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The Politics of Healthcare Reform in Postcommunist Europe: The Importance of Access

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ABSTRACT

Why do countries move from public to private financing of healthcare? This paper explores this issue by looking at the divergent reform trajectories of three postcommunist countries – the Czech Republic, Hungary, and Poland. While existing accounts emphasize veto points to explain changes in healthcare systems, the present analysis finds that moves towards private financing can be better explained by differences in access to the policymaking arm of the state. Specifically, a penetrable single-party government and weak bureaucratic capacities allow physicians to capture the reform process and implement their preferred policies. The results suggest that scholars of health policy should focus more attention on the actors seeking change and their access to policy makers.

Key words: *access, veto points, healthcare*

Much of the research on the structure of healthcare systems has focused on the move from private to public financing (Immergut 1992, Maioni 1998, Tuohy 1999). But why do some countries move in the opposite direction? Having introduced a national health service, why do they then reintroduce insurance principles or competing private insurers? The formerly communist countries of Eastern Europe present an interesting test of this question. Under communism, they shared a common healthcare model based on state ownership and control. But since then some of them have moved away from this system to introduce a national insurance authority or a system of private insurers.

This decision is puzzling because the inherited system provided reasonable levels of care at a relatively low cost (Preker and Feachem 1994). A switch to private financing might be expected to increase costs

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during a period of fiscal austerity and to reduce coverage that was popular with citizens. This paper tries to explain why three countries in Eastern Europe chose different reforms of their financing systems, specifically why the Czech Republic introduced a system of competing private insurers, Hungary moved to a single national insurer, and Poland retained its national health service.

In line with previous research, I find that political institutions are the key causes of these divergent paths, though with a twist. In existing accounts of health politics, a higher number of veto points allows physicians and insurers to block moves towards a national health service (e.g., Immergut 1992). What these accounts, however, do not explain are the motive forces for change. They show how change is blocked, but not why it happens. In Eastern Europe, by contrast, change required an initiating force to move away from the state-controlled status quo.

In this paper, institutions are important not just as veto points, but because they give groups with a desire to change the system access to the levers of power. In particular, they allow physicians to capture the policy making process and move towards a more privately-oriented system. This capture moreover depends on a different set of institutions than those usually invoked in institutional accounts of health policy. The key institutions are not presidencies, referenda, or minor coalition partners, but the permeability of governing parties and the capacity of bureaucracies. A porous governing party and a low capacity bureaucracy give physicians access to the levers of power and allow them to introduce the policies they wish. In comparison with existing theories, it is a different set of institutions acting in a different way which causes countries to abandon their state-controlled health care systems.

1. The Reform Menu

All communist countries in Eastern Europe ran what has been called a Semashko-type healthcare system. The name comes from the Soviet physician, N.A. Semashko, who in 1918 proposed a centrally-organized system of healthcare that would provide free medical care for the entire population (Marrée and Groenewegen 1997). It was his ideas which were put into practice first in the Soviet Union and then in its satellite states.

The Semashko system was a microcosm of the centrally planned economy (Preker and Feachem 1994). Healthcare was made an inherent right of all citizens. All healthcare facilities were put under state ownership and all healthcare workers were state employees paid

fixed salaries. Almost all funding came from the state through budget allocations based on numerical indicators of inputs.

By the fall of communism, both doctors and patients expressed dissatisfaction with the system. While patients received free care, they had no choice of doctor, waited in long queues for care, and often had to pay bribes to receive better service. Doctors in turn despaired of their lack of freedom to earn additional income and control their practices. Their salaries were sometimes lower than less-skilled laborers though they could earn significant income from gratuity payments or bribes for better service.

What were the options for reform? One of the defining traits of healthcare systems is how they are funded. There are three basic options for funding healthcare (Marrée and Groenewegen 1997). The first is to leave most funding to the market. This means that individuals, or more commonly employees, need to purchase health insurance or have their employer purchase it from a private insurer. Though such a system is market-oriented, in advanced industrial countries the state generally plays an important regulatory role. It may require employers to provide coverage, give citizens tax breaks or subsidies to take out insurance, and provide coverage for the unemployed and elderly.

The second and third options involve more state control. In the Bismarckian scheme, citizens are required to pay ear-marked taxes to either an independent insurance authority or to regulated insurance funds. These insurance schemes cover most necessary care. The idea is that citizens gain an entitlement to care by paying contributions into the insurance system. There is thus a partial link between contributions and benefits received. The national health service model is quite similar to the Semashko scheme it dispenses completely with the insurance principle. Instead, healthcare is completely funded from the state budget and general tax revenues. In this scheme the state plays a more dominant role than in the Bismarckian system because the healthcare authority has little independence from the state. The entitlement to care moreover extends to the entire citizenry.

