

IPF Public Health Working Paper No. 2002-01

Dist.: July 2002

English text only

**The Politics of Health Sector Reform in Eastern Europe:
An Actor-Centered Institutional Framework for Analysis**

by

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Acknowledgements

Earlier versions of this paper were presented on the Conference “European Welfare States: Dynamics and Patterns of Change, Challenges, Institutions and Actors”, Sandbjerg Castle, Denmark, May 2-5, 2002 and on the 12th OSI IPF Seminar, Budapest, Hungary, June 5, 2002. I am grateful to participants of these events for their helpful comments and critique. I am also grateful to Martin Heipertz and Dale Hsieh for their valuable suggestions on an earlier draft of this paper.

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Preface

There is little evidence that health sector reform of the last decade in Eastern Europe led to substantial improvements in the health care sector. On the contrary, the adopted Western ideals of privatisation, decentralisation and competition policies coupled with the ineffectiveness of existing health sector arrangements resulted (in different countries to different extent) in escalating health sector expenditures, overuse of services and growing health inequalities. It is, however, not surprising that reformist policies failed to bring substantial improvements in the health care sector.

On the one hand, it is difficult to acknowledge the actual effectiveness of those policies even in Western countries initiating them. It is, therefore, unclear whether the *process* of health sector reform in Eastern Europe was predominantly driven by objectives of health sector improvements or by any other factors. For example, political values of freedom and individualism associated with free market competition and democratisation or, benefits from the implementation of particular policies such as legitimisation of the political power. It is also unclear whether architects of health sector reform in Eastern Europe had a long-term view on reform and whether the outcomes of health sector reform were intended.

On the other hand, even when the most technically-effective and cost-contained Western policies were adopted, they could not work successfully in Eastern Europe if no credence was given to the *context* in which they were implemented. When policy-makers look across national borders for “best” policies, they are inclined to “pay more attention to what appears to work, not academic reasons for what is and is not transferable and why” (Marmor, 2001, p.15). As such, policy-makers in Eastern Europe could not pay attention to a lack of institutional capacities to implement, manage and sustain health sector reform. Also, little attention could be paid to existing institutions which substantively constrained and counteracted reforms.

Despite the importance of the *process and context* of health policy reform, studies of such reform have erroneously been focused primarily on the technical features of policy content (Walt and Gilson, 1994). It was disregarded that a study of the process and context of health policy reform could provide insights into factors that influence the choice of particular policies by decision makers, the ultimate success of the implementation, and why the desired results failed to emerge or even why the emerged results were coveted. More specifically, such a study can shed light on the factors that drive a transfer of health policies across national borders and affect transferability and applicability of these policies under specific institutional constraints of a given country. There is, therefore, a glaring need to study factors such as political power and interests of different agencies, pressure groups and other policy actors (at the sub-national, national and supranational levels), political, legal and social institutions that structure their interaction as well as the overall legitimacy of the policy-making system in terms of its capacity to reach good choices.

In applied health policy literature, however, little attention is paid to political challenges of health sector reform agenda and implementation. It is widely disregarded that behind any new policy there are individual and composite actors with conflicting interests and that the process of policy implementation represents a

political struggle between those actors over symbolic and material resources. For example, Reich (1997) points out that the World Development Report of 1993 contains seven chapters on the content but only five paragraphs on the process of health sector reform. Similarly, the World Health Report of 2000 disregards how politics shapes problems and affects reforms; the World Health Organisation (WHO) makes its recommendations “as if health sector reform occurs in a political vacuum” (Hsiao, Roberts, Bergman, Reich, 2001, p.70). As a result, many well-designed policies of the World Bank and the WHO proved to be ineffective or, have never been implemented at all. In agreement, Orosz and Burns (2000, p. 39) in their seminal OECD paper on health sector reform in Hungary acknowledge the importance of the politics of health sector reform:

...the recent history of healthcare in Hungary is wrought with conflicts between different agencies and care-giver interest groups. A major challenge will be to introduce reforms in a way that reduces these... [conflicts] and increases co-operation between agencies.

Notwithstanding the importance of conflicting interests in health policy implementation, “[t]he tendency to overlook implementation issues,” argues Marmor (1994, p. 217), “is not surprising, given how difficult, and unglamorous, it is to figure out the nuts and bolts of real programs—and how much more exciting for politician and policy analysts to bandy about big ideas”. Figueras, Saltman and Mossialos (1997) came to similar conclusions regarding the salience of the politics in health sector reform and a lack of research. Consequently, they argue that “a major priority [for health sector reform] research is the study of reform process, including aspects such as the effects of political and socio-economic environment or the distribution of power between key stakeholders in the health system” (ibid., p.17).

Having examined the methodology currently employed for health policy reform studies, Figueras, Saltman and Mossialos (ibid.) put forward an argument for a more multidisciplinary, analytical and comparative approach to health sector reform studies. Apparently, advantages of such an approach are as follows. One, comparative analytical studies of health policy reforms can lead to the explanation of what factors affect agenda and implementation of health sector reforms with the effect that health systems in different countries have different equity, effectiveness, efficiency and responsiveness to users’ needs as well as users have different varieties of choices. Two, multidisciplinary studies can shed light on different dimensions of health sector reform, giving us a more complete view of the logic and impact of health policy reform. More specifically, multidisciplinary study can help us to overcome “ironies” created by the former divergence of social and economic sciences (Lindenberg, 1990). One of these ironies is that those who studied decision-making situations did not pay attention to decision-making and those who studied decision-making did not pay attention to decision-making situations and to the fact that different actors can define the same situation in different ways (Lindenberg, 1993, p. 11).

