The Struggle for Access to Healthcare in Eastern and Southern Europe

Partisanship and Party Responsiveness

by

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Declaration

I, the undersigned Alexandru Daniel Moise, candidate for the degree of Doctor of Philosophy at the Central European University Doctoral School of Political Science, Public Policy and International Relations, declare herewith that the present thesis is exclusively my own work, based on my research and only such external information as properly credited in notes and bibliography. I declare that no unidentified and illegitimate use was made of work of others, and no part the thesis infringes on any person's or institution's copyright. I also declare that no part the thesis has been submitted in this form to any other institution of higher education for an academic degree.

Budapest, June 11, 2019

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Signature

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Acknowledgments

> "You don't get it", she said.
> "Don't get what?"
> "We are one."
> "We are one?" Tengo asked with a shock.
> "We wrote the book together."
> ...
> "That's true. We wrote Air Crysalis together.
> And when we are eaten by the tiger, we'll be eaten together."
>
> —Haruki Murakami, 1Q84

If academia were a running club, the PhD would be the marathon. The 40^{th} kilometer seems as long as the first 20, while the 42^{nd} seems out of reach up until you pass it. While there are only two feet crossing a finish line, they could not have gotten there without dedicated coaches, inspiring training companions, and an army of loved ones cheering from the sidelines. This dissertation has been the most challenging project I have ever attempted. Not unlike a marathon, it pushed me to my limits, and I feel grateful to have my legs intact by the end of it. This project would not only have been much poorer without the overwhelming support that I received from mentors, friends, family and colleagues; it would have been impossible.

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Beyond offering their friendship, some ventured to read and help me revise this work. If my writing makes any sense, Aron, Kristina, Olga, and many others are responsible. If there are still typos or clunky phrases, you know where to march with torches and pitchforks!

Thank you to everyone for your support. It's because of you that I feel ready to sign up for the next race.

Abstract

Governments shape policies that restrict or enable access to health services, thereby directly impacting the health and financial livelihoods of their citizens. This dissertation asks: *Under which circumstances do governments retrench or expand access to healthcare*? To address this question it builds a measure of health access to assess changes in health systems with regards to individual risks when seeking care. This measure is employed in a set-theoretic multi-method research design to understand the politics of health reform in Eastern and Southern Europe.

The first step of the analysis uses fuzzy set Qualitative Comparative Analysis (fsQCA) to untangle the necessary and sufficient conditions, and combinations of conditions, which lead to retrenchment and expansion, using a range of political, institutional and structural factors. The political color of governments and party linkages to voters form the political factors, while the number of veto points, the extent of budget deficits, and existing generosity of health systems comprise the institutional and structural factors. The analysis finds that left-wing cabinets in different combinations with low budget deficits, programmatic linkages, expanded health systems and few veto points are sufficient for explaining expansion of access, while right-wing cabinets in different combinations with high budget deficits, clientelistic linkages, retrenched health systems, with both few and many veto points, are sufficient for explaining retrenchment of access.

The second step of the analysis investigates typical and deviant cases from the QCA results in order to understand causal mechanisms and refine the cross-case analysis. Two main cases, Bulgaria and Czechia, are analyzed in depth in order to understand the role of partisanship and linkages. The logistic regression findings emphasize the special nature of public healthcare, which has broad support among lower and middle-income voters. Left-wing parties therefore have a coherent constituency in favor of expanding access to healthcare and seek to gain electoral capital by pursuing expansion policies. Right-wing parties face a dilemma between the different preferences of their middle and higher-income voters, leading them to implement layering policies or hidden changes. The presence of clientelistic linkages changes the logic for both types of parties, diminishing the need and ability of left cabinets to gain electoral capital from policy positions, while allowing right cabinets to avoid blame for retrenchment.

Table of Contents

List of Figures

List of Tables

1 Introduction

A guilty system recognizes no innocents.

—Iain M. Banks, The Player of Games

All that is gold does not glitter,
Not all those who wander are lost;
The old that is strong does not wither,
Deep roots are not reached by the frost.

—J.R.R. Tolkien, The Fellowship of the Ring

In the aftermath of the 2008 Great Recession, Greece was not merely left in an economic downturn, but faced a national "public health tragedy" (Kentikelenis, Karanikolos, Reeves, McKee, & Stuckler, 2014, p.748). Access and utilization of healthcare dropped significantly, while indicators for health, from child mortality to suicides, worsened drastically. This type of story, though less extreme, is common for many European countries currently restricting access to healthcare and cutting services (Karanikolos et al., 2013). Other countries have undermined access to care over decades, with effects visible in declining utilization rates and worsening health outcomes (Gelormino, Bambra, Spadea, Bellini, & Costa, 2011; Schoen et al., 2010).

Ultimately, whether during a crisis period or not, health policies determine how individuals can access healthcare and at what financial cost this comes to them. Depending on these policies, individuals will face different risks for their health and financial

livelihoods. These are more pronounced for the most vulnerable groups in society. Governments are ultimately responsible for these policies.

Despite this, we currently lack a comprehensive account of how governments influence access to healthcare. We do not have good models for understanding why some governments choose to expand access to healthcare, while others choose to retrench it, and still others choose to do nothing. This puzzle is important because the Greek story is not universal. Spain and Italy underwent similar macroeconomic imbalances, and are still struggling with unemployment and public debt, yet Spanish and Italian governments did not enact such harsh policies (Legido-Quigley et al., 2013). A similar discrepancy is seen between Estonia and Latvia, the latter undermining access to healthcare during the crisis (Mitenbergs, Brigis, & Quentin, 2014). Context, although an important catalyst for policy change, is therefore not destiny.

History, similarly important in its own way, is not destiny either. Bulgaria and Romania emerged from communism with similar health systems, political institutions and economic difficulties. Yet, three decades later Bulgaria is one of the only countries in the EU to have a significant proportion of the population without any health coverage, while Romania has erected far fewer barriers to access(Balabanova & McKee, 2002a; Baba, Brinzaniuc, Chereches, & Diana, 2008). An even starker contrast can be seen between Czechia and Slovakia, with the latter having one of the highest rates of unmet health needs in the EU (Fisher, Gould, & Haughton, 2007; Eurostat, 2019).

These differences are substantial and it is essential to understand what drives them. Despite comprehensive research into the historical, institutional and ideational drivers of health reforms, scholars have not yet comprehensively investigated how governments influence health policy, and specifically access. The main research question that this dissertation investigates is therefore: *Under which circumstances do governments retrench and expand access to healthcare?* Answering this question is essential

in order to understand why individuals face increasing health insecurity. The question is particularly relevant in an era of increased pressure on health systems from technological disruption, rising costs, and population aging (Pammolli, Riccaboni, & Magazzini, 2012). Health systems spend more and more, yet individuals become more vulnerable (Immergut, Anderson, Devitt, & Popic, 2019). Understanding the political drivers of reform is necessary in order to understand how individuals and organizations can use political channels to influence health policy.

This question is particularly relevant for the 17 European Union countries of Eastern and Southern Europe (hereafter ESE): *Bulgaria, Croatia, Cyprus, Czechia, Estonia, Greece, Hungary, Italy, Latvia, Lithuania, Malta, Poland, Portugal, Romania, Slovakia, Slovenia, and Spain.* The negative effects of impeding access to healthcare have more drastic consequences. Ensuing health inequalities exacerbate the existing levels of poverty and social exclusion, which are much higher among SE and EE than Western Europe (hereafter WE) (Ferrera et al., 2005; Nolan, Whelan, et al., 2011). What also sets these cases apart from WE is a common set of political characteristics, including greater institutional and political instability, informal practices and overall lagging economic development (Roberts, 2009b; Brun & Diamond, 2014), which suggest different political dynamics might be at play in welfare reforms.

In order to overcome these limitations and answer the main research question, I use a set-theoretic multi-method research design combining fuzzy-set qualitative comparative analysis (fsQCA) and case studies. The exploratory nature of the dissertation means that QCA is used in a theory-building manner, in order to understand how different factors interact to produce changes across cases. Case studies are then used to probe mechanisms for the uncovered patterns, through process tracing and individual-level statistical analysis. Combining both approaches allows the integration of in-depth mechanism tracing with cross-case validation of findings. The two

main cases, Bulgaria and Czechia, are analyzed in depth in order to understand the roles of partisanship, party linkages to voters, political constraints, and their interactions.

A driving question in understanding the politics of health is whether governments themselves matter. Peter Gourevitch famously emphasized that "policies require politics"(Gourevitch, 1986, p. 17), noting that policy ideas are plentiful, yet to prevail they must have the support of those with political power. The question this dissertation attempts to answer is whether *politics requires parties* for social policy. Welfare states have gone through immense changes over the last decades. Accelerated globalization, changing demographics and recurring economic crises have produced immense pressures for reform of these systems. At the same time, previous dependencies, established institutional structures and bureaucracies have created mounting pressures for continuity. These conflicting pressures have led to a disparity of policy responses, varying in nature and degree across countries and time, in all welfare state sectors.

As Gourevitch pointed out, understanding the politics behind reforms is necessary in order to understand when reforms can take place and what shapes them. This is vital in a context in which policy plans are plentiful, yet there is no clear understanding of the viability of such plans and what route they need to take to succeed. Importantly, healthcare has been described as one of the most difficult policy areas to reform (Nelson, 2001), with implications clearly visible in Eastern Europe's transition years where stalled reforms were at least partly responsible for the resulting national health crises (Cockerham, 1999). Moreover, changes come not only from formal reforms, but are also hidden through executive actions, neglect or other tactics (Pierson, 1994; Hacker, 2004a). The impact of such actions is further stressed considering the importance of social policy primarily to disadvantaged groups in society, but also to

the population at large.

Is Healthcare Political, yet Non-partisan?

Given the role governments play in policy-making, one would expect studies to find evidence for their role and explain it. However, scholars claim that across policy areas parties and governments have an increasingly limited, if not negligible role. One common starting point is the *new politics* literature and its debates, started by Pierson (2001), which argued that welfare states had entered an era of *permanent austerity* where governments were squeezed in between domestic and international fiscal pressure, and popular support of policies. In between these two overwhelming forces, partisanship lost its relevance (Pierson, 1998).

These findings have been replicated in health policy, across quantitative and qualitative studies. Panel studies employing various measures of partisanship repeatedly found no association between the color of a government and health spending (Potrafke, 2017; Mackenbach & McKee, 2015; Elmelund-Præstekær & Klitgaard, 2012). In addition to the *new politics* arguments, this literature has also emphasized the special nature of healthcare, as a policy enjoying cross-partisan support among the population (Jensen, 2012; Jensen & Petersen, 2017). These findings were supported by qualitative studies emphasizing the nature of healthcare as a *valence issue*, at least compared to issues such as unemployment, focusing instead on institutional processes and the power of interest groups (Roberts, 2009a). In these accounts, the popularity of healthcare made it impossible for any party to be in favor of cutting the service.

How should we understand the conclusions of these studies? Is it the case that healthcare is non-partisan? Do parties have identical positions on health? That is unlikely. The question beckons as to what differences exist, what would amount to

important or significant differences and whether they are structured along classical partisan lines. The second important question these studies leave open relates to where we would expect differences: in stated party positions, policy proposals, or the ability to pass policies. In other words, is it that healthcare is non-partisan, or do parties find it more difficult to implement their preferred policy on health?

The findings regarding the irrelevance of parties are not only counter-intuitive to our notions of what parties are and what they do, but they are deeply troubling from a democratic accountability perspective. Representing and implementing different policy views is one of the main functions of parties. Their complete inability or unwillingness to enact voters' wills would represent a blow-back to democratic accountability and responsiveness. It is therefore important to rigorously inspect the role of parties and whether they in fact play a limited role in policy-making.

Studies de-emphasizing the role of parties in health policy making go against what we know anecdotally about the ways parties behave. The US Democratic and the UK Labor parties actively struggle for and enact policies which make healthcare more accessible (Skocpol & Williamson, 2010). A broad literature on electoral politics tells us that parties are power-seekers (Katz & Crotty, 2006). They wish to gain and retain power and enact policies. They therefore want to differentiate themselves against competitors and gain electoral capital from their policy positions and policy decisions.

Given these strong expectations for the role of parties, why is it that the majority of studies have concluded that parties do not matter? I will argue that there are three important dimensions which explain why these studies have committed a type II error, that is, have found no effect when there is in fact one[1]. These three areas

[1]Grouping all of these studies together is, of course, a simplification which is useful to more clearly understand what are some common problems. Their approaches are different and their shortcomings and benefits are different. Indeed, this work has benefited largely from contrasting the benefits and downsides of many of the studies.

represent the main contributions of the dissertation to the literature.

The first area relates to the choice of measuring changes in healthcare systems. By using expenditure measures, particularly measures as a share of GDP, I demonstrate that these studies do not capture dimensions of health policy that are relevant to voters and parties. Therefore, it should not be surprising that partisan differences are not found here.

The second dimension relates to the underlying theory and mechanisms that are expected to determine party behavior. I argue that an under-specification of the mechanism through which voters' values and intentions are translated into party positions leads to incorrect expectations regarding party behavior.

The third dimension relates to the epistemological and methodological foundations of these studies: namely the "average-effects" approach which many employ and therefore the expectation that such an "effect" should be symmetrical across different kinds of cases. I argue, and show empirically, that there are certain configurations of conditions when we should not expect left or right parties to pursue ideologically-oriented policies. Moreover, this approach implicitly assumes that any differences among parties should be visible at the policy level. Of course, if differences exist in intention, but do not manifest themselves in policy, then they are arguably irrelevant. Clarifying the different roles of intentions and outcomes is still essential in order to understand party behavior. I show that differences exist at both levels yet, due to political constraints, they are necessarily smaller at the policy level.

The remainder of this introduction is structured along these three dimensions, and the ways in which this dissertation contributes to each of them. The approach taken in each is to look at the specificity of healthcare and health politics in order to show how each should be changed.

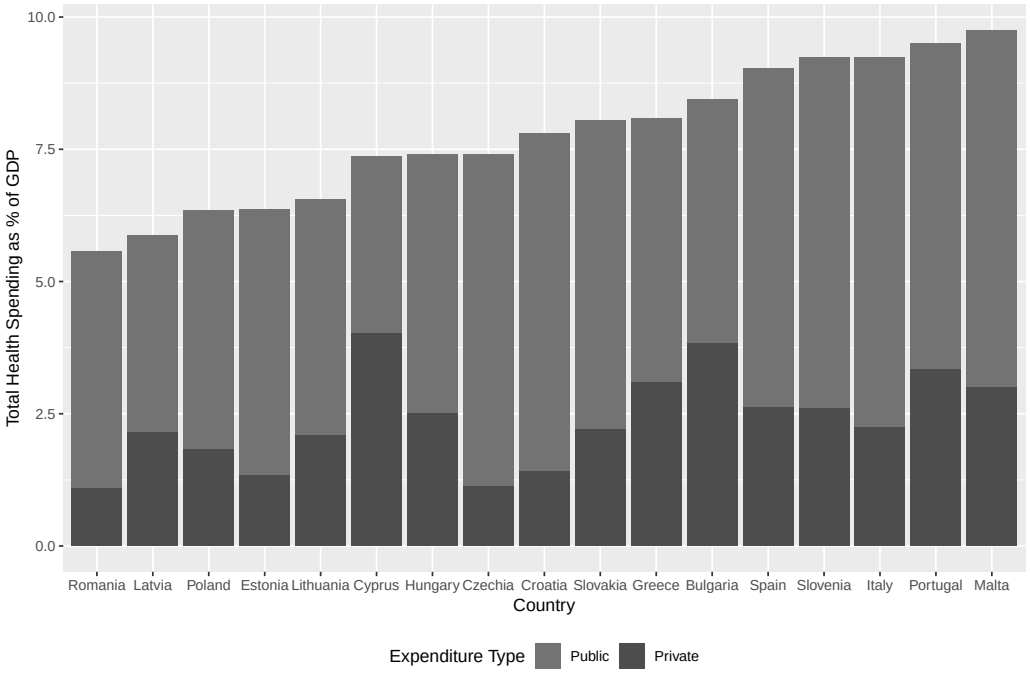
Measuring Changes in Health Systems

Castles (2009) puts forward the case that social policies should be dis-aggregated, since they likely present idiosyncrasies, which change political conflict. Castles shows how several important variables (age structure of the population, left-wing ideology of governments, globalization, economic growth and unemployment) can differently explain age-related cash expenditure (such as pensions), working-age cash expenditure (such as unemployment), health expenditure and other types of services. Interestingly, of all the different policies, he finds that health expenditure is the only one not affected by any of the variables.

Could it be that these factors are not related to healthcare? That would be surprising. What is even more surprising is that he later looks at how the different policies are related to inequality and poverty, again finding that health expenditure is the only one not having an effect. Castles suggests two possible answers to this. The first is that "health expenditure marches in tune to an entirely different drummer from other social expenditure types" (Castles, 2009, p. 56). The second is that there is simply too little variation in health expenditure among countries.

Health policy does in fact march to a different drummer. Chapter 4 shows how we can use the specificities of healthcare to better understand why political dynamics might be different. The variation argument also has some credence, but in the sense that the variation captured by expenditure is not the one of interest. Figure 1.1 shows that, at least among the cases of interest here, there is considerable variation in expenditure as well as its breakdown into public and private sources. And yet, studies find that this variation is not related to outcomes of interest to welfare state researchers. This is unlikely given the broad literature which shows how catastrophic health expenditure (Xu et al., 2003) and incomplete coverage (Pribble, 2013) affect

Figure 1.1: Health Spending in Eastern and Southern Europe - 2014



Source: WHO (2019), author's compilation

poverty and inequality. The answer is that the measure itself is flawed, and a different measure is needed. This seems to be the obvious conclusion given that health expenditure does not seem to be explained by what are likely to be important factors, and does in turn not explain differences in poverty and inequality.

Esping-Andersen (1993) effectively argued that raw expenditure is an inadequate measure of what welfare states do and that we should be concerned with *how* money is spent, rather than *how much* is spent. This is even more relevant in healthcare since healthcare expenditure is in its largest part determined by costs, which in turn vary considerably among countries (Anderson, Reinhardt, Hussey, & Petrosyan, 2003). More importantly, spending does not tell us *who* spends. Overall expenditure can simply capture higher private expenditures of the rich, while even public expenditure can reflect health gains at the top of the income distribution. Raw expenditure is therefore unlikely to reflect the dimensions that are relevant to patients, particularly

those worse off.

This begs the question of what these dimensions are. I argue that health systems should be evaluated based on two functions: the *health function* and the *welfare function*. The health function simply relates to a health system's ability to produce positive health outcomes such as increased life expectancy and decreased health inequalities. The welfare function of health systems is much less studied and refers to the financial impact of health systems, in the same way that pensions and unemployment influence income levels and inequality. Quite simply, health policy does not only impact health, but more directly impacts individuals' ability to access health and the costs at which this access comes.

Chapter 2 develops an index of *access to healthcare* and argues why it is more appropriate than expenditure and other existing measures in order to capture differences among health systems that are relevant to patients. It argues that access is more relevant to patients and therefore a more appropriate indicator which we can expect parties to affect.

A Theory of Health Partisanship

The second area of contribution to current research of health politics is developing and testing a mechanism of partisanship. Two existing, seemingly mutually exclusive, approaches exist that can explain how parties relate to voters. The first is the classical power-resource approach (PRA) (Korpi, 2011). The second is the life-course risk argument (Esping-Andersen, 1999). While PRA argues for a traditional class-based mechanism to explain how working class voters use unions and left-wing parties to enact re-distributive policies, the life-course risk literature effectively argues for why such a mechanism would not exist for healthcare and other policies. Esping-Andersen

(1999) introduces the idea of life-course risks to differentiate them from labor market risks such as unemployment. Jensen (2014) uses this distinction to argue that all voters desire health insurance, since health risks are distributed among the entire population and not just the working class, therefore making healthcare into a valence issue.

However, problems arise when conceptualizing health policy as a valence issue. The first is that if all voters want public healthcare, all parties should simply try to expand access to healthcare. Why do some parties still retrench access? The second problem is that it is hard to expect that all voters do in fact have similar preferences.

Where I depart from this literature is that I argue that social stratification still plays a role in health preferences. While it is rational for all voters to desire some type of health insurance, wealthier voters are likely to prefer private insurance that can provide better services and allow them to avoid deficiencies of public systems (such as waiting times), while lower-income voters are likely to be more sensitive to out of pocket expenditure and other barriers. The policy space in between is wide enough that parties can formulate contrasting policy solutions that should engender political conflict. Chapter 4 develops the argument.

Health partisanship is based not only on self-interest but also on values. Here too healthcare sets itself apart. Solidarity for healthcare, that is the degree to which average voters see people as deserving of healthcare, is much higher than solidarity for labor-market risks (Jensen & Petersen, 2017). However, solidarity itself is structured around social class, with lower and middle income voters showing higher solidarity than higher income voters.

I draw two hypotheses from these insights, tested in chapters 7 and 8. The first is that due to social stratification, left parties will aim to expand access to healthcare in order to capitalize on working class votes and middle class solidarity values. The

second is that right wing parties will be torn between higher income voters who will want private services, and middle class voters who will want to maintain broad access. This makes it harder for right wing parties to implement retrenchment, which is only expected in situations when they can avoid blame.

I build and test the argument on three levels, starting from its micro-foundations in voting behavior - showing how health solidarity is structured and how it influences voting, to the party level - showing how parties build alternative policies, and to the institutional level - showing how linkages and constraints influence policy outcomes.

Complex Causality and Health Partisanship

The final dimension where the dissertation contributes to the literature is in exploring the role of complex causality in health policy. Simply put, we should not expect an "average effect" of partisanship to hold across all cases of health reforms. The reason is that there are several important factors which modify partisanship, resulting in effects being present in certain circumstances and not in others.

Policy-making is a complex phenomenon, to which the varied theoretical and empirical approaches seen in the literature attest. We should therefore not expect a single explanatory factor to drive the process, nor should we expect a single causal explanation to hold across all instances of expansion and retrenchment of access. The key factors emphasized in this dissertation are partisanship, government characteristics such as coalition coherence and stability, institutional veto points, and linkages between parties and voters.

In order to explore the complex relationships between these factors, I use a nested set-theoretic research design combining qualitative comparative analysis (QCA) and case studies. The QCA analysis is used to uncover combinations of conditions leading

to expansion and retrenchment. Case studies are then utilized in order to verify the mechanisms behind the cross-case set relations. Bulgaria and Czechia, the main cases, differ in the main institutional characteristic of interest, party linkages, while individual governments within each country differ in terms of ideology and political constraints. The causal analysis in the case studies combines process tracing and statistical survey analysis in order to corroborate the different parts of the mechanism, from the individual to the party and institutional levels.

The findings of this dissertation do not directly contradict statistical findings of previous studies. Rather, they shed different light on the issue of what partisanship affects and how it does so. I have so far argued that negative findings of partisanship are due to specific choices regarding dependent variables, theoretical expectations and methodology. This section has argued that model specification, by not considering relevant contextual factors and interactions of factors, has led to negative findings by incorporating instances where we should not expect there to be an effect of partisanship. The "average effect" is therefore likely canceled out, since for every left wing cabinet that expands access, there are others which fail to do so[2].

Main Findings and Outline of the Dissertation

Health policy determines who has access to services, under what conditions and at what cost. Individuals' values and preferences regarding health policy are partly shaped by their socio-economic position, whereby wealthier individuals show less health solidarity than lower and middle income individuals. While the latter group

[2]In effect, previous statistical analyses do not prove that partisanship effects do not exist, but rather that given the data and operationalization that they use, there is no evidence that such an effect exists. While this might seem to be a subtle difference, it is a crucial one. Proving that an effect does not exist, in this case that parties have the same policies, would require different designs. Failing to find an effect under such designs can have multiple meanings, including showing problems with the data, operationalization, model choice and specification.

prefers broad access to public healthcare, the former prefers higher quality services. The political conflict generated by these dynamics incentivize parties to take distinct positions on access, left parties attempting to expand it and right parties to retrench it. Right wing parties face a dilemma due to the split in preferences between their middle and higher income voters, and therefore attempt retrenchment when they can avoid blame. Non-programmatic linkages between voters and parties disincentivize left parties from expanding access, in favor of other policies and priorities.

The dissertation proceeds according to the structure outlined above and the three dimensions of contribution to current literature. Chapter 2 develops the theoretical foundations of the health access measure, as well as an empirical application by constructing a typology of health systems. The typology itself better represents differences among countries that are relevant to patients. The access index constructed is argued to be a more valid measure of the welfare function of healthcare. It is therefore a more appropriate measure which we can expect political parties to affect, since reforms and other actions affecting it will be salient to voters.

Chapters 3 and 4 develop the theoretical framework and health partisanship argument, respectively. The theoretical framework emphasizes the role of institutions in shaping actors incentives and long-term policy, while pointing out important empirical puzzles that remain once they are taken into account. It further documents the statistical findings which, in their majority, find no effect of partisanship on health policy as well as current explanations for such findings. These explanations are critically examined and a re-specification of the partisanship mechanism for healthcare is elaborated in chapter 4 by taking into account both the nature of healthcare as a life-course risk, as well as the social stratification of preferences and values.

Chapter 5 develops the research design and complex causality approach to studying health policy. It elaborates on the reasons for looking at health policy specifically

in Eastern and Southern Europe, as well as the rationale for choosing the two case studies for process tracing, Czechia and Bulgaria.

Chapter 6 develops the first empirical application, by using QCA to untangle the necessary and sufficient conditions for health changes. This cross-case analysis shows that left cabinets, in various combinations with lax fiscal deficits, programmatic linkages between voters and parties, absence of veto points, and health systems with broad access, are sufficient for explaining access to healthcare. Right cabinets, in different combinations with high budget deficits, clientelistic linkages, retrenched health systems, with both few and many veto points, are sufficient for explaining retrenchment of access.

Building on the cross-case analysis, chapters 7 and 8 test the health partisanship mechanism at the individual, party and institutional levels by comparing the Czech and Bulgarian cabinets as well as the two countries more broadly. Health attitudes are found to be an independent predictor for party vote. A lack of health solidarity is shown to exacerbate the effect of income on voting for right-wing parties. These findings imply that while left wing parties have a homogeneous group of voters in favor of expanding health policy, right wing parties need to manage the interests of higher income voters with the more solidaristic values of their middle-income constituents. Analysis of party manifestos and parliamentary debates shows that parties pick up on voter preferences and strategically frame their policy positions in order to gain electoral capital from health policy. The non-programmatic nature of linkages between Bulgarian parties and their voters, is shown to be an important driver of the different actions of these parties compared to their Czech counterparts.

Chapter 9 presents the contributions of these findings, as well as the limitations of the approach used here. The findings of the dissertation lead to new questions, therefore the final section highlights several avenues for further research.

2 Healthcare Systems and the Problem of Access

Medicine is a social science and politics is nothing else but medicine on a large scale. Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution; the politician, the practical anthropologist, must find the means for their actual solution.

—Rudolf Virchow

Black bears rarely attack. But here's the thing. Sometimes they do. All bears are agile, cunning and immensely strong, and they are always hungry. If they want to kill you and eat you, they can, and pretty much whenever they want. That doesn't happen often, but - and here is the absolutely salient point - once would be enough.

—Bill Bryson, A Walk in the Woods

On paper, the health systems of Southern and Eastern European countries offer universal coverage. For most countries social insurance contributions are supposed to cover those in employment, while the state covers the rest through taxation (social insurance systems), or the state covers all through taxation (national health service systems), the latter being considered more encompassing.

However, in practice, several types of barriers affect individuals' access to health, and put them at risk financially. Cylus and Papanicolas (2015) use 2008 ESS data to show that across European countries, individuals who have lower income, poorer

health, are unemployed, female, young, and do not have citizenship of the country, perceive that they are unable to access care. Income is ultimately the best predictor for access.

Similar dynamics are seen when looking at OECD countries, with income being particularly important for access to specialists (van Doorslaer, Masseria, Koolman, & Group, 2006; Devaux & de Looper, 2012). This is not surprising given that many countries have user fees for specialist visits, hospital stays, or even for basic services, as well as other barriers to access. Indeed, differences in the design of insurance and out-of-pocket costs seem to explain some of the cross-country differences in access (Schoen et al., 2010).

For the purposes of understanding how health systems affect individuals, we need to redesign how we see them on paper. The way in which we look at healthcare determines how we understand changes in health policy, which influence our models, explanations, and ultimately our understanding of which factors affect the policy. Therefore, this chapter analyzes the literature classifying health systems, as well as the broader literature on conceptualizing welfare state changes, in order to build a stronger theoretical foundation for a measure of healthcare changes.

This chapter argues that a measure of health access is appropriate for capturing cross-country health and financial risks faced by patients, particularly those most vulnerable. This measure is inspired by the decommodification measure of Esping-Andersen (1993), and primarily seeks to capture the risks associated with income across three dimensions of healthcare: financing, provision and regulation. The question this measure asks is whether *individuals need (more) money in order to access services.*

The chapter first develops the theoretical background for health access, and explains how the measure is built. The measure seeks to fill a gap in constructing dimensions

which capture the *welfare function* of healthcare, meaning its impact on individuals' livelihoods. The paper then uses fuzzy set ideal type analysis in order to categorize states in Eastern and Southern Europe. These categories better describe how health systems in these two regions impact their citizens. Moreover, they allow tracing different types of changes they go through. The final section explores features of the typology and looks at how the index is related to outcome measures of healthcare.

2.1 The Problem of Measuring the Welfare Function of Healthcare

The problem of capturing the welfare function of a social policy is not limited to healthcare. Esping-Andersen (1993) showed that from an individuals' perspective it is not expenditure of services that matter but how program is structured. Esping-Andersen evaluates the structure of policies based on the degree to which they shield individuals from market risks. Healthcare can be seen as serving two related functions. The *health function* is more directly related to the system's ability to provide quality of care. An additional, and less studied dimension, is the *welfare function*, namely the degree to which the system protects individuals from loss of income associated with health problems. The latter is more closely related to the general function of welfare systems, and is therefore the focus of this study.

Studies on welfare state changes have been long plagued by what is called the "dependent variable problem" (Pierson, 2001; Green-Pedersen, 2004; Makszin, 2013). This refers to the disagreement in the literature over what measures are appropriate in order to observe changes in these systems. Several dilemmas characterize this problem: what type of concept should be used, what it should capture and what it should not (in principle), what specific indicators should be selected in order to score cases, and

what method of scoring should be used.

Two broad perspectives, in two respective strands of literature, have tackled this problem. The first is composed of studies seeking to explain variation and changes in welfare states. As chapter 3 and chapter 4 show, the type of measures the studies use can partly explain the contradictory results of their causal explanations.

The second strand of literature looks at the dependent variable problem in terms of typologies and classifications of systems. This literature emphasizes that it is relevant to know not just how systems change, but also what they change from and into. As Freeman and Frisina (2010, p .163) note, "[w]e can see and know things only to the extent that we have categories available to which they can be assigned". Classification, therefore, puts change into perspective. It orders and categorizes types of of systems (and their changes), and allows generalizations and understanding over large amounts of data. Freeman and Frisina go on to argue that the type of classification used acts as a lens which focuses what the researcher sees. In practice this means that the type of indicators used define the type of variation a researcher sees (or does not). They go so far as to argue that the development of classifications can be seen as measure of progress in comparative health policy, since new perspectives and problems are uncovered (Freeman & Frisina, 2010, p. 175). This is echoed in the welfare change literature in the idea that indicators need to be adapted to specific research interests and questions (Green-Pedersen, 2004, p. 12)

Therefore, both classifications and indicators for change need to reflect the focus of the specific study. So far, the literature has not produced a concept or set of indicators that satisfactorily capture the "welfare" function of health systems, namely, how they impact vulnerable individuals. This section will go through the current literature on the problems outlined above, as they relate to healthcare, and proposes a new approach for how to view healthcare changes from the perspective of patients.

The next sections proceed by looking at the decisions necessary in order to develop an appropriate indicator for measuring health access from a welfare perspective.

2.1.1 Inputs, Outputs, Outcomes

A first important distinction in understanding welfare state change can be defined in terms of inputs, outputs and outcomes. All three choices present advantages and limitations, and the choice between them needs to reflect the focus of a study.

Inputs refer to legislative acts adopted by national parliaments. Their main advantage is that they can be directly traced to specific parliaments and governments. As a way of tracking changes to welfare states, inputs can be clearly separated, at least conceptually, from other factors, such as external shocks. For example, austerity policies in terms of legislation, can be seen as an inputs measure, clearly distinct from an economic crisis which can trigger them; a distinction that is less clear if one looks only at spending, which is affected by both.

Their main drawback is that they do not account for the implementation of proposals. Often, policies get derailed and modified in implementation or are simply stalled (Guardiancich, 2013). Moreover, many changes are likely to occur within healthcare systems that are not present in formal laws. Neglect, policy drift, executive action or bureaucratic decisions can affect the structure of health systems and impact patients (Pierson, 1994; Hacker, 2004a). Moreover, many legislative acts affect the structure of health systems in ways that are not directly relevant to patients, for example changing management structures or contracting between hospitals and insurance companies. This makes inputs, by themselves, non-viable for tracking changes that are directly relevant for patients.

Outputs refer to the practical implementation of laws rather than the way they look

on paper. Often, secondary indicators are used to approximate certain dimensions of interest to researchers[1]. These concepts are constructed theoretically in order to better capture the variation that researchers are interested in. Indicators are selected and argued for on the basis of approximating what authors argue to be relevant changes in welfare states, that are the result of the practical implementation of legislation or other types of government decisions, or indecision. The main benefit of such indicators is that they take into account practical realities that legislative acts must confront once passed, such as reversals or modifications. Moreover, they can track less visible changes, such as policy neglect or drift, as well as lower-level policy decisions that nonetheless can be consequential, such as ministerial decrees. Crucially, they can be more precise to the scope of a study. By capturing relevant dimensions and excluding irrelevant ones, these types of measures can, in principle, more clearly show the differences of interest among cases, and better capture causal processes in analyses.

Their main drawback relates the fact that they can also track changes that, some would argue, governments are not responsible for. Specifically to healthcare, Maarse (2006, p. 987) argues that privatization is due in part to government policies, but also to technological change and simple consumer preferences and demand. The implication here would be that a researcher would hold a government accountable for actions it did not commit. However, it is arguable that inaction is as much a policy choice as active policies. Whether intentional or not, allowing a system to deteriorate, should be something that governments need to be accountable for. This is even clearer when the effects of inaction are foreseeable and, as is clear in Bulgaria, have re-distributional consequences, negatively affecting those worse off.

Outcomes refer to direct indicators of population health, such as mortality, morbidity,

[1]Two examples are Esping-Andersen's (1993) decommodification measure and Pribble's (2013) universalism measure.

smoking, or exercise rates. They can be used in absolute numbers or aggregated in different ways, for example in health inequalities. Their main advantage is that they quantify what most individuals care about, namely improved health. While health outcomes are the stated objective of health systems, they are removed from government policy to a degree that makes it difficult, if not impossible to understand the effects of political decisions. Some policies can take decades to show their effects in terms of health inequalities or general population health. Even when the effects of policy are more immediately visible, they interact with many other factors outside of the healthcare system. These factors include lifestyle choices, general economic development, education, quality of environment, as well as many others factors that are well explained by the "determinants of health" literature (Evans, Barer, & Marmor, 1994, for example).

More importantly, this type of measure would not capture the second important function of health systems, namely protecting individuals from financial risk associated with healthcare costs. Potentially, outcome measures can also be adapted to the welfare function. One example is catastrophic health expenditure (Xu et al., 2003; Arsenijevic, Pavlova, Rechel, & Groot, 2016). This measure quantifies the phenomenon of out-of-pocket medical expenses exceeding a certain threshold of household income, therefore potentially capturing the financial impact on individuals. One important drawback of this measure is that it only accounts for individuals who "choose" the medical treatments which render them bankrupt. It does not account for instances where individuals "choose" not to opt for medical interventions. This is important, since access barriers act as a deterrent, and therefore most of the individuals affected will not show up in the data.

Another range of measures rely on survey questions asking individuals to report unmet medical needs or their perceptions of their ability to access healthcare. While these

measures come closer to identifying the impact of policy on individuals, they suffer from the same problem as health outcomes, namely that they are hard to connect to policy decisions. Individual perceptions are shaped by many other factors, including their overall trust in state or private institutions, their subjective experiences with the health system, as well as socio-demographic and lifestyle characteristics. Policy decisions are expected to influence these measures. However, the impact of different policies, as well as their timeline to take effect will likely vary considerably, making it difficult to connect the two.

Outcomes are therefore better suited to more long-term analyses of the differences between types of health systems, not to analyses of government decisions. However, while it is hard to track outcomes to a specific policy, systematic differences in outcomes are expected across types of health systems, shown in the last section of this chapter.

All three types of measures imply a certain trade-off. Outputs come closest to the theoretical goal of this study. They can track changes by governments that are actually relevant to patients, with relative ease of establishing responsibility. However, to do so, a measure needs to be carefully constructed and validated. The following sections proceed by developing the theoretical ground for an access to health measure, followed by explaining the choice of indicators and construction of the measure. The chapter will show how health access is connected to other concepts of measuring health systems: legislative changes and output measures at an individual level. Ultimately, while policy outputs are more suitable to be operationalized in order to understand the political determinants of health systems as they relate to patients, changes in health systems should be visible across different types of measures. The final section of this chapter develops the links between health access and outcomes, while chapter 7 and 8 detail the legislative and hidden changes which were responsible

for the diverging outputs of the Czech and Bulgarian health systems.

Expenditure measures

The most simple output measure of health systems is health spending. Total health expenditure as a percentage of GDP and public health expenditure as a percentage of GDP have often been used as proxies for "how much" healthcare is provided, and how much public healthcare increases or decreases (Jensen, 2014; Potrafke, 2008; Herwartz & Theilen, 2014). Looking at health expenditure in this way, with the purpose of understanding political influence and the effects of healthcare, suffers from serious shortcomings. The main shortcoming was identified by Esping-Andersen (1993), namely that spending does not actually tell you where the money is going. For unemployment, spending does not necessarily track generosity of benefits but rather economic cycles. This is even more true for healthcare. Health spending tracks higher prices, reflected in higher doctor fees and more expensive medicine.

Higher spending, including higher public spending, does not necessarily track "more healthcare" but rather "more expensive healthcare". The United States is a good example. It has the highest rate of health expenditure, among OECD countries, spending more than 18% of its GDP, with its public health expenditure similar to Scandinavian countries (Anderson et al., 2003). However, expenditure is largely driven by the higher prices in the US system. Meanwhile, the US has the highest rate of uninsured in the OECD, with even insured individuals facing high barriers to access in terms of co-payments and deductibles (Himmelstein, Thorne, Warren, & Woolhandler, 2009). Even if spending would track heath utilization and quality, it would not tell us the spread of utilization. Higher spending might simply reflect wealthy individuals utilizing new and expensive treatments, or particular groups over-utilizing public services. Pure spending is therefore inadequate in comparing health systems across countries

or across time, in terms of either their health or welfare functions.

