupation in Bohemia and Moravia were mild, but in autumn 1939 3,000 of the Czech intelligentsia were imprisoned, 1,200 students sent to concentration camps, their leaders were executed, and Czech universities were closed down (Burian *et al.* 2002). Another wave of repressions began in September 1941, with the arrival of new Reich Protector Reinhard Heydrich. As well as being a leading figure behind the ‘final solution to the Jewish question’, Heydrich proposed a solution to the ‘Czech question’:

Those who are suitable for Germanization [between 40 and 60 per cent] will, whenever feasible, be sent to work in the Reich in a manner precluding their return. Those who are not suitable, we could use around the Arctic Ocean, where we will take over the Russian concentration camps. ...Czechs who are not suitable for Germanization could serve there in the name of positive service for Germany as guards, foremen, and so on...(Heydrich; cited in Burian *et al.* 2002, p.53).

The *Generalplan Ost* did not deem the Czech intelligentsia fit for Germanisation and proposed that they emigrate overseas, because they were considered hostile to German rule (Gumkowski & Leszczynski 1961). However, after the Czech government in exile planned and carried out the assassination of Heydrich, the Czech intelligentsia became the target for revenge: 10,000 members of the Czech intelligentsia were sent to concentration camps or executed (*ibid.*).<sup>30</sup>

### ***The Nedvěď Plan for health care reform after liberation***

During the Second Republic, the Communist Party was outlawed and forced underground. When the Nazis came, the Communists were the only party that had underground structures to organise effective anti-Nazi resistance (Luža 1969). During the Nazi occupation (1939-1945), doctors from a Communist underground cell devised a plan for health care reform after liberation, which became known as the Nedvěď Plan, after the leader of this cell, Miloš Nedvěď, who was captured and executed by the Nazis in 1943. Similar to the Albert-Trapl Plan, the Nedvěď Plan aimed to ensure: preventive

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<sup>30</sup> This assassination – known as ‘Operation Anthropoid’ – was planned by the Czechoslovak government in exile in London and carried out by the Czech commandos trained by British forces (Burian *et al.* 2002). The Nazi responded by massacring and burning down the entire village of Lidice and executing 10,000 of the Czech intelligentsia. This prompted Britain to denounce the Munich Agreement, which unquestionably was a huge diplomatic success for the Czechoslovak government in London. Yet, it is questionable whether this success was worthwhile because of a huge death toll of the innocent civilians.

and curative health care, guaranteed by the state and affordable for everyone; collective work of doctors across different domains and specialties of the medical profession; greater involvement of the state into health care and planning and rationalisation of health care (Mášová 2005). Unlike the Albert-Trapl Plan, which drew on US innovations, the Nedvěd Plan was inspired by the Soviet model because Nedvěd made study visits to the USSR in the 1930s in his position as Chairman of the Medical Section of the Society for Economic and Cultural Co-operation with the USSR (ibid.).

### ***Third Czechoslovak Republic: 1945-48***

#### **National socialist revolution**

While Czechoslovakia was still being liberated by the Red Army in 1945, the cartel of political parties and organisations known as the National Front (NF) proclaimed the first post-war Czechoslovak government and embarked on national socialist revolution. Effectively, the National Front superseded the infamous Committee of Five and took its anti-democratic practices even further. Czech political parties were represented in the National Front by three left-wing parties (Communists, National Socialists, and Social Democrats) and a Roman Catholic party (Czechoslovak People's Party (ČSL)). The National Front banned German and Hungarian parties, and those that they claimed collaborated with the Nazis. This was a suspiciously self-interested action because, among the banned parties, were the largest party of the First Republic – the Agrarian Party (RSZML) – and the most popular party in the last pre-WWII elections – the German Sudetenland Party.

The self-proclaimed National Front government praised the 'victorious' Soviet Union for its leading role in liberating Czechoslovakia, prioritised co-operation with the Soviet Union in all spheres, and even promised to teach Russian at schools and remove anti-Soviet references from school textbooks (Košícký vládní program 1945). This was not dissimilar to state-sponsored Francophilia during the First Republic, because France was the main Western power behind the creation of Czechoslovakia in 1918 and subsequently became her main diplomatic and military ally. However, after the 'Munich Betrayal',

France was deemed worthy of only 'limited friendship' (ibid.). Most importantly, the government proposed wide-scale nationalisation, land reform, and the persecution of German and Hungarian collaborators (ibid.); following a plan for national socialist revolution devised during WWII by ex-President Beneš and other members of the exiled Czechoslovak government in London:

In social revolution, which will come, it will be necessary to free our lands completely from the German bourgeoisie, pan-German intelligentsia, and the failed proletariat. This will be our final and satisfactory for us solution: to combine social revolution with national revolution (Beneš, 1943 cited in: Mandler 2002, p.80).

Upon return to Prague, ex-President Beneš started acting as President and ordered nationalisation of the property of Nazi collaborators, as well as ethnic Germans and Hungarians, and deportation of more than 2m of them. Consequently, approximately 32% of Czech pharmacies, which formerly belonged to Germans and collaborators, were nationalised (Rusek 2002). Then, Beneš ordered nationalisation of large trade and agricultural companies, industrial firms with more than 50 employees, private financial institutions, and private insurance funds including health insurance funds (Dekret č. 103/1945 Sb.). This nationalisation involved 61% of the workforce (Abrams 2004). As for health care, the national socialist revolution envisaged guaranteed social insurance for the employed and the expropriation of castles and spas for the people's health and recreation (Košícký vládní program 1945, § XIV). Also, President Beneš legislated to establish two new medical faculties at Hradec Králové and Plzeň Universities (Dekret č. 96/1945 Sb., 135/1945 Sb.).

### **Adolf Procházka: from London exile to Health Minister**

After the complete liberation of Czechoslovakia, there were three groups proposing ideas for health care reform: the London exiles, the Moscow exiles, and the left-wing doctors who remained in Czechoslovakia during WWII (Suchánek 2005). Although neither of the exile groups possessed a detailed plan, members of the London exiles gained control over

the Ministry of Health.<sup>31</sup> The lawyer Adolf Procházka, from the right-wing of the People's Party, became Health Minister. Despite the time he spent exiled in London, Procházka was against an NHS-style health service. He believed that the Czechoslovak medical profession did not have as much independence or bargaining power as their British counterparts, so an attempt to implement the British model in Czechoslovakia would strengthen the ultimate ambitions of the Communists (Suchánek 2005). Minister Procházka favoured a mixed health care system, with primary health care provided by independent health insurance funds and private doctors, and secondary and tertiary care provided by the state, through a network of state hospitals (Suchánek 2005). His legislative work focused on drafting laws on the obligatory vaccination against diphtheria, state-ownership and centralisation of consultation clinics of preventive health care, partial nationalisation of the pharmaceutical industry, and adjustment of health insurance benefits. The legislative process, however, was rather slow: three-quarters of parliamentary debates were on the delineation of the competencies between different organisations and government agencies and only one-quarter on conceptual issues (ibid). Furthermore, Minister Procházka devoted most of his time in 1947 to fighting the Communists, whose popularity was growing (ibid), and who promoted social legislation and were supported by trade unions.

### **Zápotocký as the unlikely father of the Czechoslovak 'welfare state'**

Soon after the liberation, the Central Council of Trade Unions (ÚRO), under the leadership of Communist Antonín Zápotocký, put forward a proposal for comprehensive National Insurance. A designated commission of the Central Council collected the required financial data and finalised the proposal, which was approved by the government in 1946 (Mařík 1948). Then, the Communist-led Ministry of Social Security drafted and put before the Interim Parliament the Act on the Establishment of National Insurance (NS RČS 1946). This Act envisaged abolishing the multitude of health and pension insurance funds and establishing a new three-level system comprised of 1) the

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<sup>31</sup> Adolf Procházka, the Chairman of the Legal Council of the Czechoslovak Exile Government in London was appointed as Minister and Karel Macháček, the Chairman of the Health Council of the Czechoslovak Exile Government in London, headed the Executive Board of the Ministry.

Central National Insurance Fund; 2) Bohemian, Moravian, and Slovak National Insurance Funds; and 3) District National Insurance Funds. However, because of disagreements between political parties, and then the government crisis, this Act was passed (with modifications) only after the Communists gained full power in 1948.

Zápotocký – the unlikely father of the Czechoslovak ‘welfare state’ – started his political career as a Social Democrat. In 1920, he was jailed for organising a workers’ strike in Kladno (Skilling 1955) and subsequently joined the Communist Party. After the liberation, Zápotocký became one of the key politicians, serving as Czechoslovak President 1953-57. He became known as the ‘Father of the Workers’ for his trade-unionist activities and generous social legislation; but, when workers at the Škoda Works in Plzeň took to the streets in protest against harsh monetary reforms in 1953, he called in tanks to crush their protest, killing dozens of them (Kramer 1999). In a way, he became a true heir to the Bismarckian tradition of brutally crushing the workers with one hand while enacting generous social legislation with the other.

### **Communists win the 1946 election**

The Communists won the election in May 1946, with 40% of the vote in the Czech Lands, and became the largest parliamentary party. Moreover, the Communists had the largest membership of all parties, rising from 28,000 in 1945, to 1.1m in March 1946, and 1.4m in 1947 (Abrams 2004, p.57). The victory of the Communist Party seemed internal to Czechoslovak politics, rather than resulting from the direct support of the Red Army, which left Czechoslovakia as early as December 1945. At the same time, the ‘Munich Betrayal’ of Czechoslovakia by Western powers in 1938 and the association of the Communists with the Soviet Union, which became Czechoslovakia’s main military ally in 1943 and liberator in 1945, ensured the popularity of the Communist Party. Although the Communists held a minority of ministerial portfolios, they included such important ones as Interior, Information and Agriculture, and the Communist leader, Klement Gottwald, became Prime Minister.

## **Two-Year Plan subordinates health care to increasing productivity**

For the period 1947-48 the government adopted the so-called Two-Year Plan, which was aimed at fast post-war restoration of the Czechoslovak economy. Under the Plan, ‘the object of social policy is not only to protect and to assist those in need, but first of all to protect and to improve the productive capacity of the population, which is the main source of the nation’s wealth and well-being’ (Šejhar 1947, p.6). The key instrument for improving productive capacity was to increase wages and salaries in the most important areas of the post-war restoration, such as industry and construction. Resources to do so were found by reducing salaries in less productive areas.<sup>32</sup> Also, health and social security were seen as instruments to increase productive capacity, so the Two-Year Plan envisaged the creation of comprehensive National Insurance. Before WWII, health insurance benefits were paid according to numerous income bands for different employment categories. In 1947, these income bands were abolished and health insurance benefits varied only between three employment categories: workers, public servants (including those employed in nationalised industries), and a higher category of the self-employed. The importance of using social policy to increase productive capacity is demonstrated by the discussion on National Insurance: the Communists strongly disagreed with the intention of the ‘reactionary’ parties to pay benefits to widows, in good health and of working age, for longer than one year on the grounds that ‘the young women would stay away from work and live on the unearned share of the national income, which instead could have been used to expand production’ (Popel 1949, p.123).

The subordination of health care to the goal of increasing productive capacity also manifested itself in the governance system. A body that prepared and co-ordinated the activities of the Two-Year Plan, and advised the government on its implementation, was the Economic Council (HR) (Šejhar 1947, p.9). It was comprised of key government ministers and representatives of the National Bank, Slovak Parliament, trade unions, etc.,

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<sup>32</sup> ‘Wages policy is no longer at the mercy of the dictates of Capital, nor of the results of the class struggle, but, in accordance with the consistent social and economic policy of the Government, is directed centrally, so as to provide just remuneration for work alone, and to be economically feasible’ (Šejhar 1947, p.20).

but the Health Minister was not included (Dekret č. 63/1945 Sb.).<sup>33</sup> The low-key role of health care on the political agenda is also evident in Parliament. When the National Insurance Act was undergoing the last stages of deliberation in Parliament, in February 1948, non-Communist ministers forced a government crisis, instead of passing the Act which had been in preparation since late 1945.

### **A mistake of non-Communist ministers**

The government crisis began when – despite the protests of Communist and Social Democratic ministers – the Cabinet resolved to increase the salaries of civil servants by 800 crowns and decrease salaries in other employment categories (FSÚ 1973, p.19). In response, the Communists called for a meeting of the Central Council of Trade Unions, to mobilise trade unions against the government. The National Socialist ministers attempted to limit the powers of the Communist-controlled Interior Ministry through Parliament, accusing the Communists of exploiting their ministerial positions for political gain and of purging non-Communist civil servants. In such circumstances, 12 non-Communist ministers resigned hoping that the Communists would concede or President Beneš would call for a premature election. However, under the 1920 Constitution, President Beneš could not call a premature election, because the 12 ministers were not a majority of the 26-minister Cabinet. Effectively, the non-Communist ministers acted on a false assumption, making a mistake, which the Communist leader and PM Gotwald described as follows:

At first, I couldn't believe it would be so easy. But then it turned out that this is just what happened – they handed in their resignations... I prayed that this stupidity over the resignations would continue and that they would not change their minds (Gottwald; cited in Abrams 2004, p.276).

The Communists skilfully exploited this mistake, using their influence in trade unions to organise mass rallies and a 2.5m-strong hour-long general strike against the ‘reactionary’ ministers (FSÚ 1973, p.23). Eventually, President Beneš accepted the resignations and asked Communist PM Gottwald to form a new cabinet, without calling for a premature election just 3 months before the scheduled election.

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<sup>33</sup> The Economic Council was abolished in 1949 when its responsibilities were taken over by the State Office for Planning (SPÚ) (Zákon č. 60/1949 Sb.).

## CHAPTER 4: COMMUNIST HEALTH CARE REFORM

### ***Communist Rule: 1948-68***

The new Communist government revamped the National Front by excluding from it their political adversaries, most notably the National Socialists. When the 300-strong Parliament reconvened in March, 221 MPs had joined the revamped National Front and 35 others had offered ‘permanent co-operation’ (Kubát 1961, p.697). Furthermore, in the run-up to the election the Communist Party absorbed the Social Democratic Party, which ceased to exist. Most importantly, the new National Front altered the ballot system, by having the ballot only for or against the National Front.<sup>34</sup> It was no surprise that the National Front won 91% of the vote in the Czech Lands in May 1948. After the election, the Communists strengthened the trade union wing of the National Front – Revolutionary Trade Union Movement – by incorporating in it or abolishing other trade unions.

### **Socialist transformation of health care begins with pre-war ideas**

#### ***Bohuslav Albert in the forefront of health care reform again***

In the new cabinet, Adolf Procházka was succeeded by his People’s Party colleague, but left-wing opponent, Josef Plojhar, who served as Health Minister for the next twenty years. He appointed Bohuslav Albert as Chief of the Ministry’s Executive Board to implement the Nedvěď Plan. Importantly, Albert was appointed to implement the Nedvěď Plan, rather than his own pre-war Albert-Trapl Plan, because, unlike the Communist martyr Nedvěď, he was a former National Socialist and ‘Batist’, i.e. supporter of industrial magnate Tomáš Baťa (Mášová 2005). Albert’s expertise was instrumental to the adoption of new health care legislation (on national insurance and nationalisation of hospitals, medical spas and the pharmaceutical industry) and the first Five-Year Plan in health care, which laid the foundations for the socialist transformation of Czechoslovak

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<sup>34</sup> This form of voting in Parliamentary elections was institutionalised in 1954 (Zákon č. 27/1954 Sb.).

health care (ibid.). Although Nedvěď was officially credited as the visionary behind the socialist transformation of Czech health care, this in fact followed the pre-war Albert-Trapl Plan and the real architect of the socialist transformation was indeed Albert, or as Hana Mášová aptly put it: ‘the [Communist] system used Nedvěď, Albert used the system’ (Mášová 2005, p.96). In addition to Albert’s expertise, there were three crucial factors behind the surge of successful reforms in 1948:

1. control of the National Front and the Revolutionary Trade Union Movement allowed the Communist government to enact legislation without major resistance;
2. most reforms were based on the traditions of social medicine and rationalisation and had been well-known since the First Republic;
3. many reforms enacted by the Communists were drafted before 1948.

Hence, though the way these reforms were adopted was revolutionary, they themselves were not; one can even argue that they were implemented too late.

The two most important reforms adopted in 1948 – the new Constitution and the Act on National Insurance – corresponded to the 1946 Government Declaration, which acknowledged health protection as the right of every citizen and pledged to develop planned and integrated state health care (Mášová 2005, p.92). The 1948 Constitution proclaimed the right of every citizen to health protection, including medical care and social insurance in accordance with the National Insurance Act (Ústavní zákon 150/1948 Sb., § 29). The National Insurance Act abolished the multitude of public and state health and pension insurance funds (private ones were nationalised in 1945), instead establishing the Central National Insurance Fund with district branches (Zákon č. 99/1948 Sb.). It expanded health insurance benefits and abolished differences between employment categories. Whereas, previously, public hospitals received just Kčs10 a day towards the treatment of workers’ dependents – which was far below the costs even of examination, making patient co-payments necessary – under the new Act all the insured and their dependants were eligible for free health care (except dental care) (Mařík 1948). The employer paid the entire National Insurance contributions for the employed, the state paid for the unemployed, and the self-employed paid for themselves. Altogether, when mandatory insurance was extended to the self-employed in 1950, 92.7% of the

Czechoslovaks were covered with health insurance (Štich 1950, p.202) and a Communist commentator remarked ‘they could not have even dreamt of such social security under capitalism’ (Popel 1949, p.124).

### ***Conceptualisation of socialist social and health policy***

The first Five-Year Plan (1949-1953) outlined the main tasks for further socialist transformation of social security and health care. Like the Two-Year Plan, the Communist planners proceeded on the assumption that the ultimate aim of both economic and social policy was to increase living standards and that social policy should contribute towards the increase in productive capacity. They argued that, unlike old social policy, which was unproductive, the new social policy should be productive: ‘we must ensure that every working person feels better and has better physical conditions for work because in this case he will work much better and thus will return expenditure on social security in excess’ (Popel 1949, p.124). The Five-Year Plan set out to (ibid.):

- a) provide all citizens with health care and improve it in line with modern medical knowledge; raising health care expenditure from Kčs4.3bn in 1948 to Kčs9.5bn in 1953, or by 121%;
- b) provide all individuals who, against their will, were incapable for work with adequate benefits; raising expenditure on benefits from Kčs12.5bn in 1948 to Kčs22.8bn in 1953, or by 82%;
- c) reduce losses in production due to work incapacity by the methodical improvement of health care;
- d) reduce losses in production by bringing health services directly to factories and building national insurance branches closer to workplaces.

As far as the development of health services is concerned, the Five-Year Plan envisaged deploying doctors where they were required; increasing numbers of medical personnel, through the conversion of excessive civil servants and mass education; freeing doctors from burdensome administrative work; using all suitable buildings to increase the number of health care facilities; and decentralising, simplifying and making cheaper the administration of health services (ibid.).

Early attempts to theorise socialist, as opposed to capitalist, health care pointed out that socialist health care is distinctive because it (Štich 1950):

1. is planned, allowing investment in health care facilities and research in line with planned economic growth, which is helped by the increased productivity of the healthier workforce;

2. prioritises prevention, hygiene and epidemiology playing a significant role in the whole of social and economic life;
3. is characterised by unity of the preventive and curative health care, and of outpatient and inpatient facilities;
4. has organisational unity and centralised administration;
5. is accessible; it is provided as a Constitutional right and ensured through a growing network of health care facilities and their proximity to citizens;
6. ensures the quality of care through the tight connection between medical knowledge and practice. Development and dissemination of medical knowledge best occurs in public health facilities where doctors work collectively, rather than in private practices where doctors work individually;
7. has a class dimension; the best health care being provided to those who deserved it most by their hard work, i.e. workers. Health care facilities should be built in industrial works and factories;
8. is characterised by the active participation of the public in various health care-related bodies of public administration and factories, Red Cross organisations, meetings of health care activists, health education, etc., according to Lenin's tenet that 'health protection of the working people is the business of the working people themselves'.

Notably, all but the last two of these features implemented by the Communists were clearly articulated by National Socialist Bohuslav Albert and accepted at government level by German Social Democrat Ludwig Czech in the mid-1930s. As for the class dimension, there was no such a thing in the First Republic but, like the Communist planners, the capitalists were aware that, by bringing health services directly to the workplace, they could increase productivity. However, Czechoslovak industry during the First Republic suffered from fragmentation and low concentration, so did not have much capital to invest in workers' health. Owing to nationalisation and centralisation of industry, the Communists were able to increase the number of health care facilities in the industrial enterprises. Whereas in 1938 only 15 industrial enterprises had health care facilities, in 1948 – 475, 1955 – 1,691, 1959 – 1,935; these facilities employing about 10% of all health care personnel (Šourek 1960, p.22). As for the active participation of the public in health care, it was peculiar to the Communists to call on workers to improve health care for themselves, whereas Social Democrat Ludwig Czech called on state, public and professional officials for charitable action to provide health care for the unemployed.

## **Socialist transformation continues after the Soviet example**

### ***Communists turn Stalinist***

In the early 1950s, the issue to what degree Czechoslovakia should emulate the Soviet example became heavily politicised, culminating in the so-called Slánský trials of 1952. In his quest for Stalin-like status, the Communist leader and Czechoslovak President Klement Gottwald accused Communist Party Secretary-General Rudolf Slánský, and 13 other top party and state officials, of driving a wedge between Czechoslovakia and the Soviet Union, deviating from socialism to capitalism, and of a Zionist conspiracy (11 of the 14 defendants were Jews). All the defendants were convicted and the majority executed. These trials were followed by other Stalin-style repressions nation-wide. After Gottwald's death in 1953 his fellow hard-liner and successor Antonín Zápotocký continued repressions, but they gradually decreased, stopping completely with Zápotocký's death in 1957. Nonetheless, with the exception of the brief period of 1968 Prague Spring, the hard-liners stayed in power until 1989.

### ***Continuity and discontinuity in health policy***

Although the Soviet model became indispensable for the late stages of the socialist transformation of Czechoslovak health care, it is a gross exaggeration to portray the whole of the post-war transformation of Czechoslovak health care as the methodical implementation of the Soviet model (e.g. Plojhar 1966). At least the portrayal of following the Soviet model was necessary for Czechoslovak politicians to survive in the aftermath of the Slánský trials. As has been shown, the Communists did not have control over health policy before 1948, so, after the liberation, health policy continued along the lines of pre-war thinking. Furthermore, the reforms of 1948-49 followed the pre-war reform proposals and drew on the post-war legislative work. The Communist take-over in 1948 provided an opportunity to realise these proposals, but in accordance with a Communist revision. From approximately 1950, the importance of following the Soviet example became elevated to the level of ideology in its own right, and this ideology became compulsory for political survival (and until Stalin and Gottwald's death in 1953 for the physical survival of politicians as well). In the 1950s, there were exchanges of Czechoslovak and Soviet doctors and administrators and Soviet public health advisors

were invited to Czechoslovakia. At the same time, the aims of the ‘Soviet’ system were not dissimilar to the Czechoslovak pre-war health care reform agenda. On the whole, the post-war transformation of Czechoslovak health care started off along the lines of pre-WWII proposals, but finished after the Soviet model. This shared the aims of Czechoslovak pre-war thinking (comprehensive health insurance and a unified health care system) but disagreed with its means, proposing full state ownership.

### ***Medical profession incorporated in the state***

The socialist transformation of health care continued in a systemic fashion, dealing with health care governance, financing, and organisation. The Communist state significantly simplified health care governance by incorporating the medical profession in the state. In 1948, the Central Association of Czechoslovak doctors was dissolved and the economic representation of doctors’ interests was incorporated in the state-controlled Revolutionary Trade Union Movement. In 1950, the Medical Chambers were abolished and the representation of the professional interests of the medical profession and its regulation was delegated to the state, represented by the Ministry of Health, local authorities, and university medical faculties. The medical profession ceased to exist as a liberal profession and was almost fully incorporated in the state or state-controlled trade unions. As such, the medical profession could no longer veto government reforms.

### ***National Insurance divided and incorporated in the state budget***

The three-year-old National Insurance system was rebuilt after the Soviet example to ‘promote production, provide a full range of top quality care for the working person, make the working people manage it and be directly responsible for it, and, in line with the development of production, to become an instrument for the constant improvement of the living standards of all working people’ (Zákon č. 102/1951 Sb.). National Insurance was divided into health insurance and pension insurance, and then incorporated into the state budget. In 1956, sickness benefits were significantly expanded and increased, but the self-employed in odd-jobs and in low-income jobs were not entitled to sickness benefits (Zákon č. 54/1956 Sb.), perhaps in order to suppress the private sector and foster

collectivisation in the countryside. Whereas the State Office for Social Security (SÚDZ) was established to manage pensions, the administration of health insurance was delegated to the Central Council of Trade Unions, which was entrusted with rebuilding health insurance according to the needs of the working people and establishing administrative structures for health insurance in factories and organisations. It is striking that the government effectively instituted the old Ghent system in health insurance, allowing the Communist state to strengthen its main supporters at grassroots level (the trade unions), save on the administration of health insurance, and bring national insurance to the workplace in a bid to cut production losses. Moreover, the state gained control of health insurance funds and pension funds to use them as an investment vehicle to increase production. Essentially, health care ceased to be an in-kind benefit of health insurance and became a state health service financed through the state budget.

### ***Health care system unified***

In 1952, the unified state health care system was created by integrating primary and secondary health care (Usnesení vlády ČSR ze 3.7.1951), preventive and curative health care (Zákon č. 103/1951 Sb.), and public health (Zákon č. 4/1952 Sb.). Accordingly, district and regional health authorities – known as Regional/District Institutions of National Health (KÚNZ/OÚNZ) – were established. In the Czech part of Czechoslovakia, there were 8 Regional Institutions of National Health and 76 District Institutions of National Health (Jaroš & Kalina 1998). Each District Institution of National Health served on average 3,750 people and included hospitals, polyclinics with GPs and outpatient specialists, a hygiene and epidemiology centre, a health education centre, community and factory health centres, mother and child services, opticians, a blood transfusion station, and sometimes other specialised services (Gazdík 1975). Each Regional Institution of National Health was comprised of higher-level specialised outpatient and inpatient facilities, often a teaching hospital, and, in addition, administrative departments to supervise, plan and organise health services on its territory (ibid.). Also, Works Institutions of National Health (ZÚNZ) were established in all large

and medium-sized industrial works and coalmines.<sup>35</sup> They normally had specialised occupational medicine units, preventive and curative general outpatient facilities, and large works often had their own inpatient curative and rehabilitation facilities. The new health system aimed to provide treatment locally, but if this was not possible, citizens were entitled to reimbursement of travel expenses.

As for pharmaceutical services, in 1950-1951, the remaining private pharmacies, which accounted for approximately two-thirds of the total number of pharmacies in the Czech Lands, were nationalised and transferred to the unitary state pharmaceutical firm Medika (Rusek 2002). In 1957, Medika was divided into regional firms, which in 1960 were further reorganised: whereas drug suppliers and control laboratories remained on the regional level, regional pharmacy networks were decentralised to the level of district pharmaceutical services and transferred under the administrative remit of the District Institutions of National Health. As during the nationalisation of other health services, pharmacists had no choice to retain their private pharmacies and had to sell them to the state on unfavourable conditions (*ibid.*). On the positive side, the nationalisation of pharmacies allowed the building of a unified health care system, improved pharmaceutical education, research and information, and rationalised pharmaceutical services. Consequently, during Communist rule, the total number of pharmacies was reduced from 1,042 in 1950 to 917 in 1990, i.e. by 12% (*ibid.*).

Public health was also significantly reorganised and decentralised. In 1949, regional branches of the National Institute of Public Health were created. The positions of Director and Deputy Director of the National Institute were then abolished and the five departments which comprised the National Institute became directly accountable to the Health Ministry (SZÚ 2003). In 1952, the Hygiene and Epidemiology Act (Zákon č. 4/1952 Sb.) outlined further measures to transform public health, modelled after the Soviet example with the help of Soviet advisers (Mášová 2005, p.97). Accordingly, the regional branches of the National Institute were transferred to regional authorities and transformed into larger units known as Hygiene and Epidemiology Stations. Furthermore,

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<sup>35</sup> The Interior and Defence Ministers and the Railways retained control over their health care facilities.

the five departments were transformed into larger units: the Institute of Epidemiology and Microbiology, the Institute of Hygiene, the Institute of Social Medicine and Organisation of Health Care (ÚSLOZ), and the Institute for Further Education of Doctors (ÚDL) (ibid.).<sup>36</sup>

### **Further reforms in health care provision and governance**

Despite the declared ‘victory of Socialism’, health care remained employment-based. The so-called First Document of the Party and Government on Health Care analysed the socialist transformation of health care and formulated further reforms (Usnesení strany a vlády 1952) in order to:

- 1) strengthen prevention;
- 2) prioritise health care for the employed in industry;
- 3) provide better care for mother and child;
- 4) improve the culture of care;
- 5) advance medical science in line with the latest developments.

Along with declaring the ‘victory of Socialism’ and proclaiming the Czechoslovak Socialist Republic, the 1960 Constitution stated the right to health protection and medical care for the employed and that this right would be ensured through the steadily expanding free health care services (Ústavní zákon 100/1960 Sb.).

### ***Free health care for everyone only in 1966***

The so-called Second Document of the Party and Government on Health Care suggested that health care was a function of the whole of a socialist society and that it was to be realised, according to the principle of ‘democratic centralism’, through its economic, social, cultural and health care institutions (Usnesení strany a vlády 1964). This Document contained a number of crucial policy proposals, such as the extension of free health care to everyone, rationalisation of health care financing and organisation, and strengthening of preventive measures. These proposals were translated into legislation through the Act on Health Care of the Population (Zákon č. 20/1966 Sb.). In addition to

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<sup>36</sup> In 1971, the public health institutions that sprang from the former National Institute of Public Health, as well as those established after 1952, were incorporated into the Institute of Hygiene and Epidemiology (IHE) (SZÚ 2003).

introducing new norms, the Act codified and augmented the existing complex and fragmented health care legislation. With many changes and modifications, this Act still continues to serve as a health care code.

***‘Democratic centralism’***

Health care governance and financing was based on the aforementioned principle of the democratic centralism (MZ ČSR 1985). The Congress of the Communist Party convened every five years to elaborate the guiding principles for the whole of the society and economy, including health care. Then, the Presidium of the Central Committee of the Communist Party developed programme documents and guidelines for the government, in order to implement the decisions of the Congress and its own decisions between the Congresses. The Czechoslovak State Planning Commission translated these programme documents and guidelines into economic and social policies. Among other things, the State Planning Commission was responsible for planning health care expenditure in the long-term macroeconomic perspective and for preparing a normative Five-Year Plan. The Ministry of Finance developed an annual state budget, according to this Plan, and, through the Ministry of the Interior, allocated funds to local authorities – the Regional and District National Committees (KNV/ONV). The Ministry of Finance also regulated wages and salaries in the health care sector (together with the Ministry of Labour and Social Affairs), set prices for drugs, and controlled the allocation of capital-intensive equipment to health care institutions. The Regional and District National Committees allocated funds to Regional/District Institutions of National Health, formulated local health policies through local assemblies, participated in the planning and administration of local health services through the designated Departments of Health, and were responsible for organising local health promotion, health education and public health programmes. Local and City National Committees did not have direct influence on health services, but nonetheless could initiate health promotion and disease prevention programmes on the community level. The Health Ministry was responsible for the overall organisation of health care, regulation of the medical profession, medical education and research, and the administration of national-level health care facilities.

### ***Residual health care financing***

Health care during Communist rule was part of the so-called ‘non-productive sphere’, ‘social sphere’ or ‘budgetary sphere’ of the economy, which was on the consumption part of the national balance sheet, as opposed to the ‘productive sphere’, associated with investments. Although Communist ideology perceived economic growth as a means of social development, planners tended to prioritise investment over consumption because they believed that higher consumption would be achieved through higher returns on investments in production. The social sphere was financed residually through the so-called ‘social quota’ which was a function of production (Krejčí 1949).<sup>37</sup> The post-WWII nationalisation and centralisation of the economy helped to increase production but, due to Cold-war isolation and excessive orientation towards the less-developed Eastern Block, the Czechoslovak economy lost access to lucrative Western markets and cutting-edge technology. By the end of the 1960s, the Czech economy could not keep up with previously high rates of economic growth. The solution was to increase investment in industry at the expense of health care and other non-productive services.

### **A ‘miracle and decay’ in health care**

During the first decade after its introduction the unified health care system proved remarkably effective. Increased health care capacities, universal and equitable access to health care, and comprehensive public health measures contributed, in particular, to a rapid decrease of morbidity and mortality. Between 1950 and 1955, the infant mortality rate more than halved (Table 3). If, during the First Republic, Czechoslovakia was seriously lagging behind the most developed countries in terms of health care, all changed in 1960 when Czechoslovakia assumed her place among the most developed countries. The success of Czech health care was recognised internationally in 1965, when Czechoslovakia was elected as a member of the Executive Board of the WHO. Because of the universal and preventive character of the Czechoslovak health care system, the WHO recommended it as a model for developing countries, Czech health professionals

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<sup>37</sup> In reality it meant that the social sphere received what remained in the national budget after allocating funds to the productive sphere.

were repeatedly invited to work as advisers or practicing doctors in developing countries, and a number of WHO reference laboratories were established in Czechoslovakia.

**Table 3: Infant mortality\* in selected countries, 1938-89**

	Czecho-slovakia	Czech Republic	Hungary	Poland	USSR	Belgium	France	Italy	West Germany	Austria	UK	USA
1938	110		131	140	161	81	66	106	***59	80	56	51
1950	78	64	86	108	81	53	52	64	56	66	31	29
1955	34	28	60	81	60	41	39	51	42	46	26	26
1960	24	20	48	57	35	31	27	44	34	38	23	26
1964	21	19	40	48	29	25	23	36	25	29	21	25
1965	**26	**24	39	43	27	24	22	36	24	28	20	25
1970		20	36	37		21	18	29	23	26	19	20
1980		17	23	26		12	10	15	12	14	12	13
1989		10	15	19		7	8	9	8	8	8	10

\* died before one year of age per 1,000 live births

\*\* the definitions of live births and infant deaths were changed in 1965

\*\*\* lands corresponding to future West Germany

Source: (SSÚ 1968) and (MZ ČSR 1980) for 1938-1965 and (OECD 2007) for 1970-89

However, the development of health care during the 1960s and 1970s has been aptly described as the ‘Czechoslovak miracle and decay’ (Drbal 1990; cited in Vepřek *et al.* 1994). In the late 1960s, health status improvements stagnated, then started to decay in comparison with Western European countries. By the end of Communist rule, the Czech Republic was no longer a leading health care nation but lagged slightly behind the most developed countries, though on par with the USA.<sup>38</sup> This stagnation was primarily due to changes in the complex socio-economic determinants of health, and the inability of the Communist society, economy and health care system to respond to this change (Potůček 1990; Drbal 2005). Czechoslovakia succeeded beyond expectation in bringing medicine to everyone and controlling infectious diseases but its ability to tackle the ‘diseases of civilisation’ – cardio-vascular conditions, cancers, Alzheimer’s, cirrhosis, depression,

<sup>38</sup> Given that the Czechoslovak GDP was significantly smaller than that of the USA (five times smaller in current US\$ and three times smaller in purchasing power parity \$), the Czechoslovak health care system still bore some signs of the previous miracle.

obesity, etc. – was limited. It was hard to change the lifestyle of the population and the economy was failing to improve the living and working environment substantially, or to invest in cutting-edge clinical research, medical technology and drugs. Czechoslovakia's health care system needed investments, in both Czechoslovak crowns and hard currency, but the economy could not afford them. In a way, health care fell victim to its own success: investments in health for the sake of increased production seemed to have hit the point of diminishing return and investments in health for its own sake had a low priority compared to production.

## ***Communist Rule: 1968-89***

### **Prague Spring**

In 1968, the progressive part of the Communist Party, led by Alexander Dubček, attempted far-reaching reforms to build 'Socialism with a human face' (Williams 1997). The Prague Spring reformers pursued political and economic liberalisation, economic co-operation with the West, expulsion of the remaining Soviet advisors, and the political devolution of Czechoslovakia. The Prague Spring was brutally suppressed by the Soviet-led military invasion of the Warsaw Pact forces. In the next years, known as 'Normalisation', most of the enacted reforms were dismantled and hard-line Communist rule continued until 1989.

The Action Programme of the Prague Spring (ÚV KSČ 1968) mentioned health care only briefly. The Action Programme focused on economic and political reforms but, nonetheless, suggested shifting the emphasis from the interests of producers to those of consumers. The main ways to achieve this were to increase wages and salaries, and accelerate production of consumer goods and services. The Action Programme suggested that remuneration in health care and other branches of the non-productive sphere should be on a par with industry and that there were some 'unexploited opportunities' to improve health care organisation and working conditions of health professionals (ÚV KSČ 1968, p.46). Moreover, it called on 'the Communists and others employed in health care to come up with an initiative to solve those problems which unnecessarily irritate citizens

and health professionals and which result from the bureaucratic methods in health care' (ÚV KSČ 1968, p.46).

The Prague Spring had important implications for Czech health care. Firstly, unitary Czechoslovakia was federalised into the Czech Socialist Republic and the Slovak Socialist Republic. Whereas the budget and the largest part of national insurance (pensions) remained a joint Czechoslovak competency, health care and sickness benefits were devolved to the republican level. Thus, the Czechoslovak Ministry of Health was split into the Czech and Slovak Health Ministries and Czech and Slovak Ministries of Social Affairs were established, responsible mainly for the supervision of sickness benefits administered through the Revolutionary Trade Union Movement. Secondly, the Prague Spring triggered an increase in social expenditure similar to the failed 1956 anti-Communist revolution in Hungary (Kornai 1997). My analysis shows that average earnings in health care, relative to average earnings in the national economy, grew at record levels after 1968, peaking in 1972 at their highest level of the period 1955-2006, and never dropping below the 1968 level (see Appendix I). Lastly, Czech doctors responded to the call of the Prague Spring reformers and established, in 1968, the 27,000-strong Czech Union of Doctors (SČL), which existed until 1970 (ČTK 1989b) and advocated a greater role for medical professionals in health care governance and other reforms (Šilhan email 2006).<sup>39</sup> Despite the Czech Union of Doctors was outlawed in 1970, and its activists persecuted, some of them contributed to early post-Communist reforms: Jaromír Novák led the re-establishment of the Czech Union of Doctors in 1989, Zbyněk Novotný chaired the Programme Committees of the Civic Forum of Health Professionals, and Milan Šilhan served as Deputy Health Minister in 1990-92.

## **Normalisation**

Although there were limited attempts to adjust the unified health system, no major changes were implemented because policy makers were constrained by previous policy choices. The government perceived the absence of choice as a problem, and committed

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<sup>39</sup> Unfortunately, we do not have a precise account of the reforms they advocated because their archive was confiscated by the Secret Police (Šilhan email 2006).

itself to allowing more choice as early as the 1960s, but attempts to introduce some choice were limited because Communist planners realised that ‘complete freedom to choose one’s doctor would disturb the system, built to a considerable degree on the responsibility of the doctor for the whole health picture in a certain sector’ (Šourek 1966, p.25). The first large-scale experiment to allow free choice of the GP, gynaecologist and dentist started only in 1987 (ČTK 1987). It was also noticed that the preventive care approach had limitations, because it burdened doctors with copious health-screening and record-keeping and doctors could not change the population’s life-style preferences: ‘Doctors can only create conditions, convince, explain. But the real effectiveness of all preventive measures depends on each individual (Šourek 1966, p.15).<sup>40</sup> Furthermore, improvements in health care provision actually *increased* demand for health care: ‘A new type of patient has appeared in Czechoslovak clinics, the person who can find time to sit in the doctor’s waiting room just to get a prescription for tablets: tablets for that tired feeling, for overweight, for a cough, for a headache’ (Šourek 1966, p.26).

### ***Low earnings in health care***

During Communist rule, average salaries in health care were below the average salaries in the national economy (see Appendix I). This does not necessarily mean that doctors and nurses had lower overall income than engineers and workers, because they compensated for low basic salaries by working extra hours, night shifts, etc. Also, some doctors engaged in rent-seeking behaviour to compensate for low salaries. In the Communist socio-economic system, one’s social and economic situation was not indicated by wealth or income, but ability to offer services in exchange for other services or goods. Arguably, a doctor’s position in such a peculiar barter system was one of the best (Výborná 1994). Secondly, some doctors received gifts and payments from their patients. An official survey suggested that only 1.6% of patients offered ‘small gifts’ and bribes to their doctors (Masopust 1989). However, it is plausible that this phenomenon was far more significant, as collective wisdom held that a Czech acronym for the district health authority in reality stood for ‘give a bribe or you will die’ (Dostál interview 2004).

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<sup>40</sup> Ironically, the last Communist Health Minister, Jaroslav Prokopec, was a heavy drinker (Klířová interview 2005).

## **Dissent to hard-line Communist rule**

Part of the society resisted hard-line Communist rule by engaging in various dissident activities. These were generally limited to small groups of the intelligentsia and their ability to reach out to wider society was limited. For example, the most influential dissident movement, Charter 77, petitioned the government to stop violation of human rights, but between 1977 and 1992 their petition was signed by less than 2,000 people (Gruntorád n.d.). Generally, only a few doctors developed an active anti-Communist position and were involved in dissident activities. Among the signatories of the Charter 77 petition, less than 1% were doctors, though they were slightly outnumbered by nurses (ibid.). One possible explanation is that having an active anti-Communist position could have easily compromised doctors' careers, because they were entirely dependant on the state for jobs. Given the time and effort required to qualify as a doctor, they were averse to taking high risks. Another explanation is that many doctors feared that their patients would suffer most if they lost their jobs as punishment for their political activities (Pohunková email 2006). Consequently, there were many doctors in the so-called 'grey zone', i.e. they were against the Communist regime but did not overtly express their opposition, and doctors who were 'radishes', i.e. red outside but white inside (ibid). At the same time, significant numbers of doctors were card-carrying members of the Communist Party, because this helped them advance their careers, for example, to obtain a job in Prague instead of the provinces, speed up a teaching and research career, or secure a managerial position in the hospital or health authority. Only a few doctors actively participated in Communist Party politics. In 1948-1969, there were only 3-6 Czech doctor MPs in the Czechoslovak Parliament while, after federalisation in 1969, there were 4-8 Czech doctor MPs in the Czechoslovak Parliament and 3-6 doctor MPs in the Czech Parliament (PSP n.d.; Senát n.d.).

In 1984, Charter 77 issued a document which critically examined the deteriorating state of health and health care and provided a liberal and democratic critique of the socialist health care system (Pohunková & Freiová 1984). When, every so often, health care problems hit the public domain, the government blamed the human factor – i.e. 'corrupt doctors, negligent nurses or grumbling patients' – but the Charter 77 document sought the

causes of the problems in the fundamental principles of the socialist health care system, such as its totalitarian character and state organisation (ibid.). The document maintained that health was part of the right to life and, therefore, it was the state's duty to guarantee provision of health services adequate to meet this right. The document argued that the borderline between the interests of the individual and society in a socialist health care system was asymmetrically drawn in favour of a totalitarian society, as opposed to a democratic society which pursues the interests of the majority of individuals. It implied that the role of the individual in health care needed to be increased and pointed out that the allocation of resources in health care was ineffective, because in some places they were abundant while elsewhere they were lacking. This ineffective allocation of resources was traced to state monopoly in health care provision, excessive bureaucratisation, and the reimbursement of doctors according to salary tariffs, rather than the cost and quality of performed procedures. The document did not suggest how to improve resource allocation, but stated a dilemma between the state-funded systems of poor developing countries and the insurance-funded systems of rich developed countries. It did not make specific policy recommendations, but advocated liberal and democratic reforms for the whole society as a starting point for the improvement of health services.

### **In search of better health care financing and administration**

As *perestroika* triggered slow liberalisation in Czechoslovakia in the late 1980s, the government also became concerned with the situation in health care. Research at the Institute of Social Medicine and Organisation of Health Care officially demonstrated the stagnation of the health status of the population and the inability of health services to improve it (Potůček interview 2006) and a Communist public opinion poll revealed health care and the environment as the most worrisome issues (Jaroš *et al.* 2005). In 1989, the Central Committee of the Communist Party concluded that 'the causes of the unsatisfactory health status lay in the insufficient quality of the environment and working conditions, in the lifestyle of a considerable part of citizens and their low interest in health, as well as in the insufficient equipment of Czechoslovak health care, especially, with modern devices and materials' (ČTK 1989c). Health Minister Prokopec argued that health care had been experiencing insufficient funding from the late 1970s, but in 1989 it

was the worst during his 19 years in office and became a real ‘financial crisis’ (ibid.). Although in response the government allocated additional funding for 1989 and 1990 to Czech health care, towards modern equipment and increased remuneration for nurses, Minister Prokopec argued that ‘until the federal government adopts the principle of allocating resources to health care directly in the plan and according to the needs of health care such [crisis] situations will persist’ (ibid.).

Moreover, in 1989, the Central Committee of the Communist Party approved the provisional reform of sickness insurance in the 1990s, to strengthen health promotion and increase health care financing. The following changes were proposed (ČTK 1989d; Prokopec 1989):

- increase the contributions of employers with above average incidences of sickness, while decreasing contributions of those below the average;
- introduce a Scandinavian-style yearly allowance of 25-30 days of sick leave for employees, during which they would be paid 100% of their usual salary or be eligible for a no-claim bonus, and reduced sickness benefits thereafter;
- introduce patient co-payments towards non-essential health care services and drugs (e.g. cosmetic surgery and vitamins) for everyone, and co-payments towards essential health services for smokers, heavy drinkers and others who deliberately damage their health.

Until 1988, health care financing and sickness insurance were separated, as the latter was supervised by the Ministry of Social Affairs and administered by the Czech Office for Sickness Insurance (ČSNP). In 1988, the Ministry of Social Affairs was merged with the Ministry of Health, and leadership of the new Ministry of Health and Social Affairs was given to Health Minister Prokopec. It is likely that this merger was implemented to allow the new Ministry to use sickness insurance as a tool of health promotion and health care financing.

Lastly, Parliament proposed to increase centralised governance in health care financing and provision by strengthening the role of the Health Ministry. According to the principle of the democratic centralism, the state, represented by the Health Ministry, had overall responsibility for health care, but the network of health care facilities was administered by regional and district health authorities which were allocated funds by regional and

district authorities. The Chairman of the Health and Social Committee of the Czech Parliament Josef Domas argued that this dualism in health care financing and provision was suboptimal because the Health Ministry did not have a direct economic influence on the network of health care facilities: only 3.5% of the yearly health care budget was allocated to the Health Ministry and the rest to regional and district authorities (Domas 1988). However, this and other proposals made under the last Communist government were not translated into legislation before the regime change.

## **PART III: POST-COMMUNIST HEALTH CARE REFORM**

## **CHAPTER 5: INTERIM HEALTH MINISTER KLENER, 1989-90**

### ***Velvet Revolution***

The Velvet Revolution that ended Communist rule came unexpectedly. On 17<sup>th</sup> November 1989, a student demonstration, dedicated to the International Student Day, turned against the government and demanded reforms. This could have remained a minor demonstration had theatre artists not picked up revolutionary momentum and gone on strike for greater freedom of artistic expression; establishing, together with dissidents, a movement for freedom and democracy – the Civic Forum (OF) (Oslzlý 1990). Under the leadership of the playwright and dissident Václav Havel, the Civic Forum spread revolution around the country, through a series of non-violent demonstrations and a two-hour general strike. These prompted the Communist Party to open negotiations with the Civic Forum, form the Interim Government of National Understanding representing the Communists and the Civic Forum activists, and to agree on a free election in June 1990.

### **Health Minister Prokopec's Action Plan**

Minister Prokopec remained in office until the Government of National Understanding took over in December 1989. During this period, his task force prepared an Action Plan for health care reform, stating that ‘effective and fair health and social care can no longer be just an unimportant appendix to the economy and politics of the state... it is more than desirable to push this sector up on the agenda of the government, the state, and the whole of society’ (ČTK 1989a). The Action Plan set out to:

- develop a set of health promotion measures in nutrition, housing, working environment, etc;
- better integrate primary health care, social care, and public health;
- allow patients to be treated beyond the administrative borders of their health authorities;
- establish ‘integrated health and old-age insurance’ to create ‘a permanent and effective source of funding for health and social care, accountable to the public’ (ibid.).

It is plausible that the reasoning underlying these suggestions for health care reform was influenced by health policy developments in other countries of the Eastern Bloc. The Communist government in Hungary launched such an integrated and independent national insurance fund in 1989 (Hungarian Ministry of Health 2004), and the Soviet Parliament also advocated the introduction of health insurance (Belenkov 1990). Soon, however, Minister Prokopec lost office, and his Action Plan did not come to fruition. The successive Health Minister never met him in person (Klener interview 2006) and post-Communist reformers did not directly utilise the proposals developed by Prokopec (Kalina interview 2006). Nonetheless, as they faced the same policy problems and, presumably, were aware of the solutions proposed by the Communists, early post-Communist proposals for health care reform bore significant ideational continuity with proposals made before the regime change.

### ***First post-Communist Health Minister Pavel Klener***

The Interim Government of National Understanding appointed Professor Pavel Klener as Minister of Health and Social Affairs. He was a respected member of the medical elite, but his only political credentials were that he had never been a member of the Communist Party. Nonetheless, after the Velvet Revolution, this proved crucial, as the leaders of the Communist Party and the Civic Forum sought a balance of Communists and non-Communists in the Interim Government. Professor Klener did not actively seek public office, but as he explains he simply answered promptly to a late night call of then Prime Minister František Pitra (Klener interview 2006). Klener initially declined the offered ministerial portfolio but, after three other candidates were rejected by the Civic Forum, PM Pitra asked him for a serious reason why he could not serve as Health Minister (ibid.). PM Pitra refuted Professor Klener's claim that he lacked political skills, arguing that if he could speak convincingly in front of students then he could do so in front of politicians too; the following morning, Professor Klener was appointed Health Minister (ibid.). The contingency and lack of programmatic discussion behind this appointment demonstrates the quickly-changing balance of power between the Communist Party and the Civil Forum; and that personnel for public office were often appointed on the basis of political affiliation, rather than their policy positions.

## **Political cacophony and administrative diarchy**

The Interim Government was characterised by political cacophony because its members included both the Communist elite, known as *nomenklatura*, and non-Communist elites vetted by the Civic Forum. As a result, during Cabinet meetings ministers not only expressed opposite views, but also addressed each other differently: Comrade Minister, Mister Minister, and even Brother Minister (Klener interview 2006). The cacophony was amplified by the fact that the Civic Forum was a broad anti-Communist movement whose members included dissidents, the ‘grey zone’ opponents of the regime, and others who wanted opportunity to capitalise on regime change. Like any bottom-up movement, the Civic Forum was rather chaotic and lacking vertical organisation. For example, in the town of Karlovy Vary there were three separate organisations of the Civic Forum; each claimed to be the only legitimate representative of the town’s citizens, produced official-looking rubber stamps to back these claims, and ‘looked for what to privatise’ before their competitors (Klener interview 2006).

In the health sector, the organisations of the Civic Forum called the Civic Forum of Health Professionals (OFZ) were established in the first weeks after the Velvet Revolution. For example, in the town of Prostějov, a local organisation of the Civic Forum of Health Professionals was established on 30<sup>th</sup> November, at a meeting in the local hospital attended by 180 people; three weeks later, 300 out of 1800 district health professionals joined this organisation (Ošanec 1989). One of its early activities was to organise a ‘dialogue with the citizens’ in the local theatre, which included two reports about the state of health care in Prostějov presented by local doctors and followed by a discussion. The Prostějov Civic Forum of Health Professionals also attempted to expel the District Committee of the Communist Party from its offices in order to use them for health care purposes (ibid.). The change of senior health care managers, appointed during Communist rule, became one of the key activities of the local organisations of the Civic Forum of Health Professionals. Soon, cases of Civic Forum activists abusing their powers to settle personal matters or advance their own careers were reported, and so Minister Klener had to appeal to MPs to help stop such practices (ČTK 1990b). The power struggle between activists of the Civic Forum and managers appointed during Communist

rule led to the administrative diarchy and uncertainty in the health sector, which persisted until the Communists lost the June 1990 election.

The Health Ministry was also affected by administrative diarchy and uncertainty. Naturally, it took time for Minister Klener to learn his new responsibilities and he recalls that during that time some local health care managers continued telephoning ex-Minister Prokopec to ask for help and advice (Klener interview 2006). Also, the change of Deputy Ministers and Heads of Departments in the Health Ministry by Minister Klener was disputed by the old and emerging new elites. Minister Klener appointed the Communist Karel Valdauf – an experienced economist and technocrat – as First Deputy Minister, simply because there were no Civic Forum activists with the required experience and expertise (*ibid.*). This appointment was acrimoniously disputed by the Civic Forum of Health Professionals, which eventually withdrew its support from Minister Klener. Interestingly, the arguments in favour of Karel Valdauf were based both on his professional qualities and the fact that he was the son of a well-off Czech artist, suggesting that he would be committed to the long-term public good rather than to short-term personal gain (Jaroš interview 2006).

As far as the reasoning of Minister Klener's health policy is concerned, there was a surprising continuity with the ideas developed before regime change. For example, Minister Klener advocated increased health care expenditure; better co-operation between the health and social affairs parts of his ministry; reduced administrative expenditure; a greater role for health prevention and primary care; and patient co-payments for non-essential health care services and drugs. In particular, he suggested that patients pay a more substantial part of the cost of prescription drugs than the symbolic 1 crown charged for any prescription (ČTK 1990a). He also agreed with local health managers who viewed the role of local authorities in health care financing and administration as suboptimal and argued for the vertical subordination of Regional and District Institutions of National Health to the Health Ministry (ČTK 1989e). Minister Klener was not keen on privatisation in health care, but did not reject the possibility of private practices in certain self-sufficient specialties, if doctors wanted so (ČTK 1989c). Overall, however, he did

not have aspirations for grand-scale health care reform, as his time in office was limited to 6 months. He devoted his time mainly to day-to-day running of health care services, but recognised the need for comprehensive health care reform and appointed the Working Group of the Minister of Health and Social Affairs for Reform (SKUPR), which later formulated the first post-Communist proposal for health care reform.

### ***Health care reform interest groups***

The process of post-Communist interest group formation in the health sector was sporadic, fluid and poorly institutionalised. At the beginning, few knew what was happening and nobody knew what was going to happen. Therefore, interest group formation concentrated around enterprising people who quickly spotted opportunities provided by the regime change and did not hesitate to act under conditions of uncertainty. Initially, participation in different health care reform groups was a matter of friendship/acquaintance and keen interest in health care reform. Approximately 50-60 people came forth and formed a health policy community which dominated Czech health politics throughout the 1990s (Bojar interview 2005). Although all were interested in health care reform, they had different interests and reform agendas.

### **Civic Forum of Health Professionals**

Shortly after the Velvet Revolution, the Prague branch of the Civic Forum of Health Professionals published the Open Letter to health professionals in the local Civic Forum organisations, asking them to spread their activities to all levels of the health care system and get ready to take over the administration of health care (OFZ Praha 1989). The Open Letter was followed by ‘The Principles of the Health Programme’, elaborated by the Programme Commission of the Civic Forum of Health Professionals and the Union of Czech Doctors. This document argued that health and health care were in crisis and proposed public discussion of the following measures to overcome the crisis (OFZ 1990):

- Abolition of the state monopoly to increase the social and economic motivation of health professionals and the quality of care;
- Promote participation; the role of citizens in dialogue with doctors; and charity, church and civic initiatives in health care;

- Establish, on all levels of the state administration, Health Councils (ZR) – initiating, advisory, and coordinative organs, formed from reliable and competent health professionals and citizens;
- De-bureaucratise health care and promote its self-governance;
- Define the real costs of health care and ensure their accountability to the public through health insurance;
- Promote the social status and other interests of health professionals;
- Reform education and research according to international standards;
- Promote the role of primary care;
- Reform public health and increase the role of health prevention;
- Pay more attention to mental and social health;
- Ensure social justice in health and social care;
- Engage all citizens, parties and movements in the formulation of modern and humanistic health policy in order to resolve the crisis in health and health care.

A month later, the first national meeting of the representatives of the Civic Forum of Health Professionals took place. Participants argued for the democratisation, humanisation and independence of health care institutions, free choice of doctor, and stressed the need to develop various models of health insurance to increase the motivation of health professionals (Bojar *et al.* 1990). They approved the idea of creating communication and information exchange system for organisations of the Civic Forum in health care and delegated its implementation to the Prague Civic Forum of Health Professionals (*ibid.*). By the end of January 1990, the Prague Civic Forum of Health Professionals started building a nation-wide network of health care reform activists, helping to strengthen the popularity of one of the leaders of the Prague Civic Forum of Health Professionals, Martin Bojar; who was already well-known for reporting to the media on the progress of demonstrators treated in Motol Hospital for injuries during the Velvet Revolution.

## **SKUPR**

Another important health care reform initiative originated in the Institute of Social Medicine and Organisation of Health Care. The sociologists and economists, who analysed the stagnation of health and health care, as part of state research programmes, decided on their own initiative to elaborate proposals for health care reform (Potůček

interview 2006). They put together a group of health care researchers and practitioners (including those from the Civic Forum of Health Professionals and other health care reform interest groups) to work on reform proposals. Initially, this group worked independently of the Health Ministry, but later they persuaded Minister Klener to appoint them on a voluntary basis as the Working Group of the Minister of Health and Social Affairs for Reform (SKUPR), responsible for analysing various reform proposals, developing their own proposals and collaborating with other reform groups (MZSV ČR 1990). For a while, SKUPR became a competitor to the reform proposals developed in the Health Ministry, under the auspices of First Deputy Health Minister Karel Valdauf, and some civil servants that SKUPR activists were building ‘a shadow Ministry’ (Potůček 1991). However, SKUPR quickly demonstrated thought leadership and the Health Ministry’s civil servants working on health care reform proposals joined SKUPR. Other reform groups continued working on their own; for example, a group of GPs from the regions put forward ‘The People’s Alternative of Primary Health Care’ (Bužga *et al.* 1990), but failed to make any policy impact. After SKUPR disintegrated in 1991, another group of health care reformers, associated with the Institute of Social Medicine and Organisation of Health Care, emerged: the Initiative Group for the Establishment of District Health Insurance Funds (INSKOP). This group formulated a proposal for a decentralised health insurance system, which is considered in the next section.

### **Czech Union of Doctors**

The doctors, who established the Czech Union of Doctors during the 1968 Prague Spring and survived the subsequent imprisonment and forced labour in the uranium mines, re-established this organisation after the Velvet Revolution. Their leader, Jaromír Novák, formulated the aims of the Union as follows (ČTK 1989b):

- Providing a critique of and finding a remedy for the current state of health care;
- proposing a new Act on People’s Health;
- elaborating new principles of health insurance;
- promoting doctors’ position in society;
- elevating a scientific level of medicine;
- exploring ways to reorganise the structure of health authorities;
- improving medical ethics;

- helping to solve environmental problems;
- resolving problematic psychological and sociological aspects of medicine;
- building an independent political and professional organisation of doctors.

The Czech Union of Doctors concentrated on two core issues: medical ethics and the independent political and professional organisation of doctors. Just a few months after the Velvet Revolution, they prepared and published a compendium of medical ethics – ‘Medical Deontology’ (Novák & Bahounek 1990). Also, in January 1990, they developed a proposal for re-establishing the independent political and professional organisation of doctors – the Medical Chamber (SČL 1990). This proposal argued for the obligatory membership in the Medical Chamber for every practicing doctor, to uphold the professional, social and moral standards of the profession (ibid.). Furthermore, the Union proposed a decentralised structure of the Medical Chamber, consisting of two regional chambers: one for Bohemia in Prague and another for Moravia and Silesia in Brno. The fact that the Czech Union of Doctors proposed two chambers was probably because the majority of their leaders were based in Brno (the capital of Moravia) but there was also a competing group of doctors in Prague (the capital of Bohemia and the Czech Republic) who were working on establishing their own Medical Chamber.

### **Prague Medical Chamber Ltd.**

In 1990, the Prague group of doctors established the Prague Medical Chamber as a private company, since at that time there was no legislation on professional associations. This group was led by Bohuslav Svoboda and Jiří Pekárek who, in stark contrast to the leaders of the Czech Union of Doctors, represented a much younger generation of doctors. The Brno and Prague groups competed mainly for ‘prestige and status’, associated with the establishing medical chambers, and to preside over the medical profession (Jedlička interview 2006). Whereas the Prague group promoted doctors’ social standing and economic interests, the Brno group emphasised medical conduct and ethics. Additionally, there was a clear centre versus periphery conflict between these two groups as the Moravians strived for autonomy. Soon, however, they put competition aside and agreed to establish one medical chamber for the whole Czech Republic (Jedlička

interview 2006). The first President of the Czech Medical Chamber was elected from neither group and the headquarters of the new Medical Chamber were in neither Bohemia nor Moravia, but Silesia (Ostrava). Later, however, Bohuslav Svoboda was elected President twice consecutively (1992-1995 and 1995-1998) and, subsequently, the headquarters of the Czech Medical Chamber were moved to Prague.