The choice among these means of financing healthcare is typically contentious. Physicians tend to prefer multiple private insurers because this competition increases their bargaining power and leads to higher salaries and greater autonomy (Immergut 1992). They least prefer public financing, which puts them in a subordinate position to a powerful state. Politicians might be expected to have the opposite preferences. Budgetary financing gives them greater control over spending, creates patronage opportunities through jobs in the healthcare bureaucracy, and provides coverage for voting citizens. Con-

versely, private insurance may leave government with little ability to contain costs and citizens without access to care.

Financing alternatives are often associated with particular means of remunerating physicians. Thus market-oriented systems typically use fee-for-service (FFS) payments where physicians set their own prices and are reimbursed for each procedure. Physicians tend to prefer this system because it gives them greater influence over their own salaries, though governments usually wish to avoid it because it leads to overtreatment and cost explosions. Conversely, the universal system is usually associated with fixed salaries which allow the state to maintain control over costs. Physicians not surprisingly oppose fixed salaries as an infringement on their autonomy. In between these extremes are payment systems like capitation and diagnostic related groups (DRGs), where doctors are paid by the patient or diagnosis which give them some autonomy and governments some means of cost control. Because of these relations, the analyses below will consider changes in both financing and payment systems.

2. Theories of Health Politics

What do existing theories have to say about choices among these alternatives? Early works focused on the causal impact of rising national income; richer states spend more on healthcare (Wilensky 1975). But these theories were inadequate for explaining the distinctive institutional forms that healthcare takes. Concerning Eastern Europe, these theories would point out that they had 'premature welfare states'; they spent more on healthcare than other states at similar income levels (Kornai and McHale 2000). One would thus expect them to cut spending when they were exposed to the free market. In fact, healthcare spending remained stable or grew in the three countries considered here; over the first five years of the transition, sspending rose from 5.0 per cent to 7.8 per cent of GDP in the Czech Republic, from 5.2 per cent to 6.9 per cent in Hungary, and from 3.5 per cent to 4.9 per cent in Poland (Chelleraj et al. 1996).[1]

A second wave of theories has emphasized the power of interest groups, particularly physicians (Starr 1982). Physicians are an important force in policy making because their livelihoods are most directly affected by healthcare institutions. Patients for their part are more concerned with coverage than with complicated financing and payment schemes whose effects are not always clear. Immergut (1992) put a useful twist on these accounts by noting that what physicians want to avoid is a government monopsony. Confronting multiple purchasers increases their bargaining power.

While such accounts are correct in putting physicians at the center of the policy process, differences in doctors' socio-economic position do not correlate well with cross-national differences (Immergut 1992). Physicians are similarly organized and have similar resources in most advanced democracies. This applies as well to Eastern Europe where physicians had a similar place in the occupational hierarchy and were present in similar numbers.[2] Even differences in the willingness of physicians to engage in contentious action do not alter this conclusion. Polish physicians were the most strike-prone in the region, but the least successful at getting their way (Ekiert and Kubik 1999). While the power of physicians is important, it does not explain different policy choices.

In place of these theories, something of a consensus has emerged that political institutions determine whether a country can alter its healthcare system. If political institutions give doctors the ability to veto changes in the direction of greater state control, they will do so. Immergut thus found that countries with more veto points tend to have more market-oriented health sectors (also Maioni 1998, Steinmo and Watts 1995). Institutions like referenda, separation of powers, and fragmented party systems allow societal actors, particularly physicians, to block moves away from the market-oriented status quo and towards statist healthcare. Stable parliamentary majorities and executive dominance have the opposite effect. Tuohy (1999) introduces an important wrinkle in these accounts, arguing that reforms can only take place during relatively rare windows of opportunity; otherwise interest groups have a relatively strong veto over major reforms. Institutions in short provide the points where interest groups – particularly physicians but latterly health insurers – can block change.[3]

What is less emphasized in these, and in fact many institutionalist accounts, is an explanation of the motive forces for change. Most studies persuasively show how changes are blocked, but they do not explain why or how they come about (though see Hacker 1997). They typically assume constant pressures towards greater state control, which may or may not be blocked by physicians and insurers. What is needed is a better understanding of the motive forces for change, of how actors get access to the policymaking arm of the state. Institutions are important not only in providing blocking points, but in opening windows of opportunity for change.

3. The Importance of Access

The challenge in Eastern Europe is to explain how countries have moved away from state-run healthcare systems. In previous accounts

doctors played the key role in vetoing potential changes that infringed on their autonomy. But in the postcommunist region, doctors had already lost that battle and had to be proactive to change the system to a more market-oriented alternative. They were battling to move away from a statist status quo rather than to preserve a market-oriented status quo.

What determines whether they could do this? Such a change could occur if physicians were to gain control of the policymaking arm of the state, that is, the government and bureaucracy in charge of preparing, enactng, and implementing reforms. These are different institutions than those usually emphasized in institutional accounts. Referenda, separation of powers, and minor political parties allow groups to stop change, not impose it. To initiate and follow through on change, it is necessary for those with an interest in change to gain control of institutions that can propose and enact changes.