A more appropriate spending measure is public expenditure as a share of total health expenditure, as used by Huber and Stephens (2010, 2015). The advantage of such a measure is that it is less determined by external factors, such as economic shocks or technological development. It better captures not just how much money is spent, but in what ways it is spent. By looking at the share of public expenditure on health out of the total, we have a better picture of the weight of the public system, while holding constant princes and other factors. Arguably, this is more important for the average patient.

Two problems persist. The fist is that the public share of expenditure is to a degree dependent on costs in the private share. Therefore, it is possible in principle that external factors lead to increased private expenditure localized in the same group who utilizes the private sector, without affecting those in the public sector. The measure would then show a change in the public share that is not related to what the concept aims to capture. The second problem, further elaborated in the next section, is that expenditure, while arguably the most important dimension of access, does not capture other facets of access. In order to overcome the latter shortcoming, I argue for the need to include other dimensions and indicators. In order to overcome the problem related to private expenditure, and to emphasize the importance of personal private expenditure, I give additional weight to out-of-pocket expenditure when considering this dimension.

2.1.2 Decommodification in Healthcare

Another strand of literature has more directly responded to the need for a measure which captures the welfare function of health systems. Several scholars have adapted Esping-Andersen's concept of decommodification (1993). Decommodification in wel-

fare has been one of the most influential concepts and measures for classifying and tracking changes in welfare states. Its popularity and merit come from its simplicity and strong theoretical justification. Its formulation is that welfare states should not be measured by how much they spend but by how they affect individuals, namely the degree to which they leave individuals dependent on the market for their livelihoods. This is an appealing idea, because it measures welfare based on its purpose: to protect individuals in market economies. However, Esping-Andersen did not include health services in his concept, rather, only sick pay. Adapting his concept to healthcare is difficult since his main indicators, such as replacement rates (which focus on payments), are not applicable, since most of the functions of health systems are in terms of services.

Noting these shortcomings, Bambra (2005a) adapts the concept to health systems. Bambra's approach uses three indicators in analyzing 18 OECD countries, building also on the classifications literature (developed in next section). The first is the private expenditure as a percentage of GDP, which is meant to cover the financing of healthcare. The second is the percentage of private hospital beds out of the total bed stock, which is meant to cover the provision side. The third is the percentage of the population covered, which is meant to cover the regulatory part. She uses the first two to construct an index which is weighed by the coverage rate. This approach has the benefit of bringing together these two literatures and helping to answer the question of which indicators to use in healthcare. One possible shortcoming of this approach is that there may be additional areas of financing or regulation which can impact patient access. A more minor concern is a general one with the scoring, also found in Esping-Andersen's work, namely that it is done relative to the sample at hand, by using a measure of variance in the rough index to compile the final score. This is problematic if the measure is to be used comparatively, on different samples or cross-time. An advantage of the deductive approach suggested here, is that cases are

scored in absolute terms, and in principle any new case can be added to the analysis without changing the score of other cases - therefore allowing clearer comparisons.

Reibling (2010) elaborates on this literature by giving it a clearer focus. Specifically, she focuses on access of patients to healthcare services. She argues that access is the most important dimension because it is a clear indication of how easy it is for patients to get the services they require in order to maintain their health. Reibling ties this to decommodification, arguing that lower access results in individuals being further commodified. Access is broken down into three dimensions: gate-keeping, cost-sharing and supply.

Both scholars considerably advanced the quest for better conceptualization of decommodification in healthcare, therefore also further bridging the healthcare literature with comparative welfare studies. While sufficient for the purposes of their research questions, the two conceptions still leave out important dimensions in healthcare systems, such as outpatient care, and regulations governing the relations between providers and beneficiaries. The problem therefore, is left at the level of conceptualizing all of the appropriate dimensions, and selecting indicators for them that are relevant for access.

2.1.3 Health Systems Classification

Expenditure, decommodification and existing access measures all leave out important dimensions which are relevant to capturing access to healthcare and the resulting health and financial vulnerabilities.

The "health systems classification" literature has come closest to producing an exhaustive analysis of health systems, by focusing on the relevant characteristics which differentiate them. One of the first works to attempt an exhaustive classification was

the the work done for the OECD by Shieber (1987). The work built a classification that is still influential, by differentiating between national health service (hereafter NHS), social health insurance (hereafter SHI) and private health insurance models (hereafter PHI).

While these ideal types are still useful in understanding many broad differences among systems, the classification suffers from several limitations. It neglects key differences within system types, which are often greater than between system types [2]. Different payment structures within system types therefore mean that simply looking at the system type cannot tell us whether payments are progressive or regressive. In order to make this differentiation we need to dis-aggregate types of payments: taxes, public and private insurance contributions and out-of-pocket expenditure.

Most importantly, this classification also lacked a clear justification of dimensions, beyond describing systems in terms of their financing and ownership of facilities. This means that such classifications are not connected, theoretically or empirically, to output measures of health systems. Wagstaff and Moreno-Serra (2009) find that for post-communist countries, the introduction of SHI impacted spending but did not impact population health. This is likely because of the different ways in which SHI was implemented in post-communist countries. Borisova (2011), recognizing these shortcomings, built a more detailed classification from Health in Transition reports and found that equity of access could explain some of the variation in health outcomes between transition countries.

These limitations have prompted scholars to ask: "for how long comparative investigation conducted according to this framework of national health services, social

[2]For example, the different degrees of privatization of provision in SHI systems - completely absent in Slovenia, while in Slovakia now forming a majority of hospital and outpatient facilities - or the much higher reliance on out-of-pocket expenditure in Southern European NHS compared to Northern European NHS systems. Private expenditure in the NHS systems of Spain or Portugal also greatly exceed that of the SHI systems of Romania or Croatia.

insurance systems and private insurance systems can realistically expect to tell us anything new about health systems and the way they work" (Freeman & Frisina, 2010, p. 175).

Beyond NHS/SHI/PRI

A first major step in addressing these limitations came from the work of Moran (2000, 1999). He first argued for a shift away from organization and to governance, in order to tease out the politics behind health systems. In his typology, he brings in three dimensions for classifying systems: *consumption* - the basis of eligibility and funding mechanisms, *provision* - who controls, regulates hospitals and doctors, and *production* - technology and medical innovation regulation. He arrives at four ideal, observable types: 'entrenched command and control healthcare states', such as Great Britain, 'corporatist healthcare state', such as Germany, 'supply healthcare state', such as the United States, and 'insecure command and control state', such as Greece and Portugal (Moran, 2000). The first three types match the NHS, SHI, PHI typologies. The last type, covering Southern European states, shows the problem of geographic limits to classifications, as new types are needed to capture new cases. This is also a more general problem with inductive classifications.

Giaimo and Manow (1999) arrive at a similar outcome by build a classification based on the dominant agent in the health system, distinguishing between 'state-led', 'corporate-governed' and 'market-driven' systems. Building on both of these works, Wendt, Frisina, and Rothgang (2009) created a systematic deductive conceptualization of health systems by looking at the dominant agent (state, social actors, the market) in each dimension (financing, provision and regulation). They arrive at 27 possible combinations with three ideal types, when one agent is dominating all three dimensions. Building on Hall's (1993) types of change, their model also accounts for

three types of changes: system change, internal system change and an internal change of levels. The first refers to the change of the dominant actor in all dimensions, the second to a change of one dimension, and the third to a change within a dimension. The seminal paper, however, stops short of a full empirical application.

This gap was later filled by Böhm, Schmid, Götze, Landwehr, and Rothgang (2013). They adapt the Wendt et al. classification and argue that there is a hierarchy between dimensions, led by regulation, therefore limiting the number of possible combinations to 10. By classifying OECD countries, they reach five observed types, of which four belonged to their initially hypothesized ideal cases, with Slovenia being a mixed type.

Schmid, Cacace, Gotze, and Rothgang (2010) develop a similar model for change, while also elaborating on a possible mechanism for convergence. They point out that the different system types: private, social insurance, and national health service, have unique deficiencies. Policy makers then try to overcome them by using non-system-type solutions. They claim that this therefore leads to a trend of convergence of health systems, but one increasingly hybrid models rather than a convergence on a specific ideal type.

These works are good examples of classifications meant to understand the nature of health systems with regards to how they are organized. However, neither model points to what dimensions in particular we should focus on. Clearly, some measures of particular dimensions can be more relevant or important than others. This however, begs the question of "relevant for what?", or for whom. When considering the welfare impact on patients, one answer is decommodification. In a sense, the problems of two strands of literature outlined above are opposite. Classifications tend to encompass dimensions relevant to patients but also go beyond them by looking at payment schemes for doctors, or relations between providers and funds. They capture too much, and thus, for the purposes outlined here, become overdetermined, while the

decommodification literature zooms in too much, leaving out important dimensions, therefore being underdetermined (Freeman & Frisina, 2010, p. 164).

2.1.4 Health Access as a Basis for Typology

This paper proposes to mix the two approaches in order to combine their benefits. The approach here is to select indicators relevant for health decommodification and score each dimension outlined by the comprehensive classification literature. To do so, I construct an access index based on the three categories of financing, provision and regulation. After selecting relevant indicators I score each dimension as either high or low in access. By looking at the combinations, I arrive at eight possible ideal types, outlined in Table 2.2.

Conceptually, commodification of healthcare is often understood as commodifying services through privatization. However, what should be of interest is the commodification of patients. As an example, what should be of interest with pensions is not primarily whether they are private or public, but rather how their specific requirements and benefits affect individuals (for example, the level of income replacement, contributions etc). In health, the primary question should not be whether services are private but how provision (or lack thereof) of services impacts individuals in terms of their reliance on the market to meet their health risks. This is more in line with Esping-Andersen's original concept which measured "the degree to which transfers allow people to live without labour income" (Esping-Andersen, 1993, p. 47). While many of the indicators used here focus, in a sense, on the private shares in different dimensions, they are adapted. For example, in financing, I look not only at private expenditure, but also at out of pocket payments, which have more impact on whether individuals can get services. Looking at the relations between patients on the one hand, and financing bodies and providers, on the other, are additional dimensions of

interest, beyond privatization.

Similarly to how Esping-Andersen discounts expenditure in favor of looking at the impact on individuals, this perspective discounts the absolute amount of expenditure or related measures. While these are extremely important to quality of care, they are less relevant from a welfare perspective. The existence of expensive, quality treatment, is less relevant for those who face impediments in accessing it.

In this way, *access* can be seen as a type of output measure of health system type (and change). By using indicators relating to the health system, an access index can capture changes that are not visible in legislative acts or by looking at the population's health. The task, therefore, is to search for indicators which capture decommodification of individuals' health and financial livelihoods across the major components of health systems: finance, provision and regulation.

2.2 Indicators and Method

2.2.1 Indicators

Ideal data would cover all areas of financing, provision and regulation which would be relevant to patients having access to healthcare and the impact this has on their livelihoods. This would include any personal expenditure, including dental and pharmaceuticals, availability of doctors and facilities according to need, and issues such as informal payments. Data is however limited. The indicators presented below are by no means exhaustive, but seek to capture the core areas of health systems which impact individuals.

In financing I look at two sub-dimensions: the degree to which financing is private, and the degree to which that has a direct financial impact on patients. Using the two

Table 2.1: Dimensions and Indicators for Access Index

Dimension	Subdimension	Indicator
Financing	1. Share Private	Share of private expenditure out of total
	2. Direct Financial Impact	Share of OOP expenditure out of total
Provision	1. Inpatient	Weighed share of private hospital beds
	2. Outpatient	Weighed share of private ownership
Regulation	1. Relations between beneficiaries and financing agencies	i. Coverage of public or mandatory insurance ii. Share of financing from taxation
	2. Relations between providers and beneficiaries	Presence or absence of formal gatekeeping

highlights the difference between the impact of private insurance and out of pocket payments (OOP). Private insurance is often more expensive, has higher premiums and covers fewer services than public types. Beyond that, OOP has an added effect of deterring healthcare utilization. Xu et al. (2003) find that countries with lower rates of insurance and higher OOP have lower utilization rates and more reporting of unmet health needs. Focusing on Eastern Europe, Tambor et al. (2014) find that inability to pay most harshly affects low-income individuals and those in poor health, concluding that patient payments constitute a major barrier to service utilization. Several other studies have concluded that private financing reduces service utilization and increases health inequalities (Mossialos & Thomson, 2002; van Doorslaer et al., 2006). Therefore, higher types of such expenditure results in greater privatization of risk in terms paying for sickness (Hacker, 2004a). To highlight the two aspects (insurance and direct payments), the dimension adds the two shares (private insurance and out of pocket payments), while giving a higher weight to the latter, as out-of-pocket expenditure is considerably more regressive[3]. Figure 2.1 shows the financing index across cases for 2012.

[3]Out-of-pocket expenditure is given a weight of 2. A system with 100% of expenditure coming out-of-pocked would therefore score 200. In practice, no case exceeds 100. The cut-off point in the analysis is therefore 50, which means that commodified countries are those who have more than 50% of financing from private insurance or more than 25% of financing from out-of-pocket expenditure, or a combination of the two.

In provision, I follow the approach set out by Böhm et al. (2013), with small differences. In a first step I divide provision into the two relevant sub-dimensions of inpatient (or hospital) and outpatient (GPs, clinics, centers)[4]. Using WHO expenditure data (WHO, 2019), I take each country and first weigh each sub-dimension according to its share of total provision expenditure. This is done in order to reflect the relative importance of each sector in different contexts. For example, a larger number of public inpatient beds is more relevant in countries which rely more on hospitals to deliver care.

In a second step I calculate the degree of privatization in each of the two sectors. For the inpatient sector, I take the share of private hospital beds (Eurostat, 2019), while for the outpatient sector I use the share of private ownership of outpatient facilities provided by country Health in Transition Reports, for each of the time periods. In a final step, I add the two scores as weighed by expenditure, which gives the score out of 100, of how much provision is based privately. As with financing, a greater share of private provision is expected to decrease access. Private providers often operate on a fee-for-service basis, and often exclude certain services or certain procedures based patients' health history (Or, Joust, & Yilmaz, 2008). For the fuzzy set categorization, the 0.5 benchmark for scoring as commodified (or low access) is set at 50% of weighed private provision.

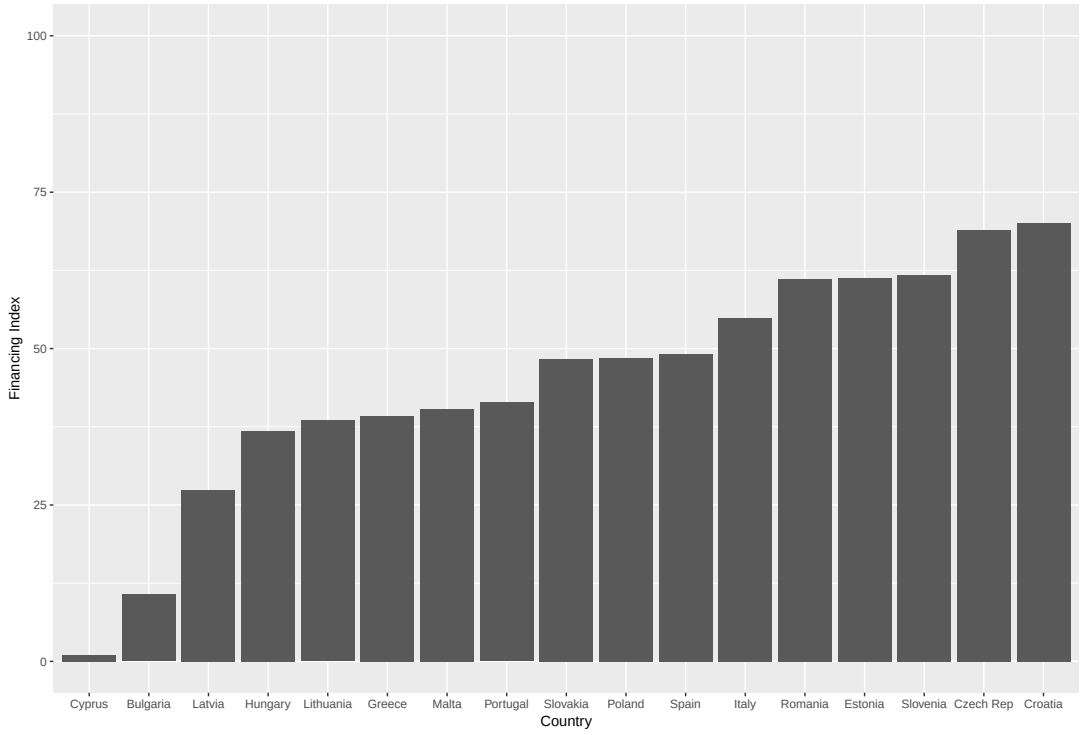
In terms of regulation, Wendt et al. (2009) suggest three types of relations which must be analyzed: between beneficiaries and financing agencies, between beneficiaries and providers, and between financing agents and providers. They suggest two indicators to measure each. However, from the three relations, only the first and second are directly relevant to patients. Relations between financing agents and provider

[4]Böhm et al. further differentiate a pharmaceutical dimension which they score in terms of public or private employment. However, from the point of view of patients, ownership of pharmacies is not relevant. What is relevant is the financing of pharmaceuticals, which is captured in the financing dimension. Most out-of-pocket expenditure usually goes to pharmaceuticals.

establish, for example, if doctors are treated as salaried employees, or whether they receive payment on a fee for service basis or through capitation. While these relations may impact doctor productivity and, to a degree, how many patients they treat, this does not directly reflect on patient ability to access the service. The second important departure from the classification literature is that I do not measure which actor is primarily responsible for regulating the relations, but rather how relations likely impact access.

Relations between beneficiaries and financing agencies are assessed first by looking at the coverage rate of insurance or state programs, and second by looking at the system of financing, and whether it is mainly based on taxation. Coverage measures the extent of the population covered by public or compulsory insurance. Broad taxation is generally considered the most progressive in terms of a financial burden, with social security contributions and private insurance being increasingly regressive. For example, Cylus and Papanicolas (2015) find that in tax-based systems, people report less difficulty in accessing needed services. Relations between providers and beneficiaries are assessed by looking at access, and specifically whether a gate-keeping system is in place. Reibling (2010) argues that gate-keeping is more than an inconvenience and actively limits individual access to certain services. Moreover, individuals often have to pay a special fee to bypass the gate-keeping system. The information on gate-keeping was coded from the WHO Health in Transition Reports, based on whether patients needed a referral from the GP in order to access a specialist. Each dimension is given 1 point if it is commodified. This corresponds to lack of full coverage, non-taxed based contributions and the presence of a gate-keeping system. In accordance with the increased importance of finance relations, the dimension contains two of the three relevant points. A case was considered commodified in terms of regulation if it scored 2 or more. For the fuzzy set categorization, these were transformed to a 0 to 1 scale, with 0 being 1, 1 being 0.66, 2, being 0.33 and 3 resulting in a fuzzy set score

Figure 2.1: Financing Access Score out of 100

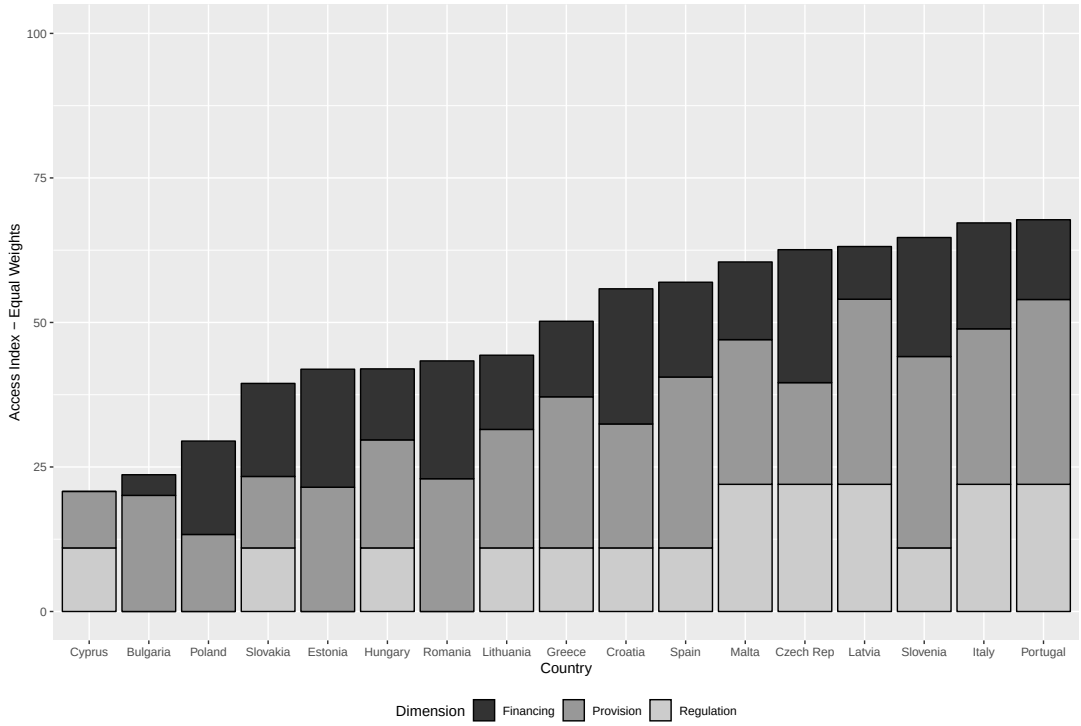


of 0.

A composite index, giving equal weight to each of the three dimensions was created. For the index, the regulation scores are converted from a 0 to 1 scale, to a 0 to 100 scale. Each dimension is therefore on a scale of 0 (low access) to 100 (high access), with the index being in the same scale as the three dimensions that are equally weighed. Figure 2.2 shows the score out of 100 for each country for 2012, absent bars reflect a score of 0.

The issue of weighing the different dimensions is particularly challenging. Different decisions can lead to different outcomes and classifications, a problem common to all such efforts. The degree of arbitrariness can be ameliorated in a few ways. The first is to consider which dimension is most important (even if we cannot tell *how* much more important it is). The literature outlined above emphasizes financing as the most relevant dimension to patients. Figure 2.1 shows the financing access score for the

Figure 2.2: Access Index Score out of 100

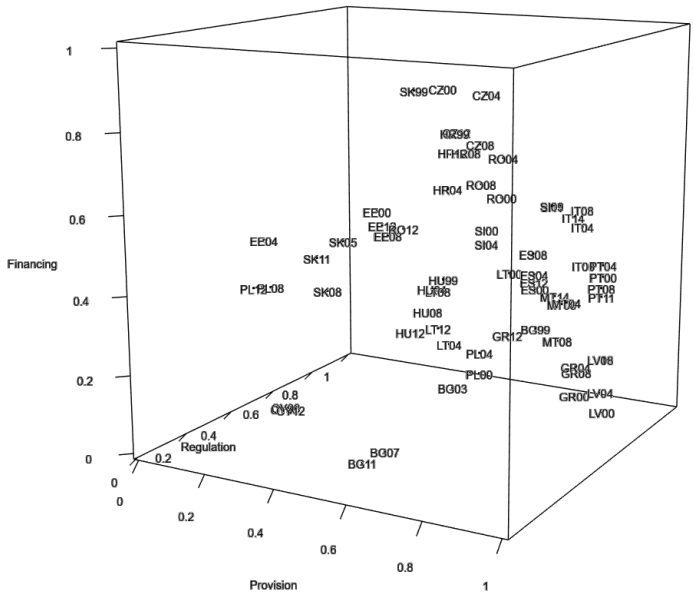


same time year, 2012, for comparison.

The overall index takes account of the importance of financing in a few ways. The first is in the coding of finance, giving additional weight to OOP, and having a lower threshold for categorizing cases as restricting access, compared to the other two dimensions. The second is that the regulation dimension emphasizes relations between beneficiaries and financing agencies, which capture a different dimension of financial barriers: exclusion from coverage and the degree to which systems rely on more progressive financing from taxation.

Ultimately, weighing, as many other decisions on indicators and scoring, will not have universal and undisputed values. However, the most notable differences between cases will be captured in a similar fashion, only marginal differences being more sensitive to such decisions. Ultimately, this project is interested in change, which is captured irrespective of such decisions, only its magnitude being affected. In addition, the

Figure 2.3: Cube Representation of Ideal Type Scores



cross-case QCA analysis is dis-aggregated on each dimension in order to corroborate the findings of the overall index analysis.

2.2.2 Ideal Type Analysis of Health Systems

Kvist (1999, 2007) introduces the concept of fuzzy set ideal type analysis. This is a deductive method of making ideal type classifications. Starting with theory, the relevant dimensions are defined as conditions. Cases are given a fuzzy set score in each condition from 0 to 1, with 0.5 representing a qualitative threshold after which the case is said to be "more in" than out in that condition. In our case each condition reflects whether a case is decommodified in the particular dimension. Each possible combination of conditions leads to a specific ideal type, resulting in a "truth table" of k^2 possible combinations. In a second step, each case's membership in the ideal type is computed. Each case can only logically belong to one ideal type, more than

Table 2.2: Ideal Types of Healthcare Access

Type	Finance (F)	Provision (P)	Regulation (R)	Formal notation[i]	Corresponding Classification[ii]
Public Encompassing	X[iii]	X	X	F*P*R	NHS
Regressive NHS		X	X	∼F*P*R	NHS/SHI
Restricted Provision	X		X	F*∼P*R	SHI
Restricted Regulatory	X	X		F*P*∼R	NHS/SHI
Insurance State	X			F*∼P*∼R	SHI
Provision State		X		∼F*P*∼R	NHS/SHI
Regulatory State			X	∼F*∼P*R	SHI/PRI
Privatized Risk				∼F*∼P*∼R	PRI

[i] Set notation, "∼" denotes the negation of the condition. For exameple "∼F" is commodified financing.
[ii] Rough approximation to the NHS/SHI/PRI classification.
[iii] X indicates that dimension is decommodified (high access). Absence of X indicated the opposite.

any other.

One way to visualize this process is to imagine a three-dimensional space, such as a cube. Each dimension can be seen as a side of the cube (length, width and height) and the eight corners of the cube can be seen as the ideal types. Each case, visualized in this space, is closest to one particular corner of the cube. Figure 2.3 plots all of the cases in this analysis in a cubic space. As can be seen, Cyprus and Bulgaria are nearest to the corner where all three dimensions are 0, therefore showing the highest possible barriers to access, while Czechia is nearest to the opposite corner where all dimensions are 1, the fewest barriers to access.

Kvist's approach is an *ideal* means to put in practice the Wendt et al. (2009) model since it looks at membership in each dimension and then membership in each combination of dimensions, or ideal type. It has the added advantage of being able to track the three kids of changes they mention: system change (in this case, moving from high access on all, to low on all), withing system change (for example, moving from high to low access on regulation), and within level change (for example, changing

the score on financing access without passing the threshold). The 8 possible ideal types, together with an approximation of the NHS/SHI/PRI classification for each for comparison, are presented in Table 2.2.

All fuzzy set scores reflect membership in the set of high access (or decommodified systems), therefore higher scores on the 0 to 1 scale, indicate greater access.

2.3 Results

Table 2.3 shows the empirical cases corresponding to the ideal types. For all cases, four time periods were taken, corresponding roughly to values from 2000, 2004, 2008, and 2012 (or closest year). Cases without a reference to a year showed no system, or within system change in the period, and are shown in **bold**. Cases with years attached denote the year belonging to each type. The last column of Table 2.3 shows the (roughly) corresponding NHS/SHI/PRI classification. The results here highlight the limits of this classification due to the heterogeneity of cases that would otherwise be grouped together in one of the three system types.

As expected, no case showed a complete system change. This would presume a complete overhaul of the health system, which is extremely unlikely given the many political, institutional and fiscal constraints on health policy reforms. Nine out of seventeen cases showed a within system change: Bulgaria, Czechia, Estonia, Greece, Italy, Lithuania, Poland, Slovakia, and Spain. Among them, Czechia, Estonia and Italy, increased access to a within-system change, while the others retrenched access, and Spain showed a reversal. Table 2.4 shows their fuzzy set scores in each dimension and each ideal type. Bold numbers highlight the within system change. Table A.1 in appendix A shows the scores for all cases across all periods.

Slovakia is the case showing the most dramatic change during this time span, covering

Table 2.3: Empirical Cases and Corresponding Ideal Types

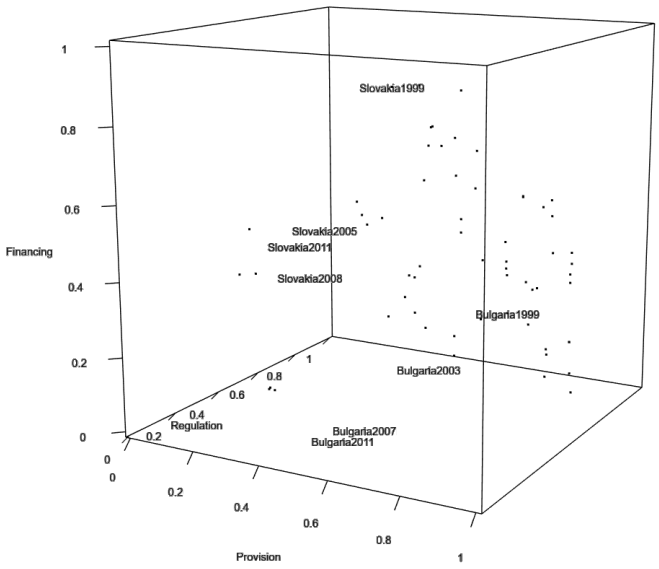
Ideal Type	Cases	Formal notation	Corresponding Classification[i]
Public Encompassing	Czechia 2004,2008,2012 Italy 2004,2008,2014	F*P*R	NHS
Regressive NHS	**Latvia; Malta; Portugal**[ii] Bulgaria 1999; Italy 2000 Greece 2000,2004,2008 Lithuania 2000	∼F*P*R	NHS/SHI
Restricted Provision	Czechia 2000; Slovakia 1999	F*∼P*R	SHI
Restricted Regulatory	**Croatia; Romania; Slovenia** Estonia 2008, 2012; Spain 2008	F*P*∼R	NHS/SHI
Insurance State	Estonia 2000, 2004 Slovakia 2005	F*∼P*∼R	SHI
Provision State	Poland 2000,2004;Greece 2012 Bulgaria 2003, 2007, 2011 Lithuania 2004,2008,2012 Spain 2000,2004,2012 **Hungary**	∼F*P*∼R	NHS/SHI
Regulatory State	No Observed Cases	∼F*∼P*R	SHI/PRI
Privatized Risk	Slovakia 2008,2011 Poland 2008,2012 **Cyprus**	∼F*∼P*∼R	PRI

[i] Rough approximation to the NHS/SHI/PRI classification.
[ii] Cases in **bold** scored in the same ideal type in all four periods.

Table 2.4: Fuzzy-set Scores for Cases Showing Within Dimension Change

Country	Year	Finance	Provision	Regulation	FPR	FP∼R	F∼P∼R	F∼PR	∼F∼PR	∼FPR	∼FP∼R	∼F∼P∼R
Bulgaria	1999	0.26	0.76	0.66	0.26	0.26	0.24	0.24	0.24	**0.66**	0.34	0.24
Bulgaria	2003	0.18	0.69	0.33	0.18	0.18	0.18	0.18	0.31	0.33	**0.67**	0.31
Czechia	2000	0.86	0.49	0.66	0.49	0.34	0.34	**0.51**	0.14	0.14	0.14	0.14
Czechia	2004	0.85	0.61	0.66	**0.61**	0.34	0.34	0.39	0.15	0.15	0.15	0.15
Estonia	2004	0.58	0.38	0.00	0.00	0.38	**0.58**	0.00	0.00	0.00	0.38	0.42
Estonia	2008	0.63	0.71	0.00	0.00	**0.63**	0.29	0.00	0.00	0.00	0.37	0.29
Greece	2008	0.16	0.87	0.66	0.16	0.16	0.13	0.13	0.13	**0.66**	0.34	0.13
Greece	2012	0.34	0.84	0.33	0.33	0.34	0.16	0.16	0.16	0.33	**0.66**	0.16
Italy	2000	0.44	0.89	0.66	0.44	0.34	0.11	0.11	0.11	**0.56**	0.34	0.11
Italy	2004	0.54	0.88	0.66	**0.54**	0.34	0.12	0.12	0.12	0.46	0.34	0.12
Lithuania	2000	0.39	0.68	0.66	0.39	0.34	0.32	0.32	0.32	**0.61**	0.34	0.32
Lithuania	2004	0.29	0.68	0.33	0.29	0.29	0.29	0.29	0.32	0.33	**0.67**	0.32
Poland	2004	0.39	0.93	0.00	0.00	0.39	0.07	0.00	0.00	0.00	**0.61**	0.07
Poland	2008	0.47	0.39	0.00	0.00	0.39	0.47	0.00	0.00	0.00	0.39	**0.53**
Slovakia	1999	0.85	0.40	0.66	0.40	0.34	0.34	**0.60**	0.15	0.15	0.15	0.15
Slovakia	2005	0.51	0.39	0.33	0.33	0.39	**0.51**	0.33	0.33	0.33	0.39	0.49
Slovakia	2008	0.38	0.34	0.33	0.33	0.34	0.38	0.33	0.33	0.33	0.34	**0.62**
Spain	2004	0.49	0.91	0.33	0.33	0.49	0.09	0.09	0.09	0.33	**0.51**	0.09
Spain	2008	0.54	0.90	0.33	0.33	**0.54**	0.10	0.10	0.10	0.33	0.46	0.10
Spain	2012	0.47	0.91	0.33	0.33	0.47	0.09	0.09	0.09	0.33	**0.53**	0.09

Figure 2.4: Cube Representation - Bulgaria and Slovakia



three ideal types in the four time points, ending in the ideal type showing least access. The second most dramatic case is Bulgaria, showing a substantial decrease in financial and regulation access, and to a lesser degree in provision. Both cases are plotted in figure 2.4 with the respective years. Their movement through the three dimensional space shows the dramatic changes they underwent. Slovakia in 1999 more closely resembled Czechia at the same time, while subsequent reforms, particularly those by the Dzurinda cabinets (Fisher et al., 2007) moved it closer to Bulgaria's position in 1999, by 2008. Bulgaria shows the most drastic change since transition. It initially started in the same place in 1989 as Czechia and Slovakia, yet by 1999 the system had deteriorated in the absence of reforms through informal payments and lack of financing (Rechel, Blackburn, Spencer, & Rechel, 2011). Subsequent reforms in Bulgaria only exacerbated the retrenchment of access as the uninsured rate increased and OOP skyrocketed.

Overall, there does not appear to be any neat and clear regional clustering with cases

from both regions mixing in different typologies, despite the fact that the two regions previously clustered into NHS (Southern Europe) and SHI (Eastern Europe).

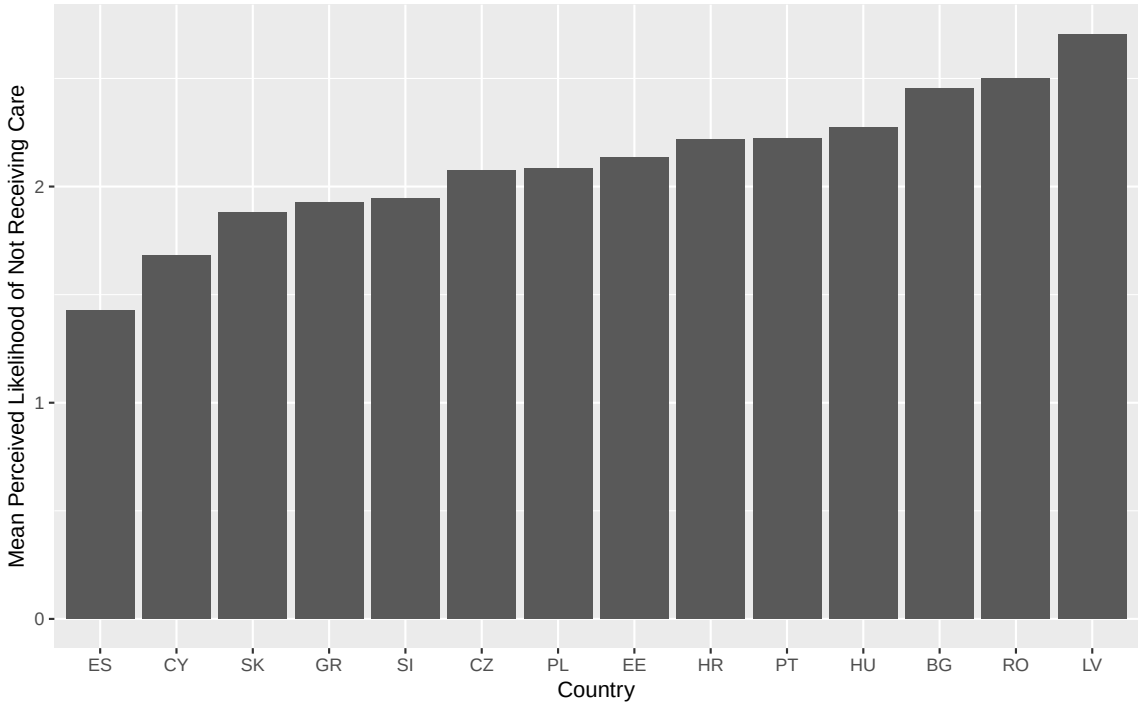
However, some patterns are visible. The only ideal type showing no empirical cases is that of showing access only in regulation. The fact that both cases which moved into low access in all three areas did so by first retrenching regulation before provision (Poland) and financing (Slovakia) suggests that retrenching regulation is a first step in overall retrenchment. Indeed, four of the six cases of within-system retrenchment are of regulation (Bulgaria, Greece, Lithuania, and Slovakia from 1999 to 2005). The opposite also seems to hold. Czechia expanded provision after first having expanded regulation, while Italy expanded financing after having expanded regulation.

2.4 Discussion

Frameworks looking at health systems in Eastern Europe place them squarely in the classical social health insurance framework (Marrée & Groenewegen, 1997; Kornai & Eggleston, 2001). Such analyses do well to trace the pre-war Bismarckian origins of these systems, as well their legacies and how they shaped the systems we see today. However, including EE countries in this broad category masks the ways in which they diverge together from our understanding of social insurance systems, as well as how they differ from each other. In doing so, such frameworks miss out key characteristics of these systems, especially in terms of how they shape access to services.

Wendt (2014) argues that EE countries maintained higher levels of state regulation compared to other social insurance regimes. The present analysis suggests that EE states have used regulation as a means of restricting access, most notably seen in the Slovak and Bulgarian cases. Moreover, the clustering of EE countries in the *Provision State* type suggests that they differ from other social insurance systems by relying

Figure 2.5: Perceived Likelihood of Not Receiving Health Services - 2008



Source: ESS (2008), author's compilation

not only on more restrictive regulation, but also erecting more financial barriers to access.