It is interesting that the older generation of doctors, represented by the leadership of the Czech Union of Doctors, did not emerge as winners from the Velvet Revolution. Among all the interest groups of doctors formed in the wake of the Velvet Revolution, the Czech Union of Doctors was the first to act. Moreover, because there was no dissident movement in health care during the Communist rule, the doctors who ran the Czech Union of Doctors in 1968-1970, and were subsequently persecuted, had proved their moral leadership. It was plausible to expect that they would become the undisputed leaders of the post-Communist political and professional movement of doctors, but they were sidelined by the younger generation of doctors. This could be explained by the role of the Medical Chamber, advocated by the older doctors. They seemed inspired by the model of the First Republic, where the state did not heavily intervene in the medical profession and the latter was left to its own devices. Therefore, they envisaged a rather inward-looking role for medical chambers – primarily to deal with doctors’ professional conduct and ethics. But these were not of concern to most doctors as much as their income. The younger generation of doctors envisaged a more outward-looking role for medical chambers – as a political instrument to promote doctors’ standing in society and defend their economic interests against the state.

### **University Hospital Královské Vinohrady**

Lastly, there was an influential group of managers and doctors at the University Hospital Královské Vinohrady in Prague, who promoted the ideas of health insurance and fee-for-service reimbursement. This group was led by the Director of the Vinohrady Hospital Zuzana Roithová and drew on the expertise of the Finance Deputy Director Petr Pasternak. Together with large university hospitals in Brno, Ostrava and Hradec Králové, the Vinohrady group ventured the enterprise called ‘Experiment R’. During Communist

rule, doctors were salaried state employees; hospitals and other health care providers were allocated funds according to historical budgets and annual projections. Therefore, the labour intensity and duration of various health care services were unknown. Furthermore, doctors were reimbursed for working extra hours, but not for the amount of health care services produced. ‘Experiment R’ sought to determine the labour intensity and duration of various health care procedures in order to define the costs of health care services and make it possible to reimburse hospitals on a fee-for-service basis. Hospital managers involved in ‘Experiment R’ believed that fee-for-service reimbursement would allow an increased revenue for hospitals and remuneration for doctors (Heger interview 2006; Pasternak interview 2006a). Another important initiative, originating in the Vinohrady Hospital, was the establishment of the Association of Hospitals of the Czech Republic, to promote the interests of large hospitals. The first President of this Association was Ivan Drašner – Director of the University Hospital Hradec Králové – which served as the co-ordination centre for ‘Experiment R’. In 1991, he was succeeded by Zuzana Roithová, who went on to become Health Minister in 1998.

### ***First post-Communist ‘Proposal for Health Care Reform’***

The first post-Communist ‘Proposal for Health Care Reform’ was published by SKUPR in May 1990, with a view to facilitating public debate on health care reform and establishing a reform agenda for the new government. The leader of SKUPR, Martin Potůček, chaired the Social Section of the Programme Committee of the Civic Forum, so the proposal was also designed to serve as part of the Civic Forum’s electoral platform (Potůček interview 2006). However, the SKUPR’s aspiration to facilitate public debate on health care reform failed because ‘the people from the street’ had no influence on its agenda, which was set by health sector interest groups, and health care reform had a low priority over economic reforms (Potůček 1995). Although, similar to other initiatives of the Civic Forum, SKUPR started as a civic initiative, it ended up as a corporatist enterprise. The 45 members of SKUPR represented a diverse group of health sector interests, including those of health care researchers, doctors and managers. Effectively, the proposal accommodated their interests without making definitive policy choices.

The proposal put forward two alternative options for health care reform with the implementation timeline spanning 4-5 years (SKUPR 1990). Both options entailed the dissolution of the existing regional and district health authorities and the formation of new organisational structures bottom-up. Under the first option, health care facilities were to become independent public institutions and organise themselves into the Associations of Health Care Facilities to optimise health care provision in a given area. The existing health authorities were to be replaced by Health Councils, which were to develop the overall health policy of a given area, approve the budgets of the Associations of Health Care Facilities and nominate their administration. Health Councils were to be formed from local councillors, health professionals and the representatives of the organisations that influenced health and health care in a given community. Under the second option, municipalities and local communities were to assume the ownership and administration of health care facilities on their territory. This proposal suggested multi-source financing of health care, including the state budget, the budgets of local authorities, employers' contributions, voluntary donations and patient co-payments. Furthermore, it advocated the introduction of both mandatory and voluntary health insurance and the creation of a network of multiple health insurance funds by 1994-1995. The proposal also recommended devolving oversight of the medical profession from the state to the autonomous Czech Medical Chamber. Lastly, it emphasised disease-prevention and health promotion, especially on the level of the employer.

## CHAPTER 6: CIVIC FORUM HEALTH MINISTER BOJAR, 1990-92

### ***1990 election and party policy pledges***

In June 1990, 13 political parties and movements participated in the parliamentary election, but only 4 passed the 5% threshold to enter Parliament. Although the last Communist public opinion poll showed health care and the environment as the most important issues (Jaroš *et al.* 2005), health care was sidelined during the 1992 election by other issues, such as freedom and human rights, democracy, decentralisation, and anti-Communism (Table 4).

**Table 4: Most salient electoral issues by the frequency of issue-related quasi-sentences in 1990 party manifestos, %**

Party \ Issue	Freedom-Human Rights	Democracy	Decentralisation	Environment	Culture	Education	Communist –	Infrastructure	Privatisation +	Social Justice	Welfare state+	Public-Private Mix in Welfare	Health Care
<b>Civic Forum (OF)</b>	5.2	5.2	3.5	2.3	1.2	4.1	19.8	2.9	0.0	0.6	0.6	4.1	<b>2.9</b>
<b>Communists (KSČ)</b>	9.4	8.1	3.8	8.1	6.3	3.1	0.0	3.2	0.0	5.0	5.0	0.0	<b>3.8</b>
<b>Autonomous Demo-crats (HSD-SMS)</b>	0.0	3.1	43.8	3.1	15.6	0.0	3.1	3.1	0.0	0.0	0.0	0.0	<b>0.0</b>
<b>Christian Democrats (KDU)<sup>†</sup></b>	11.0	2.4	1.3	6.1	1.2	0.0	8.5	1.2	2.4	3.7	1.3	2.4	<b>4.9</b>

Source: own analysis based on Klingemann & Volkens (2002) and Klingemann (2006)

Note: see Appendix for the explanation of issues and methodology

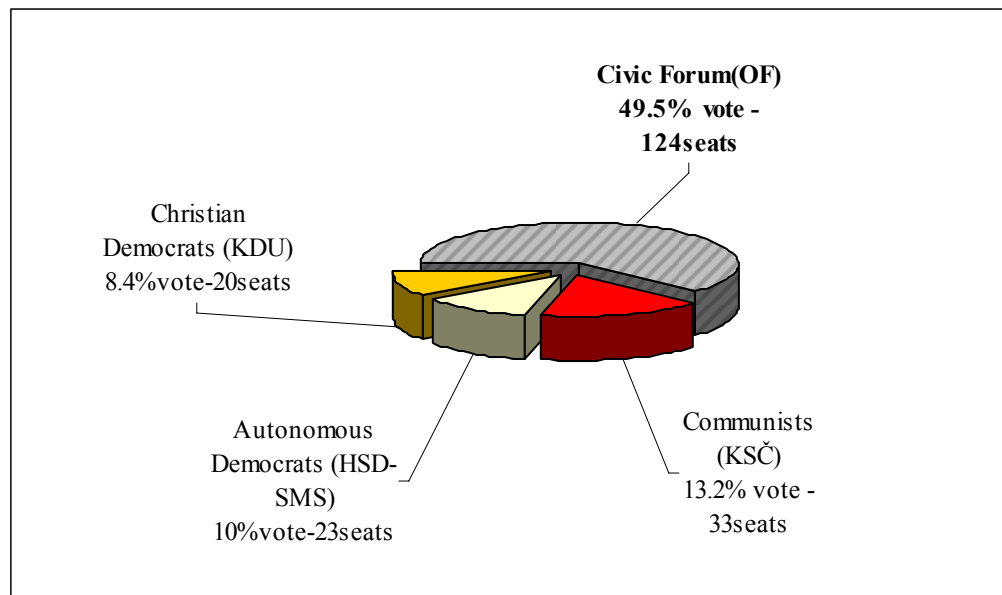
<sup>†</sup> According to the electoral manifesto of the Czechoslovak People's Party

The Civic Forum won the election with 49.5% of the vote (Figure 4 overleaf) and formed a coalition government with the Christian Democrats and the Autonomous Democrats. The Civic Forum's electoral manifesto glorified inter-war Czechoslovakia as one of the world's most developed nations and blamed Communist rule for the 'backward' state of Czechoslovakia in 1990:

...in the last forty years our average economic level sank from 10<sup>th</sup> to 40<sup>th</sup> place [in the world]. Even Austria, less advanced in the past, is viewed by us today with quiet and humiliating envy (OF 1990).

The Civic Forum formulated its goals as a ‘return to Europe’, democracy, and a market economy. The Civic Forum pledged the gradual replacement of state ownership by private, municipal and communal ownership; and the restriction of state ownership ‘chiefly to undertakings of the public good’ (ibid.). In social policy, the Civic Forum proposed to create the ‘conditions under which individuals and families may successfully solve their problems and emergencies’ while providing ‘a state-guaranteed minimum standard of living and social support (ibid.). In the health sector, the Civic Forum called on everyone to assume responsibility for their lifestyle and pledged to facilitate the creation of public and charitable self-help organisations, guarantee standard medical care for those who required it, promote free choice of doctor, prioritise comprehensive primary care and introduce health insurance gradually (ibid.).

**Figure 4: Summary of the 1990 Parliamentary election results**



Source: ČSÚ (n.d.)

The Communist Party (KSČ) came a poor second, with only 13.2% of the vote. Their electoral manifesto apologised for ‘the errors, mistakes, and injustices [the Communist] Party had committed’ and argued for ‘democratic, humanistic, and materially and

spiritually productive socialism’ and ‘a state-regulated market economy’ (KSC 1990). The Communists argued for cautious economic reforms with ‘an equitable and fair distribution of the unavoidable social impact of the reforms’, and ‘against a sell-out of the national wealth and natural resources, as well as against the return of the decisive branches of industry, banks, and insurance organisations into private hands, both domestic and foreign’ (ibid.). In social policy, the Communists pledged to increase maternity benefits and leave, support housing for young families, expand social care for older people and raise social security benefits in line with inflation. In health policy, they proposed to increase funding for the public health system substantially, keep it free for everyone, and not to commercialise medical and pharmaceutical services (KSC 1990).

The Movement for Autonomous Democracy – Society for Moravia and Silesia (HSD-SMS) came third with 10% of the vote, but made no programmatic pledges beyond promoting the autonomy and cultural revival of Moravia and Silesia (HSD-SMS 1990). The coalition Christian and Democratic Union (KDU) came fourth with 8.4% of the vote. This coalition was led by the Czechoslovak People’s Party (ČSL), which during Communist rule functioned along with the Communist Party and had a strong support base among the Roman Catholics and rural communities. The People’s Party argued for the decentralisation of public administration to the level of the ‘traditional community’, the reduction of state and public ownership to the ‘essential minimum’, and the creation of an economy based on small and medium-size companies and co-operatives (ČSL 1990). The People’s Party viewed social services ‘as the substance of its Christian mission of service to fellow human beings’ and pledged to ensure ‘important social certainties’ (ibid), proposing to increase maternity benefits significantly, improve pension provisions for farmers and support young families. The Party called for radical improvement of health and social care, through the abolition of the state monopoly, and for the introduction of private medical practice, religious and charitable organisations, free choice of doctor, and health insurance (ibid).

### ***New Health Minister Martin Bojar***

The Civic Forum withdrew its support from Minister Klener and, after the election, appointed a new Health Minister, because during his tenure Minister Klener did not show much enthusiasm for the activities of the Civic Forum of Health Professionals, did not purge the Health Ministry of the Communists comprehensively, and even chose a Communist as his First Deputy (Payne interview 2006). It is important to emphasise that Pavel Klener was not a Civic Forum activist in the first place and that his position in the Interim Government of National Unity was not conducive to partisan activities.<sup>41</sup> The Civic Forum appointed Martin Bojar as new Health Minister. He explains his appointment as follows (Bojar interview 2005). Firstly, he had gained positive publicity through the media because of his role in treating the demonstrators injured during the Velvet Revolution. Secondly, as one of the leaders of the Prague Civic Forum of Health Professionals, he had won the support of doctors, both in Prague and the regions. Thirdly, as an active member of SKUPR, he had contributed to the Proposal for Health Care Reform. Lastly, he had a good command of English, which was important for Czechoslovakia's 'return to Europe'.

The electoral victory of the Civic Forum and the appointment of a new Health Minister ended the administrative diarchy in health care and cleared the way for health policy change. Several members of SKUPR gained senior posts in the Health Ministry and started work on a detailed health care reform proposal. This work was led by the new Deputy Health Minister and Director of the Health Policy Department Kamil Kalina. He adopted a more rapid and liberal approach to health care reform than the one previously followed by SKUPR; prompting several members of SKUPR with less liberal views to leave, while others left because they found better opportunities for career development elsewhere (Potůček interview 2006). Also, two former Prague Spring activists joined the ranks of the Health Ministry: Zbyněk Novotný became Advisor to Health Minister and Milan Šilhan was appointed as Deputy Health Minister. The latter appointment followed

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<sup>41</sup> Pavel Klener recalls that, in the run-up to the election, a Civic Forum activist confronted him over the absence of the Civic Forum's electoral poster in his office. He replied that, as a Minister in the Government of National Understanding, he would need to display electoral posters of all the parties participating in the election, but his spacious office simply did not have enough room for these (Klener interview 2006).

the logic of power-sharing with the Moravians, to preserve the unity of the Czech Republic (Bojar interview 2005). Additionally, Minister Bojar invited into the Health Ministry many new reform-minded people from the periphery.

At the same time, the strong reform drive of the Health Ministry was weakened by the cadre change as the new reform-minded cadre had no administrative experience and the experienced administrators had to leave because of their Communist background. Furthermore, the 1991 'Lustration' Act (Zákon č. 451/1991 Sb.) made it impossible for the people suspected of collaboration with the Secret Police (StB) to hold high managerial positions. The career of Prague Spring activist Zbyněk Novotný was thwarted by the suspicion that he collaborated with the Secret Police, while Deputy Health Minister Jindřich Kadrnožka had to resign when his collaboration with the Secret Policy was confirmed. This significantly undermined the administrative capacity of the Health Ministry, as Kadrnožka was the only senior civil servant in the Health Ministry who knew how the Communist-time system of health accounts functioned (Háva interview 2006b). Effectively, early health care reform had to proceed on assumptions about what policy change was desirable, rather than on calculation of its cost-effectiveness or benefits for the health status of the population, because the Health Ministry had limited information resources and administrative capacities.

The Health Ministry's reform drive was first articulated in the 1990 Government Declaration (Vláda ČR 1990), which argued that 'a dismal state of people's health and a critical situation in health care require urgent reforms' and put forward the following policy proposals:

- ending the existing centralism and establishing self-administration;
- promoting individual responsibility for health, while providing standard health care guaranteed by the state;
- fostering individual initiative among health professionals through economic incentives;
- giving the citizen rights to choose doctors and, later, health care facilities;
- gradually creating a system of health insurance funds;
- providing above-standard health care through private practices;
- enlisting the help of charitable organisations, churches, and other interested groups;

- addressing the supply of drugs;
- ensuring the quality of health care, through co-operation between Medical Chambers, health insurance funds, state health inspection and non-professional organisations.

In addition, the Government Declaration announced the division of the Ministry of Health and Social Affairs into the Ministry of Health and the Ministry of Labour and Social Affairs, as it was before 1988.

### **Health care and sickness insurance go apart**

The division of the Ministry of Health and Social Affairs effectively cancelled the plans of the last Communist government for an integrated approach to health care and sickness insurance in order to use sickness insurance as an instrument of health promotion and health care financing. Furthermore, this division shunned the possibility of building an integrated public health and social security insurance fund, following the Hungarian model, because the Czech Ministry of Labour and Social Affairs became responsible for supervising both sickness insurance and social security, administered by the newly-created Czech Office for Social Security (ČSSZ) (Zákon č. 210/1990 Sb.). To a large extent, the establishment of the Ministry of Social Affairs was driven by a timely need to control Czech social security, whose budget was more significant than the budgets of Czech health care and sickness insurance combined. Whereas sickness insurance was already managed on the Czech level during Communist rule, social security was only separated from the federal Czechoslovak budget and transferred to the budget of the Czech Republic in 1990.

The separation of sickness insurance from future health insurance was not resisted by the Health Ministry because the introduction of health insurance was still under discussion, but sickness and social security benefits needed to be administered anyway. Furthermore, the separation of sickness benefits from future health insurance simplified the Health Ministry's task of establishing health insurance and was in the interests of doctors, because it relieved them of managing the duration of sickness leave and paperwork related to sickness benefits. In the long-run, however, this separation had two major negative effects on health insurance. First, thanks to the fee-for-service reimbursement

and free choice of doctor, doctors received incentives to authorise sick leave for everyone who wanted it, so as not to lose patients and to maximise reimbursement for services and drugs prescribed during sick leave. This led to an increase in the occurrence and duration of sick leave in the 1990s and the subsequent growth of health insurance expenditure (Dlouhý interview 2005). Second, health insurance did not acquire a sickness insurance budget with a positive balance, which could have compensated for the negative balance of health insurance (ibid.). For this reason, the Health Ministry repeatedly attempted to merge sickness insurance into health insurance throughout the 1990s, but without success.

Another important implication of the incorporation of sickness insurance in social security is that sickness insurance became administered by the state, whereas previously it was administered by trade unions. One might think that the nationalisation of the administration of sickness insurance was meant to undermine the powers of trade unions and, hence, the working class. However, this was not the case. During Communist rule, the Revolutionary Trade Union Movement assumed the administration of sickness insurance, in line with Communist ideology, to promote workers' self-administration and strengthen the role of the working class against the bourgeois bureaucrats. By the end of Communist rule though, the Revolutionary Trade Union Movement lost its revolutionary purpose and produced a new class of bureaucrats, like those administering sickness insurance. After the Velvet Revolution, they themselves expressed a desire for sickness insurance to be nationalised (ČTK 1989f). It is highly plausible that their motivation was to secure their jobs, on the face of the Revolutionary Trade Union Movement's uncertain future, and to gain higher incomes as civil servants. It was a great irony that Communist rule in 1948 started thanks to demonstrations of the Revolutionary Trade Union Movement against high salaries of civil servants, but concluded with the Revolutionary Trade Union Movement's own bureaucrats converting into civil servants to gain higher salaries. Another irony was that the Civic Forum, which so strongly opposed the Communist state bureaucracy, started its rule by producing even more bureaucracy. As a disenchanted Civic Forum activist noticed, the number of bureaucrats after the Velvet Revolution grew very quickly, perhaps exceeding the combined total of Communist

bureaucrats and Secret Police during Communist rule (Žák email 2007). This suggests that the self-interest of elites provides a better explanation of post-Communist policy change than class- or ideology-related interests.

### **Economic Council gives green light to health care reform**

The introduction of health insurance and other reforms initiated by the Czech Health Ministry required the approval of the Federal government, because in 1990 the Federal Finance Ministry still allocated funding to Czech and Slovak governments from the common Czechoslovak budget. Furthermore, health care reform required the approval of the Federal Finance Minister Václav Klaus, in his informal capacity as leader of post-Communist reforms and in his formal role as Chairman of the Federal Economic Council.<sup>42</sup> The latter was a non-Constitutional grouping of senior government ministers, bankers and economic experts who made decisions on post-Communist reforms, binding on both Federal and Czech governments. The Economic Council was formed to assist the weak Interim Government with decision-making on post-Communist reforms and reflected the aspirations of unelected post-Communist elites to legitimise their involvement in political decision-making through elite interest accommodation. In this respect, it was reminiscent of the infamous Committee of Five that served as the ‘real government’ (Crampton 1997, p.63) in inter-war Czechoslovakia. Although the 1990 election produced legitimate Federal and Czech governments, the Economic Council continued functioning on the Federal level, and a similar body was formed on the Czech level to streamline and legitimise decision-making for the ministers who had greater budgets and executive powers. In this respect, the Economic Council resembled the eponymous body that existed in 1945-1949 (see Chapter 3). Essentially, the Economic Council replicated the old Communist division of the economy into ‘productive’ and ‘non-productive’ spheres, because ministers in charge of the ‘non-productive’ sphere were excluded from the Economic Council. Hence, the early post-Communist transformation was overly focused on economic policy, and social policy was excluded from the post-Communist reform agenda.

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<sup>42</sup> A similar body, which was also called the Economic Council, was established in 1945 and served as a co-ordination centre for the implementation of the Two-Year Plan.

### *'Begging ministers' versus 'economic ministers'*

The distribution of power in the government after the Velvet Revolution was aptly described by the Culture Minister Milan Uhde. He argued that the government was divided between the 'economic ministers', such as Ministers of Finance, Industry, Trade and Privatisation, who had significant budgets and executive powers, and the 'begging ministers', such as Ministers of Education, Culture, and Health, who had to 'beg' the 'economic ministers' for funding and a place on their agenda (Bojar interview 2005). In order to carve up a place for health care reform on the agenda of the 'economic ministers', Minister Bojar had to gain access to the Economic Council, of which he was not a member because of the Health Ministry's 'begging' position in the government. To do so, he asked his schoolmate to solicit her friend and wife of the Chairman of the Economic Council, Klaus, to ask her husband to invite Health Minister to speak in front of the Economic Council about the proposed health care reform (ibid.). It is truly remarkable that Minister Bojar's formal position in the government was not enough to capture the attention of the 'economic ministers' and he had to resort to informal channels.

Off the record, Václav Klaus was against health insurance, because it was not in his interests as Finance Minister to lose control of the health care budget and he realised that health insurance would accelerate the growth of public health care expenditure (Bojar interview 2006). However, during an official meeting of the Economic Council in October 1990 he agreed with Minister Bojar and his colleagues: 'if you want to introduce [health insurance], do it' (Pasternak interview 2006a). In addition to the undoubted political skill of Minister Bojar, the case for health insurance succeeded because the unhinged institutional framework provided Klaus and other 'economic ministers' with a short-time horizon and adverse incentives. Evidently, health care reform was a minor issue on the agenda of the 'economic ministers', so health insurance was introduced without much debate:

There was no debate [about health insurance] – there was no time for it. In that period we decided about the separation of the republic, currency exchange reform, price liberalisation, therefore [health insurance] was not a major topic. It was said that there would be health insurance funds and that was it. It was not done in haste, but [health insurance] was a minor problem. It became a

[major] problem only when it became evident that health care financing was not possible through health insurance funds and the financial problems that exist until now had emerged (Stráský interview 2005).

The ‘economic ministers’ were busy pursuing their own reforms, to maximise their power and secure re-election. Furthermore, Klaus was building his own political party, so was interested in the support of health sector elites. Consequently, it was in the interests of Klaus, and the ‘economic ministers’ who supported him, to accommodate the interests of health sector elites instead of making political enemies by vetoing health insurance and other health care reforms.

### **‘Proposal for a New Health Care System’**

In October 1990, the Health Ministry published the ‘Proposal for a New Health Care System’ (MZ ČR 1990), which detailed future health policy change and was approved by the government as the official health care reform programme in December 1990 (Usnesení vlády ČR č. 339/1990). This proposal drew on the SKUPR proposal, published six months earlier, and was developed by a group of the former members of SKUPR under the leadership of Kamil Kalina, who became Deputy Health Minister and Director of the Health Policy Department. Like the SKUPR proposal of May 1990, it advocated the dissolution of regional and district health authorities and subsequent formation of new local governance structures bottom-up. Likewise, it did not make definitive policy choices regarding the extent and form of privatisation; merely suggesting that most health care facilities should be retained in public ownership and outlining the possibility of transferring state health care facilities to local authorities, free of charge, and letting local authorities decide which health care facilities to privatise. In contrast to the SKUPR proposal, the new proposal adopted a more liberal approach to health care reform and made definitive policy choices in favour of (MZ ČR 1990):

- competition between health care providers;
- mandatory public health insurance, administered by a public health insurance fund with a possibility of establishing additional public and private health insurance funds in the future;
- a shortened timeline for the introduction of health insurance (1993 instead of 1994-1995).

## ***Health insurance***

As shown above, a consensus on the desirability of health insurance was reached by new health sector elites in early 1990. This represented the interests of senior hospital managers and the leaders of the medical professions. Senior managers from Vinohrady Hospital and their associates from other large hospitals believed that health insurance based on the fee-for-service reimbursement would help their hospitals increase revenue and doctors' remuneration, so actively sought the introduction of health insurance. Also, the idea of health insurance became popular with the emerging leaders of the medical profession from the Civic Forum of Health Professionals, Czech Union of Doctors and Prague Medical Chamber Ltd, because they associated health insurance with higher incomes and better working conditions. Czech doctors were well aware that in countries with health insurance, such as neighbouring Austria and Germany, doctors had access to the latest medical technology and 'drove Mercedeses', i.e. were exceedingly well-off (Kalina interview 2006). The Health Ministry accommodated these interests and supported the introduction of health insurance, because it believed that funding health care through independent public health insurance would increase health care expenditure and make it no longer subservient to the Finance Ministry (Bojar interview 2005). At that time, many former Communists remained in the Finance Ministry, so it was important for the anti-Communist Minister Bojar to remove health care financing from their influence (ibid.). Another time-specific reason why the Health Ministry supported health insurance, instead of a tax-funded system, was the reform of the British NHS initiated by the Thatcher government. This indicated to Czech health policy-makers that the tax-funded NHS needed fundamental reform and, besides the NHS, there was no alternative to health insurance in rich democracies, one of which the Czech Republic aspired to become (ibid.). Although the introduction of health insurance was against the interests of the Finance Ministry, the 'economic ministers' accommodated the interests of health sector elites because the unhinged institutional framework provided them with a short time-horizon and adverse incentives. Once the 'economic ministers' agreed to the introduction of health insurance, the Health Ministry appointed the Finance Director of the Vinohrady Hospital, Petr Pasternak, as Director of the Office for the Introduction of Health Insurance, who effectively became the architect of modern Czech health insurance.

## **A new model of health insurance**

A definitive decision on the model of health insurance was taken in December 1990, when the Czech government resolved to introduce mandatory public health insurance managed by a centralised public health insurance fund, with a possibility of establishing additional health insurance funds in the future (Usnesení vlády ČR č. 339/1990). Reformers in the Health Ministry had different long-term views on the ideal model of health insurance. Minister Bojar was in favour of a centralised public health insurance fund and, later on, complementing it with a small number of specialised public health insurance funds (Bojar interview 2005). Petr Pasternak was in favour of establishing a centralised public health insurance fund first, and then allowing multiple private health insurance funds to compete against and, possibly, overtake it in the long run (Pasternak interview 2006b). Despite these differences, both believed in mandatory health insurance and thought the best strategy to introduce it was to establish a centralised public health insurance fund and, only when it was fully functional, consider improving it by introducing further health insurance funds. This belief was shared by the government which, in February 1991, mandated the Health Ministry to devise a proposal for the centralised public General Health Insurance Fund by 30.06.1991 (Usnesení vlády ČR č. 36/1991).

Yet, the Initiative Group for the Establishment of District Health Insurance Funds (INSKOP), which represented health care practitioners from districts and researchers from the Institute of Social Medicine and Organisation of Health Care, argued for the introduction of a decentralised health insurance system. In 1991, the Health Ministry commissioned INSKOP to develop a detailed policy proposal (Jaroš interview 2006). This resultant proposal closely drew on the 1924 health insurance legislation, with a view to ensuring decentralised resource allocation in health care through mandatory health insurance and creating a consortium of independent district health insurance funds (Burda *et al.* 1991). INSKOP argued for a mixed system of resource allocation to health care providers, based on salaries, capitation fees and fee-for-service reimbursement (*ibid.*). However, large hospitals supported fee-for-service reimbursement and had already started ‘Experiment R’, to determine the labour intensity and duration of various health

care procedures in order to create a fee-for-service reimbursement list. Furthermore, the Health Ministry came under pressure from the ‘economic ministers’ and their supporters in Parliament to fast-track the introduction of health insurance. Given that it would take considerably more time to introduce a decentralised health insurance system, and that this would be more difficult to administer, the INSKOP proposal was discarded and the Health Ministry proceeded to introduce centralised public health insurance based on fee-for-service reimbursement.

It is important to appreciate that both the ‘economic ministers’ and their supporters in Parliament determined and enforced tight deadlines for the introduction of health insurance under the influence of the short time-horizon of the electoral cycle. Consequently, the civil servants in the Health Ministry responsible for the introduction of health insurance worked under enormous time pressure, ‘often from 8am to 10pm’ and ‘as hard as coalminers’ (Pasternak interview 2006a; Tröster interview 2006). In December 1990, the government scheduled the introduction of health insurance for 01.01.1993 (Usnesení vlády ČR č. 339/1990), but three months later, in February 1991, the Economic Council resolved to bring the launch of health insurance forward by one year (01.01.1992). This was to synchronise it with tax reform (Usnesení vlády ČR č. 36/1991), required for the ‘economic ministers’ to start large-scale privatisation before the 1992 election. Furthermore, the MPs from the political camp of the ‘economic ministers’ criticised the Health Ministry in Parliament for slow policy change, urging Minister Bojar to accelerate the introduction of health insurance and other reforms required to start health care privatisation before the election.

### **Foreign influence: shopping for ideas and advice abroad**

During the preparatory work on the introduction of health insurance, reformers used ideas from abroad, mainly from Canada and the Netherlands. Petr Pasternak drew on the Canadian health insurance system because he appreciated its universal coverage, fee-for-service reimbursement and the fact that it was relatively easy to introduce and administer compared to other complex health insurance systems (Pasternak interview 2006a). In particular, the Czech fee-for-service reimbursement list was modelled after its Canadian

counterpart (ibid). In 1991, two Dutch health insurance experts were invited to assist the Health Ministry with drafting health insurance legislation. They were selected because the Dutch health insurance system was among the most liberal in Europe and ‘it was not German’ (Kalina interview 2006). At that time, Czech political elites were split on the issue whether the Czech Republic should seek German co-operation or reach out to wider Europe and Northern America. The Director of the Health Policy Department Kalina, who invited the Dutch experts, was in favour of a liberal health insurance system and believed that the Czech Republic should not come under German influence again (ibid.). Also, in 1992, Minister Bojar took advantage of US technical assistance, inviting US experts to help develop legislation on non-profit health care organisations (Háva interview 2006b). Likewise, the London School of Hygiene and Tropical Medicine (LSHTM) offered technical assistance and training to the Health Ministry, simply because the wife of the LSHTM’s Dean, Richard Feachem, was Czech and she initially enquired if the Health Ministry needed any help (Potůček interview 2006). What seems characteristic of the foreign ideational influence is that it developed on the basis of purposeful contacts between individual actors, in the context of the time-specific tasks and opportunities they had. Czech policy-makers seemed to have been simply shopping abroad for the ideas and advice, which were relevant to their tasks and reflective of their beliefs. They selected partner countries through a revision process, as in the case of the decisions made by Kamil Kalina and Petr Pasternak, took advantage of unexpected opportunities, as in the case of assistance from the US and the London School of Hygiene and Tropical Medicine, or refused options which were against their interests as in the following case of the World Bank.

***‘Hard money for soft advice’ or maximisation of power?***

Whereas the Czech Health Ministry actively sought foreign assistance, the Federal government, under the influence of Civic Democratic Finance Minister Klaus, acted to minimise it. In 1991, the Federal government refused a World Bank loan targeting the health care sector, on the condition of market-oriented reform, because the ‘economic ministers’ underestimated the needs of the health care sector, did not trust ‘uninformed’ advice from abroad and, subsequently, were reluctant to accept overseas policy

intervention (Jaroš *et al.* 2005). An insightful account by Klaus explains why he opposed foreign assistance (Klaus 2005a):

- 1) The size of foreign assistance is usually very small, because it is in the interests of donors to maintain a huge gap between rhetoric and actual assistance;
- 2) Foreign assistance is expensive, because it comes with non-zero interest rates and demands for state guarantees;
- 3) The donors pursue their own interests by lending money to pay for their technical assistance whose value is dubious.

In 1990, Finance Minister Klaus rejected the World Bank's assistance, famously saying 'I am not ready to pay hard money for soft advice' and formulated his conspiracy theory about supranational organisations:

[Czechoslovakia and other transitional countries] should not become victims of vested interests of a very skilfully organized group of international advisers, investment bankers, powerful auditors and bureaucrats of international financial organizations. They established a very successful rent-seeking and pressure group. (Klaus 1997)

On the one hand, Finance Minister Klaus may seem more neo-liberal than the World Bank, as far as fiscal rectitude is concerned, and foreign advisors indeed did not know Czech economic conditions as well as him – a Communist-trained economist and banker. Conversely, he could not have known much about modern market economies, from behind the Iron Curtain, and the conditions attached to foreign assistance limited his decision-making powers. It is thus plausible that, by rejecting the assistance of supranational organisations, Finance Minister Klaus acted towards eliminating potentially rival expertise and scrutiny of his policies.<sup>43</sup>

### **History influences rhetoric but not Realpolitik**

As well as foreign advice, health policy-makers could also draw ideas from history, but instead used history mainly to justify their choices *post-hoc*. There was a trend, after the Velvet Revolution, of glorifying history for the sake of political argument. For example, the 'Draft of the Main Principles and Legislature for the System of General Health Insurance' maintained that, in 1948, 'the functioning of one of the most modern systems

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<sup>43</sup> The Economist Magazine describes Václav Klaus as '...abrasive, forceful, well-informed and magnificently dismissive of views other than his own. If you have a Nobel prize for economics, he may give your views a marginally more polite hearing' (Economist 2007).

of health insurance in Europe was forcibly disrupted [by the Communists]' (MZ ČR 1991a). Working under enormous time pressure to introduce health insurance, post-Communist reformers simply did not have time to study history and therefore did not realise that health insurance in inter-war Czechoslovakia was rather dysfunctional. Although the introduction of health insurance was advocated in Parliament as an 'attempt to come back to something that was abolished 40 years ago' (ČNR 1991b), a Health Ministry's document clearly stated that '[f]or obvious reasons, it is impossible to return to that [1948] year' (Pasternak *et al.* 1991). Obviously, it was not of practical use for reformers working under time pressure to read obsolete legislation, which could not be adapted to modern conditions (Pasternak interview 2006a). Simultaneously, the INSKOP proposal for decentralised health insurance, which closely drew on the 1924 health insurance legislation, failed to make any policy impact.

Besides obsolete laws, reformers could receive historical ideas through the people who previously worked in health insurance. Those who had at least one year's work experience in health insurance during the First Republic were at least 65 years old. Nonetheless, there were instances when such people attempted to influence health policy decision-makers<sup>44</sup>, though their experience was limited to the very bottom of the administrative hierarchy so it is unclear what contribution to policy-making they could make. To use a military analogy, it was unlikely that retired soldiers could influence the commanding generals of post-Communist health care reform. One such 'retired soldier' was the lawyer Roman Karlík, who came to the Health Ministry determined to promote public control and democratic governance in health insurance, as he believed was the case during the First Republic. His belief was likely affected by his lack of practitioner's experience because, as shown in Chapter 3, the democratic provisions of health insurance during the First Republic were not realised in practice.

Roman Karlík argued against top-down organisation of health insurance and for the direct participation of employers and employees in health insurance governance (Boškova

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<sup>44</sup> Individuals with a university degree and one year of work experience gained before the First Republic collapsed were at least 22 years old in 1938, i.e. 65 in 1991.

1999). He believed that, in the new health insurance system, doctors used their overbearing influence on health insurance for their own benefit: ‘...as though the state defence policy in this country was made by the arms producers’(Boškova 1999, p.42). Because he was against the quick top-down development of health insurance, dictated by the short-term horizon of the electoral cycle, neither Minister Bojar nor the Chairman of the Parliamentary Health Committee, Lom, who both were doctors, took Karlík’s advice (Boškova 1999, p.31). Despite the fact that the Director of the Office for the Introduction of Health Insurance, Petr Pasternak, was a lawyer himself, he also discarded Roman Karlík’s advice, regarding it as ‘more of a hindrance than a help’ (Pasternak interview 2006b).<sup>45</sup> In 1993, the disillusioned Roman Karlík wrote an open letter to the Speaker of Parliament and resigned from the Supervisory Board of the General Health Insurance Fund to draw public attention to the top-down nature of health policy-making and lack of public control in public health insurance: ‘instead of public policy there came Cabinet policy’ (Karlík; cited in Boškova 1999, p.38).

### ***A new party system***

In October 1990, a centre versus periphery conflict in the Civic Forum resulted in Václav Klaus’ election as Chairman and, shortly, in the split of the Civic Forum into the right-wing Civic Democratic Party (ODS) and the centrist Civic Movement (OH). The Civic Forum had a horizontal organisational structure, without registered membership, no defined ideological boundaries and advocated participatory democracy (Hadjisky 2001). This gave most power to dissidents and other established personalities from Prague, who quickly gained political capital in the aftermath of the Velvet Revolution. In order to consolidate his powers, Václav Klaus advocated representative democracy and proposed to transform the Civic Forum into a well-organised political party with a clearly-defined ideology. Despite its emphasis on party organisation and ideological discipline, Klaus’ Civic Democratic Party was criticised as a ‘right-wing party of the Leninist type’ (Zeman; cited in Pehe 1991, p.14). Nonetheless, the party did not have a rigid vertical hierarchy; I would argue that a characteristic feature of the Civic Democratic Party was

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<sup>45</sup> Nonetheless, there were people in the Ministry of Health who highly appreciated Roman Karlík’s informal advice and mentoring (Háva interview 2006a).

Klaus' strong leadership, combined with the functional autonomy of certain party units akin to the 'franchise model of party organization' (Carty 2004). Klaus imported wholesale a Cold War-winning Thatcherite ideology, registered it in the Czech Republic under the brand of the Civic Democratic Party, and franchised it to young and ambitious but unknown political entrepreneurs from the periphery, who had small chances to succeed in politics within the Civic Forum.<sup>46</sup> They committed their own resources to political campaigning, fleshed out the Thatcherite ideology with local specifics and, later in 1992, successfully sold it to their fellow constituents with a profit: Parliamentary seats for themselves and the PM portfolio for Klaus.

### **Opportunism as a defining feature of political parties**

Time-specific opportunity, rather than abstract ideology, is key in understanding where the Civic Democratic Party was coming from. Before the Velvet Revolution, Václav Klaus and other key members of his party conformed with Communist rule, failing to develop their own political ideas or show their appreciation of freedom and democracy. For example, the future Finance Minister Ivan Kočárník (1992-1996) and Foreign Minister Jozef Zieleniec (1993-1997) enjoyed membership in the Communist Party and Václav Klaus married a high-flying Communist (Cibulka 2000). But, after the defeat of Communism, Václav Klaus quickly imported Thatcherite ideology, styling himself as a Thatcherite:

What I admire about her [Thatcher] is that she has never compromised with anyone who doesn't share the basic moral and political principles of human freedom to which she herself has been faithful all her life... I do not believe it an exaggeration to say that the meltdown of communism in Central and Eastern Europe was initiated in Britain in 1979 by her election victory. Her Conservative government demonstrated a model that postcommunist countries would be able to follow... In the early 1990s, I founded a party modelled on the British Conservative Party and I succeeded in persuading the Czech people that we had to restore capitalism. I am proud to be a Thatcherite. It's a political philosophy that combines belief in individual freedoms and free markets with the promotion of national interests and resistance to the imposition of supranational government. In Europe, politicians who aim to reduce red tape and taxation and push for

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<sup>46</sup> Similarly to young and ambitious supporters of Communist policies called the *Komsomol*, the modern-day zealous supporters of Civic Democratic policies were often referred to as the 'market *Komsomol*' (Potůček interview 2006).

**privatization**, the politicians who defend democracy and freedom, these all might be described as Thatcherite (Klaus 2006).

Conflict between opportunistic political entrepreneurs, rather than abstract ideology, seems to have been central to the split of the Civic Forum. The Civic Democratic Party was more an outlet for Václav Klaus' political ambitions than an attempt to fill an ideological void in the emerging Czech party system.

From the very beginning, the Civic Forum had a right wing, represented by the Civic Democratic Alliance (ODA). In early 1990, the Civic Democratic Alliance joined the Civic Forum aiming 'to create the core of the future right wing of the Civic Forum and by doing so to prevent the left-wingers from assuming supremacy in the Civic Forum' (ODA 1992, p.2). Founding members of the Civic Democratic Alliance, such as Pavel Bratinka and Tomáš Ježek, claimed to be followers of Friedrich von Hayek and argued for privatisation and the reduction of the role of the state (ODA n.d.). Whereas Pavel Bratinka was a distinguished dissident, other key Hayekians were associated with the Communist regime. For example, Vladimír Dlouhý had enjoyed Communist Party membership, before embarking on a career of Federal Industry Minister (1989-1992) and Economy Minister (1992-1997) and future Privatisation Minister Jiří Skalický (1992-1996) came from the family of a high-ranked member of the Communist *nomenklatura* (Cibulka 2000).

Political opportunism was also characteristic of the left-wing of the emerging post-Communist party system. The Social Democratic Party (ČSD) was established by the US pensioners-émigrés, who came to the Czech Republic to seize political leadership opportunities presented by regime change. Before emigrating in 1948, they were involved in the youth organisation of the Social Democratic Party but, when in emigration, they fell out with senior members of the Social Democratic Party in exile. The latter recognised the distinguished dissident Rudolf Battěk as leader of the Social Democrats in Czechoslovakia and supported his vision for the Social Democratic Party to join the Civic Forum, to present a common front against the Communists in the 1990 election (Kopeček & Pšejka 2007). However, the leader of the US pensioners-émigrés, Jiří Horák, registered

the Social Democratic Party in post-Communist Czechoslovakia before Battěk, and became a ‘defender of democracy’ (Manhattan College 2004). Thanks to the support of the former Communists and conformists who joined this party, Horák first defeated Battěk in the election for Party Chairman and then expelled him from the party (ibid.). Another leader of this party was Valtr Komárek – a distinguished Communist economist and former advisor to Che Guevara and the Czechoslovak Politburo. Dissidents largely remained dissidents because they did not fit into the democratic majority of new parties comprised of former conformists and Communists.

### **Dissidents versus political entrepreneurs**

As shown in Chapter 3, Communism was not installed in post-WWII Czechoslovakia by the Red Army, but by the self-interested political elites capitalising on the political opportunities presented by Czechoslovakia’s betrayal by the West in 1938 and liberation by the Red Army in 1945. Similarly, capitalism was not installed in the post-Cold War Czech Republic by the IMF or international corporations, but by self-interested Thatcherites and Hayekians, who spotted opportunities to make political profit from the defeat of Communism and adopted a Cold War-winning ideology, in a way not dissimilar to Machiavelli’s Prince:

...it is unnecessary for a prince to have all the good qualities I have enumerated, but it is very necessary to appear to have them. ...it is necessary for him to have a mind ready to turn itself accordingly as the winds and variations of fortune force it (Machiavelli 1992 [1513]).

Until 1989, liberal-democratic ideas in Czechoslovakia were promoted by dissidents, who dared to challenge the Communist orthodoxy and demand that the government stop violating political freedoms and human rights. In the most dramatic case, dissident Pavel Wonka paid the ultimate price for his liberal-democratic ideals; in 1986, he decided to run for MP against the Communist Party, but was arrested and died in prison (Gruntorád 2004). Other dissidents lost their careers and freedom for defending their liberal-democratic ideals. Given the high price of expressing liberal-democratic ideas during Communist rule, there were only a few hundred dissidents in Czechoslovakia compared to 1.4m Communists, i.e. 10% of the population (Wightman 1983). However, when,

following regime change, there were no longer significant costs attached to adopting liberal-democratic ideas, thousands of former conformists and Communists made themselves appear as ‘defenders of democracy and freedom’ (Klaus 2006) for their own political gain.<sup>47</sup>

Whereas dissidents used their careers to defend their liberal-democratic ideals, post-Communist political elites aptly took advantage of the changing winds of fortune and adopted liberal-democratic ideas to advance their careers.<sup>48</sup> Post-Communist party politics was dominated by enterprising individuals who spotted opportunities for political and economic profit from regime change and did not hesitate to act. In line with Schumpeter’s theory of entrepreneurial profit, they did not bear risks:

The entrepreneur is never the risk bearer. ...The one who gives credit comes to grief if the undertaking fails. ...Risk-taking is in no case an element of the entrepreneurial function. Even though he may risk his reputation, the direct economic responsibility of failure never falls on him. ...The leaders make no sacrifice and take no notice of a possible temporary sacrifice of those led – if and so long as the reins rest firmly in their hands (Schumpeter 1936, p.137, 139).

Unlike dissidents, post-Communist political entrepreneurs did not bear the risks of losing life, freedom or a career; it was the voters/taxpayers who bore the risks of suboptimal reforms and made temporary sacrifices to their living standards. Also, in line with Schumpeter, post-Communist political entrepreneurs did not develop original ideas:

What have the individuals under consideration [entrepreneurs] contributed to this [their entrepreneurial profit]? Only the will and the action... They have not accumulated any kind of goods, they have created no original means of production, but have employed existing means of production differently, more appropriately, more advantageously. They have “carried out new combinations” (Schumpeter 1936, p.132).

Unlike dissidents, post-Communist political entrepreneurs did not develop original ideas, but simply employed combinations of well-known ideas. It is crucial to appreciate that political entrepreneurs adopted ideas to make political profit and thus that they were

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<sup>47</sup> Cf.: ‘Yet it cannot be called talent to slay fellow-citizens, to deceive friends, to be without faith, without mercy, without religion; such methods may gain empire, but not glory (Machiavelli 1992 [1513]).’ Indeed, post-Communist opportunists gained power, but not glory. This is reserved for the likes of Pavel Wonka.

<sup>48</sup> Changing beliefs for political or personal gain is a well-established trait of Czech politicians. The greatest of them, ‘Father [of the nation]’ Masaryk, started his career as a monarchist but after, the WWI defeat of the Austro-Hungarian Empire and the Russian Revolution, became a republican (Masaryk 1927). Likewise, he initially supported the Catholic Church, then turned against it and joined the Protestant Evangelical Church, finally converting to Unitarianism (Malý 2007).

prepared to give up ideas which jeopardised political gain. Later, I use this important distinction between dissidents and political entrepreneurs to demonstrate that liberal health care reform failed because the self-styled Thatcherites and Hayekians quickly dropped their liberal-democratic ideals when the winds of fortune changed and it became costly to pursue liberal policies.

### ***National 'capitalismo-socialism'***

#### **'Economic ministers' launch rapid privatisation**

In 1990, there was a broad consensus among political elites about the desirability of liberal economic reforms, but they disagreed on the speed, sequencing and methods of privatisation. Valtr Komárek, Director of the Institute for Forecasting at the Academy of Sciences, argued for gradual privatisation, state-led restructuring of state firms prior to their sell-off, and a high level of employee-ownership (Stroehlein *et al.* 1999). This gradualist approach was shared by the majority of the Czech cabinet ministers, representing the centrist Civic Movement (Pehe 1991). However, they were 'begging ministers' and could not influence the 'economic ministers' from the right-wing Civic Democratic Party and the Civic Democratic Alliance, who pursued rapid privatisation and argued for the restructuring of former state firms by new owners and market forces. Václav Klaus, Federal Finance Minister and Chairman of the Civic Democratic Party argued against the danger of falling in the "reform trap" of high inflation and economic, social, and political disintegration' posed by gradual reforms (Klaus 1990). He was fully supported by Federal Industry Minister Dlouhý, Czech Privatisation Minister Ježek, and the Chairman of the National Property Fund Skalický, who all represented the leadership of the Civic Democratic Alliance.

Rapid privatisation succeeded because of the uneven distribution of power in the government and the unhinged institutional framework. After unitary Czechoslovakia was federalised in April 1990, the 'economic ministries' retained their budgets and power on the Czechoslovak level, but Federal Parliament lost its veto power to the Czech Parliament, which could not veto the initiatives of the Federal 'economic ministers'.

Furthermore, the Czech government agencies responsible for national property and its privatisation fully supported the Federal ‘economic ministers’, giving unrestricted opportunities to Klaus, Dlouhý, Ježek, and Skalický to start rapid privatisation, even though the majority of Czech cabinet ministers were in favour of gradualism. Privatisation began with the restitution of property to its former owners in 1990 and the first wave of privatisation, involving sales of small state firms to foreign and domestic investors, started in 1991. Also in 1991, citizens were issued with vouchers exchangeable for small stakes in larger state firms.

The ‘economic ministers’ also disagreed on methods of privatisation. The Czech Privatisation Minister Ježek favoured direct sales to foreign investors. In 1991, the Czech government accepted technical assistance from the USAID, which provided salaries to a group of 15-20 investment bankers to come to the Czech Republic to assist foreign investors with mergers and acquisitions (Meaney 1995). This group, known as Crimson Capital Corporation, greatly contributed to the first wave of privatisation and, by the first half of 1992, attracted to Czechoslovakia at least US\$2bn of foreign investment (ibid.). Despite this success, Federal Finance Minister Klaus was against strong foreign involvement in the Czech economy and pushed for voucher privatisation and direct sales to Czech entrepreneurs instead. When Klaus became Czech Prime Minister, in 1992, he replaced Privatisation Minister Ježek with his supporter Jiří Skalický and rejected further assistance by the Crimson Capital Corporation. Under PM Klaus, voucher privatisation became the leading privatisation method and Czechs were treated preferentially over foreign investors.

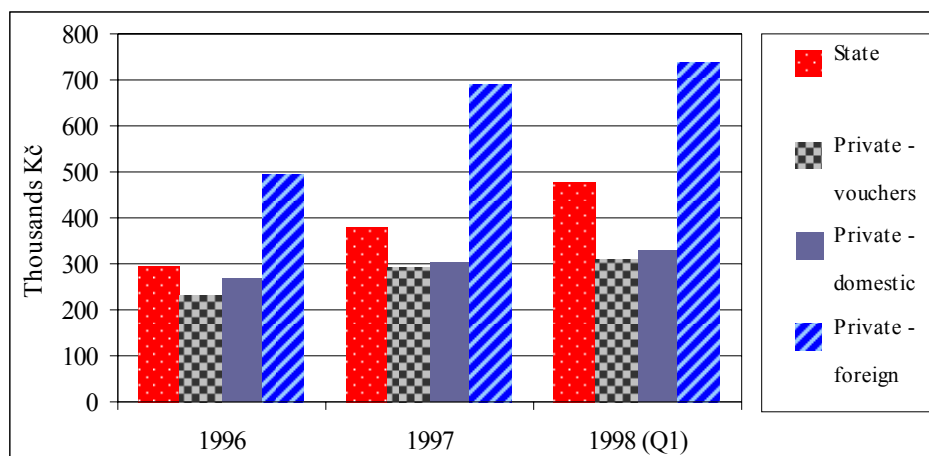
### **A political logic of privatisation**

I would like to argue that privatisation was driven by the political interests of major policy actors, rather than Thatcherite ideology. Self-styled Thatcherite Klaus clearly deviated from the logic of capitalism. Mrs Thatcher’s privatisation aimed at the maximisation of state revenue, attraction of investment and equal treatment of foreign and domestic investors. In contrast, Klaus attempted to build national ‘capitalismo-socialism’ (Mládek 2001, 2002), based on the discrimination of foreign capital,

distribution of small stakes in state property through citizens vouchers and low interest state loans to Czech entrepreneurs to privatise state firms. Although loans and losses of Czech entrepreneurs were financed through public sources, their gains remained private (Mládek 2002). The giveaway of property for political gain was not new in the Czech Lands. In 1946, the Communists and National Socialists – the main proponents of the expropriation of the Sudetenland Germans’ property and its subsequent distribution to Slavonic settlers – gained the highest vote in Slavonised Sudetenland (ČSÚ n.d.). Also, like the Communists, the self-styled Thatcherites adopted a strong nationalist stand, and denied the restitution of property expropriated by the Nazis from Jews during WWII, by President Beneš from the Sudetenland Germans in 1945 and by the Communists from Czechoslovaks who emigrated during Communist rule.

Given its anti-capitalist logic, the post-Communist privatisation proved a political success at the expense of economic failure (Mládek 2002). A survey of Czech firms conducted in the mid-1990s showed that the best economic results were achieved by the firms owned by foreign investors and the state; the worst economic results were achieved by those privatised via vouchers and state loans (Figure 5).

**Figure 5: Added value per employee in manufacturing firms by ownership and privatisation method**



Source: Mládek (2002)

The Czech entrepreneurs, who privatised state firms on state loans, did not have funds to invest in their firms and, instead, tended to asset-strip them to get rich quick. Voucher

privatisation produced thousands of small shareholders and thus weak corporate governance, preventing old Communist firms from restructuring and reform (ibid.). Furthermore, small shareholders did not have investment capital and the managers of the firms privatised through vouchers had adverse incentives to strip their firms off assets to get rich quick. A combination of weak corporate governance and adverse incentives for senior managers resulted in the ‘tunnelling’, i.e. large-scale liquidation of capital and holdings, of the privatised firms by their managers (Altshuler 2001, p.116).<sup>49</sup> Not surprisingly, the economic experiment to build capitalism without capital and capitalists failed (Mládek 2002).

## ***Decentralisation and privatisation***

### **Abolition of local governance in health care**

As shown in previous chapters, health care financing and provision in inter-war Czechoslovakia was extremely fragmented, so health care reformers attempted to increase the state’s role and build an integrated and hierarchical network of health care facilities. Communist health care reform followed this path, creating a unified state health care system with distinct territorial and functional hierarchies. Health care facilities were administered and funded by regional and district state health authorities, which were allocated funding by regional and district state authorities. Only 3.5% of the yearly health care budget was allocated directly from the state budget to the health care facilities administered directly by the Health Ministry (Domas 1988). In the last years of Communist rule, health managers criticised the Communist health care system for being too decentralised. Therefore, Parliament proposed to strengthen the role of the Health Ministry, to increase centralised state governance in health care financing and provision (ibid.). However, post-Communist policy change took the opposite direction, altogether abolishing state governance.

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<sup>49</sup> The ‘tunnelling’ dimension of privatisation was aptly described by an associate of the most successful privatisation entrepreneur Viktor Kožený, saying: ‘It’s like a country that has gone through bankruptcy and all of a sudden there is a Monopoly game created’ (Wallace 1996).

Post-Communist policy change was aimed at the decentralisation of health care administration to the level of health care providers and the devolution of health care financing to an independent public health insurance fund. I suggest that this change was driven by the political objectives of new health sector elites, rather than the objectives of improving administrative efficiency. As shown by the activities of the post-Communist health care reform groups, new health sector elites attempted to take control of health care from Communist elites and reduce the role of the totalitarian state bureaucracy in health care. During Communist rule, health care was too bureaucratised for doctors' liking, relations between doctors and patients were determined by health care managers rather than doctors and patients themselves, managerial appointments were made by the Communist *nomenklatura* according to political as much as professional considerations, and earnings in health care were below the national average. Therefore, post-Communist health sector elites set out to dissolve Communist governance structures in health care, i.e. regional and district health authorities and state financing, to reduce bureaucracy, overturn the Communist *nomenklatura*, and allow doctors to determine their earnings through private practice.

Regional health authorities were dissolved in 1990 and district health authorities in 1991. Whereas, in 1990, there were only 142 health care providers with legal personhood, after the dissolution of health authorities the number of health care providers with legal personhood grew to 430 in 1991 and 929 in 1992 (Kalina & Jaroš 2005). Effectively, this led to the abolition of any governance in health care in 1991-1992. Health care facilities were still owned by the state, but neither the Health Ministry nor district state authorities had capacities to manage them according to central or local needs. In 1991, the Health Ministry just passively allocated funding to health care facilities directly from the state budget, on the basis of historical data and the claims of health care providers. In 1992, health care financing was devolved from the state to a centralised public health insurance fund, which had no administrative influence on health care providers and, again, just passively transferred funds to them. With the beginning of privatisation in late 1992, most GPs and outpatient health care facilities became private, but most inpatient health

care facilities were not privatised; throughout the 1990s, they formally remained state-owned, but the state no longer had capacities to administer them according to local needs.

The Health Ministry envisaged that, after the dissolution of regional and district health authorities, the void in local health care governance would be filled by the Councils of Health Care Facilities, the Health Departments of district state authorities and self-governing local communities and municipalities (MZ ČR 1990, pp.13,40). The Councils of Health Care Facilities were expected to be formed bottom-up by the managers of health care facilities, to co-ordinate, plan and develop health care facilities on the local level (*ibid.*). In some districts, such Councils were indeed formed, but they soon died out because the ownership and financing of health care facilities was concentrated on the central level. Therefore, health care managers organised themselves in associations of various types of health care facilities, to defend their interests against the central government and the centralised public health insurance system. Although the Health Departments of district state authorities became formally responsible for the administration of health care facilities in their territory, they no longer had capacities to finance and govern health care facilities. The Health Ministry envisaged that self-governing local communities and municipalities would establish Health Councils in order to plan and supervise health care provision in their territory (*ibid.*). While some local authorities indeed established such Councils, these failed to materialise on a large scale because most local authorities did not become the owners of health care facilities in their territory. Therefore, neither district state authorities nor self-governing local authorities had effective means to participate in governance of health care facilities on the local level. Effectively, health care providers were left to their own devices. Altogether, the dissolution of regional and district state health authorities led to the abolition of local governance in health care and the gradual emergence of weak central governance.

Decentralisation succeeded in reducing bureaucracy. The abolished health authorities had 12,377 employees in 1988 (MZ ČR 1991a). Following the abolition of health authorities, some of these employees went to work for the General Health Insurance Fund and Health Departments of state district authorities. As of 2006, health insurance funds had 7,060

employees (PSP 2006). There are no statistics on the employees of the Health Departments of local authorities or local self-governing authorities which had such departments. If we put a liberal estimate of 1,000 employees in these health departments, then we can conclude that the replacement of the Communist bureaucracy in health authorities with the post-Communist health insurance funds and local administration led to at least a 35% reduction of bureaucracy in health care. As such, the earlier claim of Václav Žák that the post-Communist bureaucracy outgrew the Communist bureaucracy is not true of health care.

### **Delays of privatisation in health care**

Like privatisation in industry, privatisation in health care was driven by the political objectives of the ‘economic ministers’ to implement rapid privatisation to earn electoral benefits. The Health Ministry had to comply with their objectives to protect its bureaucratic turf and, to do so, the Health Policy Department distributed a questionnaire among other Health Ministry departments asking civil servants to rate which health care facilities would be easiest to privatise (Háva interview 2006b). As elsewhere, senior decision-makers in the Health Ministry shared the desirable perception of privatisation, but disagreed on its scope and sequencing. For example, Minister Bojar was in favour of a comprehensive network of public non-profit facilities and then privatising the remaining facilities (Bojar interview 2006), but at that time there was no legislation on public non-profit organisations in health care. In contrast, the Director of the Health Policy Department Kalina proposed to ‘privatise everything that is possible’ within the framework of the existing legislation (Kalina 1992 cited in; Háva & Kružík 1995, p.57). However, rapid privatisation in health care was impossible, because health insurance and a legal framework for non-state health care providers were only introduced in 1992.

Privatisation in the health care sector started with restitution as early as 1990, but its scope was extremely limited<sup>50</sup>, including only the property nationalised by the Communists after 1948 (Zákon č. 298/1990 Sb.; 403/1990 Sb.), whereas the

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<sup>50</sup> By 31.03.1998 only six properties were returned to the previous owner free of charge and seven more with additional payment (Kalina & Jaroš 2005).

overwhelming majority of health care facilities had been nationalised during Dr Beneš' national socialist revolution, immediately after WWII. Also, a few non-core health care facilities and services were privatised during the first wave of privatisation in 1991-92, on the basis of general legislation for privatisation (Zákon č. 92/1991 Sb.; 427/1990 Sb.). These included medical spas, opticians, medical supplies and distribution companies, and the Institute for Sera and Vaccines (Papeš 2005). An important implication of the privatisation of health care facilities on general terms was the exclusion of the Health Ministry from privatisation decision-making, which was the prerogative of the Privatisation Ministry and National Property Fund (Zákon č. 500/1990 Sb.).

Most health care facilities were designated to the second wave of privatisation, with 31.05.1992 as a deadline for the submission of privatisation projects (Usnesení vlády ČR č. 314/1991). However, the government decree allowing privatisation of health care facilities (Usnesení vlády ČR č. 141/1992) was only issued in March 1992, the law allowing non-state provision of health care (Zákon č. 160/1992 Sb.) was only passed in April, and the process of licensing and registration of private health care providers was not agreed until the middle of the year (Papeš 2005). Most importantly, the government only approved a list of health care facilities for privatisation on 25.6.1992, and consequently extended the deadline for submission of privatisation projects by three months (Usnesení vlády ČR č. 454/1992). The delay in the approval of the list of health care facilities for privatisation was due to confusion over the administrative responsibilities for health care facilities, after the dissolution of health authorities, and disagreement between the Privatisation Ministry and the Health Ministry, over the scope of privatisation. The Privatisation Ministry and district state authorities drew up the list of health care facilities for privatisation without the Health Ministry's involvement (Usnesení vlády ČR č. 173/1991). As a result, Minister Bojar disagreed with the list because it contained serious mistakes: some health care facilities were unaccounted for and others were erroneously put down for privatisation (Háva & Kružík 1995, p.56). Therefore, the government resolved that, in future, the Privatisation Minister should seek the Health Minister's agreement on privatisation projects concerning inpatient and blood transfusion facilities (Usnesení vlády ČR č. 454/1992).

