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Politics and Institutions in the Reforms of Health Care in the Czech Republic, Hungary and Poland

Abstract: The article discusses main developments in the organization and financing of health care in the Czech Republic, Hungary and Poland. These countries exemplify different approaches to health care reform and different processes of institutional change of health care systems. The article charts main policy developments and offers explanation of dynamics of changes. It emphasizes the role of politics and broadly understood institutions, which are often neglected in the literature on health care reform in the region. It is argued that political institutions, party politics and rivalries within the governments influenced the scope and timing of policy changes. Institutional changes were also affected by the patterns of interest representation and organizational and normative developments that resulted from decisions and non-decisions taken in the past.

Keywords: health care reform; politics; the Czech Republic; Hungary; Poland.

Introduction

Health care figures prominently on the political agenda around the world. In the post-communist countries of Central Europe it takes on similar political importance, replacing earlier preoccupation with major political and economic reforms. Health reform process in these countries exemplifies, as elsewhere in the world, a mix of change and continuity. The direction of reforms was fairly similar across countries. In most of them hierarchical state-run structures were replaced by compulsory health insurance and plurality of organizational forms in the health care delivery. However, there were marked differences in timing and scope of reforms. While some countries started radical reforms early in the transition, in other countries major changes were initiated with significant time lag. In this article, the focus is on experiences of the Czech Republic, Hungary and Poland. These countries advanced fast with major economic reforms and experienced rapid economic recovery. At the same time, they exemplify distinct patterns of health care reform with apparent convergence of the reform direction in the end of 90s. As I will argue the timing of reforms was influenced mainly by political developments. Still, the policy change was affected not only by laws and regulations, but also by beliefs and practices within the health care field. In particular, non-decisions reinforced informal institutions and provoked spontaneous bottom-up adaptation processes, which are particularly well seen in Poland. This resulted in a situation of "change without reform." An important role was also played

by the professional dimension of changes; an aspect that is often neglected in the literature on health care reform in the region.

Changes in the Financing System

Health financing is the most visible and most debated element of health care reform in the post-communist countries. The Bismarckian system of social health insurance was the model followed by most of the post-communist countries. The change was motivated primarily by the will to reduce the role of the state and break with the legacy of bureaucratized and unaccountable structures of existing system. In most of the countries single insurance funds (e.g. Hungary, Estonia, Slovenia, Lithuania, Bulgaria) were established. Some, including Czech Republic, Slovakia and Latvia, opted for a decentralized design of plurality of funds or regional funds (e.g. Poland until 2003, Romania). Although insurance contributions based on earmarked taxes are the main source of funding, the central governments still play important roles in these systems. They contribute to the health insurance budgets and usually exercise strong control powers over insurance institutions. Scope of benefits remained generous in most of the countries and insurance is weakly linked to the occupational system. That's why some of the emerging systems can be more properly described as situated in-between pure social health insurance and national health service models.

The most radical changes in financing arrangements were introduced in the Czech Republic. The state-owned insurance fund: General Health Insurance Company (Všeobecná zdravotní pojišťovna, VZP) and compulsory insurance based on employer-mandated payroll tax were established by law 1992 (see: Boncz et al 2004, Rokosová and Háva 2005). In 1993, VZP was subjected to company law and competition. Up to 26 health insurance funds emerged, including funds for employees of large companies and funds for specific occupational groups. After the wave of bankruptcies and mergers, their number decreased to 9. The system soon started to produce unsustainable rise in health expenditures, mainly due to the payment mechanism based on fee-for-service schemes. In 1997, cost containment measures practically abolished the competition between insurers. VZP has dominated the market. It insures large majority of the Czech population and is equipped with fiduciary responsibilities, such as receiving contributions for most of the non-wage earners. Large deficit of VZP, which led to delayed payments and indebtedness of health care institutions, has been a major problem of the financing system. Deficit was partly covered by the government in 2003 and 2005. Direct intervention of central government into financial management of the VZP was also tried.