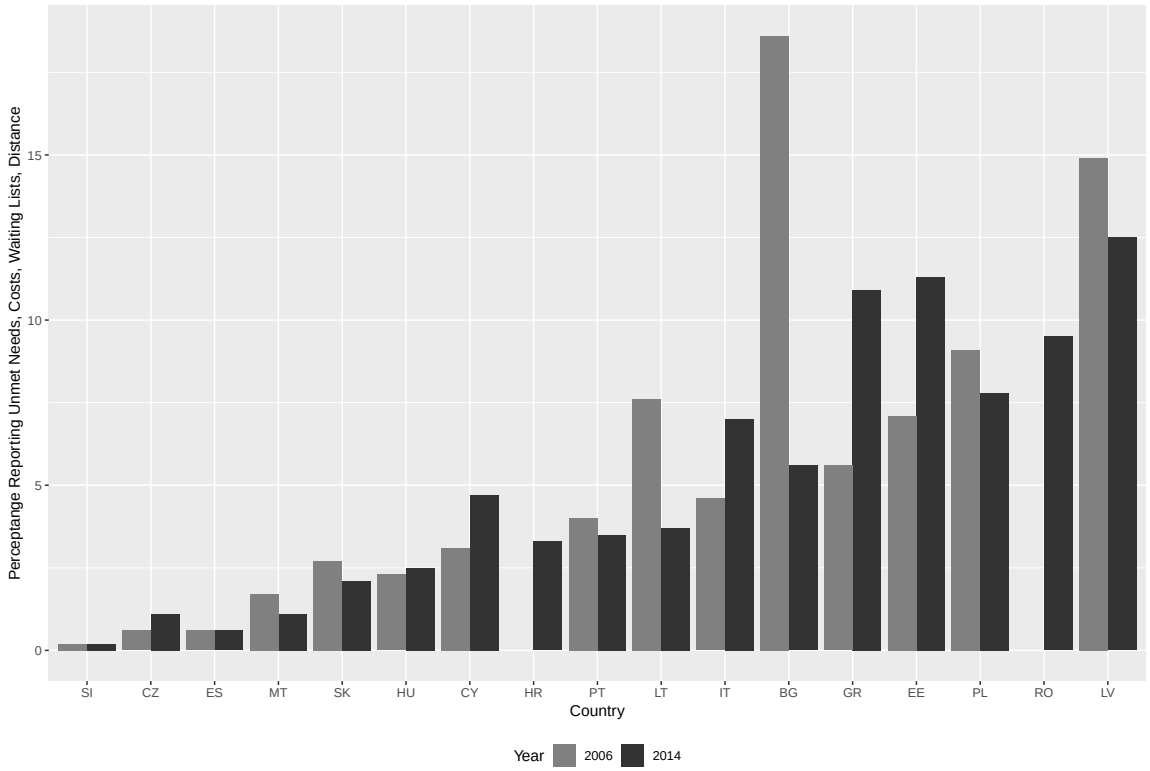
Southern European cases are usually seen as national health service types (Cabiedes & Guillén, 2001). Several recognized differences between them and more typical NHS systems in Scandinavian countries have already been noted, including their increased reliance on private financing and lower administrative capacity (Moran, 1999; Wendt, 2014). Böhm et al. (2013) continue to find Spain and Portugal in the NHS type, with Italy being characterized by more private provision, thus falling in the National Health Insurance category. The present analysis suggests that Spain, Portugal and Italy, the latter up until the early 2000's, are characterized by financial barriers to access, with Spain also showing regulatory barriers to access - therefore falling out the typical understanding of a NHS with full access.

Italy and Czechia post-2000 are the only cases that come close to full access, the *Public Encompassing* ideal type. Czechia in particular highlights the flaws of the general association that social health insurance is intrinsically less protective than a fully public, NHS system. Indeed, from a patient perspective, the much lower private expenditure and out of pocket payments in the Czech system, offer them more protection than the otherwise public Spanish and Portuguese systems. Czechia has maintained a broad principle of solidarity with mandatory public insurance which covers economically inactive parts of the population through state subsidies (Rechel & McKee, 2009). The Czech system has also marginalized the role of private spending by making opt-outs of the public system difficult. Thus, it does not observe the phenomenon seen in Romania, among other EE systems, where the private sector drains resources and political pressure from the public system. The Czech system also offers comparatively generous benefits packages, making it more akin to the Scandinavian equality of care, if not yet reaching the quality provided by those systems (Alexa, Recka, Votápková, Spranger, & Wittenbecher, 2015).

The *Restricted Regulatory* ideal type mostly contains EE countries, while Spain barely passes the threshold. Romania is the case which best fits this type. Romania also shows the importance of regulation. Despite having a high share of public financing, around 10% of Romanians cite unmet needs (Eurostat, 2019). Faced with pressures to contain costs while assuring access, as well as because of a fractured political system, Romania delayed reforms well into the late 1990s (Vladescu, Radulescu, Olsavsky, & Busse, 2000). The first cost containment attempts targeted direct access to GPs and specialists. This is illustrative of the path of many EE states.

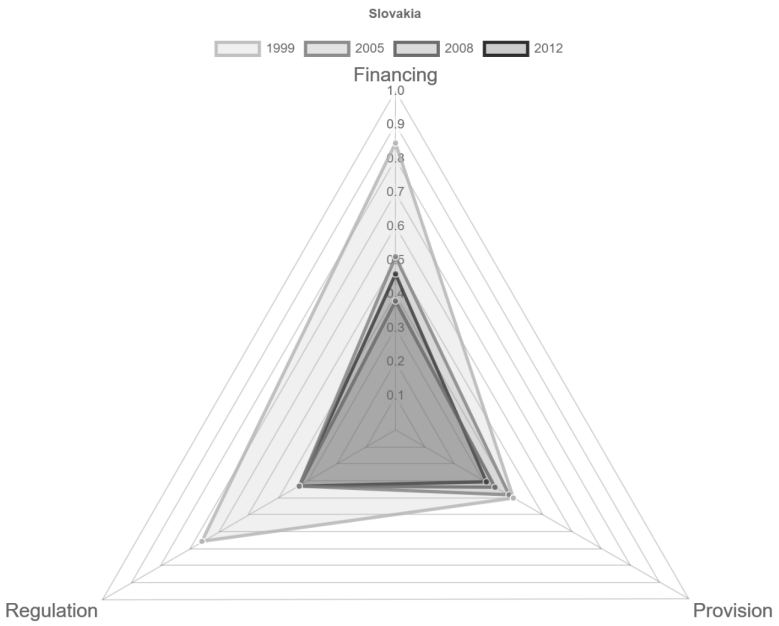
The *Provision state* type shows Bulgaria and Lithuania as the most typical cases. They are joined by Hungary, Poland, Greece and Spain. These are public provision systems, which are heavily reliant on private expenditure and out of pocket payments,

Figure 2.6: Reported Unmet Medical Needs - 2006, 2014



Source: Eurostat (2019), author's compilation

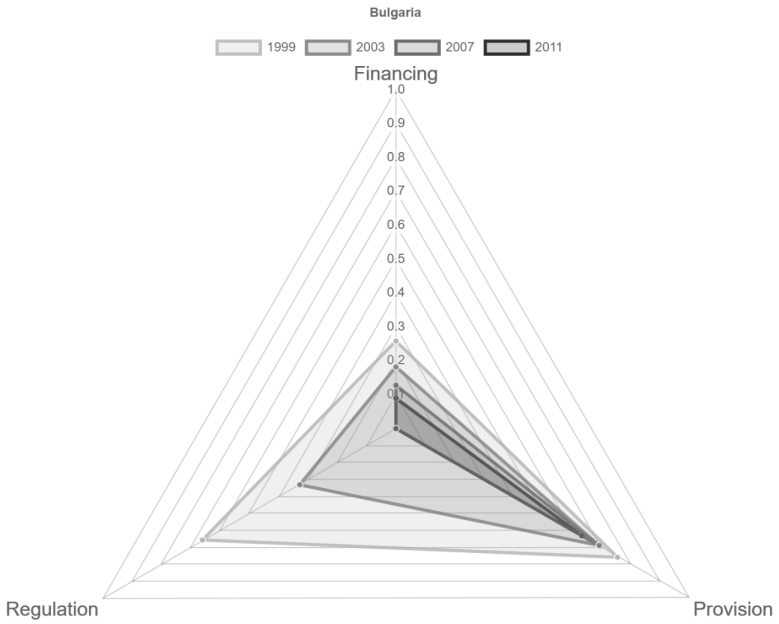
Figure 2.7: Slovakia - Change in Access Index



while also being gated in terms of regulation. They represent the "success" cases of cost containment, governments managing to restrict the most important areas of access. All of these countries also show severe access issues, with 7% of Greeks, 10% of Bulgarians and 5% of Hungarians reporting unmet health needs (Eurostat, 2019). Figure 2.6 shows unmet health needs across all cases for 2006 and 2014, using Eurostat data, while Figure 2.5 uses ESS data to show the mean perceived likelihood of not receiving services for each country in 2008.

Finally, the *Regressive NHS* type shows a moderate clustering of Southern cases: Portugal, Greece, Italy (2000), Malta, joined by Latvia and Bulgaria (1999), and Lithuania (2000). As previously noted, these are mostly regarded as NHS type systems (with the exception of Bulgaria and Lithuania), yet are heavily reliant on private spending. The effects of this are most visible in Latvia. Despite being an NHS system on paper, a staggering 18% of Latvians reported unmet health needs due to financial constraints in 2012 (Eurostat, 2019). This further highlights the need to look beyond

Figure 2.8: Bulgaria - Change in Access Index



the formal organization of a health system, and into the ways it actually impacts individuals.

Slovakia and Bulgaria showed the most dramatic instances of retrenchment. Figure 2.7 shows the evolution of the Slovak system, first restricting access through regulation and later, financing. Figure 2.8 traces Bulgaria's dramatic change of limiting regulatory and financial access to health. By the end of the 1990s, Bulgaria, like most EE countries, had transitioned to a social insurance system. However, this left it with both a high proportion of uninsured, as well as high OOP spending. A lack of reforms exacerbated these problems in the 2000s, making Bulgaria the country with the highest gap in coverage in the EU, with 23% of the population uninsured (Dimova et al., 2012). This makes Bulgaria one of the least protective health systems in Europe. In the Bulgarian case financial and regulatory barriers are coupled with an already more impoverished and therefore more vulnerable population.

Over the sample of EE and SE countries, the number of countries that retrenched

access to healthcare, as well as the depth of retrenchment, far outnumbered the cases of expansion. Ultimately, for many countries, transition to democracy has also meant a transition to greater health insecurity.

2.5 Conclusion

Classifications will always be inherently flawed. By definition, they limit the variation between cases and highlight only some aspects of each type. By doing so, they hide complexities of social phenomena, yet also structure our knowledge of such phenomena in ways that can help understand them better. This inherent trade-off is necessary in order to simplify reality into theoretically relevant chunks.

This paper has argued that looking at financial and other barriers to health services, understood as healthcare access, is important in order to understand the welfare function of health systems. By looking at dimensions relevant to patients, this chapter has built an index meant to understand health systems based on the financial risks and barriers faced by individuals. This index has classified 17 countries in Eastern Europe and Southern Europe across 4 time-periods.

Further, fuzzy-set ideal-type analysis was used in order to place these countries on a three-dimensional space based on how they score in the health system sub-dimensions of financing, provision, and regulation. This type of analysis has shown two advantages. The first is to show an intuitive way of clustering cases based on theoretically relevant dimensions. This provides a better framework of understanding several cases and regional patterns. EE, beyond its common path of moving towards social health insurance, shows an enormous variation in how patients face financial and access risks, with the Czech system being almost on par with more traditional public and protective systems in Western Europe, while Bulgaria's system shows continued de-

terioration and an increasing of risks. Latvia and Portugal also show that the broad understanding of a national health service masks complex systems that can be less protective than social insurance systems. These patterns translate into how patients report unmet health needs.

The second advantage of this type of analysis is that it is an intuitive way of showing different types of changes in health systems. The lack of a full system change shows that health systems rely on a great deal of path dependence. Changes are still visible when looking at individual dimensions. Indeed, this type of change also reveals certain patterns - for example how many EE countries have changed their systems by restricting access through regulation. Lastly, looking within individual dimensions shows us more minute changes - the type of changes that might not be captured if we only look at formal policies.

The limitations of such an approach revolve around data availability. Access to healthcare is a multifaceted concept, which would require multiple types of data beyond what was used here. From a system perspective, waiting times, availability of certain services, and geographic dispersion of hospitals and clinics are just a few of the additional indicators which would ideally be included in a classification. The most important factor omitted due to data availability is that of informal payments. These payments are common in EE (Atanasova, Pavlova, Moutafova, Rechel, & Groot, 2014; McMenamin & Timonen, 2002), and to a lesser degree in SE, and are particularly regressive (Stepurko, Pavlova, Gryga, & Groot, 2013). Their incorporation would likely alter the position of some cases in the classification. Ultimately, classifications shape the way we see social reality. Therefore, there can be no definitive way of seeing health systems that can satisfy different perspectives. New classifications and indicators will be needed to push the boundaries of our understanding. As Freeman and Frisina (2010) note: "[c]lassification is a problem [...] and so it should be".

3 Theories of Health Politics

> *Now, I have to tell you, it's an unbelievably complex subject [...]. Nobody knew healthcare could be so complicated.*
>
> —Donald J. Trump, 45th President of the United States

> *The general proposition that I wish to put to you is that the solution to many of today's problems will not be found in the research laboratories of our hospitals, but in our Parliaments.*
>
> —Sir George Young, British Minister of Health

Health is inherently political. On an individual level, health is determined by the lottery of birth both in terms of one's genes, but more so in terms of one's environment: education, sanitation, access to nutrition, medication, among many others. But health is not merely individual. Pollution, vaccination, and cultural norms, and group health practices are among the many ways in which groups and nations affect an individual's health. Governments' responsibility for protecting and promoting individual health is therefore consecrated as a human right – though one that is upheld to different degrees by different governments (Toebes, 2001).

A more fundamental way in which health is political has to do with its distribution, in the form of healthcare. As with many other goods, different social groups have different amounts of health (Bambra, 2005b). These distributions are not random, but rather map on to other economic and social vulnerabilities. While they are pro-

duced by existing social and economic structures, the fact that these distributions are amenable to policy interventions means that political conflict is expected. Government policies shape the distribution of resources and decide access to goods and services (Raphael, 2015).

Given the impact and political nature of such policies, it is important to ask what determines them. Therefore, the central question that this dissertation is concerned with is: *Why do some governments enact policies that restrict access to healthcare while others expand it?* Numerous factors shape government decisions (or lack of decisions) and their chances of passing as policy. The question then asks *which* conditions are important and *when* they are important. This chapter looks at existing answers to this question by surveying the role of institutions, legacies, and government characteristics in shaping social policy. It points out the benefits and limits of each approach in order to build a more comprehensive understanding of the role of governments in policy making.

The previous chapter aimed to answer the question of how we should conceptualize health policy in such a way as to capture its effects on individuals. It argued that an access measure can capture the health and welfare functions of health systems. It further argued that changes in access are amenable to political interventions for which governments can be held accountable for, at least in principle. However, governments can only be held accountable for policies if they have the ability to influence them.

Health politics do not play out in a vacuum, but are embedded in a context of institutions which determine vested interests, how these interests are expressed, as well as how political power is accessed and wielded. Furthermore, such institutions and accompanying practices have long histories which shape expectations and norms of which ideas and practices are acceptable. Governments also have other commitments to economic and social targets, obligations to international institutions, fiscal and

organizational constraints, as well as limited political capital. Given all of these, can there still be a role for government characteristics in explaining important policy changes? If so, how important is this role? Which policies can party politics explain and which can they not? These questions are important not only from a theoretical perspective, but also from a democratic accountability perspective - if parties do not have an impactful role in policy making, then they cannot be responsive to voters.

This chapter argues that there is space for such a role, given existing constraints. It surveys major debates in the literature and maps out possible shortcomings of existing approaches, and areas where this project can contribute to overcoming those shortcomings. The chapter's first section surveys the impact of political institutions on health policy, pointing out their importance, as well as their limitations in explaining processes of change. The second section highlights the empirical puzzle that remains once we take institutions into account, while the third section surveys existing literature on the role of governments and partisanship, in order to assess its applicability to health policy. Chapter 4 builds on these works in order to develop a more specific theory of partisanship for health policy.

3.1 Political Institutions and Healthcare

Health systems show considerable variety in terms of spending, institutional arrangements, centralization, access, and others characteristics. Much of this divergence stems from their inception. Early choices, themselves subject to existing social structures and institutions, were subsequently entrenched through political and bureaucratic institutions so that political parties had an increasingly narrow space where they could challenge existing policies (Cerami & Vanhuysse, 2009). Nevertheless, policy changes still occur. healthcare is one of the fastest changing sectors. New

discoveries bring new opportunities, but also strain budgets. Governments need to constantly make decisions about who gets treatment, when they get it, what type of services they receive and how long they need to wait for them. What this means is that it does not necessarily take deep institutional or systemic change in order to affect people's lives. The British National Health Service has basically maintained its core structure over the past 30 years. Nevertheless, the cutbacks it suffered have had a lasting effect on the quality of care and the degree to which patients could access services (Mossialos et al., 2018). Seemingly small changes, such as introducing co-payments can deter individuals from using services and can add up to a significant financial burden on low-income earners (Schoen et al., 2010). While broad systemic changes in healthcare systems are well understood, what is still missing from the literature is an understanding of what drives political decisions to expand or retrench access to healthcare.

Current neo-institutionalist approaches emphasize the self-reinforcing mechanisms of political institutions in policy-making (Cerami & Vanhuysse, 2009). Departures from the lock-in processes are caused by critical junctures - external or internal shocks which cause a re-alignment of actor preferences and a redesign of the rules of the game. In this period, departure from normal policy-making, as well as a redesign of institutions is possible, resulting in a new equilibrium and a locked-in process (Capoccia & Kelemen, 2007). These approaches have worked remarkably well in explaining the broad historical differences among health systems. Immergut (1992) develops a theory of why West European countries managed or failed to implement universal healthcare systems. In her account, physicians seeking to maintain autonomy and income managed to block universalist reforms in systems ridden with veto points such as the United States or Switzerland, but failed to do so where political will was less constrained, as in the United Kingdom or Sweden. Institutions do not operate by themselves but rather shape the preferences and behaviors of actors

seeking to enact changes.

Inglot (2008) further emphasizes how political and policy institutions constrain elite behavior. He builds a compelling historical account of the welfare states of Hungary, Poland and Czechoslovakia by showing how the initial timing and sequencing of reforms locked-in policy processes, in a way that partially withstood even the critical junctures of fascism, communism and democratization. He concludes by saying that "since 1989 the new democratic governments inherited not only laws, rules, and norms of the communist-era welfare state but also its institutional resources, bureaucratic capacities, organizational structures, personnel, and networks of expertise" (Inglot, 2008, p. 297). These continuities help explain some patterns of policy-making in a new political environment. While such persistent structures also shape new policy instruments and decisions, such an approach tells us less regarding the choice between competing legacies (for example Bismarckian and Semashko legacies) or new policy instruments (for example managed hospital competition or the introduction of DRGs).

Indeed, the major transformations of EE health systems since 1989 can be traced to their Bismarckian origins, and were possible due to the critical juncture of the transition to democracy and capitalism (Marrée & Groenewegen, 1997; Haggard & Kaufman, 2008). For Southern Europe, Greece, Portugal and Spain's reforms to National Health Service systems can be traced to the critical juncture of the transition from authoritarianism to democracy, and the take-over of power of social democratic governments, formerly in opposition. Italy went through a moment of national solidarity against terrorism and pressure from the communist party (Toth, 2010). Hacker (2004b) adapts this logic to smaller scale healthcare changes, arguing that reforms of any kind are more likely in veto-free centralized systems where neither the opposition nor the bureaucracy is in a position to resist reform attempts. Indeed,

neo-institutionalist approaches allow for changes due to ideational diffusion, interest groups, popular beliefs, and electoral competition, among others (Cerami & Vanhuysse, 2009). These changes are still expected to be path-dependent until a new restructuring of institutional arrangements.

Therefore, such institutionalist approaches are quite adept at explaining broad changes in health systems. In the cases of EE and SE, these can be traced to the change from authoritarianism, E.U. integration and the great recession. They are also adept at informing us why change is hard in the absence of such shocks. Nelson (1993) and Roland (2002) discuss the obstacles to economic reform in terms of ex ante constraints (problems with passing reforms) and ex post constraints (problems with maintaining reforms). Both highlight the importance of a government's capacity to insulate itself from opponents as a condition for managing difficult reforms.

Pierson (1994) ignited an entire debate in the field, by arguing that the politics of retrenchment are different from those of expansion, of the golden age of the welfare state (in Western Europe). The new politics, Pierson argued, left much less room for political parties to maneuver. Parties were stuck in between immense fiscal pressure to retrench welfare states, and societal pressures and institutional legacies to preserve welfare generosity (Pierson, 1998). This narrow space dictated that parties, irrespective of political color, had little space for policy innovation, and that policy processes would be fundamentally shaped by existing social policies (Pierson, 2001). Pierson therefore explained the resilience of welfare states in an era of permanent austerity. Instead of dismantling the welfare state directly, parties had to use hidden means of policy change through obfuscation in order to avoid blame (Pierson, 1994). Blame avoidance, as a strategy, has also been contested in the literature. Vis (2016) argues that avoidance strategies are not necessary for conservative and liberal parties, since retrenchment does not constitute an electoral risk for them.

While defining this space for political action, the new politics literature does not tell us under which conditions parties are likely to use these strategies in order to retrench. This is particularly important for health policy, an area where unpopular decisions and reforms have brought down entire governments. Romania, Hungary, Poland and Czechia, among others, saw massive mobilization of health workers and the general population over health reforms, contributing to the resignation of their governments (Holt, 2012; Nemec, Pavlík, Malý, & Kotherová, 2015; Edelényi, 2008). The question therefore remains as to what drives parties to make such changes, and what are the conditions under which they will attempt them. (Green-Pedersen & Haverland, 2002).

More generally, institutionalist accounts such as those outlined above do not give enough guidance so as to understand the motivations and specific context for when parties pursue reforms, hidden or otherwise. Specifically with regards to healthcare, there are reasons to believe that even more incremental policy changes can have great effects on how individuals use health services. For example, the introduction of co-payments can cause drastic numbers of individuals to defer treatment (Xu et al., 2003). Changing rules for exemptions, such as raising the age up to which young people are covered, or the extent of coverage for the old or uninsured, often require only ministerial or government decisions, yet can have drastic impact on access (Arsenijevic et al., 2016). It is therefore important to understand what motivates such decision and how and when governments are able to implement them. Changes which affect access to healthcare are more important to patients than changes to the institutional make-up of health systems, for example changing payment mechanisms between funds/states and providers. It is therefore important to understand the politics of such changes. Indeed, because changes that affect access to healthcare affect individuals the most, it is likely the arena of healthcare that will be most contested by different political and social actors.

This suggests that, at least when it comes to healthcare, it is important to look at explanations which take into account the different motivations and contexts in which parties operate. A second limitation of these studies has to do with their explanatory power given the cases this study looks into. Within the space of institutional rigidity and fiscal pressure, there are surprising patterns of expansion, retrenchment and reversal among the 17 countries examined here. These changes are divergent between similar institutional systems and legacies of countries, but also within systems where path-departing changes are enacted also in the absence of critical junctures. I now turn to these changes.

3.2 The Limits of Institutions

The health systems of Eastern and Southern Europe currently span different institutional arrangements, mixes of public and private financing and laws that regulate relations between patients, insurers and healthcare providers. While some of these differences are expected given the different historical legacies and political arrangements, others are not easily explained using such a framework. Countries with similar institutions have gone down different reform paths, while others have seen radical reversals. These changes are present not only when we look at the access index developed here, but also in terms of laws (input measures), and satisfaction with the health system (outcome measures).

The main puzzle this dissertation addresses is that countries with similar legacies and institutional arrangements followed different reform patterns. Czechia and Slovakia, emerging from, and maintaining similar institutions (in terms of veto points, electoral laws, and stability of governments), nonetheless took almost opposing paths where Czechia expanded access to healthcare, while Slovakia systematically undermined

it over successive governments. Slovak governments, beginning with the Dzurinda governments in the late 1990s and continuing with Fico and Radicova in the 2000s continuously eroded access to the health system. By making insurance funds into private, for-profit entities, consumers were often denied access to many basic services, while increasing user fees and co-payments deterred individuals from seeking care (Fisher et al., 2007). Interestingly, the Czech Topolanek government sought to implement similar policies, yet failed to do so (Lawson, Nemec, & Šagát, 2012).

Lithuania and Latvia show the same divergence after declaring independence, with Latvia increasing access to health over the early 2000s, while Lithuania retrenched it. Beyond access, this divergence can be seen in institutional arrangements as well, with Latvia removing the purchaser-provider split and closer approximating a National Health Service, while Lithuania more closely resembling a Social Health Insurance model (Mitenbergs et al., 2014). Spain and Portugal show a similar pattern, where after emerging from authoritarianism, Spain implemented a system more closely resembling NHS, while Portugal created a dual system, where certain professional groups enjoyed additional services and insurance benefits (Toth, 2010).

The second surprising pattern, in light of path-dependent explanations, regards reversals within the same country. Estonia showed policy reversal, first retrenching under the Kalls government in early 2000s by introducing higher user fees, to then expand access to health under the Ansip governments in the late 2000s. The expansion remained stable during and after the 2008 financial crash, which hit Estonia particularly hard (Atun, Menabde, Saluvere, Jesse, & Habicht, 2006). Besides reversing some user fees, Estonia also reversed back to central control of decision making over primary care, after initially decentralizing it in the late 1990s (Koppel et al., 2008). Romania shows the opposite policy reversal, retrenching access to health in the mid-2000s (before and after the crisis), after having expanded it in the late 1990s

and early 2000s (Burlacu & Moise, 2019). Moves to close down hospitals, increase user fees, and privatize health insurance funds were attempted, and partly implemented, after years of expanding eligibility criteria and covered groups (Vladescu, Scîntee, & Olsavszky, 2008).

A secondary puzzle is seen in healthcare reforms where, in contrast to expectations by the permanent austerity literature, there are cases of clear expansion of services. Slovenia, Italy and Czechia, and to a lesser degree Malta and Latvia expanded access to healthcare during the last two decades (Economou, 2010; Azzopardi-Muscat, Buttigieg, & Calleja, 2017).

A third, related puzzle, appears when we look at reform attempts that have failed, while the same governments managed to pass reforms in other economic and social policy areas. Several failures of passing health policy are visible in cases where governments managed to pass other types of policies. Hungary under Gyurcsany, Romania under the Boc government, Spain under Anzar, Lithuania under Kubilius, and Czechia under Topolanek, all put forward retrenchment policies under favorable conditions, which failed, while managing to cut unemployment, public sector salaries and other policies (Österle, 2010; Mihalyi, 2007; Björkman & Nemec, 2013). Slovenia under Pahor, Portugal under Guterres and Malta under Gonzi put forward expansionary policies which failed (Oliveira, Magone, & Pereira, 2005; Kaminska, 2013; Oliver & Mossialos, 2005).

These policy divergences between countries, and policy reversals within countries, point to the fact that at least at this level of analysis, party politics likely still plays a role within institutional settings. While their space to maneuver is limited, parties attempt and sometimes manage to implement reforms that bring long-lasting changes between countries. These puzzles do not negate the explanatory power of institutionalist approaches. Rather, they point to additional explanatory mechanisms which are

needed to understand them.

It is therefore important to understand the political dynamics and how they interact with institutions and policy legacies in order to create these changes.

3.3 Partisanship Explanations for Social Policy

Health is much broader than healthcare policies and healthcare systems, as it falls into almost every policy domain from education to disease classification. Healthcare policies, however, are likely the area to be most contested since they directly involve resources, how they are spent, who gets access to services and under what conditions. As a state policy, a good place to start is traditional partisan explanations for welfare state expansion and retrenchment.

3.3.1 The Evolution of Partisanship Arguments

The classical welfare partisanship argument claimed that parties directly represent different classes, aggregating their interests and translating them into policies (Borg & Castles, 1981). A more elaborate and influential theory, named the power-resource approach (PRA), builds on this argument, adding the importance of class mobilization and unions as mechanisms and channels of translating preferences and needs of individuals into actions by parties (Korpi, 2011). This approach has also been adapted to studying East European cases, with Lipsmeyer (2002) finding a distinct effect of right parties on retrenching pensions, unemployment and health, but not family benefits.

Navarro et al. (2006) name this an "upstream" theory where voting behavior and union characteristics flow upwards to political parties and impact policies. Specifi-

cally, this approach relies on a class mechanism to explain why left and right parties behave differently. According to Huber and Stephens (2010, p. 17), "the struggle over welfare states is a struggle over distribution". They therefore bring the class mechanism to the forefront in explaining parties' behavior and policy outcomes. And indeed, such explanations seem to fit well with the empirical reality of welfare expansion in the post-war years, up until the 1980s (Pierson, 1994).

Potrafke (2017) reviews over 100 panel data studies covering the effect of partisanship in the OECD and concludes that partisanship has diminished as an explanatory factor since 1990 with government policies in general, while maintaining importance in privatization and market deregulation. The observations in these studies led to several strands of literature which have sought to nuance partisanship claims and explain the puzzling behavior of parties in an era of globalization and recurring economic crises (Häusermann, Picot, & Geering, 2013). These studies have taken the form of introducing mediating variables as explanations for the diminishing role of partisanship.

The first such mediating factor is fiscal pressure. Huber and Stephens (2010, p. 29), arguing against the claims of the new politics literature, conclude that "what is distinctive about the current period is less the strong effect of policy legacies than the weakening of the effect of partisan government due to the constraining effect of economic difficulties on social democratic and Christian democratic governments". In this reading, the weakening of the partisanship effect is seen through the mechanism of left leaning parties losing their ability to expand the welfare state under austerity conditions. Ross (2000a) goes further and argues that left parties are actually more likely to retrench welfare in the face of fiscal pressure, since they are seen as more legitimate. Similarly, Tavits and Letki (2009) claim that in post-communist countries, social democrats are more likely to retrench so as to be seen as breaking with

their communist past, and now fiscally responsible. Fiscal pressure, more specifically to healthcare, can be broken down into demographic change and direct fiscal deficits (Pierson, 1998; Swank, 1988). The healthcare sector is especially sensitive to demographic changes. Simply put, on the entire European continent there is a growing share of people who "are living longer, retiring earlier, and demanding more medical care" (Pierson, 2001, p. 26). It is therefore likely that health policy changes will be particularly sensitive to fiscal constraints.

A second set of explanations go directly against the class mechanism of traditional partisan explanations, by considering whether electorates have changed. One side of this literature argues that parties' electoral bases have shifted, with left parties gaining more affluent highly skilled middle class voters due to social issues, while losing some of the working class vote to the populist right (Gingrich & Häusermann, 2015). Häusermann and Kriesi (2015) elaborate this argument by showing how a "universalism-particularism" dimension can be responsible for such electoral shifts, coming in addition to the classical "state-market" dimension of political conflict.

The other line of argumentation present in the literature is that the interests of constituencies have changed. Besides also voting more on socio-cultural issues, the working class has also been argued to have different interests and policy preferences based on whether they are insiders, benefiting from the current system, or outsiders (Rueda, 2005). This literature pushes partisanship explanations to consider more closely who parties actually represent and what the interests of those constituencies are, in order to understand their behavior. Considering that it argues that parties now have multiple constituencies that they take into account, what is still missing from this line of inquiry is further analysis as to how parties manage these different interests: which constituency do they generally deem more important and under what circumstances do they cater to one constituency rather than another?

One possible answer to these questions can be found in the *issue-voting literature* (Budge & Keman, 1993; Rabinowitz & Macdonald, 1989). The broad claims of this literature are that parties choose positions on policies based on their perceived ability to perform on a particular policy, and if they perceive that a policy is salient (Green & Hobolt, 2008). The implication for healthcare is that parties should choose to take positions on healthcare when it is salient, and choose to appease the constituency that can bring more political capital. Some evidence is also seen that voters punish incumbents based on their policy performance on healthcare (Konisky & Richardson, 2012).

A third set of explanations looks at how electoral and welfare institutions shape the behavior of parties. Iversen and Soskice (2006) find that proportional representation systems redistribute more than majoritarian systems because they allow for coalitions between working and middle class parties. Coalitions also shape the behavior of parties, since they are interested in gaining and maintaining power. Therefore, their position in the party system at any given time can drastically change their incentives for policy positions, for example by bringing them closer the a possible coalition partner (Green-Pedersen, 2001). In this way, parties are viewed less as an automatic aggregation of class preferences, and more as autonomous entities which can utilize policy positions strategically in relation to other parties or to mobilize specific constituencies or appeal to the median voter (Starke, 2006). Picot (2009), employs this type of framework to show how a small change in electoral incentives resulted in a policy shift of retrenching unemployment benefits. Parties can also respond to the specific welfare context in which they find themselves. Ansell (2008), for example, finds that left parties prefer to spend more on education if it is a mass system rather than an elite one. Gingrich (2011) argues that party preferences for welfare can be seen not in the classic state versus market distinction, but rather in the types of internal markets they try to build in public systems, such as healthcare internal markets.

This literature suggests that the context in which parties find themselves, can alter their preferences and behavior, and therefore explain why we might see them behave in a partisan fashion in some instances, but not in others.

A fourth type of explanation puts forward linkages between parties and the electorate as an intervening factor, explaining why some behave in a typical partisan fashion while others do not. Kitschelt (2000) distinguishes between programmatic party linkages, where parties make clear electoral platforms and keep to them in broad terms, and clientelistic or particularistic linkages, where parties gain votes either through bribery, promising public employment to loyalists, or goods targeted at narrow support bases. Pribble (2013) finds that in Chile and Uruguay the programmatic nature of left parties enabled them to pass univerasalistic, encompassing welfare reforms, whereas in Venezuela and Argentina, the more clientelistic nature of parties prevented them from doing the same. Keefer (2007) argues that clientelism sets young democracies apart from established ones, and explains the lack of encompassing generous social policies. Quite similarly to the claim of parties as autonomous agents, this argument encourages against viewing some parties as based on broad ideological families, and rather expecting fragmented policies targeted at groups which are important for gaining or retaining power (Häusermann, 2010, p. 234). This argument views relations between voters and parties as a feedback loop where voters can take cues from the credibility and scope of electoral promises, when deciding how to vote (Keefer & Vlaicu, 2007). Where I add to this literature is explaining how linkages shape policy positions and policy choices of parties, beyond acting as a mere mediator.

These amendments to classical partisanship theory suggest serious doubts that the class mechanism always operates unconditionally as a means of aggregating voter preferences into policy. Moreover, they suggest that the cases in this study are particularly unlikely to present this classical mechanism, considering that they are more

likely to be clientelistic, have less entrenched democratic norms and party systems, and less developed unions and less mobilized working class voters (Aidukaite, 2009; Volintiru, 2010; Cerami & Vanhuysse, 2009). The literature does not claim that partisanship no longer matters for welfare. Rather, it further specifies parties' behavior to better understand when and how parties act in a partisan manner. It therefore suggests to look at contextual and policy factors in order to better understand why left and right parties differ. The next section surveys the studies and arguments specific to the role of partisanship in healthcare, while the next chapter builds a detailed theoretical account of health partisanship.

3.3.2 Partisanship Approaches in Healthcare

Does the class mechanism for partisanship hold for healthcare? Surprisingly little research has focused on this question. The fact that healthcare has been neglected as compared to other policies, is particularly problematic given the fact that the class mechanism was primarily developed for unemployment and other cash benefits. The studies that have looked into health are less directly tied to decisions that specific governments can be held accountable for, by mostly looking at health outcomes and expenditures. Even if the measures are appropriate, few studies have looked at or theorized specific partisan mechanisms, beyond finding associations.

The majority of empirical studies on the effect of partisanship on healthcare policy find no evidence for such an effect. There are however a few exceptions. Muntaner et al. (2011) conduct a review and find a robust relationship, where left and egalitarian political traditions are the best predictor for improved population health considered broadly, compared to conservative political traditions. MacKenbach and McKee (2013), looking more specifically at policies find that social democratic parties are more likely to enact preventive policies such as alcohol and tobacco control. More

specific to health systems, Montanari and Nelson (2013) find that left parties have an effect on provision of health services, being associated with more hospital beds and higher employment in the health sector. Herwartz and Theilen (2014) look at 22 OECD countries over the period 1970-2008 and show that left-wing governments had a positive influence on public health expenditure, but only when they had been in power for some years.

Conversely, many more studies find no such effect. Potrafke (2017) finds little to no evidence of partisan effect on public health spending in a review of OECD panel data studies. Looking at 18 OECD countries between 1971 and 2004, Potrafke (2010) finds that both left and right parties increase public health spending before elections, with no statistically significant difference between them. Reeves, McKee, Basu, and Stuckler (2014) find that economic crises trigger cutbacks in health spending, yet neither the depth of the crisis not the ideology of the government seemed to matter. Wiese (2014) also found evidence that crises induced reforms in the case of healthcare privatizations. Their analysis of 22 healthcare privatizations in 23 countries over the period 1960-2010 finds no association between government ideology and privatization of healthcare. Castro and Martins (2017) add to these studies by breaking down expenditure categories. While they find that left governments spend more on research and development in healthcare, they find no effect on other categories, such as hospital or overall public health expenditure. An, Zhao, and Zhou (2016) also find no effect of left-right ideology on health expenditure.

Why do some studies find that partisanship matters, while some find that it does not? One set of explanations has to do with technical aspects. They use different measures for partisanship and for health policies or outcomes, as well as different model specifications and different (though overlapping) time periods. These studies also have rather small sample sizes (usually restricted to OECD countries), which can

mean that the effect is more vulnerable to type 1 and 2 errors.

Substantively, we might expect the effect to be quite different, depending on which way changes in healthcare are conceptualized. Expenditure measures taken as percentage of GDP might be capturing rises in medical costs or GPD growth, while health outcome measures likely depend on many other individual and social factors. The broader substantive issue might be due to the conditions under which partisanship matters. As outlined above, fiscal pressure, electoral and welfare institutions, changing coalitions and party linkages might all have a role in shaping when and how partisanship matters.

More importantly from a theoretical perspective, these studies show associations without verifying the partisanship mechanism (or lack thereof). If there is an empirical effect present, the question still remains as to what drives the different behavior of parties or coalitions of parties. Potrafke (2017) points out that the endogeneity problem, common to most such designs, is particularly troublesome for analyzing partisanship due to the possibility of reverse causality, omitted variables, and the lack of good instrumental variables. It is therefore likely to be more fruitful to look at the behavior of parties in order to understand their motivations and context for decision making.