## ***Parliamentary Health Committee versus Health Ministry***

### **Parliament takes lead in health policy change**

During Communist rule, Parliament routinely passed government legislation and toothlessly scrutinised government health policies; but, after 1989, Parliament became an active health policy actor because the number of doctor MPs significantly increased and the government no longer had a stable parliamentary majority. Schumpeter (1984, p.285) argued that ‘the democratic method produces legislation and administration as by-products of the struggle for political office’. This implies that MPs do not originally come to Parliament to scrutinise and legislate for health care reform, but exploit these activities to maximise their power, advance their vested interests and gain rent from their office. This is evident from the legislative activities of the Parliamentary Social Policy and Health Committee, which effectively promoted the policy preferences of interest groups against those of the government and provided Petr Lom, Chairman of the Health Committee, with institutional resources in his struggle for the Health Minister’s office.

Following the split of the Civic Forum, Minister Bojar and Chairman Lom became political opponents. Whereas Bojar adhered to the Civic Movement, Lom moved in the political camp of the ‘economic ministers’ and Civic Democratic Party, and started acting as Shadow Health Minister. Like the ‘economic ministers’, Chairman Lom advocated rapid liberal reforms and privatisation in health care. With elections imminent, he used his position to criticise Minister Bojar, in Parliament and the media, for slow policy change (ČTK 1991; ČNR 1992b, 1992c; Lom 1992) and the public’s lack of information made this criticism effective. High search costs prevent the public from gathering health policy information and, when policy change is time- and cost- intensive, the public tend to think that, instead of serving their interests, the Health Minister is lining his pockets, rather than facing time and cost constraints (Bardhan & Yang 2004). Furthermore, Chairman Lom’s struggle for the Health Minister’s office provided interest groups with opportunities to influence legislative outcomes. The Parliamentary Health Committee used its right to initiate legislation to pass two crucial laws catering for the interests of the medical profession and health insurance entrepreneurs.

### ***Medical Chambers receive extensive powers against the state***

After the regime change, the number of doctor MPs in the Czech Parliament increased to three times the previous level. Whereas in 1969-1989 the 200-strong Czech Parliament had no more than 6 doctor MPs (3%), their number rose to 11 (5.5%) in 1990-1992, then 18 (9%) in 1992-1996 (PSP n.d.). In 1996-2006, the number of doctor MPs decreased to 11-13 (5.5%-6.5%) (ibid.), perhaps because many politically-minded doctors entered the newly-established upper chamber (Senate). In 1996-2008, the number of doctor peers in the 81-strong Senate varied between 8-13 (10%-16%) (Senát n.d.). Likewise, 5 (20%) of the 25 Czech Members of European Parliament elected in 2004 were doctors. The growth of doctors' participation in politics, through the Senate and European Parliament, indicates that doctors enter politics to promote their individual careers, rather than to influence health policy-making. Compared to the Chamber of Deputies, the Senate's role in health policy-making is extremely limited and European Parliament has no influence on Czech health policy at all. The increased participation of doctors in Parliament also allowed them to promote their common interests effectively. A senior policy-maker recalls that health policy debates in Parliament in the early 1990s were disproportionately dominated by doctor MPs, 'as if every other MP was a doctor' (Němec interview 2005).

One of the common interests that doctor MPs promoted in 1991 was the autonomy of the medical profession. The Health Ministry supported the leaders of the medical profession in establishing medical chambers to ensure self-governance of the profession. Minister Bojar was against granting exclusive registration, licensing and economic interest representation rights to medical chambers (Bojar interview 2005); but Chairman Lom, and other doctor MPs from the Parliamentary Health Committee, sponsored the legislation on medical chambers, according to the preferences of the leaders of the medical profession, especially those from the Prague Medical Chamber Ltd, and influenced Parliament to adopt this legislation. Consequently, the Act on Medical Chambers legislated for Medical, Dental, and Pharmaceutical Chambers, with an extensive mandate to register their members, licence non-state facilities, maintain professional conduct and standards of care, and defend the professional and economic

interests of their members (Zákon č. 220/1991 Sb.). Effectively, the Act limited the scope of the government's regulatory action in health care, putting the Chambers in a powerful position.

***Health insurance entrepreneurs gain lucrative business opportunities***

The Parliamentary Health Committee also sponsored a law allowing competition in health insurance, despite the Health Ministry's preference not to create multiple health insurance funds until the public General Health Insurance Fund became fully functional. Moreover, the leaders of the medical profession were cautiously opposed to new health insurance funds, because they feared that these would complicate health care financing and create more paperwork for doctors (Jedlička interview 2006). However, non-doctor Civic Democratic MPs from the Parliamentary Health Committee argued against General Health Insurance Fund's monopoly and for competition between health insurance funds to improve the range, quality and efficiency of health care services, prevent the escalation of health care costs by doctors, and attract private investment in health care (Payne 1992; Raška 1992). Therefore, they sponsored the legislation on firm-based health insurance funds (Zákon č. 280/1992 Sb.) and rushed it through Parliament, shortly before it was dissolved for election. Given the lack of time for deliberation on this legislation, firm-based health insurance funds were created within a poorly-defined legal-administrative framework and without meaningful provisions for risk-adjustment between health insurance funds.

Given increased political competition in the face of the upcoming election, the MPs from the Parliamentary Health Committee sponsored this legislation in order to gain the credentials of progressive reformers, by serving the interests of enterprising senior managers at large state firms looking for lucrative business opportunities. For example, the heads of personnel departments at coalmines and industrial works in Northern Bohemia and the Czech Railways lobbied for firm-based health insurance funds (Pasternak interview 2006b). Senior managers at state firms faced the risk of losing their jobs due to privatisation, but spotted opportunities for better employment and profit on health insurance, because they had access to their employees' personal records and were

in a good position to recruit customers for health insurance funds. Therefore, the introduction of competition in health insurance is best described as the old Austro-Hungarian practice of *trafika*, i.e. opportunistic rent-seeking of public or state officeholders, using their office to obtain lucrative state concessions or employment.<sup>51</sup> The *trafika* of health insurance funds was facilitated by the new ideology of the Civic Democratic Party, which enabled co-operation between enterprising senior managers of state firms, seeking better employment and profit, and Civic Democratic MPs, seeking the credentials of progressive reformers.

### **Dissent in Health Ministry**

The political competition between Minister Bojar and Chairman Lom manifested itself not only in Parliament, but also in the Health Ministry. By 1992, Director of the Health Policy Department, Kamil Kalina, and the Director of the Office for the Introduction of Health Insurance, Petr Pasternak, gravitated towards the Civic Democratic Party and Chairman Lom. In autumn 1991, both argued that the right time for introducing health insurance had not yet come and attempted to postpone the launch of the General Health Insurance Fund (Bojar interview 2006). This would have given Lom justification for criticising Minister Bojar for slow policy change during the forthcoming election, so was not acceptable to Minister Bojar (*ibid.*). He proceeded to launch the General Health Insurance Fund according to the government's schedule, tackling dissent in the Health Ministry by closing down the Health Policy Department and replacing the Director of the Office for the Introduction of Health Insurance.

The closure of the Health Policy Department weakened the influence of Kamil Kalina, who was the principal author of the official health care reform programme, and left the Health Ministry without a unit to evaluate, develop and plan health policy in a long-term perspective (Papeš & Gladkij 1992). The dismissal of Pasternak allowed Bojar to resolve a long-standing disagreement with Pasternak over the choice of contractor for two

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<sup>51</sup> In the Austro-Hungarian Empire, licenses to run profitable street kiosks, called *trafika* were usually given to disabled war veterans in recognition of their services to the Emperor. Subsequently, the practice of state/public officeholders using their offices to obtain such licenses or other profitable concessions became known as *trafika*.

important public procurement projects<sup>52</sup> and to appoint a new Director of the General Health Insurance Fund in order to introduce health insurance according to the government's schedule. As the Office for the Introduction of Health Insurance was about to be transformed into the General Health Insurance Fund, on 01.01.1992 (Zákon č. 550/1991 Sb.), Parliament would have likely voted for Pasternak as Director of the General Health Insurance Fund. After Pasternak's dismissal, senior managers loyal to him revolted against Minister Bojar's appointee, with support from the Parliamentary Health Committee (ČNR 1991a). This instigated a protracted battle between the Health Ministry and Parliament, which claimed a heavy toll of partisan senior health insurance managers. Eventually, Jiří Němec – one of a few non-partisan senior managers at the Office for the Introduction of Health Insurance – was appointed as Director of the General Health Insurance Fund. Němec recalls that, when he was appointed, hardly any experienced senior managers remained in the General Health Insurance Fund (Němec interview 2005). Altogether, the political struggle, between the incumbent Health Minister Bojar and his challenger Chairman Lom, undermined the administrative efficiency of the Health Ministry and the General Health Insurance Fund, but eventually helped Lom win office.

### ***Protests against health insurance***

Despite criticism in Parliament for slow policy change, the Health Ministry prepared the health insurance legislation in just over a year and health insurance was launched on 01.01.1992, as requested by the 'economic ministers'. In December 1991, the Czechoslovak Parliament proclaimed the Charter of Fundamental Rights and Freedoms, tying the right to free health care to public health insurance: '[all] citizens have the right to free medical care on the basis of public insurance' (Ústavní zákon č. 23/1991 Sb, Čl.31).<sup>53</sup> Also in December 1991, the Health Ministry sponsored and successfully passed the Act on General Health Insurance (Zákon č. 550/1991 Sb.) and the Act on the General Health Insurance Fund (Zákon č. 551/1991 Sb.). In 1991, large hospitals completed

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<sup>52</sup> A health insurance IT project and a bank for the General Health Insurance Fund.

<sup>53</sup> After the dissolution of Czechoslovakia on 1.1.1993, this Charter was incorporated into the Czech Constitution (Ústavní zákon č. 1/1993 Sb.).

‘Experiment R’, seeking to determine the duration and labour intensity of various health care services to establish fee-for-service reimbursement rates. On the basis of this data, the Health Ministry prepared and published, in December 1991, a fee-for-service reimbursement list for health care providers. After attempts inside the Health Ministry to postpone the introduction of health insurance failed, the General Health Insurance Fund was launched on 01.01.1992, sparking protests in the health sector.

Grass-roots doctors protested against low fee-for-service reimbursement rates and paperwork associated with health insurance, demanding higher salaries based on hourly reimbursement instead. For some doctors, fee-for-service reimbursement clashed with their morals and humanitarian perceptions of medicine (Pohunková email 2006), while others disliked taking time off clinical work to act as lowly accountants. For example, during ‘Experiment R’, the cream of the crop of the medical profession, surgeons, simply did not return many questionnaires, because they did not consider it worthy to do lowly paperwork instead of saving lives (Heger interview 2006). Furthermore, many doctors protested against significant disparities in reimbursement rates between different specialties, perhaps arising from differences between the Czech clinical practices and the Canadian ones used as models for reimbursement rates or simply from the negligence of surgeons and other doctors during ‘Experiment R’. Most importantly, doctors protested against the expected loss of income, due to low reimbursement rates, and the broken promises of the Health Ministry that health insurance would increase their income.

Various professional organisations and trade unions protested against health insurance. The Medical Chamber issued a statement against the fee-for-service reimbursement list, arguing that it would lead to a health care ‘catastrophe’ (Mark 1992). In Brno, doctors established the Crisis Centre of Doctors of the Brno Agglomeration, organising a 1,000-strong demonstration and urging doctors to boycott their administrative duties unless the government replaced miserly fee-for-service payments with salaries at a Kčs80/hour rate (Vlk 1992). This rate was based on Minister Bojar’s earlier promise that, under health insurance, doctors would be able to earn as much as Kčs16,000 per month (ibid.), i.e. double their present salaries. The Moravian Section of the Association of Small and

Medium Type Hospitals criticised the Health Ministry and General Health Insurance Fund for creating havoc in health care, and suggested limiting health services for MPs and government officials to emergencies unless they named those responsible (ČTK 1992a). In Prague, 700 hospital doctors protested in front of Parliament, against sub-standard health care funding, dysfunctional health insurance, and the ‘absurd’ situation where they were ‘ridiculed’ for their earnest services to society with pay below the national average (ČTK 1992h). Lastly, the Health and Social Care Trade Union issued a nation-wide strike alert, which lasted for two weeks, but was eventually called off (ibid.).

These protests highlighted the fact that health insurance was introduced by elites without public discussion and, for the first time, defined the interests of grass-roots doctors against the new elites. The Brno doctors argued that the Health Ministry implemented reforms in its own interests, without considering the views of ordinary doctors, the public was poorly-informed about the development of the reimbursement list, and the Health Ministry’s *apparatchiks* ignored their feedback (Vlk 1992). The Brno doctors feared that, under the new health insurance system, the bureaucracy would prevent health care expenditure growth and doctors’ earnings would decrease because of rising costs for drugs and medical equipment (ibid.). They calculated that, if the Health Ministry continued insisting on health care privatisation, doctors would require additional employment outside health care to subsidise their private practices, because under the existing fee-for-service reimbursement rates private practices would make annual losses of at least Kčs120,000 (ibid.). Crucially, the Brno doctors put their material interests above the political objectives of new elites, arguing that health insurance and privatisation would make ordinary doctors worse-off than under the previous regime. Deputy Health Minister Šilhan sought to pacify the Brno doctors, arguing their opposition to reforms played into the hands of the Left; but the doctors maintained that the Health Ministry itself played into the hands of the Left, by sub-standard fee-for-service reimbursement (ibid.). Although these protests did not lead to abolition of fee-for-service reimbursement, in favour of higher hourly pay, as the Brno doctors demanded, the government ordered a revised version of the fee-for-service reimbursement list, which was introduced only after the election (Vyhláška MZ ČR č.258/1992 Sb.).

## CHAPTER 7: CIVIC DEMOCRATIC HEALTH MINISTER LOM, 1992-93

### *1992 election and party policy pledges*

In the June 1992 election, the salience of health care was surprisingly high, compared to both the previous election and other issues, but varied significantly between parties. Health care clearly topped the agenda of right-wing parties; for the Civic Democrats and Christian Democrats it was among the three most salient issues, and for the Civic Democratic Alliance the most salient issue (Table 5). For left-wing parties, health care had medium salience. The Left Block and the Social Democrats put social justice top of their agendas; giving health care only medium salience in their manifestos. Other parliamentary parties, including the one-issue Autonomous Democrats, the populist Republicans, and the 3-party coalition Liberal-Social Union, did not mention health care in their manifestos at all.

**Table 5: Most salient electoral issues by the frequency of issue-related quasi-sentences in 1992 party manifestos, %**

Party \ Issue	Freedom-Human Rights	Democracy	Decentralisation	Environment	Culture	Education	Law and order	Infrastructure	Privatisation +	Social Justice	Welfare state +	Welfare state –	Health Care
Civic Democrats (ODS)	8.7	3.2	1.1	8.7	4.9	0.5	1.1	0.5	1.6	0.5	1.1	2.7	4.9
Left Block (KSČM-DL)	4.4	2.4	4.7	5.3	1.5	2.1	1.8	1.5	0.0	5.6	2.1	0.6	2.1
Social Democrats (ČSSD)	1.6	4.0	1.8	4.0	0.3	2.6	2.9	1.1	0.3	12.4	3.4	0.0	1.8
Christian Democrats (KDU-ČSL)	4.2	1.1	3.2	4.2	2.1	6.3	5.3	5.3	1.1	2.1	†6.3	0.0	6.3
Civic Democratic Alliance (ODA)	1.6	2.3	6.7	7.4	3.0	4.0	3.0	2.8	2.8	1.6	†6.7	0.9	9.1

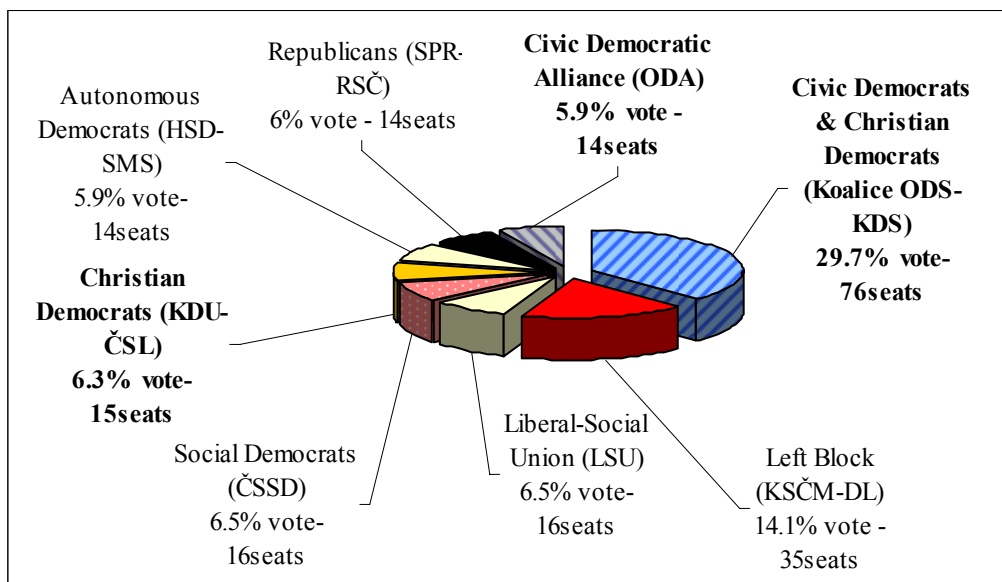
Source: own analysis based on Klingemann (2006);

Note: see Appendix for the explanation of methodology and issues

† My analysis shows the ‘welfare state expansion’ category was miscalculated in the original dataset. These parties argued for improving and expanding welfare provision, but largely by shifting responsibility from the state to individuals, families, charities and the church.

The Civic Democratic Party won the election with 29.7% of the vote<sup>54</sup> and formed a cabinet with the Civic Democratic Alliance and the Christian and Democratic Union – Czechoslovak People’s Party (KDU-ČSL) (Figure 6). The Civic Democrats argued for urgent reforms, and criticised the Civic Forum for failing to bring about change and for the inconsistent dismantling of the old Communist power structures (ODS 1992). They pledged rapid privatisation to create ‘a market economy with plenty of work opportunities because only this would enable people to provide for their needs as they see fit’ and suggested reducing social provision to a safety net: ‘[s]ocial policy must focus itself on real social problems, especially providing for those who cannot provide for themselves’ (ibid.). The Civic Democrats supported the separation of pensions and health insurance, from the state budget into independent public funds generating their own income, and the establishment of private insurance funds to create ‘significant investment capital which has a healthy influence on the whole economy’ (ibid.).

**Figure 6: Summary of the 1992 Parliamentary election results**



Source: ČSÚ (n.d.)

Unlike the Civic Democrats, who advocated a free market economy with a complementary social net, the Christian Democrats argued for a ‘market economy with a

<sup>54</sup> In coalition with the Christian Democratic Party (KDS) – a small party which later merged into the Civic Democratic Party.

substantial social and ecological dimension' including a 'well-considered social program: a trampoline instead of a net which puts people back into active life' (KDU-ČSL 1992). The Christian Democrats pledged support to families, women, young people, pensioners and the unemployed. To realise their social programme, they argued for the maximum reduction of the role of the state, strengthening the role of self-governing local authorities, and for a public-private mix in welfare provision. In health policy, the Christian Democrats pledged 'necessary health care for all', 'humanisation of health services', health care provision through private, public, religious and municipal organisations, choice of health insurance funds, and the protection of health professionals' rights (ibid.).

Another party in the government coalition, the Civic Democratic Alliance, adopted the most radical free-market stance, arguing for a 'market without adjectives [such as social]', 'protection of the market forces', reduction of state administration and rapid privatisation (ODA 1992). The Civic Democratic Alliance proposed moving responsibility for welfare away from the state, towards the individual, families and charities. They stated that health is, above all, a personal responsibility and proposed incentives for local authorities, charities, churches, employers and individuals themselves to participate in health care financing. The Civic Democratic Alliance believed that 'every property must have its proprietor' and hence argued for maximum private ownership in health care (ibid), including transforming large state hospitals into public institutions and selling most health care facilities to doctors. In doing so, they pledged to ban foreign capital from health care privatisation and ensure low prices for Czech doctors, who were 'decapitalised' under Communist rule (ibid.). Moreover, the Civic Democratic Alliance pledged to promote the social standing of doctors and bring their remuneration, relative to other professions, in line with developed European countries.

Although the government coalition had only 105 of 200 Parliamentary seats, there was no solid opposition because the main antagonists of the Civic Democratic Party, the Civic Movement, failed to gain even a single seat. Another 44 seats were scattered evenly among the one-issue Autonomous Democrats, populist Republicans, and Liberal-Social

Union, comprised of the Greens, Agrarians and Socialists. They shared a liberal political agenda, but did not have clear economic or social policies (including health care). The remaining seats belonged to the Communist-led Left Block (35 seats) and Social Democrats (16 seats), who despite ideological similarities, did not openly co-operate. Both the Left Block and the Social Democrats advocated a meaningful role for the state in the economy or, as the latter put it, against a return to ‘19<sup>th</sup> century capitalism with the unregulated market and minimum social welfare’ (ČSSD 1992). Both the Social Democrats and Left Block argued for phased privatisation, with a leading role for employees, but neither elaborated detailed health policies. The Left Block advocated the preservation of universal and free health care, on the basis of public health insurance, and emphasised that development of private health care should not jeopardise the availability of free health care (Levý blok 1992). Likewise, the Social Democrats maintained that quality health care should be available to everyone, regardless of ability to pay (ČSSD 1992).

### ***New Health Minister Petr Lom***

During the negotiation of the coalition agreement, the Health Minister’s portfolio was contested by the Civic Democratic Party and Christian and Democratic Union (ČTK 1992c). Eventually the Civic Democratic Party won and their Prime Minister, Václav Klaus, appointed Petr Lom the new Health Minister. This clearly indicated Klaus’ commitment to fast-track market-oriented reforms in health care. On the day of the Velvet Revolution, Lom celebrated his graduation from the School of Marxism-Leninism, which was obligatory for any non-member of the Communist Party hoping for a high managerial position in the Communist-run health care system (Jaroš interview 2006), but he soon adopted liberal-democratic ideas and, after the split of the Civic Forum, joined Klaus’ Civic Democratic Party. During his tenure as Chairman of the Parliamentary Health Committee, Lom advocated rapid market-oriented reforms in health care and harshly criticised the incumbent Health Minister, Bojar, for slow policy change.

The Government Declaration put health care among its priorities, pledging to ‘substantially improve the level of health care services and bring it up to the European

standard' (Vláda ČR 1992). The government acknowledged the necessity to increase citizens' responsibility for their own health, but agreed that the state would guarantee the availability of health care for everyone while it was transformed in order to (ibid.):

- begin and carry out privatisation of health care facilities;
- create conditions for the development of private health care facilities to build a whole non-state health care network alongside the state one;
- separate the health insurance fund from the state budget and complete the sickness insurance system;
- respect the principles of economic calculation in the whole health sector;
- restore the dignified standing of doctors and other health professionals in society through improved quality of medical education, health care privatisation, and health insurance.

In his inaugural press-conference, Minister Lom reiterated these measures and stressed that his foremost task was to achieve adequate remuneration for health professionals through the privatisation of medical practice (ČTK 1992f). In his early days in office, he also strove to fast-track the privatisation of health care facilities and envisaged beginning transfers of state property to new owners as soon as December 1992 (ČTK 1992i).

Party representation in the Parliamentary Health Committee was favourable to the government's plans to transform health care. Ten of the twenty committee members represented the ruling coalition, including Chairman Martin Syka and six others from the Civic Democratic Party, two from the Civic Democratic Alliance and one from the Christian and Democratic Union (ČNR 1992a). Four other committee members represented the Autonomous Democrats, the Liberal-Social Union and the Republicans, who shared a liberal agenda and supported market-oriented reforms. Only a minority of the Health Committee were drawn from the left-wing parties advocating phased privatisation (two Social Democrats and four from the Left Block).

## ***Privatisation in health care***

### **A chequered start**

The new government quickly and successfully started health care privatisation with the outpatient sector. Consequently, the number of health care providers tripled by the end of 1992. Compared to the total of 929 state health care providers with legal personhood in February 1992, there were already 2,953 non-state and 1,012 state health care providers by December 1992 (Table 6).

**Table 6: Health care providers with legal personhood, 1990-95**

	STATE			NON-STATE			TOTAL
	Health Ministry	District state authorities	Total	Local self-governance authorities	Private	Total	
December 1990	49	<sup>1</sup> 93	142	0	0	0	142
December 1991	178	252	430	0	0	0	430
February 1992 <sup>2</sup>	182	747	929	0	0	0	929
December 1992	179	833	1,012	n/a	n/a	2,953	3,965
December 1993	224	2,491	2,715	n/a	n/a	14,461	17,176
December 1994	261	1,711	1,972	463	19,850	20,313	22,285
December 1995 (rounded up)	220	1,100	1,320	500	22,000 <sup>3</sup>	22,500	23,320

Source: Kalina & Jaroš (2005)

<sup>1</sup>regional and district health authorities; <sup>2</sup>after the abolition of district health authorities;

<sup>3</sup>including 17,000 private practices

In my analysis, this success was due to a combination of positive and negative incentives and low capital intensity of outpatient care. On the positive side, many outpatient doctors welcomed the opportunity to establish their own practices because the state health system infringed on their independence, bureaucratised the doctor-patient relationship, and did not reward them according to the quality of health services provided (Kudyn interview 2006). On the negative side, those who wanted to continue practicing medicine in the outpatient sector had to comply with the government and register as private doctors. As the Chairman of the Health and Social Care Trade Union observed, the Health Ministry constantly blamed doctors who resisted privatisation for incompetence (Schlanger 2001). Most importantly, privatisation in non-specialised outpatient sector had low capital

intensity. Doctors just needed to pay legal fees to register their practices, find a place to practice and secure equipment as basic as a stethoscope. Subsequently, private doctors rented their former offices and equipment, privatising them several years later, individually or in co-operation with colleagues, or practiced from their homes or elsewhere (Kudyn interview 2006).

The transfer of health care facilities to new owners did not commence in 1992. The list prepared by the previous government was published in early July, but the new government amended it, extending the deadline for submission of privatisation projects until 07.12.1992 (Usnesení vlády ČR č. 510/1992; Usnesení vlády ČR č. 553/1992; Usnesení vlády ČR č. 562/1992). Altogether, 569 health care facilities (including pharmacy networks) were enlisted for privatisation and subsequently attracted approximately 6,000 privatisation projects (ČTK 1993p), predominantly targeting individual units, rather than entire health care facilities and pharmacy networks. Moreover, the quality of these projects was much lower than expected. The Health Ministry became especially concerned by the economic and legal standards of submitted projects (Lom 1993), but hoped it would be possible to privatise about 50% of health care facilities (ČTK 1993o).

The low quality of the submitted privatisation projects can be explained by a number of factors. First, ‘doctors were above all doctors not businessmen and hence it was more difficult for them than for those employed in industry or services to make sense of regulations’ (Papeš 2005, p.11). Second, as everywhere, privatisation in health care was characterised by the asymmetry of information. In 1992-93, almost two-thirds of privatised firms were privatised by their managers (Kortba 1994). As it was obligatory for the managers of health care facilities to submit a privatisation project, they could tamper with the books to privatise their facilities on favourable terms or simply to safeguard their jobs, by denying information to potential buyers and arguing for retention of their facilities in public ownership. Lastly, given economic uncertainty, associated with the novelty of health insurance and growing operating costs of health care facilities, it was challenging to make a compelling business case for the privatisation of health care

facilities for continued health care provision. Arguably, this would not be a problem for foreign investors, but the Privatisation Ministry did not welcome foreign capital: '[i]n no case do we want to let foreign capital in health care' (Háva & Kružík 1995, p.58).

### **Lack of specific policy**

Once privatisation projects were submitted, and their poor quality became evident, Minister Lom was criticised for the lack of a specific policy for privatising health care facilities. If, under new owners, these went bankrupt or stopped providing a full range of health services, the government would no longer be able to guarantee Czech citizens their Constitutional right to health care. The Health Ministry recognised that privatisation could threaten continued provision of health care only when projects were being submitted. The Health Ministry addressed this threat by instructing district authorities and privatisation commissions to evaluate submitted privatisation projects in a way that guaranteed the continued public ownership of a minimal network of health care facilities (Háva & Kružík 1995, p.58). Minister Lom believed that this network was sufficient to ensure continued provision of health care, and advocated proceeding with the approval of privatisation projects (ČTK 1993o). However, two partner parties in the governing coalition, the Civic Democratic Alliance and the Christian Democratic Union, disagreed, criticising Lom for lacking specific policy for health care facility privatisation.

Privatisation Minister Skalický, from the Civic Democratic Alliance, became Lom's most vocal critic, even demanding his resignation (Kalina 2005). The Civic Democratic Alliance advocated rapid privatisation, pledging to sell most health care facilities to doctors at discounted prices, while transforming large state hospitals into non-profit institutions with mixed public and private ownership (ODA 1992), but the Civic Democratic Alliance did not have a policy to fulfil this pledge. It is important to realise that the role of the Health Ministry in privatisation was extremely limited. The Privatisation Ministry was responsible for the privatisation of health care facilities and the Privatisation Minister only sought the agreement of the Health Minister on privatisation of inpatient and blood transfusion facilities (Usnesení vlády ČR č. 454/1992). Furthermore, former Privatisation Minister Ježek, also a member of the Civic

Democratic Alliance, did not have a specific policy for the privatisation of health care facilities, and hoped it could be accomplished on general terms. When the poor quality of the submitted privatisation projects raised questions about the privatisation of health care facilities on general terms, Minister Skalický advocated defining a minimally-required network of health care facilities before privatisation, and expected Lom to provide clear guidance on which facilities to privatise (Kalina 2005). I would argue that Minister Skalický also criticised Minister Lom to shift responsibility for the inevitable setback of rapid privatisation and diffuse blame from himself and his party for the lack of specific policy for health care privatisation. Minister Lom was elected on a rapid privatisation ticket, and so it was in his interest to privatise on general terms, rather than take the time to devise a specific policy. Plausibly, Lom argued against the need for a specific policy to avoid blame for the inevitable setback of privatisation.

Another strong criticism of Minister Lom came from the Christian and Democratic Unit. Unlike the Civic Democratic Party and the Civic Democratic Alliance, the Christian Democrats were not committed to rapid privatisation. The Christian Democrats had their main support base in the periphery and promoted the interests of local authorities. They worried that rapid privatisation endangered the continued provision of health care; because doctors could go bankrupt due to high costs of loan repayments and businessmen could buy health care facilities for commercial purposes (ČTK 1992b). Therefore, the Christian Democrats proposed: 1) privatisation of medical practice and transfer of health care facilities to local authorities free of charge, 2) privatisation of health care facilities 2-4 years later, to allow doctors time to calculate the profitability of their practices (ibid.). Neither the Civic Democratic Party nor the Civic Democratic Alliance rejected the possibility of transferring health care facilities which failed to attract serious privatisation projects to local authorities, but both parties opposed phased privatisation and wholesale transfer of health care facilities to local authorities, because this would leave health care facilities without definitive owners (ČTK 1993b).

## **Categorisation of health care facilities**

The 'economic ministers' discarded the Christian Democrats's proposal for phased privatisation, but agreed with the Privatisation Minister that a specific health care privatisation policy was required. The Prime Minister's advisors drafted proposals to divide all health care facilities into three broad categories to build a definitive minimal network of health care facilities prior to privatisation (Kalina 2005), which were subsequently elaborated by the Privatisation and Health Ministries and adopted as official government policy (Usnesení vlády ČR č. 137/1993). Accordingly, the Health Ministry was charged with dividing all health care facilities into those that could (ibid.):

- A. Be freely privatised; new proprietors being obliged to provide health care or public health services for at least 10 years but not having guaranteed contracts with health insurance funds or the state.
- B. Be privatised on restricted conditions; new proprietors being obliged to continue providing a specified volume of health services for at least 10 years. Additional health services do not have guaranteed contracts with health insurance funds or the state.
- C. Not be privatised, or were deemed inappropriate for privatisation at that time.

Further, the Health Ministry was to review submitted privatisation projects on a district basis, with district authorities obliged to submit their proposals for categorisation to the Health Ministry, whose representatives would visit individual districts to make categorisation decisions, plan the volume of services for the health care facilities under category B and review the submitted privatisation projects, before forwarding them to the Privatisation Ministry for approval (VSPZ 1993). The 'economic ministers' resolved that the prevalent method of privatisation would be direct sale to proprietors chosen by the Privatisation Commission of the National Property Fund.

The new policy clearly demonstrated that the government did not honour its pledge to 'respect the principles of economic calculation in the whole health sector' (Vláda ČR 1992). It was adopted four months after privatisation projects were submitted, violating the economic calculations underlying approximately one-third of the submitted privatisation projects, which under the new policy fell into category B. The Medical Chamber sided with doctors affected by changes in privatisation policy, opposing further exemption of health care facilities from privatisation because it could lead to the

conservation of the existing network of health care facilities, and demanding that representatives of the Medical Chamber be included in the categorisation decision-making (ČTK 1993d). However, the ‘economic ministers’ ignored the Medical Chamber, simply pursuing the new privatisation policy on the basis of their political calculations and at the expense of the doctors affected by the change of rules. As indicated by PM Klaus, political calculation of the self-interested ‘economic ministers’ was based on the fear of losing their jobs: ‘the government, not the health insurance fund, would be responsible for a potential breakdown in health care’ (ČTK 1993s).

The same political calculation explains why the new policy was adopted, at the expense of a free market and decentralised governance. The previous list of health care facilities for privatisation was compiled by district authorities, but now the Health Ministry became responsible for the categorisation of health care facilities and planning the volume of health services for category B health care facilities. Interestingly, the government couched the exemption of certain health care facilities from privatisation, and plans for others, in market terms, i.e. regulation of ‘local monopolies’ (Usnesení vlády ČR č. 137/1993). But, instead of breaking down and restructuring these ‘local monopolies’ under the influence of market forces, they acted to preserve the status quo, showing that the ‘economic ministers’ acted to preserve their jobs rather than adhering to free market ideology.

The categorisation of health care facilities proceeded slowly. It started in late March 1993 but, by June 1993, was fully completed only in eight districts; in nine districts it was completed pending approval of the Privatisation Ministry; in eight districts it was under way; and in six districts it was expected to be completed by the end of June (ČTK 1993i). Although Minister Lom claimed that categorisation would be fully completed in the autumn of 1993 (ibid.), this did not seem possible, because the Health Ministry’s Privatisation Department had only 15 employees and could not conduct categorisation in many districts simultaneously. Assuming that the approval of the Privatisation Ministry would not take additional time and that in the districts in which the categorisation was

under way it was half-finished, we can estimate the approximate speed of categorisation  $X$  from the following equation:

$$12weeks = 8X + 9X + 6X + 2 \times \frac{1}{2}X; X = 12weeks / 24; X = \frac{1}{2} week$$

At that time, the Czech Republic had 75 districts and 10 quarters of Prague with district status, i.e. 85 districts altogether. If approximately half a week was required to categorise one district, then it would take 42.5 consecutive weeks to categorise the whole country. Accordingly, categorisation would have been completed by February 1994, rather than autumn 1993. Obviously, this was unacceptable to a government still preaching rapid privatisation, so Minister Lom was criticised for the slowness of categorisation.

### ***Politicisation of health policy-making***

The way the new privatisation policy was adopted demonstrated that health policy-making was subject to political calculation by a few strategically positioned individuals in the government, and to power relations between, them rather than inclusive and informed policy debate. Just as the ‘economic ministers’ made decisions on the basis of their political goals and minimised scrutiny of their policies, Minister Lom avoided expert advice and minimised outside influence in the Health Ministry’s agenda, relying excessively on his own judgement and the counsel of a few trusted advisers, rather than on broad policy analysis and independent advice (Háva interview 2006b). Whereas the previous Health Minister invited US experts to help develop legislation on non-profit health care organisations, Lom expelled them from the Health Ministry (ibid.). Moreover, he abolished the Institute of Social Medicine and Organisation of Health Care, and even considered leaving the World Health Organisation (WHO). This suggests that policy-making became extremely politicised and the flow of ideas during health policy deliberation was subjected to Lom’s political utility calculations.

### **Institute of Social Medicine and Organisation of Health Care abolished**

After the fall of Communism, researchers from the Institute of Social Medicine and Organisation of Health Care led a working group that made the first comprehensive

proposal for health care reform (SKUPR 1990) and participated in developing a proposal for decentralised health insurance (Burda *et al.* 1991). However, the Institute struggled to communicate its message to previous Health Minister, Bojar, because his policy advisors vigorously protected their influence on the Health Ministry's agenda (Papeš 2005, p.15; Jaroš interview 2006). After the closure of the Health Ministry's Health Policy Department in the run up to the 1992 elections, the Institute remained the only professional body engaged in permanent health policy research and analysis. The Institute started a new research programme into the 'Possibilities of Health Care Administration in the Liberal-democratic System under the Conditions of Decentralisation and Privatisation', to scrutinise recent policy change and produce new recommendations (Papeš & Gladkij 1992). Shortly after the election, the Institute's senior management submitted to Minister Lom a document analysing recent policy changes in health care and advocating an increased role for the Institute in developing health policy (*ibid.*). Instead, Lom abolished the Institute, perhaps to avoid scrutiny of his policies, to use its funding elsewhere, or both.

### **Minister Lom considers leaving World Health Organisation**

Under the Civic Forum government, the Health Ministry actively sought the WHO's advice, using it to develop public health policies (MZ ČR 1990; Kučeřa *et al.* 1992), but this all changed under the Civic Democratic government. Similarly to PM Klaus, who believed that supranational organisations provided 'soft advice' for 'hard money' (Klaus 1997),<sup>55</sup> Minister Lom believed membership of the WHO was not worthwhile. He seriously considered leaving the WHO, arguing that the Czech annual contribution to the WHO coffers would be better spent on a modern hospital ward than membership of an organisation whose advice could not benefit Czech health care reform (Háva interview 2006a). The WHO was very slow in responding to the Czech health policy agenda. Only in March 1994, the WHO Regional Office for Europe established the Advisory Group on Health Care Reforms to 'play a *key role in leading the reform debate* towards the

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<sup>55</sup> This view was promoted in Parliament by the populist Republican Party, which advocated leaving the UN and other supranational organisations if membership in these organisations did not repay to the Czech Republic at least the costs of membership (SPR-RSČ 1992).

achievement of health gain' (WHO Europe 1996a, p.15), but this aspiration simply could not be fulfilled because Czech health policy-makers tended to implement reforms without debate and reform was already far under way. Moreover, the WHO's resources were limited and its advice was perceived as partisan and irrelevant. Because the WHO used to praise the Czech Communist health care system, and recruited Czech advisers to work in developing countries, Czech post-Communist reformers perceived the WHO as an outdated organisation for developing countries and irrelevant to the Czech Republic (Marx interview 2006). Furthermore, the WHO had no practical experience in market-oriented reforms and did not appreciate Czech political and economic conditions: 'they [the WHO] would just preach social justice without giving any practical advice' (Marx interview 2006). Altogether, the serious consideration given by Minister Lom to withdrawal from the WHO seems to have been based on the desire to avoid paying significant membership fees for irrelevant and potentially critical advice.

## ***Problems in health insurance***

### **General Health Insurance Contributions Act**

The General Health Insurance Fund was launched in 1992, funded throughout the year by the state budget. In 1993, it was to become an independent public agency with its own budget, drawn from health insurance contributions of employers, employees and the government. In order to define the level of contributions the government prepared and submitted to Parliament the General Health Insurance Contributions Act (Zákon č. 592/1992 Sb.). The importance of this Act is hard to overstate, because the level of health insurance contributions determined the budget of the General Health Insurance Fund, and thus the overall funding available to health care providers and the volume of health care services available to the population. The income of health professionals and success of health care privatisation also depended on this Act. Despite its paramount importance, Parliament had only a few weeks to deliberate on the Act, because it was only submitted in November 1992. Since, without this Act, the whole health care sector would be unable to function the following year, MPs had to pass it in 1992, without much deliberation or

substantial changes. Yet, brief deliberation was accompanied by a clash of interests between major health policy actors, revealing their strategic policy preferences.

While the Act was in preparation, different government, public and corporate actors estimated the needs of the General Health Insurance Fund for 1993 as follows (ČNR 1992d):

- Medical Chamber – Kč100bn
- General Health Insurance Fund – Kč80bn<sup>56</sup>
- Health Ministry – Kč65bn-Kč70bn
- Finance Ministry – Kč53.5bn-Kč58.5bn.

The Finance Ministry drafted the Act in accordance with its lowest estimate (Kč53.5bn), setting the general health insurance premium at 13.5%. Health insurance contributions for the employed were calculated as 13.5% of their gross wages and were split between employees (1/3<sup>rd</sup>) and employers (2/3<sup>rd</sup>s). For approximately half the population, including military servicemen, the unemployed, children, students and pensioners, health insurance contributions were paid by the state. These were calculated as 13.5% of the specially-defined base – 70% of the minimum wage. The self-employed paid health insurance contributions for themselves. These were calculated as 13.5% of another specially-defined base – 45% of their profits.

During the Parliamentary deliberations over the Act, the Medical Chamber attempted to increase the level of health insurance contributions. The leading force behind this move was Miroslav Čerbák, Vice President of the Medical Chamber and a member of the Parliamentary Health Committee affiliated with the Civic Democratic Alliance. He argued that the government simply did not know how to estimate the needs of the General Health Insurance Fund correctly (ČNR 1992d), maintaining that if it was to function without a deficit the general health insurance premium should be increased from 13.5% to 15%. As this proposal failed straightaway, he concentrated on increasing state health insurance contributions, initially proposing to increase the base for state health

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<sup>56</sup> Figures for the General Health Insurance Fund and Health Ministry refer to the initial estimates made by these agencies and subsequently leaked to the Medical Chamber. Minister Lom insisted that these figures were only early estimates and did not reflect the official positions of these agencies (ČNR 1992d).

insurance contributions from 70% to 120% of the minimum wage (ČTK 1992g); but the Parliamentary Health Committee amended this proposal and recommended that Parliament set the base at 100% of the minimum wage (VSPZ 1992), which would have raised the revenue of the General Health Insurance Fund from Kč53.5bn to Kč58.5bn, i.e. by 8.5%.

From the subsequent parliamentary debate, it appears that the positions of individual MPs on this recommendation were influenced by their individual career interests more than their professional or party loyalties. From the electoral manifesto of the Civic Democratic Alliance, we assume that they were committed to successful privatisation of health care facilities and higher remuneration of doctors (ODA 1992). Therefore, it was desirable for them to increase state health insurance contributions in order to increase doctors' pay and provide incentives to privatise health care facilities. However, Tomáš Ježek – a senior member of the Civic Democratic Alliance and Chairman of the National Property Fund – argued against his party colleague Čerbák's proposal to increase state health insurance contributions, urging MPs to defend the public interests against the 'medical lobby' (ČNR 1992d). Obviously, if Ježek had not toed the government line, he would have lost his post as Chairman of the National Property Fund. Furthermore, Martin Syka – a doctor-MP with the Civic Democratic Party and Chairman of the Parliamentary Health Committee – did not join the 'medical lobby' and rejected the proposal of his fellow doctor-MP Čerbák. If Syka had stepped out of the government line his days as Chairman of the Parliamentary Health Committee would have been numbered. Likewise, Petr Lom – a doctor-MP and Health Minister – did not join the 'medical lobby', vehemently opposing increased state health insurance contributions. Thus, high-flying doctors in Parliament and the government acted to promote their individual careers, rather than the interests of the medical profession. Like the Civic Democratic Alliance, the position of individual MPs from opposing parties on increased state health insurance contributions was determined by their individual careers, rather than their party affiliation. Whereas the Social Democrats and the Communists from the Parliamentary Health Committee supported the proposal to increase state health insurance contributions, their party colleagues from the Budget Committee and the Economy Committee opposed it (ČNR

1992d). Eventually, the proposal failed and the Act was passed according to the preferences of the Finance Ministry.

In May 1993, just seven months after the General Health Insurance Contributions Act was adopted, the government submitted to Parliament a proposal reducing the base for health insurance contributions of the self-employed (Zákon č. 161/1993 Sb.), from 45% of their profits to 35%. Again, high-flying doctor-MPs promoted their own careers, rather than the interests of the medical profession in higher health care expenditure. Minister Lom urged Parliament to pass the government proposal, to ease the tax burden for the self-employed, and did not perceive the subsequent decrease of the General Health Insurance Fund's revenue (Kč0.54bn, or 1%) as threatening sound health care financing (PSP 1993a). Similarly, the left-wing opposition did not unanimously object to the government proposal, even though it had strong implications for social justice. On the contrary, Tomáš Sojka – a businessman-MP for the Left Block and member of the Parliamentary Economy Committee – strongly supported the government proposal. Consequently, the government's proposal passed (ibid.).

### **'Financing by blame'**

The adoption of the General Health Insurance Contribution Act, with provisions for the overall revenue of the General Health Insurance Fund at just Kč53.5bn, and then a cutback of Kč0.54bn, threatened the General Health Insurance Fund with a deficit. The government and General Health Insurance Fund had three options to avoid this:

- reduce fee-for-service reimbursement rates for health care providers;
- reduce the volume of health services paid for by general health insurance;
- use a subsidy from the state budget to cover the deficit.

Reducing reimbursement rates for health care providers was the most straightforward way to balance the General Health Insurance Fund's budget. Fee-for-service reimbursement was based on a point system, whereby each item of health service was assigned a certain number of points and the Fund reimbursed providers every quarter for total accumulated points multiplied by the monetary value of a point. The latter was

reviewed by the General Health Insurance Fund quarterly, according to the availability of funds and inflation. Therefore, the General Health Insurance Fund could reduce reimbursement rates by reducing the monetary value of a point, or simply by not increasing it in line with inflation.

Second, reducing the volume of health services paid for by general health insurance was a possible, but difficult, way to offset the shortage of health care funding, because it meant leaving doctors without work and limiting the availability of health care for patients. Furthermore, the General Health Insurance Fund could not deny reimbursement to health care providers for delivered health services, because patients purchased health services for themselves. Patients could freely choose any health care provider and their purchasing power rested on their constitutional right to free health care. Nonetheless, Minister Lom tentatively proposed a number of ‘economisation’ measures to reduce the volume of health services paid for by the General Health Insurance Fund: shifting the costs of social hospitalisation (whereby older people are kept in hospitals for social care purposes) to the Labour and Social Affairs Ministry, introducing patient co-payments, controlling prescription of drugs and treatments, and replacing fee-for-service reimbursement with reimbursement through the Diagnosis-Related Groups (DRGs) (Lom 1993). However, even if Lom developed these tentative proposals into concrete policies, their ‘economising’ effect would not have been achieved quickly.

Third, using a subsidy from the state budget was the most feasible way to balance the budget of the General Health Insurance Fund in the short-run. Although, formally, the General Health Insurance Fund was an independent public agency, the Finance Ministry planned its budget and paid health insurance contributions for approximately half of the population. If the Finance Minister underestimated the needs of the General Health Insurance Funds in the first place, then it was still the responsibility of the Finance Ministry to balance the health insurance budget, to ensure the constitutional right of Czech citizens to free health care. Moreover, the political cost for the Finance Minister gambling that health insurance could function with a minimal budget were low. If the Director of the General Health Insurance Fund and Health Minister could not avoid a

deficit, the Finance Minister would be able to blame them for incompetence and demand better performance under threat of dismissal. As the Finance Minister was under pressure from the fellow ‘economic ministers’ to reduce taxes, it was more desirable for him to take this gamble, and adopt what we might call a ‘financing by blame’ approach, rather than setting general health insurance contributions at a higher level to begin with.

The new ‘financing by blame’ approach resembled the old Communist residual approach to health care financing, which aimed to use the state budget to achieve the highest attainable level of investment in the productive sector of the economy, and then allocate remaining funds to health care and other branches of the non-productive sector. The post-Communist approach aimed to achieve the lowest attainable level of taxation for the productive sector of the economy and use minimal taxes in order to finance health care and other social services. The hopes of post-Communist reformers that health insurance would make health care financing no longer subservient to the Finance Ministry did not materialise. Under the new regime, the Finance Ministry influenced legislative outcomes on the level of health insurance contributions, and thus the overall health insurance budget, controlled the schedule of payment for state health insurance contributions, and presided over decisions on the monetary value of fee-for-service reimbursement rates for health care providers.

### **Financial distress in health care**

Until 31.07.1992 hospitals were allocated funds upfront, according to historical budgets, but thereafter the General Health Insurance Fund reimbursed hospitals quarterly on a fee-for-service basis. Due to escalating running costs and insufficient reimbursement payments, many hospitals ran out of cash, experiencing shortages in medical supplies by the end of 1992. For example, Pod Petřínem Hospital was ‘short of everything’ and ‘nurses were washing used surgical gloves and rinsing plastic bedsheets and aprons, all of which, in better times, would have been thrown away’ (Simons 1992). Many hospitals experienced financial distress and could no longer meet running costs, including doctors’ salaries (ČTK 1993q). At the same time, the General Health Insurance Fund was unable to assist hospitals financially. As of 01.01.1993, the General Health Insurance Fund was

separated from the state budget and responsible for raising its budget directly from health insurance contributions, most of which were not scheduled to reach its accounts until March. The Fund advised hospital managers to secure commercial bank loans until March, but this was problematic for financially-distressed hospitals. Consequently, the Association of Hospitals and the Association of Small and Medium Type Hospitals demanded immediate upfront payments from the government to continue functioning until the scheduled reimbursement payment in March (ČTK 1993k). Eventually, the 'economic ministers' resolved to speed up the transfer of state health insurance contributions to the General Health Insurance Fund, to allow partial upfront reimbursement payments to the most affected hospitals. This only temporarily relieved financial pressure from hospitals, as they soon ran out of cash again before the next scheduled payment from the General Health Insurance Fund.

The root of hospitals' systematic financial distress was in growing running costs and insufficient fee-for-service reimbursement, associated with the low monetary value of the reimbursement point. In the third quarter of 1992, the Finance Ministry set this value at Kčs0.45, rather than the Kčs0.75 suggested by the General Health Insurance Fund or Kčs1.23 demanded by the Medical Chamber (ČTK 1992j). Even though Minister Lom had promised to the Medical Chamber that the value of the point would increase in the fourth quarter of 1992, it actually decreased. Fee-for-service reimbursement provided doctors with an opportunity to maximise their revenue by increasing the quantity of health services. In the fourth quarter of 1992 this went up by 25% (ČTK 1993g), as some outpatient doctors claimed reimbursement for points equivalent to 360 working hours per month (ČTK 1993v). Consequently, the General Health Insurance Fund had to devalue the point for state health care providers from Kč0.45 to Kč0.34, i.e. by 25% (ČTK 1993v). Although private outpatient doctors had more opportunities to increase health services than doctors in state hospitals, the value of the point was not devaluated for private doctors, to stimulate privatisation. Even though the value of the point rose to Kčs0.52, in the first quarter of 1993, for both state and private health care providers (ČTK 1993e), many state hospitals continued experiencing financial distress.

In such circumstances, hospital managers criticised the government for failing to provide sufficient funding for health care, demanding that the Health Minister increase the monetary value of the reimbursement point to a sufficient level. Given that the Finance Ministry presided over the decisions on the value of the reimbursement point, Minister Lom had no means to satisfy these demands. The fact that some hospitals managed to maintain sound finances gave him grounds to diffuse criticism; claiming that the value was sufficient and arguing that many hospitals were in a difficult financial situation due to managerial incompetence and proposing an audit inspection of financially-troubled hospitals (PSP 1993b). Unsurprisingly, this led to confrontation between Minister Lom and hospital associations.

The outpatient sector was also ridden with financial problems. Specialised outpatient care was still provided in state health care facilities, mainly hospitals, and therefore faced the same problems as hospitals. Because of the government's push for privatisation in the outpatient sector, by December 1992 there were three thousand non-state health care providers and in 1993 their number increased fivefold (Table 6, p.150). Private health care providers needed to secure contracts with the General Health Insurance Fund or emerging independent health insurance funds, but this was not always possible due to the considerable paperwork and limited administrative resources of health insurance funds. Moreover, those private health care providers that managed to secure contracts with the General Health Insurance Fund experienced delays in receiving reimbursement. Like hospital doctors, outpatient doctors were unhappy with low reimbursement rates. In particular, GPs faced large amounts of administrative paperwork associated with health and work incapacity certificates, which were not reimbursed or only at very low rates. In such circumstances, doctors from the Brno Crisis Centre threatened to strike, demanding either sufficient hourly reimbursement instead of fee-for-service reimbursement or state subsidies for private practices until fee-for-service reimbursement had reached sufficient levels (ČTK 1992d). However, Minister Lom rejected this demand outright, blaming the Brno doctors for their 'socialist thinking' and reluctance to embrace privatisation (ibid.).

## ***Growing unpopularity of government health policy***

### **Minister Lom's fall from grace with the medical profession**

Whereas, in his position as Chairman of the Parliamentary Health Committee, Petr Lom had become popular among the medical profession for criticising slow health care reforms and dysfunctional health insurance, his popularity waned soon after he took charge of the Health Ministry. Minister Lom's promise of quick privatisation and higher incomes for doctors contrasted with the apparent uncertainty over privatisation and financial distress in the health sector. The value of the reimbursement point was three times lower than doctors wanted and, when they increased output of health services to compensate, it was devalued to balance the General Health Insurance Fund budget. Effectively, doctors were made to learn the rules of the fee-for-service reimbursement game, only for the government to change them (to its advantage) as soon as doctors learnt to play.

During his time as Chairman of the Parliamentary Health Committee, Petr Lom initiated the Medical Chambers Act and promoted the interests of the medical profession, but this all changed once he won Health Minister's office. As shown above, during the deliberation of the Health Insurance Contributions Act, Minister Lom defended the interests of the 'economic ministers', openly acting against the interests of the medical profession. Furthermore, he took issue with the leaders of medical chambers over their exclusive licensing rights, which he had formerly advocated. He criticised the decision of the Pharmaceutical Chamber to charge non-pharmacists a licensing fee for opening a pharmacy, which was 1,000 times higher than that for pharmacists, as 'anti-market' because it discriminated against entrepreneurs seeking entry to the pharmaceutical market (ČTK 1992e). Later, he attempted to scrap the exclusive licensing rights of medical chambers and pass legislation allowing the state to issue licences for medical, pharmaceutical and dental care facilities if the relevant chambers had failed to do so in 60 days (ČTK 1993f). This led to confrontation between Minister Lom and the leaders of the medical profession, because this law would have decreased the power and income of the Medical, Pharmaceutical and Dental Chambers.

The confrontation between Minister Lom and the medical profession spilt over in the media, damaging his public standing. The press was keen on publishing stories about doctors confused by health insurance and privatisation, shortages in drugs and medical supplies, and hospitals on the brink of closure. But Lom maintained that reforms were progressing successfully, blaming the press for terrifying the public with ungrounded information about the collapse of health care (ČTK 1993h). Television appearances did Lom no favours either; for example, after a television debate on the environmental and health problems in North Bohemia the local press concluded that even a layman had a better understanding of these problems than Minister Lom (Severočeský deník 13.02.1993; ČTK 1993r). As early as February 1993 the press were discussing the possibility of Lom's dismissal and speculating about his successors (LN 13.02.1992).

Finally, even members of Minister Lom's own party did not spare him criticism. In doing so, members of the Parliamentary Health Committee played a major role – without questioning the government policies or breaking the party line, they criticised the way in which these were being implemented. The interest of the committee members was to increase their rather limited powers and influence policy-making in order to promote their own issues, progress in the party ranks and, ultimately, propel themselves into the government. They criticised Minister Lom for making policy decisions without consulting the Health Committee, slowing down health care reform, and for various issues that slipped Health Minister's attention. One of Lom's most active antagonists in the Health Committee was Civic Democrat Luděk Rubáš, who ran the Health Committee's Commission on the Distribution of Health Care Investment Subsidy and pro-actively advocated measures to rationalise health insurance financing.

### **Change of Health Minister**

It is difficult to ascertain whether it was the slow pace of privatisation, Minister Lom's confrontation with the medical profession, the unfavourable coverage of health care reform in the media, the antipathy of PM Klaus towards Minister Lom, or the combination of all these factors that triggered an investigation of the Control Ministry

into Lom's conduct.<sup>57</sup> What we do know is that the results of this investigation were presented at the Cabinet meeting in June and then leaked in the press. The investigation concluded that the privatisation of health care facilities was accompanied by the following mistakes (MfD 12.06.1993; cited in Kalina 2005):

- a) privatisation had started without the required legislation and policy;
- b) no decision was taken on the minimal network of hospitals and ambulatory clinics;
- c) slow categorisation of health care facilities;
- d) the mission of privatisation commissions was not adequately fulfilled;
- e) the Health Ministry started privatisation with no knowledge of districts' health care needs and the value of health care facilities;
- f) the Health Ministry could not eliminate private interests, which were often in play;
- g) health care property was often sold off or rented out without the government's agreement, leading to the uncontrolled disappearance of property before the approval of the privatisation project.

What is striking about this investigation is a political bias against the Health Ministry, which had little power to prevent these mistakes. The Privatisation Ministry was responsible for the privatisation of health care facilities, and started it with no specific policy, before Minister Lom's appointment. If Minister Lom had argued for postponing privatisation in order to develop a specific policy, estimate the districts' health care needs, define a minimal network of public health care facilities, categorise health care facilities for the purpose of privatisation, etc. then he would have been criticised by the 'economic ministers' for not complying with rapid privatisation. Furthermore, the administrative capacities of the Health Ministry to estimate and plan for the districts' health care needs in a timely manner were extremely limited. The only organisations able to do this professionally were health authorities, but these were dissolved before health care privatisation started. Lastly, by postponing privatisation of health care facilities in order to develop and implement the categorisation policy, the 'economic ministers' themselves gave incentives to district authorities and managers of health care facilities to liquidate health care assets unlawfully. At any rate, such unlawful activities were concentrated on the local level, rather than in the Health Ministry. For example, in 1995,

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<sup>57</sup> The source of the antipathy of PM Klaus towards Minister Lom could have been as trivial as Lom's greater height than that of Klaus, who was noted to be proud of his physique; following Lom's dismissal, PM Klaus became the tallest member of the Cabinet (Bojar interview 2006).

the Director of the Privatisation Department at the Health Ministry was arrested for the unlawful privatisation of health care facilities, which occurred during his work in the district privatisation commission, rather than in the Health Ministry (ČTK 1995i).

In my analysis, this investigation was sponsored by the ‘economic ministers’ to diffuse blame for their mistakes, associated with slow privatisation and financial distress in health care. Like Minister Lom, the ‘economic ministers’ preferred not to change their policies but to blame subordinates instead. Shortly after the results leaked in the media, Minister Lom learnt from the morning television news that PM Klaus had dismissed him. PM Klaus stated that the reasons for Lom’s discharge concerned specific mistakes, as much as his general inability ‘to defend’ the enacted reforms before the public and the medical profession: ‘the health service cannot always be on the defensive, as it has been’ (ČTK 1993u). As this statement suggests, PM Klaus changed Health Minister for tactical purposes, i.e. to switch the tactics of health policy implementation from defence to offence, without changing government policy.

## **CHAPTER 8: CIVIC DEMOCRATIC HEALTH MINISTER RUBÁŠ, 1993-95**

PM Klaus nominated Luděk Rubáš MP to lead the health policy implementation offensive. Rubáš had the ability ‘to fight as a lion’, as he demonstrated playing tennis with his party colleagues (ČTK 1993i) and proved Lom’s most vocal critic in the Parliamentary Health Committee. He fought his political battles with entrepreneurial ingenuity: to win his parliamentary seat in 1992 he produced both a strong health policy programme and a hard liqueur, branded after himself (Weinberger 1999). Like his predecessors, Minister Rubáš was a doctor, but unlike them he had managerial experience both at the state (as Director of a District Institution of National Health in 1990-1991) and hospital level (as Director of Kolín Hospital since 1991). He was perhaps the best hospital manager in the country, because he managed to sell a hospital building to the General Health Insurance Fund for more than it had ever paid for similar properties (LN 11.01.1994).

From day one in office, Minister Rubáš adopted a clear managerial approach to health policy implementation. He argued that the Health Ministry had low administrative efficiency as it was ridden with ‘chaos, broken communication and conflicts between individual departments’, the Economic Department lacked even basic information on health care facilities falling under its administrative remit, and large hospitals were almost uncontrollable (ČTK 1993c, 1993w). Consequently, he reviewed the Health Ministry’s administrative structure, replaced half the senior managers, and increased the Health Ministry’s personnel, especially in the Privatisation Department, which at the time had only 15 employees (ibid.). Minister Rubáš vowed to stick to the Civic Democrats’ political goals, such as strengthening the citizen’s responsibility for their own health, reducing the role of the state and speeding up privatisation, but stressed the need to rationalise health care financing and administration (ČTK 1993c).

## ***Privatisation of health care facilities***

### **Weak opposition to privatisation**

The government's commitment to rapid and extensive privatisation in health care was heavily criticised by the Czech Helsinki Committee – a human rights watchdog established by dissidents during Communist rule. In a series of open letters to Minister Rubáš and his predecessor, the Helsinki Committee criticised the commercialisation of medicine as unethical and privatisation of health care facilities as 'unconstitutional' because 'the right to socialised health protection is an indispensable part of human and civil rights and requires active state health care [provision] for all citizens' (ČTK 1993a, 1994a). Furthermore, the Helsinki Committee criticised Rubáš for privatising health care facilities according to his ideological beliefs in self-regulatory market mechanisms, rather than according to a law passed by Parliament (ibid.). The Helsinki Committee rejected wholesale privatisation of health care facilities as unlawful and unjust: 'the property of all citizens is expropriated uncontrollably for profit of a few individuals' (ibid.). Instead, the Helsinki Committee argued the best way to eliminate the state monopoly in health care provision was to transfer health care facilities to local authorities free of charge (ibid.).