In Hungary, social insurance started to operate separately from the central state budget since 1990 (see: Gaál 2004). The Social Insurance Fund, established in 1989, was split in 1993 into two separate funds for health and pensions, which gained relative autonomy. The introduction of health insurance did not change much, as health services continued to be financed by global budgets established mostly on a historical basis. Still, financing system was increasingly performance related. New financing

methods based on listing of specific medical procedures in in-patient care were introduced gradually. Financing of out-patient services has been solely based on the activity data since 1999. The Health Insurance Act of 1997 introduced rationalization and cost containment of the system. Heavily regulated system does not allows for much of the competition; selective contracting and purchasing is not permitted and the contracts are often only formal exercise (Robinson, et al. 2005: 35).

The Polish experiences contrast with the cases of Czech Republic and Hungary (see: Kuszewski and Gericke, 2005; Włodarczyk, 1997, 2003). Until 1998, health care was basically financed from the state budget. Health insurance law was adopted in 1997 and, after substantial revision of the law in 1998, 16 regional "sickness funds" (kasy chorych) were created, together with additional "branch fund" for employees of so called uniform services (policemen, railway workers etc.). They started to contract services financed from insurance contributions levied as share of the personal income tax. In 2003 sickness funds were replaced by centralized institution: National Health Fund [Narodowy Fundusz Zdrowia, NFZ], which became under strong control of the minister of health. The governance structure of NFZ was changed in 2004 following the ruling of the Constitutional Court ruling that judged the health insurance law to be unconstitutional. Sickness funds experimented with different methods of payment. Centralization did not bring much change initially, as sickness funds were simply renamed into regional branches of NFZ. However, the payment methods have been gradually unified and became more sophisticated. Mainly due to the generous benefits package and lack of rationalisation of hospital network, the system is permanently under-financed.

Reform measures are reflected in the patterns of health expenditure. OECD estimates show that some 6% of GDP was spent on health care in Poland in 1991, while this share was 7% in Hungary 4.7% in the Czech Republic (OECD 2007). In the 90s, the level of health expenditures was fairly stable in Poland. In contrast, Hungary and Czech Republic faced substantial increases. By 1994 Hungary spent 8.1% of GDP on health and in the Czech Republic they reached peak 7% in 1995 and started to rise again in 2000. In Poland health expenditures were kept low mainly due to preservation of the system based on funding from the state budget. They were also crowded out by pension spending, which was at the level of 14–16% of GDP in the early 90s, compared to 10–11.5% in Hungary and 7.5–8.2% in Czech Republic (Orenstein and Haas 2005).

A closer look at the structure of health expenditures reveals that health financing in Hungary and Poland was substantially privatized. In the Czech Republic, private expenditures increased from estimated 2.6 to 11.4% of total health expenditures between 1990 and 2005. In Hungary, private expenditures comprised 10.9% of the total in 1991 and their share reached the peak 31% in 2000. In Poland, private expenditures jumped from 8.3% in 1990 to 24.4% in 1991 and then increased slowly up to 30% in 2000. Given the limited scope of private insurance, private expenditures comprised primarily of out-of-patient payments. Their growth can be explained mostly by increasing expenditures on pharmaceuticals. For example, according the World Health Organization estimates, private expenditures comprise more than 60% of total expenditures on pharmaceuticals in Poland, much above the European standards. Private

expenditures comprise, however, also estimates of informal under-the-table payments (Lewis 2002; Allin et al 2006). These kinds of payments, common in under-developed health care systems of low-income countries, are significant element of health care financing in Hungary and Poland. They reflect the adaptation of patients and health care professionals to the vacuum that resulted from the lack of political decisions concerning the key dilemmas of health care reform. Non-decisions reinforced set of beliefs and expectations that suggested the appropriate and effective ways to act in health care domain. The resulting practices had important implications. They raise serious equity concerns. They also affect the political feasibility of reform proposals, as they create entrenched interests within the health care system.