In policy research, as it was shown above in the case of the WB and WHO documents, this irony resulted in that policy analysts felt that their job is done when a problem was identified and an appropriate policy instruments to tackle this problem were proposed. Policy outcome was considered to be the result of an action of the principal policy actor and his crafty manipulation of other actors involved in the policy process. The fallacy of this perspective of thinking about policy is best

demonstrated by the failure of the Clinton health care reform in the United States in 1993. More than 700 pages of well-design legislature were defeated in Congress and fueled a massive political upheaval as the administration did not take into considerations interests of employers and the health care sector as well as their ability to influence public debate and Congressional voting (Skocpol, 1995, Giamo and Manow, 1999). As such, a new perspective about policy needs to be formulated and applied to the study of health sector reform.

Contemporary political science has presented a perspective that can bridge the study between the decision-making and human decision-making situation. Borrowed from microeconomics, political science and sociology game-theoretic perspective can substantially refine our thinking about policy and therefore should be employed in policy analysis (Scharpf, 1997). The main focus of a game-theoretic explanation is on the interaction between purposeful actors. It is more likely that policy outcomes resulted not from an action of a principal policy actor but rather from a strategic interaction among purposeful policy actors who have different action orientations and capabilities to influence policy outcomes and who make their choices separately but with the awareness of the interdependence between their and the other actors' choices.

In my current research project at the Center for Policy Studies, I address the challenge of explaining the factors affecting feasibility of health sector reform in Eastern Europe through the study of process and context of health sector reform. In doing so, I focus on the strategic interaction between actors in health policy arena and institutionalised modes of the interaction and use a game-theoretic perspective to frame it. I also draw on the advantages of the comparative analytical approach as outlined above. Therefore, the project is designed as a comparative analytical interaction-oriented case study of the politics of health sector reform in selected Eastern European countries. In the first phase of the project, I introduce the topic of the politics of health sector reform in Eastern Europe, single out promising political science approaches to research into this topic and propose a framework for further research. In the second phase of the project, I will apply this framework to the comparative analysis of the politics of health sector reform in Hungary and the Czech Republic. In doing so, my attempt is to draw policy lessons for health sector reform design and implementation in Eastern Europe.

Abstract

The threefold purpose of this paper is to introduce the topic of the politics of health sector reform in Eastern Europe, to critically examine various approaches, theories and concepts of political science applicable to research into this topic and, using this critique, to suggest some promising lines of inquiry into this topic. The paper is organised as follows. It starts with the introduction of the topic. Then the significance as well as theoretical and methodological challenges for research into this topic are considered. It proceeds further by proposing and discussing an explanatory paradigm consisting of methodological individualism, game theory, rational choice theory and new institutionalism. On this ground, the proposition is made that the framework of actor-centered institutionalism provides a promising line of inquiry into the politics of health sector reform in Eastern Europe. It will not only allow to explain past policy choices but also to produce systematic knowledge useful for developing feasible policy recommendations and for designing institutions that maximise public good.

1. Introduction

There has been an intriguing controversy in the development of health care systems throughout Europe during the post-war period. In 1948, Britain was the first Western European country to implement a national health service (NHS). This was a health care system based on need and not ability to pay; it was free to the whole population at the point of use. The NHS was based on the universal collective provision of free-for-service at the point of use health care financed via general taxation. Following Britain, in the late 1950s and the 1960s, Sweden and later other Scandinavian countries launched their *de jure* and/or *de facto* national health services¹. During the 1970s and the mid-1980s, all Southern European countries followed this way. In sharp contrast, the years of political and economic transformation in Eastern European countries² have had a negative impact on national health services in these countries. Health care reforms³ instead of re-forming existing national health services fully or partially, dismantled them in favour of fee-for-service insurance-based health care systems. It is unclear why the reforms happened in this way. There is no evidence that the former centrally run and financed through general taxation health care systems are not viable under the conditions of democracy and market economy and are comparatively less efficient⁴. There is, therefore, a challenge to explain why Eastern European policy-makers instead of enhancing existing institutions deviated from a path-dependent way and came up with ineffective solutions for health sector reform.

¹ Here and later, I refer to the universal, i.e. covering the whole population, collective, i.e. financed via general taxation or social insurance, health care system as national health service. In doing so, I deliberately downplay the question of centralisation what allows me to put in one group such centralised national health service as the NHS and such locally run national health services as the Swedish or Italian ones.

² I use terms “Eastern European countries” and “Eastern Europe” to refer to countries of the former Eastern Block which are geographically situated in Central and Eastern Europe.

³ In this paper, I use term “reform” to refer to the process of changing national health sector arrangements in Eastern Europe, which is commonly known as “health sector reform”. I recognise that this way of describing change in national health sector arrangements arises from the political jargon. Although I stick to the common discourse, in my references to health care reform in Eastern Europe, I do not attach to “reform” any other meanings except of “change”.

⁴ For example, Norway, with effect from January 2002 onwards, is strengthening its centralised health care system by taking over the responsibilities of all Norwegian hospitals from local authorities to the central Government. Furthermore, the United Kingdom is not switching the source of funding of the NHS to social insurance but rather, with the perspective to 2020, considering allocation to the NHS of more funds raised through general taxation (Wanless, 2002).