The Helsinki Committee's campaign failed to make any policy impact because the government committed itself to rapid privatisation and was not interested in entering public debate with former dissidents. The Helsinki Committee's claim that privatisation was unconstitutional should have been investigated by ordinary courts, but these were not prepared to apply the Constitution directly, or had interests in not doing so because they were appointed by the government. Meanwhile, the public were more interested in the exchange rate between the Czech crown and the German mark and in what PM Klaus had to say about privatisation than what former dissidents thought. Furthermore, the privatised media had a pro-privatisation bias. For example, during Communist rule the newspaper *MF Dnes* was an organ of the Socialist Youth Union (SSM), also known as *Komsomol*, and propagated the virtues of socialism; after the Velvet Revolution the staff quickly privatised the newspaper and switched to extolling the virtues of capitalism. When PM Klaus announced a new wave of privatisation, this 'market *Komsomol*' newspaper enthusiastically concluded 'some Western politicians may feel embarrassed

because the state in their countries will own more than in the Czech Republic' (MfD 10.08.1995).

### **Privatisation offensive**

Although the ex-Minister Lom argued that the pace of privatisation could not and must not be increased (ČTK 1993n), Rubáš pledged to accelerate privatisation and soon did so. He agreed with the Privatisation Minister to prioritise the categorisation of outpatient facilities, pharmacies and other health care facilities that could be freely privatised (category A) and to abandon the previous approach, whereby the government reviewed privatisation projects for all categories of health care facilities on a district-by-district basis (Kalina 2005). Effectively, the new approach prioritised the speed of privatisation over creating a definitive network of public health care facilities prior to privatisation. Yet, the new approach gave the Health Ministry and district authorities more time to define the volume of compulsory health services for the category B health care facilities and to decide on their future owners. Thanks to this, the categorisation of health care facilities was completed in October 1993: out of 1,055 health care facilities, 646 (61%) were designated for privatisation and the rest as exempt or inappropriate for privatisation (Table 7). The government started reviewing privatisation projects in August 1993 and, by 1994, privatisation gathered momentum: the government approving approximately 120 projects monthly (ČTK 1994c).

**Table 7: Health care facilities with legal personhood by privatisation category, 1993**

Type of facility Privatisation category	In-patient	Out-patient	Pharmaceutical services	Mental health	Long-term care	Other	Total
A (unrestricted privatisation) + B (restricted privatisation)	166	371	76	3	14	16	646
C (exempt from privatisation)	127	43	23	11	14	191	409

Source: adapted from Polák (2003, p.132)

Altogether, the government received 5,450 privatisation projects (comprised of approximately 12,000 independent privatisation proposals) for approximately 9,000

privatisation units, comprising the 646 health care facilities designated for the second wave of privatisation (ČTK 1996w). The book value of these 646 facilities was relatively low – Kč25bn, i.e. just over 3% of the total book value of the state property in the second wave of privatisation (Kč780bn) (Loužek 2005).<sup>58</sup> The value of the health care facilities designated for privatisation and number of submitted privatisation projects were disproportionably distributed across different types of facilities. Whereas inpatient facilities represented just over a quarter of all health care facilities designated for privatisation (166 out of 646), inpatient facilities carried almost three-quarters of the total book value of all health care facilities (Kč18.6bn out of Kč25bn) (ČTK 1994c). At the same time, the overwhelming majority of the submitted privatisation projects targeted outpatient facilities and pharmacies. Given that these had a relatively low asset value and capital intensity, spread across thousands of privatisation units, privatisation in the outpatient and pharmaceutical sectors required little capital investment from prospective buyers. Although the overall quality of the submitted privatisation projects was poor, the high number of projects for outpatient facilities and pharmacies ensured that these had more quality projects than inpatient facilities. In my analysis, a combination of low capital investments and a high number of privatisation projects determined the success of privatisation in the outpatient and pharmaceutical sectors.

### ***Success in the outpatient and pharmaceutical sectors***

Given that outpatient facilities had relatively low asset value and capital intensity, privatisation of medical practice and outpatient health care facilities succeeded, but led to the disintegration of outpatient health care provision. During Communist rule, highly specialised outpatient care was provided by inpatient or designated outpatient departments in hospitals, because this type of care required capital-intensive equipment and continuous practice of certain medical procedures. Less specialised outpatient care was provided by polyclinics, housing numerous GP surgeries, specialised clinics and diagnostic services. In addition to economies of scale on equipment for the state and the benefits of collaboration for doctors, polyclinics provided patients with integrated

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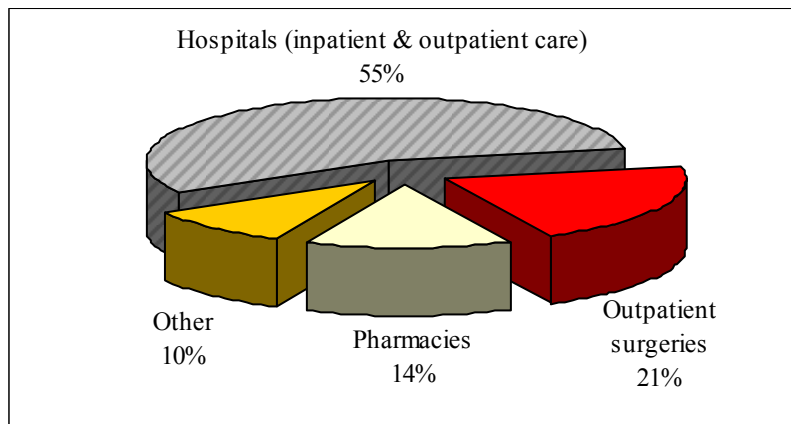
<sup>58</sup> The first wave of privatisation reached the sales of Kč31bn and restitutions were valued in the range of Kč75-125bn (Kortba 1994).

outpatient care. Compared to visiting separate clinics for each type of outpatient service, such ‘one-stop shop’ polyclinics saved patients much time and effort. However, patients from small communities, without their own polyclinics, often had to travel miles just to see a GP. As a result of privatisation, the ‘one-stop shop’ approach to outpatient health care provision was abandoned. Outpatient polyclinics were often decomposed into single practices, then privatised. Where doctors privatised their offices and equipment, or rented these from new owners, polyclinics were unaffected by privatisation, but in many cases polyclinics either did not survive privatisation or no longer provided a full range of outpatient health services. In many cases, doctors left polyclinics because the new owners converted them, fully or partially, into offices for various businesses or imposed high rents on doctors. Moreover, many doctors left polyclinics voluntarily because they found better or cheaper places to practice, which were often more convenient both for them and their patients (Jukl 1993). Likewise, new private doctors established practices in their private homes or places other than polyclinics. Throughout the 1990s, the total number of outpatient doctors remained stable, but by 1996 only 3% of all outpatient doctors worked in state outpatient facilities (Vepřek *et al.* 2002). At the same time, highly specialised outpatient care, which accounts for approximately a quarter of all outpatient care, was unaffected by privatisation and still provided in state hospitals (Jaroš *et al.* 2005).

During Communist rule, pharmacies were run by district pharmaceutical services and hospitals had their own pharmacies and drug dispensaries. Whereas hospitals mostly retained their pharmacies, district pharmaceutical services were decomposed into individual pharmacies and then privatised. New private pharmacies were also established, so pharmaceutical services developed in the opposite direction than during Communist rule. If, between 1950 and 1990, the total number of pharmacies fell 12% from 1,042 to 917, between 1990 and 2006 this number grew by 272% from 917 to 2,497 (ÚZIS 2007b). However, between 1990 and 2006, the total number of pharmacists grew only by 144% from 3,962 to 5,694 (*ibid.*). By 1996, only 11% of pharmacists worked in state pharmacies and by 2006 this declined to 5% (*ibid.*).

The successful implementation of privatisation in the outpatient and pharmaceutical sectors ensured that approximately one-third of health care services were delivered through private institutions. In order to privatise most health care provision, the government needed to privatise, above all, inpatient facilities because these delivered more than half of all health care (Figure 7). Moreover, hospitals employed over 40% of all doctors and over 50% of health care personnel (ÚZIS 1994).

**Figure 7: General Health Insurance Fund expenditure by the type of facility, 1993**



Source: ÚZIS (1994)

### ***Failure in the inpatient sector***

In contrast to the outpatient and pharmaceutical sectors, inpatient facilities had a high asset value and capital intensity, and could not be broken into many privatisation units. Therefore, privatisation in the inpatient sector required high capital investment from prospective buyers. Given that doctors lacked their own capital, they needed bank loans, which proved a major problem because the banks themselves did not have much capital and lending money for privatisation of inpatient health care facilities was risky. Privatisation in industry and agriculture was sponsored by the ‘economic ministers’: the National Property Fund deposited capital raised during the first wave of privatisation in earmarked funds in state-controlled ČS Bank in 1991; and thereafter used this capital to provide privatisation loans at a subsidised rate: 8% lower than a standard commercial rate. Only in late 1992 did the National Property Fund agree to create an earmarked fund worth Kč20m to subsidise the interest rate of loans for the privatisation of outpatient

health care facilities by 8% (Kalina 2005). Also, the European Community's PHARE Programme provided funds to the Czech ASKLEPIOS Programme, which subsidised small and medium-size privatisation in health care (ibid.). However, the government did not create a fund to subsidise loans for the privatisation of inpatient health care facilities because the 'economic ministers' prioritised privatisation in the productive sector of the economy. Without state subsidies, the banks were not interested in issuing loans for privatising inpatient health care facilities, because hospitals were in financial distress due to low reimbursement rates. Also, the 'economic ministers' were unwilling to raise reimbursement rates because it would require increasing taxes.

Health Minister Rubáš and Privatisation Minister Skalický objected to the wholesale transfer of health care facilities to local authorities, as advocated by the Christian Democrats. Both ministers agreed that it was desirable to transfer a limited number of health care facilities that could not be privatised to local authorities free of charge, to shift responsibility for maintaining these facilities from the state budget to local authorities. Local authorities were not in a position to become owners of large hospitals because these had running costs several times higher than the budgets of local authorities, required high capital investments, often had outstanding liabilities, and their catchment areas transcended the borders of local authorities. Yet, local authorities were interested in assuming ownership of pharmacies, outpatient facilities and small hospitals, because these were crucial for health care provision on their territory, feasible to maintain and could often be rented out to private doctors for profit. As a result of the government's drive to privatise everything possible, potentially profitable facilities were privatised and many local authorities either resisted a free transfer of loss-making facilities or struggled to maintain those that they accepted. In some cases, local authorities had to close down hospitals that they could not afford to maintain or return them to the state.

When, in 1994, it became evident that, without state subsidy, the privatisation of inpatient facilities would not succeed, Health Minister Rubáš and Privatisation Minister Skalický disagreed how to approach the privatisation of inpatient facilities. Minister Rubáš proposed a new health fund accumulating proceeds from the privatisation of health care

facilities, to provide subsidised loans for hospital privatisation and assist new owners with investment capital towards new medical equipment, but the ‘economic ministers’ did not support this proposal (Rubáš interview 2005). Privatisation Minister Skalický argued that many hospitals failed to attract economically sound privatisation projects and that it was in the public interest to postpone the privatisation of hospitals, on the basis of legislation for commercial enterprises, until the adoption of a law on non-profit organisation in order to convert those hospitals into public non-profit organisations. Finance Minister Kočárník, whose ministry was responsible preparing this law, also supported the conversion of large hospitals without economically sound privatisation projects into public non-profit organisations. Minister Rubáš opposed postponing privatisation and converting hospitals into non-profit organisations, because it would distort competition in health care by giving non-profit hospitals unfair tax advantages and remove incentives to improve the quality and efficiency of health services (ČTK 1994d). Nonetheless, Minister Skalický suspended the privatisation of 49 large hospitals and polyclinics with a view to converting them into non-profit organisations (MfD 16.12.1994). The law on non-profit organisations was adopted in September 1995, but did not help hospital privatisation because by that time most hospitals were on the brink of insolvency and the state had to bail them out. Therefore, Minister Skalický suspended the privatisation of 70 large health care facilities, including 60 hospitals, proposing that the government exempted them from privatisation until the stabilisation of health insurance financing (MfD 27.09.1995). Although the government rejected this proposal, they remained suspended from privatisation because of a lack of economically sound privatisation projects.

In 1995, hospital privatisation came to a standstill. By October 1995, the government approved the sale of 34 hospitals and transferred 32 hospitals to local authorities free of charge (ČTK 1995a-o). In addition, 46 new private inpatient facilities, including hospitals, were established (ibid.). These provided a very narrow range of services that were profitable under the existing public health insurance reimbursement rates or paid for directly by patients. In the following year, the government approved 2 more sales and 11 more free transfers (ČTK 1996v), before resolving to exempt 63 hospitals and 5

outpatient facilities from privatisation (Usnesení vlády ČR č. 372/1996). Essentially, this resolution implemented Minister Skalický's proposal of a year earlier, effectively terminating hospital privatisation.<sup>59</sup> It is important to appreciate that the termination of hospital privatisation was endogenous to the government and reflected the unwillingness of the 'economic ministers' to solve the main economic problem of hospital privatisation: lack of capital. The 'economic ministers' did not want to subsidise hospital privatisation through discounted loans, as they did in industry and agriculture, or to increase health insurance reimbursement rates or liberalise health care financing to make hospitals profitable enough for commercial privatisation loans. Altogether, hospital privatisation failed because health care was low on the agenda of the 'economic ministers'.

**Table 8: Hospitals and hospital capacities by the form of ownership, 1993-2000**

	1993	1994	1995	1996	1997	1998	1999	2000
Total no. of hospitals	189	199	207	208	217	216	203	198
- state	157	143	125	111	114	109	106	106
- local authorities	23	27	38	49	47	51	43	37
- private	9	29	44	48	56	56	54	55
Total no. of beds	82,061	80,321	74,510	71,587	70,457	69,450	67,365	65,353
- state, %	92%	88%	81%	78%	78%	78%	79%	80%
- local authorities, %	7%	8%	13%	14%	n/a	n/a	n/a	10%
- private, %	1%	4%	6%	8%	n/a	n/a	n/a	10%
Total no. of doctors	14,632	14,226	14,315	14,363	14,790	14,773	14,723	14,836
- state, %	92%	90%	83%	81%	81%	81%	83%	84%

Source: Vepřek *et al.* (2002, p.31)

The failure of hospital privatisation can be demonstrated by the fact that over 80% of doctors remained employed by state hospitals, which had approximately 80% of the total number of hospital beds (Table 8). Hospital privatisation succeeded only for small hospitals, providing a limited range of care. In 2000, an average private hospital had approximately 100 beds, compared to 500 in state hospitals, and employed 20 doctors, versus 120 in a state hospital (Vepřek *et al.* 2002, p.30). Also, private hospitals were

<sup>59</sup> Throughout 1997-98, previously-approved sales and transfers were being implemented, until the new Social Democratic government definitively resolved to end health care privatisation (Usnesení vlády ČR č. 788/1998, 411/1999).

usually situated in densely-populated areas with state hospitals nearby, sometimes just across the road, so did not significantly increase the spatial accessibility of health services for patients (Heger interview 2006).

### ***Regulation of health care financing***

The financial distress in health care exacerbated in 1994-95 when, for many reasons, the health insurance system started operating with a deficit. Firstly, fee-for-service reimbursement gave health care providers incentive to provide more services. Secondly, the General Health Insurance Fund experienced problems with collecting health insurance contributions, because many employers and the self-employed tried to evade payment and the Finance Ministry sometimes paid state health insurance contributions belatedly (Němec interview 2005). Thirdly, state health insurance contributions for the socially-insured with high health risks, especially children and pensioners, were often below the cost of health care they consumed. Fourthly, independent firm-based health insurance funds cream-skimmed clients with low health risks from the General Health Insurance Fund. In 1993, only 7% of the population were insured by firm-based health insurance funds, but this rose to 39% in 1995 (Vepřek *et al.* 2001). For these reasons the General Health Insurance Fund operated with a deficit from 1994 onwards. Moreover, a number of firm-based health insurance funds unwittingly destabilised their finances. As health insurance funds could not set their own health insurance premiums, they could only compete for clients by providing additional benefits for the fixed premium. Also, firm-based health insurance funds spent approximately 10% of their revenue on operational costs and investment in business projects (ČTK 1995a-m). Consequently, a number of independent health insurance funds ran out of funds for compulsory health insurance benefits.

A liberal solution to the growing health insurance deficit would have been to allow health insurance funds to set their own premiums and substantially reduce levels of compulsory health insurance benefits (NERA 1996). But this would have required the government to scrap the constitutional right for free health care and face a voter backlash. Therefore, liberal health insurance reform was not an option for a government wanting to win the

forthcoming election. Although the Helsinki Committee criticised Minister Rubáš for acting on the grounds of ideological beliefs in self-regulatory market mechanisms, this was not the case. Minister Rubáš believed that ‘the state must intervene into the too liberal system in order to utilise resources more economically’ (ČTK 1995a-m). To tackle the growing health insurance deficit, Rubáš proposed a set of regulatory cost-saving measures, such as patient co-payments, the reduction and regulation of competition between health insurance funds, merging of health and sickness insurance, restructuring of inpatient health care facilities, and the replacement of fee-for-service reimbursement for GPs with capitation fees. During his time in office, he implemented only the first two; failing to merge health and sickness insurance, and only starting preparations for the restructuring of inpatient health care facilities and introduction of capitation fees for GPs.

### **Introduction of patient co-payments**

Patient co-payments were introduced by the government in July 1994 according to the new Health Code – a document stipulating compulsory public health insurance benefits (Nařízení vlády 149/1994 Sb.). First, dozens of dental procedures and materials, and some cosmetic medical treatments, became subject to patient co-payments. Importantly, these co-payments were introduced under pressure from private dentists (ČTK 1994a-b). Dentists threatened to withdraw from health insurance, demanding direct cash payments from patients to purchase dental materials and supplies for their surgeries in a timely manner, rather than belated reimbursement from health insurance funds. At the same time, the amount of these co-payments was insignificant for health insurance funds; to increase their client base, the six largest health insurance funds offered to reimburse clients these co-payments (ČTK 1994a-a). Second, the government reviewed the list of drugs eligible for health insurance reimbursement and changed the basis for reimbursement from the actual cost of drugs to the amount of generic active substances. This change was unpopular among doctors, because they were often incentivised by drugs distribution companies to prescribe brand-name drugs. Consequently, patients and hospitals had to pay the difference between the costs of generic and brand-name drugs. Third, to increase the role of GPs and decrease the amount of specialist care, Minister Rubáš attempted to introduce a small out-of-pocket fee (Kč45) for visiting a specialist

without a GP's referral. Again, this was against the interests of specialists, who wanted to maximise their fee-for-service reimbursement. They refused to charge this fee and the Health Ministry had no means to enforce it. Lastly, Minister Rubáš drew plans to introduce, in 1997 (i.e. after the 1996 election), comprehensive patient co-payments for every visit to an outpatient specialist and for the first 14 days in inpatient care (ČTK 1995a-c).

### **Reduction of competition between health insurance funds**

The most significant measures for rationalising health care financing were concerned with the reduction and regulation of health insurance funds, effectively abolishing meaningful competition in health insurance. Minister Rubáš realised that it was a mistake to introduce multiple health insurance funds early in reform, when the functioning of public health insurance was not yet balanced and harmonised (ČTK 1995a-i).<sup>60</sup>

Therefore, he proposed regulatory measures to:

- merge or liquidate small and inefficient health insurance funds;
- ban competition between health insurance funds on the basis of expanding health insurance benefits beyond the compulsory level free of charge;
- oblige health insurance funds to provide all non-compulsory benefits through voluntary health insurance;
- forbid health insurance funds from buying stakes in health care facilities, running pension schemes and engaging in other entrepreneurial activities that diverted resources from the reimbursement of health care services;
- allow the government to supervise finances of health insurance funds and request health insurance funds to provide it with financial reporting.<sup>61</sup>

These regulatory measures were supported by the 'economic ministers' and submitted to Parliament for approval.

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<sup>60</sup> When the Lithuanian Health Ministry asked the Czech Health Ministry for technical assistance with the introduction of health insurance in Lithuania, Minister Rubáš warned Lithuania against the early introduction of multiple health insurance funds (ibid.).

<sup>61</sup> Earlier, Minister Rubáš proposed to create the Health Insurance Control Office to supervise health insurance funds, but the 'economic ministers' rejected this, instead suggesting that the Finance and Health Ministries supervised health insurance funds (ČTK 1994b).

### *Adversary politics*

Parliament accepted the government proposal (Zákon č. 60/1995 Sb.), but with a struggle. Whereas the overwhelming majority of MPs from the governing coalition supported it, the Left Block and the Social Democrats voted against it (PSP 1995e). Notably, the Social Democrats voted against on the grounds that these measures would lead to the ‘monopoly’ of the public General Health Insurance Fund (ČTK 1995d). In fact, the measures would result in the closure of only 7 out of 27 health insurance funds, some of which had just a few hundred clients. Moreover, the Social Democrats demanded from the Health Minister a detailed analysis of health insurance funds (PSP 1995e). Interestingly enough, Minister Rubáš had previously submitted such an analysis to Parliament, but MPs did not accept it because of insufficient financial information on independent health insurance funds. However, Minister Rubáš did not have such information because health insurance funds did not provide the government with financial reporting, which made the logic of the Social Democrats’ opposition circular: they rejected the government’s proposal to oblige health insurance funds to provide the government with detailed financial information, yet demanded such information from the government.

The question is now raised whether ideology alone is a good predictor of party health policies. When, three years earlier (1992), the Civic Democrats were in opposition, they challenged the government’s decision not to introduce multiple health insurance funds early in reform and initiated in Parliament legislation allowing the establishment of multiple health insurance funds and competition against the General Health Insurance Fund in a poorly-regulated environment. When in office, they were confronted with a growing health insurance deficit, and so discarded their right-wing ideology and adopted left-wing policies to fix health insurance and stay in power. Likewise, the left-wing opposition voted against the left-wing policies of the right-wing government in order to challenge the government and seize power. As shown earlier, the Social Democrats championed state regulation in the 1920s, liquidating hundreds of inefficient health insurance funds, but the Social Democrats of the 1990s voted against similar policies proposed by the government. The same applies to the Communists who, in the 1950s,

claimed that '[w]ith competition ruled out, the operation of health care facilities is much less expensive' (Šourek 1966, p.22), but in the 1990s voted against the government's measures to reduce competition. This brings us to the conclusion that the politics of health policy-making was not ideological, but 'adversary' (Finer 1975; Mansbridge 1980), since the parliamentary opposition opposed the government policies, even though they were sound and congruent with the ideological stance of the opposition.

The 'adversary' logic of the opposition squares well with Schumpeter's proposition that 'the democratic method produces legislation and administration as by-products of the struggle for political office' (Schumpeter 1984, p.285). MPs do not come to Parliament to scrutinise and legislate for health care reform, but exploit these activities to advance their vested interests, gain a rent on their office, and, above all, maximise their power. The opposition aim to depose the government; as clearly demonstrated by the Social Democratic Party, whose political rhetoric was more radical than that of the Communists' and on a par with the Republicans in populism. This was due to a 1993 leadership change, when Jiří Horák lost Party Chairmanship to Miloš Zeman. Whereas Horák saw the role of the Social Democrats as a constructive, non-radical opposition to the government, Zeman wanted to lead a radical, destructive opposition (Kopeček 2003). Evidently, health policy was no exception to Zeman's agenda of pulling down the government:

The government is an octopus which has many tentacles and therefore many throats. We are going for the throats of [Interior] Minister Ruml, [Health] Minister Rubáš, and other less capable Ministers (RP 22.10.1994).

Like the Civic Democrats when they were in opposition, the Social Democrats used health policy legislation as an instrument to attack the government for their short-term political goals, rather than to ensure sound health policies for many years to come. Also like the Civic Democrats, they had to change their short-term policy position because of the fast-changing policy environment. Just a few months after the Social Democrats voted against the reduction and regulation of health insurance funds, a pensioner died after being refused admission to hospital because his Miners' Health Insurance Fund was insolvent and would not be able to reimburse the hospital for the required treatment (ČTK

1995a-k). The Social Democrats made a dramatic policy U-turn and tried to portray the government policy that was aimed at the reduction of health insurance funds as their own policy: ‘a significant reduction of health insurance funds would allow to control better how the contributions of the insured are managed’ (ČTK 1995f).

### ***Health insurance lobby***

Minister Rubáš’ drive to reduce and regulate health insurance funds prompted two policy episodes suggesting that health insurance funds lobbied their interests in Parliament. First, MPs from the Civic Democratic Party in the Parliamentary Health Committee proposed extending government proposals to merge or liquidate health insurance funds with less than 50,000 clients to those with less than 400,000 clients, but Parliament rejected this proposal (PSP 1995e). According to the government proposal, 7 out of 27 health insurance funds would be merged or liquidated, but according to the Parliamentary Health Committee’s proposal, this would rise to 24. In the run-up to the voting, the Association of Health Insurance Funds (SZP) actively argued against the forced reduction of health insurance funds (ČTK 1995o). Also, an MP publicly acknowledged the existence of ‘a heavy insurance lobby’ in Parliament; that, during parliamentary debates on health insurance legislation, representatives of some health insurance funds ‘followed’ MPs; and, that some MPs acquired insurance policies from these funds (ČTK 1995s). It is plausible that large health insurance funds had more resources to lobby their interests in Parliament and so managed to avoid significant reductions in the number of health insurance funds. Consequently, only 7 very small insurance funds, with client bases ranging between 300 and 30,000, were enlisted for merger or liquidation, but the most indebted health insurance funds were not affected.

The second policy episode involved the Miners’ Health Insurance Fund – the second largest health insurance fund, with approximately 850,000 clients (HN 07.05.1995). Though health insurance funds were not obliged to provide financial reporting to the government, it became publicly-known that the Miners’ Fund was on the brink of bankruptcy, due to the death of the client refused hospital treatment and complaints from health care providers about their’ default on reimbursement. In such circumstances,

Minister Rubáš attempted to merge or liquidate the Miners' Fund (ČTK 1995a-a), but failed because the Miners' Fund successfully lobbied against this attempt, allegedly thanks to close connections with the Social Democratic Party (Rubáš interview 2005). This allegation could well have been politically driven, but the fact remains that the Miners' Director, Pavel Petržílek, was an MP with the Social Democratic Party, allowing the Miners' Fund to lobby its interests.

### *Non-partisan voting*

The process of merger and liquidation of insolvent health insurance funds was influenced by the interests of health insurance funds, rather than ideological debates about competition in health insurance or the regulatory role of the state. To solve the problem of the most indebted health insurance funds, and those at risk of bankruptcy due to high running costs, the government proposed to merge or liquidate these too. To this end, health insurance funds were obliged to submit their 1996 budget plans to Parliament for approval. Again, voting on the 1996 budget plans does not reveal a clear partisan pattern, implying that individual MPs were influenced by the health insurance funds trying to avoid merger or liquidation. MPs may have been offered certain benefits, or managers and employees of insurance funds who had personal relations with MPs or friends of MPs may simply have asked them to save their well-paid jobs as a favour (Rubáš interview 2005). It is likely that voting on the merger and liquidation of health insurance funds was, for many MPs, dependent on whether their spouses, children, schoolmates, friends, etc. would keep or lose their well-paid jobs.

In November 1995, the government proposed to reject the budget plans of 22 out of 27 health insurance funds (Usnesení vlády ČR č. 673/1995) and passed the relevant legislation to Parliament for voting (PSP 1995b). The chief reason for rejection was excessive administrative costs. As shown earlier, multiple firm-based health insurance funds were established to provide their managers with lucrative employment and business opportunities, so it is no surprise that they had high administrative costs. Voting on the government proposal had no clear partisan pattern, as many MPs from the governing parties voted against the government proposal (PSP 1995d). Although the Social

Democrats no longer opposed significant reduction of health insurance funds, in particular cases they often opposed the merger or liquidation of financially distressed health insurance funds. MPs from other parties were divided along ‘family and friends’ lines too. Altogether, Parliament did not approve the budget plans of 13 health insurance funds, asking these funds to submit corrected budget plans in February 1996 (PSP 1995c). Subsequently, MPs approved the corrected budget plans of three, while ten remained unapproved (PSP 1996e, 1996f). Thus, due to non-partisan voting on the budget plans of health insurance funds, the government failed to reduce the number of health insurance funds drastically (Table 9).

**Table 9: Merger and liquidation of health insurance funds, 1992-2001**

Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Health insurance funds, no.	15	19	26	27	24	14	11*	11*	9	9

\*including one in liquidation

Source: (Vepřek *et al.* 2002, p.23)

## **Limits of regulatory measures**

### ***Unsophisticated economics of drug shortages***

The Health Ministry’s regulatory cost-saving measures made limited improvements in health care financing, but health insurance system deficit continued to grow throughout 1995. Nonetheless, the ‘economic ministers’ were reluctant to increase health care expenditure because they were pursuing stringent fiscal policies. As PM Klaus explained to the audience at the Cato Institute:

...in the Czech Republic the budget must always be balanced, because we know that that’s a rule of rational behavior... There is no sophisticated economics behind it; it’s simply the result of the ability of political leaders to say no to excessive expenditures... (Klaus 1995)

Given looming budgetary crisis and the priority of balancing the state budget over the health care budget, the ‘economic ministers’ reduced health care expenditure to balance the state budget. In April 1995, the government sponsored amendments to the General Health Insurance Contributions Act (Zákon č. 59/1995 Sb.), lowering the basis of state health insurance contributions from 70% to 65% of the minimum wage, further

exacerbating the multi-billion deficit of the health insurance system. Importantly, nobody knew the precise extent of this deficit, due to lack of information on health insurance funds and health care providers, associated with the fragmentation of the health care system. While the Health Ministry estimated the overall deficit at just Kč1.5bn, the General Health Insurance Fund estimated it at Kč5bn (ČTK 1995a-q).

In addition to the unpaid debts of the Miners' and some other health insurance funds, the debts of health care providers were growing, thanks to low reimbursement rates. According to the existing reimbursement rates, each hospital acute care bed was losing Kč200/day and hospitals had to increase amounts of intensive and outpatient care provided to minimise losses (Telegraf 9.5.1994). The widespread insolvency of hospitals became apparent in May 1995, when drugs distribution companies stopped supplying drugs to twenty insolvent hospitals and some hospitals had to let out premises or mortgage property to raise funds towards drugs, medical supplies and operational costs (ČTK 1995a). Minister Rubáš tried to persuade the health insurance funds to increase reimbursement rates for inpatient care, but failed because the health insurance funds had a growing deficit themselves, so were not in a position to do so. In such circumstances, one newspaper rightly commented that Minister Rubáš had only one option – to 'beg' the 'economic ministers' for a loan to bail out insolvent hospitals (MfD 10.08.1995). Although he asked for Kč1bn, the 'economic ministers' gave hospitals only Kč0.4bn in government interest-free loans and Kč0.2bn in subsidies to cover interest on commercial loans (ČTK 1995a-h). Effectively, the 'economic ministers' gave hospitals a fraction of what they earlier took from the health insurance system through reduction of state health insurance contributions.

### ***PM Klaus advocates MSAs***

The widespread insolvency of hospitals in 1995 prompted the 'economic ministers' to diffuse blame for insufficient health care financing and look for ways to curb public health expenditure growth. PM Klaus attributed the insolvency of hospitals to inefficiency of public health insurance, blaming the previous government for introducing it, and claimed that he always opposed it (e.g. ČTK 1993t; LN 20.06.1995). As shown

earlier, in his position as Federal Finance Minister and Chairman of the Federal Economic Council Mr Klaus rightly anticipated that the introduction of public health insurance would lead to escalating health care expenditure growth, but nonetheless he silently agreed with the introduction of health insurance. If action and inaction are equally considered policy (Heidenheimer *et al.* 1990), the insolvency of hospitals and general financial distress in health care could be said to result from Mr Klaus' policy. In 1995, he changed his policy, proposing to stop public health expenditure growth by replacing public health insurance with individual medical savings accounts (MSAs), as advocated by the Cato Institute.

PM Klaus advocated MSAs because these would reduce the degree of solidarity in health insurance and make patients responsible for controlling their own health care costs (ČTK 1995t). Although Singapore was the only country where MSAs were successfully implemented, and PM Klaus was cautioned against MSAs by overseas experts (NERA 1996; Háva interview 2006b), he adamantly supported MSAs. Minister Rubáš recollects that PM Klaus gave him a book about MSAs called 'Patient Power' (Goodman & Musgrave 1992), saying that the government needed to introduce MSAs as soon as possible to solve the problem of health care financing (Rubáš interview 2005). Minister Rubáš shared PM Klaus' political goals, but was sceptical about the feasibility of a quick switch to MSAs and the desirability of the wholesale replacement of public health insurance with MSAs (*ibid.*). He believed that MSAs could successfully replace only one-quarter of public health insurance, covering dental care and some non-essential types of health care, but prevention, general practice and essential health care should still be financed through public health insurance (ČTK 1995a-p). A newspaper commented that Minister Rubáš's scepticism 'irritated' PM Klaus, who held a series of meetings with leaders of the medical profession to persuade them to support the introduction of MSAs (RP 21.7.1995). Nonetheless, Minister Rubáš' Health Ministry launched a feasibility study into the methods for introducing MSAs, which he hoped to conclude by spring 1996 and use in his forthcoming electoral campaign (ČTK 1995a-q). He also tried to test how patients would control their health care if given individual balances of health insurance contributions and health care utilisation asking health insurance funds to issue

every client with such balances; but health insurance funds refused to do so because of high administrative costs and possible breaches of medical confidentiality (ČTK 1995a-g). Alongside Minister Rubáš' half-hearted attitude to MSAs, and the long period of time required for their introduction, PM Klaus failed to replace public health insurance with MSAs swiftly because of the strong opposition of the Christian Democratic Union – the second largest party in the Civic Democratic coalition government. The Deputy Chairman of the Christian Democrats, Jan Kasal, argued that MSAs were against the European culture, based on solidarity, and that the Czech Republic should not become a 'laboratory for experiments' (RP 25.07.1995).

### ***Government's war on the medical profession***

#### **The Health Ministry takes on the Medical Chamber**

Despite the growing importance of opposition parties, especially the Social Democratic Party, the most pertinent axis of health politics during Minister Rubáš' time in office developed between the government and the medical profession, while a new axis emerged between different organisations of the medical profession. The first serious conflict between the government and the Medical Chamber took place back in 1993, when Minister Lom attempted to limit the licensing rights of the Pharmaceutical Chamber. Minister Rubáš found himself in a similar situation when he proposed to revise the Health Care Act, with a view to limiting the powers of the medical profession in licensing and post-graduate medical education. During the preceding three years, the Medical Chamber changed its licensing procedures for private medical practices as many as four times; the last change cancelled the licences issued by the regional branches of the Medical Chamber and ruled that new licenses should be issued by its Central Board, subject to at least six years of medical practice (ZN noviny 17.01.1995). As this discriminated against young doctors, and slowed privatisation, Minister Rubáš argued against the exclusive licensing rights of the Medical Chamber, in favour of delegating licensing rights to the Health Ministry, and Rubáš advocated scrapping obligatory membership of the Medical Chamber. Moreover, without even consulting the medical chambers, the Economy Ministry was preparing the Act on the Association of

Professional Chambers, with a view to merging all twelve professional chambers into one organisation, which the chambers feared would threaten their individual rights and freedoms.

The extensive powers of medical chambers allowed them to challenge troubled public health insurance. The Dental Chamber threatened to withdraw from health insurance and charge patients in cash if health insurance funds did not reimburse dentists on time, but the government could not force dentists to stay in health insurance because the Dental Chamber had exclusive rights to register and license dentists. In another example, the Health Ministry decided to impose a small out-of-pocket fee on patients visiting a specialist without a GP's referral, to prevent over-utilisation of specialist care, but the Medical Chamber instructed specialists not to charge this fee and the Health Ministry could not enforce it. Lastly, the Health Ministry was unable to correct imbalances in health insurance reimbursement rates by decreasing reimbursement rates for one specialty and increasing them for another (i.e. without increasing overall health expenditure), because the Medical Chamber opposed the reduction of reimbursement for certain specialties. Consequently, the government found itself as guarantor of the constitutional right to free health care, but was unable to coerce doctors to work in the financially-distressed health insurance system and did not want to increase health care expenditure. In fact, the government repeatedly amended the Health Insurance Contributions Act to reduce health care expenditure. Doctors argued that 'patients were provided with good care at the expense of doctors and their salaries', presenting the government with a dilemma: 'either citizens will pay more or they will get less care' (MfD 18.01.1995).

Although the Civic Democratic government was keen to reduce the degree of solidarity in public health insurance, it could not abolish the constitutional right to free health care in the run-up to elections. Consequently, Minister Rubáš attempted to abolish the extensive powers of the medical profession to strengthen the regulatory role of the state and force doctors to work for what the government wanted to pay them. That is, he proposed to abolish the exclusive licensing and registration rights of the medical profession, arguing that the medical chambers should be transformed from 'trade unions

with obligatory membership', promoting the economic and political interests of doctors, into organisations with voluntary membership, which would merely uphold professional ethics (ČTK 1995a-l). The leaders of the medical chambers were not prepared to surrender their powers or fight for higher pay, arguing that only Fascist and Communist states abolished the powers of medical chambers (ČTK 1993m) and accusing Minister Rubáš of 'autocracy, centralism, and command management' (ČTK 1995a-w). The Medical Chamber threatened to boycott the Health Ministry, and demanded negotiations on the powers of the medical profession and a pay rise directly with the Prime Minister. The government ignored these demands and the Medical Chamber twice attempted to put Minister Rubáš in front of its Disciplinary Board for acting against the interests of the profession, i.e. in breach of his responsibilities as a doctor and member of the Chamber (MfD 17.01.1995). Minister Rubáš was not prepared to surrender his fight against the Medical Chamber either; renouncing his membership in the Medical Chamber, to end the apparent conflict of interests, and continuing to push for the abolition of the medical profession's extensive powers.

***Doctors in politics look after their own interests***

This episode raises an important question about the so-called medical lobby, which allegedly pursues the interests of the medical profession at the expense of the public. Roman Karlík argued that the new health care system worked to the advantage of the medical profession because:

The whole state administration is larded with doctors. It is not only Parliament and the [Health] Ministry. Doctors sit in local governments and health insurance funds (Boškova 1999, p.38).

I believe this statement fails to consider the career strategies of doctors vested with political and administrative power. When Petr Lom was Chairman of the Parliamentary Health Committee, he proposed the Medical Chambers Act, granting extensive powers to the medical profession. On this occasion, he acted as a politician, maximising the support of the medical profession and his credentials as a progressive reformer within the Civic Democratic Party. When he became Health Minister, he was minimising his chances of dismissal by the Prime Minister, and therefore supported limiting the powers of the medical profession and reducing the health insurance budget. At the same time, another

doctor, Miroslav Čerbák – Vice President of the Medical Chamber and an MP with the Civic Democratic Alliance, went against his party and the government to increase the health insurance budget. In his capacity as Health Minister, Luděk Rubáš criticised the General Health Insurance Fund for passively transferring funds to hospitals without controlling their claims because the General Health Insurance Fund had a deficit; but as Director of Hospital Kolín he successfully claimed from the General Health Insurance Fund the most expensive price for a hospital building ever because, as he explained, he wanted to maximise profits for his hospital and did not care whether the Fund could afford the price without getting into a trouble (LN 11.01.1994). In Parliament, a proposal to scrap the obligatory membership in the Medical Chamber (PSP 1995a) was drafted by a doctor, Petr Čermák, who was Deputy Chairman of the governing Civic Democratic Party. Altogether, what matters for the promotion of the medical profession's interests is what career strategies doctors with political and administrative power adopt to maximise their income, influence, prestige or other utilities which are most important to them. If their career strategies contradict the interests of the medical profession (e.g. Health Minister, high-flying party official, member of the health insurance fund's board, etc.) then doctor-MPs do not hesitate to act against the interests of the medical profession. This empirical finding confirms Schumpeter's theoretical proposition:

The doctor or engineer who means to fill the cup of his ambitions by means of success as a doctor or engineer will still be a distinct type of man and have a distinct pattern of interests; the doctor or engineer who means to work or reform institutions of his country will still be another type and have another pattern of interests (Schumpeter 1984, p.286).

### **The Medical Chamber boycotts the Health Ministry**

In January 1995, the Medical Chamber (together with five other organisations of the medical profession) fulfilled its threat to boycott Minister Rubáš and refused to continue stakeholder negotiations with the Health Ministry on licensing rights, obligatory membership, reimbursement rates, privatisation, regulation of health insurance funds, and some other issues. Given the government's recurrent hostile attempts to reduce the powers of the medical profession, the Medical Chamber declared a state of war: delegates during its February Conference voted to continue the Conference on a permanent basis, in

order to be able to respond to new threats or propositions from the government promptly. Although in February PM Klaus personally sought the Medical Chamber's co-operation in negotiations with the Health Ministry, he failed to provide a definitive solution to health care financing, as demanded by doctors, and Minister Rubáš maintained his hard-line position against the medical profession. Consequently, the Medical Chamber's permanent conference and boycott of the Health Ministry continued for most of 1995.

The left-wing opposition parties were mere bystanders in the conflict between the government and the medical profession, but nonetheless took the opportunity to criticise the government, siding with medical professionals against the state. The Communists argued against 'the normative subordination of the professional issues in health care to the state bureaucracy' and supported the Medical Chamber (ČTK 1995r). This was quite a policy shift for the party which abolished medical chambers in the 1950s and had the medical profession subordinated to the state bureaucracy for almost four decades. The Social Democrats took a more radical stance: maintaining that the autonomy of the medical profession should be preserved by all means and Minister Rubáš must resign (ibid.).

In his analysis of the causes of the conflict with the medical profession, Minister Rubáš indicated that licensing rights and obligatory membership were just a pretext for the Medical Chamber to push their demand for higher pay and pledged to nearly double doctors' salaries through cost-saving measures, the adjustment of health insurance reimbursement rates and performance-based contractual pay (RP 18.01.1995). However, the Medical Chamber did not believe that cost-saving measures, such as the reduction of pharmaceutical expenditure and restructuring of hospital beds, would generate enough funds to increase salaries in health care. Moreover, they boycotted negotiations with the Health Ministry on performance-based contractual pay and the adjustment of reimbursement rates, because doctors opposed increasing reimbursement for one specialty or group at the expense of others. In the beginning of his ministerial career Minister Rubáš claimed that doctors deserved higher pay and set out to achieve this by replacing salary tariffs in state health care facilities with a performance-based contractual

system (ČTK 1993j). The Medical Chamber and other organisations of the medical profession objected to the abolition of tariffs, because it would disadvantage the senior doctors who dominated their organisations: they had higher tariffs due to their senior positions and an incremental pay rise. The abolition of tariffs was also opposed by the Health and Social Care Trade Union (OSZSP), which represented mainly nurses and ancillary staff, because less-skilled health workers would lose most from the abolition of tariffs.

### **The Doctors' Trade Union Club splits the medical profession**

During the boycott, a new health politics axis emerged between different organisations of the medical profession. The Medical Chamber was a professional association of doctors, which at times acted as a trade union, but did not compete against trade unions. The Medical Chamber had obligatory membership for all 36,000 doctors and was dominated by middle-aged senior doctors who, in the competition for executive positions in 1992, defeated an older generation of doctors from the Union of Czech Doctors. This became a cross between a professional association and a trade union. As it grew, its 'dissident' leaders, many of whom participated in the 1968 Prague Spring, were sidelined by a younger generation of doctors, mostly from the periphery. In 1995, the Union of Czech Doctors had up to 3,000 members and did not directly compete against the 103,000-strong Health and Social Care Trade Union, which represented 97,000 nurses and ancillary staff, and 6,000 doctors (ČTK 1995n). The peaceful co-existence of major organisations of the medical profession changed in March 1995, with the emergence of the Doctors' Trade Union Club (LOK) – a trade union of state hospital doctors.

Despite its initial membership of just 300, the new organisation immediately made a strong impact on health politics due to a clear programme and time-specific political opportunities. Firstly, on threat of industrial action, the Doctors' Trade Union Club demanded that the government triple hourly-pay for hospital doctors to Kč150 and increase monthly pay to Kč25,000 (ČTK 1995m).<sup>62</sup> Importantly, the leaders of the

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<sup>62</sup> The average hourly wage in the national economy was Kč76 (ČTK 1995a-e) but doctors were earning just between Kč27 and Kč55.

Doctors' Trade Union Club were not the most disadvantaged doctors who badly suffered from poor pay, such as those working in remote rural areas. On the contrary, the Doctors' Trade Union Club was established at the prestigious Motol Hospital in Prague and its leaders came from privileged backgrounds. For example, the Chairman of the Club, David Rath, was the son of the infamous Professor Ratmír Rath – a former member of the Communist *nomenklatura* in the medical profession who, after the Velvet Revolution, went into 'hiding' in Kuwait (Bojar interview 2006). Secondly, the leaders of the Club launched a bid to replace the incumbent leaders of the Medical Chamber, calling on members of its Executive Board to resign because they had failed to protect doctors' economic interests, instead 'defend[ing] other than doctors' colours – the interests of health insurance funds on whose boards they sit, or the interests of the pharmaceutical companies, or their own political ambitions' (ČTK 1995k). Thirdly, Chairman Rath distanced his organisation from the Health and Social Care Trade Union, which he ridiculed as 'the association of janitors, female clerks, and laundresses who envy doctors for their privileged position', promising that his organisation would advance the economic interests of doctors (ibid.). To this end, he established co-operation with the Union of Czech Doctors, which was sidelined in the health politics arena in 1992 by the incumbent leaders of the Medical Chamber. The crucial difference between the two organisations was that the membership of the Union represented older generations of doctors from the periphery, while the Club represented junior doctors from prestigious hospitals in Prague. Most importantly, the Club opportunistically took the place of the Medical Chamber in negotiations with the government when medical elites boycotted the government.

Given the imminent threat of doctors' strike and the fact that the elites of the medical profession boycotted the government, Minister Rubáš started negotiations with Chairman Rath. This was an opportunity for Minister Rubáš to capitalise on the split of the medical profession to legitimise his regulatory cost-saving policies and the abolition of tariffs by offering the Doctors' Trade Union Club a small pay rise. Earlier, the Medical Chamber refused the government's offer of a 10% pay rise with effect from August 1995, backing the demand of the Health and Social Care Trade Union for a 20% pay rise, and opposed

the abolition of tariffs (ČTK 1995n). After Minister Rubáš started negotiations with Chairman Rath and ignored the incumbent leaders of the Medical Chamber and the Health and Social Care Trade Union, the latter joined opposition calls for Rubáš' resignation. In contrast, the leaders of the Doctors' Trade Union Club were keen to negotiate with the government, to establish themselves and their organisation in health politics. In just a couple of months, the previously unknown David Rath was making headlines and negotiating with the government on behalf of the entire medical profession. He supported the Health Ministry's proposal to replace tariffs with performance-based contractual pay and agreed that the regulatory cost-saving measures proposed by the Health Ministry would generate enough funds for a pay rise (ČTK 1995q). It is important to stress that the introduction of performance-based contractual pay benefited Chairman Rath's constituents – junior doctors, who usually worked more than senior doctors but under the tariff system were paid significantly less.

### ***Ultimatum to the government***

Negotiations between the Doctors' Trade Union Club and Health Ministry led to a preliminary agreement on an incremental pay rise, in line with the growth of funds due to the Health Ministry's cost-saving measures; consequently the Club pledged to call off the strike provided that the government offers a sufficient pay rise through contractual pay (ČTK 1995a-r). However, negotiations on contractual pay eventually collapsed as the Club accused the Health Ministry of 'dumping' pay of less qualified doctors, i.e. its members. Therefore, the Club demanded a sufficient increase in tariffs and issued an ultimatum to the government: to increase tariff-based salaries, or face a strike (ČTK 1995a-j). As the 'economic ministers' were adamant not to increase health expenditure in order to increase tariffs, Social Affairs Minister Vodička threatened to cancel the medical diplomas of the doctors who went on strike and Minister Rubáš requested that hospital directors provided the Health Ministry with information on strike activists and sack them (ČTK 1995a-n, 1995a-b). Although hospital directors opposed the strike, they refused to inform on strike activists. If the Health Ministry succeeded in taking over licensing from the Medical Chamber then it would be possible to avoid the strike, by threatening doctors with cancelling their licences, but the threat to cancel university diplomas was empty

because it would not affect licences issued by the Medical Chamber. A chance to resume negotiations between the Club and the Health Ministry was lost and the Club joined the calls of the rest of the medical profession for Minister Rubáš to resign.

With the strike drawing closer and the popularity of the Club's leader, David Rath, growing, the leaders of the Medical Chamber and the Health and Social Care Trade Union started criticising Rath as 'radical' and the strike as 'unethical' because it would negatively affect patients and doctors would lose 'respect and prestige' among the public (LN 22.09.07). It looked like the elites of the medical profession were more concerned with losing influence in the health sector to David Rath than the ethical implications of the strike. In a way, the growing conflict among the elites of the medical profession was similar to the conflict between the group of Bohuslav Svoboda and the Union of Czech Doctors for control of the Czech Medical Chamber in 1992. At that time, Bohuslav Svoboda defeated his more senior and accomplished competitors who, unlike him, were more interested in promoting medical ethics rather than doctors' economic interests and social standing. Furthermore, the Health and Social Care Trade Union itself threatened the government with a strike in February 1992. Accordingly, it seems that the elites of the medical profession opposed the strike simply because, if it succeeded, the leading role of their organisations and their personal positions would suffer a blow from the Club and David Rath personally.

The reaction of political parties to the threatened doctors' strike clearly demonstrated that politicians supported the doctors only when it was beneficial for them. To be precise, the doctors threatened the government with a one-day demonstration and an administrative strike, whereby they would continue treating patients but stop proceeding paperwork such as health insurance claims, work incapacity certificates, etc. This was a legitimate expression of their constitutional right for industrial action, without breaking the Hippocratic Oath. Doctors followed in the footsteps of taxi drivers, miners, railway workers, teachers, judges and other professions who previously called for industrial action. However, the Health Ministry proclaimed that it was 'illegal' for doctors to strike (ČTK 1995a-e) and PM Klaus judged that 'doctors played foul' (ČTK 1995a-s). The left-

wing opposition parties also disapproved of doctors exercising their constitutional right. The Social Democrats stated that, although they supported industrial action as a last resort in resolving social conflicts, in the case of the doctors they took the side of patients, and were against the strike (ČTK 1995a-s). The Communists also cited the interests of patients as the reason why they did not support the strike (ibid.). In terms of sheer numbers, patients were a far more important voter group than doctors. As politicians were interested in maximising votes, they were better off supporting patients than doctors.

### **Change of Health Minister**

When the Doctors' Trade Union Club urged Minister Rubáš to resign and started a countdown to the strike, scheduled for 01.11.1995, the government found itself in the dangerous situation of health policy stalemate just eight months before general elections. Financial distress in health care had been a usual state of affairs since the introduction of health insurance, but after an elderly client of the insolvent Miners' Health Insurance Fund was refused hospital admission and subsequently died, health care financing became a worrisome problem for everyone. The imminent threat of the doctors' strike exacerbated people's worries and the fact that PM Klaus personally engaged in the negotiations with the medical profession justified these worries. In December 1994, he asked his followers at the Civic Democratic Party Congress not to engage in political discussions on less political and ideological issues, requiring only expert knowledge, but a few months later he himself engaged in negotiations with the medical profession and a newspaper commented that '...such a non-political and entirely non-ideological issue as citizens' health is becoming the utmost political problem' (ZN 21.07.95). However, the government was unable to solve this problem: the Prime Minister and his 'economic ministers' did not want to increase health expenditure and the medical profession resisted the policies of Minister Rubáš.

Following the boycott of the medical profession, Minister Rubáš was criticised not only by the medical profession and opposition parties, but also by a high-ranked member of his own party. Miroslav Macek – former Federal Deputy Prime Minister and a dentist by

trade – published a series of proposals for health care reform, publicly criticised Minister Rubáš, and openly sought to replace him (e.g. Český týdeník 17.02.1995). In such circumstances, Minister Rubáš asked the Civic Democratic Party Executive Council to review his conduct as Health Minister, offering to resign if it was unsatisfactory, but the Party Executive Council and its Chairman Klaus backed Minister Rubáš and his policies (ČTK 1995a-x). Therefore, unilateral action overriding the powers of the medical profession, which led to a health policy stalemate in 1995, was preferred by PM Klaus to co-operation with the medical profession. As shown earlier, PM Klaus dismissed Minister Lom because of his inability to defend enacted reforms and seemed to want someone with Rubáš' ability 'to fight as a lion' (ČTK 1993i), as demonstrated in his dealings with the medical profession. That is, Luděk Rubáš was appointed because PM Klaus preferred unilateral action to co-operation.

Less than a month before the announced date of industrial action, and eight months before the general election, Minister Rubáš was still in a fighting mood:

I am not tired. I am a fighter. I shall not allow myself to let the [health care] sector down. I am used to working under pressure from the medical profession. I do not intend to capitulate under any circumstances. (Svobodné slovo 05.10.1995)

At the same time, the costs of fighting the medical profession, in terms of bad press and the public unrest, were rising for the government. Whether Minister Rubáš crushed the medical profession before the election or the government entered the election with bad press was a costly gamble for the government. In such circumstances, PM Klaus decided to change the mode of interaction with the medical profession from competition to co-operation, at least, as far as political rhetoric was concerned. He replaced Rubáš as Health Minister with the experienced negotiator, and then Transport Minister, Jan Stráský to 'stabilise' the health care sector and 'make a step forward in the communication with the medical profession' (ČTK 1995a-u).

As for ex-Minister Rubáš, he saw as the main reason for his dismissal the fact that he fell into a 'political trap', which he set for himself by revealing his plans too early and promising more than he was able to deliver as Health Minister (MfD 12.10.1995). Indeed, his regulatory cost-saving policies had a long implementation lag and, in the

meantime, the ‘economic ministers’ refused to provide funding towards higher pay in health care. At his final press conference, ex-Minister Rubáš aptly summarised one of the key features of Czech health politics, that the Health Minister has a rather limited ability to influence key health policy issues over a short period of time, as follows:

For every future Health Minister in this country it will be imperative to be very modest about what is possible to accomplish in short term in health care (ČTK 1995a-f).

## CHAPTER 9: CIVIC DEMOCRATIC HEALTH MINISTER STRÁSKÝ, 1995-96

### *Precedence of health politics over health policy*

The change from the ‘fighter’ Luděk Rubáš to the ‘diplomat’ Jan Stráský clearly demonstrated the growing importance of health care on the government’s agenda and that health politics took precedence over health policy. PM Klaus opted for the change, although it sent a clear message about the government’s instability, because this was the fifth change in the government since 1992. Jan Stráský recollects that PM Klaus specifically wanted to appoint a new Health Minister from the ranks of experienced ministers, to end the unrest in the health sector (Stráský interview 2005). As a seasoned political heavy-weight, Jan Stráský had impressive experience in solving critical political problems. As Transport Minister, he had skilfully averted a strike by railway workers, by splitting trade unions and then brokering a compromise. Prior to that, caretaker Prime Minister and acting President of Czechoslovakia, his diplomatic skills had ensured the smooth dissolution of Czechoslovakia (HN 10.10.1995). Moreover, PM Klaus had full trust in Stráský: before the Velvet Revolution they were colleagues and office-mates in the Czechoslovak State Bank.<sup>63</sup> At the same time, the change of Health Minister did not manifest policy change. PM Klaus credited ex-Minister Rubáš with leading the health care sector ‘in the right direction’ and stressed that Minister Stráský was appointed to continue his predecessor’s policies (ČTK 1995h). This policy continuity was also evident at the level of personal appointments in the Health Ministry. Minister Stráský did not make significant personal changes in the Health Ministry, even offering ex-Minister Rubáš the post of Deputy Health Minister. Though ex-Minister Rubáš rejected this offer, he agreed to stay on as advisor to Minister Stráský for three months to ensure a smooth handover (MfD 17.10.1995). In my view, the change of Health Minister was meant to give symbolic concessions to the elites of the medical profession and bring trade unions

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<sup>63</sup> One may also suggest that appointing the popular and successful Stráský to the problematic Health Ministry was a deliberate attempt to end his political career, since Klaus had a record of ending the careers of colleagues as soon as they became his competitors.

back from the streets to the negotiation table instead of fulfilling the doctors' core demands for a pay rise.

### **Is a non-doctor Health Minister better?**

Jan Stráský's appointment as Health Minister was welcomed almost unanimously by the leaders of the medical profession because he was an economist and banker, and thus a third-party to conflicts in the health care sector. But, as soon as he got involved in these conflicts, he became subject of the usual contentions among the medical profession. The fact that Stráský is still the only non-doctor Health Minister since 1989, and managed to implement a number of important health policy changes, leads some commentators to suggest that a non-doctor Health Minister actually benefits the health care sector (Jaroš *et al.* 2005). PM Klaus was strongly in favour of appointing health care managers from economists and lawyers, though trade unions strongly criticised this approach, dubbing it 'Klausism' (Rath 1996). Both PM Klaus and the trade unions were biased as they wanted people they trusted, and who would advance their interests, in managerial positions. In fact, the political and managerial skills pivotal for any government minister or an MP do not depend on their trade and occupation. In previous chapters, I showed that doctors in politics advanced their own political interests, rather than those of the health care sector; but the same applies to economists. For example, PM Klaus, an economist by trade and banker by occupation, has been the most successful politician so far in the Czech Republic, but failed miserably as an economist and banker: during his rule Czech GDP in real terms remained below its 1989 level and the balance of payments in 1996-97 had the worst deficit ever recorded in the Czech Republic (IMF 2007). Returning to Jan Stráský, a non-doctor does not know the specifics of the health care sector as well as a doctor and thus may be less efficient in dealing with professional issues<sup>64</sup> or prone to excessive reliance on advisers, who may be pursuing their own agendas:

Minister [Stráský] is not a doctor, but put in office the strongest clique of [doctors] lobbyists. ...as though the state defence policy in this country was made by the arms producers (Karlík cited in: Boškova 1999, p.42).

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<sup>64</sup> Luděk Rubáš recollects: 'I am telling him [Minister Stráský] about the importance of CTs and MRIs [computed tomography and magnetic resonance imaging scanners] and he agrees "yes, IT is very important [for record-keeping]"' (Rubáš interview 2005).

Altogether, there is no reason why an economist or any other non-doctor would be intrinsically a better choice as Health Minister than a doctor. It is political and managerial skills that matter for the success of any Health Minister and these skills can be developed by both doctors and non-doctors. Because it takes a lot of professional knowledge to enter health politics, doctors have a fair advantage over non-doctors in being appointed as Health Minister, yet an experienced and seasoned politician, like Jan Stráský, had a clear advantage over any doctor-politician in political and managerial skills.

### **Change of Health Minister fails to pacify doctors**

The changeover of Health Minister was not enough for the Doctors' Trade Union Club to call off the strike as the doctors demanded from the government an action programme with a definitive timeline for a pay rise. With only three weeks left before the prospective strike, Minister Stráský had a challenging task putting together an action programme that would appease the Club. As the government did not want to increase funding for health care, it was unlikely that any programme would appease the Club. Another reason why it was challenging, if not impossible, to pacify the Club was that the political star of the Club's leader, David Rath, was rising. The strike would provide him with a unique opportunity to promote himself as a public politician nation-wide. However, any programme would satisfy the leaders of the Medical Chamber and Health Care Trade Union, provided they were invited back to the negotiation table. The leaders of these organisations had established positions and no ambitions as public politicians. Resumed negotiations and a few government compromises would be enough to legitimise their leadership positions.

With the notable exception of the Dental Chamber, all the major organisations of the medical profession agreed that the 6-page Short-Term Programme, proposed by Minister Stráský (MZ ČR 1995b), was a good starting point for alleviating financial distress in health care. This was probably because of Stráský's commitment to negotiations with the leaders of the medical profession:

Not all the measures [of the Short-Term Programme] are fully in the competence of the Health Ministry. During the implementation of many of these co-ordination with a number of partners is

indispensable, especially with the representatives of the [medical] chambers, organisations of employers and employees, health insurance funds, founders and managers of health care facilities, interest groups, and professional associations (MZ ČR 1995b, p.2).

Like the Doctors' Trade Union Club, the Dental Chamber had a concrete demand, which the Short-Term Programme failed to address, i.e. belated reimbursement of private dentists by health insurance funds. As Chairman Rath correctly observed, the Short-Term Programme essentially reiterated the regulatory cost-saving measures proposed by ex-Minister Rubáš months ago, without estimating the savings these measures would produce or setting a timeline for a pay rise (ČTK 1995a-d). Therefore, the Short-Term Programme did not appease the Club and the strike was not called off. Minister Stráský made what was either a last-ditch attempt to appease doctors or the first attempt to diffuse blame for the strike on 31<sup>st</sup> October, on television. He argued that the strike 'did not make sense because the government has showed interest [in fulfilling the doctors' demands]' and promised to increase doctors' salaries in January, on the basis of expected economic growth and efficiency gains in the health sector (ČTK 1995a-v).