A different solution to understanding when we should expect partisan effects on healthcare, and on which dimension of healthcare, is to have clearer theoretical expectations regarding partisan dynamics. To put it differently, existing studies find inconclusive results because they still rely on an implicit mechanism of class partisanship, which is unlikely to hold. Esping-Andersen (1999) provides a possible explanation for this by distinguishing between labor market and life-course risks. Labor market risks such as loss of employment, correlate strongly with class, since they affect lower-income workers the most. Life-course risks, such as health and pensions,

affect all individuals and do not correlate as strongly with class. While pensions might still be related to class, since they represent income during old age, health needs are universal and mostly randomly distributed (Jensen, 2012). Moreover, the direct cost of health treatments are staggeringly high. This means that even for wealthy individuals, insurance is welfare-improving. Jensen (2014) takes these insights and argues that left and right parties will have the same approach to health spending, since they need to cater to the median voter, unlike unemployment where they mold on the class cleavage. Elmelund-Præstekær and Klitgaard (2012) corroborate this finding by showing that both types of parties have greater incentive to cater to the median voter than their core constituencies when it comes to health or pensions.

These studies claim that the median voter has the same preferences as lower-income voters when it comes to health, therefore resulting in redistribution but no redistributive conflict (Jensen, 2012, p. 278). Based on experiments showing how individuals use a "deservingness heuristic" in offering more support to public health, Jensen and Peterson conclude that "healthcare is a clear-cut valence issue where support cuts across standard political cleavages and people from the left and right stand united in their demand for more and better healthcare" (2017, p. 81). These findings are supported by Mackenbach and McKee (2015) who find no effect of social-democrats on health policy over 20 years and Tromborg (2014), who finds that debt affects spending for labor market risks but not life-course risks.

There are two major issues with the conclusions drawn from this research - that health is a valence issue. The first is that, while there are theoretical reasons to expect that all individuals prefer some type of health insurance over none, it is not clear why all individuals would prefer the same type of health insurance. All health systems, from the most private to the most public, offer some type of insurance. The core of the political conflict is exactly what type of insurance is offered and what types of

provision and regulation influence access. The second is that parties do differentiate themselves, as is visible in their manifestos and policy positions. Given these, why do these studies fail to find an empirical effect? One answer is that they use a dependent variable, public spending as a percentage of GDP, that does not capture partisan differences in healthcare. While the conclusions of these insights might not hold, they do suggest that class is less relevant than what the partisanship literature expects.

What is needed, therefore, is a different theory of health partisanship which takes into account both the specificities of health, in particular its role as a life-course risk and its higher popularity, while also taking into account the role of social stratification, and finally the role of parties in adopting policies based on the resulting voting patterns.

4 Health Partisanship

> *In order to be in control, you have to have a definite plan for at least a reasonable period of time. So how, may I ask, can man be in control if he can't even draw up a plan for a ridiculously short period of time, say, a thousand years, and is, moreover, unable to ensure his own safety for even the next day?*
>
> —Mikhail Bulgakov, The Master and Margarita

While health is akin to other goods in terms of the importance to individuals and its distribution, there are many particularities which set it apart from other goods. We might therefore expect that the specific ways in which political conflict gets carried out differs from other goods or policies. While some claim that health is so different as to engender social consensus (Jensen, 2012), empirical reality shows that governments favor vastly different arrangements for ensuring healthcare.

If health is not a valence issue, the question beckons as to how political conflict resolves disputes over policy: over different principles, institutional design or methods of resource allocation. Does the conflict mold onto traditional left-right divides? Is it similar to other welfare state policies? This chapter will develop the main argument of the dissertation, namely, that health partisanship follows from both the broader support for healthcare and the socially-stratified nature of this support. Health is neither a valence issue, nor does it mold on classical left-right divides, but rather, because of its specificities, falls somewhere in between.

The class-based partisanship mechanism does not hold for health in the same way it holds for unemployment or other policies. However, there are still strong reasons why parties will want to differentiate themselves in terms of health policy. Parties are ultimately interested in gaining votes and obtaining and keeping power. To do so they need to compete with other parties and differentiate themselves on policy positions, or other metrics that are relevant to voters. Healthcare in particular is likely to be a disputed arena since it entails managing the spending of approximately 9% of GDP (EU average) in terms of social expenditure (Eurostat, 2019).

Healthcare at different points in time has represented one of the two most important problems on voters' minds. For about 17% of the population (the average in the sample studied here), healthcare was one of the dominant issues on the political agenda (Commission, 2019). While health will not always be the most salient policy, all parties have incentives to have policy positions. Given scarce resources and the almost unlimited need for health services, parties can always point to deficiencies and promise solutions and improvement. Even in cases where parties are not strictly programmatic, they still have incentives to respond to social and electoral pressures, and take policy positions. Another important reason to expect parties to battle over healthcare has to do with redistributive battles over collecting and allocating resources. This is particularly important given the impact that such policies have on individual well-being and income. A broad literature shows that welfare state policies in general, and health policies in particular, can produce more equal outcomes and shield individuals from financial risks (Lee et al., 2010; Schoen et al., 2010; Tuohy, Flood, & Stabile, 2004; Xu et al., 2003).

This chapter proceeds by elaborating on the reasons for why healthcare is perceived differently than other policies. It continues by theorizing how political institutions and party characteristics affect the ultimate policy decisions that governments propose

and implement. The final section presents a summary of the main argument of the dissertation.

4.1 The Particuliarities of Health Policy

The previous chapter has documented extensive reasons why the class mechanism of partisanship is increasingly in question, or at least faces several amendments and intervening variables. The health partisanship literature, while inconclusive, points to additional reasons why this mechanism might not hold for healthcare policy. If the class mechanism doesn't properly explain the differences between parties, what does?

One answer, suggested by the partisanship literature, is to look at constituencies which parties represent and the institutional context they face. In other words, one needs to look at the particularities of healthcare as perceived by party constituencies, in order to understand how parties position themselves and how they act.

Healthcare preferences and health solidarity

There are several broad reasons why health is different from other policies in a way that would affect partisan politics. The first is that public perception of health is different from perceptions of other programs, where healthcare recipients are deemed more deserving than recipients of other benefits (Jensen & Petersen, 2017), resulting in a greater consensus for the availability of insurance, service, including subsidies and redistribution than is the case with other programs (Carpenter, 2012). Overall, compared to other welfare policies, healthcare is considerably more popular (Freeman & Moran, 2000; Pierson, 1994). This should mean that it will be harder to retrench and easier to expand than others social policies. However, popular opinion does not automatically turn into public policy. It does mean that parties need to be careful

regarding what changes they make, and how they present them.

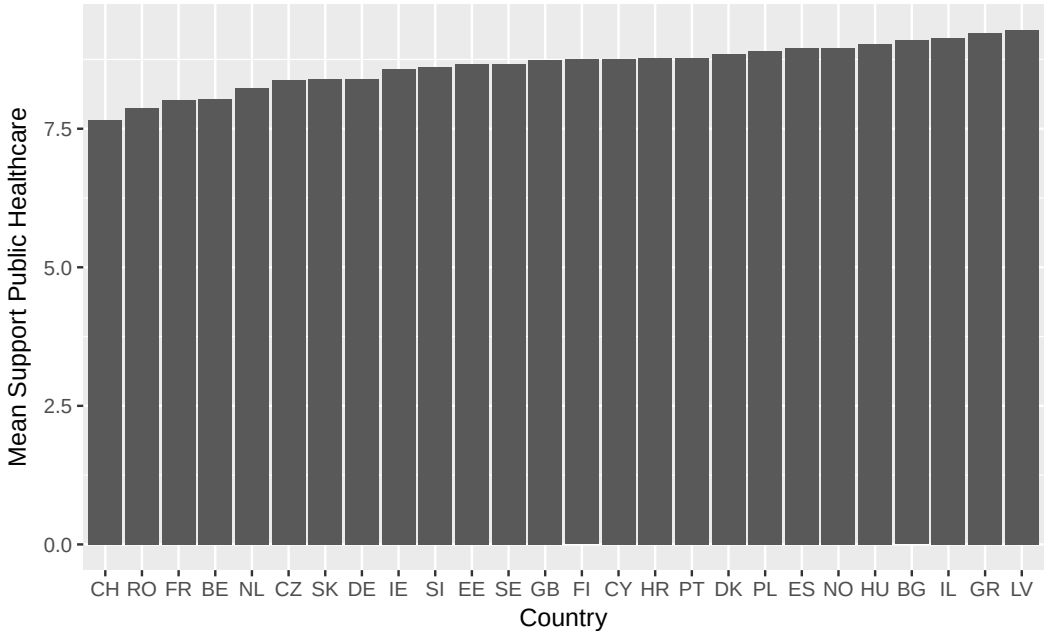
The second particularity is that citizens seem to have a deeper and more emotional attachment to healthcare, as shown by survey work (Missinne, Meuleman, & Bracke, 2013; von dem Knesebeck, Vonneilich, & Kim, 2016), and protests by medical professionals and people, for example, in Romania (Holt, 2012), Czechia (Nemec et al., 2015), but also the U.K. and France (Jenkins, 2018; Rubin & Peltier, 2018), in support of public healthcare.

These characteristics are often summed up in the concept of "health solidarity" (Burlacu & Roescu, 2019). Solidarity is argued to be one of the backbones of welfare states, acting as the main underlying mechanism of accepting redistribution (van Oorschot & Komter, 1998). General social solidarity has many roots, including shared identity, tradition and interpersonal trust. What sets health solidarity apart is the uncertainty of the risk among all members of society. No one knows how much healthcare they will need and when, as opposed to unemployment risks. Individuals are therefore more likely to pool their risks and accept redistribution to others. Tied to the uncertainty is also the different judgment of health problems as opposed to unemployment, the former not being perceived as the fault of the individual who is then perceived to be more deserving of social benefits (van Oorschot, 2000)[1].

It is therefore not surprising that health solidarity is quite high. One way to measure solidarity in the population is to ask whether the government should be responsible for providing healthcare to the sick. The European Social Survey (ESS) asks respondents to place themselves on an 11 point scale, ranging from 0 - no responsibility to 10 - full responsibility of the government for healthcare for the sick. Figure 4.1 shows

[1] An additional reason why it is important to compare healthcare to unemployment is that it is likely that health will come to resemble unemployment more. Health solidarity will likely be eroded with the advent of individualized medicine, which will take away some (and eventually all) of the uncertainty regarding risks for specific diseases such as cancer, but also health more broadly (Prainsack, 2018).

Figure 4.1: Average Support for Public Healthcare - 2008



Source: ESS (2008), author's compilation

that across European countries, support for government responsibility for healthcare is high, the average European respondent positioning themselves around a mean of 8. What is less clear is what the implications of such attitudes are for parties and policy. While solidarity does not aim towards any specific policy, the attitude likely implies that the majority of voters favor health systems with broad access that protect sick individuals from risks. Supporting this hypothesis, J. Jordan (2013) finds a strong cross-country association between health solidarity and inclusiveness of health systems.

The issue-voting literature, detailed in the previous chapter, also supports this hypothesis, as does the analysis in chapter 7 and chapter 8, showing that solidarity is associated with voting for left parties. The implication is that solidarity should foster more inclusive health policy. However, it seems that this is not always the case. Figure 4.1 shows that Bulgaria has one of the highest solidarity rates, which makes it puzzling why it has one of the least inclusive health systems. This points to the need

for additional layers of explanation in order to understand how voters' preferences and values get translated into policy.

Social stratification in healthcare preferences and solidarity

What has been more neglected in the literature on life-course risks and health solidarity is the social stratification of such preferences and values. As a life-course risk, health is less correlated to income than labor-market risks. However, this does not mean that preferences for healthcare policy are the same across income and education groups. Although compared to unemployment, health is less correlated with income, richer individuals still enjoy healthier lifestyles, due to better access to nutrition, exercise and type of work. They also enjoy access to a broader spectrum of health interventions and generally tend to utilize healthcare more, especially preventive and diagnostic care (Jung, Baerveldt, Olesen, Grol, & Wensing, 2003).

Even if health needs were similar across income and education groups, financial needs still differ. Individuals are willing and able to pay different amount for health services and are willing to make different trade-offs between waiting times, quality of services and expenditure. Lower income individuals place greater importance on geographical proximity of health centers and lower costs, while higher income individuals care less about proximity and prefer greater diversity of services and direct access to specialists (Jung et al., 2003). While middle income voters might support public insurance and redistribution, the most vulnerable groups will be more sensitive to copays and other financial barriers. Existing institutional arrangements also affect this dynamic. If private insurance and services exist, they will be used mostly by the rich, who will then increasingly resist paying for a public service that they do not use (Bevan, Helderman, & Wilsford, 2010). As Wildavsky observed: "the rich don't like waiting, the poor don't like high prices, and those in the middle tend to complain about both"

(Wildavsky, 1979, p. 285).

Health needs and ability to pay are socially stratified. In terms of voting behavior we can consider this a self-interest mechanism of voting for policies that leave individuals better off. The first way in which I depart from the life-course risk studies is to incorporate social stratification. The second way in which I depart from this literature is in exploring the "values dimension". Apart from self-interest, solidarity is a value, which can explain why middle-class and even some wealthy voters still display health solidarity. However, solidarity as a value is also socially stratified.

One conclusion from these particularities is that healthcare enjoys overall broader support that can cut across typical class divides. Empirical work shows that individuals in disadvantaged positions: older, female, low income, and with minimal education have greater health needs; as do individuals suffering from chronic diseases irrespective of income levels (Carpenter, 2012; Kikuzawa, Olafsdottir, & Pescosolido, 2008). These groups are added to those whose socio-economic position means they will push for greater public healthcare. Added to this are greater parts of the general population who can more easily be persuaded to support healthcare than other social polices, and interest groups in the health sector whose incentives align with greater public provision. This "healthcare coalition" is broad enough that, if other factors did not intervene, it could ensure that all parties need to promote public healthcare that ensures greater and greater access. However, voters' preferences and intentions do not translate directly into party behavior, nor do they determine the chances for policy success.

Two factors will affect this mechanism and are elaborated on in the next two sections. The first is political institutions, in particular the linkages between parties and voters. The second is parties' ability to tap into voter interests and values in order to gain support for different policies.

4.2 Party Responsiveness to Healthcare Preferences

The conclusion from the new partisanship literature (section 3.3.1) is that there are several intervening factors between parties and the electorate. Strong electoral support from their base means that right-wing parties can afford to lose some general support, while catering to their richer voters. Electoral vulnerability means that any government might be weary of unpopular policies. Non-programmatic electoral linkages mean that parties do not use social policy in order to gain votes, or that citizens or interest groups do not trust politicians to enact change, be that due to fears of government control over services or fears of corrupt privatizations. The logic of coalitions implies that health policy can be delegated to coalition partners with different policy preferences. What this means is that while parties are likely to hold different positions, they will not always be able to implement their preferences. The question remains as to which of these many factors are important, and under which circumstances they become relevant.

I argue that linkages are the most important factor affecting the nature of partisanship through both policy formation and policy outcome, as well as substantially affecting other institutional constraints. That is to say that, when facing other constraints, parties will be more likely to de-prioritize health policy when they perceive that little political capital will be gained or lost due to the nature of linkages.

Linkages between politicians and voters affect the broader concept of party and government responsiveness. Parties, as office-seekers, politicize issues that are salient to voters and seek to implement policies preferred by their constituencies if they believe this will gain them political capital. Two prerequisites are necessary for this. On the *demand* side, voters need to effectively voice their preferences and punish parties that go against their preferences, while on the *supply* side parties need to be dependent on

issue-voters for their electoral success and be able to meet their demands (Wessels & Klingemann, 2006).

Clientelistic linkages disrupt both processes. On the *supply* side it weakens party dependency on voter reactions to policy, since they gain some of their support from vote-buying and informal networks (Volintiru, 2010). On the *demand* side, voters become more apathetic and have less trust in political promises (Keefer, 2007). What results is a feedback loop where, even if parties try to make programmatic promises to gain electoral capital, these will be more ineffective and parties will prefer to turn to informal networks for support (Keefer & Vlaicu, 2007). The end result is that in clientelistic systems there is much less electoral capital to be gained from policy promises and from expending resources to meet popular policy goals.

There are several implications of this mechanism for partisanship and policy outcome, which can be empirically observed. Expanding access to healthcare should be de-prioritized, since parties will be less willing to expend the necessary resources to achieve it. This should be visible in delayed policy decisions or neglect of problems of access. Health policy will more likely be delegated to junior coalition partners, even if their stance on health policy diverges with the larger coalition partner. During parliamentary processes, health policy will be more likely to be bundled with other policies, or offered as a trading item over other policies to coalition partners or opposition parties[2].

A final issue to consider regarding linkages is their relation to other concepts such as corruption, level of democratization, and strength of civil society. Kitschelt (2000, p. 870) argues that clientelism is empirically but not conceptually related to corrup-

[2]This line of reasoning is distinct from the literature arguing that clientelistic parties actively use social policy to reward loyalists (Kitschelt, 2015). This mechanism is less applicable to health care since it comprises mostly of services, which are harder to target to specific constituencies. Such patronage networks are likely to affect decisions such as where to build hospitals, how to allocate resources and make bureaucratic appointments. However, they are less likely to affect policy directly.

tion and related concepts[3]. Clientelism therefore tends to coexist, on average, with lower levels of democratization, less developed civil societies and pervasive corruption. For the empirical cases studied here, however, linkages play a more important role in affecting party responsiveness to voter values and preferences.

4.3 How Parties Navigate The Health Policy Space

Parties are not mere conduits of voter preferences. Beyond the electoral, institutional and other influences and constraints they face, parties have a degree of agency. Parties decide which issues to politicize, how many resources and political capital to expend, in a manner that is far from deterministic. Parties' choices regarding when and how to politicize health policy can therefore tell whether they are in fact responsive to voters, and to which voters they are responsive. Moreover, these choices also affect the chances of implementing (or resisting) policy change.

Based on their political-opportunity structure, when parties approach health policy they need to navigate a fine line between appeasing their particular base of voters and the "healthcare coalition". Parties are therefore squeezed into a narrow policy space. Left parties attempting to increase protection for the most vulnerable individuals need to justify their policies in ways that appeal to general values of fairness and solidarity. Right wing parties attempting to marketize healthcare need to appeal to values of responsibility and greater efficiency in order to attract middle income voters to their position.

[3]There is also a question of endogeneity regarding linkages. It could be the case that both linkages and the influence on partisanship are determined by a third factor. Historical accounts suggests a complex relationship between the timing of democratization, bureaucratization and other factors in explaining the emergence of clientelism (Hicken, 2011). Clientelism is therefore not directly related to development and democracy in the short term. Indeed, among the cases studied here, the less developed and more recently democratic Estonia and Czechia experience less clientelism than Greece and Portugal. Whatever the origins of clientelism, it is likely to have an independent effect on party responsiveness.

Parties are further squeezed in by fiscal pressures to retrench, and policy legacies and electoral expectations to maintain benefits. This means that the types of policies that parties enact, and more importantly, the way in which they enact them, will be restricted. In order to navigate this fine line, parties need to carefully frame their policies in ways that will seem acceptable to voters. Changes to health systems need to be motivated in light of existing problems in the systems. The nature of the problems of the health systems, and the ability of parties to argue for their particular solutions, will determine their ability to attract enough support in order to pass the policy.

An additional reason for focusing on how parties frame their policies is that parties themselves consider it important. They spend vast amounts of time and resources into campaigning for policies and trying to dominate the discourse agenda. Even if they are mistaken, and their efforts are in vain, this view helps to understand their actions and which policies they believe they can pass. Importantly, this argument does not rely on there being an objective risk of electoral punishment for parties. It is enough for parties to believe there is a risk of electoral backlash. This perception is likely to be heightened if parties do not hold a firm majority, or if they believe they are acting against popular beliefs (Vis, 2016).

Given the specificities of health described above, it is unlikely that any political party will argue in favor of providing less healthcare. Drastic changes to healthcare are visible and will likely stoke the anger not only of the public, but also of doctors, nurses and civil servants. Therefore, the policies that parties pursue are likely to be more subversive: changing payment systems, decentralizing ownership or budgets in the hope of future cuts. Conversely, when parties seek to expand access, they also need to operate carefully not to stoke the anger of pharmaceutical companies, hospitals or wealthier taxpayers, and generally to avoid being seen as reckless spenders. However,

even these types of subversive changes require careful framing of the problems and solutions they are proposing.

Framing generally refers to using cognitive shortcuts in order to make an association between a new policy and existing popular norms. Framing can be seen not only as a public relations tactic, but as actually shaping policy since parties look at existing norms in order to shape policies (Schmidt, 2008). Parties cannot simply make up norms or use any type of justification for policies. Rather, they have to embed them in existing views in society (Ross, 2000b). Parties generally use frames to justify policies to others and to themselves. Vis (2016) concludes that framing is particularly important for avoiding blame with life-course risks such as health, and for social-democratic parties wishing to avoid blame in particular.

Due to the nature of healthcare, I argue that there are two broad frames that parties employ when seeking to enact changes which may be contested. These are based on two existing social norms, which are at odds: equity and efficiency. Equity refers to increasing access as much as possible for all citizens, by eliminating financial, geographical, and informational barriers. The equity norm emphasizes equal access to healthcare, and pays special attention to barriers faced by the most vulnerable social groups (Williams, 2005). The efficiency principle revolves around a more utilitarian metric of getting the most amount of services to the largest amount of people, without considering specific barriers for certain social groups. It revolves around concepts such as "bang for buck", getting the most value out of a finite amount of resources. (Carr-Hill, 1994; Bevan et al., 2010). These are the general goals of all health systems: improve health as much as possible, and ensure that everyone benefits at least to some degree.

There are, of course, other frames and other norms available. What is of interest here are frames which differentiate the rhetoric and policy positions of parties. All parties

will argue that their policies achieve greater quality, or choice, or foster medical innovations. These are not norms which are likely to be contested. What this means is that all parties will argue in favor of them, and will claim that their policy will achieve them. What will differentiate parties are frames which tackle the existing underlying principles of health systems. Equity and efficiency are likely to be contested particularly because they create deep conflicts at the base of modern health systems (Weale, 1998).

Why do they create conflicts? Simply put, in a context of scarce resources policy decisions need to prioritize between different goals. Equity-based arguments try to address issues with healthcare inequalities through basic care packages offered by insurance providers, financial burdens placed on individuals, utilization rates and unmet medical needs. Efficiency-based arguments are concerned with over-utilization, waste, and resource allocation. While the most pressing problem in a system might make one or the other seem more important or urgent, adjusting one problem often exacerbates the other. There is usually a trade-off implied. The important thing to note is that both frames can be used to make claims of providing "more and better health" and of making the system "fairer", but the way in which is done is strikingly different. Williams (2005) argues that there are implicit trade-offs in resources and political capital between the two fundamental objectives of healthcare: improving health over the entire population as much as possible, and reducing inequalities within the population. Different policies and government decisions need to prioritize these different objectives, and references to efficiency and equity help justify these (Peter, Mark, & Laura, 2004).

There are many examples of this trade-off in action. In a scenario of scarce resources, and especially under current trends of sky-rocketing costs, scarce resources require prioritizing. Finite investment resources need to be allocated between developing a

new oncology wing at a major hospital in an urban center that can treat many patients (increased efficiency), or a new hospital or clinic in a geographically more remote area that might treat fewer, but much needier patients (higher equity). Introducing user fees can deter individuals who do not really need care but might otherwise use it because of a lack of costs (increasing efficiency) but will, at the same, time deter lower-income individuals from seeking needed medical attention (decreasing equity).

Other trade-offs are more specific to particular types of systems. In NHS or hierarchical command models, centralized pricing systems can drive down the costs of medicine and services (increasing equity) while at the same time disincentivizing investment into or use of better medicine or interventions (decreasing efficiency). Overall, increased access at the point of delivery means much more utilization of services (equity) which often results in long waiting times for specific services (efficiency), which wealthier individuals can bypass if there is a skip and pay system (decreasing equity). In SHI systems with multiple funds which are allowed to compete, risk selection can leave more vulnerable individuals in worse-performing funds, which will then also be more likely to go bankrupt. Measures decreasing competition, such as risk-equalization methods, combat this at the cost of lowering performance incentives. Creating internal markets in public systems can incentivize doctors to increase productivity but means spending less time with patients. In insurance companies, profit-making can attract more talented and productive workers and managers, which can improve performance. Yet, the same profit motive can make the companies refuse to pay for certain treatments (Bevan et al., 2010).

Another inherent trade-off between the two principles revolves around the way certain efficiency measures can erode public services. For example, allowing double employment of doctors in hospitals and private clinics increases efficiency but erodes the public system by lowering the number of patients in the public system and by in-

centivizing shifting certain types of care to private practice. Especially in Eastern Europe there is a Hirschmanian (1970) effect of *exit* from the public to the private system, eroding the *voice* for improving services. Since the first to go are those most dissatisfied with the public system, which are also the most capable to voice their discontent due to having more social and political capital, there is much less pressure to improve access and quality. All this is to say that it "is not possible to finance publicly an affordable comprehensive service available for all that meets the demands of the rich for a high-quality service" (Bevan et al., 2010, p. 255).

These examples show how different policies create trade-off. When arguing for these policies, parties seek to frame the trade-off favorable to them by appealing to the existing popular norm of increasing efficiency or equity of the health system. Parties also need to argue for the importance of either principle, and its urgency in the particular context they face. That is to say, based on the existing problems (or perceived problems) in the health system, they can argue that waste or unequal access are the most pressing problems.

There are two broad reasons why it is helpful to look at reforms through these lens. The first is simply that parties themselves refer to them when making arguments about passing a particular policy. The second is that they better explain parties' behavior when attempting policy change - since policy changes will be more in line with these two than with the market-state dimension. Lastly, it is important to look at these frames because healthcare systems are not rigid models. It is therefore possible to see equity-oriented policies in private systems, such as the Affordable Health Care Act in the United states, or efficiency-oriented policies in typical NHS systems, such as provider competition reforms in the British NHS (Schmid et al., 2010; Gingrich, 2011). Policies therefore need to be viewed on an individual basis and within the context they are operating in. The same policy will have different results depending

on the existing system.

How do parties use framing in practice? Goldstein (1993, ch. 1) suggests that there are four stages. Initially, old policy programs are deligitimized when they are perceived to fail. New policy programs then get developed by policy entrepreneurs, which conform to their normative frameworks and cognitive paradigms. In the last two steps, based on the perceived performance of the new policy after testing, they may become institutionalized. As discussed in this chapter, many other factors are likely to influence the success and institutionalization of policy. However, in initial stages, it is likely that diagnoses of existing problems, and ability to design new programs which fit expectations, determine how parties are able to propose new policies and when they believe it is optimal to do so. Therefore, in order to be persuasive parties need a) to tap into existing and pressing problems in health systems and b) use existing norms in order to frame their policy solutions.

Since existing policies and their legacies shape what individuals consider to be normal, existing systems are likely to be entrenched not only in institutions but also in people's minds. In most circumstances, therefore, existing social norms will incetivize parties to propose solutions that are in line with the current system. When perceptions of problems of the system are greater than the attachment to current norms, parties will be incentivized to propose solutions from different systems.

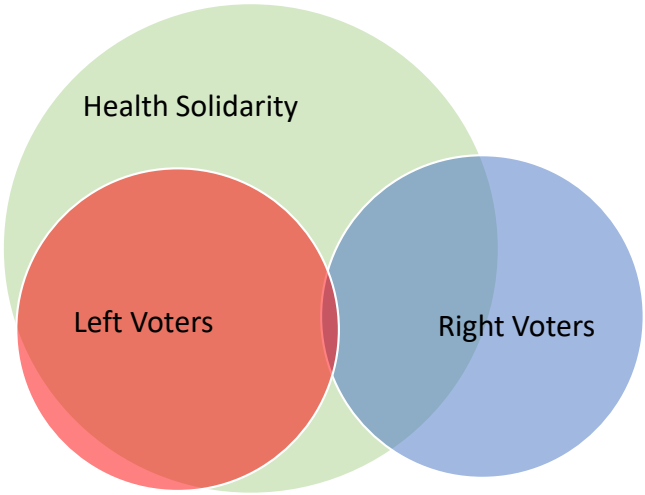
When analyzing empirical material, equity frames are operationalized as statements from parties or individual politicians which imply (explicitly or implicitly) the increase of access to healthcare for vulnerable groups. These may take the form of emphasizing state responsibility for healthcare, emphasizing the need for solidarity in healthcare or proposing policies to lower financial barriers, among others. Efficiency frames are operationalized as statements which imply prioritizing quality of care, rationing resource allocation or disincentivising usage, among others.

4.4 Main Argument in Brief

Health policy is different from other social policies because it enjoys greater support, which cuts across socio-economic groups. The resulting "healthcare coalition" broadly supports health policy which ensures greater access to all. While the general public supports public healthcare, socio-economic differences still exist, with wealthier individuals preferring private insurance and competition in order to increase efficiency of services, and lower-income individuals being more concerned with costs and direct access, and thus how equitable the system is. In between these positions, parties have some leeway to frame their policies in such a way as to persuade voters and interest groups of their policy program.

Because of these specificities, parties are unlikely to act as simple aggregates of policy preferences of different socio-economic groups. As office-seekers and vote maximizers, they are incetivized to use health policy to further their electoral position. To do so, they need to navigate the fine line between catering to their voter bases and seizing political opportunities to persuade broader groups of voters of the necessity of a specific policy. While they can partly do this through promising higher quality services or broadly "more and better" healthcare, they need to differentiate themselves from other parties. Based on existing identified problems with health systems, which are always in abundance, and existing societal norms with regards to the importance of underlying principles of health systems, parties can differentiate themselves and promote policies by framing them as increasing either equity or efficiency of healthcare. Right wing parties will lean more towards efficiency frames while left parties will lean more towards equity frames. As opposed to classical partisanship that assumes a unidirectional effect flowing "upstream" from voters to parties, this argument recognizes that voters take cues from institutional characteristics of health systems and party

Figure 4.2: Solidarity Argument Representation as a Venn Diagram



systems when deciding on which problems are most pressing and which principles are best to address them. A second "downstream" is represented by parties' abilities to persuade voters that health policy is a pressing issue and that their solutions are desirable.

While left-wing parties will have a more stable electorate in favor of health solidarity and expanding public access, right-wing parties will have their electorate split among higher income voters who prefer marketization and private services, and middle-income voters who will be more solidaristic and prefer public health services. Figure 4.2 shows a stylized rendering of this part of the argument. While the voters of left-wing parties are more homogeneously solidaristic, voters for right wing parties are split.

While parties will have such distinct policy preferences, their actual chances of success depend on the broader context of their political-opportunity structure. Veto points, party linkages, coalition coherence, support in parliament and support of key interest groups will determine their possibilities for success. While this is true for any policy,

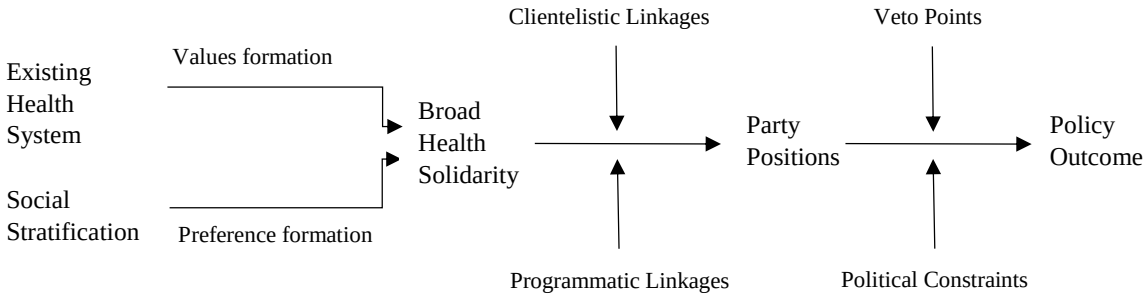
what sets health policy apart is its broader popular support. Party linkages to citizens in particular will be crucial in transferring individual preferences and attitudes into policy positions that parties will prioritize.

Programmatic linkages imply that parties rely on their electoral promises in order to gain votes and will therefore prioritize public health policy, especially when it is highly salient. Clientelistic linkages between parties and voters imply that parties have other avenues of ensuring electoral support and will therefore de-prioritize health policy according to the preferences of the majority of voters either in favor of narrower policies for their voter base, or in favor of other policies that require political resources. I depart from existing literature on clientelism and social policy by treating linkages as more than an intervening variable. Clientelism actively shapes policy proposals and outcomes, and partisanship itself, by affecting how parties choose to prioritize social policies.

Given the breadth of the "healthcare coalition", programmatic linkages are expected to be associated with greater health access, by making it easier for left parties to expand access and to resist retrenchment efforts from right wing parties. Right wing parties in such systems are torn between catering to their constituency and the broader electorate, and will likely attempt to retrench only under special circumstances. Such changes are more likely in non-programmatic systems under right wing parties.

Figure 4.3 shows a stylized version of the argument. Existing healthcare institutions and individuals' socioeconomic positions determine their attitudes towards healthcare and their distinct policy preferences. Due to the existing healthcare arrangements in the countries of this study, as well as the status of health as a life-course risk, this results in a broad coalition of support for health policy that crosses over traditional party lines. However, the way in which these attitudes are picked up by parties de-

Figure 4.3: Health Partisanship Mechanism



pends on the nature of linkages between parties and voters. The resulting positions of parties, as well as their decisions of when to politicize health and attempt policy change (or policy blocking) are then passed through political institutions, specifically coalition formation and other government characteristics and veto points, which determine policy outcome.

Table 4.1 further specifies the expectations based on the type of linkages and the degree of political constraints faced by cabinets. Cabinets are considered constrained if they do not hold a majority of seats in parliament, or form an incoherent coalition among parties with different views on health policy or have a short duration. Under programmatic linkages and less constrained scenarios, left parties are expected to expand access to healthcare. Right wing parties are expected to enact layering policies, that cater to wealthier voters demanding higher quality care while not angering middle income voters. Constrained programmatic left parties are expected to attempt more mild expansion of health, termed "updating" since these policies often refer to adapting instruments to new circumstances, such as introducing additional protection for individuals who cannot pay health contributions, or bailing out public insurance funds with state funds during periods of crisis. Right wing cabinets under these circumstances are not expected to attempt policy change.

Under clientelistic linkages and less constrained scenarios, left parties are expected

Table 4.1: Policy Outcomes, Party Linkages and Political Constraints

(a) Left Parties

Linkages	Political Constraints: Unconstrained	Political Constraints: Constrained
Programmatic	Expansion	Updating
Clientelistic	Updating	No Change

(b) Right Parties

Linkages	Political Constraints: Unconstrained	Political Constraints: Constrained
Programmatic	Layering	No Change
Clientelistic	Retrenchment	Layering

to enact updating policies in as much as they might expect some amount of electoral gain from such policies. Right wing parties are expected to attempt more direct retrenchment since they expect less electoral backlash. In more constrained government scenarios, right wing parties are expected to attempt layering policies, or allow policy drift. Policy drift is the opposite of updating, where in the face of new risks or economic downturns, policies are not adapted and therefore have a similar result to retrenchment policies: lowering access to healthcare.

Given these expectations, several hypotheses can be formulated and empirically tested. The first is that left and right parties do hold distinct positions on health. This will be tested by looking at party manifestos, policy positions, parliamentary discussion and policy campaigning in the media.

Secondly, left parties will generally aim to maintain greater access within a mostly public health system. They will be likely to expand health access under favorable conditions when they have stable majorities, lax fiscal obligations and when they can effectively argue that the health system is not equitable.

Thirdly, right parties will stay away from health policy unless they can a) effectively argue that the system is inefficient and needs market solutions or b) enact policies without electoral repercussions either because changes are hidden or citizens do not hold them to account. Clientelistic linkages between parties and voters will allow right-wing parties greater discretion to limit access to health services.

5 A Set Theoretic Multi Method Research Design

The world makes much less sense than you think. The coherence comes mostly from the way your mind works.

—Daniel Kahneman, Thinking, Fast and Slow

Everything about us, everything around us, everything we know and can know of is composed ultimately of patterns of nothing; that's the bottom line, the final truth. So where we find we have any control over those patterns, why not make the most elegant ones, the most enjoyable and good ones, in our own terms?

—Iain M. Banks, Consider Phlebas

Political parties take different stances on health policy based on their ideological orientation. Parties conceptualize changes based on problems with existing systems and use policy frames to argue that their policies achieve either higher equity or efficiency. However, that does not mean that parties will always be effective. The literature suggest several intervening mechanisms that can stop parties, or even have them behave differently: institutions such as party linkages, veto points and existing healthcare arrangements, and government characteristics such as coalition coherence, stability and parliamentary control. The question of how these factors interact, and which gain prominence under which circumstances requires a research design that can untangle complex causal relations.

The 17 E.U. countries of Southern and Eastern Europe are taken as empirical cases in a mixed methods design, in order to understand this question. A total of 67 government episodes are analyzed in a fuzzy-set qualitative comparative analysis (fsQCA) in order to untangle necessary and sufficient conditions for health policy change. A wide array of considerations, including the results of the QCA analysis are used in order to extract cases for in depth analysis and comparison.

This chapter proceeds by discussing the rationale for choosing the entire sample of cases, then discussing the QCA methodology and the mixed methods design rationale. It continues by detailing the rationale for the in depth case selection (taken from the sample of cases), and lastly by analyzing the health system and political institutional characteristics of the main cases, Bulgaria and Czechia.

5.1 Why Study Eastern and Southern Europe?

The 17 countries were chosen for both theoretical and empirical reasons. Empirically, Eastern (EE) and Southern (SE) EU countries are far less present in the literature than their Western European (WE) counterparts[1]. This is important because they present a set of circumstances that set them apart. These circumstances are reflected in both political institutions and norms, as well as the structure of their health systems. Studying these countries is important since much of the literature on changes in welfare systems emphasizes mechanisms which rely on assumptions such as stable institutions and party systems, a degree of membership in unions, and bureaucratic efficiency (Hacker, 2004b; Beramendi, Häusermann, Kitschelt, & Kriesi, 2015; Korpi, 2011).

Existing studies on EE and SE emphasize that these key variables are different, both

[1]The many notable exceptions are documented in section 2.4 and chapter 3.

sets of countries having industrialized later (Inglot, 2008), had less experience with democracy (Roberts, 2009b), show reduced membership in unions as well as greater institutional instability (Crouch, 2011; Bohle & Greskovits, 2012; Ferrera, 1996), and present characteristics of informal practices and clientelism (Aasland, Grødeland, & Pleines, 2012; Afonso, Zartaloudis, & Papadopoulos, 2015). A selection of cases which differ on these key characteristics is important because it is likely to yield new theoretical insights into the determinants of health policy-making. The universe of cases we choose determines the empirical variation that informs hypothesis testing and theory building. By holding certain characteristics constant and allowing others to vary, delimiting the population of interest is a powerful tool for exploring new theoretical insights (Lieberman, 2005, p. 449; Przeworski & Teune, 1970).