During the pre-war period, health care provision in Eastern European countries were mainly modelled according to the so-called *Bismarkian model* or social insurance model. At the same time, this paradigm developed differently in various countries. For example, the Czech health care system was amongst the best in Europe and provided almost all population with health insurance. In contrast, the Polish health care system was highly fragmented and underdeveloped; more than two thirds of the Polish population were not insured (Marrée and Groenewegen, 1997). After the war, Eastern European countries adopted, with many variations, the Soviet-style *Semashko model* of health care provision. Under this model, provision of health care, as in the case of the above-mentioned NHS (also commonly referred as the *Beveridge model*), was both universal and collective⁵. It proved to be effective as well efficient. During the 1950s, health improvements in Eastern European countries outpaced those in most Western countries and by the mid-1960s life expectancy in Eastern European countries was only one or two years less than in Western countries (Barr, 1996, p.24). In the 1970s, however, declining effectiveness, efficiency and equity of national health services in Eastern European countries demonstrated a need for improvements in health care provision. Many Eastern European countries came up with proposals for health care reform in the 1980s; continuing into the 1990s, when transition to market economy and democracy began, none of the substantial changes in health care provision had yet been implemented.

In the beginning of transition, health sectors of different Eastern European countries faced similar challenges. For example, the health sectors were underfinanced, overstaffed, and misbalanced in favour of inpatient curative services. To address these challenges, Eastern European countries adopted more or less similar strategies; mainly, a switch of the major source of funding from general taxation to the compulsory contributory insurance, decentralisation, and introduction of the private sector while also promoting competition, and development of the private institute of the general practitioner. For example, in 1990 the deputy state secretary at the Hungarian Ministry of Social Welfare clearly stated priorities for reform: “We want to change the structure of the [health] system to create new facilities, new ownership circumstances, and involve more and more market elements” (cited in: Williams,

⁵ The difference between the Beveridge model and the Semashko model is that the former separates financing and providing of services while the latter simultaneously controls them.

1993, p.1093). The pace of reform differed among the countries. Hungary, for instance, was the first Eastern European country that came up with clear proposals for radical health care reform but implemented them slowly and to a less radical degree. Although the Czech Republic formulated its strategies for health care reform later and in less radical terms, it appeared to be the first country in the region that completed radical transition to the social insurance based system of health care provision. In Poland, despite the early fragmented privatisation of the medical health industry and the establishment of the private sector, the state deliberately slowed the process of health care reform. The Polish government promised to retain the publicly funded health care system in order to relieve hardship caused by economic liberalisation, also known as “shock therapy”, but it was only in 1999 when the final stage of reform was carried out.

Fee-for-service health care provision, privatisation as well as introduction of competition among insurers resulted in ineffective fragmented organisational structures and uncontrolled escalation in health care spending. It also created incentives for growing health inequalities between different social groups, between cities and rural areas, and for the division between health care and public health services as well as between different services of health care. For example, in the Czech Republic, privatisation of medical practice combined with the switch to the fee-for-service health care provision accounted for the over-prescription of medical services and generally increased national spending on health care compared to the pre-transitional period (Potucek, 1994; Scheffler and Duitch, 2000). Cost escalation was rapid, from 6.5% of GDP in 1991 to 9.5% of GDP in 1995 (Goldstein et al, 1996). Furthermore, 18 of 27 health insurance funds went bankrupt to the effect that now the state General Health Insurance Fund controls more than 80% of the “market”⁶. In Poland there were also no efficiency gains from introducing the quasi market in the health sector (Aksman, 2000) and, starting January 1, 2003, local health insurance funds will be centralised under the auspice of the National Health Protection Fund. In Hungary, created in 1993, the Self-Governments of Social Insurance proved to be a failure and were re-centralised in 1998 (Kahan and Gulácsi, 2000).

⁶ Data of the Institute of Health Policy and Economics, 2002.

The focus of the health sector reforms on funding and organisation coupled with a disregard to the delivery side seem to be a common pattern of health care reform in Eastern European countries. The delivery side of the health sector in general and the quality, quantity and proportions of different health services in particular, still need reform just as in the beginning of transition. Although in the course of transition the results of the early reforms were revised to the effect that the opposite strategies (nationalisation and re-centralisation) were opted for, reform of the reforms is still on the agenda. At the same time, de-democratisation of health sector governance—which resulted in the increased participation of various interest groups in health sector decision-making process, reallocation of decision-making functions and susceptibility of reforms to conflicting ideologies—dramatically reduced a problem-solving capacity of the health sector governance system. Therefore, feasibility and consistency of further reforms is in question.

The above insights into health sector reform in selected Eastern European countries demonstrate the significance of technically complex economic and social policy issues regarding health sector funding and organisation⁷. Although there is a view that, ideally, health care funding and organisation should not be ideologically or any other way biased (Barr, 2001, Ch. 4), in this paper, I take the opposite view, *viz.* the actual results of health sector reform in Eastern Europe are outcomes of political rather than technical process. Thus, in order to explain these outcomes one needs to reconstruct causal mechanisms of political actions and interactions through which the reform took place as well as non-political factors that shaped the political actions and interactions. Explanation of past events is crucial for finding feasible and effective options for future reform. Such explanation can shed light on process of interest formation and institution building in the health policy arena. Therefore, one can identify institutional constraints resulting from past actions and incentives built into new institutions. Furthermore, given the argument of path dependence⁸, past events could have initiated causations that have effects on the present.