### ***Strike of Doctors' Trade Union Club***

On 1<sup>st</sup> November 1995, 5,000 doctors attended a demonstration in front of the Health Ministry in Prague (ČTK 1995a-t). The demonstrators made mixed demands, which showed that they were interested in a pay rise, regardless of whether it was delivered by the market or government. They deemed it unacceptable that reimbursement rates for health care services were dictated by the government while the prices of medical equipment and drugs were determined by the market. Therefore, they demanded market-oriented reforms and urged the government to define the services for which health insurance could reimburse doctors at sufficient rates and the services for which doctors could charge patient co-payments. They also demanded an immediate injection of government funds, from the state budget into the health care sector, to repay the debts of insolvent hospitals and increase doctors' salary tariffs to the level of other civil servants. The demonstrators clearly showed their ambitions for power in the health sector and attacked the incumbent health sector elites, accusing the current leadership of the Medical Chamber of acting against the interests of the medical profession and urging doctors to

vote for representatives of the Club in the forthcoming election to the Medical Chamber's Executive Board. Their placards read 'Rath Yes, Svoboda No', 'Rath Speaks for Us', and 'Government Harms Patients' (ibid.) and the demonstration was followed by a two-week administrative strike across the country, though without much impact.

In drawing attention to the health sector, and promoting the Doctors' Trade Union Club and its leaders, the strike succeeded beyond expectation: David Rath made headlines more often than PM Klaus or the leader of the opposition (HN 02.11.1995). The press, however, was divided. The centre-left newspaper *ZN noviny* criticised as 'arrogant' the government's position that the health sector did not need extra funding, but only a better organisation and management system: for, after three years in power, the government had failed to create such a system and, instead of taking responsibility, blamed doctors for harming patients during the strike (*ZN noviny* 03.11.1995). In contrast, the 'market *Komsomol*' newspaper, *MF Dnes*, blamed doctors:

The forty years lost under communism is a bitter fact which everyone must put up with. Doctors can do so by becoming better accountants or businessmen (*MfD* 01.01.1995).

This was undue criticism, because the demonstrators favoured market-oriented reforms that would liberalise the price of health care services and allow them to charge patients directly. As shown earlier, in the first attempted doctors' strike, by the Brno Crisis Centre in 1992, doctors were against privatisation *because* they were good 'accountants' and 'businessmen': they calculated that, under the reimbursement rates dictated by the state, privatisation did not make economic sense (Vlk 1992). Another right-wing newspaper, *Lidové noviny*, produced a more perceptive analysis of the situation:

The present health system can be called surviving socialism. Even the right-wing government has done little to change this. What is the outcome of its privatisation programme? (*LN* 02.11.1995)

Indeed, one of the underlining causes of the doctors' strike was the fact that the self-styled Thatcherite Klaus's government had failed to implement market-oriented reforms, allowing doctors to take a winning position in the market-place; instead pursuing anti-liberal policies to force doctors to work for insufficient pay.

Besides doctors' economic interests, another underlining cause of the doctors' strike was Rath's emerging leadership. He was fighting against the incumbent leaders of the medical

profession to establish his Doctors' Trade Union Club as a major political force in the health sector. The strike showcased his leadership, establishing the Doctors' Trade Union Club as a major health politics player, and re-drew alliances among the medical profession. When it was established, in March 1995, the Doctors' Trade Union Club had only 300 members and Rath was hardly known outside Motol Hospital; but seven months later the Club boasted 6,000 members and Rath became a household name (ČTK 1995p). After the strike, the alliance between the Club and the 4,000-strong Union of Czech Doctors grew even closer. In protest against the 'radicalisation' of the Union, Petr Sucharda stepped down as the Union's Chairman and was succeeded by the Deputy Chairman of the Club, Pavel Horák (ČTK 1995p). The alliance of these two doctors' organisations significantly increased their combined influence: whereas the Club mainly represented junior doctors from Prague, the Union drew its membership from more senior doctors across the country, especially Moravia.

### **The Doctors' Trade Union Club versus the Medical Chamber**

Rath and his associates aimed their main criticism at the leaders of the Medical Chamber. Rath accused the Medical Chamber of taking orders from the government to pacify strike-minded doctors and of supporting the government which undermined doctors' economic interests: while the judiciary enjoyed a starting salary of Kč24,000 per month, doctors had only Kč8,000 per month (ČTK 1995a-d). Yet, when the Medical Chamber boycotted the government a few months earlier, David Rath himself collaborated with the government. Moreover, there was no ideological difference between the positions of the Club and the Medical Chamber on health care reform as they were void of ideology: both demanded that the government either liberalise health care or increase doctors' salaries. The conflict between the two organisations was rather based on the political ambitions of their leaders and the actions their followers were willing to undertake to advance their economic interests. First, Rath and his associates simply wanted to oust the incumbent leaders of the Medical Chamber in order to take their places. This is evident from the subject of the most heated debate at the Conference of the Medical Chamber before the strike – the place from which David Rath ought to speak. He stormed through the audience in an unsuccessful attempt to capture the Chairman's microphone but, after

being rebuked and told to speak from the audience, insisted that he would either speak from the Chairman's microphone or not at all (HN 02.12.1995). Second, there was a notable difference in the age of the followers of the Doctors' Trade Union Club and the Medical Chamber. As the Medical Chamber's President Svoboda put it, doctors under 27 initially supported the Club, then gradually changed their attitudes until the age of 35, while the overwhelming majority of doctors over 35 supported the Medical Chamber (ČTK 1995b). It is plausible that junior doctors supported the Club because they were worst affected by low pay and long hours. Senior doctors enjoyed higher tariffs and an incremental pay rise, and could shift less desirable responsibilities onto junior colleagues. Also, senior doctors had more responsibilities at work and home, preventing them from participating in demonstrations and strikes.

The Club used the Medical Chamber's Conference in December 1995 to continue its assault on the leadership of the Medical Chamber for failing to protect doctors' economic interests. According to law, the Chamber was created both to uphold professional standards and promote doctors' economic interests. The Club maintained that the Chamber should have done more to protect doctors' economic interests, whereas the Chamber's leaders argued that it should concentrate on professional issues. Elections to the Chamber's Executive Board demonstrated growing support among the medical profession for the Club's position, though for David Rath himself. Out of 375 votes, he received only 1 vote for the post of Vice President and 11 for the post of Executive Officer (ČTK 1995g). Although the Club's nominee, a more senior doctor, Jaroslav Štrof, lost a close battle for the post of President to the incumbent, Bohuslav Svoboda, he managed to topple the incumbent Vice President, Miroslav Čerbák. Two other Club nominees and its six 'sympathisers' gained representation on the 19-strong Executive Board (ibid.).

### **Short-lived social dialogue in health care**

Besides splitting the medical profession, the Doctors' Trade Union Club's strike served as a catalyst for short-lived social dialogue in health care. Following the proposal of the Union of Employer Associations (Unie ZS), the Council for Dialogue between Social

Partners in Health Care was established in September 1995, to avoid industrial action in health care through tripartite dialogue between employers (associations of hospitals and independent providers), employees (trade unions) and the government. This body was part of a large semi-tripartite body, the Council for Dialogue of Social Partners (RDSP), in which the government participated only as an observer. Nonetheless, even in the heyday of the Council for Dialogue between Social Partners in Health Care, government representatives did not attend Council meetings regularly. The government believed that tripartite dialogue was unnecessary because health care was the responsibility of government and Parliament (ČTK 1996d). Essentially, the Council's role was reduced to facilitating bipartite dialogue between employers and employees.

Despite the often conflicting interests of employers and employees, the Council recommended that the government (ČTK 1995l):

- build a network of state health care providers;
- regulate health insurance reimbursement rates and the prices of medicines;
- ensure the functioning of the General Health Insurance Fund and raise state health insurance contributions in line with inflation;
- make a single health insurance fund to collect and manage health insurance contributions;
- reimburse health care providers not only for the volume but also quality of provided care.

These recommendations represented a massive shift in the attitude of health care providers to reform. As shown earlier, the providers initiated the introduction of health insurance to maximise their revenue. But, in the resultant health insurance system, they could not do so because the state dictated fee-for-service reimbursement rates in order to minimise public health expenditure, while the prices of drugs, medical devices, etc. were set by private companies to maximise their profits. As a result, 85% of hospitals were in debt in early 1996 (ČTK 1996g). In order to have their debts repaid and ensure a continuous supply of pharmaceuticals and medical devices, health care providers suggested bringing the state back in. It is crucial to realise that the answer to the question 'to what degree the health care system should be market-oriented' was determined by the economic interests of the health care providers, rather than abstract political ideology. When providers thought that market mechanisms would maximise their revenue they supported the market; but when the state intervened in the market to regulate the revenue

of health care providers, they called on the state to regulate health insurance funds and the prices of drugs, medical devices, etc. too.

The same applies to the state: the government pursued anti-market regulatory policies in health care, yet rejected the idea of building a network of state health care providers to avoid taking financial responsibility for it. Instead, the Long-Term Programme of the Health Ministry suggested that a network of providers would be formed spontaneously, i.e. by patients choosing doctors, health insurance funds contracting providers, the state regulating the capacity of state-owned providers, and the accreditation process (MZ ČR 1995a). As this Programme went against other recommendations of the Council, which required increasing financial obligations of the state to health care providers, the Council emphatically rejected it (ČTK 1995c).

In addition, trade unions' demands for higher pay were ignored by the government and employers. Although employers, i.e. hospital managers, disagreed with government policies, they blocked in the Council trade unions proposals for higher pay because most hospital managers were under the government's administrative remit. Consequently, the Council lacked any problem-solving capacity and served only to relieve pressure from employers by postponing industrial action. After six months of fruitless discussions, the Co-Chairman of the Council, Jiří Schlanger, who represented the Health and Social Care Trade Union, together with the leaders of other trade unions, walked away from the Council in March 1996 and launched a series of industrial actions for higher pay and against the re-election of the government (ČTK 1996n).

### **The Doctors' Trade Union Club's policy proposals**

Two months after the strike, the Doctors' Trade Union Club concluded that:

The hopes pinned on [Minister] Stráský are diminishing week by week. Neither his Short-Term, nor his Long-Term Programme gives an answer to the fundamental question – where to find the lacking financial means [for a pay rise] (Právo 30.12.1995).

Therefore, in addition to calling for a new strike, the Club submitted a series of policy proposals to the Health Ministry, namely the Short-Term and Long-Term Programmes of

Health Care Reform. Given the Club's reputation for radical rhetoric, one would expect radical policy proposals, but this was not the case. Essentially, the Short-Term Programme rephrased the government's proposals to raise funds for a pay rise through regulatory cost-saving measures and suggested a few measures to increase health care expenditure (Rath *et al.* 1996b):

- Liquidate insolvent health insurance funds under 100% state guarantee in order for these funds to repay their debts to health care providers;
- Reduce the administrative costs of health insurance funds;
- Return to health care the full amount of VAT raised in the health care sector;
- Introduce patient co-payments for hospital stays and prescription drugs;
- Reduce pharmaceutical expenditure and introduce administrative control of drug prices;
- Claim unpaid health insurance contributions and tighten sanctions for non-payment;
- Remove occupational health care screening from general health insurance;
- Separate social care from health care paid for by general health insurance;
- Change point-based fee-for-service reimbursement to crown-based and raise reimbursement rates in line with inflation;
- Postpone privatisation until the new system of health care financing is introduced;
- Establish Supervisory Boards in state health care facilities, with employee representatives.

The Long-Term Programme (Rath *et al.* 1996a) did not propose anything radical, besides creating a three-tier general health insurance system with three levels of benefits corresponding to the actual level of contributions. It is likely that this proposal was inspired by the 1947 legislation introducing different levels of benefits for workers, public servants and the self-employed. However, the underlying logic of the Club's proposal, decreasing solidarity to increase health insurance revenue and decreasing health insurance benefits, was similar to PM Klaus' proposal for MSAs. Moreover, the Club argued that the general health insurance premium of 13.5% should not be increased and only the base for state health insurance contributions should be increased, from 65% of the minimum wage to 65% of the average pension. Compared to the Medical Chamber's earlier demand, to increase the health insurance premium to 15% and the base for state health insurance contributions to 120% of the minimum wage, the Club's proposal would generate considerably less additional funding for health care. Furthermore, like the government, the Club proposed to decrease the health insurance premium in the future,

when economic growth would ensure enough funding for health care through a decreased health insurance premium.

Although the Club's policy proposals essentially paraphrased and extended the government's policies, the Club claimed that the health policies of the governing Civic Democratic Party were 'helpless and awkward' (Rath *et al.* 1996a). Despite demanding less funding for health care from the government than the Medical Chamber, the Club claimed that the Chamber acted against the interests of the medical profession. I would like to argue that the contradiction between the radicalism of the Club's rhetoric and its moderate government-like policies could possibly be explained by the fact that the Club's leader, David Rath, was seeking a place in the government. He seemed to employ harsh rhetoric simply to generate publicity in the run-up to the election. Previously a member of the Civic Democratic Party, he joined the Free Democrats – Liberal National Social Party (SD-LSNS) shortly before the 1996 election and became the electoral leader of this party in East Bohemia.

## ***Government's health policy proposals***

### **Medical Savings Accounts**

Besides reiterating the regulatory cost-saving measures pursued by the Health Ministry, the Long-Term Programme of the Health Ministry (MZ ČR 1995a) proposed to make the patient 'a responsible consumer of health care' by dividing the existing general health insurance into two streams: solidarity-based health insurance (70%) and individual MSAs (30%). While MSAs were supposed to pay for 'cheap, optional, and foreseeable' health care services and drugs, solidarity-based general health insurance was expected to cover 'costly, urgent, and unforeseeable' health care costs (*ibid.*). The main idea behind MSAs was to control public health care expenditure, by providing patients with negative incentives to avoid over-prescription of drugs and over-utilisation of health care services: patients had to top-up their MSAs with cash if they had an overdraft.

Although PM Klaus personally promoted MSAs, political parties (with the exception of his own Civic Democratic Party and the Civic Democratic Alliance) and the medical profession were against MSAs. Even the Christian Democrats – the second largest party in the governing coalition – rejected MSAs. Both the Medical Chamber and Doctors' Trade Union Club opposed MSAs because they were unlikely to bring substantial additional funding to health care, while the costs of setting up MSAs could have been better used to increase doctors' salaries. Like his predecessor, Minister Stráský was sceptical about MSAs and did not actively pursue their introduction. Speaking less than a month after he presented the Long-Term Programme, he stated that it was uncertain whether MSAs would be introduced at all; explaining that the main disadvantages of MSAs were their high administrative costs and the risk that some patients might try to save on medical treatment (MfD 29.12.1995). Moreover, the Civic Democratic Party's electoral manifesto did not even mention MSAs, making only general statements about 'individual choice' and being 'a responsible and informed consumer [of health care]' – alluding to MSAs without explicitly mentioning them (ODS 1996). Altogether, the government and Civic Democratic Party did not actively pursue the idea of MSAs, concentrating on urgent cost-saving measures instead.

### **'Martial law' in health care**

The government tried in vain to pacify trade unions by increasing the value of the reimbursement point. PM Klaus argued that a pay rise would not solve the cause of the health sector problem – the overproduction of health care, which kept the value of the reimbursement point down – and suggested 'the administrative blockage of the volume [of health care services] or blockage of the supply [of health care services]' in order to increase the value of the reimbursement point (ČTK 1996f). In essence, he was covering up the government's command and control measures known as 'Action Frequency' with bits of supply and demand economics. The government ordered the General Health Insurance Fund to increase the value of the reimbursement point by Kč0.12, drugs distribution companies to lower sales margins for drugs by 3%, and the managers of state health care facilities to freeze the 'frequency' (i.e. volume) of provided health care services at 110% of 1995 levels for the same period (Usnesení vlády ČR č. 162+P/1996).

Health care managers were promised their bonuses would be increased if they complied with the order; otherwise – slashed (ibid.).

Despite high inflation (21% in 1993, 10% in 1994, and 9% in 1995), the value of the reimbursement point had not been increased since early 1993, because of growing health insurance deficit. The government blamed this deficit on doctors abusing the fee-for-service health insurance reimbursement system and turning it into a ‘self-service’ system. The government justified not increasing the value of the reimbursement point in line with inflation by claiming that providers compensated for inflation by increasing output. ‘Action Frequency’ sought to control output to increase the value of the reimbursement point. For most health care providers, this would decrease, rather than increase, revenue. The largest part of hospitals’ revenue came from reimbursement for hospital bed occupancy (bed-days), rather than point-based services. When the government ordered hospitals to freeze the number of bed-days, hospitals seemed to lose more than they gained through the increased value of the reimbursement point. The revenue of outpatient clinics came mainly from point-based services, so the increased value of the reimbursement point favoured them. However, the General Health Insurance Fund divided its budget into four chapters for different types of health care and increased the value of the reimbursement point differently for each type of health service: higher for hospitals and lower for outpatient clinics.

Everyone in the health sector opposed ‘Action Frequency’. Associations of hospitals dubbed it ‘martial law’ (MfD 22.02.1996), but had to comply because, otherwise, hospital managers would lose their bonuses, if not jobs. Trade unions were strongly against ‘Action Frequency’. The Health and Social Care Trade Union criticised employers for their complicity with ‘Action Frequency’ and walked out of the Council for Dialogue of Social Partners in Health Care to strike against it (OSZSP 2000). The Union of Private Doctors also supported the strike, rejecting ‘Action Frequency’ on the grounds that it was ‘heavy state dirigisme when a state clerk together with a health insurance fund decide about [private doctors’] existence or non-existence’ (ČTK 1996t). The Union of Private Doctors announced that, if the government did not introduce new

reimbursement rates in crowns instead of points which it changed as it pleased, private doctors would start charging patients according to their own rates (ibid.). The Medical Chamber maintained that a strike and ‘Action Frequency’ would ‘destroy hospitals in three weeks’ (ČTK 1996a).

### **The value of the reimbursement point increased**

Command and control regulation of the supply of health care services could possibly improve the balance of the health insurance system in the long run, but was unlikely to generate the resources required to increase the value of the reimbursement in the few months before the election. Although the government ordered the General Health Insurance Fund to increase the value of the reimbursement point by Kč0.12, the Fund insisted that this was impossible without increasing health insurance funding and bringing forward the payment of state health insurance contributions (ČTK 1996p). In its budget plan for 1996, the General Health Insurance Fund did not plan for an increase of the existing value of the reimbursement point because of lack of funds (PSP 1995b). Therefore, to comply with the government’s order, the Fund had to convince the government to increase state health insurance contributions, bring forward their payment by the Finance Ministry, and settle for a lower increase – Kč0.08 on average. The government agreed to increase the base for state contributions from 65% to 80% of the minimum wage and bring the payment of state contributions forward, from the second to the first half of the year. Nonetheless, under the pressure from the government to announce the increase of the value of the reimbursement point before a doctors’ strike, the General Health Insurance Fund had to do so before the necessary amendment of the Health Insurance Contributions Act was approved by Parliament (Zákon č. 149/1996 Sb.).

This amendment demonstrates how haphazard and short-sighted health policy-making was: this was the government’s fourth attempt in four years to set the level of health insurance contributions right and ran against the logic of the previous amendments. When the General Health Insurance Contributions Act (Zákon č. 592/1992 Sb.) was being adopted, the government fought off the Medical Chamber and MPs who wanted to set the

health insurance premium and base for state contributions at a higher level. Then, the government amended this Act to lower the base for the contributions of the self-employed from 45% to 35% of their profit (Zákon č. 161/1993 Sb.), and the base for state contributions from 70% to 65% of the minimum wage (Zákon č. 59/1995 Sb.). When these amendments led to the insolvency of 85% of hospitals and doctors' strikes, the government increased the base for state contributions from 65% to 85% (Zákon č. 149/1996 Sb.). These amendments prove that Miroslav Čerbák MP was right when he argued that the government simply did not know how to estimate the needs of the General Health Insurance Fund correctly (ČNR 1992d). These amendments also square well with Schumpeter's proposition that 'the democratic method creates professional politicians whom it then turns into amateur administrators and "statesmen"' (Schumpeter 1984, p.288).

Another important observation about these amendments is that every Health Minister is under permanent pressure from the 'economic ministers' to reduce public health expenditure but, in exceptional circumstances, such as forthcoming election, the alternative logic of self-preservation may apply. It is irrational for a Health Minister to reduce funding for health care, because this may cause problems for him in the future. Yet, this can be rational, if we consider the Health Minister's 'begging' position in the government and that he has to comply with the 'economic ministers' to keep his job. The 1993 and 1995 amendments to the General Health Insurance Contributions Act reduced the revenue of the General Health Insurance Fund, contributing to its Kč5.5bn deficit by the beginning of 1996. As Jan Stráský put it:

Every Finance Minister argues with [the Health Minister] about each extra crown and will tell that 5bn is a lot, but then there is the government which by a certain vote will brush off that Finance Minister (Stráský interview 2005).

### **Debts of insolvent health insurance funds partially repaid**

Another contentious issue in the health care sector was the liquidation and merger of insolvent and inefficient health insurance funds, as proposed by ex-Minister Rubáš. The government initially refused to guarantee the repayment of debts of the insolvent health

insurance funds to health care providers. Then the government agreed to repay debts only to the providers with the highest outstanding liabilities, which included state hospitals and large pharmacies, but not private doctors, dentists and small pharmacies. Therefore, private doctors, dentists and pharmacists threatened to withdraw from health insurance, if the government did not repay them the debts of the insolvent health insurance funds. The Association of Paediatricians and the Dental Chamber threatened that they would start charging patients in cash and let them claim reimbursement from health insurance funds, if the government did not repay the debts of insolvent health insurance funds (ČTK 1995j). The Czech Pharmaceutical Chamber also argued for similar measures because the majority of pharmacies were burdened with the debts of insolvent health insurance funds (ČTK 1995e). Interestingly enough, the doctors, dentists and pharmacists justified their threat to charge patients in cash and let them claim reimbursement from health insurance funds on the grounds that this was how health insurance functioned during the First Republic. Under such a ‘historical’ threat, the government agreed to pay liabilities of insolvent health insurance funds to everyone, but only at 80% (Usnesení vlády ČR č. 184/1996).

To raise funds towards these liabilities, the government proposed to liquidate assets of insolvent health insurance funds, but this was not enough. As the government was strapped for cash, it had to sell off some of its own assets to meet the demands of health care providers. The National Property Fund deposited the state’s shares in privatised companies with a view to using them, among other purposes, for the needs of health and social insurance (Zákon č. 171/1991 Sb.). Therefore, the government decided to sell off Kč0.8bn worth of its equity, deposited in the National Property Fund, to pay the liabilities of insolvent health insurance funds (Usnesení vlády ČR č. 174/1996).

### **Abolition of salary tariffs**

Minister Stráský’s proposal to abolish salary tariffs in health care further demonstrated how haphazard, short-sighted and un-programmatic health policy-making generally was. Although the Health Ministry’s Long-Term Programme aimed to define its policies for two years ahead, the Programme failed to mention the actual policies of the Health

Ministry just one month ahead; for instance, Stráský's unexpected proposal to abolish salary tariffs in health care. This became the single most important health policy proposal of 1996, provoking a wave of new strike action in health care. If we recollect Stráský's earlier statement that it was undecided whether the MSAs would be introduced at all, despite being part of the Long-Term Programme, it appears policy-making was driven by swiftly-changing politics rather than a stable set of commitments and ideas.

In January 1996, Minister Stráský argued that salaries in health care should be increased by 20%, which was more than the 6-7% proposed by the Labour and Social Affairs Ministry for the 'budgetary sphere', i.e. public services (ČTK 1996c). In health care, salaries were calculated according to tariffs common to the whole of the 'budgetary sphere'. If Minister Stráský wanted to increase tariffs in health care then this would lead to considerable budgetary expenditure on increasing salaries across the rest of public services. Therefore, he proposed abolishing salary tariffs in health care and introducing a performance-based contractual payment system instead (ibid.). Accordingly, the suggested 20% pay rise would be implemented at the discretion of hospital managers. Although ex-Minister Rubáš had tried several times to abolish salary tariffs, and failed because of the medical profession's opposition, Stráský's proposal was swiftly endorsed by the 'economic ministers' and submitted to Parliament for deliberation.

## ***New strike actions***

### **Trade unions united against abolition of salary tariffs**

The proposal for the abolition of salary tariffs made a much more powerful impact on health policy than any other policy proposal that year. While the idea of MSAs died peacefully, without generating much public discontent, the proposal to abolish salary tariffs generated powerful protests in the health sector. Given that, in the beginning of 1996, 85% of hospitals were insolvent, the abolition of tariffs would give hospital managers an opportunity to improve their balance sheet by reducing labour costs. Thus, hospital managers favoured the proposed contractual pay. Also, Finance Minister Kočárník argued that the existence of 15% of hospitals with no debt was enough to prove

that it would be possible to increase the salaries of health workers at the discretion of hospital managers (ČTK 1996g). However, trade unions insisted that the 85% of hospitals would actually reduce salaries of doctors and nurses, if their managers were given the right to set salaries for their employees. The largest confederation of trade unions, the Bohemian-Moravian Chamber of Trade Unions (ČMKOS), opposed the abolition of salary tariffs, criticising the government for shifting the responsibility to improve remuneration in health care onto hospital managers (ČTK 1996g).

The replacement of tariffs with performance-based contractual pay would affect different groups of employees differently. Whereas most junior doctors could gain, senior and very junior doctors could lose out. Moreover, everyone could lose out if hospital managers desperately needed to cut labour costs. Therefore, the Medical Chamber opposed the abolition of tariffs. The Doctors' Trade Union Club, which in the beginning of its activity had favoured performance-based contractual pay, now adopted a more cautious position. The Club did not reject the contractual pay, but argued that, prior to the abolition of tariffs, the lower limits of contractual pay should be set at sufficient levels, i.e. higher than existing tariff-based salaries.

### **Nurses to go on strike**

As for less qualified employees, such as nurses and ancillary staff, these were most susceptible to pay cuts under the contractual system. Even Minister Stráský admitted that this was the case, suggesting that the contractual system should stipulate the minimum pay and fixed proportional relations between the salaries of various groups of employees in health care (ČTK 1996a-a). Effectively, this proposal preserved the tariff system, but shifted responsibility for it onto hospital managers. Given that 85% of hospitals were insolvent, it was unrealistic for nurses and the ancillary staff to expect that hospital managers would maintain their salaries. Therefore, it was not long before they reacted: the 5,000-strong Independent Trade Union Organisation of Nurses (NOOSZP) issued a strike alert in protest against the abolition of salary tariffs, demanding that the salaries of nurses be increased to 120% of the average salary in the national economy (ČTK 1996a-b). Moreover, they announced that they would closely co-ordinate their activities with the

Doctors' Trade Union Club, and accept its leadership in the preparation of the strike. This was a momentous decision because, for the first and only time, health sector employees consolidated their forces, despite the perennial struggles between different groups of employees:

Nurses and ancillary staff against doctors, nurses against nurses, and doctors against each other (GPs against hospital doctors, non-state doctors against state doctors, individual specialties against each other) (Sojka 1996).

Initially, the largest trade union, the Health and Social Care Trade Union, opposed the strike and instead sent Parliament a petition against the abolition of tariffs, signed by 66,373 out of some 120,000 health workers whose pay would be affected by the abolition of tariffs (ČTK 1996s). Also, professional organisations of nurses such as the Czech Association of Nurses (ČAS) and the Czech Society of Nurses (ČSS) disapproved of the strike alert of the Independent Trade Union Organisation of Nurses. At the same time, the 15,000-strong Professional Trade Union of Health Care Workers (POUZP), which previously criticised the Doctors' Trade Union Club and its November 1995 strike (ČTK 1995u), supported the strike alert and later joined the decision of the Doctors' Trade Union Club to go on strike (ČTK 1996a-c). Moreover, the largest confederation of trade unions in the Czech Republic, the Bohemian-Moravian Chamber of Trade Unions, supported the strike alert because the Professional Trade Union Organisation of Nurses was a member of this Confederation. Under threat of losing momentum and thus members, the Health and Social Care Trade Union supported the joint strike and later organised its own 'Campaign Titanic', which was supported by the Doctors' Trade Union Club (ČTK 1996q).

## **Spring 1996 strikes**

### ***Joint nation-wide strike of doctors and nurses***

The Doctors' Trade Union Club led a two-day nationwide strike of major health care trade unions. On 25<sup>th</sup> March 1996, 16,500 health workers and 150 ambulances participated in demonstrations in Prague and approximately 80% of state health care facilities went on strike nationwide (ČTK 1996b). The Club protested against Minister

Stráský's 'authoritarian' position towards trade unions and reiterated its demands for a pay rise in tariffs (LOK 1996b). The nurses protested against being paid 'less than cleaners' and demanded pay of 120% of the average national wage (ČTK 1996b). The Association of the Non-State Health Service Transport demanded an increase in reimbursement rates for ambulance services. Although the members of the Union of Private Doctors (SSL) did not participate in the strike, for economic reasons, their Union issued a note supporting the strikers and blaming the government for the fact that '[p]rivate doctors have hit the economic rock bottom and have to ponder whether to treat patients because of their best conscience as many in their virtuous occupation are in loss' (ČTK 1996d).

The strike had a clear anti-government sentiment. The demonstrators carried signs against the governing Civic Democratic Party (ODS) that read 'ODS Harms Health', 'ODS Voters – You'd Rather Be Healthy', 'Support Your Doctor', and 'You Can't Buy Health on the Market' (ibid.). The strike did not promote a certain political party, even though some of its organisers were politically engaged. For example, Richard Falbr, the leader of the largest confederation of trade unions, was former Deputy Chairman of the Social Democratic Party and was running for Senator with this Party. The Chairman of the Doctors' Trade Union Club, David Rath, was one of the electoral leaders of the Free Democrats – Liberal National Social Party. Nonetheless, the Club claimed that it 'did not have either ambition or ability to unite doctors in the political field under the flag of one party' (LOK 1996a). It is questionable whether the Club indeed lacked political ambition, but David Rath's subsequent electoral failure proved that at that time their leaders certainly lacked the ability to capitalise politically on their trade union activities.

### ***'Campaign Titanic'***

The March 1996 strike was followed in the middle of May by 'Campaign Titanic', organised by the Health and Social Care Trade Union, and a low-key strike organised by the Doctors' Trade Union Club. 'Campaign Titanic' brought together all major health care trade unions in an attempt to convince the public and the government that 'health care was sinking like the Titanic' (ČTK 1996k). The Health and Social Care Trade Union

hired a cruise ship and invited government officials, representatives of various health care organisations, the public and the media to join them aboard for a jazz and champagne reception. According to the organiser of the event, Chairman of the Health and Social Care Trade Union, Jiří Schlanger, ‘Campaign Titanic’ aimed to provoke political parties to put a greater emphasis on health care in their electoral programmes and to demonstrate that health care problems should be solved through dialogue, in the media spotlight, between politicians and trade unions (ibid.).

### ***‘Educational’ strike***

The Doctors’ Trade Union Club organised its third, and rather low-key, strike with an ‘educational’ purpose (ČTK 1996o). Doctors stopped work for a couple of hours and invited hospital management and the public for a talk on the current state of health care. The purpose of this strike was to reveal the ‘authoritarian and autocratic’ practices of the Health Ministry behind its ‘democratic mask’ (ibid.). For example, the Club referred to the case where Minister Stráský first announced the joint employers and employees selection procedure for appointing the Director of Motol Hospital, but then overturned the results of the vote in favour of his personal choice. This was not the first time that the Health Ministry did not honour its own commitments to the democratic appointment of hospital managers. It was legitimate for the Health Ministry to make appointments in its hospitals as it pleased, but David Rath argued that the Health Ministry was wasting doctors’ time and taxpayers’ money on ‘staging a game in democracy and just choice’ (ibid.).

The protest actions of trade unions had mixed results. On the one hand, trade unions neither achieved the desired pay rise nor convinced Parliament that health care was in crisis. MPs did not support the motion of the Left Block that the situation in health care was ‘unsatisfactory’ (PSP 1996g). On the other hand, Parliament did not approve of the abolition of tariffs. The opposition attempted to block the first reading of the government’s proposal to abolish tariffs but did not succeed, so the proposal was forwarded to the Budgetary Committee for further scrutiny. Even though this proposal was against the interests of the medical profession, doctor-MPs from the governing

parties supported it, with the exception of Miroslav Čerbák MP (PSP 1996b). The government did not succumb to pressure from trade unions and did not withdraw the proposal, but the Budgetary Committee did not recommend that Parliament vote on the proposal (PSP 1996c). Most likely, this was due to the fact that Parliament was about to be dissolved for the general election. After the election, the Civic Democrat-led government no longer had a parliamentary majority and the proposal for the abolition of tariffs was easily defeated by the opposition (PSP 1996a).

## CHAPTER 10: CIVIC DEMOCRATIC HEALTH MINISTER STRÁSKÝ, 1996-97

### *1996 election and party policy pledges*

In the 1996 election, health policy achieved perhaps the highest salience compared to the previous elections (Table 10), due to a series of strikes in health care and the widespread insolvency of hospitals. For the Communists, health policy became the single most salient issue; for the Christian Democrats it was one of the two most salient issues; for the Civic Democratic Party – the second most salient issue, for the Social Democrats – the third most salient issue, and for the Civic Democratic Alliance – the fourth most salient issue. Other dominant issues were financial incentives, law and order, environment, and welfare expansion (including health care).

**Table 10: Most salient electoral issues by the frequency of issue-related quasi-sentences in 1996 party manifestos, %**

Party \ Issue	Incentives	Democracy	Decentralisation	Environment	Culture	Education	Law and order	Infrastructure	Privatisation +	Social Justice	Welfare state +	Welfare state–	Health Care
<b>Communists (KSČM)</b>	4.4	8.4	1.3	6.3	4.9	1.3	4.0	0.9	0.0	4.9	5.3	0.0	<b>8.9</b>
<b>Social Democrats (ČSSD)</b>	5.6	4.8	3.0	6.3	3.2	3.7	5.2	4.8	0.0	3.2	6.2	0.6	<b>5.0</b>
<b>Civic Democratic Alliance (ODA)</b>	10.0	2.6	5.5	3.3	2.2	1.7	7.6	3.6	1.0	4.0	† 5.3	4.1	<b>5.2</b>
<b>Civic Democrats (ODS)</b>	4.3	1.5	2.2	2.0	2.0	2.7	6.9	2.9	2.4	1.6	2.3	1.6	<b>4.8</b>
<b>Christian Democrats (KDU-ČSL)</b>	4.4	2.2	3.8	6.0	2.6	2.9	4.2	3.6	0.7	2.6	† 7.1	0.7	<b>6.0</b>

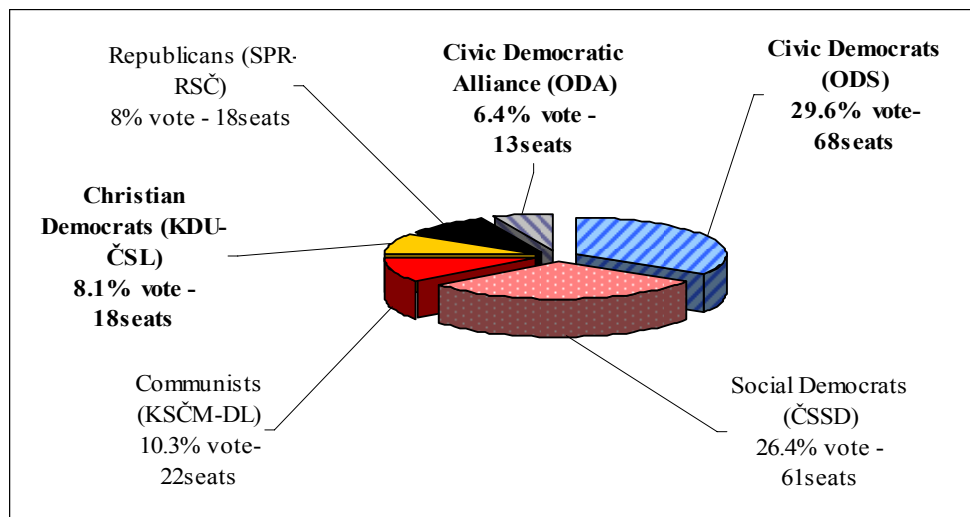
Source: own analysis based on Klingemann & Volkens (2002) and Klingemann (2006)

Note: see Appendix for the explanation of issues and methodology

† According to my analysis, the ‘welfare state expansion’ category is miscalculated in the original dataset. These parties argued for improving and expanding welfare provision, but largely by shifting responsibility from the state to individuals, families, charities, and the church.

The Civic Democratic Party won the election by a thin margin and formed a minority government with the Civic Democratic Alliance and Christian Democrats (Figure 8). In their ‘Freedom and Prosperity’ manifesto, the Civic Democrats deemed post-Communist reform successful in creating ‘a modern European health care system’ characterised by a non-state character, greater availability of services, quality, and freedom of choice (ODS 1996). Yet, they recognised that an increase in the use of new medical equipment, drugs and services often led to higher health care costs without medical benefits and pledged ‘to stabilise the health care system and to limit its purposeless extensive growth’ (ibid.). They proposed to speed up privatisation of inpatient health care facilities; convert excessive hospital beds into long-term social care facilities; strengthen state control over health insurance funds; and introduce contracting in the state-owned facilities to raise funds to increase pay for the most qualified medical staff. The Civic Democrats also pledged to reconsider unreasonable solidarity in health care financing, increase the role of voluntary health insurance, and ‘to put the individual in the centre of decision-making in health care, both on the side of demand, and on the side of supply’ (ibid.). There was a clear contradiction between the Civic Democrats’ pro-market electoral rhetoric and their actual policies: since 1993 they had consistently increased the state’s role in health care decision-making and, just a few months before, PM Klaus himself argued for ‘the administrative blockage’ of supply and demand in health care (ČTK 1996f).

**Figure 8: Summary of the 1996 Parliamentary election results**



Source: (ČSÚ n.d.)

The Civic Democratic Alliance – the closest ally of the Civic Democratic Party – broadly mirrored the health policies of the Civic Democrats, in particular, arguing for substantial patient co-payments (ODA 1996). An interesting aspect in the Civic Democratic Alliance’s manifesto was that it completely dropped privatisation. Four years earlier, selling health care facilities to doctors at discounted prices had been their flagship policy but, after the privatisation of inpatient facilities flopped, the Civic Democratic Alliance did not even mention health care privatisation in their 1996 manifesto. Yet, as in 1992, the Civic Democratic Alliance advocated converting large state hospitals into non-profit organisations with the participation of the state, region and local authorities.

The Christian Democrats’ manifesto emphasised the state regulation of health insurance, pharmaceutical expenditure, and the utilisation of health services (KDU-ČSL 1996). In particular, they advocated changing the fee-for-service reimbursement to DRGs, capitation fees and budgeting. Importantly, the Christian Democrats disagreed with the Civic Democrats on several substantial issues. Although the Christian Democrats supported increasing the role of voluntary health insurance, they argued that the state should provide a full scope of standard health care to everyone, through solidarity-based general health insurance. Also, they opposed the privatisation of hospitals. Lastly, the Christian Democrats advocated the creation of a network of public health care facilities, which was strongly opposed by the Civic Democrats.

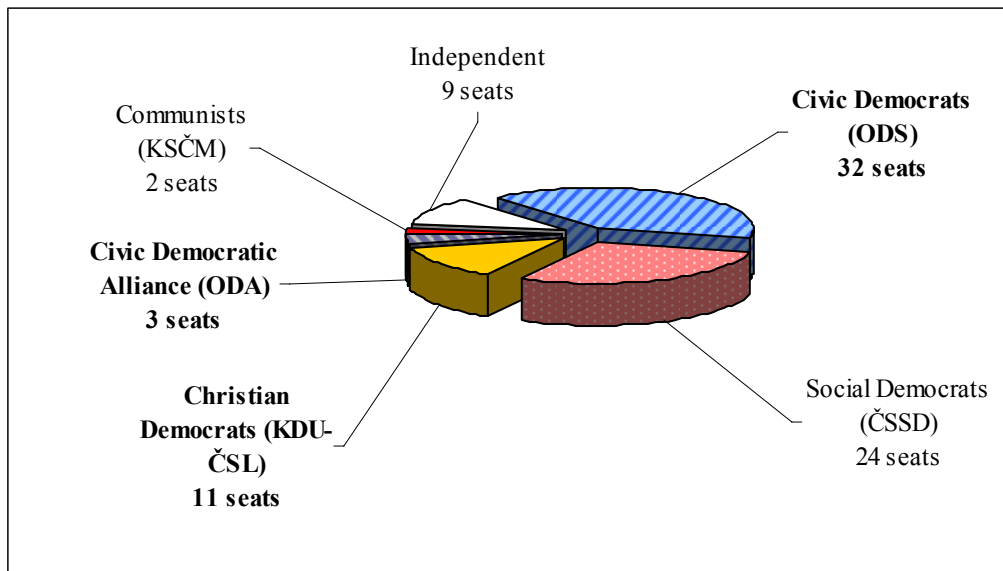
The Social Democrats came second with an impressive 26.4% of the vote. In their ‘Humanism against Egoism’ manifesto, they pledged to ‘preserve the traditions of the European non-commercial solidarity-based health insurance without patient co-payments for essential preventive and curative medical services’ and increase state contributions to the General Health Insurance Fund (ČSSD 1996). Like the Christian Democrats, they opposed ‘chaotic privatisation’ and supported the free-of-charge transfer of hospitals to local authorities with a possibility of further privatisation. The Social Democrats suggested regulating the prices of medicines and promoting domestic producers of quality medicines and pledged to support the organisations of the medical profession.

The Communists brought the left-wing agenda in health care a step further than the Social Democrats (KSČM 1996), advocating: free and accessible health care (including essential spa treatment) for everyone; abolition of patient co-payments; a leading role of the state in health care financing; state regulation of health insurance funds; liquidation of the fee-for-service health insurance reimbursement; termination of the privatisation of health care facilities; revision of the past privatisation decisions; establishment of a nationwide network of public health care facilities; and adequate social recognition and pay for health workers.

The emergence of the Social Democrats as the second strongest political party fragmented the already divided party system even further, leading to a hung Parliament. Whereas right-wing parties – the Civic Democratic Party and Civic Democratic Alliance – had 81 seats, left-wing parties – the Social Democrats and the Communists – had 83 seats. The Christian Democrats had 18 seats and a mixed program, allowing them to participate in any government. However, a left-wing coalition was not possible because the Social Democrats rejected any collaboration with the Communists in April 1995, when their 27<sup>th</sup> Conference passed the so-called Bohumín Resolution. Also, despite having been loyal supporters of the Communists for forty years, the Christian Democrats rejected collaboration with the Communists after 1989. However, the right-wing coalition of the Civic Democratic Party, Civic Democratic Alliance and the Christian Democrats had only 99 seats in a 200-strong Parliament and rejected collaboration with the Republicans – a populist protest party with 18 seats. The solution came in the form of a minority right-wing government endorsed by the Social Democrats. Even though, before the election, the Social Democratic leader Zeman harshly attacked PM Klaus' for turning the Czech Republic into 'the scorched earth' (Kopeček & Pšejja 2007), Zeman endorsed PM Klaus forming a minority government. The Social Democrats promised to obstruct votes of no confidence in PM Klaus' minority government, in exchange for the post of Parliament Speaker for Zeman and four out of ten chairperson positions in Parliamentary Committees, including the Health Committee.

In November 1996, the Czech Republic held the first elections to the Senate – the lower house of Parliament. Unlike the upper house (the Chamber of Deputies), the Senate could not initiate laws; its role was limited to scrutinising legislation passed by the Chamber of Deputies. In the period under consideration, the Senate had no significant impact on health politics due its limited role and the comfortable majority secured by the ruling coalition (Figure 9).

**Figure 9: Summary of the 1996 Senate election results**



Source: (ČSÚ n.d.)

### **Jan Stráský continues as Health Minister**

In the Civic Democrat-led minority government, the Civic Democrats retain the Health Minister's portfolio and Jan Stráský continued as Health Minister. The Coalition Agreement (ODS *et al.* 1996) stated the need to achieve 'much-needed systemic change' through:

- increasing state control and regulation of the supply of health care;
- strengthening state supervision and reducing the number of health insurance funds;
- providing patients with financial incentives to participate in the economical and rational health care financing;
- merging sickness and health insurance;

- defining the ownership structure in health care, including state guarantees [to state health care facilities] and the speeding up of privatisation;
- converting part of hospital beds for the purpose of long-term care.

The subsequent Government Declaration (Vláda ČR 1996) outlined additional measures in medical education and public health, but did not clarify the key measures of the Coalition Agreement. We can only guess that the government's commitment to 'delineate the definitive ownership structure of health care facilities' (ibid.) implied the tentative agreement of the Civic Democrats to create a network of public health care facilities, as advocated by the Christian Democrats. In turn, the Christian Democrats seemingly agreed to accelerate the privatisation of health care facilities besides this network and build 'a system of incentives for the citizen to utilise health care economically and rationally' (ibid.). The latter could refer either to MSAs or patient co-payments, which were previously rejected by the Christian Democrats. Overall, the vagueness of the Government Declaration suggests that coalition partners did not agree on health policy and that the government did not have a clear vision for health care reform.

## ***Foreign influence minimised***

### **The Ljubljana Charter**

In spite of the government's lack of a clear vision for health care reform, the Health Ministry followed PM Klaus' agenda of avoiding international advice and minimising the influence of supranational organisations. In June 1996, the WHO Regional Office for Europe formulated the Ljubljana Charter on Reforming Health Care (WHO Europe 1996b), which was signed by all European countries except the UK and Czech Republic. The Ljubljana Charter was a non-binding document, which in broad terms acknowledged the failure of market mechanisms in recent European health care reforms and argued for a stronger role of the state. It is argued that the Czech 'liberal-conservative' government did not sign the Ljubljana Charter for ideological reasons (Jaroš *et al.* 2005). Although, since 1993, the Civic Democratic Government had consistently increased state regulation and dismantled market mechanisms in health care, the Civic Democratic Party was still keen to appeal to voters as a liberal party to distinguish itself from other parties. This

apparent contradiction, between the rhetoric and policies of the Civic Democratic Party, can be explained by elite theory: the party elites, who are void of ideology and pursue policies in order to attain or preserve power, employ ideologically-charged rhetoric to appeal to partisan voters. Yet, the decision of the Czech Republic to opt out of the Ljubljana Charter could be better explained by the logic of power-maximisation. In my view, the Czech government simply did not want to tie itself to international agreements to avoid the influence on and scrutiny of its policies by better-informed experts. As shown earlier, although foreign experts warned PM Klaus that MSAs were a risky and less desirable option than public health insurance (NERA 1996, p.101), he discarded this advice and wanted to introduce MSAs.

The fact that the government did not sign the Ljubljana Charter was noticed by the government's opponents, who exploited it to support their own agendas. For example, the Health and Social Care Trade Union referred to the Ljubljana Charter to criticise the government for considering the possibilities of further privatisation, because this could lead to lower salaries for trade union members (ČTK 1996r). At that time, the salaries of doctors and nurses in private hospitals were lower than those in state hospitals. The Patients' Association (SOP) referred to the Ljubljana Charter's tenet that 'the citizens' voice should influence health services' to demand representation in health policy-making (ČTK 1996l). The Chairman of the Patients' Association was pursuing a political career in the Social Democratic Party and attempted to influence the agenda of the Health Ministry, but the Health Ministry rebuked him for not minding his own business of defending patients' rights and for meddling in the competencies of Health Ministry (ČTK 1996e). But, even on the level of rhetoric, the Ljubljana Chapter made little impact on Czech health politics.

## **EU accession**

Like other supranational actors, the EU did not significantly influence Czech health policy because health care was not included on the agenda of EU accession. The health care sector was only indirectly affected by the general discussion on signing up to the Social Policy Agreement of the EU Maastricht Treaty, i.e. the so-called EU Social

Chapter. Initially, the Czech Republic wanted to opt out from the Social Chapter. This seemed to be driven by the Euroscepticism of PM Klaus, who maintained that the Czech Republic's relationship with the EU was a 'marriage of convenience' rather than a 'marriage of love', and opposed EU influence on Czech policies (Klaus 2005b). In addition to Klaus' rhetoric, the Czech government's desire to opt out from the Social Chapter was driven by the interests of Finance Minister Kočárník to minimise public expenditure (ČTK 1996j):

The point of departure for our practice and policy is that we must be very responsible towards public finances. It means [that we should] strive for a balanced budget and for the reduction of the share of public expenditure in the GDP, regardless of whether this requires the reduction of the government consumption or reform of the social system. On this basis, it is possible to decrease this share by a certain percentage every year and, thus, reduce the tax burden, which in turn will stimulate investment.

However, Brussels ruled out the possibility of the Czech Republic opting out of the Social Chapter, so the Czech Republic had to sign it. Interestingly enough, to gain the Czech Republic's co-operation, the EU used the rhetoric of the 1947 Czech Communist vintage: EU Commissioner Padraig Flynn arguing that increased social policy expenditure would increase the productivity of the Czech economy (ČTK 1996m). Essentially, he was recycling ideas that the Czech Communists articulated half a century earlier (see Chapters 3 and 4 on the 1947 Two-Year Plan and 1949 Five-Year Plan).<sup>65</sup> Beyond rhetoric, however, the EU's influence on Czech social expenditure was nil, because it was driven by domestic politics.

The most significant direct influence of the EU on the health care sector came thanks to the Agenda 2000 document on the EU enlargement (COM/97/2000). This document criticised the Czech Republic for the absence of full-fledged social dialogue beyond the issues of remuneration. To comply with Brussels, the Civic Democratic government had to restore a body for tripartite dialogue, which they had abolished in 1992. However, social dialogue in health care was not restored to the level of the Council for Dialogue between Social Partners in Health Care, which existed between September 1995 and

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<sup>65</sup> Furthermore, the 2000 EU social policy 'Five-Year Plan' (COM/2000/0379) clearly drew on the old Czech Communist ideas of social policy as a productive factor.

March 1996, but only to the level of the Health Care Working Group of the new tripartite body – the Council for Economic and Social Agreement (RHSD 1997). Moreover, the Health Care Working Group predominantly focussed on the health and safety issues that interested Brussels, rather than the remuneration and core health care reform issues that interested most Czech doctors and nurses. The Brussels-inspired social dialogue on health and safety favoured the Health and Social Care Trade Union, which had permanent staff to deal with the health and safety regulations required by Brussels. At the same time, the leaders of the Doctors' Trade Union Club were practicing doctors with political, rather than bureaucratic, ambitions. Therefore, the divide between these two major trade unions grew even further: while the leaders of the Health and Social Care Trade Union reinvented themselves as Brussels' health and safety warriors, the leaders of the Doctors' Trade Union Club continued fighting on the streets for higher remuneration.<sup>66</sup>

Later in 1998, the EU urged the Czech Republic to adopt a law prohibiting spit tobacco, which simply bemused the Czechs because this was hardly consumed in the Czech Republic. Beyond health and safety and spit tobacco, the EU did not influence Czech health care reform, because the EU mandate in health care was limited to health and safety and public health (Article 152 (ex Article 129) of the EC Treaty), and the EU did not want to go beyond its mandate. The Czech EU Accession Chief Negotiator Telička acknowledged that 'our Western counterparts say that health care is too specific and they do not want to discuss it' (Telička 2004).

## ***A new health policy concept***

### **'Regulation, regulation, and again regulation'**

Under political pressure from the Social Democrats, who claimed that the Health Ministry lacked a health policy concept, Minister Stráský formulated his policy concept as 'a deviation from liberalism and the strengthening of regulation' (ČTK 1996u). He

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<sup>66</sup> The Council for Dialogue between Social Partners in Health Care, and thus full-fledged social dialogue in health care, was restored bottom-up only in 2000, when the new Social Democratic government neglected the demands of doctors and nurses for higher pay (OSZSP n.d.). But similarly to 1995-1996, social dialogue failed again, because the Social Democratic government was unwilling to increase expenditure on health, so doctors had to strike.

argued that the situation where every patient could freely choose a doctor and every doctor could open further health care facilities conflicted with the scarcity of the financial resources available to health care, and proposed to reconcile this conflict through ‘regulation, regulation, and again regulation’ (ibid.). To flesh out and implement his reform concept, he made new appointments in the Health Ministry, which looked like a bid to co-opt health sector elites, who would otherwise become his opponents. The ex-MP and Vice President of the Medical Chamber, Miroslav Čerbák, and the Vice Chairman of the Association of Hospitals, Joseph Heller, had distinguished themselves as vocal critics of the government, but Stráský took them on the government payroll as Deputy Health Ministers. Essentially, they were made to fight on the side of the government, against the interests they formerly represented. Another potential opponent, Miroslav Macek, who distinguished himself as the strongest critic of ex-Minister Rubáš, was appointed as the Secretary of the Health Minister. This appointment provides valuable insights as to why doctors may enter politics and the civil service.

In the early 1990s, dentist Macek made a spectacular political career as Deputy Prime Minister of Czechoslovakia, but he undermined his political career through a privatisation corruption scandal. Being left out of the government, he engaged in a privatisation consultancy business and continued his involvement with the Civic Democratic Party as a member of the Executive Board and then Deputy Chairman. Furthermore, he unsuccessfully contested the post of Health Minister, strongly criticising ex-Minister Rubáš. Perhaps to minimise Macek’s criticism, Minister Stráský offered him the post of Deputy Health Minister. Initially, Macek did not show much enthusiasm, because he claimed that ‘[i]n addition to personal problems and greater responsibilities, the post of Deputy Health Minister would not be overly profitable for me in economic terms’ (ČTK 1996i). Eventually, Macek agreed to become the second man in the Health Ministry with responsibilities for the preparation of a health policy concept; however, a new post was created for him – Secretary of the Health Minister. It is not implausible to think that, in addition to greater powers, this post was better remunerated than that of Deputy Health Minister.

Remuneration seems to be a significant factor that influences politicians, irrespective of their political orientation. The Chairman of the Parliamentary Health Committee, Social Democrat Špidla, criticised the Civic Democrat Macek for putting his own interests before the public interests (ČTK 1996h) but, eight years later, Špidla himself was heavily criticised for doing exactly the same. Amid criticism from his party colleagues for the party's underperformance in the 2004 election, Špidla opportunistically swapped his job as the party leader and Prime Minister for that of EU Commissioner for Employment, Social Affairs, and Equal Opportunities; which, to use Macek's terminology, was remunerated four times better, had less responsibilities, and did not create personal problems.<sup>67</sup> This was detrimental to the public interest because Špidla did not speak English and took the job away from Pavel Telička, who was highly acclaimed for many diplomatic victories in his role as Czech Chief Negotiator for the EU accession (1998-2004).

### **Macek's health policy concept**

When Minister Stráský left for a mountaineering holiday in the Himalayas in October 1996, he did not sound very optimistic about continuing as Health Minister and the press speculated whether he was going to resign upon his return (MfD 23.10.1996). Perhaps in a bid to become the first man in the Health Ministry, Macek published his policy concept while the boss was away (ČTK 1996z); the main lines of the proposed policy concept are:

- health care to be financed equally by general health insurance, private health insurance, and the state;
- lowering the general health insurance premium;
- establishing the Health Insurance Administration to co-ordinate and regulate health insurance funds;
- allowing competition between health insurance funds;
- introducing an annual health service registration fee, instead of patient co-payments for each visit to a doctor or hospital day;
- defining a network of health care facilities;

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<sup>67</sup> The discrepancy between the monthly salary of Czech Prime Minister and Czech EU Commissioner was staggering: Kč135,000 (€4,230) and Kč580,000 (€18,190) respectively (HN 3.6.2004).

- reducing the number of acute hospital beds by 25,000 and the total number of hospital beds by one-third.

Macek was heavily criticised by his own Civic Democratic Party for the breach of party discipline, as he did not discuss with anyone his health policy concept. In turn, the opposition criticised the Civic Democratic Party for being unable to govern itself, let alone the country. The government, the opposition and the medical profession had a hard time deciding whether this reform concept was an official document of the Health Ministry or just an eccentricity of Macek. Upon his descent from the Himalayas, Minister Stráský concluded that to manage health care was as hard and enjoyable as scaling mountains (ČTK 1996y), dismissed speculations about his resignation, and endorsed Macek's reform concept as an official position of the Health Ministry (ČTK 1996x). This seemed to be a diplomatic move, aimed at saving the government's face, because Macek's proposal contradicted Minister Stráský's position on increasing patient co-payments and he asked Macek to revise his reform concept.

The second version of Macek's reform concept increased state regulation and allowed for patient co-payments, but was criticised by PM Klaus and Minister Stráský (ČTK 1997f). Macek suggested dividing health insurance into mandatory general health insurance, for basic health care services, and voluntary private health insurance, without specifying the range of services to be covered by each. Therefore, PM Klaus criticised Macek's health policy concept for failing to specify the extent of mandatory health insurance. Minister Stráský criticised Macek for relying on competition between health insurance funds as the main cost-containment mechanism. Nonetheless, Minister Stráský accepted Macek's second proposal as a starting point for the Health Ministry's policy concept and established seven working groups in the Health Ministry to detail various aspects of the policy concept.

A consultation with the 'economic ministers', held on 16.02.1997, discussed the Health Ministry's reform concept (ČTK 1997m). Firstly, the 'economic ministers' agreed with the short-term measures of freezing investment in large hospitals and restructuring a certain number of acute hospital beds into social care beds. Secondly, the 'economic

ministers' resolved to replace fee-for-service reimbursement with capitation fees for GPs and reimbursement for diagnosis for hospitals. Thirdly, PM Klaus agreed not to insist on the introduction of MSAs. Lastly, the 'economic ministers' asked the Health Ministry to present to the government a revised version of the health policy concept by 15.03.1997. During the discussion of the revised health policy concept, on 24.03.1997, the 'economic ministers' confirmed their agreement to replace fee-for-service reimbursement with capitation fees and diagnosis-relate reimbursement, rejected the lowering of the general health insurance premium, and agreed to introduce substantial patient co-payments, but at a lower rate than proposed by the Health Ministry (ČTK 1997l).

### ***Governing coalition falls out over health care reform***

The fact that these discussions took place during the informal consultations of the 'economic ministers', as opposed to formal Cabinet meetings, marginalised the influence of junior coalition partners on health policy. The Civic Democratic Alliance and Christian Democrats expressed discontent with the quality of the discussions and criticised the Civic Democratic Party for failing to consider their views on health policy. The Civic Democratic Alliance argued that the 16.02.1997 and 24.03.1997 consultations of the 'economic ministers' were 'unproductive', because the Civic Democratic Alliance was marginalised by the members of the Civic Democratic Party, who believed that health care was so important that only they should influence health policy, yet had no agreement on health policy among themselves (ČTK 1997n). In sounding their discontent with the conduct of the Civic Democratic Party in the coalition, the Christian Democrats went even further, because this was not the first time that the Civic Democratic Party had failed to accommodate their interests. In December 1996, the Civic Democratic Party outright rejected a proposal for a law on the network of health care facilities drafted by the Christian Democrats (PSP 1996d). This time, the Christian Democrats were marginalised in health policy decision-making because only one out of four Christian Democratic ministers was invited to the aforementioned consultations of the 'economic ministers'. Therefore, the Christian Democrats argued that the Health Ministry had failed to present a health policy concept to the government by 15.03.1997 and threatened to

leave the coalition if the Health Ministry would not present its policy concept to the government (ČTK 1997e).

The discontent of the junior coalition partners with the lack of influence on health policy seemed driven by the opportunity to maximise their standing in the government, rather than their concern about health policies alone. In spring 1997, the Civic Democrats were losing ground because of their poor economic and monetary policies, so the junior coalition partners had a chance to improve their standing in the government. In such circumstances, Minister Stráský argued that he presented a health policy concept to the government, because the consultations of the 'economic ministers' had a status similar to Cabinet meetings (ČTK 1997r). The Christian Democrats argued otherwise, calling for an emergency meeting of coalition partners to discuss the health care reform concept. According to PM Klaus, the coalition parties agreed in this meeting that an agreement must be achieved within the coalition to avoid new problems in health care (ČTK 1997h). However, the coalition was far from in agreement, as PM Klaus's government was plunging into a crisis. PM Klaus was caught by Deputy Prime Ministers Lux and Zieleniec hiding a communication from the IMF, alerting the government to its weak monetary policies, from senior Cabinet members (ČTK 1997y). The Czech Republic lost approximately US\$3bn propping up its weak currency before PM Klaus admitted economic mistakes and the crown was devalued. This was a good opportunity for the junior coalition partners to gain more ministerial portfolios. Both the Christian Democrats and Civic Democratic Alliance suggested their candidates for Health Minister and Minister Stráský offered to resign to save the coalition. Eventually, the coalition was saved by a reshuffle of three more important ministerial portfolios (Finance, Industry, and Economy), and Minister Stráský carried on as Health Minister.

As the government was sinking and the Secretary of the Health Minister, Macek, got involved in a scandal, he resigned from the Health Ministry in June 1997 (ČTK 1997j); thereafter any attempts to develop a coherent policy concept ceased. The subsequent health policies were enacted in a haphazard manner, under pressure to alleviate growing financial distress in health care. For example, the unpaid debt of 17 hospitals to the

Pharmaceutical Distributors Association (AVEL) amounted to Kč1.3bn and distributors threatened to file for the bankruptcy of VFN and Motol hospitals (ČTK 1997a). Given that the vast premises of VFN Hospital, at the very centre of Prague, were valued at Kč20-30bn and the total deficit in health care amounted to approximately Kč10bn, the Secretary of the Health Minister Macek argued that ‘if VFN Hospital were to burn down, there would be no detriment to the health status of the Prague population’ and the government attempted to close down VFN Hospital and sell off its premises (ČTK 1997t). Given that VFN Hospital was the oldest teaching hospital in Bohemia (established in 1790), it is important to appreciate that the preservation of the historical traditions of Czech health care was less important for the Health Ministry than revenue from the sell off. However, the 6,000-strong hospital staff, which treated 2.5m patients yearly, launched a series of protest actions with the strong support of trade unions and the opposition (ČTK 1997z, 1997c). The Social Democratic Party brought a parliamentary investigation against Macek as it emerged that he had stakes in a company which rented premises from VFN Hospital for commercial purposes (PSP 1997a). Eventually, PM Klaus resolved against the sale of VFN Hospital and the government had to provide VFN and other insolvent hospitals with Kč2.5bn of funding (ČTK 1997g, 1997x). This was a painful decision for the ‘economic ministers’, because the economy was in dire straights and shortly after they had approved Kč20bn cutbacks in the state budget (ČTK 1997w). To balance the budget, the Health Ministry proposed to close down 11 hospitals and transform 39 hospitals into long-term care facilities (Vepřek *et al.* 2002, p.39), but this was not implemented because the government collapsed. Below, I concentrate on health financing reforms which were implemented before the government’s collapse.