Changes in the Delivery of Health Services

While financing has been at the centre of political debates, significant changes took place also in the organization of health provision. Here, decentralization and privatization were the leading themes of reforms. Ownership of health facilities was decentralized and local governments became responsible for the maintenance and capital costs of their health care facilities. In few cases, partial responsibility for financing was also transferred to municipalities (Bulgaria, Estonia, experiments in Poland). Privatization progressed first in dental services and pharmaceutical sector, and to some extent, in the primary care. The primary care stood out in the reform rhetoric, because of the will to offset the legacy of the socialist regime, in which health services and health care manpower were oriented towards more expensive specialist and hospital care. In contrast to primary care, restructuring of hospitals in the countries of the region did not occur as fast expected (see Jakab et al 2002). To make contracting systems viable, state-owned hospitals were given special status of public non-profit organizations. Still, responsibilities of owners of facilities (e.g. local government) and payers were often not clearly defined. Both on central and local levels, politicians were reluctant to let the considerations based on efficiency and effectiveness have greater role in directing funds or decisions that would limit excess capacity.

In the Czech Republic, primary care and some specialized services experienced rapid privatization stimulated by the introduction of free choice of general practitioners and, since 1992, direct access to ambulatory specialists. By the end of 1993, about one-third of all general practitioners moved from salaried public sector employment to private practices. Despite the announcement of mass-scale privatization in the early 90s, most of the hospitals remained in public hands. Major restructuring measures were introduced in 1997, when they were reorganized into new regional health care facilities network. While initially funds were obliged to contract services with every hospital, a special governmental program was launched and upon the recommendation of government, the VZP could restrict number of contracting institutions. As part of administrative reform, ownership of hospitals was transferred to regional self-governments and municipalities in 2000. Although the number of hospital beds was gradually reduced, it is still much above the European average. Majority of hos-

pitals have financial deficits that resulted mostly from the bankruptcies and financial difficulties of the insurance funds. More recently, debts accumulated because of the payment caps and limited possibilities for discretionary allocations from the state budget.

In Hungary, ownership of most of health facilities was transferred to newly-founded local governments in 1990, which became responsible for their maintenance and investment costs. In 1989 the government decree on private social and health enterprises authorized private medical practices. More popular way of strengthening the private sector was, however, so called 'functional privatization' scheme, in which self-employed family doctors worked in facilities and on equipment owned by local-governments (Orosz et al 1998, 245). By 1996, some 75% of primary care physicians were self-employed or worked in private partnerships. Privatisation policy was reinvigorated in 2002, when the state started to subsidize purchase of property and equipment by general practitioners. The plans to privatize hospitals were abandoned in 1992. To remedy the problem of excess capacity centrally planned approach was tried first. In 1995 four-member committees were set up, which determined maximum bed capacity for each hospital. Their decisions resulted in massive protests and the whole program failed. Next year, county-level standards were defined by law and so called, consensus committees were set up, grouping major stakeholders to decide reductions. As the result, some 12% of the total number of beds were closed in 1996 (Orosz and Halló 2001). New wave of hospital reform initiatives followed 2002 elections. The Fidesz government, which was ousted by socialists in the elections, had already allowed turning hospitals into non-profit trusts. However, it placed limits on participation of private capital. New government proposed to abandon restrictions on privatization to bring additional resources for the modernisation of hospitals, of which many were on the verge of bankruptcy. The new law was annulled by Constitutional Court, however, due to mismanagement of parliamentary procedures. 65% voted against privatisation in the national referendum in December 2005, but it was rendered void by low turnout of mere 24% of eligible voters.