How might physicians gain control of the policy making arm of the state? Two conditions are key in the cases considered here, though they are not the only possibilities. First, a strong but porous governing party can help physicians to get their way. Since healthcare reforms are complicated and contentious (Nelson 2001), they require a government with considerable power to get its way; the governing parties must be able to pass their plans. At the same time, the government must be open to capture by physicians; it must be porous. While many governments are sympathetic to the aims of physicians, doctors are a small enough group that they have to consider the impact of reforms on other groups like patients and businesses as well as the state budget. Physicians thus must be able to control key policy posts in government.

Second, a bureaucracy susceptible to capture can have similar effects. Typically healthcare bureaucrats want to preserve their own role in the system and, if they are well-trained, to find means of rationalization, providing better and more efficient care at a reasonable cost. But if, as was the case with some communist bureaucracies, they were unschooled in healthcare policy or discredited by their behavior under communism, they can be overpowered by physicians providing better elaborated and more persuasive proposals.

The combination of these two conditions – a dominant but porous party and a weak bureaucracy – would leave policy making in the hands of physicians and allow radical change. This is how reform played out in the three cases here. Health professionals were the initiators or the main agitators for reforms. They protested, lobbied, and even went on strike in support of or in opposition to government measures. And in all cases, doctors supported moves that would give them greater market power (Nelson 2001). It was differences in their

institutional access to power that determined whether they would be successful.

In the Czech Republic doctors gained access to the policy process through the relatively open structure of the Civic Forum (OF) party, which essentially delegated health care policy planning to a group of doctors. There was likewise little opposition from the healthcare bureaucracy because the bureaucracy had virtually no knowledge of or capacity to prepare health care reforms. Hungary and Poland presented a different constellation of institutional access. In both countries, the initial elections produced both a multiparty government and relatively programmatic political parties. These parties put forward different and competing proposals for health care reform and were not simply conduits for the physicians' lobby. Further, both countries possessed competent healthcare bureaucracies who could take the initiative in producing reforms and standing up to the physicians' lobby. Opponents of reforms in Hungary and Poland had the will and opportunity to counter the power of physicians.

This account does not so much supplant the existing veto players theory as extend it. In Hungary and Poland, important actors could veto physicians' plans as the existing logic predicts and as a result changes were moderate. However to explain more radical changes in the Czech Republic, one needs to consider more than just the absence of veto players, but the ways in which actors could gain control of the policy process. To give a complete account of why changes go forward, one needs to emphasize both the actors pushing for changes and the institutions that give them access to policy levers.

4. Evidence

To confirm these ideas, I employ both structured focused comparisons and process tracing (George and Bennett 2005). The three countries chosen for the comparisons are the Czech Republic, Hungary, and Poland. They are similar in many respects – particularly their pre-transition health systems and political and economic situations – yet they differed in the reforms they undertook. It is thus possible to isolate the key causal forces even in this small sample. For each country I trace the process of events leading to the outcome in question in an effort to identify the proximate and ultimate causes. To help orient the reader, Table 1 presents the main outcomes along with their main hypothesized causes.

4.1. The Czech Republic

Commentators have referred to Czechoslovakia in the 1970s and 1980s as an example of 'frozen' totalitarianism (Linz and Stepan 1996).

Table 1. Differences in Politics and Health Policies

	Causes		*Outcomes*	
Country	*Party system*	*Healthcare bureaucracy*	*Financing*	*Payment*
Czech Republic	Dominant but diverse and porous governing party from 1990 to 1992	Low capacity	Multiple private insurers	Fee-for-service throughout system until 1997
Poland	Fragmented party system and emotional conflict between erstwhile opposition and successors to communists	Medium capacity	National health service except for regional insurers between 1999 and 2003	Multiple, but mostly salary-based
Hungary	Strong conservative, socialist, and liberal blocs from start of transition	High capacity	Single state insurer	DRGs for hospitals, capitation for primary care

The description aptly fits the healthcare sector. Though hospitals continued to be built and standards of care improved, the basic organization of the system remained unchanged from the original Semashko prototype (Potůček 1994). Even worse, almost all competent experts were purged from the bureaucracy after the Soviet invasion in 1968 and replaced with party hacks (Williams 1997).

Though this stagnation meant that the Czech Republic had more to do after the fall of communism than in Hungary or Poland, healthcare reform moved ahead quickly under the new democratic government. It was doctors who were the leaders of these reform efforts, preparing three basic documents within ten months of the resignation of the communist government. As early as January 1990, just two months after the Velvet Revolution which overthrew communism, a group of healthcare professionals took the initiative to prepare a report 'Theses to a Health Program' that proposed a system of health insurance.