⁷ It is important to be clear that my primary interest in selecting particular cases, i.e. Hungary, Poland and the Czech Republic, is not of nomothetic nature. Rather, I am interested in selected Eastern European countries *tout court* because they represent “crucial cases” (Eckstein, 1975, p.113).

⁸ It holds that individual preferences and consequent political changes are linked not only to institutions, but also to previous decisions and as time goes by, the probability of deviating from the current path decreases unless a ‘window of exceptional opportunity’ emerges (Wilsford, 1994).

2. Significance of the topic

Before I launch into the main purpose of this paper—to discuss how to explain outcomes of health sector reform in Eastern Europe—I believe it is necessary to clarify reasons why I chose this topic. The reasons are as follows. First, research into this topic has real-world policy implications; second, it attempts to make a contribution to the existent body of literature (King et al., pp.14-19).

With regard to the latter, *viz.* contribution to the existent body of literature, such a contribution can be done in three ways. One, the topic under consideration potentially addresses one of the agendas in recent literature on the comparative politics of the welfare state, i.e. sustaining and reinvigorating the tradition of treating development of welfare states as long-term, macro-historical process (Pierson, 2000b, p. 792). It aspires to fill a very important regional, i.e. Eastern European, void. In spite of the facts that developments of Western welfare states were influenced and stimulated by the relevant developments in the former Eastern Block and that recent welfare state reforms in this group of countries were inspired by the West, there has been done little comparative research on the region of Eastern Europe. My aspiration is to go beyond conventional area studies by comparing a number of cases and using an explicit theoretical perspective.

Two, there is a substantial imbalance in the literature on comparative politics of the welfare state in favour of the study of social security, pensions and overall welfare spending. The health sector is “often semi-detached from the wider literature on the welfare state” (Moran, 1999, p.1). Therefore, the study of the health sector aspires to redress the imbalance in the study of the welfare state. Variations in the health sector arrangements in different countries significantly structure social, political and economic life as well as contribute to substantial cross-national differences in life expectancy and quality of life. Because of this and also because of the fact that the health sector comprises a major part of social spending, many political and economic interests are vested in the sector of health care. Moreover, because of the strong requirements to enter the medical profession and divisions in the medical profession itself (e.g. Lewis, 1996), the health sector is characterised by the existence of a strong medical lobby and internal interest groups (e.g. Marmor and Tomas, 1972). As such,

the health care sector is rich material for political analysis which appeals for more research to be done.

Finally, research into the politics of health care reform in Eastern Europe aspires to go beyond the traditional scope of analysis in the comparative politics of the welfare state. Traditionally, political scientists focused on the effects of institutions and paid less attention to the origins and change of institutions (Pierson, 2000a). The topic of the politics of health sector reform in Eastern Europe provides a rich soil to combine examination of the origins and change of institutions of health sector governance with examination of their effects on health policy.

With regard to the second reason, *viz.* having real-world policy implications, research into the politics of health sector reform in Eastern Europe has a potential to address the real-world significance of this topic by “giving voice” (Ragin, 1994, p. 83) to this topic in Eastern Europe as well as in the wider international community. It attempts to draw policy relevant normative implications that could be used to increase understanding of this topic in public debate as well as to increase problem-solving capacity of the health sector governance system. Having discovered mechanisms through which the reform took place, one can see limits and inefficiencies of particular institutions in dealing with certain health policy problems. Being aware of these mechanisms, one can discover feasible institutional changes that can improve the capacity of the health sector governance system to produce effective solutions. On the other hand, it is difficult and costly to change institutions. As such, in the first instance, a primary concern should be with finding unexploited effective policy options within the limits of existing institutions.

3. Explanatory Paradigm

3.1 Methodological Individualism

There are two modes of explanation of social phenomena: methodological individualism⁹ and holism or determinism (social or historic). Broadly, in the history of social science, they correspond with “the more historical and interpretative Weberian tradition and the more strictly nomothetic Durkheimian tradition” (Mayntz, 1992, p. 29). The latter attempts to construct a grand theory explaining society as a whole and as a macro-system with many interdependent elements and their specific functions. In such explanations, actors are disembodied and represented by units such as classes or nations rather than individuals with flesh and bones. Although this holistic mode of explanation may be useful for construction of interesting theoretical conceptualisations of long-run societal developments, it has a little relevance to empirical policy research and to the explanation of particular policy outcomes in a relatively short time. On the contrary, the methodological individualism mode of explanation has a great deal of relevance to policy research.

The central tenant of methodological individualism is a bare fact that all social interactions are interactions among individuals. Methodological individualism asserts that a purported explanation only counts as an explanation if it is wholly couched in terms of facts about individuals (Lukes, 1968, p.122). Thus, methodological individualism prescribes to explain social phenomena in terms of individuals not other categories. As such, policy outcomes should be explained in terms of choices of individuals. However, in empirical interaction-oriented policy research, a unit of analysis is a set of interactions among policy actors usually represented by governments, ministries, trade unions, professional associations, political parties, etc. Such composite representation of individuals does not contradict with the above prescription of methodological individualism. The reason is that individuals also act

⁹ Here, the distinction should be kept between methodological individualism as methodology and individualism as ideology even though they are interconnected. To quote Friedrich von Hayek, “true individualism...is primary a theory of society, an attempt to understand the forces which determine the social life of a man, and only in the second instance a set of political maxims derived from this view of society” (Hayek, 1948, quoted in Arrow, 1994, p. 1). It is plausible to assume that the fact that health sector reform in Eastern Europe was driven by political forces with individualistic values makes a stronger case for applying methodological individualism to the study of this reform.

in a representative capacity and they have the ability to act from a perspective of larger units (Scharpf, 1997, p.61). At the same time, when it is necessary, analysis still should be focused on the level of individuals.