In Poland, the crucial legal backbone of the organization of health services: the act on health care institutions was adopted in 1991. It envisioned the transformation of existing organizations into new organizational form of public "self-governing" institutions, equipped with managerial and financial autonomy. The law made it also possible to separate funding from provision and contract private services from the public funds. Still, number of government ordinances needed for full implementation of its provision was issued with delay; First new autonomous organizations were created only in 1993–1995, the process fuelled by the pilot decentralization of the responsibility over health care to local governments of the largest Polish cities. Worsening situation of the state budget in 1990 and relaxed law enforcement in health care led to the institutionalization of the set of beliefs and expectations of patients and associated templates of inter-organizational linkages. Private sector of ambulatory care grew in importance. The essence of the private sector activity of those physicians, who were well positioned in the public health care institutions, was inasmuch provision of the service, but facilitating access, offering guidance or securing better

quality care of public sector services (Tymowska 1999). The major wave of organizational change accompanied the introduction of health insurance in 1999. Out-patient services benefited from the functional privatization, analogous to Hungarian one. The changes in the hospital sector appeared to be more difficult. Although hospitals obtained greater managerial autonomy, there were no radical changes to their logic of operation. Many local governments were reluctant to support radical decisions, while the government failed to provide sound regulatory framework for such changes and strategic direction. When the revenue received from sickness funds and NFZ did not match the expenses of hospitals, they started to accrue debts of substantial value. In 2004 low interest government loan established by law helped to mitigate the problem in the short term, while more radical measures, which aimed at restructuring of the hospital sector, were rejected by the parliament.

Changes on the supply side of the health system are difficult to compare quantitatively. Different patterns of utilization of ambulatory care in three countries were preserved in the transformation period. The annual number of consultations per capita, for example, is significantly higher in the Czech Republic and Hungary than in Poland. In the hospital sector, bed capacity fell dramatically. Czech Republic reduced the number of acute beds gradually from 8.7 acute beds per 1000 population in 1987 to 5.7 in 2005 (OECD 2007). In Hungary, it started to fall from 7.1 in 1994 to 5.5 in 2005. In Poland, the decrease was smaller: from 6.1 in 1989 to 4.7 in 2005, but started from much lower value. At the same time admissions increased in all three countries, the process that followed changes in payment methods and likely over-reporting of admissions by providers. Substantial decrease in average length of stay was also noted. In Poland, it declined in the acute care from 10.1 days in 1998 to 6.5 days in 2005. The decrease was more gradual in Czech Republic (from 12.8 days in 1989 to 8 days in 2005) and Hungary (from 9.9 to 6.3 days). These changes resulted from organizational reforms, increased efficiency and introduction of new therapies. Important role was played by changing contracting arrangements and associated incentives for organizational behavior. In the Czech Republic and Poland, for example, introduction of fee-for-service payments for hospital services has resulted in dramatic increases of admissions, a trend that partly offset shortening length of stay and reduced bed capacity. General pattern of state regulation in all three countries is evolution towards the rationalization of the purchasing function by introduction of more sophisticated methods of payments (see: Langenbrunner et al 2005). This rationalization still concerns mainly cost considerations. Less attention has been so far given to the quality of services, effectiveness of medical technologies or the priority setting activities.

The pace of institutional change in ambulatory and in-patient care diverged. As a consequence of governance and ownership changes, the health care system became more fragmented. There is growing understanding among experts that modern health care delivery requires more integrated approaches and new thinking about the interactions of ambulatory and hospital care that would secure continuum of care and could reduce transaction costs. In response, there appeared attempts to provide incentives for integration of hospital and ambulatory care. In Hungary, for example pilot managed care programme was introduced in 1998 and expanded in 2004, which

opened the possibility to contract population-based packages of full range of health services.

The Politics of the Reform Process

Experiences of health care reforms in post-communist countries show that opening period of transition can be described as a specific critical juncture that set countries on specific paths of health care reform. The literature on the democratic transitions emphasizes in particular the importance of first democratic elections, which were particularly consequential. It is believed that these were initial choices that resulted in virtuous or vicious circles of the transformation and post-socialist diversity (Ekiert 2003). Making inferences from limited set of case studies is troubled by many methodological difficulties. Including broader pool of post-communist countries is not a solution, however, as number of contextual factors, related for example to different macroeconomic conditions, would need to be taken into account. In three cases discussed in this article, it appears that in health care reform process, the role of political institutions shows off clearly at the outset of the transition. In the Czech Republic and Hungary, concentration of authority and longevity of governments and parliaments enabled instituting health insurance, while it stalled health care reform in Poland. It can be hypothesized that important role was also played by the salience and approach of first governments to social policy issues.