The authors of the Theses went on to form a Programmatic Commission of the Civic Forum of Healthcare Professionals. Civic Forum (OF), the umbrella party that was soon to govern the country, had a unique structure (Wheaton and Kavan 1992). The party's founders, Václav Havel among them, by practical necessity had to rely on the idea of a forum, a free, non-binding association of individuals, in place of a hierarchical, centrally-led political party. Indeed, their

motto going into the first free elections was 'Parties are for party-men, Civic Forum is for everyone.' The consequence was that Civic Forum was an amalgam of numerous independent groups throughout the country and was ideologically diverse. Any group was free to set up its own forum and affiliate itself with the movement. This is what physicians did in setting up their programmatic commission.

The Czech Republic's bureaucratic legacy also played into physicians' hands. While late communist governments in Poland and especially Hungary pursued healthcare reform and consulted genuine experts, Czechoslovakia not only avoided all mention of reform, but in the wake of the Soviet invasion prevented experts from emerging and working for the Ministry of Health (Jaroš et al. 2005).[4] As a consequence, bureaucrats at the Ministry lacked the competence to prepare serious reforms after the revolution. It was thus a necessity for them to turn over the initiative to more competent actors from civil society. Lawson and Nemec (2003) thus find that the agenda was set and reform documents prepared by Civic Forum activists, not senior bureaucrats. Potůček (1994) notes that the bureaucrats at the Ministry looked at the Programmatic Commission with distrust and tried to prepare their own counterproposal with more statist elements but were unable.

The Commission's initial proposal for health insurance was followed by the first democratic elections in June 1990. The Civic Forum won more than half the vote and two-thirds of the seats in the Czech parliament. Martin Bojar, one of the main activists in the Civic Forum of Health Care Professionals became the new Minister of Health.[5] With his main advisors coming from the Programmatic Commission, Bojar had a major reform plan prepared by October 1990. The short time span is testimony to the amount of work that had been done independently before the elections and outside the bureaucracy.

The new plan was a more complete version of the original proposal but now with a faster timetable and a greater emphasis on competition between health insurers and privatization. The decision for these more market-oriented elements in part reflected the desires of physicians. A poll conducted among doctors in 1991 found 80 percent in support of this plan (Potůček 1994). Most expected it to provide higher incomes (Jaroš et al. 2005). Nevertheless, it should be emphasized that it was specialist physicians at major hospitals who were behind most proposals. At the same time, healthcare professionals had already formed into powerful interest groups who criticized plans that went against their professional interests (Lawson and Nemec 2003). Public opinion supported physicians whose image was helped by their prominent role in the revolution. Polls found that most citizens wanted radical changes

in a system they viewed as broken (Jaroš et al. 2005, Lawson and Nemec 2003).

The new experts in the Ministry also debated the payment system for doctors. They were divided between a universal FFS scheme and a mix of FFS with capitation and other payment methods. An influential group of doctors from the Vinohrady Hospital appear to have been behind universal FFS, which tended to benefit specialists who could order more procedures (Potůček 1994).

The World Bank published its own set of recommendations for Czech health care reform in April 1991 (World Bank 1991). These recommendations were far more statist than the government's plans and urged the maintenance of many features of the old system, including state funding. The World Bank warned the government that its plans for FFS reimbursement would lead to a cost explosion and did not contain enough controls. These warnings were ignored, a sign that external influence did not determine policy choice.

Instead the Ministry's recommendations were passed and put into place almost immediately. The General Health Insurance Fund, a public insurer, was set up at the end of 1991. In 1992 private insurers – representing ministries, enterprises, and unions – followed. Many firms lobbied for the right to enter the insurance market and used access in the same way as physicians, though their access was mainly to individual MPs rather than the bureaucracy. These changes were implemented a year ahead of the original schedule. The same applied to the payment system. By 1993, the government, with help from physicians at the Vinohrady Hospital, had prepared a point system for all medical procedures according to which doctors would be paid. Potůček (1994: 52) writes that throughout this period the health profession 'held its position as the main initiator of the tempo and direction of the changes taking place.'

When a neo-liberal government led by the Civic Democratic Party (ODS) replaced OF in 1992, it oversaw the implementation of the new system. It was here that problems arose. Twenty-seven insurance companies entered the healthcare market, far more than the market could bear. Many found themselves in financial difficulty. On the one hand, they could neither set premiums (a prerogative of parliament), choose whom to insure (open enrollment was guaranteed), or limit their costs (they were required to pay for all services and could not set reimbursement rates).[6] The only way they could compete was by offering clients extra services, above and beyond the standard package. The result was financial losses and ultimately bankruptcy. By 1998, only nine insurers remained. The expected benefits of market competition did not appear.