3.2. Game Theory

Apparently, methodological individualism does not attempt to formulate a macro-theory but still allows making limited generalisations that are essential for drawing policy lessons. These limited generalisations come in the form of mechanisms of human action and interaction. The way to describe these mechanisms is game theory. This is not a specific theory of social interaction but rather a “language” for such a theory (Arrow, 1994, p. 4). In short, in a game, each player chooses independently one strategy from a finite set of strategies available to him or her. An outcome or payoff of the game for each player is a function of the strategies of other players. Therefore, outcome or payoff functions of all players include interactions among all the players. An equilibrium outcome is an outcome in which players cannot increase their payoffs by unilaterally changing their strategies. Obviously, the optimising strategy for each player depends on choices of other players, but, naturally, human knowledge is limited. Moreover, although it is assumed that each player makes his or her choice individually and rationally, their rationality in reality is bounded and in making their choices they are influenced by social factors (Arrow, 1994, Scharpf, 1997). In other words, the game is influenced by social factors and rules of the game are socially constructed. Hence, in order to benefit from game-theoretic perspective, we need to take into account the bounded rationality of a human action and social factors that affect human behaviour. In the next section, I will outline political science approaches that can help us to do so, but first I digress to discuss how strict the assumption of rational choice should be.

3.3. Rational Choice Theory

Basic assumptions of rational choice theory—i.e. actors are always *a)* means-end instrumental, *b)* far-sighted and that *c)* effects of actions are intended—are functionalistic. In the functionalist analysis, explanation of institutional origins and change associated with health sector reform to be found in their functional consequences for those who created them. There are currently two that complement

each other's lines of arguments accounting for the insufficiency of such analysis. According to the first line of arguments advanced by Pierson (2000a), basic assumptions of rational choice theory, are too strict. It is argued that, in reality, institutional designers may not be instrumental, have short-term horizons and institutional effects may not be anticipated. It is therefore proposed that:

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

As the argument goes on, such contrast of antagonistic hypotheses or “theoretical imageries” (Jepperson, 1996; cited in Pierson, 2000a, p.495) is to “recognize that distinct bodies of theories may provide greater leverage for analyzing particular context and dynamics” and that

They may cover different aspects of process, with different theories contributing “modules” that can potentially be linked to produce more complete accounts (Scharpf, 1997) (Pierson, 2000a, p.495).

According to the second line of arguments advanced by Miller (2000), although functionalist premises about institutional origins and change are not defensible, emphasis should be put on “cooperation” rather than competition between rational choice and other forms of explanation. Miller's concern is that for rational choice such competition may result in the loss of policy arenas where it fails to provide ideal explanation. For Miller, the goal of the application of rational choice analysis to such arenas is explanation of inefficient or “dysfunctional” institutions through inefficiencies of the world of politics. For example, in the case of the Clinton health reform, the American political system did not allow to rational policy actors representing powerful interest groups to generate enough trust to co-operate with each other in order to design a more effective health system (*ibid.*). As in a prisoner's dilemma game, no one was particularly happy with existing arrangements but everyone decided to pursue his or her optimising strategy with the effect that the outcome of the game was inferior to some other outcome.

Albeit I do not share Miller's concern, I find his suggestion worthwhile to use rational choice premises in order to, *inter alia*, explain inefficiency of institutions through inefficiencies of politics. I recognise that it is one of the ways of looking at the problem of the institutional bias that may gain important normative implications. I am

therefore very sympathetic to the idea of proceeding with a research agenda premised on rational choice in order not to necessarily have the best explanatory model in the first instance but to have an insight into how inefficiency of politics accounts for the inefficiency of the health sector. Most important, I agree with Pierson's account on that distinct bodies of theory should be used to overcome the limits of rational choice theory.

3.4. *New Institutionalism*

When I started thinking why health sector reform in Eastern European countries did not bring substantial improvements to the health sector but rather overburdened the ailing economies of these countries with extra spending on health, I was puzzled by 'bounded innovation' (Weir, 1992) in health policy; political institutions channelled the flow of ideas regarding health care reform with the result that some ideas became increasingly likely and others increasingly unlikely to influence actual policy making. Recognising the role of ideas and expertise as a special resource in policy-making (King, 1999), I was amazed to see that national Governments were tempted to use them selectively and to enjoy the symbolic side of expertise (e.g. Meyer and Rowan, 1977). For example, in the beginning of the 1990s the Polish Government was willing to listen to advice in favour of radical liberal health policies but it kept its ears closed to more Fabian, in a sense "gradual", policies. The latter led to a dispute with the World Bank which, unlike in the case of the Czech Republic, strongly recommended that Poland postpone liberal health sector reform (Millard, 1994).