### ***Changes in fee-for-service reimbursement***

The Public Health Insurance Act (Zákon č. 48/1997 Sb.) and the Health Ministry’s directive on reimbursement rates (Vyhláška MZ ČR č.45/1997 Sb.) significantly changed fee-for-service reimbursement of health care providers and introduced ‘the national negotiation framework’ (Jaroš *et al.* 2005, p.230) for health insurance funds and health care providers. As ‘Action Frequency’ failed to alleviate financial distress in hospitals, the Health Ministry proposed to replace fee-for-service reimbursement in the inpatient

sector with diagnosis-related reimbursement. Yet, the Health Ministry had no expertise in diagnosis-related reimbursement and the process of setting up DRGs was rather time-intensive. Therefore, the Health Ministry agreed with the proposal of the General Health Insurance Fund that, until the introduction of DRGs, fee-for-service reimbursement in hospitals be replaced with historical budgets, whereby each quarter of the current year hospital were provided with the budget of the same quarter of the yesteryear adjusted to inflation. Whereas DRGs never materialised, historical budgets were introduced as of 01.07.1997. A number of significant changes in reimbursement were also made in the outpatient sector. Fee-for-service reimbursement for GPs was replaced with a mixed capitation fee/fee-for-service reimbursement, predominantly based on age- and sex-adjusted capitation fees. Setting up capitation fees was not as complex and time-intensive as DRGs, so the Health Ministry managed to implement capitation fees. Transition to capitation fees started on a voluntary basis in the fourth quarter of 1997 and was completed over 1998. Also, implicit budgeting was introduced for outpatient specialists through working time and expenditure restrictions within fee-for-service reimbursement.

Whereas hospitals accepted historical budgets without resistance, because most of them were under the administrative remit of the state, transition to capitation fees and regulated fee-for-service reimbursement in the outpatient sector was rather violent because the weak Civic Democrat-led government did not have enough political power to coerce doctors to accept the terms of fee-for-service reimbursement. As a result, the second half of 1997 was characterised by the struggle of the political opposition and the medical profession against the government. Notably, this struggle followed Schumpeter's logic of democratic political struggle (1984, p.279):

...the decision of the political issues is, from the standpoint of the politician, not the end but only the material of parliamentary activity. Since politicians fire off words instead of bullets and since those words are unavoidably supplied by the issues under debate, this may not always be as clear as it is in the military case. But victory over the opponent is nevertheless the essence of both games.

## **National negotiation framework**

The Civic Democrat-led government did not have a parliamentary majority and yet attempted to pursue heavy-hand regulatory policies against the interests of the medical profession. Not surprisingly, Chairman of the Parliamentary Health Committee, Špidla, and other Social Democratic MPs sided with the medical profession in their struggle against the government. Material for this struggle was provided by the government's proposed Public Health Insurance Act. In clause 2 (§17), the government proposed that health insurance reimbursement rates should be set by the Health Ministry and the value of the reimbursement point should be regulated by the Finance Ministry in consultation with the Health Ministry (PSP 1997d, §17(2)). Social Democratic MPs in the Health Committee scrapped this clause (VSPZ 1997) and then, together with the Communists and other opposition parties in Parliament, voted for the new clause, stipulating that health insurance reimbursement rates and the value of the reimbursement point should be set through negotiations between health insurance funds, health care providers and professional associations of the medical profession (Zákon č. 48/1997 Sb. §17(4-5)). The new negotiation framework worked to the advantage of the medical profession and the opposition gained political capital during the resultant conflict between doctors and the government.

Conflict erupted during the very first negotiations under the new negotiation framework. While outpatient doctors demanded Kč1.0 per reimbursement point for the third quarter of 1997, the General Health Insurance Fund categorically insisted on Kč0.46 (ČTK 1997u). Given that, in the beginning of the third quarter of 1997, there was no agreed value for the reimbursement point, the Medical Chamber called on outpatient doctors to charge patients in cash the difference between Kč1.0 and Kč0.46. Doctors charged co-payments for just a few days, but this was enough to generate public unrest and give the opposition plenty of opportunities to attack the government. President Václav Havel, who very seldom intervened in politics, summoned Minister Stráský to discuss the situation in health care (ČTK 1997q). The Communists who, together with the Social Democrats, created the unrest by scrapping the government's clause, supported the Medical

Chamber, publicly urging doctors to continue charging patient co-payments to force Minister Stráský to resign (ČTK 1997d).

In response, the government put pressure on the General Health Insurance Fund to increase the value of the reimbursement point to Kč0.77 and the doctors accepted it (ČTK 1997s). Soon, however, the General Health Insurance Fund broke peace with the doctors by changing the working hours restriction for outpatient doctors from 12 to 10 hours per day. This restriction limited the doctors' gain from the increase of the reimbursement point, because it was not uncommon for outpatient doctors to claim reimbursement for points equivalent to 360 hours per month (ČTK 1993v). Since outpatient doctors did not reach an agreement with health insurance funds on the value of the reimbursement point and working hours restriction for the fourth quarter of 1997, the Medical Chamber again called on outpatient doctors to charge patients co-payments (ČTK 1997i).

Minister Stráský appealed to district authorities to prohibit doctors charging patient co-payments from practising medicine on their territory and threatened to sack the managers of the state hospitals which charged co-payments (ČTK 1997i), but to no avail. As it was only the Medical Chamber that could legitimately prohibit certain doctors to practise medicine, and the government could not legitimately set the value of the reimbursement point, the uncertainty over patient co-payments prevailed until the fall of the government at the end of 1997. As the Social Democrats were set to win the 1998 premature election, they withdrew their support from the medical profession and voted for the amendment to the Public Health Insurance Act, which excluded the Medical Chamber from the negotiation framework and allowed the government to set reimbursement rates and the value of the reimbursement point if health insurance funds and health care providers failed to agree (Zákon č. 2/1998 Sb.). Ever since, the negotiation framework works to the advantage of the government and health insurance funds as health care providers, represented by the associations of various specialities of the medical profession, fight against each other for higher reimbursement rates within the limits set by health insurance funds and the government.

### ***Patient co-payments***

It is crucial to realise that the fight of the Civic Democrat-led government against the Medical Chamber was void of ideology as the government itself wanted to charge patient co-payments. Since ex-Minister Rubáš introduced patient co-payments for the first time, through a number of Health Ministry's directives, the issue of patient co-payments had become rather politicised. In the face of the upcoming election, 43 Social Democratic and Communist MPs appealed to the Constitutional Court in October 1995 against these directives on the grounds that co-payments were against the constitutional right to free health care. Perhaps because the Constitutional Court was appointed by the government, it considered this appeal only after the election of July 1996, but nonetheless ruled that co-payments had indeed breached the constitutional right to free health care; consequently cancelling the Health Ministry's directives from April 1997 and suggesting that all co-payments be approved by Parliament (Nález ÚS č. 206/1996). Subsequently, the government included these co-payments in the Public Health Insurance Act and Parliament voted for it without much resistance (Zákon č. 48/1997 Sb.). In my analysis, the co-payments introduced by ex-Minister Rubáš were not significant enough to make a big issue after the election because they affected non-essential services such as some dental services, cosmetic surgery and vitamins, or had a sound demand-controlling purpose, e.g. as a fee for visiting a specialist without a GP's referral. But, when the government attempted to introduce significant co-payments, a major political battle erupted.

Under Minister Stráský, the Health Ministry's view on patient co-payments evolved from mainly a demand-controlling instrument to a source of funding. Stráský proposed to offset the growing health insurance deficit by introducing significant patient co-payments. In spring 1997, the 'economic ministers' agreed to introduce significant patient co-payments, but could not decide on the exact amount until autumn 1997. First, Minister Stráský had to review the economic calculations behind co-payments, as he acknowledged that the Health Ministry overestimated the possibility of offsetting a multi-billion health insurance deficit through patient co-payments alone (ČTK 1997v, Slovo 24.03.1997). Then Stráský became concerned that the costs of installing tills in hospitals

could be higher than the revenue from co-payments (ČTK 1997k). As a solution, he suggested setting co-payments at sufficiently high levels and issuing patients with special health insurance chequebooks to minimise cash handling costs (Právo 19.07.1997), though the ‘economic ministers’ urged him to avoid high co-payments to minimise public discontent (ČTK 1997l).

### **The government’s proposal for co-payments fails**

The government decided on the exact amount of co-payments only in November 1997 (Usnesení vlády ČR č. 717/1997). The government’s draft of the new Public Health Insurance Act proposed that patients pay, in cash, Kč50 for every day of hospital care, Kč50 for any emergency treatment, Kč100 for a GP’s home visit, and Kč50-100 for a visit to a GP; it was also proposed that patients pay 30% of the cost of a specialist’s consultation via the health insurance fund (PSP 1997c). This proposal was welcomed by the Medical Chamber, but the Patients Association strongly protested against co-payments (ČTK 1997o). More importantly, the governing coalition split on the issue of co-payments. The second largest coalition party, the Christian Democrats, did not object to co-payments for hospital care, but rejected co-payments for outpatient care (ČTK 1997p). Yet, contrary to PM Klaus’ conclusion that an agreement must be achieved within the coalition to avoid new problems in health care (ČTK 1997h), his party failed to reach an agreement with the Christian Democrats on co-payments and the Christian Democrats publicly criticised the Civic Democrats, pledging to vote against the government’s proposal in Parliament (MfD 22.11.1997).

Given that the Social Democrats and Communists strongly opposed any significant co-payments (ČTK 1997b), the government’s proposal was doomed to fail in Parliament. Firstly, the government made a simple mistake by not submitting an electronic version of the proposal on time for the Parliamentary session in December 1997 and, on procedural grounds, the Social Democrats postponed the deliberation of the proposal until the next session, even though they had hard copies of the proposal (PSP 1997b). Shortly after that, the Civic Democratic Party was shaken by a party-donations-for-privatisation-favours scandal and the government collapsed. When Parliament reconvened for the next session,

the Public Health Insurance Act, which contained the proposal for co-payments, was voted down completely, without much deliberation, because the Social Democrats and other opposition parties were exploiting co-payments as a campaigning issue for the premature election. Besides co-payments, the Public Health Insurance Act contained a very sound policy proposal for the establishment of the Health Insurance Administration to supervise health insurance funds and redistribute 80% of health risks across health insurance funds. However, this proposal never materialised because the two consecutive Social Democratic governments did not dare to redistribute health risks across health insurance funds as it was against the interests of firm-based health insurance funds (Háva interview 2006b). It is important to appreciate that the absence of risk-adjustment is a major factor of continued financial distress in the public General Health Insurance Fund (Němec 2001; MZ ČR 2005) and that the risk-adjustment failed to be implemented in 1998 and ever since due to the precedence of health politics over health policy.

## CONCLUSION: OPPORTUNISTIC TINKERING OF ENTERPRISING ELITES

This chapter reviews the actors, institutions, ideas and history behind the Czech health policy process, and uses insights from Schumpeter's theory of democracy, elite theory, interest group politics and rational choice theory to explain the political process which brought about post-Communist health policy change in the Czech Republic. It demonstrates that, while history and ideas were prominent in the rhetoric accompanying health policy change, in *Realpolitik*, they were merely disposable instrumental devices of opportunistic, self-interest seeking elites. The chapter stresses the importance of inherited policy problems (institutional outcomes) versus historical institutions, and the primacy of agency over structure. The interests of health policy actors and the way they interacted within an unhinged but fast-consolidating institutional framework plausibly explain the political process behind health policy change. The explanation proposed here consists of four important mechanisms of health policy change: opportunism, tinkering, enterprise and elitism. In conclusion, the relevance of major welfare state theories to the given case is assessed and implications for welfare state research are drawn.

### ***A brief overview of the study***

After the collapse of Communist rule in 1989, the Czech Republic replaced a centralised, integrated state health service with a decentralised model of contracted public health insurance, reduced non-essential health services covered by public health insurance and introduced patient co-payments. This policy change did not result in any substantial efficiency and solidarity gains; rather, it increased health care costs, fragmented the health care system and amplified inequality. It is therefore puzzling why this policy change occurred; particularly since it took place during an unprecedented transition to democracy and a market economy, and in the context of social policy change in mature welfare states. Whereas mature welfare states had been founded and changed within a

framework of well-established capitalism and democracy, in the post-Communist Czech Republic it is rather democracy and capitalism that developed within a framework of the well-established welfare state. Therefore, post-Communist health policy change in the Czech Republic presents a useful source of evidence for exploring linkages between the welfare state, democracy and capitalism in Central and Eastern Europe (CEE). The advantage of focusing on one welfare state sector in one country is that we can avoid the 'ecological fallacy' (Robinson 1950) of aggregating possibly opposite policy dynamics in different welfare state sectors of different countries (Seeleib-Kaiser 1995).

The Czech Republic is a 'crucial case' (Eckstein 1975) because it witnessed more successful, failed, and reversed health policy change than any other CEE country. Moreover, the Czech Republic is the most advanced sizeable political economy in the CEE region. After Slovenia, the Czech Republic has the second most developed economy in terms of GDP per capita (IMF 2007) and the second highest public health expenditure per capita (Waters *et al.* 2008). However, Czech health politics is more representative of CEE because Slovenia's population (2m, versus 10.3m in the Czech Republic and 14.7m CEE average) and health sector (18,000 doctors and nurses, versus 130,000 in the Czech Republic and 121,000 CEE average) are among the smallest in the region (Albrecht *et al.* 2002). Thus, Slovenia is not representative of the most advanced CEE political economies or CEE generally.

In order to explain post-Communist health policy change in the Czech Republic, I investigated the political process of health policy-making, drawing on two distinct strands of Western European and North American literature: politics of the welfare state and health politics. Although the theoretical concepts in this literature were developed in different contexts, when treated as 'sensitising concepts' they helped to reduce the complexity of the phenomena under investigation, by setting parameters to the organisation of evidence (Ragin 1994, pp.87-89). Since in today's fast-changing world of 'post-something' there is no 'real' theory to explain welfare state change (Esping-Andersen 2000), I employed various partial theories to produce 'modular' explanations based on assumptions of rational choice theory linked by narratives (e.g. Scharpf 1997,

pp.29-35; Bates *et al.* 1998; Pierson 2000, pp.494-495; Palier 2001). My framework was organised around the main tenets of ‘actor-centered institutionalism’ (Scharpf 1997), within which special attention was paid to history and ideas. The resultant explanation was informed by Schumpeter’s theory of democracy, elite theory, interest group politics, and broader generalisations about human interactions based on rational choice theory.

## **History**

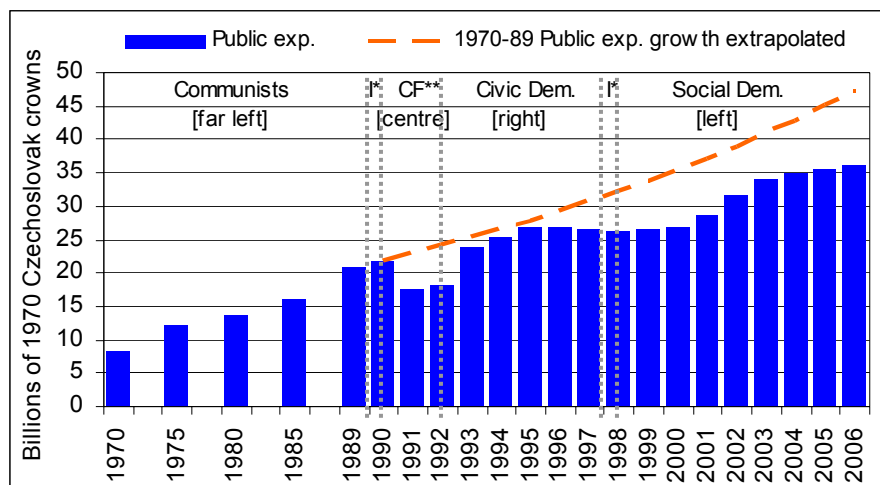
In broad historical terms, history mattered, but in narrow historical institutionalist and path dependency terms, it did not. To demonstrate this, I examined the history of health insurance and how it was introduced in 1992. In the Czech Lands, mandatory health insurance for industrial workers was first introduced by Austro-Hungary’s Iron Ring regime, after Bismarck in 1888, and was split between workers (2/3<sup>rd</sup>s) and employers (1/3<sup>rd</sup>) (Grandner 1994). When the Austro-Hungarian Empire collapsed, approximately 2,000 health insurance funds in the Czech Lands insured approximately one million out of ten million Czechs (Sociální revue 1922). In newly-born Czechoslovakia, ‘[o]wing to fiscal reasons... a general system of national insurance [was deemed] not being feasible’ (Gruber *et al.* 1924, p.219), but incremental extension of social insurance succeeded more than anywhere in CEE. When new legislation came into force in 1927, the number of health insurance funds was reduced to 311 and approximately half the population became insured (Deyl 1985; Niklíček 1991). However, even in the first year of operation, these health insurance funds generated a deficit, so benefits were decreased (*ibid.*). With the arrival of the Great Depression in 1930, benefits were slashed for the insured and abolished for their family members. The unemployed (up to one-third of workers) lost both health insurance and income, as Czechoslovakia had no unemployment insurance. This adversely affected the nation’s health, with the Health Minister sarcastically observing ‘we have a steady lead over other civilised nations’ in high child mortality rates (Šlapák 1936b, p.14).

In 1946, trade unions led by the Communist Zápotocký developed proposals for comprehensive national insurance with nearly-universal health insurance entirely paid by employers (Mařík 1948), but Parliament failed to pass them until the 1948 Communist

takeover. In a way, the father of the Czechoslovak ‘welfare state’, Zápotocký, was a true heir to the Bismarckian tradition of supplementing generous social legislation with brutal repressions: as Czechoslovak President he sent tanks to kill dozens of workers protesting against a harsh monetary reform (Kramer 1999). In 1951, the Communists separated health insurance from national insurance, incorporating the former in the state budget to ‘promote production, provide a full range of top quality care for the working person, make the working people manage it and be directly responsible for it, and become an instrument for the constant improvement of the living standards of all working people’ (Zákon č. 102/1951 Sb.). By the 1960s, the Communists built an integrated state health care system, giving Czechoslovakia a real lead over other civilised nations in health care outcomes.

In broad historical terms, ‘the past... survives in the present’ and history provides knowledge of what can be done, on the basis of what was achieved in the past (Collingwood 1961, pp.14, 256). From this historical perspective, it is puzzling why post-Communist reformers opted for health insurance. Did they not expect that health insurance would immediately generate a deficit and that health expenditure growth would stagnate due to a likely post-Communist economic depression, which was what actually happened (Figure 10)?

**Figure 10: Public expenditure on health in constant prices, 1970-2006**



\* I=Interim Government; \*\* CF=Civic Forum

Source: own analysis based on (ÚZIS 2000, 2002; IMF 2007; OECD 2007; ÚZIS 2007a)

My research evidence suggests that the reformers were not interested in history, but used it as a rhetorical device to justify their policy choices *post hoc*. As post-Communist political competition was aimed at taking power from the Communists, aspiring political elites glorified history to make compelling arguments against the Communists. The Civic Forum coalition manifesto went as far as claiming that pre-Communist Czechoslovakia was the tenth most economically developed country in the world and blamed the Communists for the fact that, in 1990, '[e]ven Austria, less advanced in the past, is viewed by us today with quiet and humiliating envy' (OF 1990).<sup>68</sup> In Parliament, the introduction of health insurance was portrayed as an 'attempt to come back to something that was abolished 40 years ago' (ČNR 1991b). Without realising that health insurance in inter-war Czechoslovakia was rather dysfunctional, the Civic Forum government praised it as 'one of the most modern systems of health insurance in Europe' (MZ ČR 1991b). Nonetheless, the government stated that 'for obvious reasons [obsolete legislation], it is impossible to come back to that [1948] year' (MZ ČR 1991b). It was of no practical use for reformers, working under time pressure, to read obsolete legislation which could not be adapted to modern conditions (Pasternak interview 2006a). Instead, they drew on Canadian and Dutch experience and, foremost, on their own judgement (*ibid.*).<sup>69</sup>

Looking beyond historical institutions, at their outcomes, reveals that history did influence post-Communist health policy choices. When, in the 1970s, economic growth slowed, the Finance Ministry prioritised investment in industry at the expense of health care. Due to slow incremental growth of health expenditure, doctors and nurses earned less than engineers and workers, hospitals had limited access to modern medical technology and drugs, health care outcomes dropped below affluent democracies, the

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<sup>68</sup> It took a long decade until the first critical publication on the level of Czechoslovakia's pre-Communist economic development had appeared (Kubů & Pátek 2000).

<sup>69</sup> Interestingly, problems inherited from the past influenced the choice of the countries whose experience was employed during the introduction of health insurance. The senior decision-maker, who invited Dutch experts, regarded as one advantage of the Dutch health insurance system that 'it was not German' (Kalina interview 2006). This decision was driven by historical animosity between Germany and the Czech Republic. In the early 1990s, part of Czech elite favoured of minimising German influence on the grounds of national interests. They were weary of Germany's hegemonic ambitions and potential claims for the restitution of the property of the Sudetenland Germans, expelled from Czechoslovakia in the aftermath of WWII.

dissident movement Charter 77 criticised the state of health care (Pohunková & Freiová 1984), and the last Communist public opinion poll revealed health care to be one of the most worrisome issues (Jaroš *et al.* 2005). Other Communist nations also experienced insufficient health care funding. Hungary, the most liberal of them, launched an integrated health and social security insurance fund in 1989, to increase health expenditure. The Czech Communist Health Minister argued for ‘allocating resources to health care directly in the plan [i.e. budget] and according to the needs of health care [i.e. independently of the Finance Ministry]’ (ČTK 1989c), and the government committed itself to national insurance reform (Prokopec 1989). The collapse of Communist rule provided an opportunity for strategically-positioned health sector elites to streamline health care financing reform, but it was based on the historical policy problem (insufficient health care funding) and a solution was developed before regime change (hypothecated taxation). The subsequent introduction of health insurance resulted from the interplay of five strategic preferences of elites, under the influence of an unhinged institutional framework.

First, managers of large hospitals actively sought to introduce health insurance to increase the revenue of their hospitals (Pasternak interview 2006a). The managers of Vinohrady and other large hospitals ventured an enterprise called ‘Experiment R’, seeking to define the costs of medical procedures required for fee-for-service reimbursement (*ibid.*). Second, leaders of the medical profession hoped that health insurance would improve doctors’ working conditions and income, since they knew that, in countries with health insurance, doctors enjoyed the latest medical technology and ‘drove Mercedeses’ (Kalina interview 2006). Third, the Health Ministry believed that funding health care through an independent public health insurance fund would increase expenditure on health and make it no longer subservient to the Finance Ministry (Bojar interview 2005). As such, the first post-Communist government pledged to introduce health insurance (Vláda ČR 1990) and appointed Finance Deputy Director of the Vinohrady Hospital as Director of the Office for the Introduction of Health Insurance. Fourth, the Finance Minister and other ‘economic ministers’ accommodated the interests of health sector elites, by introducing health insurance, because the unhinged institutional

framework provided the ‘economic ministers’ with a short-time horizon and adverse incentives. They did not have time to debate health insurance because they were busy pursuing their own reforms, to maximise their power and secure re-election. Furthermore, Václav Klaus – Finance Minister and Chairman of the supreme decision-making body called the Economic Council – was building his own political party and, thus, wanted the support of health sector elites. Off the record, he opposed health insurance because he rightly anticipated that it would inflate public health expenditure (Bojar interview 2005), but during an official meeting of the Economic Council in October 1990 he silently agreed with the Health Ministry’s representatives: ‘if you want to introduce [health insurance], do it’ (Pasternak interview 2006a). Fifth, senior managers of large state firms were confronted with uncertainty and risk of losing their jobs, due to privatisation, but spotted an opportunity to secure better employment and make profit by establishing firm-based health insurance funds. Against the Health Ministry’s position not to establish multiple health insurance funds before public health insurance became functional, enterprising senior managers engaged in the old Austro-Hungarian practice of opportunistic rent-seeking, known as *trafika*. They successfully used the opposition-led Parliamentary Health Committee to pass legislation allowing firm-based health insurance funds and competition against the public General Health Insurance Fund (Bojar interview 2005; Pasternak interview 2006a).

My explanation for the introduction of health insurance stresses the inherited policy problem, strategic interaction of policy actors, and their time-specific costs and benefits, rather than the structural impact of institutions and path dependency. Although it was argued that, during hard-line Communist rule, CEE countries deviated from their historical path and thus, sooner or later, would re-enter the same trajectory (Szelényi 1988), the choices of Czech post-Communist reformers were not influenced by obsolete pre-Communist institutions. They were building a new system, which resembled the previous one only by virtue of Hobson’s choice between a state-run system and health insurance. Likewise, the argument that ‘it is the differing paths of extrication from state socialism that shape the possibility of transformation in the subsequent stage’ (Stark 1991, pp.20-21) did not hold true. Czech health insurance did not take a distinctive path

immediately after the collapse of Communism, as the initial single public insurer system was swiftly changed to one of multiple competing insurers. Then, competition was abolished, two-thirds of health insurance funds were liquidated, and fee-for-service reimbursement for hospitals and GPs was replaced with historical budgets and capitation fees respectively. Lastly, if PM Klaus' party had won a parliamentary majority in 1996 then social health insurance would probably have been replaced with the Medical Savings Accounts he advocated.

The apparent 'non-stickiness' of institutions may well be a problem of the dependent variable. Formal institutions have historically been highly volatile in the Czech Lands. For example, constitutionally, over the last century the Czech Lands have been part of Austria in the Austrian-Hungarian Empire, the Czechoslovak Republic, the Czechoslovak Republic, a German Protectorate, the Czechoslovak Republic again but within new borders, the Czechoslovak Socialist Republic, the Czech Socialist Republic in the Czechoslovak Socialist Republic, the Czech Republic in the Czech and Slovak Federal Republic and, eventually, the independent Czech Republic. At the same time, informal institutions like Austro-Hungarian *trafika* have stuck. Furthermore, in stark contrast to Stark's argument for path dependency – '[c]apitalism cannot be introduced by design in a region where the lessons of forty years of experimentation by a rational hand have made the citizenry cautious about big experiments' (Stark 1991, p.19) – our evidence demonstrates the continuity of rational-hand experimentation. It can be argued that this is, in sociological institutionalist terms, path dependent. Altogether, to explain the change of formal institutions through the continuity of informal ones is a challenge for welfare state research in CEE countries.

### ***Ideas***

The Czech Republic is a fine case to demonstrate that, in politics, the interests of individuals are prior to ideas, so ideas on their own do not bring about policy change. Moreover, this case reveals the opportunistic and instrumental use of ideas in politics, not dissimilar to Machiavelli (1992[1513]): 'it is necessary for [a prince] to have a mind ready to turn itself accordingly as the winds and variations of fortune force it'. To

demonstrate this, I draw on Hall's (1993) notion of a policy paradigm shift. According to Hall, a new paradigm succeeds the old one when the state finds itself in a crisis and the old paradigm fails to explain it; a new paradigm provides both an explanation of the crisis and a way out. The crisis of the state socialism paradigm became apparent in 1968, when Prague Spring reformers attempted limited liberalisation but were crushed by Soviet tanks. Since then, and until the Communists lost the Cold War to Reaganists and Thatcherites, liberal-democratic ideas in Czechoslovakia were promoted by a few hundred dissidents<sup>70</sup> who failed to mobilise collective action in a country of 1.4m Communists (Wightman 1983).<sup>71</sup> However, after 1989, when there were no longer significant costs associated with adopting liberal-democratic ideas, thousands of former conformists and Communists adopted liberal-democratic ideas.<sup>72</sup> These ideas succeeded because they were adopted by the self-interested actors, who needed such ideas to seize the economic and political opportunities arising from the fall of Communism.

The first post-Communist election, held in 1990, was won by the Civic Forum – a broad coalition against the Communist Party without a clear policy paradigm. Therefore, early health policy change was not influenced by a paradigm shift, but the inherited policy problems and solutions proposed before regime change. As shown above, the introduction of health insurance was driven by the same logic of health expenditure maximisation developed under the old state socialism paradigm, rather than the purchaser-provider split dictated by the new policy paradigm. Similarly, free choice of doctor was not incongruent with the old policy paradigm. The Communist government perceived absence of choice as a problem and committed itself to allowing more choice as early as the 1960s, but this commitment was constrained by the previous policy choices, as policy-makers realised that 'complete freedom to choose one's doctor would disturb the system' (Šourek 1966, p.25). First pilot projects into completely free choice of

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<sup>70</sup> It is difficult to estimate the number of dissidents, but we can assume they all signed the dissident Charter 77 petition against the violations of human rights. Between 1977 and 1992 it was signed by 1,898 people (Gruntorád n.d.), but the overwhelming majority of these were not dissidents and we do not know how many people signed after 1989.

<sup>71</sup> In the 1980s, membership of the Czechoslovak Communist Party reached as high as 10% of the population, or one-seventh of adults, and was the highest in CEE (Wightman 1983).

<sup>72</sup> This was not dissimilar to post-war Czechoslovakia, when membership of the Communist Party grew from 28,000 at liberation in 1945 to 1.4 million by the end of 1947 (Abrams 2004, p.57).

doctor only started in 1987 (ČTK 1987). Post-Communist reformers abolished the Communist-built regional and functional hierarchical system of health care facilities, introducing complete freedom of choice of doctor, which indeed ‘disturbed’ the health care sector – resulting in soaring health care expenditure, since fee-for-service reimbursement allowed patients to wander between different doctors and hospitals as they pleased (Němec interview 2005).

A new paradigm arrived in 1991, thanks to the political enterprise of self-styled Thatcherite Václav Klaus and his Civic Democratic Party ‘modeled on the British Conservative Party’ (Klaus 2006).<sup>73</sup> Yet, to win the 1992 election he corrupted the Thatcherite paradigm by giving away, through citizens’ vouchers, small stakes in state property to voters for free and offering, through state-controlled banks, subsidised loans to aspiring entrepreneurs to privatise larger state properties. The new paradigm was aptly conceptualised as ‘national capitalism’ for its hostility towards foreign capital (Mládek 2001) and ‘capitalismo-socialism’ for financing discounted loans and losses of Czech entrepreneurs from public sources (Mládek 2002). The self-styled Thatcherites successfully used this new paradigm to banish a few former dissidents from power.<sup>74</sup> The banishment of dissidents also occurred on the left; the pensioners-émigrés who came to the Czech Republic to establish the Social Democratic Party expelled Rudolf Battěk, a leading Czech dissident and long-serving political prisoner, from their party (Kopeček & Pšejja 2007). The banishment of dissidents and appropriation of their ideas by the self-styled ‘defenders of democracy and freedom’ (Klaus 2006) suggests that, in democratic politics, ideas are powerful instruments for political gain. The power of ideas is based on their ability to mobilise collective action and co-operation of self-interested actors to implement certain policy options. For example, the new paradigm enabled co-operation between the managers of state firms, seeking secure employment and profit, and opposition MPs seeking credentials as progressive reformers. Although the introduction of multiple health insurance funds was driven by material interests and *trafika*, the new

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<sup>73</sup> Not unlike the post-war Communists, who justified their policy paradigm by praising Comrade Stalin as a liberator from the Nazis, the self-styled Thatcherites paid lip-service to Mrs Thatcher as a liberator from the Communists: ‘...the meltdown of communism in Central and Eastern Europe was initiated in Britain in 1979 by her electoral victory’ (Klaus 2006).

<sup>74</sup> Václav Havel remained figurehead President until 2003 but did not have executive power.

paradigm justified firm-based health insurance funds, on the basis that competition against the public health insurer would reduce health insurance costs (Payne 1992; Raška 1992).

The instrumental use of policy ideas implies that politicians can act outside their chosen policy paradigm as long as it suits their dominant interest – the attainment and preservation of power. While in opposition, the Civic Democratic Party advocated giving strong powers to the medical profession, creating multiple competing health insurance funds, and fast-tracking privatisation of health care facilities. When in office they faced soaring health care expenditure, refused to subsidise loans for the privatisation of large health care facilities, scrapped competition between health insurance funds, liquidated or merged two-thirds of these funds, and attempted to reduce the powers of the medical profession. Thus, the failure of liberal policies under the liberal government can be explained by the instrumental use of ideas in politics: politicians dispose of their ideas as soon as they jeopardise their position of power. To put it bluntly, politicians are not dissidents, prepared to fight for ideas and lose their freedom rather than give up their ideas, politicians are entrepreneurs who make profit from ideas and easily surrender those that jeopardise political gains.

Besides paradigm shifts, health policies are influenced by changes in second- and first-order policy ideas, i.e. those related to the policy instruments and their precise settings used to attain goals specified by policy paradigms (Hall 1993, p.278). Intended health policy instruments and their precise settings are usually specified in policy documents known as ‘health policy concepts’. Since 1990, it has become tradition for every aspiring and incumbent Health Minister to prepare such documents, which serve functions at different levels. In party politics, a ‘health policy concept’ is *an aptitude test and a progress review device*: one needs to have a ‘concept’ to be considered for and keep the job of Health Minister. In interest group politics, a ‘concept’ is *a heuristic device for interest accommodation*: every Health Minister needs a ‘concept’ to start negotiations with interest groups. In public politics, a ‘concept’ is *a transparency and accountability device*: the press eagerly publicises the main features of new ‘concepts’, especially

negative ones, and follows their implementation. However, the last function is rather limited, as health policy remains the game of political and professional elites. Therefore, second- and first-order policy ideas function more as elites' job-hunting and interest accommodation tools than 'weapons of mass persuasion' (Béland 2005).

Paradoxically, the instrumental role of ideas in party politics adversely affects the quality of ideas in health policy-making, as the flow of ideas is subject to the utility calculi of strategically-positioned individuals and power relations between them, rather than cost-benefit analysis of aggregate social welfare. The latter can damage the position of the Health Ministers who pursue costly policies and thus benefit contenders for their job. For example, in 1993, an autocratic Civic Democratic Health Minister closed down the Institute of Social Medicine and Organisation of Health Care. Although a Social Democratic government re-established a public body to develop and evaluate health policy (Institute for Health Policy and Economics), a new autocratic Social Democratic Health Minister abolished it in 2006. Health policy has become de-institutionalised as the Czech Republic does not have partisan think-tanks, independent research institutes, or any other permanent institutions to develop and evaluate health policy. Thus, the development and evaluation of health policy is captured by entrepreneurial health sector elites and serves as their 'cottage industry'. This enables strategically-positioned actors to exercise strong personal influence over the health policy agenda on the basis of limited information.

### ***Institutions***

A characteristic feature of the early post-Communist period was an unhinged but fast-consolidating institutional framework. As old institutions became unhinged from their pre-1989 stasis, because the Communist Party lost its hegemony, health policy entrepreneurs gained unrestricted opportunities to dismantle old institutions and establish new ones to advance their interests. As the new institutional framework was consolidating, under the influence of new interests, policy-makers became increasingly influenced by the new institutions. It is possible to assert that the impact of institutions on health care reform was different in the period when the institutional framework was

unhinged, i.e. when it was upheld by weak interests, and in the period when it was consolidated, i.e. when it was upheld by strong interests. In what follows, I discuss the effects of five post-Communist institutions on health policy-making and demonstrate that their ability to impact policy-making depends on the power resources, capabilities and time horizons of actors behind these institutions.

### **Political competition**

The effects of political competition on health policy-making are mixed. Political competition provides incentives for the incumbents to act in the interests of the public, who otherwise may not re-elect them, but it also shortens the time horizon of policy-making, weakens health sector governance and increases the opportunities of interest groups to influence legislative outcomes. The most striking manifestation of political competition is the frequent turnover of Health Ministers. In 42 years of Communist rule, there were only 3 Health Ministers, serving 20, 3 and 19 years respectively; whereas, in the 7 governments between the fall of Communism (1989) and the 2006 election, there were 12 permanent Health Ministers, serving on average 17 months each.<sup>75</sup> Frequent changes of Health Minister weaken health sector governance and lead to the haphazard termination of old policies and initiation of new ones. Furthermore, a short time in office provides adverse incentives for each new Health Minister and his appointees. As the incumbent knows that his chances of keeping office for a prolonged period are low, he may prioritise rent-seeking over public interests (Bardhan & Yang 2004). Several post-Communist Health Ministers started their tenure by allocating top ministerial jobs to their cronies and signing dubious privatisation and public procurement contracts. Also, in 2004, a Health Minister was removed from office after allegations of embezzlement.

Asymmetric information between the incumbent Health Minister and the public allows challengers to criticise the incumbent easily and provides interest groups with opportunities to influence legislative outcomes. Only the government has access to certain types of information and the high costs of collecting and processing publicly

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<sup>75</sup> In the democratic-oligarchic First Czechoslovak Republic (1918-1938) there were 11 permanent Health Ministers serving on average 23 months each (own analysis based on Čapka 1998).

available data prevent the public from gathering health policy information. Therefore, when new policies are time- and cost- intensive, the public tends to think that instead of serving public interests Health Minister is lining his pockets rather than facing actual time and cost constraints.<sup>76</sup> This can be easily exploited by the opposition and interest groups. For example, following the split of the Civic Forum, political competition between the incumbent Health Minister from the Civic Movement and his challenger from the Civic Democratic Party culminated in the passage of crucial legislation in the run up to the 1992 election. This legislation went against the government's position not to grant excessive autonomy to the medical profession or introduce competing health insurance funds before public health insurance system becomes fully functional (Bojar interview 2005). However, the interest groups easily influenced the challenger and his Civic Democratic Party to sponsor this legislation because it helped them to take credentials as progressive reformers, to persuade the public that the Civic Movement was incapable of reforms, and eventually to win the election. When in office, the challenger and his party faced the adverse consequences of this legislation and attempted to reverse it, with only partial success. In another example, in the midst of struggle against the ruling Civic Democratic Party in 1997, the Social Democrats overturned a government proposal, allowing the government to set health insurance rates and the value of the reimbursement point, and legislated for the national negotiation framework, which put the medical profession in a strong position against the government and health insurance funds in negotiations on health insurance rates and the value of the reimbursement point. This led to significant unrest in the health sector, to the detriment of the Civic Democrats and benefit of the Social Democrats, because, having reached no agreement with health insurance funds on the value of the reimbursement point, doctors started charging patient co-payments. However, with the Social Democrats set to win the 1998 election, after the Civic Democratic government collapsed, they withdrew their support from the medical profession and altered the national negotiation framework, allowing the government to set the value of the reimbursement point if the medical profession and health insurance funds could not agree in a timely manner.

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<sup>76</sup> See Bardhan & Yang (2004) for the original formulation of this argument based on the notion of 'public investment'.

## **Proportional representation**

Proportional representation makes radical policy change difficult and increases the opportunities of interest groups to influence legislative outcomes. Proportional representation produces weak coalition governments which rarely have agreement on health policy. The rise of the Social Democrats as a major party capable of leading a coalition endowed the Christian Democrats – a small right-wing-leaning swing party – with a veto point inside the government. The Christian Democrats often disagree with the dominant coalition party because they have their own health policy agenda, influenced by their support bases among the local authorities and the Roman Catholics. The Christian Democrats can afford disagreeing with the dominant coalition party because they are inevitable coalition partners for both left- and right-wing governments. Moreover, proportional representation in the Czech Republic produces governments without stable parliamentary majorities, which increases opportunities for interest groups to overturn government proposals and decisions. For example, in 1996, the trade unions of doctors and nurses were supported in Parliament by the Social Democrats, who vetoed a proposal by the Civic Democratic minority government to abolish salary tariffs in health care because this would decrease earnings in health care (PSP 1996a). The dysfunctionality of proportional representation is aggravated even further by the fragmentation of the political left. To capture moderate voters, weary of the Communists, the Social Democrats institutionalised non-co-operation with the Communists, through the 1995 Bohumín Resolution. Consequently, the Communists – the third largest party, commanding 10-20% of the vote, and only other left-wing party – have never been included in Social Democratic governments and have often voted against them.

## **A Constitutional right to free health care**

The ability of institutions to influence policy-making depends on the existence of actors capable of making these institutions work to their advantage. Even the Constitutional declaration that '[all] citizens have on the basis of public insurance the right to free medical care' (Ústavní zákon č. 23/1991 Sb, Čl.31) is not self-enforcing. In 1993-95, the

Health Ministry issued directives excluding provision of some non-essential health care services from public health insurance and introduced minor patient co-payments for visiting a specialist without a GP's referral. Also, former dissidents from the Helsinki Committee human rights watchdog campaigned against the government's decision to privatise health care facilities as 'unconstitutional' because the right to socialised health protection is an indispensable part of human and civil rights and requires active state health care [provision] for all citizens' (ČTK 1994a). Ordinary courts should have investigated the Health Ministry's directives and the claims of the Helsinki Committee, but were not prepared to apply the Constitution directly (Den Exter 2002, p.169) or had interests in not doing so because they were appointed by the government. The Constitution was upheld only thanks to 43 opposition MPs appealing to the Constitutional Court in the face of the upcoming election. The Constitutional Court resolved this appeal only after the election, cancelling the Health Ministry's directives and ruling that any limitations of free health care should be approved by Parliament (Nález ÚS č. 206/1996). But, if there was no powerful opposition interested in using the Constitution in their struggle against the government, the Constitution would not have impacted on policy-making.

### **Autonomy of the medical profession**

After the collapse of Communist rule, the medical profession succeeded in establishing several institutions to uphold its autonomy, but their ability to influence policy-making strongly depends on the actors capable of using them as instruments of organised collective action. This is in stark contrast with the US, where Alford famously conceptualised the 'professional monopoly' of US doctors as a 'dominant structural interest', which is 'served by the structure of social, economic, and political institutions as they exist at any given time. ...[US doctors] do not continuously have to organize and act to defend their interests; other institutions do that for them' (Alford 1975). Czech doctors, conversely, constantly have to organise and defend their interests in a trade union fashion. In the medical profession's struggle for higher pay, their technical autonomy serves as a weapon against the economic diktat of the government. The success of the struggle for higher pay strongly depends on the ability of Czech doctors to engage

the government, both in the boardroom and on the streets. This is evident from numerous doctors' strikes and the fact that, in 1998, leaders of the militant Doctors' Trade Union Club replaced the leadership of the doctors' professional association (Medical Chamber), who sided with the government and deemed strikes unethical.

The most significant institutions upholding the medical profession's autonomy are the compulsory membership in the Medical Chamber, its licensing rights and its obligation to defend both the professional and economic interests of the medical profession (Zákon č. 220/1991 Sb.). For the medical profession, these institutions allow for collective action against the government without fear of retribution. For example, in 1993, the Dental Chamber threatened to withdraw from public health insurance if the government did not ensure that health insurance funds reimbursed dentists on time. In 1994, the Medical Chamber instructed specialist doctors not to charge patients without a GP's referral a small fee, introduced by the Health Ministry to reduce specialists' fee-for-service reimbursement. When, in 1995, doctors decided to strike over low pay, the government threatened to sack them and cancel their medical degrees; but this threat was empty because the cancellation of medical degrees, awarded by state universities, could not have affected the licences issued by the Medical Chamber. For the government, the medical profession's autonomy limits the possibility of regulatory action to uphold the constitutional right to free health care without increasing health care expenditure. In 1995, doctor-MPs loyal to the government drafted legislation reducing the powers of the medical profession (PSP 1995a), but this was eventually withdrawn. With just 7 months left before the election the Prime Minister could not afford to gamble on whether the Health Ministry could break the medical profession before doctors spoiled his party's chances of re-election. The PM pacified the Medical Chamber by sacking the Health Minister and abandoning the idea of limiting its powers.

### **Social dialogue in health care**

The failure of social dialogue in health care highlights that in some zero-sum games, such as health care financing negotiations cannot bring outcomes superior to unilateral action and that the problem-solving capacity of certain institutions, such as social dialogue,

depends on power resources of actors. In the run-up to the 1995 doctors' strike over low pay, the Union of Employer Associations initiated the Council for Dialogue between Social Partners in Health Care to bring together associations of hospitals and independent providers, trade unions and the government in an effort to prevent industrial action. Yet, the government was not prepared to raise expenditure to increase pay in health care. Employers could not meet employees' demands either: 85% of hospitals were insolvent and the government was unwilling to increase their funding (ČTK 1996g). Employees and employers could not put a common front against the government, because most hospital managers were under the administrative remit of the government, which could slash managers' bonuses or even fire them. Furthermore, the government rarely attended the Council's meetings and even then only as an observer. Essentially, the Council was just an ad hoc consultative group of employers and employees, with no problem-solving capacity. The only function the Council could perform was to relieve pressure from employers by postponing industrial action. After seven months of fruitless negotiations, trade unions walked away from the Council and launched a series of strikes for higher pay and against the government's re-election.

Eighteen months later, social dialogue was renewed but on different premises: to comply with the EU accession terms, rather than to solve burning industrial relations matters. The EU criticised the Czech government for the absence of social dialogue, beyond remuneration on matters which interested Brussels, such as health and safety (COM/97/2000). These, however, were not of great concern to low-paid doctors and nurses in Prague. To satisfy Brussels, the right-wing government had to reverse its five-year-old decision to abolish the Council for Economic and Social Agreement and to establish within it the Health Care Working Group to facilitate social dialogue on health and safety. A full-fledged social dialogue restarted, bottom-up, only in 2000, when the new Social Democratic government neglected the demands of doctors and nurses for higher pay. But social dialogue failed again, as the Social Democratic government was not willing to increase expenditure on health, so doctors had to strike.

## **Actors**

### **'The people' vs. elites**

In focusing on elites, rather than the people, as agents of public policy change, Schumpeter's account of democracy well describes post-Communist health policy change in the Czech Republic. According to what he calls 'classical doctrine', democracy is the rule of 'the people', who have rational policy preferences on every issue (including health care) and select representatives to translate them into policy. However, Schumpeter (1984) showed that such rationalisation is dangerous because in reality 'democracy is the rule of the politician' – a type of the entrepreneur 'dealing in votes' – who, on their initiative, select issues and compete to win political office. If incumbent political leaders do not act in the interests of 'the people' they risk not being re-elected, but 'the people' do not control political leaders in office. Political parties further restrict the free selection of the people's representatives, because parties and not 'the people' decide who appears on party lists of electoral candidates. Thus, in democratic politics, the role of 'the people' is limited to accepting one of the competing candidates, vetted by their parties, to produce Parliament which, in turn, produces the government.

Essentially, elites are 'those who are collectively the influential figures in the governance of any sector of society' (Marvick 1977, p.111). The Velvet Revolution led to the accelerated replacement of the Communist *nomenklatura* with the Communist-time elite-in-waiting, to the emergence of new elites through their enterprise as politicians or businessmen, and then to competition between elites for a place within a new institutional framework. In 1997-98 in the Czech Republic, only 23% of the political elite, 35% of the cultural elite, and 55% of the economic elite had been Communists in 1988 (Róna-Tas *et al.* 1999).<sup>77</sup> Yet, radical dissidents look at qualitative data and argue that the whole Velvet Revolution was 'a privatisation coup', organised by the Communist Party and its Secret Police, because of the strong links between the government of self-styled Thatcherites and Hayekians and the Communist regime: PM Klaus was married to a high-flying member of the Communist Party, the Privatisation Minister was a son of a top

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<sup>77</sup> In the 1980s, roughly one in seven adults (10% of the total population) were members of the Czechoslovak Communist Party (Wightman 1983).

Communist *nomenklatura* member, and the Ministers of Finance, Economy and Foreign Affairs were former members of the Communist Party (Cibulka 2000). Although I do not subscribe to Cibulka's theory<sup>78</sup>, it is evident that – despite the accelerated replacement of Communist elites – there was a significant degree of continuity between Communist and post-Communist elites, simply because ideology was secondary to the competition between old and new elites for power and wealth. Since approximately 1996, the competition between elites has been contained within a stable institutional framework and thus has been decreasing. In line with elite theorists (Mills 1956; Domhoff 1967; Dye 2001), I argue that this framework produces elites that learn to accommodate each other's interests and avoid conflicts to preserve their positions of power within the existing framework. By positing an elite consensus, aimed at the preservation of power, within the existing institutional framework, elite theory helps to explain why competition between elites is structured around a narrow set of issues and political parties do not offer clear ideological alternatives.

### **Political parties**

Although political parties neither set the agenda for health policy change, nor enacted it in accordance with their ideologies, they were still major health policy actors. To run a country requires many individuals, so the political entrepreneurs who spotted opportunities for political gain after the collapse of Communism established parties to coordinate their activities. It is crucial to realise that, for parties, ideology is just one of the devices to win the votes necessary to realise the power ambitions of their members. For example, in order to win a parliamentary seat in 1992, a future Health Minister supplied voters with both a strong health policy programme and his own-brand hard liqueur (Weinberger 1999). The latter might have been the more effective for winning votes as, obviously, more voters drank than read health policy programmes. But, precisely because

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<sup>78</sup> Cibulka makes a simple mistake in assuming that the Communist elites, who contributed to post-Communist reforms, remained loyal to the Communist Party. They were loyal to the Communist Party only when it was in power because this was necessary for their main ambition – well-paid jobs and power. Likewise, they remained loyal to their careers after the collapse of Communist rule and formed new parties to promote their careers. But Cibulka, who spent five years in Communist jail for not conforming with Communist rule, did not conform with post-Communist rule either. Whereas elites exploit any rule to their advantage, dissidents think critically about any rule.

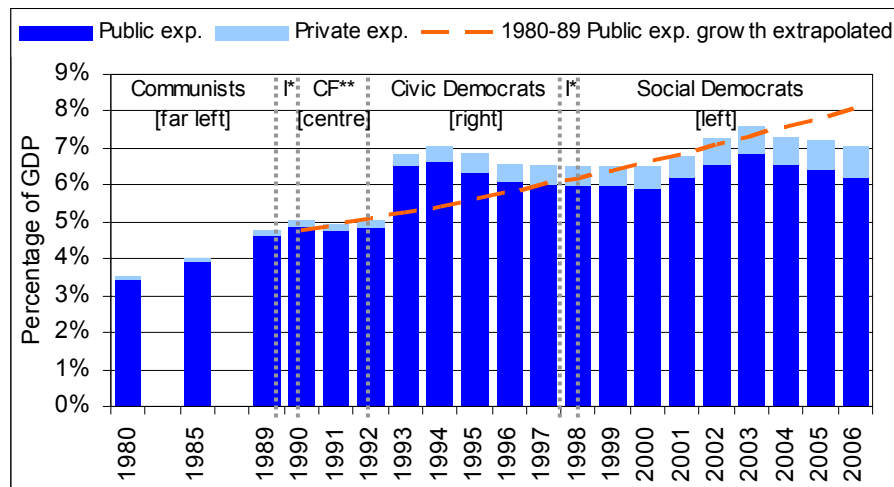
some voters preferred food for thought over branded liqueur, balloons, or other vote-winning devices, the parties had to produce electoral manifestos, in which they selected campaigning issues and adopted ideologies to solve them.

In mature democracies, there is a strong correlation between what parties stand for during elections and what they actually do when elected (Klingemann *et al.* 1994), but Czech political parties often fail to fulfil their electoral pledges. In 1992, the Civic Democrats argued that '[health insurance] must be removed from the state budget and become an independent fund generating its own income' and pledged support to competing independent health insurance funds which would create investment capital for the economy (ODS 1992). But, four years later, the Civic Democratic government ended up issuing directives to the 'independent' General Health Insurance Fund, which generated a multi-billion debt, and scrapped the right of health insurance funds to invest and compete, liquidating two-thirds of them. As voters have no means of controlling the government, the latter has no scruples in deviating from its stated ideology. During the 1992 election, the Civic Democrats styled themselves as liberals but, when pursuing liberal health policies became costly, they heralded their new policies as 'regulation, regulation, and again regulation' and 'a deviation from liberalism' (ČTK 1996u).

Refusing to 'put their money where their ideology is' is a feature of both right-wing and left-wing parties (Figure 11 overleaf). Although improvement the citizenry's welfare was the utmost goal of the Communists, during the last decades of their rule health care expenditure grew slowly in line with economic growth. As economic growth slowed down, by the 1980s, the health care sector became under-funded and public expenditure on health, as a percentage of GDP, lagged behind most capitalist welfare states (OECD 2007). Although, under the Civic Forum government, health care expenditure stagnated, this government launched health insurance in 1992 and in the following year public health care expenditure as a percentage of GDP jumped far above the would-be Communist level and in real terms was on a par with the would-be Communist level in 1993-95. It is important to appreciate that, before assuming office in 1992, the Civic Democrats criticised the government for the slow introduction of health insurance and

sponsored legislation on multiple health insurance funds which increased health care costs. During right-wing rule, public expenditure on health as a percentage of GDP was also high, because the contribution of other sectors of the economy to GDP decreased due to economic depression. The two successive Social Democratic governments achieved formidable economic growth, but failed to translate it into higher public expenditure on health as a percentage of GDP.

**Figure 11: Total expenditure on health as a percentage of GDP, 1980-2006**



\* I=Interim Government; \*\* CF=Civic Forum

Source: own analysis based on ÚZIS (2000, 2002, 2007a); IMF (2007); OECD (2007)

The most important role of parties is not to implement policies, according to their ideology, but to recruit personnel for public office, who then make health policy decisions in Parliament and the government. A characteristic feature of Czech political parties is that, together with a strong leadership, they allow functional autonomy of certain party units, as is the case in the ‘franchise model of party organization’ (Carty 2004). One such autonomous unit is health policy because, due to its complexity, party leaders cannot formulate health policy and parties do not have collective bodies or think-tanks to do so either. Health policy entrepreneurs compete in front of party leaders to have their ‘health policy concepts’ adopted as party line. Effectively, there is no such thing as party health policy – there are just health policies of individual health policy entrepreneurs. As parties do not have the health policy expertise to evaluate the programmatic proposals of competing health policy entrepreneurs, the adoption of a

health policy party line boils down to a popularity contest between individuals, their loyalty to party leaders and their managerial and leadership skills. When serious health policy problems emerge, the incumbent Health Minister is criticised by fellow party members as much as the opposition. Another corollary of the functional autonomy of health policy within parties is that it may be incongruent with party ideology, but party leaders accept this incongruence because they need health policy to capture doctors' and patients' vote. For instance, in 1992, the leaders of the Civic Democratic Alliance styled themselves as Hayekians, but had to accept an anti-liberal pledge to sell health care facilities only to doctors, ban foreign capital from health care privatisation and ensure low privatisation prices for Czech doctors (ODA 1992).

## **Parliament**

The role of Parliament is defined as much by its formal functions – to set up the government, scrutinise its policies and legislate – as by whether the government has a stable parliamentary majority. During Communist rule the government had a stable parliamentary majority, so Parliament simply endorsed a cabinet proposed by the Communist-led National Front coalition, toothlessly scrutinised government health policies, and routinely passed government legislation. Since the post-Communist governments did not have stable parliamentary majorities, due to proportional representation and a fragmented party system, Parliament tended to use its legislative and administrative scrutiny functions to pull down the government. As Schumpeter (1984, p.285) put it, 'the democratic method produces legislation and administration as by-products of the struggle for political office'. MPs do not come to Parliament to scrutinise and legislate for health care reform, but to exploit these activities to maximise their power, advance their vested interests and gain a rent on their office. Understanding health policy administration and legislation as by-products of the democratic political process explains why health policy-making in Parliament is more 'adversary' (Finer 1975; Mansbridge 1980) than ideological, i.e. the opposition takes the opposite position to the government, even when the government proposes health policies congruent with the opposition's ideological stance.

In 1993, the Social Democrats abandoned their traditional strategy of constructive, non-radical opposition and adopted the traditional Communist strategy of a radical, destructive opposition, aiming to pull down the government. To this end, a growing health insurance deficit made the Health Minister a perfect target for the Social Democrats:

The government is an octopus which has many tentacles and therefore many throats. We are going for the throats of the Minister [of the Interior], the Minister [of Health], and other less capable Ministers (Zeman; cited in *Rudé právo* 22.10.1994).

The deficit was partly caused by high administrative costs of independent health insurance funds, excessive executive pay, investments in dubious businesses, and the promises of more services to new customers than it was possible to pay for. As independent insurers cream-skimmed high-income and low-risk clients from the public General Health Insurance Fund, its deficit also grew. In such circumstances, the Health Ministry proposed regulatory measures to control the administrative costs of independent insurers, scrap their right to invest and compete on the basis of additional services, merge or liquidate inefficient and insolvent health insurance funds, and demand financial reporting from them (*Zákon č. 60/1995 Sb.*).

The proposed measures matched the best traditions of the Social Democrats, who in the 1920s championed reform to merge/liquidate hundreds of inefficient health insurance funds and establish the public Central Social Insurance Fund (*Zákon č. 221/1924 Sb.*; *268/1919 Sb.*). The proposed legislation also followed Communist ideology and experience: '[w]ith competition ruled out, the operation of health care facilities is much less expensive' (Šourek 1966, p.22). However, instead of applauding the right-wing government for its left-wing policies and supporting them, the Social Democrats and Communists voted against them (PSP 1995e). The Social Democratic leaders accused the government of trying to create the 'monopoly' of the public General Health Insurance Fund (ČTK 1995d). Importantly, the government's measures would affect the Miners' Health Insurance Fund, whose Director happened to be a Social Democratic MP. The Social Democrats made a U-turn and supported the state regulation of health insurance funds (ČTK 1995f) only after a tragedy showed that such regulation was belated – a pensioner died after being refused hospitalisation because his Miners' Health Insurance

Fund was insolvent and could not reimburse the hospital for the treatment (ZN 21.7.1995). In other examples, the Communists publicly urged doctors to charge patient co-payments in order to force Health Minister to resign (ČTK 1997d), and in 1998 the Social Democrats voted against the government's proposal for the distribution of health risks across health insurance funds.

## **Government**

The elitist argument that '[p]ublic policy is whatever governments choose to do or not to do', rather than a series of transparent goals and interventions planned to improve the welfare of 'the people' as desired by 'the people' themselves (Dye 2001, p.2) held true in the Czech Republic soon after the regime change. In 1993, a disillusioned member of the Supervisory Board of the General Health Insurance Fund resigned to draw public attention to the top-down nature of health policy-making and show the lack of public control in public health insurance: 'instead of public policy there came Cabinet policy' (Karlík in: Boškova 1999, p.38). However, my research shows that the government is not a unitary actor and that the interests of the Prime Minister, Cabinet, individual ministers, and civil servants disproportionately influence health policy-making.

The Prime Minister calls the shots in health care reform: he appoints the Health Minister, controls the government's agenda, and presides over vital health policy decisions. The appointment of the Health Minister is based on both the 'health policy concept' of candidates and the PM's tactical considerations. For instance, in 1993, the PM dismissed the Health Minister with the formulation 'the health service cannot always be on the defensive, as it has been' (ČTK 1993u) and appointed a new Health Minister to launch an offensive on health care reform. When the new Health Minister's assault on the medical profession prompted its leaders to boycott the Health Minister in the boardroom and trade unions mobilised for street warfare, just seven months before the 1996 election – the PM tactically retreated and appointed a new Health Minister to resolve the conflict through negotiations without changing health policy.

The leadership of the Health Minister in policy change is further constrained by the Cabinet, individual ministers and their formal or informal groupings. In 1989-1992, the role of the Cabinet was marginalised by the Economic Council – a formal grouping of senior government ministers, bankers and experts who made decisions on post-Communist reforms. As ministers in charge of health, education, culture and other sectors funded from the budget were excluded from the Economic Council, they described themselves as ‘begging ministers’: they had to ‘beg’ the ‘economic ministers’ for attention and funding for their sectors (Uhde in: Bojar interview 2005). In order to put health care on the government’s agenda in 1990, the Health Minister had to ask a schoolmate to solicit her friend, the wife of the Chairman of the Economic Council, Klaus, to ask her husband to invite the Health Minister to speak in front of the Economic Council about proposed health care reform (ibid.). In 1992-97, the formal institution of the Economic Council was replaced by PM Klaus’ informal consultations with the ‘economic ministers’. This not only concentrated decision-making in the hands of the PM and ‘economic ministers’, but also changed the balance of power inside the governing coalition, because only one of four Christian Democratic ministers was an ‘economic minister’. In spring 1997, health policy deliberation took place during such informal consultations of the ‘economic ministers’, thus leaving the Christian Democrats without influence on health policy. The Christian Democrats threatened to leave the governing coalition if the Health Minister did not present his health policy proposals to the Cabinet (ČTK 1997e). The Health Minister argued that he had presented his policies to the ‘economic ministers’, during their informal consultations, which he claimed had the status of Cabinet meetings (ČTK 1997r), but the Christian Democrats dismissed this claim and forced an extraordinary meeting the coalition partners to discuss their participation in the coalition (ČTK 1997h). This was a powerful threat to the PM, who promised to accommodate the health policy interests of the Christian Democrats, but reneged so the Christian Democrats left the coalition and the government collapsed.<sup>79</sup> After the collapse of PM Klaus’ government, in 1997, successive governments adopted more collective forms of decision-making through Cabinet meetings.