The second set of characteristics that set these cases apart have to do with their health systems. As documented in chapter 2, the health systems in SE are differentiated from their WE counterparts due to higher reliance on out-of-pocked expenditure and the segmentation visible through the special insurance funds (Toth, 2010), while EE presents a combination of social insurance without social actors, high reliance on private expenditure and incomplete coverage (Kaminska, 2013). Both sets of countries also exhibit low-level corruption in health systems through informal payments (Stepurko et al., 2013). These differences are important because they represent unique deficiencies in these health systems and therefore unique challenges to policy-makers. The menu of reform will therefore look quite different in Eastern and Southern Europe (ESE) than in WE.

More important, from the perspective of health systems and their health and welfare functions, are the higher levels of poverty and social exclusion in ESE than WE (Ferrera et al., 2005; Nolan et al., 2011). The number of individuals facing health insecurity, as well as the amounts of risk they face, are therefore higher in these

countries. An access perspective on healthcare is therefore more important in these cases, as is the understanding of the political dynamics which influence access.

Beyond their differences with WE cases, the cases in this study share similarities that hold certain variables constant. Both SE and EE experienced transitions to democracy, the former in the 1970's and the latter in the 1990's. This meant that they experienced similar challenges in terms of policies, legitimacy towards the population and more importantly in terms of a similar process of shifting political coalitions. Although there are considerable differences in timing, international context and the type of transition itself, EE also transitioning from a state to a market economy (Offe, 2004), these types of pressures are similar. Other conditions that they share include EU membership, similar electoral systems (mostly variants of proportional representation) and parliamentary systems (with a few notable exceptions of semi-presidential systems which nonetheless rely on parliamentary control), as well a high degree of overall health solidarity.

While they these similarities differentiate them from other groups of countries, ESE cases vary considerably in both health system arrangements and the consequential political factors emphasized in this dissertation: linkages between parties and voters and political constraints. A noteworthy difference regarding health systems is that at the point of transition, SE had incomplete health systems which they had to build up, while EE states had universal (but low quality) health systems which all entered into budgetary problems. However, by the end of the 1990's all countries had achieved universal coverage and were facing budgetary constraints, which were exacerbated by economic crises.

Therefore, governments in these countries were hard-pressed to reform their systems. On the one hand, the fact that these countries experienced several economic crises, and on the other, the fact that they all had universal systems which enjoyed popular

support, make them an extreme example of what Pierson (1998) called the effect of "irresistible forces on immovable objects", and thus an ideal study sample to test the limits of partisanship and party responsiveness. Responsiveness is particularly relevant since they are facing a new crisis of democratic legitimacy, which is closely tied with provision of services, since the latest economic downturn.

While the units of interest are countries, the unit of analysis is each government episode of countries, starting from the point of transition in 1989 until most recently available comparable data, in 2014. In practice, due to data limitations, this yields 67 cabinets to be taken as cases for the QCA analysis (Armingeon, Leimgruber, Beyeler, & Menegale, 2002). While the number of cases could also allow for statistical analysis, QCA is more suitable to the research question of this study, as detailed in the next sections.

5.2 Multi-Method Research and Causal Analysis

I address the question of *the circumstances under which governments retrench and expand health access* by using a set-theoretic multi-method research design. The first part of the analysis uses fsQCA in order to discern combinations of factors which lead to changes in access. The second part uses process tracing to compare the two main cases, Bulgaria and Czechia, in order to understand the mechanisms behind the observed set relations.

This section proceeds by explaining the rationale for using a nested set-theoretic design, followed by a discussion of the advantages and shortcomings of the cross-case method (QCA) and the within-case method (process tracing).

The Quantitative-Qualitative Divide

Some argue that qualitative and quantitative methods[2] are not simply different methods, but represent starkly different epistemologies, which entail different notions of causation, concept-formation, scope, and fit of explanation (Mahoney & Goertz, 2006). Is it no wonder that the divide between the two camps has been so stark, social sciences having been practically bifurcated for decades between a "quantitative-systematic-generalizing" branch and a "qualitative-humanistic-discursive" branch (King, Keohane, & Verba, 1994, p. 5). How big are these differences? Are the two strategies irreconcilable?

In terms of scope, qualitative designs tend to define their scope narrowly, with limited claims to generalizability. Qualitative research does not necessarily view this as a methodological limitation, but rather sees it based in an epistemology which assumes causal heterogeneity to be the norm in large populations (Mahoney & Goertz, 2006, p. 11; Ragin, 2014) Quantitative studies, on the other hand, put generalizability to the forefront. They use large numbers of cases and often see their sample of cases as representative of a much larger population. Part of the belief is epistemological - if a causal explanation does not travel sufficiently, it is likely idiosyncratic or might be mistaken - additional cases breaking the pattern. A limited number of cases, opens researchers to risk of selection bias, spuriousness and other problems which can bias analyses (Landman, 2002, ch. 2; Geddes, 1990). However, these problems are not automatically solved by adding more cases, nor are they absent from large-n studies.

A second important distinction between the two is their approach to causality. Quantitative research has an "effects-of-causes" approach wherein it seeks to find general

[2]There are, of course, important differences within quantitative and qualitative designs. Here I refer to positivist/empirically-driven research. I also use the concepts quantitative/large-n(LNA)/between-case and qualitative/small-n(SNA)/within-case, interchangeably. While the concepts do not overlap completely, for the purposes of this discussion they capture the same idea.

laws that hold across a population of cases - where the object of interest is the average effect, as opposed to the effect on an individual unit of observation (Mahoney & Goertz, 2006, p. 4). This has also been called the "laws" approach since it aims to find general laws and principles that can predict or explain how the world works (Dharamsi & Scott, 2009). Qualitative research, specifically case-oriented research, has a "cause-of-effects" approach whereby it attempts to uncover the mechanism determining an outcome for each of the cases (or sets of cases) that are within the scope of the theory (Mahoney & Goertz, 2006, pp. 228–231).

A third important difference between the two approaches relates to concept-formation. Coppedge (1999) distinguishes between the "thick" concepts that result from the in depth analyses of small-n comparisons and the "thin" concepts required by quantitative analyses in order to analyze a large number of diverse cases. A trade-off is implied wherein "thick" concepts and explanations, *because* they are sensitive to complex causal relationships which take account of the specific contexts of cases, cannot travel in the same form to other cases. The "thin" concepts and measurements of quantitative studies are necessarily more abstract and brush over important differences and nuances of concepts, in order to be able to compare cases and gather data.

The challenge therefore remains to connect the rather "thin" general abstractions with more "thick" descriptions (Coppedge, 1999). The method proposed here, and described below, is to use the "mechanism" approach in order to understand what "thin" concepts and analyses capture in cross-case explanations. This applies not only to explanations but to concepts themselves. "Thin" measurement and analysis can be combined with "thick" description in order to refine and add to the meaning of concepts, as well as the validity of measures.

One example, used in this study, is that of party ideology. A large-n approach to

understanding the role of ideology would be to collect comparable data across a large number of cases and utilize a method to detect the presence and importance of the variable across cases. In this case, the QCA analysis uses an indicator of weighed expert-ratings of parties in the analyzed cabinets. Such a "thin" measure can have two problems. First, ideology has different meanings in different contexts[3]. Two parties that receive a rating of 6 on the 10-point scale (making them center-right parties) can have vastly different sets of ideas and policies that will influence how they act once in power. The second problem is that an average effect of ideology, or discovering its status as an INUS condition, does not explain *how* ideology in fact influences policy. What are the intermediary steps going from ideology to policy change? What is the underlying mechanism operating and what are its triggers? Are there factors which can impede this mechanism?

Does this mean that it is not useful to look at the cross-case effect of ideology? I argue that it still is - and this dissertation shows that there are unique insights to be gained from looking at this effect. While it does brush over many country-specific differences of how parties operate, an "ideology" indicator still captures valid differences among parties - how they see themselves, how they are seen by voters, and how they operate. Testing cross-case hypotheses about the role of ideology gives us a an understanding of how important this factor is. In QCA, it can tell us under what conditions and in which context it is relevant - when and in combination with which other conditions will party ideology trigger changes in health systems [4].

More importantly, combining QCA with in-depth analysis can complement both shortcomings. On the one hand it can uncover the underlying mechanism and causal chain. On the other, it can also help refine and possibly validate the concept. In this

[3] A growing literature argues that left-right is no longer a meaningful way to capture the differences between paties. For example, see Mölder (2017).

[4] Statistical analysis can also answer questions about context and importance compared to other factors, as well as allow for interaction effects between variables. However, they still fall short of addressing causal complexity fully, nor do they aim to do so.

example, later case studies show that ideology does in fact matter for health policy, and by looking at party manifestos, policy documents and parliamentary speeches, I show that ideology still differentiates how parties see themselves and how they act on health [5].

A final important difference to be addressed here, is how the two traditions deal with alternative explanations. Quantitative designs employ a control-variable approach where models are expected to contain all the theoretically relevant variables. The effect of the variable of interest is only to be believed when all other theoretically relevant explanations are "controlled for", by including indicators in the analysis. This design does well to address the problem of spuriousness that plagues all designs. In practice, however, data and theoretical limitations make it implausible that models are ever "fully specified". Moreover, while such designs can allow us to compare the size of different effects, they usually cannot tell us the causal importance of one variable as compared to another.

QCA takes a different approach by using consistency and coverage measures to determine which combinations of conditions are sufficient or necessary for an outcome, and how relevant they are. In a sufficiency analysis, QCA uses a minimization algorithm that discards irrelevant conjuncts (Schneider & Wagemann, 2012). In practice, QCA also suffers from data limitations and the problem of limited diversity (Schneider & Wagemann, 2012, chap. 6), which limits the number of conditions that can be introduced in the analysis.

Small-N analyses have different strategies of dealing with alternative explanations. The most common strategy is to use case selection to approximate statistical control

[5] For another example, in Selway (2015), the author uses an ethnic homogeneity variable as a proxy for the complex ways in which individuals act in ethnically diverse societies in choosing politicians. The simplistic indicator is initially used in a statistical analysis, after which the mechanism behind it is unpacked in case studies - showing how ethnic heterogeneity and electoral systems interact to elect politicians which influence access to health.

of other variables. This comes most often in the form of using Mill's methods of difference and agreement. In both forms of this design the claim that two or more cases are similar or dissimilar in all but a key variable of interest, is most often at odds with empirical reality. Cases will almost always have differences, even in causally important variables, which can plausibly become rival explanations (Lieberman, 2005, p. 439). This is connected to a more general problem of Small-N designs, that of "many variables, small number of cases", or too few degrees of freedom (Lijphart, 1971, p. 685). For this reason, it is more difficult for small-n studies to test alternative hypotheses. This is also a reason why one detailed mechanism is unlikely to hold for other cases, since additional variables will likely interfere in the causal chain (Coppedge, 1999, p. 471).

Quantitative and qualitative strategies have symmetric costs and benefits, and each choice entails a certain trade-off. It would therefore be logical, and tempting, to attempt to combine the advantages of the two in order get the best of both worlds. The challenge is to reconcile the different logic outlined above, and build a design that incorporates these elements. King et al. (1994) and Gerring (2011) try to reconcile qualitative and quantitative epistemologies into a single logic of causal inference, while Lieberman (2005) presents the first systematic attempt at a mixed design, which I now turn to.

Mixed-Method Designs

In order to address the outlined shortcomings, social scientists have sought ways of combining the different elements of qualitative and quantitative designs into what are often called "mixed-method designs". Small (2011) reviews much of the literature employing such designs and points out that mixed-methods can mean different approaches. These designs are employed for a variety of reasons and can have different

epistemological justifications. For example, mixed designs can refer to using different kinds of data, mixed kinds of analyses on the same data, or on different data, and can involve a range of qualitative, quantitative and other techniques.

One important distinction that Small (2011) draws is between complementary and confirmatory designs. Confirmatory logic aims to confirm the same finding (mechanism, effect or otherwise) across the levels of analysis between and within cases. In effect it claims to answer the same research question with the same answer, but coming from a different analysis. Complementary logic has the much less ambitious goal of providing a different perspective on the same research question, or answering a related research question that can add to the study. While it is helpful to think of these two as distinct approaches, in practice the line between answering the same question with different data or answering a related question with a complimentary analysis, can be quite blurred. The clearer distinction relates to the scope of generalizability - to what degree can scholars claim that a mechanism uncovered within a case can travel to all cases in the analysis (confirmatory) or simply add detail to the explanation in a different fashion (complementary).

Claims of confirmatory logic are usually made with nested designs - where multiple data-points or types of data are collected for the same observations, and one analysis can inform the case selection or variable selection for the other (Lieberman, 2005; Small, 2011). Lieberman formalized this practice by advocating for a combination of large-n analysis (LNA), usually statistical techniques, and small-n analysis (SNA), namely case studies. In a first step, a preliminary LNA is performed in order to test different hypotheses. Depending on whether the results of the analysis are robust, SNA is used in either a confirmatory or a model building logic.

Despite the advantages of using a nested analysis, some remain skeptical of the merits of such research strategies. Some challenge whether the two approach are reconcil-

able, even in principle. Sale, Lohfeld, and Brazil (2002) argue that it is impossible to confirm the same hypothesis with different types of data, since they produce inherently different types of knowledge which cannot verify one another. However, they still consider it possible to use different types of data in a complementary fashion, in order to answer similar questions. This perspective negates the most important advantage of nesting: that of inferring from different levels and analyses. In effect this leaves nested designs as two related (but separate) analyses answering similar questions.

A second, and more fundamental, issue is the problem of reconciling different levels of analysis: the cross-case level of large-n and the within-case level of small-n. The issue relates to regularity, the assumption that the uncovered mechanism in one case can travel to other cases. Chatterjee (2013) argues that mixed-method designs do not overcome this issue, since they do not check the underlying mechanism for every case, and therefore fail to deliver on their most important promise.

5.2.1 Nested fsQCA

Set-theoretic methods provide possible solutions to these methodological shortcomings by conceptualizing an integrated within and between case analysis (Rohlfing & Schneider, 2018). Lieberman's design is not directly applicable because of important differences between regression analysis and QCA (Schneider & Wagemann, 2012, pp. 83-90). Building on Lieberman's logic, Schneider and Rohlfing (2013, 2016) adapt and develop the nested design framework for combining QCA and process tracing (PT).

Before delving into the advantages of using QCA in a multi-method design, it is worth considering the advantages and perspective that QCA, as a set-theoretic method, brings to understanding changes in health systems. As a causally-complex phe-

nomenon, health reforms can be better understood by looking at how combinations of conditions impact them. The exploratory nature of this study also benefits from an analysis that can untangle when and how certain conditions impact the outcome, therefore focusing the analysis.

If ordinarily cases are viewed as having certain characteristics of interest, captured by variables, in set theory cases are viewed in terms of belonging to a set - the degree of belonging also being measurable. A case's membership, or partial membership, in a number of sets, can define its characteristics of relevance. Simultaneous membership in sets can also serve create new sets, as exemplified in the ideal-type analysis in chapter 2.

Sets, however, are useful beyond their descriptive and categorization functions. Across a number of cases, membership in sets can describe relationships of subset and superset. A set can be said to be a subset of a different set when all cases in the former are members of the latter, but the opposite is not true (Schneider & Wagemann, 2012, p. 4). In the analysis here, the set of right-wing governments (in conjunction with other sets) is a subset of the set of governments that retrench access to healthcare, since all right-wing governments (in that conjunction) belong to the set of governments that retrench healthcare. However, not all the member of the set of retrenching healthcare belong to the right-wing set, which also means that there are other sets or conjunctions that describe governments that retrench healthcare.

A superset relationship exists between the set of governments not undergoing a large public deficit and the set of governments expanding access to healthcare. This is the case since all governments which expand access to healthcare also belong to the set of not experiencing large public deficit, yet there are also cases which do not expand access to health in the latter. In this sense, the set of not experiencing large public deficit is larger than the expanding access set, therefore encompassing it. Superset

and subset relations are analogous to relationships of necessity and sufficiency. In this example, not having a large public deficit can be said to be necessary for expanding access, since expansion does not occur in the presence of large budget deficits.

Untangling relationships between an outcome of interest and the investigated conditions into necessity and sufficiency is particularly useful in research where explanations and the phenomenon of interest are thought to be causally complex. This complexity can be seen in the fact that conditions are not expected to have the same role in all circumstances, but are context dependent. Complex phenomenon such as policy-making can also be triggered through multiple, and not mutually exclusive mechanisms. As the many research approaches to welfare state changes show, a varying mix of conditions, from government characteristics to industrial relation and embeddedness in global markets are argued to be causal in expanding or retrenching the welfare state. These characteristics of the processes of policy change are captured well in set-theoretic designs. For example, arguing that right-wing governments are sufficient but not necessary for retrenching access to healthcare implies that there are other sufficient conditions for retrenching healthcare (Schneider & Wagemann, 2012, p. 5). This is referred to as equifinality, the idea that different explanations and causal paths can lead to the same outcome.

Another element of causal complexity is the fact that explanations are not isolated from context or other factors. Set-theoretic approaches allow for identifying conditions that may not be sufficient or necessary on their own, but are so in combination with other conditions. This is referred to as conjunctural causation and implies that the simultaneous membership in multiple sets can be necessary or sufficient for an outcome (Ragin, 2000). This is different from a "net-effects" approach which tries to clearly separate the effect of a variable from others, across cases. Showing that a variable does not have a significant "net effect" does not necessarily rule out its

causal significance, since it is possible that its impact is different depending on other variables (Mahoney & Goertz, 2006, p. 9).

What sets QCA apart from other set-theoretic methods is its use of "truth-tables" in the analysis of sufficiency. Truth tables specify all the logically possible combinations of selected conditions which may or may not be empirically observed. The principle of minimization then simplifies the empirical information into a more parsimonious expression of the data (Schneider & Wagemann, 2012, chap. 4). This allows a qualitative assessment of a large number of cases, which would not be possible by using less systematic approaches (Ragin, 2014).

Even more important for this study, QCA has certain advantages for theory-building. An exploratory QCA analysis, as this study also performs, allows for simplifying the complex connections between conditions and identify relationships which warrant further investigation. The back and forth between analysis and case knowledge also allows for more careful refining of concepts and specification of conditions (E. Jordan, Gross, Javernick-Will, & Garvin, 2011, p. 1162). In particular for this analysis, QCA has the advantage of bringing together several strands of literature and showing how different explanations interact and which are more relevant to the cases at hand.

MMR

Ultimately, despite being more grounded in cases and allowing for using qualitative data in a systematic manner, QCA analysis can still be considered a cross-case method which looks at patterns across cases in order to show relationships of necessity and sufficiency. Ultimately, such set relations still refer to associations among sets, and therefore fall short of reflecting causation, as with other cross-case methods (Beach & Rohlfing, 2018, p. 10). However, QCA does have certain advantages in MMR designs.

The most important advantage relates to the logic of inference employed in the MMR

design. In designs that are centered on mechanisms, necessary and sufficient conditions are hypothesized to trigger a mechanism (or chain of mechanisms) which lead to an outcome (Beach & Rohlfing, 2018, p. 7). The actual mechanism and subsequent causal inference is made on the case level through process tracing, while QCA aims to generalize the mechanism by showing how its triggering causes are associated with the outcome across cases (Rohlfing & Schneider, 2018)[6].

QCA and PT can be combined in different ways depending on the research question and the state of the theoretical expectations. In the absence of strong theory, process-tracing can be conducted first in order to uncover causal mechanisms and associated sufficient terms. The purpose of the QCA then becomes to test whether the identified sufficient term travels to other cases, and whether there are other sufficient terms not uncovered by the case study (Rohlfing & Schneider, 2018, p. 19). When theoretical expectations are stronger, a QCA-first design can assess the power of the explanation across cases, afterwards informing the case study selection. This study uses a QCA-first design in order to explore the relevance of existing welfare-change explanatory factors for healthcare changes and uncover when and how these factors affect healthcare. PT is then used to probe the mechanisms that are specific to health politics.

Ultimately, QCA MMR can be seen as a compromise between a deductive theory approach where clear yet necessarily simplistic hypotheses are formulated and tested, and an inductive theory approach where case knowledge can highlight and test complex mechanisms (Fischer & Maggetti, 2017). The next three sections detail the process starting from QCA, selecting cases, and developing the causal analysis strategy.

[6] Rohlfing and Schneider (2018) aim to overcome the criticism of statistical-based MMR that it follows different logics of inference for the between and within case analyses (Chatterjee, 2013). They show how QCA and PT can be integrated by arguing that causal inference through single-case counterfactuals and QCA across cases follow the same inferential logic.

5.2.2 Fuzzy Set Qualitative Comparative Analysis

Set logic implies a fundamental differentiation of cases into belonging to a set or not. However, it is not simply the same as dychotomizing data. As Schneider and Wagemann (2012, p. 6) argue, there is an asymmetry of concepts (as well as causal relations) at play. The reasons for belonging to a set can be multi-faceted and can be different from the reasons for not belonging to a set.

Crisp sets simplify the information of belonging to a set by assigning a single value of belonging or not belonging to the set (1 and 0). Fuzzy sets allow for different degree of membership in a set with the cutoff point being set in the middle (0.5). By doing this, it allows the assessment of differences in degree within the differences in kind that csQCA allows (Ragin, 2000, 159). Further on, this allows for better selection of cases in the post-analysis, by allowing the selection of the most deviant and most typical cases (Schneider & Rohlfing, 2013, 578).

The process of transforming quantitative or qualitative data into sets is known as calibration. Fuzzy sets therefore present a distinct advantage on variable measurement. It allows for a better transition of "thick" concepts into "thin" measurements, by allowing researchers to use in-depth case knowledge and data in order to make decisions about how to categorize cases within concepts that are multi-dimensional. One example in this study is that of access, detailed in chapter 2, where qualitative data about regulations on access to healthcare was collected and systematized in order to categorize cases.

Limitations of QCA

Beyond the limits of causal inference when taken alone, QCA presents several other limitations and possible pitfalls. One limitation relates to the calibration of data

into sets. More often than not, sets do not have objectively clear cut-off points for memberships, therefore leaving a certain amount of discretion to researchers. It is for this reason that calibration needs to be done in a transparent manner, and be supported by arguments. If done properly, calibration can be an asset as opposed to a limitation, since researchers can employ their qualitative knowledge of cases in order to specify conditions in a more accurate way than large datasets do.

Connected to calibration are other decisions that researchers need to make, such as setting the cut-off point for consistency of sufficiency of rows in the truth table, that will enter the process of minimization. Ultimately, all of these decisions need to be justified. Moreover, robustness analysis needs to show that different decisions do not lead to vastly different outcomes.

Another limitation of QCA relates to the issue of limited diversity - the problem that there will usually not be enough empirical cases to populate all the possible combinations of different conditions (Schneider & Wagemann, 2012, chap. 6). In practical terms, this tends to limit the number of conditions that researchers use. From the perspective of theory this is problematic since it requires certain assumptions about logical remainders - the unpopulated rows. Even the conservative solution makes assumptions about these rows, the assumption in question being that they do not lead to the outcome, therefore possibly missing relevant conditions or failing to identify irrelevant ones due to the absence of certain cases. While there are no perfect solutions to this, QCA allows for a transparent way of treating logical remainders, as well as checking which remainders violate assumptions of the analysis. Moreover, this problem is by no means limited to QCA, but rather more directly acknowledged by researchers who employ QCA.

The final limitation of QCA relates to its ability to deal with data which presents a panel structure, such as having a cross-section of cases across time, as is the case

here. The problem, analogous to the problems in statistical analysis, is that the identified solutions might not hold for different periods or cases (Garcia-Castro & Ariño, 2016). QCA has further limitations in attempting to model time, although there are certain approaches which allow certain time dynamics (Schneider & Wagemann, 2012, chap. 10; Ragin & Strand, 2008). Since this study does not seek to model time dynamics directly, I use consistency measures across time and cases in order to make sure that the analysis does hold. In addition, case studies are able to fill in part of the gap in identifying and explaining time related mechanisms. For example, a conjunction identified in a solution might be a sequence or other time structure in the case study (Beach & Rohlfing, 2018, p. 19).

5.2.3 MMR Case Selection Principles

These limitations of QCA warrant additional analysis in the form of case studies. Considering that the strength of QCA can be assessed based on how well it relates to cases, both the theory and the analysis itself can benefit from case studies. More specifically, systematic case selection and analysis can feed back into the QCA by uncovering reasons for deviance and providing evidence for adding or dropping conditions (Schneider & Rohlfing, 2013, p. 577). Moreover, no matter how high the scores for consistency and coverage are, there is usually room for improvement of the analysis and the theory.

After any type of cross-case analysis, cases can defined as typical or deviant. Typical cases are generally used in a confirmatory fashion in order to probe causal mechanisms. Deviant cases may generally be exploratory or confirmatory, and can be used to probe for new explanations or to disconfirm alternative arguments (Seawright & Gerring, 2008).

QCA allows for a more detailed and analysis-informed case selection, than other

techniques. It distinguishes between different types of typical and deviant cases and different types of case comparisons or within case analyses[7]. Typical cases can be distinguished into more and less typical cases and a comparison between the two can check whether the same mechanism holds for cases that are good examples of the explanations and cases that barely fit into the explanation. Deviant cases can be distinguished into deviant cases consistency, which display the condition but not the outcome, and deviant cases coverage, which display the outcome but are not part of the solution. Analyzing both types of cases can reveal additional missing elements of the explanation (Schneider & Rohlfing, 2016).

In fsQCA, a typical case for necessity is one which has a score above 0.5 in both outcome and condition, with a higher score in the condition, while in sufficiency the case has a higher score in the outcome (Schneider & Rohlfing, 2013, p. 580). The most typical case has the highest score in both the subset and the superset, while the least typical is the one has only above the threshold score in both, namely 0.51 or whichever comes closest. This is particularly useful in comparing two typical cases as the purpose of such a comparison is to prove that the same causal mechanism is at play in the best empirical example as well as in a barely qualifying one (Schneider & Rohlfing, 2013, p. 583).

Considering cases which do not fit, a most deviant case for necessity in terms of consistency in fsQCA is one which has the highest membership in the outcome, with the lowest in the condition. The reasons for such deviance can be manifold. However, once it can be ascertained that deviance is not caused by misspecification of the case (Ragin, 2006, p. 335), or by miscalibration of outcome and conditions, a comparison to a typical case would yield insights into the model specification, most likely meaning that a condition was omitted (Schneider & Rohlfing, 2013, p. 568). The most deviant

[7] fsQCA analysis also produces so-called "irrelevant" cases, that are part of neither the outcome nor the condition. While these cases are not directly relevant for the analysis, they are useful for between cases comparisons.

case for sufficiency has the highest membership in the condition, with the lower membership in the outcome. A deviant case for necessity is a case where the outcome is present in the absence of the condition, while a deviant case for sufficiency is a case where the outcome is absent in the presence of the condition (Ragin, 2014).

Deviant cases coverage are important because they are a member of the outcome for reasons that are not captured by the solution. This means that the QCA solution is under-fitted and that any uncovered explanations and mechanisms do not travel to those cases. A comparison of a typical and deviant case coverage can yield the missing INUS condition that makes the difference for the outcome (Schneider & Rohlfing, 2013, p. 574).

5.2.4 Causal Analysis Strategy

The *health partisanship* argument developed here operates through different levels of analysis. Its micro-foundations argue that groups in society have different preferences for health policy, while a broad coalition is in favor of expansive access for healthcare. These preferences are picked up on by political parties, which together with preferences for other policies and in contrast with other priorities they have, use them in order to shape their position on healthcare. This party level further interacts with institutional characteristics, such as the quality of linkages with voters, veto points and electoral rules which shape coalition dynamics. A causal analysis strategy therefore needs to provide evidence for how the mechanism operates through the different levels. While the QCA focuses more on the interaction between parties and institutions, the case study analysis further probes the connection between voters and parties and the way this shapes the behavior of parties. By doing so, it analyses the mechanism behind the conditions identified in the QCA.

The types of evidence for the argument at the different levels will also differ. For the

micro level the logistic and multinomial logistic analyses will show that individuals have these different preferences and there is broad support for healthcare and that this influences party choice. The connection to the party level is made through analyzing how parties think and act by looking at manifestos and parliamentary speeches. The connection to the institutional level is made through the cross case comparison, asking how parties would have behaved in different institutional settings.

The challenge in connecting the different levels of analysis is to build a concrete causal analysis. Causality entails making explicit connections between social phenomena, and explaining how phenomena occur and are linked to each other, rather than just describing a series of events (Hedström & Ylikoski, 2010). Process tracing is the most adequate strategy in order to achieve this. PT aims to identify each individual step in a causal process, so as have a firm account of how the outcome is generated (George & Bennett, 2005). Process tracing allows for a "thickening" of the "thin" concepts and explanations of cross-case analysis, by looking at the complexities of mechanisms and how they operate in specific contexts. However, PT, broadly taken, is not enough to establish causality. The problem of spuriousness means that tracked processes need not be the cause, or the only cause, of a phenomenon. Moreover, the absence of an event can also be causal (Rohlfing & Schneider, 2018, p. 47).

For a process to be credibly linked to an outcome, the process tracing needs to take the form of a chain of causation. Social scientists usually think of this chain as a mechanism or series of mechanisms, generally seen as the underlying entities that produce the observed phenomena (Hedström & Ylikoski, 2010; Bennett & Checkel, 2012). The approach taken here is to follow the chain of the partisanship mechanism, from individual voting preferences until the policy outcome. Counterfactual analysis is used in order to ask how policies would have been different if they were proposed by ideologically opposed cabinets, in different institutional settings.

5.3 Case Selection Strategy

The two main case studies of this dissertation, Czechia and Bulgaria, were chosen based on two interrelated rationales. The first is that they exhibit the most typical governments in the QCA analysis of expansion and retrenchment. Specifically, the Spidla and Zeman cabinets in Czechia, and the Kostov, Saksoburgotski, and Borisov cabinets in Bulgaria, were the typical cases for expansion and retrenchment, respectively. The individual cabinets are used in order to probe the mechanism behind causal paths at the government level.

The second rationale relates to the differences in health and political systems between the two countries. The similar starting points of the two countries in terms of health system, which later drastically diverged, as well as their similar political institutions, bring them close to a most-similar-systems design (Seawright & Gerring, 2008). The key difference, explored in detail in the case study chapters, is the nature of linkages between politicians and voters.

Therefore, while highlighting the typical cabinets, the main case studies go beyond the individual governments in order to analyze the party systems and institutions of the two countries. The analysis in chapters 7 and 8 emphasizes the importance of linkages in health policy-making, and explore the causal argument. The following section explores the differences and similarities in health and political systems that are relevant for the comparison.

5.3.1 Czechia and Bulgaria - Political and Health Institutions

Most-similar-systems designs are adequate for contrasting cases which are broadly similar, yet differ in a key variable of interest as well as the outcome. In practice, it is close to impossible to argue that two countries are identical, with the exception of one characteristic. However, what is important for this comparison is that theoretically relevant explanatory factors are similar. This section therefore explores the similarities and differences among Czech and Bulgarian health and political institutions.

Health systems - similar legacies

By the time of regime change, in 1989, Czechia (then Czechoslovakia) and Bulgaria had, what appeared to be, similar health systems. After starting with Bismarckian insurance in the last part of the 19th century, the communist regimes of the second half of the 20th century adopted the soviet Semashko health system. The Bismarckian model was based on the insurance principle, emphasizing work-related accidents, where contributions were directed to a central fund from which provision was financed (Marrée & Groenewegen, 1997). By contrast, the model that followed, the soviet one, was characterized by a centralized state monopoly both on provision and finance. Provision was universal and financing was done directly from the state budget. In essence the Semashko system was quite similar to the British National Health Service, with the notable difference that most care was provided in polyclinics and hospitals, with an underdeveloped primary care system (Kornai & Eggleston, 2001).

There were, of course, also differences between the two countries. Czechia started the transition ahead of many of its neighbors in terms of population health and development of the health system. In terms of spending, in 1989 Czechoslovakia was

spending 5.8% of GDP on health, comparable to many Western countries (Marrée & Groenewegen, 1997, p. 52). Bulgaria, by contrast, was spending only 3.3% of its rather small GDP on health in 1989 (Romania was spending even less, at 2.5%) (Sotiropoulos, Neamtu, & Stoyanova, 2003, p. 663). The second noteworthy difference between the two was in terms of health system organization. While Bulgaria exhibited a more typical Semashko, fully-centralized system, Czechoslovakia had developed some decentralized elements, such as district level health institutes (Busse, Struck, Marshall, Pyrmula, & Petrakova, 2000, p. 5).

The Semashko systems of the two countries had similar inherent problems, which meant that reforms were necessary after transition. The main effects of such a system were characterized as being "defenselessness of patients, low quality of care, and sluggish scientific and technological development" but also "security, solidarity, and equality, albeit at an extremely low level" (Kornai & Eggleston, 2001, p. 139). In terms of outcomes and policy reform these legacies set the stage for semi-permanent emergency and excessive bureaucratization (Inglot, 2008, p. 127). This "permanent emergency" can be seen both in political discourse and policy practice.

Health systems - divergent outcomes

These deficiencies were a challenge for both countries during the 1989 double transition to democracy and capitalism, which meant a gradual return to Bismarckian social insurance. While both systems are currently characterized as Social Insurance Systems (SHI), they show stark differences in how patients access the system, and what financial barriers they meet along the way. Table 5.1 summarizes the main health system characteristics.

Currently, Czechia has a Social Health Insurance-type system with multiple quasi-public insurance funds, 7 in 2014 (Alexa et al., 2015). However, behind the appearance

Table 5.1: Health System Characteristics Comparison - 2014

	Czechia	**Bulgaria**
Legacies	Bismarckian, Semashko	Bismarckian, Semashko
Expenditure	7.4 % GDP	8.4 % GDP
Main financing sources	Social Insurance, state subsidies	Social Insurance, out-of-pocket
OOP expenditure	14.33% out of total	44.19% out of total
Insurance type	Multiple funds, public	Single fund, public
Coverage	Full coverage	Incomplete coverage
Gate-keeping	Absent	Present
Provision	Inpatient public Outpatient private	Inpatient public Outpatient private
Administration	Decentralized	Partly decentralized
Barriers to Access	Low	High
System type	Public Encompassing	Provision State

of a typical SHI system is one that relies on multiple mechanisms to ensure access. The funds ar not allowed to select patients based on risk or other criteria. At the same time, out-of-pocket payments are limited, with some public funding of pharmaceuticals and low co-payments that have had a contentious history (Kinkorová & Topolčan, 2012). Private insurance plays a very limited role and 85% of overall expenditure is public, with a total of 7.4% of GDP spent on health in 2014 (WHO, 2019). There is no official gatekeeping system, therefore allowing patients direct access to specialist care without extra cost. Outpatient care was mostly privatized in the 1990s, similar to other Eastern European countries, but the inpatient, hospital system has resisted privatization and other major transformations. What resulted is a system that is overwhelmingly public with few direct financial barriers to access. As we will see, this is not an accident, but a result of the ability of political parties and social actors to resist retrenchment and to promote access.

The Czech health system was decentralized in 2003, transferring a majority of care facilities, including hospitals and institutions of long-term care to the new system of 14 regional governments (Bryndová et al., 2009, p. 62). In terms of inpatient provision, approximately 15% hospital beds were private in 2014, with a slow growth from 10% in 1995 (Alexa et al., 2015). Outpatient provision was fully privatized during the 1990's, with family doctors owning their own practices as the norm.

Overall, since 1989 until today the trend has been one of maintaining and expanding the solidaristic elements of the Czech system. Especially when compared to most of their neighbors, Czechs enjoy a wide range of health benefits, with fewer barriers to access. These norms have survived successive governments and attempts at retrenchment. Nevertheless, one dimensions which has deteriorated has been pharmaceutical expenditure from the pockets of patients. The percentage of private pharmaceutical expenditure has climbed from 16.4% in 1995 to 40% in 2014. However, overall out-of-pocket expenditure has climbed only from 9.1 to 14.3% in the same period, with private insurance virtually nonexistent (Alexa et al., 2015).

Bulgaria, on the other hand, is an SHI only in name, having close to a majority of its spending directly out-of-pocket, and an incomplete coverage of the population in social insurance schemes. While the state covers certain vulnerable groups, such a pensioners, children, and the unemployed, many fall out of any insurance coverage. The main insurance fund began withdrawing insurance from those who could not pay starting in 2003, with 27.5% of the population remaining uninsured in 2016 (Dimova et al., 2018, p. 68). Many of these are Bulgarians living abroad, in informal work, and those who cannot meet payments.

In terms of provision, Bulgaria is a mostly privatized system. Outpatient services are almost fully private, similar to other countries in the region. The more discrepant change can be seen in the hospital sector where the share of private beds rose from

2.65% in 2004 to 19.95% in 2014 (Georgieva et al., 2007). In terms of administration, the Bulgarian system is partly decentralized. The Ministry of Health maintains centralized control over public health and the main social insurance fund controls social insurance reimbursements (Koulaksazov, Todorova, Tragakes, & Hristova, 2003).

What is even more stark than the outlook of the current system is the speed of change. Starting from a purely public system in 1989, out of pocket expenditure reached 26% of total health expenditure in 1995 and climbed to a high of 44.2% in 2014, equal to social security funds (44%), the rest being supplied from taxes 10.5% (WHO, 2019). The main drivers for this trend are user fees, as well as private pharmaceutical expenditure, which has maintained above 70% since the 1990's (Georgieva et al., 2007).

Political Institutions

What is relevant in explaining the divergent outcomes and different pace of reforms of the two countries? Ultimately, successive governments were responsible for policy making, either through actions or neglect. Thus, political competition, shaped by parties and the various political institutions which enable or constrain them, is important in order to understand how decision are made or unmade. Table 5.2 summarizes the similarities and differences between the two political systems.

In terms of linkages between parties and the electorate, Czechia more closely resembles established party systems where electoral bribery is rare, and parties make little use of political and administrative appointments as means of gaining and securing power (Kitschelt, 2013).