It was also equally puzzling to see how the democratic policy process influenced explicit articulation of interests vested in the health care sector and allowed various interest groups to exercise pressure on particular policy proposals. The most significant example is the interests of the medical profession. Many of these interests were articulated along the lines of pre-existing divisions in medicine, e.g. divisions between doctors and administrators, doctors and auxiliary staff, curative and preventive medicine, health care and medical industries, central and local health care organisations, age and gender groups within the medical profession. The medical profession in Eastern Europe might even be stronger than in the West because it has both the parliamentary as well as the ministry of health "veto points" (Immergut,

1992, p. 227). Unlike in the West, in Eastern European countries the health minister is often a doctor, as are many parliamentarians, and the ministry of health who could easily be the ministry of the medical profession (Barr, 1996, p. 27). The interests of medical profession in Eastern Europe are also unlike ones in the West. While early reformist Governments in Eastern Europe tried to introduce free markets in health care, the medical profession mainly was struggling to preserve centrally run and publicly funded health care for the sake of keeping all doctors employed and adequately paid. Later, however, new divisions in the medical profession emerged along the lines of profitability of particular medical specialities and along the lines of new approaches to administration and funding.

As evident from the above, political institutions can channel policy debates and enable interest groups to exercise pressure. In doing so, political institutions provide a general frame within which actual policy making is happening. Political institutions however neither create an agenda nor solely determine the result of political bargaining between various interest groups and other political actors. The latter bring their agendas and compete for their implementation in different policy arenas. Naturally, different governments have different commitments to health care reform; they can prioritise differently the urgency and strategies of health care reform. For example, in 1996, in the dispute over the urgency of health care reform, Hungary's reformist minister of finance resigned (Nelson, 1999, p. 6). Furthermore, even if a consensus regarding certain health policies has been reached between different political actors, such policies can still be hard to implement due to the lack and limits of organisational and bureaucratic capacities. In order to explain the origins and change of institutions within a given health care system, it is not enough to just assess the effects of political institutions on the process of health care reform. Closer attention should be paid to actors as well as organisational and bureaucratic capacities.

Whereas, it is not in question that the institutional approach can provide us with valuable insights into the politics of health sector reform in Eastern Europe, here, I would like to give a brief outlook of alternatives in the history of political science for the institutional approach and, later, its variations in contemporary political science. The idea of institutions is not new in political science, e.g. Plato and Aristotle in their writings dealt with institutions. They predominantly focused on values, such as

freedom and justice, imbedded in institutions. Later, political philosophers, e.g. Marx, kept their attention on values as well as found an interest in looking at the social determinants of institutions. The core of the political philosophy enterprise was to apprise and evaluate political institutions and acts employing certain values. The behaviour movement, which emerged in the 1920s and gained particular strength in the 1950-60s, switched the attention of political scientists from ideal values to preferences of real individuals. Being concerned with real individuals and fascinated with the achievements of natural science, students of the political behaviour “scientificed” political science by introducing the natural science research programme, empirical methods (as opposed to deductive thinking of political philosophers), quantification, and the interdisciplinary focus. Students of the political behaviour also abandoned political appraisal and evaluation by introducing the issue of value-neutrality or scientific objectivity and starting describing values as empirical data or variables (Dahl, 1961, p. 771). The assumptions of behavioralism were that preferences are revealed through behaviour and that aggregation of interests through efficient summation leads to an equilibrium outcome.

Table 3.4.1: Behavioralism and New Institutionalisms

	Institutions	Preferences	Aggregation
Behavioralism	Arenas	Revealed through political behaviour	Efficient summation
Rational Choice Institutionalism	Decision rules	Strategic choice	Choice imposed by institutions
Sociological Institutionalism/ Organisational Theory	Information processing routines, symbol and classification systems, moral templates	Bounded rationality, Interpretative frames	Standard operating procedures
Historical Institutionalism	Rules, norms, procedures, legacies	Alternative rationalities, Social construction of interests	Contextual logic of causality

Based on: Immergut, Ellen M. (1998) The Theoretical Core of New Institutionalism, *Politics and Society*, Vol. 26 No. 1, pp. 5-34 and Hall, P.A. and Taylor, C.R. (1996) *Political Science and the Three New Institutionalisms*, MPIFG Discussion Paper 96/6, MPIFG, Koeln.

New institutionalism, which emerged in the 1970s, questioned the above assumptions of behavioralism. The counter-assumptions were that institutions somehow channel choices and that interests cannot be simply aggregated and equilibrium therefore is problematic (Immergut, 1998). Table 3.4.1 summarises prepositions on the concept of institutions and ways of preferences' formation and aggregation of choices which are developed by behavioralism and three branches of the new institutionalism.

Theoretical perspectives from different political science approaches can elevate our understanding of politics. Rational choice theory provides the most consistent account of human rationality and the role of strategic interaction between various actors in determining policy outcomes. Rational choice theory is especially appealing in supplying a well-developed set of concepts, particularly in game theory, that are very helpful in generalising and theory-building. However, basic assumptions of rational choice theory are very strict and can hardly match any reality; they hold that actors are always means-end instrumental, far-sighted and that institutional effects are intended. As such, according to the rational choice, policy outcomes are always the most efficient solutions to particular problems at the moment when they appear. Students of sociological institutionalism go beyond considerations of efficiency. They almost break down the conceptual divide between “institutions and “culture” (Hall and Taylor, 1996, p. 14)¹⁰. Sociological institutionalists emphasise that institutional arrangements can be adopted not because they are efficient but because they are “appropriate” (Pierson, 2000a, p. 478) or because of “the role that collective processes of interpretation and concerns for social legitimacy play in the process” (Hall and Taylor, 1996, p. 20). As such, these arrangements may easily be inefficient for a particular local context. However, this sociological approach, from the political science point of view, has a fallacy of being “bloodless” as it can miss “a clash of power among actors with different competing interests” when an organisation or the Government adopts new institutional practices (ibid., p. 21). Historical institutionalism also has this kind of fallacy because it, like sociological institutionalism, which favours existing “appropriate” institutions, looks at the existing template of institutions to borrow the design of historically feasible ones. Collingwood, in “The Idea of History” (1961), considers history as the study of