Despite these problems, there has been no important move to change the system of competitive insurers. Although the Social Democratic government elected in 1998 spoke of returning to a single-payer system, it never prepared any concrete plans. In addition to the strong physicians' lobby, there is now a strong health insurance lobby which supports the existing system.[7] As Tuohy (1999) has suggested, once the window of opportunity passes, it is difficult to make fundamental reforms. A strong set of stakeholders has congealed around the current system of financing, making major changes unlikely. At the same time, the party system has hardened and the bureaucracy has been populated by more qualified experts.

Meanwhile, the FFS payment system soon led to exploding healthcare costs. As institutions like the World Bank predicted, physicians began overtreating patients in an effort to raise their incomes. As a result, healthcare spending rose by nearly 3 per cent of GDP, contributing to the financial problems of insurance companies (Chelleraj et al. 1996).

Ultimately, the government had to lower the monetary value assigned to each point. By 1997 the system had become unsustainable and a caretaker government introduced capitation and fixed budgets in several areas of the healthcare system (Jaroš et al. 2005). Though doctors opposed the reform, serious economic problems forced most to recognize the necessity of change. The Social Democratic government elected in 1998 tried to make up for these changes by increasing physicians' salaries without altering the system in other ways. This strategy of paying off stakeholders while ignoring fundamental reform has increasingly come to characterize the Czech approach to healthcare which has not seen substantial reforms since this time.

4.2. Poland

Whereas the Czech Republic retained an almost pure form of the Semashko system until 1989, Poland had undertaken several reforms before the revolution. In the 1980s the government began to tolerate private practices as long as they were conducted after the doctor's regular hours. In 1986 the government introduced limited free choice of doctor for 20 percent of the population (Marrée and Groenewegen 1997: 102). The same year also saw the founding of an independent Social Insurance Fund that collected payroll taxes and paid out benefits, though there was no separate fund for health nor were insurance principles applied.

Healthcare reform appeared on the agenda in the Round Table Talks heralding the end of communist rule. Though far from its prime

concern, the opposition Solidarity union was able to extract a written commitment to introduce a universal health insurance scheme (Osiatynski 1996). This reflected the union's desire to dismantle the centralized aspects of the communist economy. Following through on this agreement, the Ministry of Health in the first Solidarity-led government did produce a formal proposal for national health insurance. The proposal foresaw an independent Central Health Insurance Fund that would run a universal insurance system with funds coming from contributions by employers. Physicians would be paid according to the type and quantity of service, but not through FFS.

In contrast to the Czech Republic, this was not only the proposal and in further distinction the alternative proposals came from political parties, not physicians. These plans then confronted Poland's fragmented political system. The first free elections in Poland in 1991 yielded a high number of political parties; altogether 29 were represented in parliament and none held more than 15 per cent of seats. Further, parties were divided not just on socio-economic issues but also on a far more emotional axis that separated parties connected with the old regime from those connected with the erstwhile opposition, especially Solidarity (Gryzmala-Busse 2001).

The effect of this political system on the fate of reforms is clear (Nelson 2001). Although the reform proposals were similar, 'there was considerable emotional conflict among the participants and confusion about the roles of the different groups making the proposals' (Bossert and Włodarczyk 2000: 9). The Health Minister favored an independent proposal, but felt compelled to support the Ministry's proposal. The result was no clear move to pass either bill. The fall of the first government after a little more than a year in office and its rapid replacement by three more short-lived governments combined with pressing problems like unemployment and hyperinflation further stalled reform.

At this time the Polish government began cooperating with the World Bank. The proposals that came from the World Bank (1992) did not recommend market solutions and mainly advocated increased efficiency within a highly centralized system and continued central budget financing. Even though the World Bank's proposal accompanied a loan agreement, its recommendations were 'totally ignored' and 'played no role in influencing concepts applied in the reform process' (Bossert and Włodarczyk 2000: 10). The reason is that they were too similar to the old system and were 'entirely opposite to the way of thinking of the overwhelming majority of political and medical establishments' (Bossert and Włodarczyk 2000: 10).

Under the Suchocka government (1992–1993), Poland's fourth democratic government, four separate healthcare reforms were pro-

posed. This large number was related to the shaky nature of the minority coalition that was composed of seven parties. Two major proposals came from Solidarity-associated parties and were supported by their trade union base.[8] These bills would have created multiple independent insurance institutions and privatized provider organizations. Another proposal came from the centrist Democratic Union (UD), Prime Minister Suchocka's party; it would introduce regional health insurers and maintain public providers. A fourth proposal focused on local government issues, a perennial issue in Polish politics.

Though physicians initially rejected all four proposals and organized protests against 'pseudo-reforms', they ultimately realized that the two Solidarity proposals were in their interest and came to support them (Bossert and Wlodarcyzk 2000). The Health Committee of the Sejm, the Polish parliament, in turn rejected the UD proposal and called for a reconciliation between the two Solidarity proposals. The UD, however, continued battling within the government for its own plans. The result was a stalemate that lasted until the government fell in 1993.