Bulgarian parties, on the other hand, have far reaching and entrenched clientelistic networks which they use in order to engage in electoral bribery, as well as patronage politics in order to deliver benefits to party loyalists (Kolev, 2012). These practices

Table 5.2: Political Institutions Comparison

	Czechia	**Bulgaria**
Veto Points	Veto-ridden	Veto-ridden
Linkages	Programmatic	Mixed/Clientelistic
Political system	Parliamentary	Parliamentary
Voting system	Proportional representation	Proportional representation
Party system	Volatile[i] Multi-party	Volatile Multi-party
Government Stability	Predominantly unstable[ii]	Predominantly unstable
Main Parties[iii]	Left - CSSD Right - ODS	Left - BSP Right - SDS, NDSV, GERB

[i] Volatility refers to varying coalition configurations as well as the appearance of new parties.
[ii] Instability refers to a large proportion of cabinets ending before their term and/or facing major reshuffles.
[iii] CSSD - Czech Social Democratic Party (Česká strana sociálně demokratická); ODS - Civic Democratic Party (Občanská demokratická strana); BSP - Bulgarian Socialist Party (Bălgarska sotsialisticheska partiya); SDS - Union of Democratic Forces (Sayuz na demokratichnite sili); NDSV - National Movement for Stability and Progress (Nacionalno dviženie za stabilnost i văzhod); GERB - Citizens for European Development of Bulgaria (Graždani za evropejsko razvitie na Bălgaria).

are coupled with other forms of patronage whereby successive governments give preferential public contracts to firms close to them (Spendzharova & Vachudova, 2012).

Beyond linkages between voters and politicians, the two political systems share important similarities. Both produce unstable governments which often lack parliamentary majority, relying on the tacit support of parts of the opposition. This has meant that a majority of Bulgarian and Czech cabinets have been dissolved before the end of their term. The use of proportional representation voting systems has resulted in a fragmented party system. In order to form a government, parties are often forced to make coalition deals with ideologically opposed partners.

One notable difference is that the major parties in Czechia, the ODS and the CSSD, have maintained their dominance in forming successive cabinets (a pattern broken in 2017 when a new party, ANO, formed the government). While the Bulgarian center-left has remained dominated by the BSP, the center-right has been successively

occupied by three different parties: the SDS in the 1990s, the NDSV in the 2000s, and GERB in the 2010s.

In institutional terms, both systems show a similar veto-points structure, giving opposition parties and social actors similar avenues to block policy reform. Indeed, both countries most notably saw instances of judicial review being used in order to successfully contest policy decisions.

6 Qualitative Comparative Analysis of the Politics of Health Access

Hacker: The statistics are irrefutable...
Sir Humphrey: Statistics? You can prove anything with statistics.
Hacker: Even the truth.
Sir Humphrey: Yes... No!

—Yes Prime Minister, The Smoke Screen

Current theoretical approaches to explaining welfare state change place different emphasis and importance on either politics, institutions or structural pressures. While it is likely that all these factors play some role in shaping health policy, albeit roles of different importance, what is less understood is how they interact to produce change. This is important, since many studies show that these factors do not operate in isolation but rather impact each other in complex ways.

Path dependency arguments emphasize the role of outside pressures in generating critical junctures which allow for systemic change (Capoccia & Kelemen, 2007). Theories that emphasize the role of governments show how their efforts can be disrupted by institutional veto points, or enabled by their lacking (Roberts, 2009a). Other theories emphasize the importance of economic crises as either pushing governments to retrench welfare provisions (Ross, 2000a) or to provide more welfare in order to cover

new social risks (Iversen & Soskice, 2006).

The mixed findings for the role of partisanship in health policy as well as the "new partisanship" literature[1], suggest that it plays a complex and as of yet not clearly understood role. This chapter starts from the understanding that government ideology is unlikely to operate in isolation from other factors, or in a simple additive dynamic, together with other factors. Rather, what the literature points to is that we should expect conjuctural causation, that is, that ideology will affect the outcome only in specific combinations with other factors (Ragin, 2000). Fuzzy set Qualitative Comparative Analysis is therefore used to untangle the necessary and sufficient conditions, and combinations of conditions, for expanding and retrenching access to healthcare.

The absence of large fiscal deficits is found to be necessary for expanding access to healthcare. Sufficient combinations for expanding access to healthcare show left-wing dominated cabinets, without large fiscal deficits in combination with programmatic linkages or already expanded health systems. Right wing cabinets appear in combinations with clientelistic linkages, large fiscal deficits, existing low access systems and both veto-free and veto-ridden systems.

The chapter proceeds by discussing the choice of causal conditions. It then discusses the chosen indicators, method of calibration and results. The chapter concludes with a discussion of the implication of the results.

6.1 Data

The analysis covers 63 government episodes from the 16 countries of Eastern and Southern EU countries for which data was available[2]. The outcome condition was

[1]For the overview of partisanship, see chapter 3.

[2]Data were not available for Malta for the party linkages indicator (Kitschelt, 2013).

constructed as an index of health access[3], defined as health decommodification and being formed of three sub-dimensions: financing, provision and regulation of access to healthcare (Wendt et al., 2009; Bambra, 2005b)[4]. Both the index and its sub-dimensions were analyzed. Four government episodes were selected for each country[5], corresponding to available data for the access index. The four government episodes broadly correspond to four time periods: 1999-2001, 2004-2005, 2008-2009, and 2012-2014.

6.1.1 Outcome

The main analysis looks at the combination of conditions which lead to increasing or retrenching access to healthcare, therefore looking at increases and decreases in the access index. Figure 6.1 shows the absolute values of the index and the changes associated with each government. The change value associated with each government was calculated by taking the index value associated with the government and subtracting the value from one year before its start date. The index value associated with each government was calculated by averaging the value of the index over the duration of the government, starting with 6 months from the starting date of the cabinet. What we see is a wide spread of values of the raw index score. Most changes to the scores were within 5% of the index (scaled from 0 to 100), with a few more extreme cases of change, most notably in retrenchment (negative change in the index).

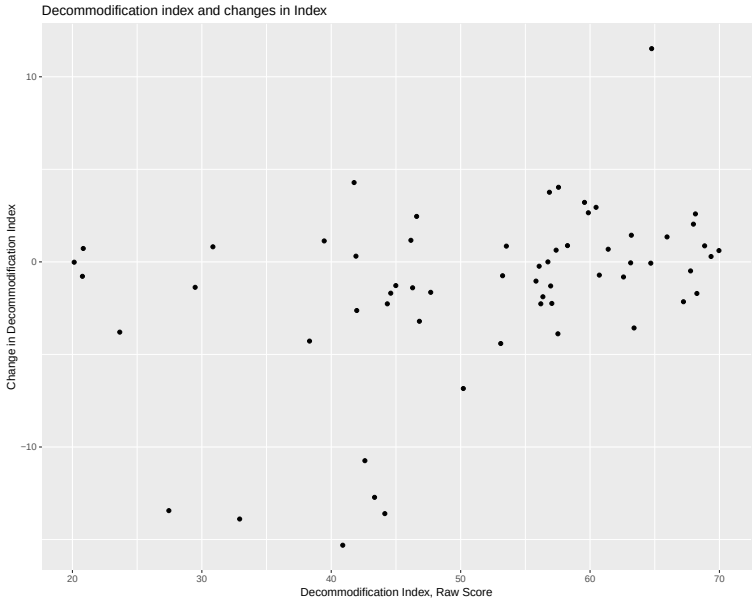
Figure 6.2 shows the absolute and change values for two out of the three subdimensions of decommodification: financing and provision. What can be seen is that financing undergoes the most drastic changes, in both increasing and decreasing finan-

[3]For a detailed presentation of the index and its construction see chapter 2 and appendix A.

[4]For the remainder of the paper I use the terms decommodification and expansion of access interchangeably; Therefore also decommodifying as expanding access, and commodifying as retrenching access to healthcare.

[5]Data availability allowed only 3 government episodes for Cyprus.

Figure 6.1: Access Index and Change



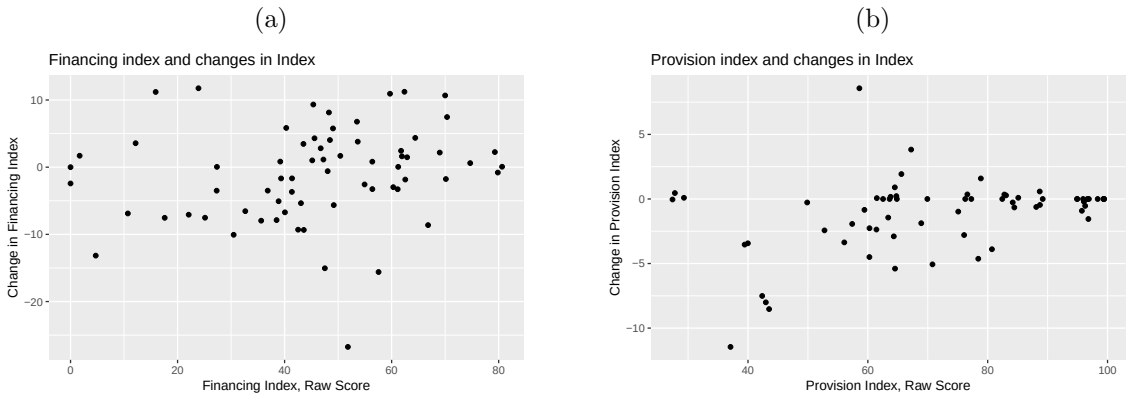
cial access. The provision score shows less change, and the most drastic are negative. This makes sense given the fact that the provision change covers physical assets such as hospital beds and outpatient facilities, which are harder to close down or privatize. The negative trend also highlights the overall move in these health systems towards outpatient care, which tends to be more private. The last component of the index, regulation, shows the least change, with no cases of expansion observed in the data, while seven governments retrenched regulation access.

Therefore the analysis focuses more heavily on the overall index and the financing subdimension, which is arguably the most important for patient access, but also for parties when seeking political capital.

Calibration

Fuzzy sets show the membership score of a case into a set. A case is considered a full member with a score of 1 and a full non-member with a score of 0. The 0.5 threshold sets the qualitative difference between membership and non-membership. Calibration

Figure 6.2: Financing and Provision Indexes and Change



for the threshold of belonging to the set of expanding access was set at a change of 0.5 and retrenching at -0.5 in the index. An alternative calibration of 1 and -1 was used as a robustness check[6] . Table 6.1 shows a sample of the governments used in this analysis, with their raw score on the access index, followed by the calibration into a fuzzy set. A negative number in the raw score (third column) represents a retrenchment change (or commodification), while a positive number represents the opposite.

Fuzzy sets allow for more fine grained analysis by distinguishing the level to which a case belongs to a set, compared to crisp sets. Notice the Pahor I cabinet, which barely qualifies in the set of decommodifying governments with a raw score of .813 (just above the .5 threshold), while the Gonzi II cabinet is the most typical case of an expanding access government with a raw score of 5.84, and therefore a score of almost 1 in the calibrated set. Conversely, with a change of -18.66 in the index (affecting all three sub-dimensions) the Kostov government is the most typical case in the retrenching set, and therefore the least typical in the expanding set. Cases which show no change belong to neither set (and were analyzed separately).

[6]While these changes might seem small, this is due to how the index is calculated, as a weighed average of three dimensions. Therefore, if a cabinet only affects financing, the overall index will only show a change equivalent to one third of the financing index. As the examples given here, and subsequently elaborated in the case studies show, these changes cover important policy decisions.

Table 6.1: Sample of Governments: Raw Access and Calibrated Score in Outcome Sets

Country	Cabinet	Change in Index Raw Score	Expansion Calibrated Score	Retrenchment Calibrated Score
Czechia	Spidla	2.96	0.833	0.136
Czechia	Topolanek	-3.57	0.316	0.651
Bulgaria	Kostov	-18.66	0.025	0.975
Bulgaria	Borisov	-3.76	0.308	0.66
Spain	Zapatero I	1.907	0.715	0.216
Spain	Rajoy	-1.68	0.398	0.56
Hungary	Gyurcsany II	-2.02	0.383	0.576
Hungary	Orban I	-5.02	0.256	0.714
Romania	Nastase I	3.68	0.889	0.097
Romania	Boc III	-12.4	0.079	0.918
Slovenia	Pahor I	0.813	0.551	0.331
Malta	Gonzi II	5.84	0.971	0.032

The Gyurcsany II cabinet in Hungary shows an index change of -2.02. A look at sub-dimensions shows that only financing shows changes, of -5.21 on the financing index. The value for financing retrenchment is caused by the coalition government introduction of co-payments in 2006 (Mihalyi, 2007). The Spanish Rajoy cabinet[7] also shows a modest change of -1.68 in the index which is driven by financing retrenchment, where there is a change of -5.64. The laws responsible for the observed retrenchment are a series of reforms by the cabinet in 2012 and 2013 (RDL 16/2012, RD 1192/2012, and RD 576/2013) which restricted the definition of coverage from citizenship to work status, reduced the benefit package covered by the health system, and therefore led to an increase in direct payments by patients (Bernal-Delgado et al., 2018, pp. 120-122). Financing is the main dimension driving change, but there are also important changes to provision. The Spidla cabinet shows an overall change towards expansion of 2.96, which is driven largely by the provision score of 8.57. This change reflects the hospital reforms of 2004-2006 (Bryndová et al., 2009).

[7]The Rajoy cabinet is a typical case for retrenching financing, covered by the financing solution path showing a combination of right-wing cabinet and existing retrenched financing.

The calibration of the outcome therefore captures important changes in health systems, while also differentiating in degree between large and smaller changes.

6.1.2 Causal Conditions

The causal conditions selected for the analysis follow from the major debates in the welfare state change literature. They can be broken down into partisanship, institutional and fiscal factors. Table 6.2 summarizes the definition and calibration of each condition into fuzzy sets.

Partisanship is operationalized using the expert coding from the ParlGov dataset (Döring & Manow, 2010). The score was calculated from the individual score of each party in the governing coalition, weighed by their share of seats in parliament. The final score, between 0 (left) and 10 (right) gives a general idea of the ideological orientation of the government, accounting for how large the parties are in parliament (larger parties having more influence). The set "RIGHT" includes governments scoring over 5 on the scale. In general, left wing parties are expected to be associated with increasing access and its sub-dimensions, while right wing parties are expected to decrease it.

The veto-points measure was constructed by the author from several indicators from the V-Dem data-set (Coppedge et al., 2015). Following the literature (Huber & Stephens, 2010, 2015; Immergut, 1992) it was compiled through the cumulative score of the variables assessing the ways in which parties and social actors can block reforms:

- Permitted plebiscite: 0 - not allowed, 1 - allowed and non-binding, 2 - allowed and binding;
- Head of state veto: 0 - no, 1 - yes but overridden with simple parliamentary majority, 2 - yes but absolute majority override, 3 - yes but extraordinary majority override, 4 - yes with no override;

Table 6.2: Causal Conditions: Definitions and Sources

Condition	Definition	Calibration
DEC FINDEC PRODEC REGDEC	Set of decommodified health systems Sub-dimensions of decommodification Financing, Provision and Regulation	0 (commodified) 100 (decommodified) 0.5 threshold set at 50
RIGHT	Set of right wing governments Calculated by weighed ideological position of parties in cabinet (Döring & Manow, 2010)	0 (extreme left) - 10 (extreme right) 0.5 threshold set at 5
VETO	Set of veto-ridden governments Own coding by taking together: Presence of Referendum 0-2 Head of State Veto 0-4 Bicameral Legislature 0-2 Judicial Review 0-1 (Coppedge et al., 2015)	9 point variable 0.5 threshold set at 5
DEF	Set of governments running a high deficit Budget deficit as % of GDP (Eurostat, 2019)	0.5 threshold set at one standard deviation above sample mean
PROG	Set of party systems with programmatic linkages Original indicator: "b15nwe" Composite of 5 indicators 5-fully programmatic 20-fully clientelistic (Kitschelt, 2013)	0.5 threshold set at 12 based on case knowledge and spread of data

- Bicameral legislature: 0 - no parliament, 1 - 1 chamber, 2 - 2 chambers;
- Judicial review: 0 - does not exist, 1 - exists.

Veto points are expected to impede increases in access since, most often, active policy needs to implemented in order to increase access in either of the three subdimensions. The same is not expected for decreases in access, since these can also operate through neglect or policy drift[8]. Other types of decreasing access do imply active legislative changes, such as introducing co-payments or introducing a referral system. The 0.5 anchor of belonging to the set of veto-ridden (VETO) governments was set at a score of over 4. This most often implied the presence of a bicameral legislature and the existence of some form of presidential veto, the most common avenues for impeding legislation.

Deficit was taken as a percentage of GDP. The set, "DEF", was created to capture governments running a high deficit. This was calculated as one standard deviation (3.02) below the mean (-4.49). The reason for this is that healthcare services are usually not the first to be cut in order to cover a budget deficit, due to the more strenuous political process involved. Instead, changes are expected during higher deficits which cause governments to consider (and justify) cuts to access in healthcare.

The final substantive factor used in the analysis is the quality of party linkages to voters. Linkages between parties and voters can be seen on a continuum from programmatic - where in order to gain support parties make substantive policy promises which voters trust that they will attempt, to clientelistic - where parties gain support through bribery, offering employment and other informal means (Kitschelt & Wilkinson, 2007). In more clientelistic party systems, parties are expected to provide fewer universal public goods, and target voters more directly through informal networks in order to gain support. Conversely, in more programmatic party systems,

[8]For example by allowing hospitals or care centers go to bankrupt, or allowing the uninsured rate to rise, or not supplementing social insurance budgets, among others.

parties believe that voters trust their promises and can therefore gain political capital from promoting broad public goods. We would therefore expect more programmatic linkages to be associated with increasing access.

The indicator used for this condition was taken from the expert surveys from the DALP data-set (Kitschelt, 2013). Individual parties are coded over 5 dimensions covering the main areas where parties can substitute programmatic promises with clientelistic practices: providing citizens direct consumer goods, preferential access to social benefits, preferential access to public employment, preferential access to public contracts and preferential treatment under the law. The indicator used here takes the cumulative score of these dimensions (themselves the mean response from expert coders), weighed by the parties within a country. While the indicator could vary from 5 (completely programmatic) to 20 (completely clientelistic), in this sample, it ranges between 10.52 and 15.81. This means that most parties fall within some mixed type. The 0.5 threshold was set at 12 following individual inspection of cases and comparing to qualitative case knowledge, the value also being close to the mean and median in the sample. Substantively, we would expect mixed or clientelistic linkages to interfere in politics of health. If parties are not fully accountable to promises and don not fully trust that universalist policies (such as increasing access to healthcare) will gain them political capital, they will be less likely to attempt to expand health access, and more willing to retrench access in the face of tight budgets.

The final indicator used in the analysis of change is the absolute value of the index and its sub-dimensions for each government. DEC/FINDEC/PRODEC/REGDEC represent the sets of decommodified health systems associated with each government (Decommodified Overall, Financing Decommodified, Provision Decommodified, Regulation Decommodified). This factor was included in order to assess the impact of existing institutional arrangements in healthcare on governments' ability to enact

change.

6.2 Results

In total, 6 analyses for sufficiency were conducted, two each for the overall index and the three sub-dimensions: one set for positive changes (expansion) and one for negative changes (retrenchment)[9]. For the necessity analysis, only two of the outcome analyses revealed necessary conditions. Only the two main analyses, on retrenching and expanding overall access to healthcare, are presented in detail here. Analyses of the sub-dimensions are found in Appendix B, and summarized below in Table 6.5.

For the sufficiency analysis, the intermediate solutions are presented, following the Enhanced Standard Analysis procedure, described by Schneider and Wagemann (2012, chap. 8)[10]. The intermediate solution uses directional expectations set by established findings and theoretical arguments in order to decide which logical remainder rows to include in the analysis (Schneider & Wagemann, 2012, chap. 6). Logical remainders are rows representing possible combinations of conditions for which there are no observed cases. They are a problem with no perfect solution, and they are not unique to QCA. Rather, QCA deals with them explicitly and transparently. Choices over which remainders are included or excluded need to be justified.

The directional expectations in the analysis were set in line with the theoretical framework discussed in chapter 3. For the analysis on expansion these were: already expanded system (decommodified), veto-free, left wing, no deficit and programmatic linkages. For retrenchment they were: not expanded systems (commodified), right

[9]The small number of changes towards expanding access in the sub-dimensions of provision and regulation meant that analyses were not feasible there.

[10]In addition to established procedures of managing logical remainders, Schneider and Wagemann add the need to check for assumptions which might contradict statements of necessity, contradictory assumptions which might unknowlingly be used for both the outcome and its negation, as well as other untenable assumptions.

wing, deficit, clientelisitc and no expectations regarding veto points. In this analysis, there were relatively small or no differences between the conservative and intermediate solutions. The intermediate solution is, by definition, a superset of the conservative solution. The truth tables for the main analyses, presented in full in Appendix B, include which logical remainder rows were included in the analysis, denoted by 1 in the outcome.

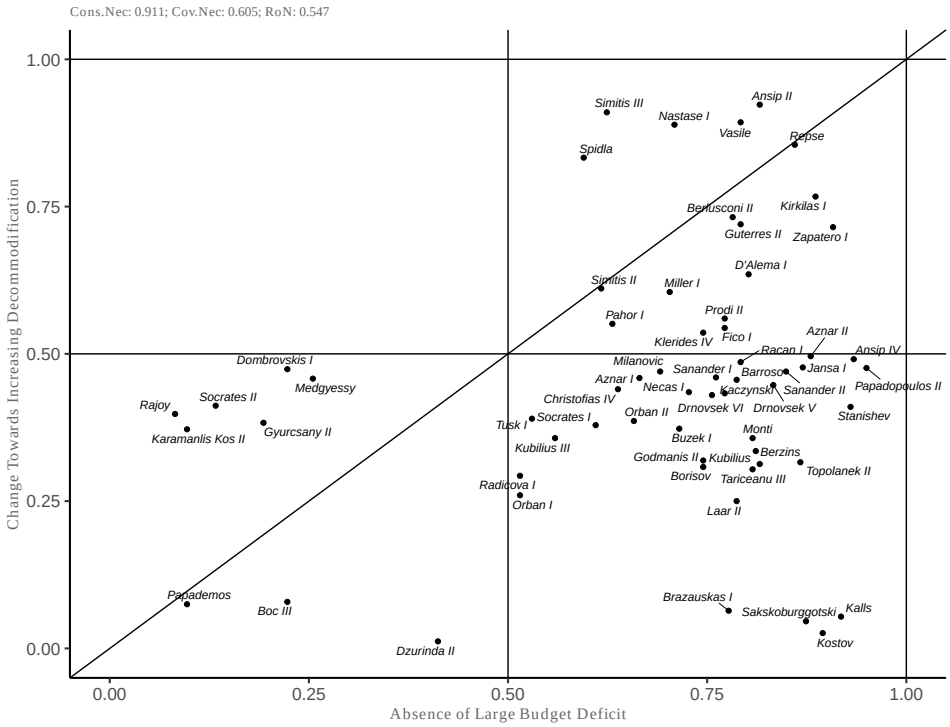
Necessity Analysis

The analysis of necessity revealed single necessary conditions for only two of the analyses: expansion in the overall access index and retrenchment in the regulation sub-dimension.

The absence of large fiscal deficits appears necessary, but insufficient, for increasing overall access. Consistency of necessity is above the commonly accepted 0.9 value, while figure 6.3 shows that there are no true logical contradictions (no case occupying the upper-left quadrant, which would mean that the case would increase access in the presence of a large budget deficit). This finding is consistent with the sufficiency analysis seen in table 6.3, as well as other findings in the literature concerning the timing of expansionary welfare reforms (Reeves et al., 2014). This relationship is robust to changes in the calibration of the deficit indicator. However, the small number of cases exhibiting a large budget deficit, and the rather unimpressive value of the relevance of necessity measure (0.547) suggest that by itself, the presence of large budget deficits is a trivial superset of expanding health access.

The second analysis which revealed necessary conditions was of that of retrenching regulation access. Seven governments out of the sample engaged in retrenching regulation. This meant either introducing a gate-keeping system, or decreasing coverage, or switching from tax-based public financing to the more regressive social-security

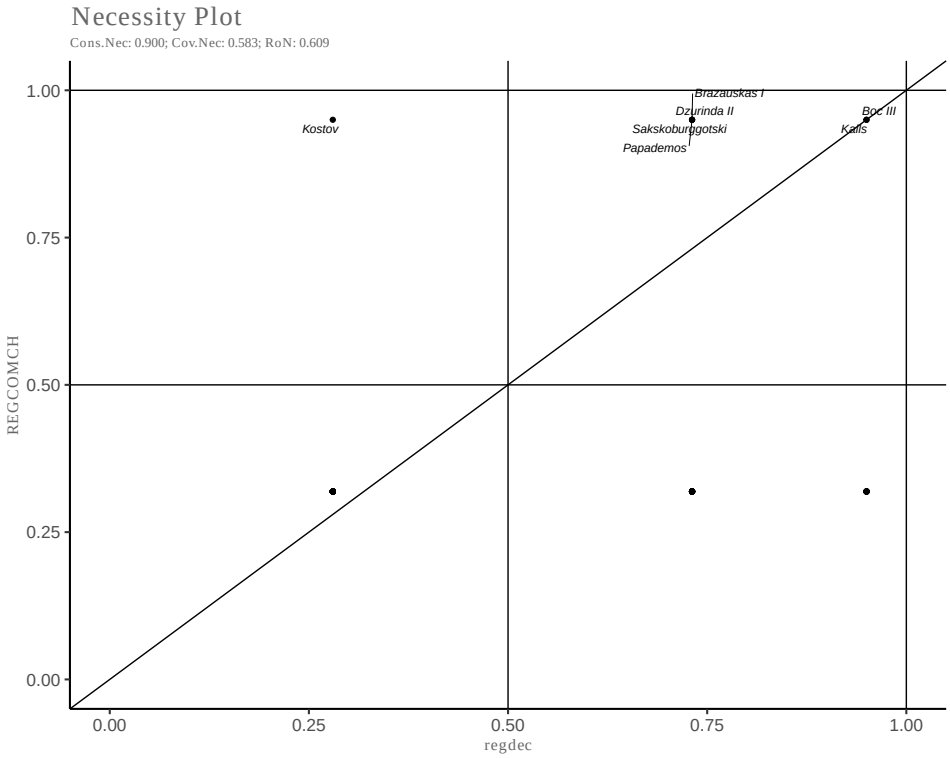
Figure 6.3: Necessity Analysis - Expanding Access to Healthcare



contributions form of public financing. All of these instances occurred in systems that were already commodified - meaning that at least two of the mentioned conditions were present - except for the Bulgarian Kostov government. Besides being a true logical contradiction (TLC) in the analysis, the Kostov government more generally breaks the pattern seen also in the sufficiency analysis - of existing levels of access influencing changes. The Kostov government is even more interesting because it presents the strongest instance of retrenchment. It is discussed in detail in chapter 8.

From the cases seen in Figure 6.4, the two Bulgarian governments, Kostov and Sakskoburggotski, cover two changes in the Bulgarian system: switching from taxes to social insurance in 1997 and losing full coverage (by withdrawing coverage for non-payers in 2003). The Romanian Boc government oversaw the first instance of decreasing coverage in Romania - a result of the austerity measures following the crisis.

Figure 6.4: Necessity Analysis - Retrenching Regulation Access



Slovakia lost full coverage during the Dzurinda governments, while also introducing referrals in 2013. The small number of cases in this analysis, as well as the presence of a TLC suggest only limited evidence of commodified systems being necessary for retrenching regulation. However, sufficiency analyses across all dimensions of the index corroborate the importance of existing healthcare arrangements as the condition is present in many combinations.

Sufficiency Analysis

As Table 6.3 shows, the necessary condition "def" (absence of large deficits) appears in combinations in both sufficient terms for expanding access. Both solutions, which partly overlap in cases as well, show a combination of left-wing governments and absence of budget deficits, with the first including an already expanded system, and the second showing programmatic linkages.

Table 6.3: Sufficiency. Expanding Access to Healthcare

	cons.	PRI	covS	covU	cases
DEC*right*def[i]	0.87	0.59	0.60	0.12	Milanovic,Racan I,Simitis II,Simitis III, D'Alema I,Prodi II; Spidla,Drnovsek V, Drnovsek VI,Pahor I,Zapatero I; Guterres II,Socrates I,Nastase I
right*def*PROG	0.92	0.62	0.54	0.06	Spidla,Miller I,Zapatero I;Pahor I,Fico I; Drnovsek V,Drnovsek VI
Solution	0.87	0.58	0.66		

[i] Note, upper case letters indicate the presence of the condition ("PROG" referring to presence of the programatic linkages condition, while lowercase letters refer to the negation of the condition, "right" referring to the presence of the set of left-wing governments.)

Figure 6.5: Sufficiency Analysis - Expanding Access to Healthcare

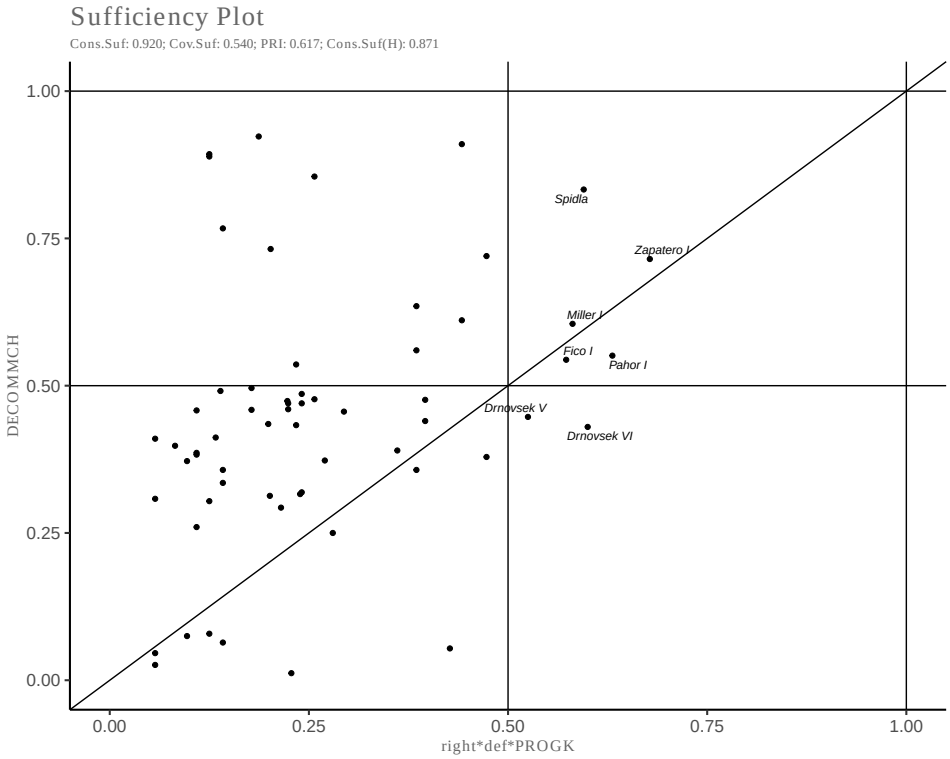


Figure 6.5 shows the second path in an xy plot. The Czech Spidla cabinet is the most typical case. The Spidla score is mostly driven by change in provision access, as a result of the Spidla government policy of freezing hospital privatization and reversing hospital fees (Bryndová et al., 2009). The Zapatero I and Miller I cabinets are also typical cases, with Zapatero's score driven by access in financing (appearing in combinations in that analysis as well). The Fico I and Pahor I cabinets are deviant cases in degree, since they have higher membership in the conditions than in the outcome, though they still show the presence of both. The two Slovene Drnovsek cabinets are deviant in kind, since they show the same combination of conditions but not the outcome.

Table 6.4 shows solution for the analysis of retrenching health access. All three solution terms (two of them partly overlapping) contain the right-wing INUS condition, two in combination with existing low access in the system, and two in combination with clientelistic linkages, the last also in presence of large budget deficits. What is also noteworthy is the ambiguity of the "veto-points" condition, both the condition and its negation appearing in sufficient combinations. This lends support to the hypothesis that right-wing governments can retrench even in veto-ridden systems since retrenchment can happen in hidden ways, or through neglect (Hacker, 2004a). The solution overall confirms expectations of right wing governments engaging in retrenchment in existing commodified and non-programmatic systems.

Figure 6.6 shows the second path. The Bulgarian Sakskoburggotski appears to be the most typical case, with Klerides IV being the most deviant (and a TLC).

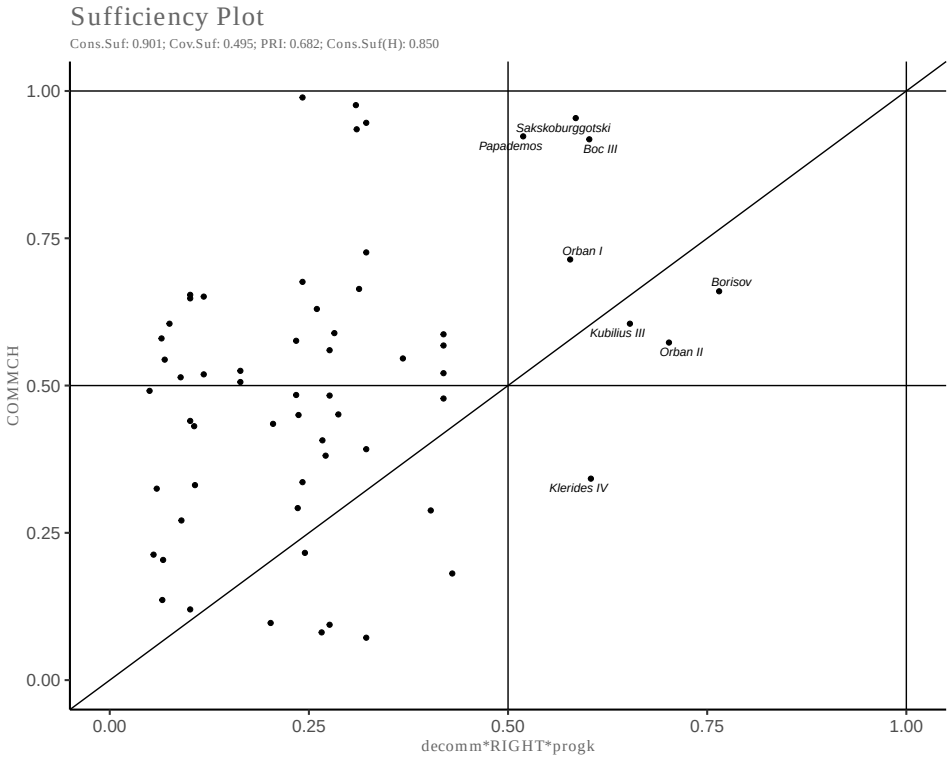
Analysis of sub-dimensions

Sufficiency analyses were also conducted for the sub-dimensions of the index: financing, provision and regulation. The results are presented in Appendix B. The results

Table 6.4: Sufficiency. Retrenching Access to Healthcare

	cons.	PRI	covS	covU	cases
dec*VETO*RIGHT	0.91	0.75	0.48	0.06	Borisov,Sakskoburggotski,Orban I, Orban II; Buzek I,Kaczynski,Tusk I, Radicova I; Boc III; Dzurinda II
dec*RIGHT*prog	0.90	0.68	0.49	0.03	Klerides IV,Kubilius III; Papademos; Borisov,Sakskoburggotski,Orban I, Orban II; Boc III
veto*RIGHT*DEF*prog	0.95	0.72	0.38	0.06	Papademos; Karamanlis Kos II
Solution	0.89	0.68	0.62		

Figure 6.6: Sufficiency Analysis - Retrenching Access to Healthcare



for the financing sub-dimension are particularly important, since financing is most directly impactful on patients, while the financing index also presents the greatest variation. Table B.1 shows that two of the paths for expanding financing access are identical to the general expansion analysis paths. This is partly due to the fact that changes in financing are responsible for many of the changes in the overall index, provision and regulation showing less change. The larger variation and the importance of partisanship suggests that financing is the main dimension of political conflict among the three.

The analysis of all sub-dimensions shows broad similarity to the index analysis, suggesting that similar political dynamics are present. Table 6.5 shows a simplified summary of all analyses. A few differences between analyses are noteworthy. The expanding financing analysis has two additional paths which show that having a veto-free system is an INUS condition. The analysis of retrenching provision, in contrast, shows that having a veto-ridden system is an INUS condition in three of the four paths. In contrast to the retrenching financing analysis, programmatic linkages are an INUS condition. Both suggest that retrenchment in provision is less salient than in financing, cabinets achieving such retrenchment in spite of veto points and greater accountability. It is possible that cabinets engage in retrenching provision precisely when retrenchment in financing is not possible, because of the two factors.

6.2.1 Parameters of Fit and Robustness

Consistency and coverage

Consistency and coverage are the main parameters of fit used to evaluate QCA results. Consistency assesses the degree to which solutions conform to statements of necessity or sufficiency. Both statements of necessity discussed above pass the com-

monly accepted 0.9 (out of 1) threshold. Consistency for sufficiency (cons. in tables) is often accepted above a 0.75 level (Schneider & Wagemann, 2012, p. 127), which all sufficiency analyses presented here exceed[11]. In addition to consistency, we also need to evaluate cases which directly contradict statements of sufficiency or necessity. Both main sufficiency analyses present at least one contradictory case, which require further investigation.

Coverage assesses the degree to which solutions explain the cases at hand, that is, how many of the cases which present the outcome are present in the solution. While there is no commonly accepted threshold for coverage, low coverage scores point to problems with QCA solutions, since many cases will not be captured by them. This points out the need for additional conditions or a general revising of theoretical claims. Coverage scores for the overall solutions (covS in tables) of the main analyses are 0.66, and 0.62 respectively. This indicates that a majority of cases are covered by the solution. The fact that many cases are still not covered points to the need for additional explanatory factors. Beyond the overall solution coverage, each solution path has a raw coverage score (covS in each row for each solution path), and a unique coverage score (CovU) indicating how much of the coverage is specific to that path, therefore excluding overlapping coverage.

Calibration decisions

Beyond looking at consistency and coverage scores, transparency over key decisions is necessary in order to interpret the validity of QCA results. One such decision, which solution to interpret (conservative, parsimonious or intermediate), was already discussed.

Another important set of decisions lie with calibration thresholds. While fuzzy sets

[11] Table B.5 shows the consistency scores for sufficiency and necessity analyses performed (Pooled Consistency), as well as distance scores for between and within consistencies.

allow for specifying the degree to which a case belongs to a set, the choice for the 0.5 threshold is crucial since it decides when a case is more "in than out". Certain conditions have intuitive thresholds for belonging to a set. For example, right-wing dominated governments are those where right wing parties control more parliamentary seats than other parties in the cabinet (i.e. the weighed ideology is above 5). Other conditions do not have such clear thresholds.

For causal conditions, alternative thresholds were set for veto points, large deficits and programmatic linkages. The results remain overall stable, with small changes in solutions, all of which are in subset relations to the findings. An inspection of the figures for solutions for both necessity and sufficiency analysis indicates the results of such changes - different calibrations mean that cases move in the x or y axes accordingly. The same holds for calibration of the outcome where an alternative calibration of -1 and +1 resulted in similar solutions, in subset relations to the findings. Moreover, the important cases shown in the analysis and discussed further all have high membership in the outcome, which would not change substantively with different calibrations[12].