¹⁰ In doing so, they even create a possibility to accommodate culture theory to political change (e.g. Eckstein, 1988).

human thought and argues that history provides one with ‘human self-knowledge’; this essentially means knowing what can be done on the basis of what has been done (*ibid*, p. 10). History, therefore, as a “template” for institutional reform, can explain institutional change. Immergut proposes to make a distinction between this “methodological” usage of history in institutional research, i.e. history as a context for institutional change, and history as a “theory” or “anti-theory” (1998, p. 19-20). The latter stresses historical irregularities and objects plausibility of general causal model. The former, on the contrary, maintains that particular policy outcomes are explainable in terms of general causal models and critical historical junctures. For example, Immergut (1992) demonstrates that the issues of nationhood related to the return of Alsace and Lorraine were critical for the enactment of the first French national health insurance law.

4. Analytical Framework

4.1. Framework versus Theory

The value of employing an analytic framework for policy research is two-fold. First, an analytical framework helps to draw “limited generalisations” from small-n case studies (Ragin, 1987) which can be used for practical policy-oriented purposes. Second, it allows using previous research to reduce complexity of a phenomenon under investigation (Scharpf, 1997). With regard to the first value, if we study a case descriptively and separately from other cases, we cannot draw any policy lessons from it. Only when we go beyond a description of a given case and compare it with other cases we can generate systematic knowledge applicable to other cases. In other words, only case studies that employ analytic frameworks can be comparable and cumulative (Marmor, 2000, p.63).

With regard to the second value, an analytic framework substitutes theory in its role of guiding research. One needs to recognise that, currently, neither a general macro-theory, nor a specific theory of policy change in Eastern Europe exists. Therefore, we cannot deduce hypotheses for explanation of health sector reform in Eastern Europe from such theories but rather we need to formulate our own hypotheses. Esping-Andersen argues that although in the today’s dramatically changing world of “post-something” there is no “real” theory; there are challenges to reduce variance of the phenomenon under study as well as to preserve disciplinary coherence (2000, p.59-63). He therefore puts forward an argument for suggestive *Leitmotifs viz.*

“...anchors, some stable, universally recognised, ‘social constraints’ against which we can gauge the importance of the mass of variation before our sociological eyes”; they are perceived as concepts akin to ‘democratic class struggle’ or ‘welfare capitalism’, which ‘are almost slogans, but condense meaning, summarising the spirit of the epoch’. As the argument goes on, the utility of a *Leitmotif* is that it “suggests that beneath all ... chaotic variation, there lurks some fundamental principle of organisation and coherence (ibid, p.62).

The Esping-Andersen’s idea of suggestive *Leitmotifs* comes close to the Ragin’s notion of “sensitising concepts” which are to be drawn from state-of-the-art literature in order to get research started (1994, pp.87-89). These sensitising concepts are supposed to be significantly clarified or even abandoned in the course of research.

They, however, allow limiting research by collecting and organising evidences according to these concepts and related categories. At the same time, if initial sensitising concepts are significantly altered, there is a possibility to come back to the data initially abandoned as irrelevant.

In my analysis, the main flaw of the notions of *Leitmotifs* and sensitising concepts is that despite acceptance of the fact that there is no “real” theory, their proponents are still looking for a complete explanation of a phenomenon under study that is based on one *Leitmotif* or one sensitising concept. I think that a more appropriate way to cope with the apparent absence of theory was suggested by Scharpf, namely that complete explanation can only be modular, i.e. consisting of several theoretical modules which can be linked by a partial theory or narrative (1997, pp. 29-35). Furthermore, these theoretical modules should not have a nature of “general-law-like regularities” about human behaviour but rather they should specify “small and medium-sized causal mechanisms of human action and interaction”, i.e. casual mechanisms (ibid.). Broadly, an example of such a modular explanation can be found in Marmor’s book “The Politics of Medicare” (2000). Throughout the book, Marmor uses three non-mutually exclusive “models” to explain outcomes of Medicare reform in America, viz. “the rational actor model”, “the organisational process model” and “the bureaucratic politics model”.

Having accepted the fact that explanations of policy outcomes can only be modular, one can borrow such modules from previous studies. Then, one can test whether they have any explanatory power in our own study. An analytical framework therefore should lead one to domains where such modules can be found. It is argued that a rule of the thumb for identifying them is that they have a nature of specifying “small and medium-sized causal mechanisms of human action and interaction (Scharpf, 1997, p. 30). It is also argued that these mechanisms should be attuned to specific policy actor constellations, modes of interaction among actors and institutional settings. Indeed, this argument bears a great deal of *prima facie* plausibility. For example, in the study of health care reform in Southern Europe, Guillén argues that, *inter alia*, democratisation, accounted for the introduction of national health services in Southern Europe (Guillén, 1999). Apparently, radical democratisation in Eastern Europe contributed towards the opposite outcome.

4.2. Actor-Centered Institutionalism

Although many studies have been done on the politics of health sector reform, there are no studies that would fully use the arguments developed in the previous sections of the paper, *viz.*

- relevance of methodological individualism and game theory to policy analysis;
- usefulness of rational choice theory for explanation of a rational side of human decision-making;
- necessity to build in institutions to explain social and historical factors affecting human decision-making.