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<sup>79</sup> Surprisingly, even the Communist Politburo seemed more democratic than the Czech government under Klaus’ rule. This is well demonstrated by a popular joke of the Klaus period: ‘What is the difference between God and PM Klaus? – God does not believe he is Klaus’ (Independent 31.5.1996).

The influence of the ‘economic ministers’ on health policy between elections usually aims at controlling public health care expenditure; yet, in anticipation of elections, they can agree to increase public health expenditure to secure re-election. In three consecutive acts, the ‘economic ministers’ successfully reduced public health insurance contributions (Zákon č. 59/1995 Sb.; 161/1993 Sb.; 592/1992 Sb.); but, four months before the 1996 election, the government legislated for the increase of public health insurance contributions (Zákon č. 149/1996 Sb.) to pacify doctors on strike and reduce the multi-billion deficit of health insurance. This, obviously, went against the interests of the Finance Minister, but the government’s common interest in survival prevailed over the departmental interests of the Finance Minister:

Every Finance Minister argues with [the Health Minister] about each extra crown and will tell that 5bn is a lot, but then there is the government which by a certain vote will brush off that Finance Minister (Stráský interview 2005).

Health Ministers can be influenced by civil servants, who maintain that Czech Health Ministers often lack the intelligence and administrative skills to run the Health Ministry and develop health policy (Háva interview 2006a). This is not surprising because, in every democracy, ‘the democratic method creates professional politicians whom it then turns into amateur administrators and “statesmen”’ (Schumpeter 1984, p.288). Most Czech Health Ministers had excellent leadership and political skills, as required for their job, but they did not have a civil service able to challenge their decisions effectively. In the early 1990s, the Health Ministry was purged of the experienced civil servants appointed during Communist rule, then almost every new Health Minister appointed new Deputy Ministers and Directors of Departments. As Health Ministers changed on average every 17 months, senior civil servants changed too. Moreover, as senior civil servants were appointees of the Health Minister, they enabled the actions of the Health Minister rather than constraining them. Junior civil servants did not change that often but, because of the fear of losing their jobs and lack of bargaining power, they did not exercise strategic influence over health policy-making. The Czech Republic is, therefore, a case of strong Health Ministers and weak civil servants, effectively meaning that health policy

strongly depends on the Health Minister's leadership. Consequently, health policy-making is overly politicised and personalised.

### **Interest groups**

Together with elected politicians, interest groups are the most influential health policy actors. Although, in the last years of Communist rule, public opinion demanded better health care, after the Velvet Revolution, there was no public debate on health care reform and 'the people from the street' had no influence on the health care reform agenda set by health sector interest groups (Potůček 1995). Then, interest groups were rather informal coalitions of entrepreneurial people who spotted the same opportunities and co-operated to capitalise on them. For example, those interested in health policy joined forces with researchers from the Institute of Social Medicine and Organisation of Health Care, under the umbrella of the Group for Reform (SKUPR), and developed the very first proposal for health care reform; a similar group called INSKOP later put forward a proposal for decentralised health insurance; the doctors, who during the 1968 Prague Spring established the Czechoslovak Union of Doctors to improve medical ethics and professional autonomy, re-established the Union on the same platform in 1989; the younger doctors, who wanted an organisation to defend doctors' interests against the state, set up the Prague Medical Chamber Ltd., which later turned into a professional association (Czech Medical Chamber); and the managers at the University Hospital Královské Vinohrady and other large hospitals launched an enterprise called 'Experiment R' to lay foundations for fee-for-service reimbursement to increase hospitals' revenue. Many members of these groups and other health professionals, who wanted to engage politically or simply take the place of the Communist-time management at their hospitals or health authorities, joined the Civic Forum of Health Professionals (Klener interview 2006). As the institutional framework consolidated, these informal interest groups either gave way to formal organisations or disintegrated.

Contrary to popular belief, there is no united 'medical lobby' in the Czech Republic. Rather, there are many groups – professional associations and trade unions of the medical profession, associations of health care providers, health insurance funds and

distributors/producers of medical devices and drugs – who often have competing interests and do not hesitate to act against each other:

Nurses and ancillary staff against doctors, nurses against nurses, and doctors against each other (GPs against hospital doctors, non-state doctors against state doctors, individual specialties against each other) (Sojka 1996).

This is so not only because of the contradictory interests of the various groups of the medical profession, but also because of the political competition between elites for power and influence in the health care sector. Like political parties, members of the organisations of the medical profession did not appoint their leaders to realise their policy preferences, but the doctors who wanted to be leaders established these organisations to realise their leadership ambitions. Although the elites of the medical profession reached a consensus on the desirability of health insurance and privatisation of health care facilities, in 1992 grass-roots doctors established the Brno Crisis Centre in protest against these policies. They argued that, due to low health insurance reimbursement rates and control of health expenditure by the government, these policies would decrease their income (Vlk 1992). Furthermore, the leaders of the militant Doctors' Trade Union Club repeatedly went on strike in 1995-96, both against the government and the leadership of the Medical Chamber. The latter supported the government and condemned the strikes as unethical. Since 1997, professional associations of various medical specialties and associations of health care providers negotiate reimbursement rates directly with health insurance funds, resulting in competition for the limited resources available to health insurance funds.

Another popular belief – that doctors in political parties, Parliament, government, health insurance funds, etc. promote the interests of the medical profession – does not match reality either. Schumpeter's (1984, p.286) argument that 'the doctor... who means to work or reform institutions of his country will still be another type and have another pattern of interests [than the doctor who fills the cup of his ambition solely as a doctor]' holds true. Such doctors act in their own interests, and those of the organisations who pay them. If the interests of doctors-reformers contradict those of the medical profession then they may be even more effective in undermining the interests of the medical profession than anybody else. For example, in 1995, the doctor-Health Minister, who acted to increase the regulatory powers of the state, renounced his membership in the Medical

Chamber after the latter attempted to bring him before its Disciplinary Board for acting against the interests of the medical profession (MfD 17.01.1995). Furthermore, a doctor-MP loyal to the government drafted a proposal to limit the autonomy and powers of the medical profession (PSP 1995a).

Independent health insurance funds and distributors/producers of medical devices and drugs neither have a formal role in health policy-making nor go on strike. Nonetheless, they are able to influence Parliament and the government. In November 1995, the government prepared legislation to merge or liquidate 22 out of 27 health insurance funds (PSP 1995b) but, in case-by-case voting, Parliament voted to merge or liquidate only 10 health insurance funds (PSP 1996e, 1996f). The voting on the government proposal did not have a clear partisan pattern, as MPs from the governing parties often voted against the government's proposal, but we do not know why. It is likely that the managers of the insurance funds in question had personal relations with MPs and simply asked them to help save well-paid health insurance jobs for themselves, their spouses, children, schoolmates, friends, etc. Also, some MPs acknowledged that, when Parliament discussed legislation related to health insurance funds, their representatives 'chased' MPs and, eventually, some MPs acquired health insurance policies from these funds (ČTK 1995s).

Altogether, interest group politics was rather competitive as the unhinged institutional framework was still consolidating in the early 1990s. But, since approximately 1996, this competition has been contained within a stable institutional framework, which provides elites with incentives to avoid conflicts to preserve their positions of power. In 1996, in a bid to avoid conflicts with the medical profession, the Civic Democratic Health Minister appointed representatives of the Medical Chamber and Association of Hospitals to positions as high as Deputy Health Minister. The conflict between the leaders of a militant Doctors' Trade Union Club and their antagonists in the Medical Chamber was settled in 1998, when the trade unionists won the Presidency of the Medical Chamber. In 2005, the Social Democratic government appointed the President of the Medical Chamber as Health Minister. More recently, the government passed a directive

establishing the Round Table on the Future of Health Care Financing to ‘initiate and organisationally facilitate public debate on the future of Czech health care financing, and the establishment of an expert group for this discussion’ (Usnesení vlády ČR č. 632/2007). The Round Table put together various agencies and interest groups representing ‘the professional public’ from the health sector (MZ ČR 2007), effectively substituting elite bargaining, aimed at interest accommodation, for public debate. The outcome of this bargaining was the introduction of substantial patient co-payments in 2008.

### **Supranational organisations**

Although it is argued that Washington-based supranational organisations set a right-wing social policy agenda in Hungary, Bulgaria and the Ukraine (Deacon *et al.* 1997), the supremacy of Czech domestic actors over supranational organisations challenges the argument for ‘global social policy’ (ibid.). In the early 1990s, Czech political entrepreneurs spotted opportunities for making profit from right-wing policies and used their appeal to banish former dissidents from power. To maximise power, right-wing political entrepreneurs shunned the assistance of supranational organisations, because its conditions limited the sovereignty of national decision-making. In 1990, Finance Minister Klaus rejected a World Bank loan on the grounds that he was ‘not ready to pay hard money for soft advice’ and formulated his conspiracy theory about supranational organisations:

...[Czechoslovakia and other transitional countries] should not become victims of vested interests of a very skilfully organized group of international advisers, investment bankers, powerful auditors and bureaucrats of international financial organizations. They established a very successful rent-seeking and pressure group (Klaus 1997).

On the one hand, it was sensible for Mr Klaus to reject a non-zero interest loan and resist the advice of supranational organisations, whose advisors did not know much about the Czech Republic. On the other hand, living behind the Iron Curtain, Mr Klaus knew little about market economies and the conditions attached to such loans limited his decision-making powers. It is plausible that, by rejecting the assistance of supranational organisations, he acted to eliminate potentially rival expertise and the scrutiny of his

‘amateur’ policies. During the monetary crisis of 1997, two Deputy Prime Ministers criticised PM Klaus for hiding communications from the IMF, alerting the government to its weak monetary policies, from senior Cabinet members (ČTK 1997y). Eventually, PM Klaus’ autocratic antics, the worst deficit of the balance of payments ever recorded in the Czech Republic (IMF 2007), and a party-donations-for-privatisation-favours scandal led to the collapse of his government.

Whereas health policy was no exception to Mr Klaus’ drive to avoid international advice and scrutiny, other parties did not reject international co-operation. Even though in 1991 Klaus, in his position as Federal Finance Minister, rejected a World Bank loan targeting the health care sector (Jaroš *et al.* 2005), the Czech Health Ministry under the Civic Forum’s Minister employed two Dutch and two US experts in 1991-92. However, this changed when Klaus’ party came to power. In 1992, the Health Minister expelled the US experts from the Health Ministry and even considered quitting the WHO to save on membership fees (Háva interview 2006a). Also, the WHO’s advice was considered impractical: ‘they would just preach social justice without giving any practical advice’ (Marx interview 2006). Although the Ljubljana Charter on Reforming Health Care (WHO Europe 1996b) acknowledged the failure of market mechanisms in health care, when the Health Ministry was busy dismantling these, the government did not sign the Charter, perhaps so as not to tie itself to international agreements. The Czech attitude towards international co-operation changed with the arrival of the new government. In 1998, the Finance Ministry under the Social Democratic government wanted to break entrenched domestic interests resisting health policy change with the help of the World Bank (Sedláček interview 2006). The latter was so eager to establish its presence in the Czech Republic that it even waived a consultancy fee (Matesová email 2006), but it failed to overcome the resistance of entrenched domestic interests. This suggests that supranational organisations are not potent policy actors with their own political agenda, but rather service firms driven by organisational purposes and void of ideological goals.<sup>80</sup>

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<sup>80</sup> This is in line with the hypothesis that domestic politicians use supranational organisations to ‘present their own policy preferences as mandated by international agencies’ (Stark 1991, p.52) – which has recently been confirmed in the case of Bulgaria (Ganev 2007).

The EU did not significantly influence Czech health policy actors either. In 1992-93, the EC helped finance loans for privatisation in the outpatient sector through the PHARE Programme, but the uptake of these loans was small (Kalina 2005). Although Czech social policy commitments were above the minimum required by the EC Social Charter, PM Klaus' Eurosceptic government was toying with the idea of opting out of the Social Charter. But, when accession negotiations started in 1997, the Czech Eurosceptics no longer considered opting out as they simply did not have bargaining power vis-à-vis Brussels. Furthermore, Brussels had a very limited mandate in health care. As the Czech Accession Chief Negotiator acknowledged: 'our Western counterparts say that health care is too specific and they don't want to discuss it' (Telička 2004). Brussels only marginally influenced public health, by widening the scope of social dialogue to include health and safety and outlawing spit tobacco. Also, unintentionally, Brussels set the agenda for a new round of health care privatisation. As a result of the administrative reform required for the EU accession, self-governing regional authorities were created, taking over ownership of health care facilities on their territory. The regions attempted to shun responsibility for health care, because they lacked sufficient budgets to maintain health care facilities. Another indirect influence of the EU is the 'brain drain' of able health care reformers, because higher pay and lesser responsibilities in Brussels lure them away from Prague. In 2004, the Prime Minister, who previously served as Chairman of the Parliamentary Health and Social Policy Committee, resigned from domestic politics to take up an EU Commissioner job in Brussels. Furthermore, among the 25 Czechs elected to the European Parliament in 2004, there were five doctors, including one former Health Minister.

## ***Conclusions and implications for welfare state research***

### **Mechanisms of health policy change**

In analysing the chain of events that brought about post-Communist health policy change in the Czech Republic, I stress the importance of inherited policy problems (institutional outcomes) versus historical institutions, and the primacy of agency over structure. My

explanation of the political process behind institutional change consists of four important mechanisms: opportunism, tinkering, enterprise and elitism.

First, health policy change was driven by an opportunistic logic rather than an ‘accidental logic’ (Tuohy 1999). The opportunistic logic stresses the time-specific conditions, or ‘opportunity structures’ (Kitschelt 1986), and self-interest seeking of policy actors. The policy actors who implemented post-Communist reforms did not actively seek policy change before regime change but, when it happened irrespective of their will and action, they did not hesitate to take advantage of it. In doing so, ideology did not matter much as, naturally, actors wanting to capitalise on regime change adopted a Cold-War-winning ideology, with variations on the speed, sequencing and methods of liberalisation and privatisation. In the early 1990s, the unhinged institutional framework provided policy actors with copious opportunities for unilateral self-interest seeking. As the framework consolidated, it constrained opportunities for unilateral self-interest seeking and provided policy actors with incentives to co-operate to preserve their positions of power. This reduced opportunistic practices, but did not change the intrinsically opportunistic behaviour of policy actors.

Second, health policy change resulted from ‘tinkering’ (Jacob 1977), rather than ‘recalibration’ (Ferrera *et al.* 2000; Pierson 2001) or similar processes which presuppose ideological or fiscal engineering. Post-Communist health policy change can be compared to the work of ‘a tinkerer who does not know exactly what he is going to produce but uses whatever he finds around him... to produce some kind of workable object’, rather than the work of an engineer who knows what he wants to produce and has all the necessary information and tools at his disposal (Jacob 1977, pp.1163-64). The concept of ‘tinkering’ (*ibid.*) further stresses opportunism and brings to the fore the problems of bounded rationality, limited computational abilities, and incomplete information.<sup>81</sup> Policy

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<sup>81</sup> The notion of ‘tinkering’ used here is similar to ‘muddling through’ (Lindblom 1959) in acknowledging bounded rationality, but differs in emphasising opportunism and political decision-making over incrementalism and bureaucratic decision-making. However, as an institutional framework consolidated, i.e. from approximately 1996 onwards, we observe more incrementalism and less political decision-making. Thus, in the long-run, ‘muddling through’ may prove a better way of conceptualising Czech health policy-making.

change was often suboptimal because it was not directed by the state as a 'single rational actor' (Marmor 1970), but resulted from the aggregation of the utility functions of multiple competing government agencies and interest groups. Furthermore, excessive politicisation and de-bureaucratisation limited the number of individuals involved in health policy-making, thus reducing the computational abilities of the health policy-making system. Lastly, the abolition of hierarchical health authorities and their integrated information system (1991), the absence of data on independent health insurance funds (until 1996), and the liquidation of health policy research institutes (1993 and 2006) ensured that policy-makers had incomplete information about the health sector and the objectives of health policy change.

Third, health policy change was brought about by enterprising individuals who spotted opportunities for making political and economic profit from health policy change and did not hesitate to act. In line with Schumpeter's theory of entrepreneurial profit (Schumpeter 1936), they neither bore risks nor developed original policies. As elsewhere, entrepreneurs in the health care sector quickly saw off the competition of former dissidents, i.e. risk-takers and original thinkers. Unlike older doctors, who were persecuted after fighting to restore the autonomy of the medical profession in 1968, or the younger doctors, who were involved in dissident activities before the Velvet Revolution, the entrepreneurs who brought about post-Communist health policy change did not risk losing their freedom or careers. It was the voters/taxpayers who bore the risks of suboptimal health policy change. Moreover, the health policy entrepreneurs did not develop original policies, but simply employed combinations of well-known policies. What health policy entrepreneurs really contributed towards health policy change were 'the will and the action' (Schumpeter 1936, p.132) – they acted to change legislation and public administration according to their will.

Fourth, health policy change was enacted according to the will of elites rather than that of 'the people'. Schumpeter's doctrine of democracy squares well with the realities of post-Communist health policy-making. Even though public opinion in the late 1980s was concerned with the state of health care and, thus, elites presumably acted in the interests

of ‘the people’, there was no meaningful public debate on health care reform. In the early 1990s, elites decided on and implemented health policy change according to their preferences rather than those of ‘the people’. Health sector elites managed to put health policy change on the government’s agenda and won the resources to implement it. At that time, competition between emerging elites for resources was significant, so it is difficult to adjudicate between pluralist and elite theories. But, once the institutional framework consolidated circa 1996, competition between elites decreased as they sought to avoid conflicts to preserve their positions of power within the existing institutional framework. I argue, in line with elite theory, that an elite consensus emerged. As demonstrated by the Round Table on the Future of Health Care Financing and recent government policies, this consensus favours increasing health care finances through patient co-payments.

Overall, I stress the importance of inherited policy problems for starting the chain of events which brought about institutional change. My analysis of the political process which determined the pattern of institutional change stresses the primacy of agency over structure and institutional outcomes over institutions per se. After the collapse of Communist rule, policy actors gained copious opportunities to change old institutions and build new ones to maximise their interests. In doing so, however, policy actors did not act entirely voluntarily. The starting point for institutional change was provided by the outcomes of historical institutions. These defined the policy problems which policy actors attempted to solve by replacing historical institutions with new ones. Subsequent institutional solutions to inherited policy problems were not necessarily new, as they drew on tentative solutions to similar problems that had been developed before the regime change. Furthermore, emerging institutions, most notably a new policy paradigm institutionalised by the Civic Democratic Party, provided policy actors with novel opportunity structures that allowed them to define and maximise their interests. From a long-term perspective, spanning many electoral cycles and Health Ministers in office, institutional change looked rapid and haphazard. However, when the volatility of opportunity structures and the short time-horizons of policy actors are taken into account, a close examination of institutional change reveals significant continuity of policy problems and solutions, which shaped institutional development.

## **Limits of conventional welfare state theories**

The case of post-Communist health policy change in the Czech Republic highlights the limits of conventional welfare state theories that focus on social rights, power resources, interest group politics, state structure, industrialisation, retrenchment, and varieties of capitalism. It was first argued that the expansion of social rights followed the expansion of democracy (Marshall 1950). But, in the Czech Republic, social rights were universally expanded under one-party rule and then were limited, although not abolished, with the advent of democracy in 1989. Whereas, during Communist rule, health care was funded entirely through employers' contributions, health insurance contributions are now split between employers (2/3<sup>rds</sup>) and employees (1/3<sup>rd</sup>). Also, many non-essential services and drugs were taken out of health insurance and substantial patient co-payments were introduced. Later, it was suggested that democracy did not automatically expand social rights, but only created the conditions for trade unions and Social Democratic parties to act to expand the welfare state (Korpi 1983; Shalev 1983; Korpi 1989). But, in the Czech Republic, different doctors' trade unions acted against each other, because of power struggles between their leaders to preserve or improve their leadership positions. Also, doctors' trade unions usually acted against nurses' trade unions because the doctors' salaries could be increased at the nurses' expense and vice versa.

Further research criticised the class-based perspective, formulating the interest group politics theory: '(1) economic and demographic changes affect the structure of group resources and demands for welfare spending, and (2) the existence of democratic political institutions facilitates the realization of group interests' (Pampel & Williamson 1989, p.39). In line with this theory, democratic political institutions were key to post-Communist health policy change, while class-based groups were irrelevant. However, this theory is based on the pluralist notion of democracy, which assumes that the elites making health policy act according to the will and interests of their constituents. But the preceding analysis has shown that the elite understanding of democratic politics better approximates Czech health policy change, because post-Communist elites acted according to their own will and interests. A consensus on the introduction of health insurance and privatisation was reached by health sector elites. Grass-roots doctors and

nurses protested against these reforms, through setting up the Brno Crisis Centre and organising demonstrations in Prague, but their actions led only to a revision of the health insurance reimbursement rates rather than an overhaul of health insurance and privatisation policies.

State-centred theories emphasised state structure, corporatism, and the bureaucratic strength of state agencies (Wilensky 1975, 1976; Tufté 1978; Skocpol 1980; Evans *et al.* 1985). But the effect of the state structure on health policy change in the Czech Republic was limited and changed over time. Despite the ‘begging’ position of the Health Ministry in the government, health care reformers successfully overcame the structural influence of ‘economic ministries’ in 1990 and launched health insurance. The Czech Republic is a case of weak civil servants and strong politicians, who frequently change senior civil servants. Still, the electoral cycle influenced allocative decisions in health care financing, the new state taxation system demanded bringing forward the introduction of health insurance by one year, and the public administration reform required for EU accession spurred a new wave of health care privatisation. Whereas – following the collapse of Communist rule – government, trade unions and corporate elites in the health care sector became decentralised, they have been converging again since circa 1996. However, this new elite consensus favours increasing patient co-payments, so is not conducive to welfare state expansion.

As for capitalism, it was argued that the needs of groups affected by industrialisation prompted the state (regardless of the economic system) to increase social welfare expenditure to protect them and facilitate economic growth (Wilensky & Lebeaux 1965). This was the case in the beginning of Communist rule. The First Five-Year Plan significantly increased social welfare expenditure to protect workforces and increase their productivity: ‘we must ensure that every working person feels better and has better physical conditions for work because in this case he will work much better and thus will return expenditure on social security in excess’ (Popel 1949, p.124). In the 1970s, investments in health care reached the point of diminishing returns so the growth of health care expenditure stagnated. Even though the 2000-2005 EU Social Policy ‘Five-

Year Plan' (COM/2000/0379) adopted the same ideology, of social policy as a productive factor, it did not help to recover Communist-time growth rates of health care expenditure. This might be justified by post-Communist de-industrialisation, i.e. workforces are moving away from industry to services, but the size and health care needs of the aged urban population created by industrialisation are increasing. The retrenchment of the welfare state in the 1990s – i.e. 'policy changes that either cut social expenditure, restructure welfare state programs to conform more closely to the residual welfare state model, or alter the political environment in ways that enhance the probability of such outcomes in the future' (Pierson 1994, p.17) – was couched in monetarist terms and explained as an economic austerity measure. But post-Communist health policy change did not conform to the monetarist logic of retrenchment. The self-styled Thatcherites supported alterations of the political environment, leading to economic depression and the growth of public expenditure on health as a percentage of GDP. The varieties of capitalism theory suggested that employers were interested in maintaining certain levels of the welfare state because it allowed them to have well-trained workforces, who would not leave due to contingencies of life (Ebbinghaus & Manow 2001; Estevez-Abe *et al.* 2001; Hicks & Kenworthy 2003). In the interwar period, Czechoslovakia indeed had the capitalist luminary Tomáš Baťa, who championed new forms of workers' welfare and whose close associate Bohuslav Albert went on to lead early Communist health care reform (Mášová 2005), but post-Communist capitalists showed more interest in new forms of getting-rich-quick than workers' welfare.<sup>82</sup> The Czech variety of 'capitalismo-socialism' (Mládek 2002) provided incentives for managers to strip their companies of assets and dodge health insurance contributions. Large-scale non-payment of health insurance contributions by employers in the 1990s significantly exacerbated the multi-billion deficit of the health insurance system (Němec interview 2005).

Despite a quest for general theory in welfare state research, welfare state theories seem to come with a 'best before' date and a 'region code', restricting when and where in the not-so-globalised world they can be used. At the same time, many explanatory factors that

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<sup>82</sup> A Czech way of getting-rich-quick is known as '*tunnelling*' – 'a uniquely Czech term to describe the illicit, large-scale liquidation of the capital and holdings of a company, bank or investment fund', which is 'technically not illegal according to current Czech laws' (Altshuler 2001, p.116).

developed within these theories plausibly apply to the Czech Republic. Thus, if one aims to explain social policy continuity and change, they are likely to profit from ‘modular’ explanations (Scharpf 1997), linked by a partial theory or narrative, to obtain country-, sector-, and time-specific explanations. Moreover, they are likely to profit from in-depth research, which takes into account policy options and the environment in which policy-makers made their choices. The most valuable insights into the political process of health policy-making that I gained came from interviews with the policy-makers who made the choices under investigation. I found Schumpeter’s theory of democracy, elite theory, interest group politics and broader generalisations about human actions and interactions based on the assumptions of rational choice theory particularly useful in explaining our case. It is likely that Czech post-Communist health care reform did not create opportunism, tinkering, enterprise and elitism to begin with but, rather, unrestricted their workings due to the unhinged institutional framework. Therefore, it would be interesting to test whether the same mechanisms were at work in other transitional economies and other welfare state sectors.

# APPENDIX

## ***I. Average earnings in health care, 1955-2006***

In inter-war Czechoslovakia, ‘the medical profession belonged to one of the most profitable professions’ (Gazdík 1975, p.47), but this changed during Communist rule. Unfortunately, there is no standardised Czech data to illustrate this change, but it might have been similar to Hungary (Table A1), though social inequalities in Communist Czechoslovakia were less than in Hungary. In 1986-87, the Gini coefficient was 19.7 in Czechoslovakia, compared to 22.1 in Hungary (Atkinson & Micklewright 1992, p.81).<sup>83</sup> It is thus interesting to compare earnings dynamics in Czech health care during and after Communist rule.

**Table A1: Earnings in selected occupations relative to the manual industrial worker, Hungary, 1937 and 1957**

<b>Occupation</b>	<b>1937</b>	<b>1957</b>
Head of department in a ministry	9.1	2.7
University professor	7.9	2.6
District attorney	5.7	1.5
Doctor of medicine	4.0	1.5
Engineer, technician	3.1	1.6
Primary school teacher	2.9	0.9
Manual industrial worker	1.0	1.0

Source: Ferge (1979, p.72)

I estimated and compared the dynamics of earnings in health care in the Czech Republic before and after Communist rule in four steps<sup>84</sup>. First, I collected, collated and verified data on inflation and average earnings in health care for 1955-2006. Second, I calculated earnings in health care in real terms, by deflating earnings in current prices to 2006 Czech crowns (Kč) using the Current Price Index (CPI). Third, I computed the rates of average yearly increase in earnings in health care during Communist rule and statistically extrapolated these to the post-Communist period. Last, I calculated the ratio of average

<sup>83</sup> This compares to 24.2 in Poland, and 26.7 in the UK, and 27.6 in the USSR (ibid.).

<sup>84</sup> I am grateful to Martin Karlsson who kindly assisted me with extrapolating past trends and making computations in MS Excel.

earnings in health care to average earnings in the national economy. The limitations of the data and method employed here are as follows.

First, the earnings and inflation time series stretch over more than half a century, so methodological changes in national statistics might affect the inter-temporal comparability of the time series. Therefore, before using the data collected from the national statistics yearbooks I sought advice on the inter-temporal comparability of this data from the Czech Statistical Office. The generous advice I received exceeded my expectations. Not only was I assured that the inflation and salaries time series were methodologically homogeneous, but I was also given revised data on inflation by the Department of Consumer Prices (Trexler email 2007) and revised data on average earnings in health care by the Department of Labour Statistics (Porubská email 2007). Given that, until 1955, CPI did not fully incorporate changes in prices for services, there is no inter-temporally comparable data on inflation for the period before 1955. Also, because the most recent revision of the data on earnings according to the current NACE 1.rev methodology (ČSÚ 2007) was limited to five year intervals for the period 1955-1970 I had to use data for this period from the 1970 statistical yearbook (SÚS 1970).

Second, the data on earnings in health care employed in this study represents gross salaries. However, there may be a shortcoming in comparing gross earnings over the whole period under investigation because changes in personal taxation affected net earnings. Personal taxation seems to have increased after 1989, putting downward pressure on net earnings after 1989. For example, during Communist rule health insurance contributions were entirely paid by the employer but, after the post-Communist reforms, employees became responsible for paying 1/3 of health insurance contributions. Unfortunately, there is no aggregated data on net earnings, so data on gross salaries have to be used as the best possible approximation of earnings in health care.

Third, there might be limitations in employing the Current Price Index as a measure of inflation. Whereas in a market economy CPI captures inflation well, in a centrally-planned economy this may not be the case. Theoretically, there should be no inflation in

centrally-planned economies because planners regulate both the earnings of the population and the amount of available goods (Adam 1979). Practically, due to errors in planning, a centrally-planned economy is often characterised by ‘shortage’ of goods (Kornai 1980) in the form of long searches, queues and waiting lists (sometimes even queues to join waiting lists and waiting lists to join queues), black markets, rationing, barter, and access to goods at official prices being limited to elite groups (Nutti 1986). Thus, the official CPI may not fully account for actual inflation including *repressed inflation* (forced savings) and *hidden inflation* (which occurs if there are higher black-market prices, if retailer organisations charge higher prices within their discretionary power, if CPI understates the relative weights of goods whose actual market prices rise relatively fast, and if customers are forced to substitute cheap goods which are in shortage by more expensive goods which are available) (Nutti 1986).

Unfortunately, there is no authoritative conclusion about actual inflation in Czechoslovakia for the period in question and, therefore, the official CPI is the best available approximation of actual inflation in Czechoslovakia. For example, whereas Culbertson and Amacher (1978), in a simplistic and heavily criticised study (Farrell 1984), suggest that in 1960 actual inflation was about 3.8 percentage points higher than the official CPI, Ferltenstein and Ha (1996) produce a rather sophisticated econometric model which shows that essentially there was no repressed inflation in Czechoslovakia in the 1980s. It is difficult to evaluate the reliability of these and other similar studies because they employ different methodologies over different periods of time. Furthermore, the research design of such studies limits their reliability. They all use different ways of aggregating various official indicators to find a flaw in official statistics, but they do not collect and analyse any original data on a scale even remotely close to national statistics.<sup>85</sup> With varying degrees of success such studies can still assess the reliability of the official CPI, but their research design is intrinsically inferior to the real data collected

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<sup>85</sup> In a study of the Soviet economy Nutter went as far as suggesting that Soviet ‘statistics are grist for the propaganda mill... and consequently, officially reported indices... suffer from lack of reliability because of selectivity, ambiguity, and misrepresentation’ (Nutter 1962; cited in Culbertson and Amacher 1978). By the same token, those who are politically-biased can dismiss all Czechoslovak statistics collected during Communist rule as Communist propaganda. My approach highlights possible limitations of selected statistical indicators in a centrally-planned economy but still uses them for a critical inquiry.

and aggregated by the organs of national statistics. Although it is reasonable to assume that there was some repressed inflation in Czechoslovakia, this appears lower than in the majority of countries with a centrally-planned economy. Also, the influence of repressed inflation on earnings in health care might have been limited. Many doctors seemed to have better access to goods at official prices, because they were able to offer their services in exchange for other services or goods (Výborná 1994) through the network of their patients. Altogether, it is extremely difficult to assess whether hidden inflation existed and, if so, how far it devalued earnings in health care. Therefore, I follow to the official CPI as the best available approximation of actual inflation in Czechoslovakia.

My analysis proceeds in four steps using the following formulae. First, to estimate change in inflation relative to 2006, I convert the chain CPI – which indicates change in consumer prices relative to the previous year – into the base-year index, which indicates change in consumer prices relative to 2006 (Table A2). Second, to estimate earnings in real terms, I use the base-year index to inflate nominal earnings to 2006 Czech crowns (Kč):

$$\text{Real Earnings} = \frac{\text{Nominal Earnings}}{\text{Price Index}} \cdot 100$$

Third, to estimate the average rate of increase of earnings in health care in any given period  $t_1$ - $t_n$ , I use a logarithmic function to smoothen the trend:

$$\text{Rate of Increase } t_1 - t_n = \frac{\ln(\text{Real Earnings } t_n / \text{Real Earnings } t_1)}{\Delta t}$$

Lastly, to extrapolate a trend from the previous period (ending with  $t_0$ ) onto a year  $t$  beyond this period, I employ an exponential function to smoothen extrapolation:

$$\text{Extrapolated Earnings}_t = \text{Earnings}_{t_0} \cdot e^{\text{Rate of Increase} \cdot (t-t_0)}$$

In what follows, I present my analysis in tables and figures and discuss its results.

**Table A2: Average monthly gross salaries in health care, 1955-2006**

YEAR	CPI, %			AVERAGE MONTHLY GROSS SALARIES					
	Chain	1955= 100%	2006= 100%	Average health care, social care, and veterinary		Doctors		Nurses	
				Current Kčs/Kč	2006Kč	Current Kčs/Kč	2006Kč	Current Kčs/Kč	2006Kč
1955	-3.2	100.0	17.9	1,016	5,678				
1956	-2.7	97.3	17.4	1,073	6,163				
1957	-2.1	95.3	17.0	1,115	6,541				
1958	0.1	95.4	17.1	1,154	6,763				
1959	-2.5	93.0	16.6	1,179	7,087				
1960	-1.8	91.3	16.3	1,176	7,199	2,273	13,914	1,104	6,758
1961	-0.6	90.7	16.2	1,185	7,297				
1962	1.0	91.7	16.4	1,181	7,201				
1963	0.6	92.2	16.5	1,205	7,303				
1964	-0.1	92.1	16.5	1,218	7,390				
1965	-0.4	91.7	16.4	1,228	7,480	2,345	14,284	1,136	6,920
1966	0.5	92.2	16.5	1,273	7,716				
1967	2.0	94.0	16.8	1,400	8,319				
1968	1.3	95.3	17.0	1,508	8,846				
1969	4.0	99.1	17.7	1,736	9,792				
1970	2.2	101.3	18.1	1,787	9,862	3,766	20,784	1,647	9,090
1971	-0.4	100.9	18.0	1,927	10,678				
1972	-0.4	100.5	18.0	2,088	11,616				
1973	0.3	100.8	18.0	2,144	11,892				
1974	0.4	101.2	18.1	2,203	12,171				
1975	0.6	101.8	18.2	2,266	12,444	4,562	25,053	2,154	11,829
1976	0.9	102.7	18.4	2,275	12,382				
1977	1.3	104.0	18.6	2,312	12,422				
1978	1.5	105.6	18.9	2,354	12,461				
1979	3.7	109.5	19.6	2,413	12,317				
1980	2.9	112.7	20.2	2,481	12,307	4,640	23,017	2,439	12,099
1981	0.8	113.6	20.3	2,537	12,485				
1982	5.0	119.2	21.3	2,561	12,003				
1983	1.0	120.4	21.5	2,573	11,940				
1984	1.0	121.6	21.8	2,601	11,950				
1985	2.3	124.4	22.3	2,672	12,001	4,729	21,239	2,678	12,028
1986	0.5	125.0	22.4	2,706	12,093				
1987	0.1	125.2	22.4	2,754	12,295				
1988	0.2	125.4	22.4	2,793	12,444				
1989	1.4	127.2	22.8	2,857	12,554	5,072	22,287	2,838	12,470
1990	9.7	139.5	25.0	3,043	12,189	5,444	21,806	3,109	12,453
1991	56.6	218.5	39.1	3,663	9,369	6,335	16,204	3,772	9,648
1992	11.1	242.7	43.4	4,387	10,100	7,801	17,960	4,545	10,464
1993	20.8	293.2	52.5	5,525	10,530	10,347	19,720	5,899	11,243
1994	10.0	322.5	57.7	6,475	11,218	13,384	23,189	6,896	11,948
1995	9.1	351.9	63.0	7,529	11,957	15,860	25,187	7,990	12,689
1996	8.8	382.9	68.5	9,068	13,236	19,116	27,902	9,722	14,190
1997	8.5	415.4	74.3	9,622	12,944	20,258	27,252	10,193	13,712
1998	10.7	459.9	82.3	9,945	12,086	20,857	25,346	10,339	12,564
1999	2.1	469.5	84.0	11,312	13,464	23,692	28,199	11,760	13,997
2000	3.9	487.8	87.3	11,747	13,457	24,936	28,566	12,221	14,000
2001	4.7	510.8	91.4	13,356	14,613	28,814	31,527	14,326	15,675
2002	1.8	519.9	93.0	15,051	16,177	33,240	35,726	16,418	17,646
2003	0.1	520.5	93.1	16,311	17,513	35,814	38,454	17,837	19,152
2004	2.8	535.0	95.7	16,755	17,500	37,077	38,726	18,176	18,984
2005	1.9	545.2	97.6	17,511	17,949	38,668	39,635	18,787	19,257
2006	2.5	558.8	100.0	19,021	19,021	42,390	42,390	21,298	21,298

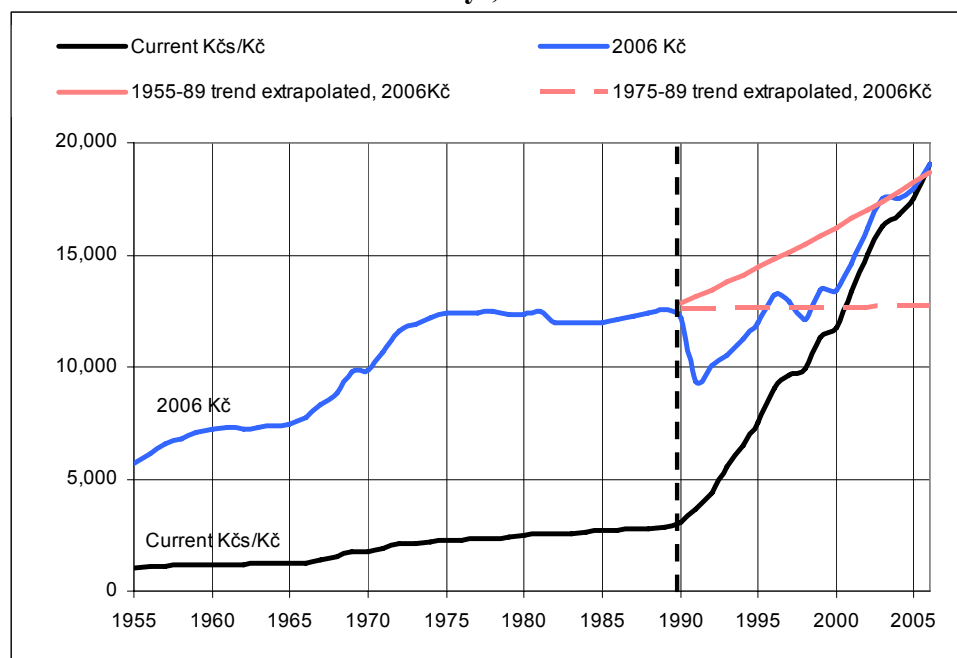
Source: own analysis based on SÚS (1970), ČSU (2007) and UZIS (2005, 2007b)

**Table A3: Average yearly increase in monthly gross salaries, 1955-2006**

Increase	Average health care, social care, and veterinary			Doctors			Nurses		
	1955-1989	1975-1989	1990-2006	1960-1989	1975-1989	1990-2006	1960-1989	1975-1989	1990-2006
<b>Nominal</b>	3.04%	1.66%	11.15%	2.77%	1.57%	12.49%	3.26%	1.97%	11.86%
<b>Real (deflated)</b>	2.33%	0.06%	2.44%	1.62%	-0.84%	3.78%	2.11%	0.38%	3.15%

Source: own analysis based on the data from the table above

**Figure A1: Average monthly gross salaries in ‘health care, social care, and veterinary’, 1955-2006**

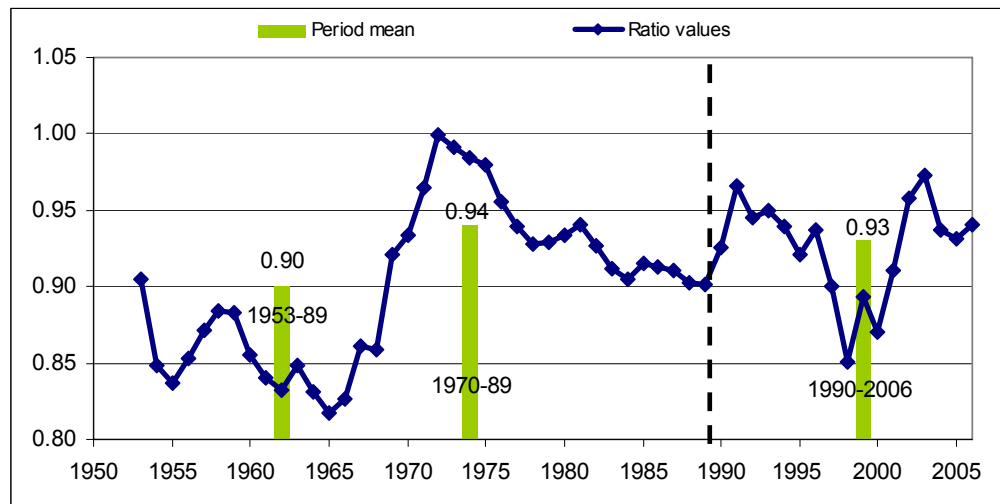


Source: own analysis based on SÚS (1970) for 1953-69 and ČSÚ (2007) for 1970-2006

Figure A1 demonstrates aggregate earnings in the large statistical category ‘health care, social care, and veterinary’ calculated by the Czech Statistical Office. This category allows us to estimate the dynamics of earnings in the health care sector over a long period of time and to compare these dynamics to other sectors of the economy. As we can see, there is a huge difference between nominal earnings and earnings in real terms. Whereas, in the period 1955-2006, nominal earnings increased approximately twenty times, real earnings increased less than four times. Also, there are two distinct trends in the

dynamics of earnings during Communist rule: growth in 1955-1975 and stagnation in 1975-89. In the post-Communist period, real earnings dropped in the early 1990s, recovered in 1997, dropped again in 1998, but since 1999 have been growing at unprecedented rates. If we ask, hypothetically, what might have happened to earnings in health care if the Communist system stayed on, there are two options for the extrapolation of the past trends onto the post-Communist period. First, if we assume that the 1975-89 trend continued then average earnings in 2006 would be approximately two-thirds of 2006 actual earnings. Second, if we assume that the 1955-89 trend continued, then average earnings in 2006 would match 2006 actual earnings.

**Figure A2: Average gross salaries in ‘health care, social care, and veterinary’ relative to average gross salaries in the national economy, 1953-2006**



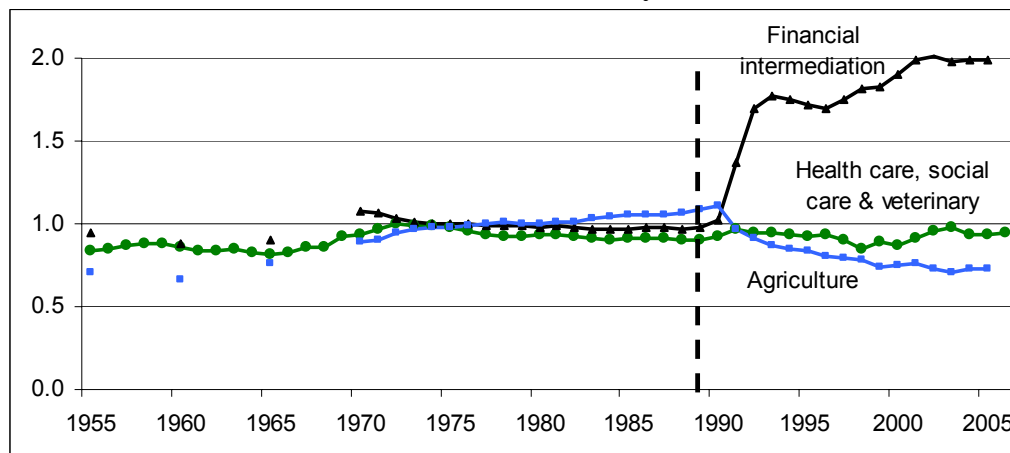
Source: own analysis based on SÚS (1970) for 1953-69 and ČSÚ (2007) for 1970-2006

How do average earnings in health care compare to other sectors of the national economy? Modern economics does not settle whether absolute or relative earnings matter to people most. According to the relative income hypothesis, an individual’s attitude towards consumption and savings (and thus their perception of well-being) is determined by their earnings in relation to others in their community, rather than by absolute earnings or standards of living (Duesenberry 1949). Although some economists dismiss this hypothesis as irrational, others have shown that people not only see a higher status associated with a higher relative income as a goal on its own, but also that a higher status can be instrumental in achieving a higher absolute income (Sen 1983; Frank 1985). As

shown in the earlier substantive chapters, the Doctors' Trade Union Club successfully fought for higher salaries for doctors on the grounds of their higher status than that of nurses and ancillary staff.

To investigate how average earnings in health care changed relative to the national economy, I calculated the ratio of average earnings in health care to average earnings in the national economy (Figure A2). Surprisingly, post-Communist reforms did not increase the relative earnings in health care. Indeed, earnings in health care in the post-Communist period neither increased, as in the financial intermediation sector, nor decreased, as in agriculture (Figure A3). In the post-Communist period, earnings in health care relative to the national economy slightly increased compared to 1953-89, but hardly changed compared to 1970-89 (Figure A2). With the exception of 1972, average earnings in health care have been consistently below average earnings in the national economy.

**Figure A3: Average gross salaries in selected sectors relative to average gross salaries in the national economy, 1955-2006**

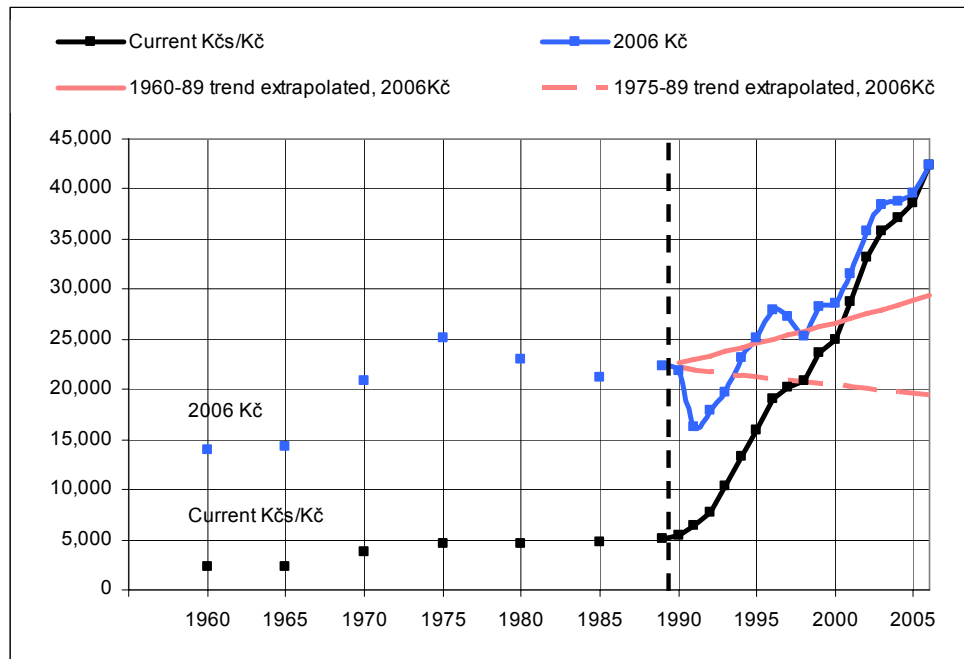


Source: own analysis based on SÚS (1970) for 1955-69 and ČSÚ (2007) for 1970-2006

Although the ‘health care, social care, and veterinary’ category allows us to estimate the dynamics of earnings in the health care sector over a long period of time and relative to other sectors of the economy, this category is subject to the ‘ecological fallacy’ (Robinson 1950) – that is, it does not allow us to make inferences about the nature of individual earnings. In addition to aggregating earnings in health care with social care

and veterinary, this category aggregates the earnings of such dissimilar groups as doctors, nurses, technicians and other ancillary staff. In order to compare the dynamics of the earnings of doctors and nurses, I use data collected by the Czech Institute of Health Information and Statistics for the period from 1960 onwards.

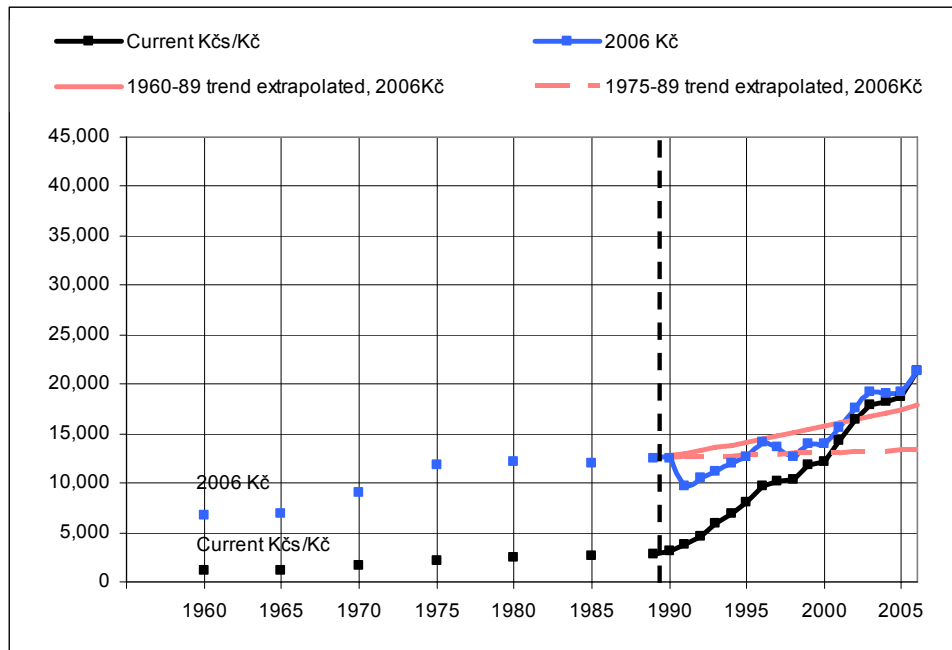
**Figure A4: Average monthly gross salaries of doctors, 1960-2006**



Source: own analysis based on ÚZIS (2005)

Like the aggregated average earnings in ‘health care, social care, and veterinary’, there are two distinct trends in the dynamics of disaggregated doctors’ earnings during Communist rule. An important difference, however, is that doctors’ earnings did not just stagnate in 1975-89, but decreased (Figure A4), which might explain why doctors were dissatisfied with the Communist health care system and wanted radical reform. If the Communist health care system had survived and the 1975-89 trend in the growth of doctors’ earnings continued, then in 2006 doctors would have earned less than half of what they actually earned in 2006. Although, doctors’ earnings dropped below the 1989 level in 1990-93, since 1994 (with the exception of 1998), doctors’ earnings have been steadily growing at much higher rates than in 1960-89.

**Figure A5: Average monthly gross salaries of nurses, 1960-2006**



Source: own analysis based on ÚZIS (2005)

In stark contrast to doctors, the earnings of nurses were stable during 1975-89, and grew at slower rates after the collapse of Communism (Figure A5). Nurses' earnings outgrew the 1960-89 rate of increase only in 2002. In fact, the income inequality between doctors and nurses increased thanks to post-Communist reforms. Whereas in 1989 the gross salaries of nurses represented 56% of the gross salaries of doctors and reached 60% in 1991, after the introduction of health insurance and privatisation in 1992, nurses' earnings decreased to 50% in 2006.

## II. Health care expenditure, 1970-2006

After the collapse of Communist rule, the Czech Republic underwent a profound economic transformation. This has significantly complicated the evaluation of health care expenditure before and after post-Communist reform. This difficulty can be illustrated in the example of GDP.

**Table A4: GDP and Current Price Indices, 1980-2006**

Year	GDP, current Kčs/Kč, bn	1970 Price Index	1980 Price Index	GDP, 1980 Kčs, bn	GDP, current US\$, bn	GDP, purchasing power parity (PPP), current intl. \$, bn	Foreign direct investment, net inflows, % GDP
1970	...	100.0	...	...	...	...	...
1975	...	100.5	...	...	...	...	...
1980	443.9	111.3	100.0	443.9	47.1	71.6	...
1985	512.8	122.9	110.5	464.1	45.3	101.7	...
1989	571.0	125.6	112.9	505.8	57.5	125.6	...
1990	617.6	137.8	123.8	498.7	52.1	128.8	...
1991	799.1	215.8	193.9	412.0	27.2	118.0	...
1992	902.7	239.7	215.5	419.0	31.9	116.8	...
1993	1068.5	289.6	260.3	410.5	36.7	120.1	1.9%
1994	1224.5	318.5	286.3	427.7	42.5	126.6	2.1%
1995	1466.5	347.5	312.4	469.5	55.3	137.4	4.7%
1996	1683.3	378.1	339.9	495.3	62.0	145.8	2.3%
1997	1811.1	410.2	368.7	491.1	57.1	147.2	2.3%
1998	1996.5	454.1	408.2	489.1	61.8	147.7	6.0%
1999	2080.8	463.7	416.8	499.3	60.2	151.8	10.5%
2000	2189.2	481.8	433.0	505.5	56.7	160.8	8.8%
2001	2352.2	504.4	453.4	518.8	61.8	168.7	9.1%
2002	2464.4	513.5	461.5	534.0	75.3	174.9	11.3%
2003	2577.1	514.0	462.0	557.8	91.4	185.1	2.2%
2004	2817.4	528.4	474.9	593.2	109.6	199.1	4.1%
2005	2994.4	538.4	484.0	618.7	125.0	218.9	...
2006	3220.3	551.9	496.1	649.2	142.5	240.2	...

Source: IMF (2007) and own calculations of price indices based on Trexler (email 2007)

During Communist rule GDP was not calculated, because the socialist economy used other macroeconomic indicators such as national product and national income. In the early 1990s, the Czech Republic switched to the System of National Accounts which enabled calculating GDP but, unfortunately, the Czech Statistical Office did not make

retrospective estimates of GDP. Therefore, I use the IMF estimates, which go back only to 1980 (IMF 2007). Accordingly, the Czech GDP in the national currency in real terms reached its 1989 level only in 2000. The estimation of the purchasing power parity of the Czech GDP shows that this fluctuated around the 1989 level in the first five years of the economic transition and then started growing from 1995 onwards. The switch towards the more lucrative Western markets and opening up of the economy to foreign investment enabled Czech GDP to grow in hard currency too, although belatedly. The Czech GDP calculated in current US\$ surpassed the level of 1989 in 1996, then fluctuated around the 1989 level for five years, before starting growing strongly from 2002 onwards.

**Table A5: Health care expenditure, 1970-2006**

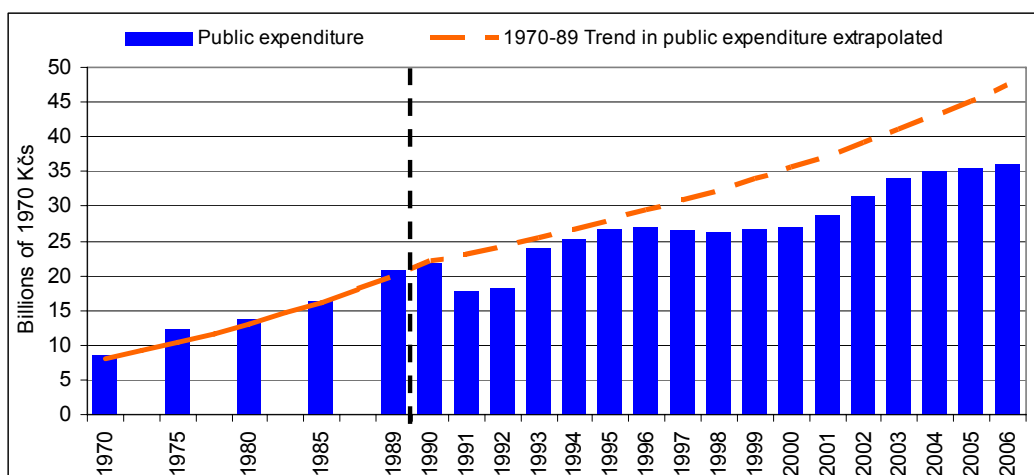
Year	Public, current Kčs/Kč, bn	Public, % GDP	Private, current Kčs/Kč, bn	Private, % GDP	Public, 1970 Kčs	1970-89 Trend in public exp. extrapolated, 1970 Kčs, bn*	1980-89 Trend in public exp. extrapolated, %GDP*
1970	8.4	...	0.3	...	8.4		
1975	12.4	...	0.4	...	11.7		
1980	15.2	3.4%	0.5	0.1%	12.4		
1985	20.0	3.9%	0.7	0.1%	14.0		
1989	26.3	4.6%	1.0	0.2%	17.4	17.4	4.6%
1990	30.1	4.9%	1.2	0.2%	18.1	18.0	4.8%
1991	38.2	4.8%	1.3	0.2%	14.7	18.7	4.9%
1992	43.6	4.8%	2.1	0.2%	15.1	19.5	5.1%
1993	69.3	6.5%	3.8	0.4%	19.8	20.2	5.3%
1994	81.1	6.6%	5.3	0.4%	21.1	21.0	5.4%
1995	93.3	6.4%	7.4	0.5%	22.3	21.8	5.6%
1996	102.4	6.1%	8.3	0.5%	22.5	22.7	5.8%
1997	108.9	6.0%	9.9	0.5%	22.0	23.6	6.0%
1998	119.3	6.0%	10.6	0.5%	21.8	24.5	6.2%
1999	123.6	5.9%	11.5	0.6%	22.1	25.4	6.4%
2000	129.6	5.9%	12.2	0.6%	22.3	26.4	6.6%
2001	145.1	6.2%	13.8	0.6%	23.9	27.4	6.9%
2002	162.3	6.6%	16.6	0.7%	26.2	28.5	7.1%
2003	175.6	6.8%	19.6	0.8%	28.3	29.6	7.3%
2004	184.8	6.6%	21.9	0.8%	29.0	30.8	7.6%
2005	191.4	6.4%	24.2	0.8%	29.5	31.9	7.8%
2006	199.2	6.2%	28.4	0.9%	29.9	33.2	8.1%

\* See Appendix I on the method used here to extrapolate past trends

Source: own calculations based on ÚZIS (2000, 2002, 2007a); IMF (2007); OECD (2007)

It is difficult to estimate the real extent of private health care expenditure during Communist rule because of the unmeasured extent of under-the-table payments. Since 1989, these payments have decreased, but have not disappeared completely. The Czech Institute of Health Information and Statistics estimated private health care expenditure (without under-the-table payments) for 1970, 1975, 1980, 1985, and 1989 for the OECD Health Data Set (Popovič email 2007). I use this data here but, for the period from 1990 onwards, I use the most recently updated data from the Institute of Health Information and Statistics rather than the OECD data, which is less up-to-date.

**Figure A6: Public health care expenditure in constant prices, 1970-2006**



Source: own analysis based on Table A5

Public health care expenditure has been growing steadily in the period under investigation, both nominally and in real terms. Public health care expenditure in real terms significantly dropped in 1991-1992; recovered in 1993-1995 due to the introduction of health insurance, and then stagnated until 2001 (Figure A6). I used the same technique to extrapolate past trends as described in Appendix I to estimate what public health expenditure would have been after 1989, if the 1970-1989 trend had continued. This estimation shows that, with the exception of 1990 and 1993-1995, public health care expenditure did not keep up with its 1980-89 growth level.

We do not have data to estimate the share of public health care expenditure in foreign currency. Although most Czech health care expenditure incurred in the national currency,

a sizeable part of the pharmaceuticals, medical devices and non-durable supplies was purchased abroad. Owing to price liberalisation and change of currency exchange regimes in the 1990s, it became possible for the Czech Republic to increase the share of the pharmaceuticals and medical supplies purchased abroad, which significantly improved the utilisation of the latest drugs and technology and the overall quality of provided health care. This technological shift, however, goes unnoticed if we compare health care expenditure in the national currency before and after 1989. To avoid this, we need to take into account the purchasing power parity of the Czech national currency (Table A6).