The elections of 1993 produced a more consolidated political system with only six parties in parliament and a majority coalition of the Social Democrats and Peasants that controlled two-thirds of seats and could easily implement its preferred policies. The new government built on the work already done, but now set up a series of conferences to develop a consensus of all parties. Out of these meetings emerged general agreement on creating large regional insurance funds that would negotiate with providers. Funding would come from insurance premiums paid by employers and employees.

The decision to create regional insurance monopolies instead of a single national insurer had much to do with the politics of decentralization in Poland.[9] Solidarity had been a steadfast advocate of decentralization as a result of its traditional battles against central control of industry under communism (Włodarczyk and Karkowska 2005). The Social Democratic government had already passed a Large Cities Act that gave some municipalities a larger role in ownership and management of health facilities. The decision for regional insurers seems to be part of the general support for decentralization. The insurance reform was finally passed in 1997 despite continued opposition from Solidarity.

The long delays in moving to insurance appear to be the result of partisan politics. Numerous parties, especially Solidarity, were able to bring their own expertise and constituencies to bear on the reform. Further evidence of partisan haggling is that debate over the reform law continued even after Solidarity again came to power in 1997. Many factions in Solidarity hoped to revise the already passed law to more

closely conform to their original plans for a private system and unregulated fees. It was only the influence of the Minister of Finance Leszek Balcerowicz, a representative of the liberal Freedom Union (UW) party, who prevented these changes (McMenamin and Timonen 2002). Balcerowicz for his part pushed an alternative proposal focused on local governments that was rejected by Solidarity. In the end, the new coalition's law introduced relatively minor changes reducing contributions and appointing the members of the funds' boards.

Partially because of the lack of consensus over reform, there were massive problems in implementation that began in January 1999. Patients were confused about where to go for care and how to pay; there were problems in channeling money to the funds; the funds themselves overspent; hard budgets were not enforced; and bargaining between payers and providers was illusory because both were under political control (McMenamin and Timonen 2002). The reform was thus deeply unpopular and the Social Democrats contested the following elections on a platform of dismantling it. They did this after their victory in September 2001. Beginning in January 2003, all of the regional funds were liquidated and replaced by a single national fund, returning Poland almost to its starting position (Filinson et al. 2003, Włodarczyk and Karkowska 2005).

Unlike the Czech Republic, Poland's reforms did not definitively resolve mechanisms for the payment of physicians and hospitals. Though physicians and parts of Solidarity pushed for FFS reimbursement across the system throughout the decade, politicians were able to resist this pressure (McMenamin and Timonen 2002). In general, salary-based remuneration remained an important part of reimbursement. The Large Cities Act allowed local governments more freedom to use different forms of reimbursement, but did not mandate any one system. This same hands-off policy continued after the passage of the health insurance law. These trends are summed up by Bossert and Włodarczyk (2000: 19) who write, 'the medical associations in Poland, while strong and influential, were countered by the active interest in health policy by the political parties, the government bureaucracy and the international donors.'[10]

4.3. Hungary

Of the three countries, Hungary went the farthest in reforming its healthcare system under communism. Hungary's goulash communism relied heavily on a technocratic elite (Tokes 1996). In contrast to Czechoslovakia, where commitment to communism determined one's access to state administration, Hungary wooed talented individuals into

government regardless of their politics and allowed them to study non-communist models of administration.[11]

In 1987, the well-staffed Ministry of Social Affairs and Health set up a reform secretariat to produce policy proposals. Among the fruits of the secretariat was the adoption of a novel American model for hospital reimbursement, diagnostic related groups (DRGs) through which doctors were paid by the diagnosis rather than the procedure or the patient (Mihályi 2000).[12] Allowances were also made for private practice. Just before the revolution in 1989, the government separated the social insurance fund from the state budget (Marrée and Groenewegen 1997).

The first free elections in Hungary in 1990 produced a conservative government led by the Hungarian Democratic Forum (MDF) as well as a strong opposition divided between liberals and social democrats. Despite the sea change in politics, there was a great deal of continuity in healthcare policy. The strongest sign of continuity was that the communist-era head of the reform secretariat remained in his post even after the revolution in 1989. One factor promoting continuity was that previous reforms had produced a system that was acceptable to many doctors.

The most significant change introduced under the conservative MDF government was a law changing the financing system from state funding to insurance (Orosz et al. 1998). This meant that money for the social insurance fund would come from employer and employee contributions rather than from the state budget. This was intended to produce more reliable and transparent flows of money. As opposed to the Czech Republic, a single fund covered all citizens. Hungary's healthcare bureaucrats felt that this would allow them to keep control over spending and use resources more efficiently. Moving further in the direction of insurance led parliament to condition entitlement on contributions in 1992.[13]

At the same time, the ownership of health facilities was transferred to municipalities. Along with the creation of an independent insurance fund, this produced a separation between payers and providers. The social insurance fund would now have to contract with local providers for healthcare services. Though it should have had considerable bargaining powers as a monopsonistic buyer of health services, the fund actually had little autonomy to select providers and services. Rather it was obligated to pay for all services covered under the old system (Orosz et al. 1998).