What distinguishes the Czech Republic of the early transformation period was a clash of neo-liberal views of the finance minister Vaclav Klaus with social democrats grouped around the President Vaclav Havel, which resulted in social-liberal policy mix (Orenstein 1995). As Orenstein argues, the blueprint of reform was a compromise between the proponents of system that guaranteed universal access to relatively high standard of health services and those who argued for radical privatization (Orenstein 1995: 187). The reform process was facilitated by the relatively high cabinet stability. The government of Ĉalfa, formed after first democratic elections of 1990 lasted until 1992, the year in which crucial health insurance was adopted and the final year of existence of Czechoslovakia. Next two cabinets headed by Vaclav Klaus, the leader of Civic Democratic Party, the off-shot of disintegrated Civic Forum (1993–1996 and 1996–1997) promoted privatization of health services and introduced competition between health insurance funds and, in its second term, introduced cost containment and rationalization measures. Relatively low level of political polarization made it possible for governments to gain cooperation from opposition parties in the parliament.

In Hungary, political conditions were also relatively stable. Despite decreasing popularity and political splits, the coalition government elected in the first democratic elections served for full four-year term in office. Transition to health insurance was decided prior to the democratic elections. First democratic government continued with this policy and avoided more radical reforms. Socialist-liberal coalition formed after the 1994 elections introduced broad austerity program, which included substantial changes to welfare state arrangements and cuts in welfare benefits. Since then, cost

containment became the priority in health care, the policy pursued also by the next government headed by Victor Orbán (1998–2002), which promoted centralization of control over health care finance.

In Poland, early years of transition were characterised by substantial political instability and fragmentation, which contributed to the volatility of health reform ideas (Bossert and Włodarczyk 2000). Government of Tadeusz Mazowiecki elected in semi-democratic elections of 1989 lasted until 1991. Governments formed after elections of 1991 did not have strong parliamentary support. Only in 1993 the political conditions became more stable. Still, for most of the 1991–2005 period Poland was ruled by minority governments. In contrast, first three cabinets in Hungary survived until scheduled elections and so was the case with Czech Republic (with exception of short-lived minority government of Vaclav Klaus). Moreover, questions of the reform of the welfare state were largely absent from the political agenda of first governments in Poland. It was assumed that broader reforms of the welfare state can wait until basic measures of economic recovery are introduced. Social policy was viewed primarily in terms of providing a cushion for the shock therapy and therefore health policy was overshadowed in importance by unemployment benefits, assistance to the poor and changes in the pension scheme. This contrasted with the experience of Czech Republic, where the liberal programme of the Vaclav Klaus as the finance minister needed to be compromised with the social democratic camp or the case of Hungary, where economic stabilisation was more gradual.

It can be argued that complex institutional reforms, such as health care reform need political stability and sustained effort. The literature on the post-communist transformation shows, however, that the relationship between political stability and reforms is complex. The argument goes that power sharing and fragmented party systems help to resolve emerging social conflicts and make reform efforts sustainable by alternating power. Diverse, fragmented political coalitions disciplined by frequent elections and political competition helped to prevent the concentration of power and situation of stalled partial reforms (Hellman 1998). Polish case is often quoted as an example of such beneficial situation (Orenstein 2001). Experience of health care reform appears to contradict these views. Consequences of political instability and fragmentation for policies that require policy co-ordination, more long-term and structural change such as health care reform were mostly burdensome. Political instability is also consequential for the sustainability of reform efforts. After the introduction of major changes in Poland in 1999, for example, the coalition government broke down and minority government was unable to introduce much needed corrections to the sickness funds' system.