The framework of actor-centered institutionalism (ACI) developed by Renate Mayntz and Fritz Scharpf (Scharpf, 1997) is based on the above considerations and therefore provides a promising line of enquiry into the politics of health sector reform in Eastern Europe. Below, I will sketch out central tenants of this framework: game-theoretic modelling, actor constellation, mode of interaction and institutional setting.

This framework is applicable within the domain of interaction-oriented policy research (Figure 4.2.1). In order to explain a particular policy outcome, ACI prescribes to model interaction among policy actors as a game. A game is characterised by a particular actor constellation. The latter comprises the players involved in a given game, their strategies, outcomes associated with strategy combinations and preferences of players over these outcomes.

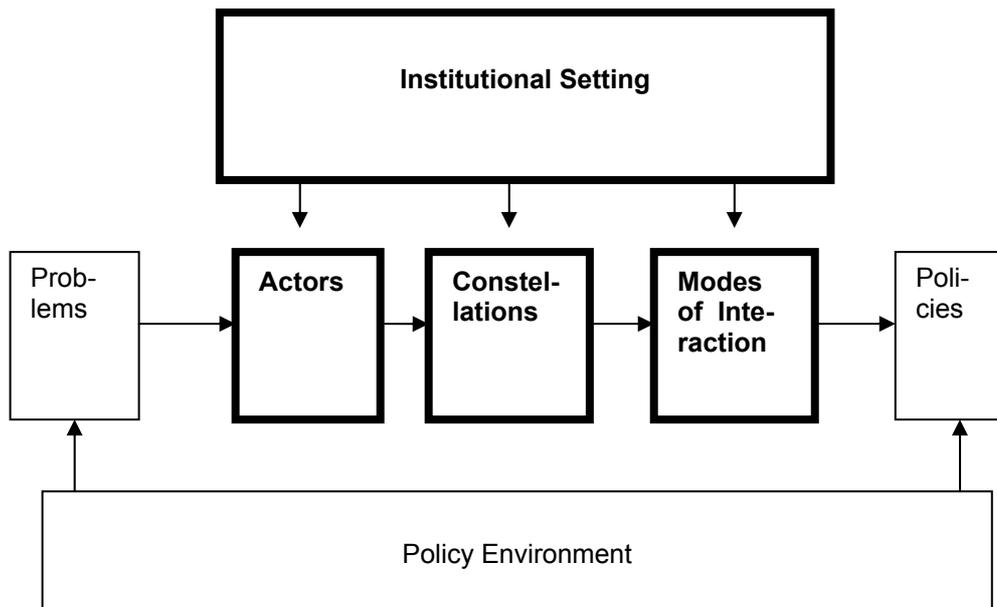


Figure 4.2.1. The domain of interaction-oriented policy research

Based on: Scharpf, F. W. (1997) *Games Real Actors Play: Actor-Centered Institutionalism in Policy Research*, Westview, Boulder, CO, p.44.

Game constellations therefore bear information about a potential conflict and whether it can be resolved, i.e. whether players can maximise their payoffs, through coordinating their strategies or competing with each other. A game is also characterised by certain modes of interaction through which the conflict between the actors could be resolved, such as unilateral action, negotiated agreement, majority vote, hierarchical direction. In real-world situations, a policy outcome can depend not only on one game but also on several “nested” games. For example, the explanation of particular health policies will not solely depend on a “Government-World Bank” cooperative game. Since the Government is not a unitary actor we need to complement this module with at least a nested competitive game “Ministry of Finance-Ministry of Health”. Altogether, actor constellations and modes of interaction allow us to discuss the capacity of given systems of policy interactions to deal with certain policy problems. The institutional setting within which interaction is taking place also influences the problem-solving capacity of the system. In ACI, institutions are usually understood as rules that structure the courses of actions that actors may choose. Although it is common to ascribe to institutions a meaning of organisations, organisations are represented by actors in the context of ACI. As such, institutions are defined as legal rules, social norms, organisational practices, etc. (Table 3.4.1.).

5. Conclusion

The main task of this paper has been to introduce the topic of the politics of health sector reform in Eastern Europe and to single out some promising lines of inquiry into this topic. The paper proposed that in order to explain outcomes of the reform, one needs to reconstruct causal mechanisms of political actions and interactions through which the reform took place as well as non-political factors that shaped the political actions and interactions. In other words, it has been proposed that explanation should be sought in the domain of interaction-oriented policy research. As such, it has been suggested to employ in further research the framework of actor-centered institutionalism.

The chief concern of the paper was that democratic and liberal reforms in Eastern Europe brought about ineffective and inefficient policies for the health care sector. Furthermore, such reforms attempted to dismantle former institutions and to create new ones. Apparently, institutional changes take time and therefore future reforms face the problem of fragmented institutions that are still in flux. Furthermore, the reforms reallocated decision-making functions in the health policy arena with the effect that local authorities and various interest groups featuring among others the medical profession and pharmaceutical companies can influence the policy-making process. In such conditions of fragmented fluid institutions and multiple veto-points, future reformers need to either introduce institutional changes creating possibilities for effective governance or to discover unexploited options that rely on existing institutional capacities and are acceptable to actors controlling veto-points. It is our claim that these changes and options can be discovered by tracing interest formation in the health policy arena and by careful examination of specific policy relevant constellations of actors and their modes of interaction within given institutional settings.

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