In 1992, further changes were introduced. The single social insurance fund was split into a Pension Insurance Fund and a Health Insurance Fund (HIF). Both funds were made self-governing with

elections to be held in 1993. Contrary to the hopes of the government, these first elections were won by the successor to the communist-era trade union which came to dominate both funds. The powers of these self-governments, however, were limited as contribution rates continued to be set by parliament and little freedom was granted to contract with providers.[14]

The change to an insurance system aroused little political controversy. It appeared to promise something to everyone. Medical professionals were pleased that funding would no longer depend on wrangling over the budget. The public, largely dissatisfied with the state of the healthcare system, was also in favor of more consistent funding and opposed to continued centralization. By maintaining a single insurance fund, the government could also keep some control over cost increases. Indeed, to some extent the insurance basis of the system was fictional as payers and providers both remained under government control (Mihályi 2000).

Meanwhile, Hungary moved away from salary remuneration and towards performance-based financing (Orosz 1999). They managed, however, to avoid the more serious problems of FFS encountered by the Czech Republic. Even before the revolution Hungary had started to develop a case-based reimbursement system for hospitals, the DRGs referred to earlier. Bureaucrats had accomplished much of the administratively onerous work on the system in the late 1980s and early 1990s. Capitation payments were introduced for primary care physicians. Though outpatient care would be paid through FFS, the Ministry of Welfare knew enough to put a national budget cap on the system to prevent a cost explosion.

It was only when the flaws of the financing system became more apparent that controversies arose. Because of high unemployment, a growing informal sector, and tax avoidance, the revenues raised from payroll taxes could not cover the benefit package that the government guaranteed. After the election of a Socialist government with a large majority of seats in 1994, a policy debate began over how to change the financing system to meet these problems. The debate, however, remained mostly within the Socialist Party.[15]

On the one hand, the Ministry of Finance hoped to raise new revenues through patient copayments and add-on private insurance. Some even suggested a system of private competitive insurance. Opposing these proposals were the Ministry of Welfare and the HIF which wanted to keep their monopoly on funding and argued for the efficiency of a single-payer system. In 1996 the Ministry of Welfare proposed to eliminate the HIF and return funding to the state budget. The Ministry of Finance by contrast argued that the HIF should have

real responsibilities and be allowed to selectively contract with providers. It proposed a three-tiered system that included government financing for public health and catastrophic care with four to six insurers competing for standard care (Mihályi 2000).

Although the Socialists controlled enough seats to implement their polices, ultimately nothing came out of these debates. Actors with a stake in the status quo, especially the HIF and the Ministry of Welfare, were able to prevent any changes. Influential doctors who benefited from under-the-table payments from patients also opposed reforms. As in the Czech Republic and Poland, specialists associated with large hospitals were better represented in the policy process.

Interestingly, these debates recurred when the Socialist government was replaced in 1998 by a conservative coalition led by the Fidesz Party (Young Democrats). Again, debates over the form of the system were confined within the government. The Ministry of Finance hoped to change the public/private mix in the direction of the private, while the Ministry of Welfare and the Health Insurance Fund wanted to preserve the status quo (Nelson 2001). As Füzesi et al. (2005) argue, the debate throughout the nineties was not along party lines but within governing parties. Hungary's legacy of strong and capable bureaucracies encouraged this dynamic (Orosz 1998).

5. Conclusion

In 1989 many groups in Eastern Europe wanted to break with the past system of healthcare. Patients were dissatisfied with their lack of choices and the low quality of care. Physicians wanted more autonomy and higher salaries. It was this dissatisfaction that led politicians in all three countries to pursue many of the same reforms. Soon after the revolution, the Czech Republic, Hungary, and Poland allowed citizens to freely choose their doctor, physicians to set up private practices, and healthcare spending to rise (Marrée and Groenewegen 1997).

However, when it came to changing finance and payment arrangements, they made different choices. The Czechs moved to competitive insurers and FFS payment, while Hungary and Poland took more conservative paths. Standard explanations cannot explain these differences. Economics was not determinative as all three countries suffered large recessions and yet still managed to increase the generosity of their systems. Neither does ideology seem to matter. The most market-oriented reforms were introduced by a centrist government in the Czech Republic; a left-wing government in Poland both introduced and rescinded reforms; debates in Hungary bisected both major parties.

As far as interest groups go, physicians were similarly organized in all three countries and in fact were most strike-prone but least successful in Poland.