Executive Rivalries and Administrative Capacity

Power relationships within executive are the second major fact that can help to explain the dynamics of reforms. Social policy in the early years of the transition was mainly dominated by small groups of domestic experts, who were to a large extent insulated

from the political process (Orenstein and Haas 2005). Different access to the strategic decision-making and variability in expert views contributed to haphazard and unpredictable policy developments. In Poland, for example, the discussion on health care reform in the first years of the transition was stalled partly because of the divisions in views of the narrow group of experts. Later on, patterns of relationships within executive, in particular between the ministries of finance and ministries responsible for health started to play important role in the policy developments. Reform ideas of the ministers of health were either blocked by ministers of finance, who saw the reform as a potential source of financial problems, or failed to emerge due to inability to agree and coordinate the work of different ministers. Compared to the situation in the advanced liberal democracies, the pattern of executive dominance was weakened by the underdevelopment of professional civil service and lack of parliamentary discipline. On the other hand, it was strengthened by the lack of clear programmatic stances of political parties, their lack of expertise and weakness of civil society organizations.

In Hungary, reform process was initially made smooth by the continuity of expertise. In 1987, health care reform secretariat was established at the Ministry of Health and Social Affairs. The head of the Secretariat became the permanent Secretary of State in 1990 government and number of experts working on pilot projects remained in office. What stalemated reform efforts were rivalries within the executive and lack of intra-government coordination. Reform process in first years of the transformation was described as haphazard, dominated by short-term political interests and play of power relations, mostly through bargaining between ministries and insurance fund (Szalai and Orosz, 1992: 163–164). In Poland, weak administrative capacity of the ministry and weak position of the minister of health within the government is crucial for understanding policy failures. Finance ministry was able to block decisions that would lead to increases in health care budget and could influence heavily specific financial arrangements. At the same time, ministry of health failed to issue regulations of good quality. Important role was also played by decentralization. It made local governments important stakeholders, which were usually not interested in rationalizing the existing health infrastructure. Diffused responsibilities within the public administration hampered the ability to create coherent health policy.

The Professional Dimension

The role of medical profession and other stakeholders in the reform process is perhaps a most salient feature that distinguishes post-communist health care reform from similar efforts in advances welfare states. Paradoxically this aspect of institutional changes is practically absent in the literature on health care reform in the region. Health care reforms can be interpreted as attempts to change the evolving balance of power between professions, the state, patients and medical-industrial complex (Light 2000). The claim is often made that we have recently faced a move away from professional power towards strengthened role of the state or, in the case of United States, the reinforcement of the corporate rationalisers within medical-industrial complexes. In

post-communist countries attempt to redress the balance of power between the medical profession and the state was also central aspect of changes. However, while the institutional context in the West was about strong, although declining professional power, in post-communist countries, the reforms were about rising professional influence, but also, in many cases, creating professional bodies in the first place. The legacy of the socialist system was complex. Health professionals lost most of the attributes of the free profession, but it would be mistake to look at the socialist health care systems as fully controlled by the state. Physicians control over clinical matters was practically not challenged by the state administration. Moreover, position of patients in the system was weak and there were no accountability mechanisms that would put professional performance under the public scrutiny.

In all three countries professional self-government bodies were re-established around the date of the transition to democracy: in 1988 in Hungary, in 1989 in Poland, in 1991 in the Czech Republic. In addition to physicians and dentists, self-regulation was also extended to other health professionals. This included pharmacists, but also nurses and midwives (Poland, 1991) or laboratory diagnosticians (Poland, 2004). In Hungary, the Chamber of Non-medical Health Professionals was established in 2003. Professionals chambers were entrusted important functions, such as licensing physician practices or overseeing professional conduct. Although professional bodies played at times important role in policy decisions, they needed time to establish their position among medical professionals and were often unclear about their role as representative of interests of the profession. Their relationships with governments were often poor and marked by conflicts (Healy and McKee 1997). In Hungary, for example, they were seen by the government as the main opposition to health care reform and weakening their power is claimed to be prime motivation behind the law adopted in 2006, which terminates compulsory membership in medical chambers since 2007.