**Table A6: Total health care expenditure per capita, Purchasing Power Parity US\$, 1990-2005**

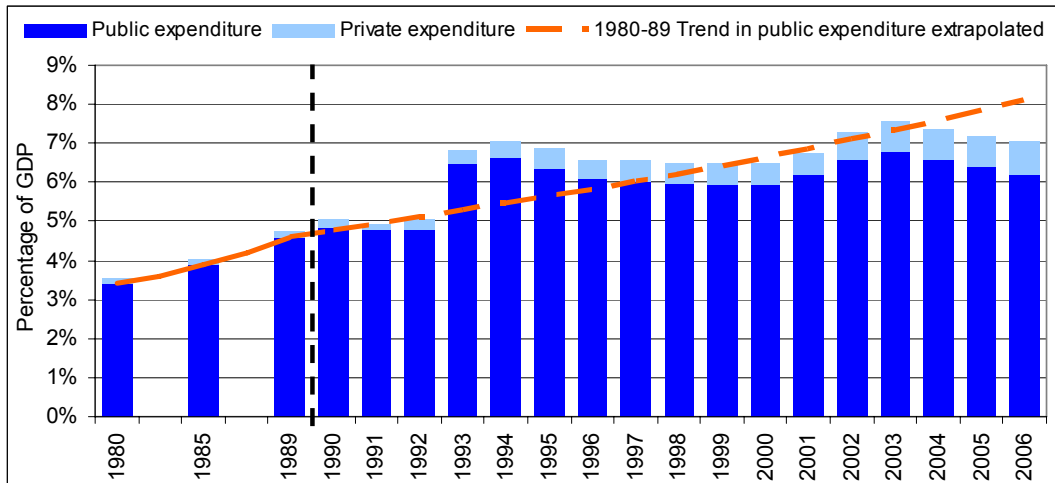
<b>Country \ Year</b>	<b>1990</b>	<b>1995</b>	<b>2000</b>	<b>2005</b>
Austria	1327	2250	2825	3519
Belgium	1341	1830	2301	3389
Finland	1392	1429	1717	2331
France	1499	2065	2487	3374
Germany	1730	2225	2634	3287
Greece	843	1250	1950	2981
Ireland	796	1211	1822	2926
Italy	1380	1562	2078	2532
Luxembourg	1532	2032	2984	5563
Netherlands	1434	1821	2258	3300
Portugal	673	1096	1625	2041
Spain	872	1193	1520	2261
EU 12 average	1235	1664	2183	3125
United Kingdom	989	1389	1859	2724
<i>Czech Republic</i>	<i>570</i>	<i>915</i>	<i>971</i>	<i>1479</i>
Czech Republic as percentage of EU 12	46.2%	55.0%	44.5%	47.3%
Czech Republic as percentage of UK	57.6%	65.9%	52.2%	54.3%

Source: OECD (2007) and own calculations

Surprisingly, my comparison shows that there has been no lasting change in the level of Czech health care expenditure in 1990-2005 in comparison with the EU12 average. Whereas health care expenditure in less well-off European countries such as Portugal, Greece and Ireland increased 303%, 354%, and 368% respectively, Czech health care expenditure increased only 259%, implying that the Czech Republic could not afford

necessary increases, or attempted to contain health care costs like the more well-off Western European countries.

**Figure A7: Public health care expenditure as percentage of GDP, 1970-2006**



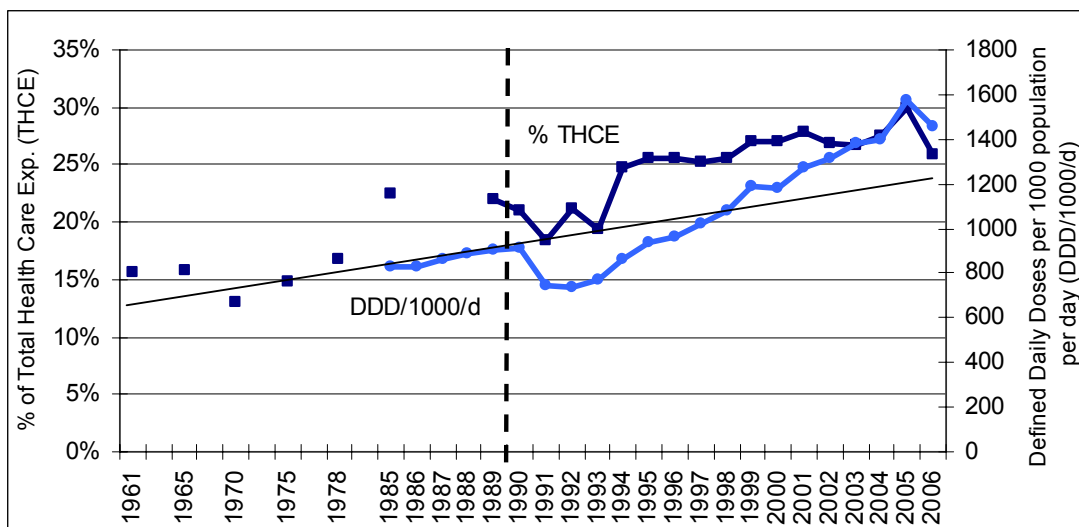
Source: own analysis based on Table A5

Public health care expenditure, as a percentage of GDP, grew steadily during the 1980s, stagnated in 1991-1992, hiked in 1993, and stagnated thereafter (Figure A7). At the same time, private health care expenditure has not increased significantly to compensate for the lack of growth in public health care expenditure. The extension of the 1980-1989 trend in the increase of public health care expenditure as a percentage of GDP yields two important observations. First, public health care expenditure in 1993-1996 was higher than what it would have been if the 1989 trend had continued. Since 1998, actual public health care expenditure has been lower than the projected one but, thanks to the increase in private health care expenditure, the overall health care expenditure was higher than or equal to the projected public health care expenditure, until 2003. Second, since 2004, actual overall health care expenditure has been lower than the projected one. In general, post-Communist governments were less committed to increasing public health care expenditure, or more successful in controlling it, than Communist governments.

Nonetheless, controlling pharmaceutical expenditure proved difficult and this was perceived by policy-makers as a major problem. Surprisingly, even the most informed

analyses of Czech pharmaceutical policy start with 1990 and conclude that pharmaceutical expenditure exploded in the mid-1990s (e.g. Durba 2003; Prokeš 2003). The truth of the matter is that pharmaceutical expenditure had been rising well before 1990 (Figure A8). Improvements in health care provision, due to Communist reforms in the 1950s, did not reduce but increased the demand for health care including pharmaceuticals: ‘A new type of patient has appeared in Czechoslovak clinics, the person who can find time to sit in the doctor’s waiting room just to get a prescription for tablets: tablets for that tired feeling, for overweight, for a cough, for a headache’ (Šourek 1966, p.26). After the collapse of Communism, expenditure on pharmaceuticals dropped, reaching its 1989 level only in 1994. The consumption of pharmaceuticals dropped too, recovering to the 1989 level only in 1995. Unfortunately, we do not have data on the consumption of pharmaceuticals before 1985 but, if we visually extend the 1985-89 trend in the consumption of pharmaceuticals, it is evident that this surpassed the 1985-89 trend line only in 1999. Thereafter, the consumption of pharmaceuticals grew faster than in 1985-89, probably due to increased consumption of expensive imported state-of-the-art drugs.

**Figure A8: Expenditure on and consumption of pharmaceuticals, 1961-2006**



Source: MZ ČSR (1980) for 1961-78; ÚZIS (1995, 2000, 2007b) for 1985-2006

It is difficult to explain the improvement in the health care outcomes after 1990 (Table A7), but the preservation of extensive mother and child care developed during

Communist rule combined with the influx of the state-of-the-art drugs and medical technology seems to be a good hypothesis to start with. Hypothetically, positive changes in lifestyle could have marginally improved infant mortality but, after 1989, there were no major changes in diet and tobacco consumption, whereas consumption of alcohol even increased (Rychtaříková 2004). Therefore, increased expenditure on imported state-of-the-art drugs and medical technology could be a major determinant of the improvement in health care outcomes after 1990. If so, the policy problem would be to find either public or private ways to increase pharmaceutical expenditure, rather than to contain it.

**Table A7: Infant mortality, 1960-2005**

<b>Year</b> <b>Country</b>	<b>1960</b>	<b>1970</b>	<b>1980</b>	<b>1989</b>	<b>1990</b>	<b>1995</b>	<b>2000</b>	<b>2005</b>
Czech Republic	20.0	20.2	16.9	10.0	10.8	7.7	4.1	3.4
United Kingdom	22.5	18.5	12.1	8.4	7.9	6.2	5.6	5.1
EU 12 Average	35.7	25.0	13.0	8.3	7.8	5.9	4.9	3.8
Austria	37.5	25.9	14.3	8.3	7.8	5.4	4.8	4.2
Belgium	23.9	21.1	12.1	7.0	6.5	5.9	4.8	3.7
Finland	21.0	13.2	7.6	6.0	5.6	3.9	3.8	3.0
France	27.7	18.2	10.0	7.5	7.3	4.9	4.4	3.6
Germany	35.0	22.5	12.4	7.5	7.0	5.3	4.4	3.9
Greece	40.1	29.6	17.9	9.7	9.7	8.1	5.4	3.8
Ireland	29.3	19.5	11.1	8.1	8.2	6.4	6.2	4.0
Italy	43.3	29.0	14.6	8.7	8.2	6.2	4.5	4.7
Luxembourg	31.6	25.0	11.4	9.8	7.3	5.6	5.1	2.6
Netherlands	17.9	12.7	8.6	6.8	7.1	5.5	5.1	4.9
Portugal	77.5	55.5	24.2	12.2	11.0	7.5	5.5	3.5
Spain	43.7	28.1	12.3	7.8	7.6	5.5	4.4	4.1

Source: OECD (2007) and own calculations

### **III. Electoral salience of health policy versus other issues**

To estimate the importance of health policy, among other electoral issues, for political parties, I used the Comparative Manifestos Project Dataset, compiled by the *Wissenschaftszentrum Berlin für Sozialforschung* (Klingemann 2006). The advantages of using electoral manifestos (election programmes) instead of other policy documents are as follows (Volkens 2002, p.2):

1. Election programmes cover a wide range of political positions and themes and, therefore, can be seen as a ‘set of key central statements of party positions’ (Budge *et al.* 1987, p.18).
2. Election programmes are authoritative statements of party policies because they are usually ratified in party conventions.
3. Election programmes are representative statements for the whole party, not just statements of one faction or group within it or of individual members.
4. Election programmes are published before every election. Thus, changes of policy positions of parties over time can be studied.

The Comparative Manifestos Project Dataset is built through the sequential application of the following research procedures. In each election program, quasi-sentences (arguments) are identified and coded into 56 different categories. Then, the frequencies of each category are calculated relative to the overall number of arguments in a given election program. A major limitation of this dataset is that it does not identify health policy as a separate category. Therefore, I attempted to do this myself using the original data and coding instructions. Thanks to the generous help of Andrea Volkens, one of the key investigators in the Comparative Manifestos Project, I obtained photocopies of the Czech election programmes with coded quasi-sentences and category frequencies (Klingemann & Volkens 2002). Then, I identified health policy-related quasi-sentences in each Czech election programme and coded them into a ‘health policy’ category using the original coding instructions (Volkens 2002). Finally, I recalculated the total number of quasi-sentences and category frequencies in each programme to estimate the salience of health policy against other issues. It should be noted that the resultant estimations are obtained

through the alteration of the original dataset. In the latter, each quasi-sentence is coded into one and only one category, i.e. the quasi-sentences which I coded into the health policy category are already coded into other categories, such as ‘welfare state expansion’, ‘social justice’, ‘privatisation: positive’, etc. Therefore, my estimations of the salience of health policy issues are only very approximate. Nonetheless, they still allow us to see how important health policy was for political parties among other electoral issues identified by the Comparative Manifestos Project. The definitions of electoral issues employed in the Comparative Manifestos Project are listed below (Volkens 2002):

### **Freedom and Human Rights**

Favourable mentions of the importance of personal freedom and civil rights; freedom from bureaucratic control; freedom of speech; freedom from coercion in the political and economic spheres; individualism in the manifesto country and in other countries.

### **Communist: Negative**

Against communist involvement in democratic government; weeding out the collaborators from governmental service; need for political coalition except communist parties.

### **Democracy**

Favourable mentions of democracy as a method or goal in national and other organizations; involvement of all citizens in decision-making, as well as generalized support for the manifesto country’s democracy.

### **Decentralization**

Support for federalism or devolution; more regional autonomy for policy or economy; support for keeping up local and regional customs and symbols; favourable mentions of special consideration for local areas; deference to local expertise.

### **Governmental and Administrative Efficiency**

Need for efficiency and economy in government and administration; cutting down civil service; improving governmental procedures; general appeal to make the process of government and administration cheaper and more effective.

### **Incentives**

Need for wage and tax policies to induce enterprise; encouragement to start enterprises; need for financial and other incentives.

### **Technology and Infrastructure**

Importance of modernization of industry and methods of transport and communication; importance of science and technological developments in industry; need for training and research. Note: This does not imply education in general.

**Environmental Protection**

Preservation of countryside, forests, etc.; general preservation of natural resources against selfish interests; proper use of national parks; soil banks, etc; environmental improvement.

**Culture**

Need to provide cultural and leisure facilities including arts and sport; need to spend money on museums, art galleries etc.; need to encourage worthwhile leisure activities and cultural mass media.

**Social Justice**

Concept of equality; need for fair treatment of all people; special protection for the underprivileged; need for fair distribution of resources; removal of class barriers; end of discrimination such as racial, sexual, etc.

**Welfare State Expansion**

Favourable mentions of need to introduce, maintain or expand any social service or social security scheme; support for social services such as health service or social housing.

Note: This category excludes education.

**Welfare State Limitation**

Limiting expenditure on social services or social security; otherwise as Welfare State Expansion, but negative.

**Private-Public Mix in Welfare**

Necessity of private welfare provisions due to economic constraints; desirability of competition in welfare service provisions; private funding in addition to public activity (subcategory of Welfare State Expansion).

**Education Expansion**

Need to expand and/or improve educational provision at all levels.

**Law and Order**

Enforcement of all laws; actions against crime; support and resources for police; tougher attitudes in courts.

**Privatisation: Positive**

Favourable references to privatisation.

#### ***IV. Policy aims and instruments of political parties, 1990-2002***

To find out where different political parties stand with respect to general economic and social policies which affect health policy, as well as with respect to their intended health policies, one needs to study election programmes. To guide my inquiry I use the framework of ‘Ideal Social Policy Aims and Instruments of Political Parties’ (Seeleib-Kaiser *et al.* 2005). I expand and customise this framework for the needs of the current study by including separate sections on the role of the individual and family policy, and on health policy. Then, I flesh out this framework with quasi-sentences from election programmes. A quasi-sentence is essentially an argument defined as ‘the verbal expression of one political idea’ (Volkens 2002). Very often, one sentence expresses more than one argument, so it is important to decompose it into quasi-sentences. When fleshing out this framework with quasi-sentences from electoral manifestos, I have tried to preserve their original form. However, because of the limited space, I do not always provide word to word citations but strip down lengthy sentences to their more succinct equivalents. These are presented in Tables A8-A10 overleaf.

**Table A8: Policy Aims and Instruments of political parties, quasi-sentences from electoral manifestos, 1990**

1990	Civic Forum (OF)	Communists (KSČ)	Christian Democrats (KDU) <sup>86</sup>	Social Democrats (ČSSD)
<b>Political aims</b>	Reintegrating Czechoslovakia with developed European countries; ensuring economic efficiency and prosperity; a market economy; pluralism; democracy; rule of law; empowering local communities and their autonomous organisations.	Democratic, humanistic, and materially- and spiritually- productive socialism; a state-regulated market economy; rule of law; social justice; equality.	Freedom instead of socialism; a social market economy; decentralising public administration to the traditional community level; respect and autonomy for churches and religious organisations; rule of law.	Freedom, social justice, and citizens' solidarity; protecting interests of employees, farmers, and small entrepreneurs.
<b>Role of the individual/family policy</b>	Taking responsibility for the future; willingness to make sacrifices; working to the limits of their abilities; replacing a humble timidity with confidence.	Individual, political, socio-economic, and cultural rights of the individual; equality between men and women.	Family as a basic element of society; protection of life; development of every individual's personality.	Family is a basic element of society; the role of mothers cannot be replaced by public facilities; increasing benefits for parents who stay with their children beyond a maternity leave; gradually decreasing expenses on nurseries and kindergartens to increase children's benefits; extending maternity leave legislation on fathers; extending maternity leave to 5 years.
<b>Role of the state</b>	Restricting state ownership chiefly to the undertakings for public good; restricting redistribution through the central budget; the state not intervening in the economy to alleviate unemployment but relieving its negative consequences through social policies.	Preserving and developing state ownership; progressive taxation.	Minimising state and public ownership, rejecting destructive Communist collectivism.	
<b>Economic/employment policies</b>	Rapidly creating a market economy; gradually replacing state ownership with private, municipal, and communal ownership; domestic economy as a counterweight to foreign capital;	Strong and independent trade unions advocating interests of workers; workers' participation in the management of state	A free market with mostly private ownership of the means of production; denationalisation through transformation of state enterprises into joint-	Entrepreneurship is a basis for a long-term prosperity; free entrepreneurship; support privatisation but not absolute privatisation; private ownership presents a risk for the people's property to be sold abroad and on unfavourable conditions; state/communal ownership for enterprises that

<sup>86</sup> According to the electoral manifesto of the Czechoslovak People's Party

	incomes and wages being determined solely by the market.	enterprises; no uncontrollable unemployment; state-sponsored jobs for the unemployed and their retraining; supporting employment for young people.	stock and similar companies; an economy based on small and medium-size companies and voluntary co-operatives to prevent monopolies.	pursue public interests; change most state enterprises into joint-stock companies with employees' stakes; a universal right to work; solve the problem of unemployment through retraining, life-long learning, and early retirement; adjusting remuneration according to the growth of living expenses must be included in all collective agreements; rationalising the tax system and eliminating social biases in the calculation of salaries; supporting the unemployed.
<b>Social policy</b>	A state-guaranteed minimum standard of living and social support; conditions under which individuals and families may successfully solve their problems and emergencies; partnership between the citizen and the state; making available all forms of welfare (state, private, self-help, charities); investing in education and comprehensive reform of education and science.	Equitable and fair distribution of the unavoidable social impact of reforms; raising a maternity benefit and extending a maternity leave; housing for young people; extending social care for the elderly and disabled; increasing social security benefits in pace with inflation.	Social services are the substance of Party's Christian mission of service to fellow human beings; guaranteeing important social certainties (family, young marriages, employment, sickness and disability benefits); improving pensions; improving health and social care, making use of services provided by religious and charitable organisations.	Equal opportunities; social justice and social certainties for everyone; extending annual leave for workers in hazardous environments, mothers with children under 14 y.o., and trainees; adjusting salaries and pensions according to inflation; pensions promoting social justice; pensions being maximally depend on the salary level; creating possibilities for citizens' voluntary contributions towards their pensions; housing reform, developing housing co-operatives; separating social housing from the housing market.
<b>Health policy</b>	Promoting personal, corporate, and state responsibility for the environment and lifestyles; guaranteeing standard health care for everyone; promoting self-help, charitable, and private initiatives by citizens; free choice of GP/specialist; outpatient care instead of hospitalisation; gradually introduce health insurance.	Substantially increasing public funding for the health care system; ensuring the right to free high-quality health care; expanding fitness, rehabilitation, and spa facilities for everyone.	Abolishing state monopoly by allowing private medical practice and free choice of doctor; health insurance reform.	Promoting public health care and a modern approach of the individual to his health; relationship between the doctor and the patient should be based on humanism and economic interest of the doctor; free choice of doctor; improving health care provision and administration; guaranteeing the right to health care; promoting the participation of voluntary and religious organisations; ending employment discrimination on the grounds of health; investing in medical device industry; public control over pharmaceutical industry; building rehabilitation facilities for the disabled; improving health information for the public; ensuring a stronger dependence of sickness benefits on the level of salary.

**Table A9: Policy Aims and Instruments of political parties, quasi-sentences from electoral manifestos, 1992**

1992	Civic Democrats (ODS)	Left Block (KSCM-DL)	Social Democrats (ČSSD)	Christian Democrats (KDU- ČSL)	Civic Democratic Alliance (ODA)
<b>Political aims</b>	Prosperity; parliamentary democracy based on clearly defined political forces; market economy based on private ownership, individual initiative and responsibility.	Socialism of a new age: society of free and equal citizens, democracy, self-governance, political pluralism, economic productivity and social justice; preventing a return to repressive capitalism of yesterday; developing direct democracy along with representative democracy.	Quickest and least painful surmounting of everything that separates us from Europe and the rest of the developed world; democracy; social concern and justice; a market economy; economic growth; social and political stability; integration into the global community; hard work and sacrifice from all.	A market economy with a substantial social and ecological dimension; refusal of socialism of any form; stable parliamentary democracy; free life for the man as a worthy, responsible, and independent personality; mutual understanding and tolerance.	Free society; democratic capitalism; dual-chamber parliament; a market without adjectives; a stable currency; the rule of law.
<b>Role of the individual /family policy</b>	Society based on the citizen, family, municipality, and state in this order; ending state-organised collectivistic thinking; family personifying the feeling of safety and security; renewing and strengthening the traditional position and importance of family.	Family as a basic part of society has the right to protection; equality of men and women; benefits for single mothers and fathers; choice for women to work or care for their family.	Individual freedom cannot exist without conscious recognition of connections and solidarity with others – with members of one’s family, community, nation, and ultimately with humanity in general.	A family salary for mothers who decide to care for their child full-time until the age of 6; substantial support to young couples, equal educational opportunities for men and women; able women to replace unable men.	Family is not an anachronism, it has simply irreplaceable cultural, moral, social, and economic functions; protection of the family is the protection of society; family to be the recipient of social security benefits.
<b>Role of the state</b>	State institutions will only be formed when their services cannot be provided for by citizens, their organisations, clubs, or entrepreneurial or	Public control of and regulatory state intervention in the economy; the state budget as an active tool of economic development; state cannot	Balance between the influences of the market and the state; effective governmental regulation; privatisation is an opportunity for the government to free itself from	Maximum reduction of the role of the state in the whole economy.	Simplification of the state institutions and reduction of the number of civil servants; a small state budget; protection of the market forces; promo-

	employee organisations; radical reduction of state administration.	discard its responsibilities for basic welfare; state administration must be maximally decentralised.	unnecessary responsibilities; healthy competition between institutions controlled by the central and local governments.		tion of competition.
<b>Economic/employment policies</b>	A stable and non-inflationary economy; lower taxes; increased entrepreneurial activity; ending state ownership of the means of production; privatisation.	Budget deficit is a lesser evil than a collapse of the national economy; plurality of forms of ownership; limiting restitution; gradual privatisation; protection of national property; rejecting a privileged position of German capital; Czech ownership of key enterprises; ensuring right to employment; active employment policies.	Supporting viable enterprises; creating attractive conditions for foreign capital; privatisation not to present obstacles to economic revival; ending restitutions beyond the limits established by the law; emphasising anti-inflation policy; partnership between employers, employees and the government; strong trade unions and responsible organisations of employers; co-operating with trade unions and supporting their role in maintaining social harmony; promoting employee representation on all levels of management; support for entrepreneurial activities; collaboration in business between the public and private sector; invest in public works rather than in unemployment benefits; minimum hourly wage.	Completing radical economic reform; consistent anti-monopoly policy; tax preferences for starting businessmen; creating trade chambers; family farms; protecting agricultural markets; privatising agricultural services; creating the institution of public works.	Only non-interfered functioning of the market leads to economic growth and increase of employment opportunities; labour relations are contractual relations; every property must have its proprietor; quick and comprehensive privatisation; restitution; voucher privatisation; a stable currency; a lower tax burden.
<b>Social policy</b>	Equal conditions not outcomes; a market economy with many work opportunities will enable people to provide for their needs; social policy must focus itself on real social problems, providing for those who cannot provide for them-	Adjusting salaries in health care, education, and culture according to inflation; social housing; differentiated education; no private education.	Poverty is unacceptable; we must closely follow the living conditions of socially- and economically-disadvantaged groups... and be prepared to intervene where necessary; protecting children and young families; flexible hours for working mothers; preventing the	Parents are responsible for education and schools for instruction; differentiated education system; allowing pensioners to work; adjusting pensions and other social	Paying social security benefits always to the family; a national system of targeted social insurance and social assistance benefits; social insurance benefits are to partly compensate for the lost income; means-tested social assistance

	<p>selves; a social net in which public and private programs are combined; education, job training, support to private sector instead of unemployment benefits.</p>		<p>dissolution of those protective systems that still function; implementing a modern social welfare and health care policy.</p>	<p>security benefits according to inflation; pension-type homes for the lonely; integrating the disabled into society.</p>	<p>guaranteeing a minimum standard of living; privatising municipal housing; creating a housing market; assistance to the socially-disadvantaged; social housing for the disabled.</p>
<p><b>Health policy</b></p>	<p>Pensions and health insurance must be removed from the state budget and become an independent public fund generating its own income; the state creating conditions for a variety of social and health insurance provided either by employers or employees; combining public and private insurance to create a significant investment capital for the whole economy; funding health care from public and private insurance and additional individual insurance.</p>	<p>Preserving universal and accessible health care; ensuring free health care on the basis of universal obligatory health insurance; state guarantees the accessibility of health care; private health services not jeopardising the level of health care provided on the basis of universal health insurance.</p>	<p>Guaranteeing quality medicine and humane care for all seriously ill patients and especially the poor; preventing the deterioration of the health care system for children and mothers.</p>	<p>Necessary health care for all; humanising health services; developing all forms of health care: private, public, church, municipal; choice between insurance funds; protecting health professionals' rights.</p>	<p>Health care based on solidarity and universal health insurance; patient rights; multi-source financing; multiple health insurance funds financing health care and sickness benefits; free choice of doctor; privatising health care; every health care facility must have its proprietor: a private person, community, church, university, etc; a maximum number of facilities owned by private persons; low prices for facilities because doctors have been decapitalised; the state must ensure development of research, preventive medicine, and health policy; the state must organise public health policies on the regional level and co-ordinate health promotion programs which cannot be financed otherwise.</p>

**Table A10: Policy Aims and Instruments of political parties, quasi-sentences from electoral manifestos, 1996**

1996	Civic Democrats (ODS)	Social Democrats (ČSSD)	Christian Democrats (KDU-ČSL)	Civic Democratic Alliance (ODA)
<b>Political aims</b>	Society where everyone can find place for self-realisation; individual freedoms, entrepreneurship, private ownership; equality of opportunities; a prosperous and stable economy; freedom, a free market, individual responsibility.	A socially- and environmentally-oriented market economy; supporting the tenets of the European social model which encompass respect to democracy and human rights, free trade unions, participation of employees in company management, social protection on the principles of solidarity, equal opportunities and dignified living conditions for everyone; decentralising public administration; ensuring the responsibility of the state for education, health care, social care, and other services.	Society based on natural institutions such as family, community, religious, professional, and interest associations; European integration and international co-operation; a social market economy based on private ownership, a free market, equality of opportunities and equal conditions for economic activities, social partnership between employers and employees, and indispensable solidarity.	More freedom and less state regulation; wider opportunities for the citizen's free determination.
<b>Role of the individual /family policy</b>	Prosperity of society is based on free determination and activity of the individual; family is an intrinsic basis of society; family members are responsible for their family's living standards; the state paying targeted social assistance mainly when childcare lowers family's income.	Paying child benefits and providing proper childcare [facilities], rejecting the current targeted system which overtly reduces the amount of paid benefits and establishes the administration-intensive ways of their payment; improving child benefits, maternity leave, shortening and making working time more flexible, easing return to work after a maternity leave, creating an opportunity for early retirement depending on a number of brought up children.	Strengthening the responsibility of the individual and increasing solidarity in society.	Family encapsulates a tradition, support, and responsibility for the closest ones; creating a universal family support system with minimum redistribution which would not favour incomplete and dysfunctional families.
<b>Role of the state</b>	The state is a traditional institution which together with families and communities creates a framework for life of citizens; the state being limited in extent but strong; limiting public expenditure; lowering	Wherever markets do not work perfectly, increasing the 'visible hand' of the state and public self-administration; rejecting premature reduction of taxes; not rejecting the possibility of the temporary budget deficit of up to 3% of GDP according to the Maas-	The state correcting the market in social policy and elsewhere where the market fails; increasing state investment into housing, road maintenance and construction, conservation of historical monuments, support of important research and	Controlling state expenditure and limiting state redistribution; rejecting arrogant centralism, promoting full decentralisation; limiting state bureaucracy; letting professional

	the redistributive role of the state.	tricht Agreement; rejecting a sell out of state and public enterprises or stakes in them, as often done to mend holes in the budget.	environmental programs.	associations to deal with ethical issues in their professions.
<b>Economic/employment policies</b>	Rejecting borrowing from the future generation; ensuring a balanced state budget; lowering the tax burden; liquidating excessive regulation and bureaucratic barriers to business; ensuring a strong and stable currency; privatising all enterprises in which there is no reason for state operation; unemployment benefits not demotivating the unemployed to seek employment; not working must pay off to nobody.	State supporting the competitiveness of Czech enterprises; supporting the flagships of the Czech industry; supporting small and medium companies according to the example of the EU; developing tripartite mechanisms; wide and permanent dialogue of social partners is a base-line condition for social peace; tackling unemployment by providing not only support but above all publicly-beneficial jobs and retraining.	A free market must be everywhere it is possible, other principles only where it is necessary; ensuring a balanced state budget and macroeconomic stability; restructuring and modernising industry; lowering taxes; completing restitution; gradually privatising the remaining strategic sectors such as banking and energy by Czech firms and preserving a blocking minority of the state's shares in these sectors; promoting medium and small enterprises and increasing their share in GDP.	Promoting a free economy based on private business with no possibility of a hidden socialist economy; completing restitution and privatisation; opening up the monopolised sectors to other entrepreneurs; investing in human capital; strengthening bankruptcy procedures; lowering all types of income tax.
<b>Social policy</b>	Three basic principles: 1) responsibility of the individual for themselves and their family, 2) mutual solidarity, and 3) targeted social measures; social policy being subject to the economic capability of the state; social assistance being paid to those in real need and minimising its abuse; simplifying social assistance administration; promoting voluntary pension schemes for younger generations; promoting non-governmental, humanitarian, and charitable organisations; integrating the disabled into society; decreasing a number of those dependable on the direct	Abolishing an increase of the pensionable age; when our average life span is shorter than in the EU, an increase of the pensionable age means abolishing the state responsibility for older citizens; voluntary pension insurance must result from free determination but never from economic pressure; creating a Social Insurance Fund which would be independent from the state budget; making it obligatory for the state to participate in the investment of land into the construction of new housing and making easy for citizens to find land for this purpose; lowering taxes for all investors into construction of new housing; rejecting an increase of housing rent; enabling young couples to acquire housing with help of pub-	Social policy is based on social security, social partnership between employers and employees, equality of opportunities for everyone and citizens' solidarity; social policy aimed only at those tasks that are beyond the possibilities of the individual, family, and other solidarity associations; family being the main object of social policy; increasing the support of family through taxation; lowering taxes for families with children; simplifying the system of targeted benefits; ending the trend of lowering pensions; affordable housing; abolishing state regulation in housing; increasing the state subsidy for the construction of new housing for renting out.	Increasing individual responsibility through decentralisation and other reforms; when the citizen cannot solve his problem himself, the family solidarity steps in, then the community, region, and state; the social security system not making the citizen dependent on social assistance but motivating his return to active life; separating the pension system from the state budget into a fund distinguishing between resources of each citizen; improving conditions for the creation of non-profit organi-

	state assistance in line with growing prosperity.	licly-funded loans; increasing the role of local authorities and self-governance in housing policy; creating funds for the construction of new housing in communities.		sations; creating a competitive environment for social services; integrating the disabled into society.
<b>Health policy</b>	Stabilising the health care system and limiting its purposeless extensive growth; lowering expenditure on drugs; converting part of acute hospital beds into long-term care beds; speeding up privatisation of health care facilities; toughening the state supervision of health insurance funds; improving health insurance funds' discipline of payments to doctors; rethinking the role of the individual in the bloated and often disproportional and illogical solidarity of current health insurance, searching for a greater place for the individual's decisions and active position in the health system; defining the scope of health care services covered by general health insurance; establishing a normal relationship between demand for health care and its price; the citizen being a responsible and informed customer; the state being the final guarantor for the citizen's health; developing quality standards and accreditation of health care facilities; integrating health insurance and social insurance; prioritising outpatient care over inpatient care.	Promoting the traditional European values of solidarity between generations and between the healthy and the ill; ensuring equality of citizens in health rights; state guaranteeing the quality of care; delineating a basal network of health care facilities; chaotic privatisation is a cause of the disproportional growth of expenditure; most appropriate method of de-etatisation is a free transfer of inpatient and large outpatient facilities to appropriate territorial units and towns with a possibility of their further privatisation; increase of state health insurance contributions; rejecting patient co-payments for essential preventive and curative measures; defining the volume of standard care; promoting research, prevention, rehabilitation, and spa treatment; rejecting the current bureaucratic and centralised way of hospital management; converting hospitals into publicly-beneficial companies with the participation of the representatives of self-governance; controlling the quality of medicines and regulating their prices, supporting domestic producers of quality medicines; improving hygienic control; supporting associations of health professionals as their self-governing bodies; ensuring an appropriate social recognition and economic remuneration of health professionals.	The state's responsibility is to ensure accessible health care for everyone; public health care system being based on mandatory universal health insurance; stabilising health care expenditure by standardising procedures; replacing fee-for-service point-based reimbursement with DRGs and capitation fees; lowering expenditure on drugs by categorising drugs, regulating monopolist producers of drugs, controlling prescriptions, optimising treatment procedures and supply of drugs in hospitals; limiting the excessive growth of a number of health care facilities through their accreditation; selecting the best regional health care providers through public tenders; creating a network of such providers and the state guaranteeing that everyone can access them; not supporting rapid de-etatisation of hospitals; public non-profit organisations becoming an important organisational form in inpatient care; promoting multi-source health care financing including central and local/regional budgets; reducing a number of health insurance funds; limiting administrative costs by integrating health insurance and sickness insurance; professional chambers remaining the guarantors of ethics and professionalism.	Combining accurate fee-for-service reimbursement and capitation fees; introducing patient co-payments for all types of health care as an additional source of funding and not only as a regulatory mechanism; introducing additional voluntary health insurance; strengthening the patient's role; improving the supervision of health insurance funds; integrating health insurance and social insurance; de-etatisating and converting large hospitals into non-profit organisation controlled by the state, region, and community; finding ways to finance large hospitals from sources other than just health insurance funds; responsibility for the professionalism and ethics of the medical output lies, along with the state, on professional chambers; differentiating a pay rise for health professionals; the state guaranteeing the spatial, timely, and financial accessibility of basic health care.

## ***V. Sample interview schedule***

**Jan Stráský (ex-Health Minister), České Budějovice, 06.10.2005**

1. Byla reforma zdravotnictví důležitým tématem vlády před rokem 1989?  
Was health care reform on the political agenda before 1989?
2. Měla poslední komunistická vláda nějaké plány na reformu zdravotnictví?  
Did the last Communist government have any plans for health care reform?
3. Proč se reforma zdravotnictví stala po roce 1989 tak naléhavým tématem?  
Why was health care reform high on the political agenda after 1989?
4. Systém zdravotní péče fungoval – nebylo by tedy rozumnější, kdyby se vláda plně soustředila na naléhavější systémové reformy a podporu ekonomického růstu.  
The health care system worked—so, wouldn't it have been more sensible to concentrate on crucial structural changes and policies fostering economic growth, instead of health care?
5. Neuvědomila si vláda, že náročné financování reformy by mohlo vest k růstu veřejných výdajů na zdravotní péči a že zdravotní pojištění placené firmami by mohlo zpomalit ekonomický růst? Nelobovali zástupci průmyslové sféry proti zdravotnímu pojištění?  
Didn't the government realise that costly financing reform might lead to the escalation of public expenditure on health care and that health insurance contributions paid by companies might inhibit the economic growth?
6. Pokud vláda usilovala o zlepšení v systému zdravotní péče v zájmu obyvatelstva, bylo by logičtější zavést relativně levné reformy na úrovni nemocnic namísto drahého zavedení zdravotního pojištění. Proč byla reforma odstartována zavedením zdravotního pojištění?  
If the government wanted improvements in health care for the population, it would be more rational to introduce relatively inexpensive reforms in health care delivery instead of costly reforms in the area of financing. Why did reform start with financing?
7. Proč byl v roce 1992 zaveden systém, v němž spolu soupeří více zdravotních pojišťoven?  
Why was a system of multiple competing insurance funds introduced in 1992?
  - Byl to nápad lékařů: očekávali, že jim přinese více peněz a svobody?  
Was it the doctors' idea (they thought it would bring them more money)?
  - Vláda usilovala o zavedení tržní ekonomiky v systému zdravotní péče?  
Did the government want a market in health care?
  - Šlo o to zbavit se všeho “komunistického”?  
Is it that the government did not want anything “Communist” left?

- Existovala obava, že by se komunisté mohli opět dostat k moci a proto se vláda snažila zavést nezvratné reformy, jak nejrychleji to bylo možné?  
Is it that it was feared that Communists might come back and the Government wanted to introduce irreversible reforms as fast as possible?
  - Šlo o snahu vrátit se zpět k systému, který fungoval před rokem 1948?  
Was it an attempt to return to the system which was in place before 1948?
  - Šlo o snahu mít podobný systém jako Německo a Rakousko?  
Was it a move towards a system like that of Germany and Austria?
8. Nebyl Václav Klaus proti velmi časnému zavedení zdravotního pojištění? Nebyli to lékaři, kdo věřil, že zdravotní pojištění jim přinese více peněz, a proto tlačili na jeho brzké zavedení?  
Wasn't Vaclav Klaus against the early introduction of insurance? And didn't doctors believe that insurance would bring them more money, pushing the early introduction of health insurance?
9. Proč si lékaři mysleli, že zdravotní pojištění jim zajistí vyšší příjmy?  
Why did doctors believe health insurance would result in higher incomes for doctors?
10. Kdo podporoval / prosazoval brzké zavedení zdravotního pojištění?  
Who was lobbying for the early introduction of health insurance?
11. Hlasovali poslanci pro nový systém ve spěchu, protože zbývalo pouze několik měsíců do voleb a oni doufali, že to zvýší jejich šanci získat důležité pozice v nově zakládaných zdravotních pojišťovnách?  
Did MPs vote for a new system in a rush because they had just a few months left in the Parliament and were thinking about their future employment? Did they believe that they would have a chance to get on the Boards of the newly-established health insurance companies?
12. Proč si vláda nepřála silnou lékařskou komoru s povinným členstvím, která by udělovala licence?  
Why didn't the government want a strong Medical Chamber with the obligatory membership and licensing?
13. Jaké jsou hlavní možné střety ekonomických zájmů v lékařství?  
What are the main economic cleavages in the Czech medical profession?
- Mladší vs starší lékaři: starší lékaři mají větší možnosti získat úplatky od pacientů / farmaceutického a zdravotnického průmyslu a mladší ne?  
Young vs senior doctors: can senior doctors earn under-the-table money from patients and pharmaceutical/medical industry when the young can't?
  - Praktičtí lékaři vs specialisté vs lékaři v nemocnicích vs lékaři ve fakultních nemocnicích.  
GPs vs specialists vs hospital doctors vs doctors in University hospitals
  - Soukromí lékaři vs státní lékaři?

- Private doctors vs state doctors?
  - Specialisté vs specialisté: míra refundace ze zdravotního pojištění a distribuce zdrojů v Přístrojové komisi zvýhodňuje některé specializace na úkor jiných?  
Specialists vs specialists: do health insurance reimbursement rates and distribution of resources by the MoH favour certain specialties and disadvantage others?
14. Které formální a neformální profesionální lékařské skupiny jsou dostatečně silné na to, aby mohly prosadit svoje zájmy? Jaké příjmy jim to umožňují?  
What formal and informal groups of the Czech medical profession have the capacity to pursue successfully their interests? What resources help them to do so?
- Sponzorské dary farmaceutického / zdravotnického průmyslu?  
Sponsorship of the pharmaceutical/medical industry?
  - Osobní vztahy s politiky, kteří jsou tvůrci zdravotní politiky? Mají např. urologové a chirurgové bližší vztahy než ostatní lékaři? Mají osobní lékaři nejvyšších politiků vliv na zdravotní politiku?  
Personal connections among health policy decision-makers? Do urologists and surgeons have more useful connections?
  - Organizační kapacity jejich formálních a neformálních sdružení?  
Organisational capacities of their formal association/informal club?
  - Přístup k médiím (TV, rozhlas, noviny)?  
Access to the media (TV, radio, newspapers)?
  - Rychlá mobilizace velkého počtu lékařů v případě stávký?  
Quick mobilisation of a significant number of doctors for a strike?
15. Jaký typ reformy zdravotnictví by vyhovovaly jednotlivým skupinám lékařů ve vztahu s jejich zájmy?  
What kind of health care reform would different doctors' groups want in order to maximise their interests?
16. Jak vysvětlit úspěch LOK? Jak je možné, že organizace bez nutného organizačního zázemí a s takovým silným oponentem jako je Odborový svaz získala takový vliv?  
How would you explain the success of the independent trade union LOK? How could an organisation without a strict membership system, financial resources, experts (lawyers, economists, etc.) and with such a strong opponent as "Odborovy svaz" become so influential?
- Osobnost Davida Ratha?  
Personality of the leader David Rath?
  - Náhoda (Luděk Rubáš chtěl, aby ho LOK podpořil proti Bohuslavovi Svobodovi ve sporu o udělování licencí a díky tomu získal LOK vrch nad ČLK)?

Chance (Luděk Rubáš wanted LOK to support him against Bohuslav Svoboda on licensing and it gave an opportunity to LOK to take over CLK)?

- Silná podpora lékařů a/nebo občanů?  
Strong support of doctors and/or the public?
- Pozornost médií?  
Media attention?
- Pochopení situace v zdravotnictví: vláda / veřejnost věřila expertíze LOKu?  
Understanding of the situation in health care: the Government/public trusted the expertise of LOK?

17. Jaké byly podle vás hlavní změny implementované vašimi předchůdci?  
In your opinion, what were the main changes implemented by your predecessors?
  - Pavel Klener
  - Martin Bojar
  - Petr Lom
  - Luděk Rubáš
18. Proč Luděk Rubáš odstoupil?  
Why did Luděk Rubáš resign?
19. Proč jste byl jmenován ministrem zdravotnictví? Kdo byli vaši konkurenti?  
Why were you appointed Health Minister? Who were the other candidates?
20. Proč se ministři zdravotnictví mění tak často?  
Why do Health Ministers change so often?
21. Proč jste byl jediným ministrem zdravotnictví, který nebyl lékařem.  
Why were you the only Health Minister who was not a doctor?
22. Když se změní ministr, změní se i ředitelé oddělení a další klíčové osoby na Ministerstvu zdravotnictví?  
When health ministers change, do heads of the departments and other key figures in the MoH change?
23. Když jste přišel na ministerstvo, byli tam nějací zaměstnanci z doby před r. 1989?  
When you came to the Ministry, were there any pre-1989 people left?
24. Kdo poskytoval ministerstvu analýzy a poradenství poté, co Petr Lom zrušil Ústav sociálního lékařství a organizace zdravotnictví?  
Who provided MoH with advice after Petr Lom closed the Centre for Social Medicine and Health Care Organisation?
25. Využívali jste služeb mezinárodních expertů / poradních organizací?  
Did you use any international experts/consultancies?

26. Ve vašem Dlouhodobém programu určujete následující problémové oblasti. Které reformy v těchto oblastech byly uzákoněny a implementovány, pokud selhaly; proč?

In the following problematic areas from your Long-term programme for health care reform, what were the main reforms that you enacted, failed; why failed?

- Růst výdajů?  
Growth of expenditure?
- Nadbytek kapacity ambulantních i lůžkových zařízení?  
Excess hospital capacity?
- Nedostatečná kontrola nad objemem poskytované zdravotní péče?  
Lack of control over the volume of guaranteed health care?
- Nedostatečně ujasněné postupy při privatizaci?  
Insufficient clarity of approaches to privatisation?
- Růst nákladů na léčiva vyvolaný změnami v struktuře předepisovaných léčiv?  
Growth of expenditure on drugs caused by changes in the structure of prescription drugs?
- Relativní růst mezd a platů zdravotnického personálu?  
Relative growth of salaries and wages of medical staff?
- Neujasněná funkce všeobecného zdravotního pojištění a rychlý vznik více pojišťoven?  
Undefined function of social health insurance and mushrooming of independent health insurance companies?
- Nedostatečně kvalitní řízení na všech úrovních?  
Insufficient quality assurance on all levels?

27. Do jaké míry jste měl možnost se ve výkonu funkce řídit naplňování Krátkodobého a Dlouhodobého programu a do jaké míry jste byl nucen přizpůsobit se okolnostem?

To what extent were you able to follow the Short- and Long-term Programmes? And to what extent were you acting according to the necessity of the day?

28. Pracovala vláda na strategii MSA v době, kdy jste byl ministrem? Pokud ano, kdo byl autorem tohoto materiálu?

When you were in office, did the Government work on Medical Savings Accounts? If so, who was responsible for this?

29. Který z členů vlády kromě Václava Klause prosazoval myšlenku MSA a věřil, že je aplikovatelná v ČR?

What members of the Government, apart from Vaclav Klaus, liked the idea of MSA and believed that MSA could be successfully implemented in the Czech Republic?

30. Kteří političtí aktéři jsou účastni v tvorbě zdravotní politiky? Jaké jsou jejich politické a ekonomické zájmy? Jaké příjmy jim umožňují lobbovat? S kým spolupracují a s kým soupeří?

What policy actors are involved in the health policy process? What are their political and economic interests? What resources to lobby their interests do they have? Who do they co-operate with and compete against?

➤ **Political parties**

- soutěží politické strany ve volbách na základě návrhů reformy zdravotnictví nebo toto téma není pro volební kampaň podstatné a teprve když je strana u moci, začne pracovat na plánu reformy?

Do political parties compete in elections on the basis of health care reform proposals? Does it play a significant role during the election campaigns? Or is it that only when in office the ruling party starts developing a plan for reform?

- stínový ministr zdravotnictví  
Shadow Health Minister

➤ **Parliament**

- Obvykle je v Poslanecké sněmovně 10 – 15 lékařů, mají stejné zájmy a jednají jednotně?

Usually, there are 10-15 doctors in the Lower Chamber; do they share the same interests and act together?

- Existuje v parlamentu lékařská lobby? Pokud ano, kdo k ní patří?  
Is there a “medical lobby” in the Parliament? If so, who are its members?

➤ **President**

Václav Klaus nedávno vetoval zákon, který by regionům umožnil převést nemocnice na obchodní společnosti. Existují jiné příležitosti, kdy president intervenoval do zdravotní politiky?

Vaclav Klaus has recently vetoed a law banning regions from privatising hospitals, but are there any instances when the President intervened in the health policy process?

➤ **Government**

- Ministerstvo zdravotnictví  
Ministry of Health
- Ministerstvo sociálních věcí  
Ministry of Social Affairs
- Ministerstvo finance  
Ministry of Finance
- Ministerstvo školství  
Ministry of Education
- Jiná ministerstva nebo organizace vlády?  
Any other ministries or government agencies?

- **Local authorities**  
Místní úřady (před a po 2000)
- **Regional authorities**  
Regionální úřady
- **General Health Insurance Fund**  
VZP
- **Other health insurance companies**  
Jiné zdravotní pojišťovny (lobují pro své zájmy jednotlivě nebo prostřednictvím Svazu zdravotních pojišťoven)?  
Other health insurance companies (do they lobby their interests on their own or together via the Union of Health Insurance Companies)?
- **Medical profession**  
Lékařské organizace a neformální zájmové skupiny  
Doctors' organisations and non-organised interest groups
  - ČLK
  - Česká lékárnická komora nebo podobné organizace
  - Česká stomatologická komora nebo podobné organizace
  - LOK-SČL
  - Odborový svaz
  - Další důležité formální a neformální organizace
- **Medical device industry**  
Zdravotnický průmysl
- **Pharmaceutical industry**  
Farmaceutický průmysl
- **Patient organisations**  
Pacientské organizace
- **EU and other international organisations**  
EU a další mezinárodní instituce
- Kdo se ještě účastní na vytváření zdravotní politiky?  
Who else influences health policy-making?

31. Jaké články/příspěvky o reformě zdravotnictví a pro jaká media jste napsal?  
Could you refer me to your articles/papers on Czech health care reform?

## **VI. Glossary of Czech acronyms and abbreviations**

AVEL	Pharmaceutical Distributors Association (Asociace velkodistributorů léčiv)
ČAS	Czech Association of Nurses (Česká asociace sester)
ČLS JEP	Czech Association of Doctors (Česká lékařská společnost Jana Evangelisty Purkyně)
ČMKOS	Bohemian-Moravian Chamber of Trade Unions (Českomoravská komora odborových svazů)
ČNSS	Czechoslovak National Socialist Party (Československá národně socialistická strana)
ČSD	Czechoslovak Social Democracy (Československá sociální demokracie)
ČSDSD	Czechoslovak Social Democratic Worker's Party (Československá sociálně demokratická strana dělnická)
ČSL	Czechoslovak People's Party (Československá strana lidová)
ČSNP	Czech Office for Sickness Insurance (Česká správa nemocenského pojištění)
ČSS	Czech Society of Nurses (Česká společnost sester)
ČSSZ	Czech Office for Social Security (Česká správa sociálního zabezpečení)
DSDAP	German Social Democratic Workers' Party (Deutsche socialdemokratische Arbeiterpartei)
HN	Hospodářské noviny, newspaper
HOS	Movement for Civil Freedom (Hnutí za občanskou svobodu)
HOS	Movement for Civil Liberties (Hnutí za občanské svobody)
HR	Economic Council (Hospodářská rada)
HSD-SMS	Movement for Autonomous Democracy – Society for Moravia and Silesia (Hnutí za samosprávnou demokracii – Společnost pro Moravu a Slezsko)
INSKOP	Initiative Group for the Establishment of District Health Insurance Funds (Iniciativní skupina pro zavedení okresních pojišťoven)

IPVZ	Institute of Postgraduate Education in Health Care (Institut postgraduálního vzdělávání ve zdravotnictví)
KAN	Club of the Politically Engaged Non-Party Members (Klub angažovaných nestraníků)
KDS	Christian Democratic Party (Křesťanskodemokratická strana)
KDU-ČSL	Christian and Democratic Union – Czechoslovak People’s Party (Křesťanská a demokratická unie – Československá strana lidová)
KNV	Regional National Committee (Krajský národní výbor)
KSČ	Communist Party of Czechoslovakia (Komunistická strana Československa)
KSČM	Communist Party of Bohemia and Moravia (Komunistická strana Čech a Moravy)
KUNZ	Regional Institution of National Health (Krajský ústav národního zdraví)
LN	Lidové noviny, newspaper
LOK	Doctors’ Trade Union Club (Lékařský odborový klub)
MfD	Mladá fronta DNES, newspaper
MGL	Young Generation of Doctors (Mladá generace lékařů)
NCPZ	National Centre for Health Promotion (Národní centrum podpory zdraví)
NF	National Front (Národní fronta)
NOOSZP	Independent Trade Union Organisation of Nurses (Nezávislá odborová organizace středních zdravotnických pracovníků)
ODA	Civic Democratic Alliance (Občanská demokratická aliance)
ODS	Civic Democratic Party (Občanská demokratická strana)
OF	Civic Forum (Občanské fórum)
OFZ	Civic Forum of Health Professionals (Občanské fórum zdravotníků)
OH	Civic Movement (Občanské hnutí)
ONV	District National Committee (Okresní národní výbor)

OSZSP	Health and Social Care Trade Union (Odborový svaz zdravotnictví a sociální péče)
OÚNZ	District Institution of National Health (Okresní ústav národního zdraví)
POUZP	Professional Trade Union of Health Workers of Bohemia, Moravia and Silesia (Profesní odborová Unie zdravotnických pracovníků Čech, Moravy a Slezska)
RDSP	Council for Dialogue of Social Partners (Rada pro dialog sociálních partnerů)
RHSD	Council for Economic and Social Agreement (Rada hospodářské a sociální dohody)
ROH	Revolutionary Trade Union Movement (Revoluční odborové hnutí)
RP	Rudé právo (since August 1995, Právo), newspaper
RSZML	Republican Party of Farmers and Peasants, also known as the Agrarian Party (Republikánská strana zemědělského a malorolnické lidu)
SD-LSNS	Free Democrats – Liberal National Social Party (Svobodní Demokraté – Liberální strana národně sociální)
SdP	Sudetenland German Party (Sudetendeutsche Partei)
SKUPR	Working Group of the Minister of Health and Social Affairs for Reform (Pracovní skupina ministra zdravotnictví a sociálních věcí ČR pro reformu)
SPL	Association of Doctors of Health Insurance Funds (Spolek pokladenských lékařů)
SPÚ	State Office for Planning (Státní plánovací úřad)
SSL	Union of Private Doctors (Svaz soukromých lékařů)
SSM	Socialist Union of Youth (Socialistický svaz mládeže)
StB	Secret Police (Státní bezpečnost)
SÚDZ	State Office for Social Security (Státní úřad důchodového zabezpečení)
SZP	Association of Health Insurance Funds (Sdružení zdravotních pojišťoven, from 1997 Svaz zdravotních pojišťoven)

SZÚ	National Institute of Public Health (Státní zdravotní ústav; in 1949-52 Státní zdravotnický ústav)
ÚDL	Institute for Further Education of Doctors, predecessor of IPVZ (Ústav pro doškolení lékařů)
ÚJČL	Central Association of Czech Doctors (Ústřední jednota českých lékařů; since 1918, Ústřední jednota československých lékařů)
Unie ZS	Union of Employer Associations (Unie zaměstnavatelských svazů)
ÚNP	Central National Insurance Fund (Ústřední národní pojišťovna)
ÚRO	Central Council of Trade Unions (Ústřední rada odborů)
US-DEU	Freedom Union – Democratic Union (Unie svobody – Demokratická unie)
ÚSLOZ	Institute of Social Medicine and Organisation of Health Care (Ústav sociálního lékařství a organizace zdravotnictví)
ÚSP	Central Social Insurance Fund (Ústřední sociální pojišťovna)
ÚZV	Institute for Health Education (Ústav zdravotní výchovy)
ZN	Zemědělské noviny, newspaper
ZÚNZ	Factory Institution of National Health (Závodní ústav národního zdraví)
ZR	Health Council (Zdravotní rada)

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ZÁKON Č. 551/1991 SB. o Všeobecné zdravotní pojišťovně České republiky.

ZÁKON Č. 68/1870 Ř. Z. o organizaci veřejné služby zdravotní, a předpisy vydané podle něho.

ZÁKON Č. 102/1951 SB. o přebudování národního pojištění.

ZÁKON Č. 103/1951 SB. o jednotné preventivní a léčebné péči.

ZÁKON Č. 149/1996 SB. kterým se mění a doplňuje zákon České národní rady č. 550/1991 Sb., o všeobecném zdravotním pojištění.

ZÁKON Č. 160/1992 SB. o zdravotní péči v nestátních zdravotnických zařízeních.

ZÁKON Č. 161/1993 SB. o změnách ve všeobecném zdravotním pojištění a o změnách a doplnění některých dalších zákonů.

ZÁKON Č. 171/1991 SB. o působnosti orgánů České republiky ve věcech převodů majetku státu na jiné osoby a o Fondu národního majetku České republiky.

ZÁKON Č. 2/1998 SB. kterým se mění a doplňuje zákon č. 48/1997 Sb., o veřejném zdravotním pojištění a o změně a doplnění některých souvisejících zákonů, ve znění zákona č. 242/1997 Sb.

ZÁKON Č. 20/1966 SB. o péči o zdraví lidu.

ZÁKON Č. 210/1990 SB. o změnách v působnosti orgánů České republiky v sociálním zabezpečení a o změně zákona č. 20/1966 Sb., o péči o zdraví lidu.

ZÁKON Č. 218/1925 SB. o zřízení, působnosti a organizaci Státního zdravotního ústavu Republiky československé.

ZÁKON Č. 220/1991 SB. o České lékařské komoře, České stomatologické komoře a České lékárnické komoře.

ZÁKON Č. 221/1924 SB. o pojištění zaměstnanců pro případ nemoci, invalidity a stáří.

ZÁKON Č. 242/1920 SB. o prozatímní úpravě právních poměrů ústavů léčebných a humanitních v republice Československé.

ZÁKON Č. 268/1919 SB. jímž se mění předpisy zákona o nemocenském pojištění dělníků.

ZÁKON Č. 27/1954 SB. o volbách do Národního shromáždění.

ZÁKON Č. 298/1990 SB. o úpravě některých majetkových vztahů řeholních řádů a kongregací a arcibiskupství olomouckého.

ZÁKON Č. 33/1888 Ř.Z. o nemocenském pojištění dělníků.

ZÁKON Č. 4/1952 SB. o hygienické a protiepidemiologické péči.

ZÁKON Č. 403/1990 SB. o zmírnění následků některých majetkových křivd.

ZÁKON Č. 427/1990 SB. o převodech vlastnictví státu k některým věcem na jiné právnické nebo fyzické osoby.

ZÁKON Č. 451/1991 SB. kterým se stanoví některé další předpoklady pro výkon některých funkcí ve státních orgánech a organizacích České a Slovenské Federativní Republiky, České republiky a Slovenské republiky, ve znění pozdějších předpisů.

ZÁKON Č. 477/1921 SB. o zdravotní přírázce ku přímým daním státním, podléhajícím přírážkám, a utvoření veřejného fondu pro podporu veřejných nemocnic a ústavů léčebných v republice Československé.

ZÁKON Č. 48/1997 SB. o veřejném zdravotním pojištění a o změně a doplnění některých souvisejících zákonů.

ZÁKON Č. 500/1990 SB o působnosti orgánů České republiky ve věcech převodů vlastnictví státu k některým věcem na jiné právnické nebo fyzické osoby.

ZÁKON Č. 550/1991 SB. o všeobecném zdravotním pojištění.

ZÁKON Č. 59/1995 SB. kterým se mění a doplňuje zákon České národní rady č. 550/1991 Sb., o všeobecném zdravotním pojištění.

ZÁKON Č. 592/1992 SB. o pojistném na všeobecné zdravotní pojištění.

ZÁKON Č. 60/1949 SB. o hospodářském plánování (plánovací zákon).

ZÁKON Č. 60/1995 SB. kterým se mění a doplňuje zákon České národní rady č. 551/1991 Sb., o Všeobecné zdravotní pojišťovně České republiky.

ZÁKON Č. 92/1991 SB. o podmínkách převodu majetku státu na jiné osoby.

ZÁKON Č. 99/1948 SB. o národním pojištění.

## ***People interviewed***

### **Oral interviews**

ANTOŠOVÁ, LUCIE (Ministry of Finance)

BOJAR, MARTIN (ex-Health Minister)

BOŠKOVÁ, VLADĚKA (Civic Association for the Protection of Patients)

BOUČEK, JAROSLAV (Library of the Health Ministry)

CIKRT, TOMÁŠ (Editor-in-chief of Zdravotnické noviny)

DLOUHÝ, MARTIN (Prague School of Economics)

DOSTÁL, JIŘÍ (Medical Chamber)

DOSTÁL, ONDŘEJ (President of the Czech Association for Medical Law and Bioethics)

GARDNER, ANDREW (journalist, Transitions Online)

HÁVA, PETR (ex-Director of the Institute of Health Policy and Economics)

HEGER, LEOŠ (Director of the University Hospital Hradec Králové)

HROBOŇ, PAVEL (Chairman of the Association for Health Care Reform)

JAROŠ, JAN (Association for Health Services Research, ex-member of INSKOP)

JEDLIČKA, JIŘÍ (Medical Chamber)

JULÍNEK, TOMÁŠ (Chairman of the Senate Health and Social Policy Committee)

KALINA, KAMIL (ex-Deputy Health Minister)

KLENER, PAVEL (ex-Health Minister)

KLÍROVÁ, MARIE (journalist, Health and Social Care Trade Union)

KROČEK, LUMÍR (Director of the Association of Pharmaceutical Companies)

KUDYN, MILAN (Deputy Chairman of the Association of Paediatricians)

KUDYNOVÁ, KAROLINA (journalist, Právo)

MARGETÍNOVÁ, LUCIE (medical device company Mediglobe GmbH)

MARX, DAVID (ex-advisor to Health Minister)  
MRÁZEK, JOSEF (Vice President of the Patients Association)  
NAVRÁTILOVÁ-ŠTURSOVÁ, BARBORA (pharmaceutical company, Novartis)  
NEMEC, JIŘÍ (ex-Director of the General Health Insurance Fund)  
PASTERNAK, PETR (ex-Director of the Office for the Introduction of Health Insurance)  
PAYNE, JAN (Charta 77 and Movement for Civic Freedom activist)  
POTŮČEK, MARTIN (ex-Chairman of SKUPR)  
RUBÁŠ, LUDEK (ex-Health Minister)  
SCHLANGER, JIŘÍ (Chairman of the Health and Social Care Trade Union)  
SEDLÁČEK, TOMÁŠ (Ministry of Finance)  
SOJKA, MICHAL (Editor-in-Chief of Tempus Medicorum)  
STRANSKY, JAN MARTIN (Director of the Národní Polyclinic)  
STRÁSKÝ, JAN (ex-Health Minister)  
TRÖSTER, PETR (ex-Deputy Health Minister)  
ZAPLETNYUK, KATYA (journalist, The Prague Post)

### **Email correspondence**

KALINA, TOMÁŠ (Czech National Archives)  
MATESOVÁ, JANA (World Bank)  
POHUNKOVÁ, DAGMAR (Charter 77 activist, ex-Editor-in-chief of Zdravotnické noviny)  
POPOVIČ, IVAN (Institute of Health Information and Statistics)  
PORUBSKÁ, ANNA (Czech Statistical Office)  
ŠILHAN, MILAN (ex-Deputy Health Minister)  
TREXLER, JIŘÍ (Czech Statistical Office)  
ŽÁK, VÁCLAV (Civic Forum and Civic Movement activist)