Where the countries differed was in political institutions. The standard veto players logic helps to explain why Hungary and Poland did not radically change their healthcare systems. Multiparty governments and competent ministries allowed partisan and bureaucratic actors to block physicians' desired reforms. But the standard logic falls short in understanding why the Czech Republic could achieve radical changes. It was not just the absence of veto points that explains reform, but the presence of access. Physicians had to control the policy making arm of the government to get their preferences enacted. To do this they needed a dominant but porous party and a low capacity bureaucracy.

Speaking more generally, this account adds two new twists to traditional institutional explanations of healthcare reform. First, it draws attention to the motive forces for change. While veto players accounts emphasize how change is blocked, they often ignore how it takes place, the way that groups in favor of change manage to enact it. Second, it refocuses attention on a different set of institutions, those that can positively enact change, the dominant parties in government and bureaucrats in charge of writing legislation. Future studies in the institutionalist tradition should pay closer attention to both of these actors if they wish to explain positive changes rather than simply the absence of change.

Institutionalist accounts can help to explain both welfare state expansion and retrenchment. However the ways that they do so differ. In the expansion literature, peripheral institutions are important in giving physicians and insurers the ability to block expansions which appear to have a natural tendency to move forward. In the present account, physicians and insurers need much stronger access to governing institutions because they are trying to enact change. The mass public meanwhile, which presumably was the force behind expansion, recedes here because of the opacity of these changes and the flux of the transition.[16]

The evidence also provides support for Tuohy's (1999) idea that reform only occurs when relatively rare windows of opportunity open. Once a choice was made, usually at a relatively early point in the transition when institutions were in flux, it became difficult to undo this choice. Interest groups of physicians and insurers quickly congealed around these new choices and made further change difficult. Poland did manage to introduce and rescind a major reform, but only because its implementation was so disastrous that interests could not find a foothold in the new system.

What does the future hold for these countries? Observers of Eastern European health systems have identified the major problem as the oversupply and overuse of services relative to available funds (Jakab et al. 2002). States are trying to provide too much healthcare with too few resources. What is needed according to healthcare experts is to enforce discipline on consumers and providers (Jakab et al. 2002). This means reforms like copayments, limitations on coverage, or hospital closures which would either raise additional funds or reduce publicly-provided services. But cuts in supply or charges for services are unpopular with citizens and physicians. Reformers hoped that such changes could be avoided by turning first to financing and payment reforms. Since this magic bullet has failed, governments are now turning to reforms of consumption and provision.[17]

NOTES

1. Spending did fall in some of the poorer states in the region.
2. The ratio of physicians per thousand of citizens was 2.7 in the Czech Republic, 2.7 in Hungary, and 2.1 in Poland (Chelleraj et al. 1996).
3. The institutions emphasized in these accounts did not play an important role in the three cases considered here. Presidents had little veto power, referenda were uncommon, and smaller coalition partners did not often block policy changes.
4. One of the conditions for getting a place in state administration was signing a declaration that one approved of the Soviet invasion in 1968. This was a hard pill for most Czechs to swallow. Meanwhile vocal supporters of the Prague Spring were removed from their jobs.
5. Healthcare was mainly under the jurisdiction of the two constituent halves of the federation. Thus, Czech officials were making policy for the Czech lands and Slovaks for the Slovaks. Interestingly, the Slovaks mainly followed the Czech lead in designing their system. Slovakia also featured a dominant but porous party, Public Against Violence (VPN).
6. For these reasons, some have argued that the system fits the Bismarckian model more than the private insurance model. Nevertheless, the system was qualitatively different from the Hungarian and Polish models and did feature greater private ownership and at least some competition.
7. Interview with Jan Jaroš, Prague, 9 September 2000.
8. This reflects the large ideological divisions within the Solidarity union.
9. Also important was the power of large regional teaching hospitals around which the reform was built.
10. Another factor standing in the way of change was the entrenched system of gratuity payments. Influential doctors who profited from these payments were leery of any reform that had the potential to eliminate them. The negative experience of the Czech Republic also influenced policymakers.
11. The communist party leader Janos Kadar famously proclaimed, 'He who is not against us is with us.'
12. The system is intended to encourage doctors to find the most cost efficient way of treating a patient.
13. In fact, non-contributors were rarely denied care.
14. This did not prevent the self-government of the Health Insurance Fund from developing a reputation for corruption. It appeared that union representatives were accepting kickbacks for contracts and new purchases. The self-government's reputation suffered enough that the conservative government elected in 1998 was able to eliminate it.
15. Interview with Eva Orosz, Budapest, 14 March 2000.
16. The public has played a much more active role in opposing proposed restrictions on coverage, introductions of copayments, and closures of healthcare facilities.
17. The recent introduction of copayments in the Czech Republic and Hungary has aroused extreme controversy and their future is uncertain.

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