Much more visible actors were trade unions. Their role is perhaps most complex in Poland. Solidarity trade union had its medical section, which since the 80s opted for the introduction of compulsory health insurance with multiple competing insurance companies. Although important figures from this section occupied key ministerial positions they were unable to fully influence the direction of health reform. Next to the Solidarity movement, several trade unions of different health professionals and specialties of medicine existed. In the early years of transition new and more aggressive trade unions representing physicians were created, such as the Medical Union Club—Association of Czech Doctors, the Democratic Trade Union of Health and Social Workers in Hungary or All-Poland Trade Union of Physicians. Their emergence reflected the dissatisfaction of physicians with the performance of professional chambers and existing trade unions.

Contrary to the tradition of the Bismarckian social insurance, corporatist governance arrangements do not play important role in governing health care. The Hungarian experience is illustrative. Governing board of health insurance fund (Health Insurance Self-Government) was created in 1993. It comprised of representatives of employee associations, elected in national social insurance elections from trade

unions lists, and delegated representatives of employers. This corporatist experiment failed. The board was in constant conflict with the government over the deficit of the fund and was abolished by law in 1998. Health Insurance Fund was subordinated by the government. The board representing social partners was re-established in 2005, but with limited responsibilities. In Czech Republic organizations representing interests of professionals and providers, including medical chambers, participate in negotiations on the reimbursement tariffs and conditions of the service provision, which are then issued as government regulation for the health insurance funds. This kind of corporatist arrangements have been practically non-existing in Poland.

Especially in the early years of the transition, the leverage of professional self-governments and trade unions often relied on informal influence rather than formal position in the policy-making structures, which makes it difficult to judge their real role in the process of health care reform. It is argued, for example, that health professionals assumed key positions in expert groups of the Civic Forum, the ministry of health and the parliament and their influence was central to the instituting of change through parliamentary legislation adopted in 1991 in Czechoslovakia (Jaroš et al 2005: 207). On the other hand, in Poland and Hungary, health professionals failed to act as unitary actors and influence the direction of reform. Important and growing role was played by divisions on the basis of type of employment, specialty or profession (Nelson 2001). The trade unions' scene was most divided in Poland: firstly into two main competing trade union structures: Solidarity and All-Poland Trade Unions Agreement (OPZZ) and secondly into smaller trade unions representing various segments of health care workforce. Due to diverse economic interests of health care employees, trade unions had serious problems in cooperating and presenting a unified position vis-à-vis government. The divergence of the interests and influence of specific groups of professionals and specific type of providers, e.g. hospitals, specialists, general practitioners is a common trend in all three countries. This is unsurprising in the light of international evidence, which shows that this kind divisions trouble even the most established professional organizations in the world (Krause 1994).

Despite substantial differences in health expenditure trends, there is a common discontent with the level of funding. Wages of health professionals are seen as disproportional and are much lower than in countries of Western Europe. Even in the Czech Republic, where the increase of public health expenditures was substantial, the changes were seen by the profession as too slow and not particularly successful. In 2005, the Czech Medical Chamber demanded doubling the average monthly salary of physicians. In Hungary, strikes and protests of health professionals are recurrent themes in the media. Under this pressure, the pay of public employees, including health professionals was increased by 50%. The strikes and protests are even more salient feature of health care politics in Poland, where waves of strikes appear regularly from 1996. For example, mass protest was staged in 2003 of primary health care physicians operating under the newly founded representation of family doctors "Zielonogórskie agreement" [Porozumienie Zielonogórskie]. In May 2006, a nationwide protest of was staged in Poland by trade unions, which demanded an immediate 30% pay rise for healthcare employees and an increase in public health expenditure

to 6% of GDP. Interestingly, despite the decentralization and transition to health insurance, which assumed decentralization of wage bargaining, the central government remained to be main addressee of demands.