Truth table decisions

Another important decision, specific to the sufficiency analysis, is the choice of raw consistency threshold for including truth table rows in the sufficiency analysis. The standard procedure of choosing a benchmark according to consistency and PRI suffers from the problem of possibly including rows with no typical cases where consistency and PRI are driven by irrelevant cases. A second problem for which the PRI score is only a partial solution is that of including the same row in the analysis of both the

[12]Beyond the 0.5 thresholds presented in Table 6.2, the decisions for the 0 and 1 are also important since they affect consistency and coverage measures. In the majority of cases, the minimum and maximum of a variable were used as the 0 and 1 benchmarks. The only exceptions are represented by the conditions with extreme outliers, where the threshold was set at three standard deviations from the mean, cases above being coded as 1.

outcome and its negation (simultaneous subset relations). In addition to looking at the consistency score, it is also important to consider the presence of true logical contradictory (TLC) cases, which are more problematic for the statement of sufficiency (Schneider & Wagemann, 2012, p. 205).

Given these insights, the approach used here was the following. Firstly, no row with consistency below 0.75 was included in the analysis. Secondly, of the rows with consistency above 0.75, all were inspected with xy plots in order to check typical cases and TLC's to see whether the row belonged to outcome or its negation. Truth tables are shown in full in Appendix B.

Testing for panel structure

In order to check whether there is a panel structure to the data, consistency scores were calculated for each analysis across cases and across time for the same case. Table B.5 in the Appendix B shows the Pooled Consistency (POCONS) as well as its distance to the Between Consistency (BECONS) and Withing Consistency (WICONS), for each analysis. Overall, the test does not seem to show the existence of a panel structure in the data. Looking at the distance scores, all of them are below 0.1, which indicates that approximately 95% of consistencies fall within an interval lower than +/- 0.1 around the average consistency (Garcia-Castro & Ariño, 2016).

Distance scores tell us the average distance of consistency scores from the pooled consistency. Special attention needs to be paid to the time dimension. While this analysis is not interested in modeling time directly, special attention is given to ensure that time dynamics do not bias the analysis. Two time dynamics might be expected to function that would be relevant to the outcome across all cases. The first is the effect of the 2008 crisis which could impact health reforms through domestic political mechanisms or conditionality for bailouts or other funds. To a degree, the impact

of the crisis is captured in the "deficit" condition. While deficits do not cover all macroeconomic imbalances, they are related to such imbalances and to conditionality. More importantly, large deficits are more directly related to health reforms than other macro-economic indicators, since they put direct pressure on public budgets and insurance funds which governments often need to supplement from public funds (Heller, 2006). Looking at deficits also covers economic imbalances outside of crises.

The second time dynamic relates to political and health system institutions. One would expect that the longer the time since transition, the more likely both Eastern and Southern European countries would be to have consolidated democracy. However, there are many instances of democratic backsliding, suggesting that this is not a purely time dynamic. The solution was therefore to also capture the dynamics with conditions, incorporating the most important institutional factors, including the existing level of healthcare expansion and linkages between voters and parties.

These being said, it is still important to test in more detail for the presence of time dynamics. Table B.6 in Appendix B shows the BECONS scores for each of the four time periods. The necessity analysis for deficits shows lower consistency scores for the second and fourth periods, falling slightly below the accepted 0.9 threshold. Coupled with the relatively low relevance score, this suggests that there is only moderate evidence that the absence of deficits are necessary for expansion. Of the main sufficiency analyses, none have period specific consistency scores that fall below 0.75, with most being above 0.9, suggesting the absence of time effects beyond what is captured in conditions[13].

The analysis presented shows good parameters of fit and is robust to different decisions of calibration, sufficiency thresholds and panel dynamics. While different decisions

[13]In the analyses of the subdimensions of the index, two of the four paths of the Financing Retrenchment solution show scores below 0.75 for the second period, 2004. The other two paths, as well as all other analyses show robust consistency scores across time periods.

lead to slightly different consistency and coverage scores, this is to be expected. What is important is that these differences are not large enough to warrant substantively different interpretations of the findings. The same can be said for solutions, which maintain subset relations under different decisions, therefore maintaining the validity of substantive interpretations.

6.3 Discussion

6.3.1 Summary of Results

The results of the QCA analysis show several broad patterns in line with theoretical expectations. Table 6.5 summarizes the results for the main analysis (the first two rows), as well as the sub-dimension analyses which are presented in full in Appendix B. The table shows whether individual INUS conditions were present in sufficient paths for each outcome. As noted, INUS conditions do not have "individual effects" and should not be considered in isolation, but rather with the other factors in the solution path. The table is merely indicative of the patterns in the results and only individual solutions should be considered for interpretation.

The solution paths presented in the results suggest that left-wing cabinets are associated with increasing access, in combination with a lack of fiscal deficits and existing decommodified systems or programmatic linkages. Right-wing cabinets are associated with retrenching access to healthcare, in combination with non-programmatic linkages and in existing commodified systems.

Table 6.5: Summary of fsQCA Necessity and Sufficiency Analyses

	Ideology	**Deficit**	**Veto Points**	**Linkages**	**Existing Health System**
Expanding Access	Left	Absent[i]	-	Programmatic	Expanded Access
Retrenching Access	Right	Present	-	Clientelistic	Restricted Access
Expanding Financial Access	Left	Absent	Veto-free	Programmatic	Expanded Access
Retrenching Financial Access	Right	Present	Veto-ridden	Clientelistic	Restricted Access
Retrenching Provision Access	Right	Present	Veto-ridden	-	Restricted Access
Retrenching Regulation Access	Right	Present	Veto-ridden	Clientelistic	Restricted Access

[i] Note, all conditions refer to INUS conditions. Absence of fiscal deficit for expanding access is also a necessary condition.

6.3.2 The Cross-Case Impact of Partisanship

What does the QCA analysis tell us substantively about the role of partisanship in health policy? The first thing to note is that partisanship by itself is neither necessary not sufficient for policy retrenchment or expansion[14]. The lack of necessity implies that the outcome occurs in the absence of the condition. What this means is that, to a lesser degree, expansion is also carried out by right wing dominated governments and retrenchment is also carried out by left-wing dominated ones[15]. This is in line with theoretical expectation given that fiscal pressure, electoral accountability and coalition politics mean that parties will sometimes trade-off preferred policies[16].

Partisanship, by itself, is also inconsistent with sufficiency, meaning that there are

[14]Consistency of necessity of right wing cabinets for retrenchment comes closest to acceptable levels, at 0.837.

[15]Five right-wing cabinets expanded access: Ansip II, Repse, Vasile, Berlusconi II, and Klerides IV, compared to 12 left-wing cabinets. Seven left-wing cabinets retrenched access: Brazauskas I, Socrates I and II, Stanishev, Guircsany II, Christofias IV, and Drnovsek VI, compared to 23 right-wing cabinets.

[16]One path in the analysis of retrenching provision captures non-programmatic left-wing dominated cabinets such as the Hungarian Medgyessy and Gyurcsany cabinets. The fact that many other such cases are not covered by the solutions suggests that additional factors are needed in order to explain them.

instances where it is present and the outcome is absent. This is to be expected since not all left-wing cabinets will want or be able to expand access, nor will all right-wing cabinets be able to retrench it.

While ideology does not appear necessary or sufficient by itself, it is part of sufficient combinations as a INUS condition in all analyses. For expansion there are two paths, both of which contain left-wing cabinets. The first path can be describes as "typical left partisanship", where programmatic left parties seek to gain electoral capital by expanding health policy under low fiscal pressure. This dynamic is explored in chapter 7 with a micro-analysis of the foundations of partisanship and process-tracing which shows the role of linkages in translating voter preferences into CSSD cabinets prioritizing expanding health access in Czechia.

The second path can be described as "path-continuing expansion", where left parties further expand access to healthcare in systems that already have expanded access, under low fiscal pressure. This path is interesting because it shows both programmatic and non-programmatic cabinets expanding access. It suggests that both programmatic and clientelistic parties have greater incentives to expand access in systems which already cover and protect vulnerable individuals. The dynamic of this path might be institutional, through a path-dependent mechanism where institutional complementarities make expansion more likely, similar to a Variaties of Capitalism logic (Hall & Soskice, 2001). The mechanism might also be electoral, whereby voters in already expanded systems are more sensitive to changes, similar to the argument that welfare programs eventually create their own constituencies (Pierson, 1994). However, given the lower consistency score and the higher number of deviant cases consistency in kind, this path is not further explored in subsequent analysis. A short discussion for the possibilities of exploring this path is presented in the conclusion.

The retrenchment analysis shows three paths. The first can be described as "typical

right partisanship", where non-programmatic right-wing parties retrench access in existing low access systems. This dynamic is explored in chapter 8, showing how Bulgarian right-wing cabinets engage in more drastic retrenchment that the more programmatic Czech right-wing cabinets, although facing similar dilemmas between their middle and high income voters. Process-tracing lends support to the necessity of the linkages term in the solution path by showing how these cabinets de-prioritize health policy due to the lower returns of political capital.

Two additional paths are observed for retrenchment suggesting a multifinality role for veto-points. Non-programmatic right wing parties managing a large fiscal deficit seem to require few veto points in order to deliver retrenchment. Right-wing cabinets in existing commodified systems retrench in the presence of veto points. Process tracing analysis on two of the Bulgarian cabinets, which are typical cases in the path, suggests that these are hidden changes.

6.4 Causal Complexity and Partisanship

Health policy reforms are characterized by causal complexity. Individual factors cannot account for policy outputs in isolation or a simple additive logic. Different factors in different combinations lead to retrenchment or expansion. The findings in this chapter suggest that the "net-effects" approach of studying the impact of partisanship on health policy is not appropriate since we should not expect, and indeed do not find, that partisanship matters in all circumstances. By looking at how ideology interacts with other important factors, this chapter has uncovered some of the complex relationships leading to policy reform. This findings are corroborated by case studies and micro-analysis in the following two chapters, adding further evidence for the impactful role of partisanship.

7 The Politics of Expanding Health Access

If a hiker gets lost in the mountains, people will coordinate a search. If a train crashes, people will line up to give blood. If an earthquake levels a city, people all over the world will send emergency supplies. This is so fundamentally human that it's found in every culture without exception. Yes, there are assholes who just don't care, but they're massively outnumbered by the people who do.

—Andy Weir, The Martian

Power resides only where men believe it resides. [...] A shadow on the wall, yet shadows can kill. And ofttimes a very small man can cast a very large shadow.

—George R.R. Martin, A Clash of Kings

The QCA analysis in the previous chapter has outlined several causal recipes leading to expanding access to health. While set relations capture the cross-case relevance of factors and their combinations, they do not tell us what the underlying mechanism behind a solution is. This chapter explores the mechanism of health partisanship from an individual level, and shows how health solidarity forms its basis. It then explores the role of programmatic linkages between voters and parties, by looking at how parties position themselves on health policy and which concrete actions they take in order to promote or oppose reforms.

While focusing on the most typical case of expansion, the Czech Spidla cabinet, the chapter looks at the different configurations of Czech cabinets in order to understand how party ideology influences expansion and retrenchment to access. It moreover

Table 7.1: Policy Outcomes, Ideology and Constraints - Programmatic Linkages

		Political Constraints	
		Unconstrained	Constrained
Ideology	Left	Expansion	Updating
	Right	Layering	No Change

looks at the broader institutional and political context in order to understand how left and right parties behave when faced with political and institutional constraints. Table 7.1 shows the policy outcome expectations for left and right parties under programmatic linkages.

The chapter is structured in two parts. The first part builds a survey analysis in order to test the individual-level expectations regarding the formation of preferences for health policy and their impact on voting for parties. The second part analyzes the main case study for programmatic linkages, Czechia, to see how individual preferences are adapted to political parties and how they further act in the institutional environment.

7.1 The Micro-Foundations of Health Partisanship

Parties are primarily office seekers. The institutional rules of the game, such as electoral laws, linkages to voters or types of party organization, determine how parties compete with each other for votes. When linkages between parties and voters are programmatic, parties primarily compete based on policy promises which they believe will attract voters. Once in power, parties need to navigate the policy space available to them. In making decisions, they need to keep in mind the promises made to their voters, less they risk losing them. However, they also need to face the reality of power

negotiations and appeasing the opposition or coalition partners. They also need to face the reality of fiscal constraints and prioritize their policies and goals. Strategic decision therefore need to be made regarding when and how to approach a particular policy field, such as when and how to justify retrenchment and expansion of health access.

Parties will therefore not be mere conduits of voters' will - an embodiment of social structures and preferences. However, parties still need to take account of public opinion. The question is, which voters matter to parties and when? Governments regularly pass unpopular policies, with consequences suffered only occasionally. The reason is two-fold. On the one hand, not all citizens vote. On the other, parties need not care about all voters. Most often, the voters most angered by a particular policy decision are voters who would not have voted for the party in the first place.

There are therefore two groups of voters parties care about. One is their core supporters, their "base". Parties seek to keep them loyal, to not lose them, and to make them turn out to vote. The second groups is that of potential voters (actual or perceived), which parties want to attract. The third group is formed of unlikely voters (non-voters or voters the party cannot expect to get on their side), and are more or less safely ignored. The core question for parties is therefore how to appease their base without angering or alienating other voters, while attracting additional voters. Voter bases of parties can be more or less homogeneous on any given issue. When the base is divided, parties need to consider which positions to take so as not to alienate either group.

Several questions emerge when applying this framework to health policy. The first is whether health policy is electorally salient. Do voters care about health and do they have strong preferences regarding health policy? The second question is whether these preferences are coherent across support for political parties. The issue-voter theory

suggests that we can expect voters to be at least partly influenced by their attitudes towards healthcare when voting. While it is not reasonable to assume that a single policy-issue will determine voter actions, it is plausible that attitudes to healthcare form an independent component of voting behavior, especially during times of high salience of the policy.

The particularities of health policies tell us that support for healthcare, or health solidarity, is much higher than for other policies, and can cut across socioeconomic divides. Lower and middle income voters are expected to have similar levels of health solidarity and policy preferences. Higher income, younger and healthier voters are expected to have less health solidarity and prefer less provision of public health, and prefer higher quality services even at a cost.

The expectations are therefore straight-forward. For left parties, their voter base forms a coherent set of preferences for high levels of access to public healthcare. Right parties have their electorate split on healthcare, between higher income voters and middle-income voters. This leaves them electorally vulnerable to left wing parties on healthcare. Empirically, this would suggest that health solidarity will be related to support for left parties, while its absence will be related to support for right parties only for wealthier individuals.

In order to test these expectations, I follow a procedure used by Häusermann and Kriesi (2015) to analyze the overall determinants of supporting political parties in advanced capitalist democracies. Häusermann and Kriesi (2015) theorize an economic and cultural dimension to voting. In a first step they analyze how socioeconomic factors are linked with their two dimensions. In a second step, they use logistic regression to show how their two dimensions are predictive of voting for party families.

A similar sequence is followed here in order to establish the electoral relevance of health policy. I do not claim that health attitudes restructure party competition

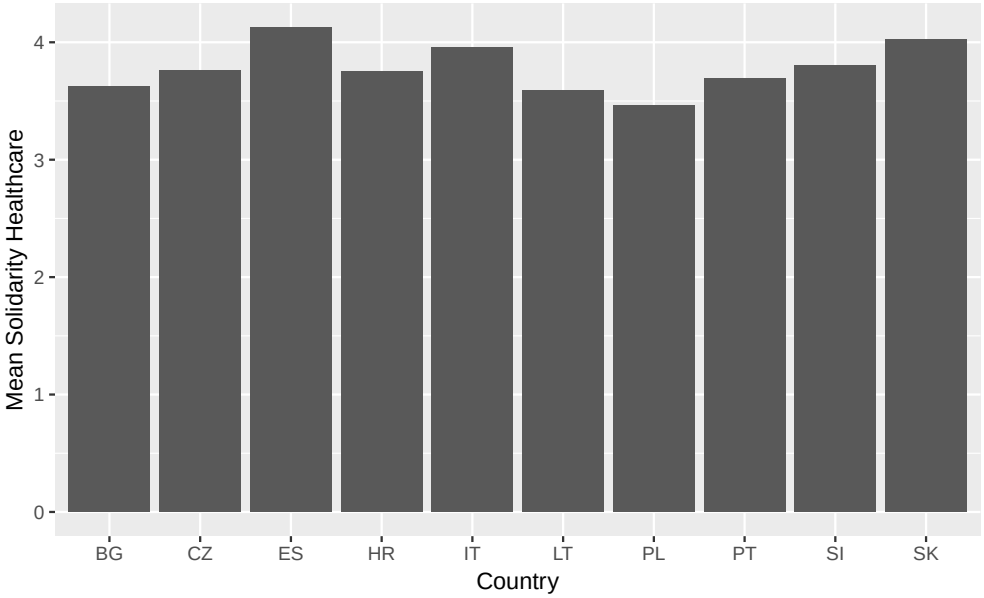
in the sense that Häusermann and Kriesi (2015) do, but rather that it is a distinct dimension which influences voting to a degree that parties can pick up on. In a first step I analyze how attitudes towards health policy relate to other attitudes and socio-demographic characteristics. The second step shows that health attitudes are predictive of party preferences.

7.1.1 Determinants of Attitudes to Healthcare

In order to understand the determinants of health solidarity I use data from the International Social Survey Programme (ISSP). The 2011 "Health and Healthcare" module contains several of the key variables of interest for this analysis, across ten of the cases that are the focus of this dissertation (Bulgaria, Czechia, Spain, Croatia, Italy, Lithuania, Poland, Portugal, Slovenia and Slovakia), including the two main cases (ISSP, 2015). The survey asks the *health solidarity* question in a more precise manner than the ESS or other surveys. Instead of asking if government should be responsible for ensuring healthcare for the sick, it asks if government should "provide only limited healthcare services", with five possible responses ranging from strong agreement (1) to strong disagreement (5), and an in between category of neither agreeing nor disagreeing (3). Figure 7.1 shows the mean response across the 10 cases present in the survey. For the purposes of the analysis the indicator was dychotomized in order to capture individuals displaying health solidarity (categories 4 and 5).

In predicting individual levels of health solidarity, Bayerl and Mielck (2006) found that age, education and gender are powerful predictors for support for public healthcare. Age is particularly important here since older patients are much more in need of, and reliant on, public health services. One of the most comprehensive and more recent reviews, by Jung et al. (2003) revealed other consensus factors which influence attitudes towards healthcare. Among their reviewed studies, 33% also found age to

Figure 7.1: Mean Health Solidarity Across ISSP-included Countries



Source: ISSP (2015), author's compilation

be a reliable predictor. Education, gender and utilization appeared relevant in 25% of their sample of studies.

Table 7.2 presents the results of GLM regression analyses, predicting the individual levels of solidarity with a range of variables related to socioeconomic and sociodemographic status. Coefficients are shown as odds ratios of having health solidarity, with z-values in parentheses. Country dummies are included in order to control for country-specific characteristics, but are not shown in the table.

The first column shows the results for the pooled sample, while the other two break down the sample into countries with high access health systems (Czechia, Spain, Italy, Portugal and Slovenia) and low access health systems (Bulgaria, Slovakia, Poland, Lithuania and Croatia). In line with other studies, the analysis finds that individuals with higher education, lower income, union-members, female and who show a higher degree of satisfaction with the healthcare system, are more likely to be solidaristic.

The effect of income is particularly interesting. With every additional level of income

Table 7.2: Determinants of Health Solidarity, Odds Ratios, Z-values and Significance Levels

	All Countries	High Access	Low Acess
Education	1.104***	1.109***	1.094***
	(4.935)	(3.794)	(2.941)
Income	0.921***	0.870***	0.956
	(−2.963)	(−3.575)	(−1.125)
Income^2	0.943***	0.910***	1.014
	(−3.356)	(−3.904)	(0.526)
Union Member	1.274***	1.226**	1.374***
	(3.888)	(2.329)	(3.757)
Pub. Sector Job	1.098*	1.250***	0.991
	(1.657)	(2.677)	(−0.121)
Age	0.996**	0.997	0.993**
	(−2.180)	(−1.062)	(−2.396)
Rural	0.904*	0.864**	1.058
	(−1.944)	(−1.994)	(0.765)
Unemployed	0.968	0.937	1.019
	(−0.518)	(−0.777)	(0.206)
Female	1.202***	1.212***	1.246***
	(3.734)	(2.786)	(3.118)
Bad Health	1.077	1.030	1.138
	(1.228)	(0.347)	(1.511)
Satisfaction	1.142***	1.033	1.247***
	(6.320)	(1.049)	(7.726)
Access Non-Citiz.	0.965*	0.956	0.991
	(−1.649)	(−1.545)	(−0.294)
Observations	9,442	5,362	4,080
Akaike Inf. Crit.	10,785.920	5,449.305	4,939.139
Note:		*p<0.1; **p<0.05; ***p<0.01	
		Data from ISSP 2011	

(self-placement on a 10 point scale), individuals are 8% less likely to be solidaristic. The quadratic term for income shows that this effect is not linear but but increases with income. The coefficient for income increases with 5.7% points for each additional level of income. That is to say, that the higher the income, the stronger the effect, in line with the expectations outline above. As an individual's income goes up, their likelihood to be solidaristic goes down, the effect being drastically more pronounced for high income individuals.

7.1.2 The Impact of Solidarity on Party Vote

The next step is to see whether health solidarity is associated with voting for different kinds of parties. To explore this question I build a multinomial logistic regression model to see how solidarity can predict voting for different parties. Looking at the pooled sample across the 10 countries, it is not feasible to consider every individual party. Parties are therefore grouped into five party families according to ISSP coding: Far Left, Left, Center/Liberal, Right/Conservative, and Far Right. While these categories mask a wider variety of parties, party families are useful in comparing parties across countries.

Table 7.3 shows the results of the multinomial pooled GLM regression, showing odds ratios as coefficients, z-values in parentheses and significance levels. Multinomial logistic regression uses one category as a baseline for comparison with others. In this analysis, coefficients are shown comparing the likelihood of voting in the last election, comparing the other four party families to voting for left parties.

The coefficient of 1.258 of solidarity predicting far left vote means that compared to voting for center-left parties, voters who are solidaristic are 25.8% more likely to vote for far left parties (at the mean value of income, since there is an interaction effect and variables have been centered). Voters who are solidaristic are 8.2% less likely to vote

Table 7.3: Multinomial Regression. Predictors of Support for Party Families Compared to Left, Odds Ratios, Z-values, and Significance Levels

	Far Left	Center/Liberal	Right/Conservative	Far Right
Solidarity	1.258***	0.860***	0.918**	0.750**
	(2.772)	(−3.797)	(−2.244)	(−2.000)
Income	0.717***	1.101**	1.067	0.793
	(−4.428)	(2.092)	(1.518)	(−1.231)
Education	1.084***	1.033***	1.030***	1.022
	(5.243)	(2.923)	(2.975)	(0.426)
Age	0.997	0.988***	0.992***	0.966***
	(−0.620)	(−3.813)	(−2.833)	(−2.777)
Female	0.942	1.030	0.850**	0.315***
	(−0.476)	(0.374)	(−2.238)	(−3.484)
State of Health	1.395**	0.665***	0.880	0.669
	(2.300)	(−4.146)	(−1.461)	(−0.931)
Union Member	1.521***	0.817**	0.860*	1.367
	(2.744)	(−2.016)	(−1.673)	(0.826)
Unemployed	0.748*	0.820**	0.903	0.770
	(−1.945)	(−2.065)	(−1.167)	(−0.697)
Rural	0.793*	0.884	1.043	0.469**
	(−1.700)	(−1.449)	(0.556)	(−2.076)
Religious	0.610***	1.162	1.999***	2.790**
	(−3.651)	(1.527)	(8.107)	(2.371)
Solidarity:Income	1.084	0.947	0.913**	0.672***
	(1.050)	(−1.376)	(−2.346)	(−2.726)
AIC		11486.64		
BIC		12038.60		
Log Likelihood		-5659.32		
Deviance		11318.64		
Num. obs.		5398		

Note: *p<0.1; **p<0.05; ***p<0.01

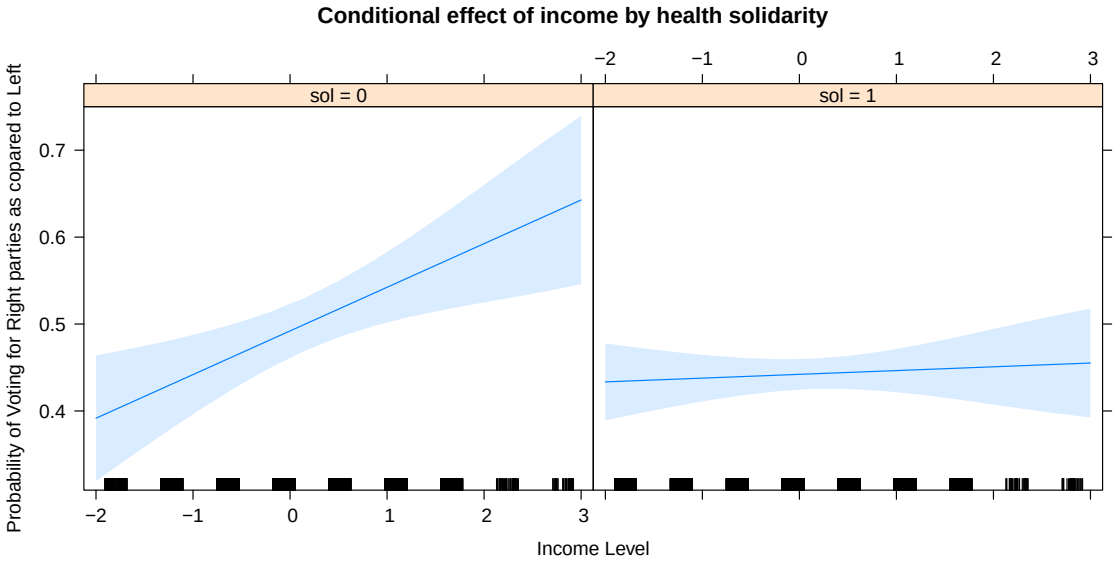
Data from ISSP 2011

for right/conservative parties than they are to vote for left parties, and 14% less likely to vote for center/liberal parties. This effects is for the average level of income. The interaction effect of income and solidarity tells us that for right/conservative parties, for each increase in the level of income the negative effect of solidarity increases by 8.7%. Which is to say that as income rises, individuals who are not solidaristic are increasingly likely to vote for right/conservative parties than they are to vote for left parties. This lends support to the hypothesis that right parties have their electorate split on health. What it tells us is that for middle income individuals, their belief that the state should provide only limited healthcare is much less predictive of their vote for right parties than it is for high income individuals.

Figure 7.2 shows the interaction. It plots the effect of income on party vote, comparing voting for right/conservative to left parties, when solidarity is absent (sol = 0) and when it is present (sol = 1). What can be seen is that for the group showing low solidarity, lower income voters are still less likely to vote for conservative as copared to left parties, middle income voters are slightly more likely to vote for right wing parties, while higher income voters are much more likely to do the same. However, all three groups of solidaristic individuals are less likely to vote for right wing parties. The effect is less precise for higher income individuals, as shown by the wider confidence interval at the higher end of income.

Comparing effect size across predictors tells us that health attitudes are a relatively strong predictor of party vote, even when controlling for sociodemographic characteristics, perceived state of health or religiosity. Standardizing coefficients (not shown in table) shows that a one standard deviation increase in health solidarity results in a 28% increased likelihood to vote for left parties as opposed to right parties. This is comparable to the effect of income, one of the best predictors of party vote, where one standard deviation is associated with a 46% increase in the likelihood to vote for

Figure 7.2: Interaction Effect Comparing Left and Conservative Parties



right wing parties.

These effects hold for the pooled sample of Eastern and Southern European countries when comparing party families. Two questions arise about these results. The first is whether they hold when looking at national samples and national parties. The second, and more substantive question, is how these attitudes are picked up by parties. How do left and right parties pick up on health attitudes and their impact on voting? The next section aims to answer these questions for Czech parties and voters.

7.2 Czechia: Health Partisanship under Programmatic Linkages

Most studies of Czech welfare take historical, path dependent and institutionalist perspectives (Inglot, 2008; Janekov, 2001; Lawson et al., 2012). What this chapter will show is that there are reform episodes that these perspectives do not explain, and

Table 7.4: Policy Outcomes, Ideology and Constraints - Czechia

	Unconstrained	**Constrained**
	Expansion Policies	*Updating Policies*
Left	1. Spidla 2002 State subsidy to funds 2004 Hospital reform	1. Zeman - Failed reforms 2. Gross 2005 Expansion risk-adjustment 3. Paroubek - no change 4. Sobotka 2015 Removing user fess
	Layering Policies	*No Change*
Right	1. Klaus I and II Privatizing primary care 1992 Introducing multiple funds 1995 Risk adjustment scheme 2. Topolanek II 2008 Expansion of user fees 3. Necas I and II 2011 Cuts to benefit package 2011 Skip and pay system	1. Klaus III 1996 Introduction user fees 2. Topolanek I - no change

that are better explained by looking at *health partisanship*. However, explanations are not always mutually exclusive, but can interact to add to each other. Therefore, the chapter will also aim to explain what health partisanship can add to reform episodes currently viewed through the lens of historical institutionalism.

Following almost three decades of policy struggle in Czechia, what resulted is a system that is overwhelmingly public,with few direct financial barriers to access. As we will see, this is not an accident, but a result of the ability of political parties and social actors to resist change and to promote access. Table 7.4 shows how the main Czech cabinets since the start of transition fit into the expected policy outcomes given political ideology and political constraints. The individual cabinets and reforms are analyzed in subsequent sections.

The Civic Democratic Party (ODS) supervised the move to a competitive SHI system in the early 1990's. However, the lack of financial incentives drove the system to financial collapse. The same party attempted stabilization, until it was ousted out of power in 1997. The Czech Social Democratic Party (CSSD) continued the stabilization policies as a minority government until it reached majority in 2002, when it proceeded with a restructuring of the hospital sector and changes to the risk-adjustment scheme, as well as increasing state subsidies to insurance funds. The return of the ODS in 2006 resulted in new attempts at introducing user fees, which were met with opposition from the opposition and ultimately the Constitutional Court. The user fees were later removed under a CSSD administration.

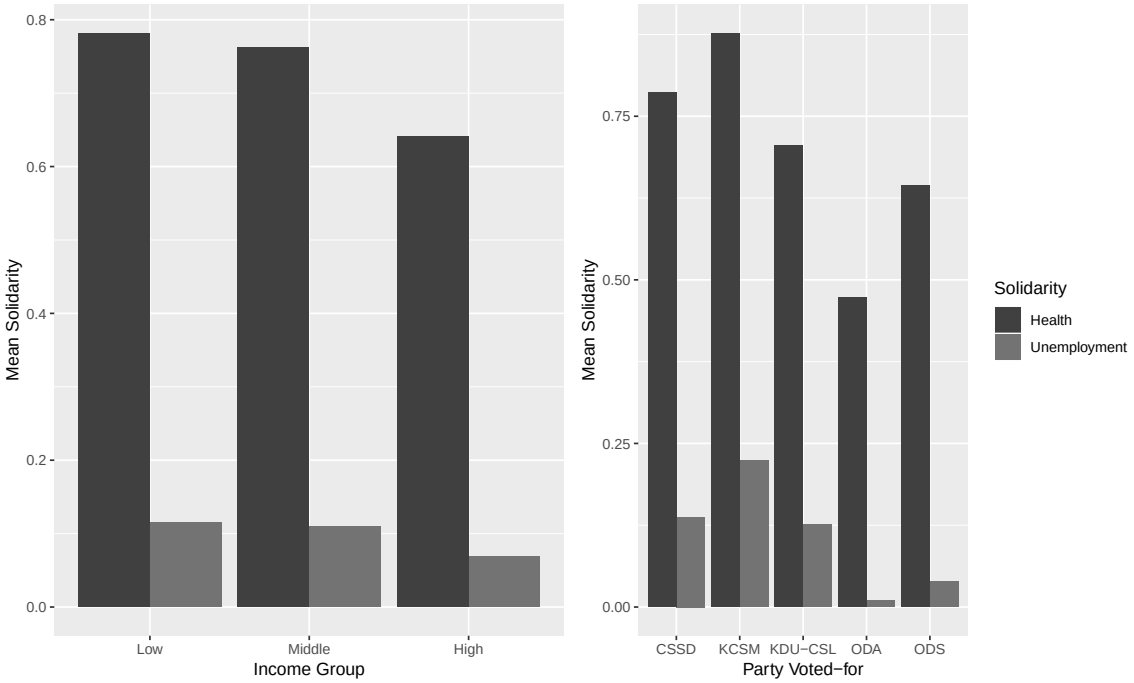
Before delving into the individual cabinets and policy reforms, the next section replicates the analysis of health attitudes' impact on party voting using ISSP data.

7.2.1 Czech Attitudes to Healthcare

As with most countries in the ESE, health solidarity is high in Czechia, with a majority of individuals supporting more than limited health services to be provided by the government.

However, the important question for policy is who these individuals are and who they vote for. I use two ISSP surveys from different time points in order to highlight these dynamics. Figure 7.3 uses data from the 1996 "Role of Government III" wave (ISSP, 1999) and shows a comparison between unemployment and health solidarity. Both questions are asked in the same manner as the ESS (2008) question, namely whether the government should be responsible for providing health for the sick and living standards for the unemployed. What can be seen is that health solidarity is considerably higher than that of unemployment. Health solidarity drops with higher income and for individuals who voter for right wing parties (ODS, ODA, KDU-CSL),

Figure 7.3: Czech Health and Unemployment Solidarity - 1996

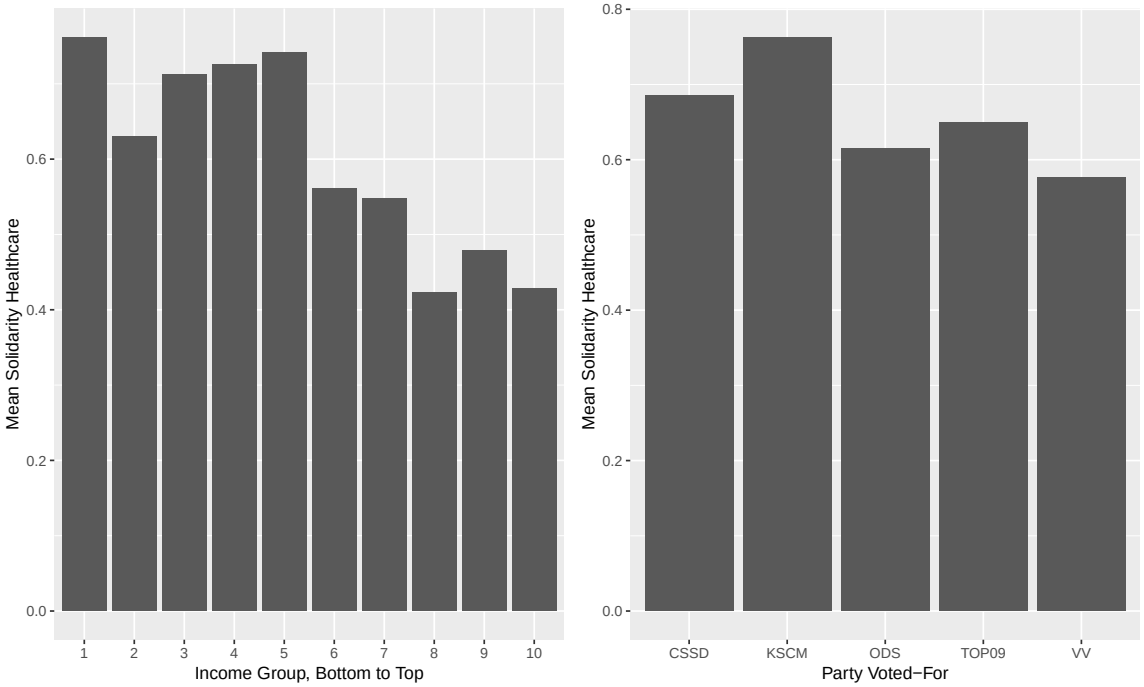


Source: ISSP (1999), author's compilation

yet remains high overall.

Figure 7.4 shows the breakdown in 2011 using the same ISSP survey as in the pooled analysis, with a more detailed breakdown on income groups. The survey did not contain a question regarding unemployment solidarity. Similar dynamics are seen with the alternative specification of the health solidarity question. The left side shows the mean value of health soldarity across self-positioned income groups. Low and middle income groups show a high degree of health solidarity, with more than 70% of individuals disagreeing or strongly disagreeing that government should provide only limited health services. A drop is seen for upper-middle income groups (6-7), and a further drop for higher income groups, which are the only groups where fewer than 50% of respondents disagree with the statement. This is in line with the self-interest hypothesis of health solidarity. The higher the income the less risk individuals face and therefore the less willing they are to pool their risk with lower income individuals.

Figure 7.4: Czech Health Solidarity Across Income Group and Party Support - 2011



Source: ISSP (2015), author's compilation

Moreover, the higher an individual's income, the more she is likely to prefer private services or insurance, which offer additional benefits, allows skipping waiting times and perhaps offer higher quality.

The right side of Figure 7.4 shows the distribution of health solidarity among voters for the main political parties in the 2010 legislative election, where the CSSD emerged as the largest party but the government was formed as a coalition between the ODS, TOP09 and VV. The highest degree of health solidarity is seen among voters for the communists, KSCM, followed by the socialists, CSSD, and then the three right-wing parties. While these differences exist, it is noteworthy that across the spectrum of voters, health solidarity is high. Even for the right wing parties it exceeds 50% of respondents. This points to the heart of the problem for right-wing parties: a larger heterogeneity of health attitudes among their middle and high income supporters, which left wing parties do not face.

Table 7.5: Multinomial Regression. Predictors of Voting for Parties Compared to CSSD, Odds ratios, Z-values and Significance Levels

	KSCM	ODS	TOP09	VV
Solidarity	1.098	0.837**	0.979	0.665***
	(0.675)	(−1.991)	(−0.161)	(−2.841)
Income	0.768*	1.203	1.158	1.325
	(−1.739)	(1.598)	(0.934)	(1.394)
Education	0.945	1.215***	1.218***	1.127*
	(−0.871)	(4.371)	(3.372)	(1.685)
Age	1.015	0.976***	0.955***	0.975**
	(1.514)	(−3.667)	(−4.919)	(−2.261)
Female	1.184	0.805	1.081	1.118
	(0.687)	(−1.161)	(0.312)	(0.365)
State of Health	1.812**	1.105	0.936	0.788
	(2.079)	(0.418)	(−0.179)	(−0.545)
Solidarity:Income	0.948	0.952	0.898	1.040
	(−0.392)	(−0.539)	(−0.866)	(0.274)
(Intercept)	0.179*	0.242**	0.220*	0.124*
	(−1.647)	(−2.040)	(−1.657)	(−1.862)
AIC		2067.31		
BIC		2216.05		
Log Likelihood		-1001.66		
Deviance		2003.31		
Num. obs.		802		

Note: *p<0.1; **p<0.05; ***p<0.01

Data from ISSP 2011

Table 7.5 shows the multinomial analysis for Czech parties using the same 2011 ISSP data. The table shows the odds ratios of voting for the communists or the three right-wing parties as compared to voting for the left CSSD. Solidarity shows the same type of effect, with solidaristic individuals being 16.5% less likely to vote for the ODS than for the CSSD, and 33.5% less likely to vote for VV (at the mean level of income, and controlling for other voter characteristics), but is not significant when comparing to the communists or TOP09. This is likely due to the small sample size, since less than half of respondents in the survey voted. The same is likely true for income, which is only significant in the comparison with the communists. The interaction term is not significant for this sample. However, the analysis does suggest a similar dynamic as was the case for the pooled sample.