Disscussion

All three countries appear to be set on the self-reinforcing path of change. In all three countries the reform was about long process with episodes of major legal changes rather than single event. The process tended to follow similar cycle, in which the major policy change was followed by the partial reversal and incremental rationalization. Still, the developments in specific policy streams, such as reform of the financing system or hospital reform, were not complementary. As I showed, the reforms failed to address some key fundamental issues. Most importantly, in all three countries the growing costs of services are not matched by sufficient public funding. Hard political decisions are needed that would realistically define the public and private roles in financing. As I argued, the understanding of the reform process requires not only the knowledge of the reform blueprint, but also the institutional constraints of the health care field, which include organizations and set of institutional logics that influence their behaviour. It is also necessary to take into account the developments in the political system, which creates additional constraints on the reform process.

In most post-communist countries, public opinion polls reveal continuing discontent with the functioning of health services. The popular dissatisfaction, together with the visibility of strikes and protests of health professionals make health care reform a contentious political issue. In fact, politicians and experts call for new reform measures. In the Czech Republic government declared that competition between funds should be reintroduced and that they should be transformed into joint stock companies, which would be in line with liberal declarations of the early 90s. In Hungary, health insurance fund is to be replaced by regional funds, in which private companies will be permitted to acquire minority shares. Poland appears to take more incremental approach of delimiting the basket of services that is financed of health insurance, introducing supplementary health insurance and rationalization of hospital network. However, some trade unions and politicians in Poland call for more radical liberal changes, as well.

As I argued, the key factor that contributed to the stalemate over the health care reform was the lack of concentration of executive power and fragmentation of the political system. This factor distinguished Poland from countries that instituted health insurance early in transition, such as Czech Republic or Hungary. Inclusion of the broader arena of health care sector offers additional explanations for the pattern of regulatory changes. Although professional chambers were instituted early in the transition and were given important powers, they faced substantial problems in overcoming divisions in the professions and find a common denominator of complexity of interests they represented. Unlike their counterparts in advanced liberal democracies, they could not count on institutional traditions. At the same time they

face the same challenges that endanger the logic of professionalism, such as growing specialisation and increased media exposure of malpractices. The weakness of representations of medical professions was an important obstacle in the reform process. What is missed in the discourse of reform is the major problem in health care reform is inasmuch a choice between market and the state, but ability to strike the balance between market forces and entrepreneurial activity, state regulation and stewardship, and professional control exercised by self-governing professional bodies. The state, often uneasy about its role, remained to be the dominating actor of the health arena in Central and Eastern Europe, with limited powers accorded to employers and employees, as well as sectoral actors, which are traditionally involved in governing health care in social insurance systems. The relationships between representations of professional interests and the sphere of politics was characterised by conflicts, rather than cooperation. It followed peculiar pattern: only after the open conflict erupted, the negotiation with a given professional group started and the government was often interested in overcoming a crisis, rather than finding more long-term solution. Medical professionals, on the other hand, often presented unrealistic and radical demands that could not be met.

The process of institutional change in three countries shows the significance of timing and complementarities of various policy measures. The inability of politicians to make decisions in the early 90s contributed to number of spontaneous and unplanned developments and brought dissatisfaction of both public and medical profession. The culture of utilization of health services and informal patterns that emerged under the socialism survived the collapse of the regime and started to play increasing role in the 90s in Poland and Hungary. Problem of limited health care budget was left to be solved by providers of health services and patients themselves. This approach, in which difficult political decisions were avoided, had adverse consequences. Excessively relaxed regulatory framework led to corruption and growth of informal markets for health services within the public sector. This has led to a pattern of "change without reform" reflected in the sharp increase in the private financing of health care, which was not matched by the privatization of health care delivery. This contrasts with the case of Czech Republic, where detrimental tradition of corruption in the health sector was weaker and where there was a radical break with the legacy of socialism. On the other hand, radical change in Czech Republic shows the problems that are created by too liberal changes, in which the issues of institutional design and proper role of the state regulation were disregarded.

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