7.2.2 Czech Party Positions on Healthcare

What the previous section has shown is that there is evidence to believe that attitudes towards healthcare, health solidarity in particular, have an impact on voting for parties that is distinct from other attitudes and sociodemographic characteristics. While it is difficult to claim a causal path from health attitudes to voting with observational data, the strong association between the two makes it plausible that parties pick up on such attitudes, particularly when considering implementing reforms - specifically their timing and framing. This is more likely in Czechia since its political parties are broadly more programmatic than other ESE countries.

Table 7.6 shows the major Czech parties and a set of characteristics relating to linkages to voters. The characteristics are taken as the average response of expert ratings from the Democratic Accountability and Linkages Project (Kitschelt, 2013). The first two items suggest that the two major parites, CSSD and ODS have the traditional ties to unions and business associated with left and right-wing parties. The following five

Table 7.6: Czech Party Linkages Characteristics

	KCSM[i]	ODS	CSSD	KDL-CSU
Ties to Unions[ii]	0.706	0.000	1.000	0.200
Ties to Business[ii]	0.176	1.000	0.360	0.280
Clientelism Goods[iii]	2.000	1.826	2.043	1.958
Clientelism Benefits[iii]	2.609	2.042	2.667	2.583
Clientelism Employment[iii]	1.957	2.000	2.045	2.043
Clientelism Contracts[iii]	1.762	2.478	2.261	2.292
Clientelism Regulations[iii]	1.864	2.391	2.304	2.136
Target Poor[iv]	0.875	0.000	0.870	0.625
Target Middle[iv]	0.208	0.667	0.826	0.750
Target Rich[iv]	0.000	0.875	0.043	0.208
Health Policy[v]	8.667	3.917	7.333	6.320
Target Loyals/Strategic[vi]	1.217	2.000	2.130	1.167

[i] Data from Democratic Accountability and Linkages Project (Kitschelt, 2013)
[ii] Mean expert evaluation, 1=Ties Present
[iii] Mean effort level 1=Negligible, 2=Minor,3=Moderate,4=Major
[iv] Mean evaluation, 1=Target Group
[v] 1=Supports Reduction...10=Supports Expansion
[vi] Target loyalists=1, Both loyalists and strategic=2, Target strategic voters=3

items break down the plausible dimensions of clientelistic linkages - these are also the five dimensions used to construct the "PROG" condition in the QCA analysis. All four parties are suggested to display only minor efforts at targeting voters with non-programmatic types of policies and promises. The dataset also contains a question as to whether parties are displaying more efforts to engage in clientelistic practices or fewer, the overall response for Czech parties being that the effort was about the same in 2009 as in 1999.

The next three items ask which social groups the parties might target with clientelistic promises. While this is less relevant since clientelism is not as prevalent, it is still indicative of which groups parties likely focus on - with the communists focusing on lower-income voters, the conservatives focusing on wealthy and to a lesser degree on middle income voters, and the socialists and christian-democrats focusing on lower and middle-income voters. The health policy item asks whether the party supports

a reduction of expansions of health spending. The ODS is the only party evaluated to support a reduction in health spending - a fact corroborated by both their policy decisions, as well as policy positions expressed in manifestos and parliamentary debates. The last item asks whether parties target loyal or strategic voters. The Christian Democrats and communists have a more stable (and finite) base of voters. It is therefore unsurprising that they might target those more. The CSSD and ODS are believed to target both strategic and loyal voters, as would be expected of center left and right parties.

Given the socioeconomic structuring of health attitudes and their influence on party voting, as well as the programmatic nature of the linkages between voters and parties, we would expect parties to build policy positions that are reflective of these attitudes. The remainder of this section adds to the plausibility of the issue-voting theory working in healthcare by analyzing party manifestos, policy documents and parliamentary debates over health legislation of the main Czech parties that have been in government since 1990. What this analysis shows is that parties do indeed clearly differentiate themselves by taking different positions on health and framing their positions in ways that is consistent with health partisanship.

This analysis is agnostic in terms of strict causality. For policy purposes it does not matter whether parties take cues from their voter bases in order to develop policy positions or whether voters use these policy positions in order to assess their proximity to parties (it is likely that both are at play, in a feedback mechanism). The analysis investigates the major parties which have been in government since 1990: the two main parties, CSSD and ODS, as well as the KDU-CSL, the christian-democrats who have joined most cabinets with both major parties and have been influential in swaying health policy. I use the Comparative Manifesto Project data (Volkens et al., 2018), and party manifestos directly, across elections, as well as parliamentary

debates.

A few things stand out from analyzing these documents. The first is a high degree of continuity in positions and language. The second is how parties employ arguments for particular policies. Parties attempt to appeal to voter values regarding healthcare. Equity and efficiency are the main contrasting dimensions through which parties appeal to swing voters and their norms. They are important beyond a mere description of how parties act. They are designed to persuade voters of the merits of policy. They therefore act as part of the mechanism that parties use to gain political capital from proposing or opposing certain policy positions.

Equity Frames - CSSD

Equity frames are seen in the socialists' party manifestos going back to the 1990s. What is noteworthy is that in every election since, healthcare has been emphasized in all CSSD manifestos, often taking the forefront of social policies. This suggests that at least for the party, health was perceived as one of the most salient topics - one which the party believed it could use to gain more votes and political capital. The visibility of this strategy is even clearer in the ways in which the CSSD later chose health as one of the strategic fields in which to contest ODS cabinets.

One example is their 1992 manifesto for the first elections of the separate Czech state, where the social-democrats positioned themselves as protecting universal healthcare, and ensuring access to all services regardless of ability to pay (CSSD, 1992). The 1996 manifesto spelled out the issue clearer, the CSSD pledging to "preserve the traditions of the European non-commercial solidarity-based health insurance without patient co-payments for essential preventive and curative medical services" (CSSD, 1996). The party also pledged an increase in state contributions to the VZP, the general insurance fund. This can be seen in connection with the financial struggles the fund

had at the time, as a re-distributive solution since taxes are more progressive than social security contributions.

The manifesto for the 1998 elections, the first leading to the CSSD forming a government, defined health as a "public property, a source of the society's wealth and good living conditions and not just private property and goods" (CSSD, 1998). The party also advocated for not treating healthcare (and education) as market commodities, and emphasized the need for "greater equality for individual groups of citizens in health" (CSSD, 1998). The manifesto also highlighted the need to maintain solidarity with individuals of lower income, those in ill health and the elderly. These principles were later reflected in the Zeman cabinet's Health Policy Statement of 1998 and Healthcare Concept of 1999 documents (Rokosová et al., 2005). The 2002 manifesto, emphasized that health reform should not bring increased financial burdens to middle and lower income citizens. The manifesto specifically tried to frame the issue around the new vulnerabilities of lower income individuals (CSSD, 2002).

The CSSD manifestos make it clear that they targeted their messages at lower and middle income individuals, trying to emphasize the importance of health solidarity as a value. These efforts were also visible in two parliamentary debates, one during the CSSD Spidla cabinet, the other during the following ODS Topolanek cabinet. The Spidla cabinet put forward a motion to turn hospitals into non-profit entities, in a move that would preempt or in some cases stop local government efforts to privatize them.

The first debate took place in the lower chamber on December 16th. The Health Minister at the time, Milada Emmerová, emphasized the move as a means to preserve the public status of hospitals, arguing that healthcare in general cannot act as a business, because it is a public service (Chamber of Deputies, 2004). These views were expanded on during the debate by fellow CSSD MP, Dr. Jaroslav Krakora, who

linked the status of hospitals to the the constitutional principle of equality of access to healthcare. He further argued that the provisions of the law that gave the Ministry of Health powers to require regions and municipalities to establish health facilities, would ensure greater geographic access to healthcare and increase equality of access (Chamber of Deputies, 2004).

Beyond the parliamentary debate, the CSSD also defended the bill in public. The Deputy Health Minister, Vladimir Dryml, argued that the bill, together with other efforts such as putting the VZP under forced administration, were meant to minimize the health financing impact on low-income individuals (Horáková, 2006).

A second revealing example occurred during the parliamentary debates over the Public Budgets Stabilization Act of 2007 under the ODS-led Topolanek Cabinet (Bryndová et al., 2009). Importantly, both the ODS, arguing in favor of its measures, and the CSSD arguing against it, put the healthcare part of the more wide-ranging economic reform at the forefront of the discussion. The CSSD would go on to make the co-payments introduced by the reform one of their main issues in the next two elections. The first reading of and debate of the law took place on June 6th 2007. Prime Minister Topolanek took the floor first in order to defend the reform, and was strategically followed by his Health Minister, Julinek.

When the CSSD took the floor they followed a similar sequence, former Prime Minister and leader of the party Paroubek took the floor first, followed by the Shadow Health Minister, David Rath. Paroubek began by contesting the framing of the measures as a means of stabilizing budgets and instead argued it was about "ending the solidarity of the rich with the poor, [...] taking from the poor and giving to the rich" (Chamber of Deputies, 2007a). Shadow Health Minister Rath continued the same line, framing the reform as a "millionaire's revolt" which sought to end solidarity with middle and lower-income citizens (Chamber of Deputies, 2007a). During the

second reading of the bill on August 14th, former Prime Minister Paroubek narrowed the focus of the dissent on the health reforms, arguing that introducing fees would place an "unnecessary financial burdens for citizens, especially the largest recipients of healthcare, i.e. seniors and families with young children" (Chamber of Deputies, 2007b).

These arguments were echoed in the press as well where Shadow Minister Rath argued that chronic and elderly persons would be hit especially hard (Lazarová, 2007). This was a particularly strategic talking point, since the Christian Democrats - a major coalition partner of the ODS at the time, had initially opposed the law on grounds of it affecting pensioners and children.

Both examples show that the CSSD attempted to gain political capital through proposing or opposing bills by framing their message in terms of solidarity in healthcare. The party went on to make the user fees one of their major campaign issues - winning 13 out of 14 regions in the 2009 Senate elections with the user fees at the policy forefront. They later made several attempts to remove the user fees through legislation and in the courts, ultimately succeeding at the regional level and later in the Constitutional Court.

Mixed Framing: Christian-Democrats

The second important party to also primarily advance equity frames in defining their stance on health policy were the Christian-Democrats, the KDU-CSL. The KDU-CSL are a particularly interesting case, since their stance on healthcare tends to differ with their other more conservative policy stances. This is due to the fact that their voter base is mainly composed of middle income individuals and older individuals. In electoral manifestos they often frame policy positions with respect to their impact on the elderly and on families. Their more conservative stance on economic issues, along

with their stable vote-share in the multi-party system is part of the reason why they have joined both major parties in most coalition governments since 1990. However, they do not take a completely equity or efficiency based formulation of their position on health, but rather a mix.

A good example is their 1996 manifesto which contained specific references to protecting public healthcare, arguing in favor of a "state duty to all citizens" to guarantee the service through "compulsory, solidarity health insurance" (KDU-CSL, 1996). The same manifesto makes reference to "lifting regulation of healthcare costs" and introducing performance payments to health establishments as a means of rationing the health budget. Ultimately, their opposition to the ODS proposals at the time proved pivotal to maintaining public access.

A similar mix of messaging is seen in their 2006 manifesto. One the one hand it argues in favor of not increasing contributions and for the increased role of the state in health provision and prevention in order to reduce health disparities. On the other hand, it makes reference to individuals abusing the health system as a problem of efficiency while supporting a two-tier system where complimentary insurance and out-of-pocket payments could be used for additional services (KDU-CSL, 2006). Similar points are emphasized in the 2010 and 2013 manifestos which show a preference for public insurance and opposition to any privatization, while claiming that abuse of the public system reduces quality (KDU-CSL, 2010, 2013).

During the 2004 debate on turning hospitals into non-profit institutions, the party took a clear stance in favor of maintaining hospitals in the public sphere. One of the MPs supporting the position was MP Karel Janeček, who argued that health cannot be subject to market forces, since it holds absolute value (Chamber of Deputies, 2004).

Efficiency Frames - ODS

The ODS messaging on healthcare took shape with their 1992 manifesto. While the document was mostly concerned with economic policy, healthcare was at the forefront of social policy. After identifying under-funding and over-centralization as the main problems of the system, the party promised to combine public and private insurance in order to increase health funding and capital investment in facilities (ODS, 1992). The focus on efficiency was strategic since it allowed the party a way to argue for privatization that took the focus away from deteriorating quality in public facilities. Its emphasis in the manifesto also suggests that the party believed it could gain political capital with their stance on healthcare. This is corroborated in their 1996 manifesto where they emphasized their reforms as a major accomplishment. The party emphasized the "non-state character of the system" as well as greater availability of services, quality and freedom of choice (ODS, 1996). This highlighting is noteworthy since these points are more salient for higher income voters.

Three episodes of parliamentary debate further highlight the party's position on health. The first was during debates for a law put forward by the CSSD-led government in 1999 to significantly increase sickness benefits to employees, which was ultimately signed into law at the end of March 1999 (Bryndová et al., 2009). During the Senate hearing on March 11th of 1999 the ODS voiced several arguments against increasing the benefit. The first argument, developed by ODS MP Seitlova, was that the measure would create incentives for abuse of sickness benefits, arguing that a bigger gap between salaries and the replacement of income through sick pay would increase incentives for abuse (Senate, 1999). The second major argument brought against the bill was that it would increase the tax burden on citizens. ODS MP Jan Ruml developed the point arguing that it was unfair for the bill to place a special tax on higher income individuals, arguing that it violated the principle of proportionality,

in which individuals should not take more out of the system than they put in (Senate, 1999). Although the MP did not make the point explicitly, a proportionality principle constitutes the polar opposite of solidarity, where individuals take what they need irrespective of contributions.

The second episode exemplifies the ODS response to the 2006 bill transforming hospitals into non-profits in order to prevent and reverse privatization. The party argued from the perspective that the measure would reduce efficiency. MP Lucie Talman of the ODS argued that the move was akin to nationalizing hospitals and therefore suppressing competition which would lead to reduced quality and availability of care, further infringing on freedom of choice (Chamber of Deputies, 2004).

The final example relates to the 2007 law on Public Finance Stabilization, which introduced, among many economic measures, user fees in the health system. Health Minister Tomas Julinek was second to speak in defense of the bill, following the Prime Minister, suggesting that the party was aware of the controversial nature of the measures. In defending the law, the regressive nature of the reform was downplayed. Instead, the minister focused on efficiency gains. He argued that the fees would reduce waste in public health funds, by making citizens more responsible for consuming healthcare: "The proposed changes provide patients with incentives for efficient healthcare and protection from high healthcare costs"(Chamber of Deputies, 2007a). Public statements by the minister maintained the messaging that health fees were necessary for improving quality, as was the need to make citizens responsible for healthcare (Lazarová, 2007).

These examples highlight the electoral strategy of the ODS when positioning themselves on health reforms. In line with the expectations of their base of wealthier voters, the ODS attempted measures of privatization and marketization of healthcare. However, in order to not alienate middle income voters, the party carefully

crafted their messaging in order to argue that they improve healthcare by making efficiency gains.

The next sections analyze some of the major reform episodes in Czechia in order to see how these policy positions of parties were filtered through the electoral and institutional systems. What emerges is that in addition to the constraining effect of public opinion (specifically that of middle-income voters), the Czech party system was conducive to maintaining public health access though the ability of the socialists to utilize veto points, and of the christian-democrats to position themselves in coalitions.

7.2.3 The Constraining Effect of Public Opinion and Coalition Politics

Table 7.7 shows all Czech cabinets from 1990 until 2014 with characteristics of the cabinet, governing parties, ideology and the salience of healthcare during that time (only available from 2002 onward). Two things stand out from the table. The first is the degree of instability in the Czech political system. The two main parties, the ODS and the CSSD, maintained their status across the decades as the two main ideological competitors forming cabinets (a pattern broken in 2017 when ANO formed the government, not included in table). However, many governments ended before their term, many others were minority governments relying on tacit support from opposition parties, while others were ideologically incoherent. The second noteworthy fact is that the ODS cabinets (Klaus II, Topolanek II, Necas I and II) were the only ones to both hold a majority and be ideologically coherent. The CSSD came closest with the Spidla cabinet which, while being incoherent due to having two right-wing coalition partners, was nonetheless dominated by the CSSD which had 70 out of the 101 seats necessary to hold a majority (the Christian Democrats KDU-CSL were second with 22 seats). This arrangement also held for the following two CSSD

cabinets. However, both were short lived.

The final column shows the salience of health among the population. The share of respondents considering healthcare to be one of the top two issues facing the country is relatively high in Czechia, adding to the expectation that issue-voting is likely to hold for healthcare. What is noteworthy is the higher salience starting from 2005 lasting through the first years of the great recession. This occurred during the controversy over user fees and other retrenchment efforts by the ODS. As the analysis below will show, the CSSD took this opportunity to capitalize in their opposition to the reforms.

The remained of this section proceeds by analyzing different government episodes in order to see how the structure of these cabinets affected health policy.

Overall, the change to social insurance can be viewed through the prism of path dependence interrupted by the critical juncture of the regime change. However, beyond the historical legacies and the original Bismarckian origins of Czechoslovak healthcare, the health partisanship paradigm adds additional layers of understanding to this process of change and explain why the Czech reforms did not go further. While the same historical legacies meant that individuals had certain expectations for the state to assure healthcare, and bureaucrats had ample incentives to fight to keep their jobs and positions (Inglot, 2008), it is when we look at parties that we can understand how these legacies influenced policies.

The Civic Forum tried to directly capitalize on the reform process in order to gain further electoral support. The fact that a broad portion of the population expected market driven economic reforms, while expecting a more efficient public health system as opposed to a private one, explain the Civic Forum split between the two policies. Moreover, as the next government episode of the Civic Democrats shows, health was also more resilient than unemployment and pensions. I argue that this is not only due to the policy legacies of pre-war and communist healthcare, since similar legacies

Table 7.7: Czech Cabinets and Characteristics 1990-2014

Start date[i]	Prime Minister	Government Type	Governing Parties	Ideology	Salience[ii]
29.06.1990	Pithart (OF)*	Majority Coherent Coalition	OF,HSD,KDS,KDU-CSL	Center-Right	-
02.07.1992	Klaus I (ODS)*	Majority Coherent Coalition	ODS,KDS,KDU-CSL,ODA	Center-Right	-
01.01.1993	Klaus II (ODS)	Majority Coherent Coalition	ODS,KDS,KDU-CSL,ODA	Center-Right	-
02.07.1996	Klaus III(ODS)*	Minority Coherent Coalition	ODS,KDU-CSL,ODA	Center-Right	-
02.01.1998	Tosovsky (KDU-CSL)	Caretaker	ODS,KDU-CSL,ODA	Center-Right	-
17.07.1998	Zeman (CSSD)*	Minority Single-Party	CSSD	Center-Left	-
15.07.2002	Spidla (CSSD)*	Majority Incoherent Coalition	CSSD, KDU-CSL, US	Center-Left	-
04.08.2004	Gross (CSSD)	Majority Incoherent Coalition	CSSD, KDU-CSL, US	Center-Left	17.15
25.04.2005	Paroubek (CSSD)	Majority Incoherent Coalition	CSSD, KDU-CSL, US	Center-Left	37.6
18.08.2006	Topolanek I (ODS)*	Minority Single-Party	ODS	Center-Right	45.05
09.01.2007	Topolanek II (ODS)	Majority Coherent Coalition	ODS, KDU-CSL, SZ	Center-Right	38.14
09.04.2009	Fischer	Caretaker	-	-	16.03
28.06.2010	Necas I (ODS)*	Majority Coherent Coalition	ODS, TOP09, VV	Center-Right	18.29
27.04.2012	Necas II (ODS)	Majority Coherent Coalition	ODS, TOP09, LIDEM	Center-Right	10.96
25.06.2013	Rusnok	Caretaker	-	-	11.69
17.01.2014	Sobotka (CSSD)*	Majority Incoherent Coalition	CSSD, ANO, KDU-CSL	-	11.13

[i] All party data taken from the ParlGov data-set (Armingeon et al., 2002). Government type and ideology computed by author, see chapter 6 for details.
[ii] Salience of healthcare calculated from Eurobarometer surveys 2002-2016 (Commission, 2019), as percentage citing healthcare among top two most important issues facing the country.
* Cabinets formed as a result of an election.

should be in play when it comes to assuring employment protection and old age protection. What comes on top of these legacies is the fact that healthcare enjoys overall broader support.

Czechia can be considered an early reformer among EE countries. The Civic Forum of Health Professionals, part of the Civic Forum movement that brought an end to Czechoslovak communism, took on an early role that was to be crucial, by publishing a document of principles of health reform in 1990 (Busse et al., 2000, p. 9). This proposal called for a state guarantee for health, increased choice of patients, decentralization of facilities, and a diverse financing system combining public and private compulsory insurance (Jaros, Kalina, Dlouhy, & Malina, 2005). Over the next two years, the Civic Forum government would completely revamp the Soviet Semashko healthcare system into a decentralized Bismarckian social insurance system. However, the speed of the reforms and the subsequent ones by the successor ODS would plunge the system into a deep financial crisis that would take years to correct.

Although the changes brought about by the first post-communist government of Pithart between 1990 and until the dissolution of the Czechoslovak state in 1992 were more radical than what the Proposal of the Forum of Health Professionals envisioned, they were nonetheless much less radical and market oriented than economic reforms during the same period. Part of why this was the case was to do with the fact that separate teams were working on the different reforms. The team focusing on economic policy, led by Finance Minister and future Prime Minister of Czechia, Vaclav Kalus, had a strong neoliberal orientation. The team in charge of social policy, led by Petr Miller, the Minister of Labor and Social Affairs, had a much stronger social democratic orientation (Inglot, 2008).

The Pithart reforms brought about a system of competing public insurance funds, while maintaining overwhelmingly public expenditure and public provision. The main

insurance fund, the General Insurance Fund (VZP) started out first. It was later joined by a peak of an additional 26 funds, while maintaining its dominant position (Busse et al., 2000, p. 59).

What the first Klaus government envisioned for healthcare was an expansion of previous policies. They sought to completely privatize inpatient and outpatient facilities, as well as expand competition among health insurance funds. Ultimately, Klaus directly advocated for a more radical system of fully private Mutual Savings Account (MSA) system, similar to the United States, that would replace public and private insurance (Ovseiko, 2009). These policies were promoted in the name of increasing efficiency in healthcare by cutting down on what the party perceived to be over-utilization, especially of hospital services, bureaucratic inefficiencies and lack of investment in the health sector.

What the coalition ultimately achieved was partial success in terms of privatization, and in fact an ultimate reversal of principles of competition in provision and financing. By the end of the Klaus era in 1998, the Czech system was still predominantly publicly financed, with managed competition among funds, and a predominantly public provision system dominated by the hospital sector. Before analyzing the reform efforts and understanding why the reforms took the shape they did, it is important to consider additional reasons why it would have been expected that this government would pursue more drastic reforms in health.

The fact that the ODS had simply made electoral promises to drastically privatize healthcare is coupled with the fact it kept those promises in the realm of economic reforms and labor market reforms. They themselves had put healthcare on top of their electoral agenda, which was in response to the perceived sense of urgency of reform, and the salience of health policy among the population. Furthermore, Klaus himself had modeled the party's electoral campaign and the actual reform agenda as

a means of gaining political capital through privatization reforms. It is therefore not immediately obvious we he would not want to continue this in the health sector.

It could be the case that the party simply de-prioritized health reform in favor of more pressing economic reforms. Or it could be that it wanted to continue the "social-liberal hybrid" of the Pithart government where neoliberal economic reforms were coupled with more social-democratic social policy (Popic, 2014). If such a compromise was reached, it was clearly not the initial intention of the party. Rather, it was due to the particularly high support that healthcare hard as compared to other policies, that shifted the balance of power in the coalition towards scaling back market reforms in the health sector. Two key points strengthen the idea that the compromise was not planned, beyond the rhetoric of the party manifestos. The first is that Klaus appointed Petr Lom as the new Health Minister. This clearly signaled Klaus' commitment to health reform since Lom was the previous chairman of the Health Parliamentary Committee where he had criticized the previous minister Bojar for the slow pace of reforms and for not going far enough (Ovseiko, 2009, p. 138). The second is that as reforms went on, Klaus took a personal stake in trying to steer the privatization efforts and the move to private insurance.

The final piece of evidence also points to the reason for the failure of health reforms: the comparison with labor market reform. By the end of its tenure, the ODS government had succeeded in securing a residualist unemployment system with a benefit period reduced from 12 to 6 months, and the benefit level reduced to 60% of the previous net income for the first 3 months, and 50% for the next 3 months (Saxonberg, Sirovátka, & Janoušková, 2013). The explanation advanced by Saxonberg et al. (2013) is that healthcare was better institutionalized while unemployment was a new policy instrument which lacked the historical dependencies, institutional bureaucracies and societal expectations that health or family policy had. While legacies likely play a

role, they do not fully explain the divergent levels of public support that the two policies received.

During the privatization process, fearing electoral backlash particularly following successive protests by doctors and patients unions, the government backtracked on its universal privatization measures, designating many facilities ineligible for privatization (Ovseiko, 2009, p. 155).

The insurance market reform initially proved successful. However, the financial incentives of the new funds quickly drove the system into a crisis. The fee-for-service payment scheme, in absence of capitation and other controls, incentivized providers to overcharge and oversupply, draining the funds (Stolarov-Demuth, 2019). Moreover, the absence of a risk-adjustment scheme allowed funds to select their patients, leaving the riskier and sicker patients in the main fund, VZP (Lawson & Nemec, 2003, p. 228).

In absence of other mechanisms, the government needed drastic to curb the spiraling costs produced by the competition between funds and the fee-for-service system. Interestingly, instead of fully privatizing the funds and allowing them to adjust in successive waves of competition and bankruptcy, the otherwise neoliberal government opted for the introduction of a risk-adjustment scheme which meant a re-allocation of up to 70% of contributions between funds in order to ease financial difficulties (Busse et al., 2000). This effectively limited the open competition, rolling back the original logic of the reform.

In order to curb utilization of health services, the government attempted an introduction of copayments and user fees which would have increased treatment costs by 10% (Jaros et al., 2005). The Parliamentary dispute which ensued was eventually resolved by a ruling by the Constitutional Court which claimed the fees violated the right to healthcare (den Exter, 2002, p. 168) The efforts were further stalled by protests from

the Medical Union Club in March 1996 which demanded changes in the financing system and higher wages (Rokosová et al., 2005).

7.2.4 Expanding Access to Health - The Quality of Linkages

The Czech Social Democrats are comparable to the Bulgarian Socialists in most ways. They both dominated the center-left of politics in the post 1989 era. They both had similar electorates which showed high health solidarity, and both had chances to influence health policy once in power. There are two important factors which set them apart. The first is the quality of linkages to voters. More than being an issue of the political system as a whole, in Bulgaria clientelism was rooted in the history of the socialist party. Akin to the Romanian (PSD) and Hungarian (MSzP) socialists, the Bulgarian socialists inherited not only some of the elite of the former communist party, but also its infrastructure. As the next chapter will show, this meant that it had an electoral advantage through clientelistic networks, and consequently needed to rely less on programmatic policies. The Czech Socialists, on the other hand, were not formed as the successors of the communist party, but rather traced their roots to the interwar period. Therefore, they did not benefit from the infrastructure set in place during communism.

The second key difference is related. Because they were not the inheritors of the communist party, the reformed-communist KCSM became the main competitor for votes of the CSSD on the left. Neither the Bulgarian, nor the Romanian or Hungarian socialists had a serious competitor for votes on the left. Competition from the left, and the need to make programmatic appeals to voters made the difference for the Czech socialists. While many policy attempts were failed (as detailed further in this section), the more consistent successes of the CSSD in proposing or blocking policy can be attributed to them pushing healthcare to the top of their agenda.

The 1998 snap elections brought the first turnover in power in Czechia with the Social Democrats taking power in a single-party minority government. Healthcare remained high on the agenda and had prominent places in the party manifesto. The Zeman government had ample incentives to reform the system it inherited from ODS. Firstly, the financial crisis of the funds made the reforms unpopular. Secondly, it had already scored, together with the unions, a victory against the previous government by defeating the co-payment bills.

The problem it faced is that it could not form a stable majority and therefore relied on the tacit support of the ODS in parliament. In effect, this limited the cabinet's ability to bring a new reform agenda. However, two reform episodes (one of which failed) highlight the ideological goals of the CSSD cabinet. The first was abolishing the two-year limit on the risk-adjustment scheme introduced by the ODS, which meant a continuation of limiting competition among funds (Busse et al., 2000). This is an example of policy updating. The policy was further updated in later CSSD administrations in order to further redistribute among the funds. The second example is the Zeman cabinet proposal of a range of reforms to the health insurance system in June of 2000 which aimed to reduce financial risks for patients (Rokosová et al., 2005). However, the proposals were ultimately withdrawn due to the opposition from the ODS, which the cabinet needed to maintain parliamentary support.

While initially puzzling, the policy failures and the continuation of ODS policies by the CSSD, is an example of ideological mediation due to political instability. While the CSSD had the motivation and some degree of popular support for passing more equitable health reforms, its dependence on political support from the ODS meant that it was unable to pass those policies.

The CSSD formed a new cabinet after the 2002 elections, under Vladimir Spidla. The cabinet attained parliamentary majority by including the conservative Chris-

tian Democrats (KDU-CSL) and the liberal Freedom Union (US) party. While the coalition was to some degree incoherent, due to the presence of the two right-leaning parties, the CSSD was by far the largest party in the coalition. Nonetheless, in the long term conflict between the parties led to two cabinet changes before the next elections (Döring & Manow, 2010).

The more stable Spidla cabinet (which is also the most typical case for expansion in the QCA analysis), eventually passed three reforms, two in financing and one in provision. The first financing policy included institutional design, by forming the Czech Consolidation Agency in 2002, which provided a mechanism for clearing off healthcare debts of the VZP (Alexa et al., 2015). In effect, this meant increased public spending in healthcare, and greater redistribution since state funds came from general taxation. The second policy came in 2004 in the form of a revised risk-adjustment scheme between funds. The reform meant that funds would be redistributed based on age and risk, further securing the main public fund from financial trouble. The Health Minister, Souckova, specifically recognized that the law would would negatively affect several insurance funds, though claiming that it would benefit all in the long term (Horáková, 2004). Reactions from ODS characterized the law as ending any form of competition among the funds leading to decreased revenue overall. The law was ultimately passed and came into effect during the Gross cabinet, which followed Spidla under the same party configuration.

The reform of provision concerned hospital ownership. At the time, hospitals were still under state ownership. However, successive debates in parliament brought forward proposals by the ODS to transform hospitals into joint-stock companies, effectively privatizing them. Following decentralization measures in 2002-2003 hospitals were under local government ownership, which wanted to transform them into joint-stock companies in order to stabilize their financing (Bryndová et al., 2009, p. 93). As a

preemptive measure the Paroubek CSSD coalition passed Law 245/06 to turn hospitals into non-profit institutions, therefore blocking privatization (Nemec et al., 2015, p. 111). The rationale behind the law was clearly an attempt to preserve the public status of hospitals. The CSSD Health Minister, Milada Emmerova, expressed concern to prevent the privatization of hospitals arguing that profit incentives would make hospitals focus away from general services and onto profitable interventions (Horáková, 2005).

The end of the CSSD cabinets saw higher state contributions to the VZP through bailing out of excess debt, increased risk-adjustment between funds in order to protect the main public fund, and a higher reliance on public hospital services as opposed to the private outpatient care. The Spidla and subsequent CSSD cabinets can therefore be seen as a successful case of an left wing cabinet maintaining and expanding public healthcare.

7.2.5 Maintaining Access - Veto Points and Party Politics

A new ideological battle began when the ODS returned to power in 2006, with an agenda of privatizing hospitals and introducing user fees, under a slim majority coalition headed by Mirek Topolanek, in a coalition with the KDU-CSL and the Greens, SZ. The same agenda was continued by the next ODS cabinet of Necas who formed a more coherent majority with two new right-wing parties: TOP09 and VV. The ambitious agendas of both cabinets were initially toned down and ultimately delayed and reversed through the opposition exploiting veto points in the form of constitutional court vetoes, the power of regional government and the electoral vulnerability of coalition partners, especially the christian-democrats.

The Topolanek cabinet started with a particularly ambitious policy agenda of transforming the health sector. The reform package however quickly ran into trouble as

the Greens and christian-democrats, the coalition partners of the ODS, expressed concerns over the reform. The CSSD made several attempts to block the reforms, including courting votes from MPs of the Greens and Christian Democrats, starting public petitions, and bringing up the user fees to the constitutional court (Lazarová, 2008, 2007).

Resistance to the reforms scaled them back considerable. The Topolanek cabinet nevertheless succeeded in pushing though user fees by including them in a general bill covering public budget stabilization (261/2007). The new user fees applied to doctors visits, hospital stays, ambulatory services and emergency treatments (Bryndová et al., 2009).

The user fees became the most politicized reform in the post-communist history of Czechia (Nemec et al., 2015). After its passing, the CSSD turned the measure into political ammunition at every turning point until they were ultimately abolished in 2014. The Constitutional Court initially dismissed the CSSD appeal on May 28th 2008, ruling that they would not significantly impede on the constitutional right to healthcare. Later, in 2008, the CSSD made significant gains in the Senate elections where they made several failed attempts to remove the fees, while pledging to end the fees if they win general elections. The CSSD also made the fees the forefront policy ahead of the 2009 regional election. In a sweeping victory, they claimed 13 out of the 14 regions and promptly moved to end user fees indirectly, by having the region pay the fees on behalf of patients (Alexa et al., 2015). By 2010, the CSSD had launched a 'struggle against fees' campaign and filed two complaints with the Constitutional Court.

The user fees were rolled back 7 years later under a decision by the Constitutional Court which gave an impetus to the CSSD dominated Sobotka government. The government canceled the user fees, leaving only the emergency service charge (Alexa

et al., 2015).

Programmatic right health reforms

The ODS Necas cabinet put forward two reforms during its tenure: the Law on Health Services (373/2011), which replaced the old communist 1966 Law on the Healthcare of the People, and the Law on Specific Health Services (373/2011) (Alexa et al., 2015). Both reforms were considerably less ambitious in terms of marketization than the previous Topolanek attempts, and can be considered layering policies.

The first reform raised hospital fees in 2011 from 60 crowns to 100 crows a day and reduced the categories of drugs covered by public insurance. The second introduced a skip and pay system whereby individuals could pay additional fees in order to access preferred specialists and skip waiting times, and receive additional services (Lazarová, 2012). The second reform in particular can be seen as an example of layering, a policy which does not directly retrench the public system, but rather creates a parallel system for wealthy individuals who can then opt out of public services.

The CSSD explicitly made the argument that a two-tier system would disadvantage socially weaker groups by concentrating resources towards wealthier individuals and eroding solidarity (Lazarová, 2011). This line was also taken by the head of the Czech Patients Association, Lubos Olejar, who argued that the best physicians would be driven only into the second tier of the system to cater to wealthy individuals (Lazarová, 2012). The CSSD ultimately took the issue to the Constitutional Court, arguing that it infringed on individuals' right to healthcare, since the more vulnerable would receive less effective treatment.

What Necas cabinet reform attempts show is the difference between programmatic and clientelistic right wing reforms. While programmatic right wing parties such as the ODS are constrained by public opinion in the reforms they attempt, resulting in

policies of more mild financial restrictions and layering, clientelistic right wing parties such as the Bulgarian ones delivered much more drastic cuts in all areas of healthcare, eroding coverage, financial access and public provision.

The Resilience of Czech Public Health

The Czech case shows how party competition in a country whose population showed broad support for healthcare went through cycles of policy reform and rollback, resulting in a system that still allows broad access to healthcare. In doing so they employed frames of equity and efficiency in order to justify their policies in front of voters and attempt to gain electoral support and political capital. The early reforms in the 1990s show Czechia to be a case which experienced some amount of marketization. However, due to subsequent reforms that put important limits on market mechanisms, marketization did not translate into commodification and significant access barriers to patients.

8 The Politics of Retrenching Health Access

For a moment, nothing happened. Then, after a second or so, nothing continued to happen.

—Douglas Adams, The Hitchhiker's Guide to the Galaxy

Half at least of all morality is negative and consists in keeping out of mischief. The lords prayer is less than 50 words long, and 6 of those words are devoted to asking god not to lead us into temptation.

—Aldous Huxley, The Doors of Perception & Heaven and Hell

Bulgaria, along with other political systems that are characterized by clientelistic or otherwise non-programmatic linkages between citizens and parties, presents a unique challenge to political analysis. Some have asked if it is even worth trying to understand politics in a country where power is gained and wielded in patterns that do not conform to typical democratic norms (Häusermann, 2010). As this chapter will show, clientelism is relevant and it does in fact gravely affect health partisanship by allowing parties to avoid blame for retrenchment and neglect, and providing them with fewer incentives to use health policy to gain electoral capital with lower and middle-income voters. Table 8.1 shows the expectations for left and right parties under clientelistic linkages.

Bulgaria appears to show overall signs that the political system is not based on programmatic linkages between politicians and the population: seemingly indistinct

Table 8.1: Policy Outcomes, Ideology and Constraints - Clientelistic Linkages

		Political Constraints	
		Unconstrained	Constrained
Ideology	Left	Updating	No Change
	Right	Retrenchment	Layering

political parties proposing equivalent policies and then opposing them when other parties are in power; parties seemingly switching ideology, and party members defecting (Stolarov-Demuth, 2019). Seen in this light, Bulgarian politics seem to be a pure play for power, as opposed to defined by ideological principles or by parties representing constituencies (Kolev, 2012).

Is this really the case? This chapter will show that Bulgarian parties do in fact represent separate constituencies and hold distinct ideological positions. However, this process is muddied due to the specificities of the Bulgarian political system, including its instability, the different roots of left and right-wing parties, and electoral clientelism. Despite these, health politics is subject to party competition. Health is just as political in Bulgaria as it is in Czechia, if not more so, due to its high saliency. The difference between the two countries consists in how the saliency of health gets transformed into policy, or lack thereof. Bulgarian politicians face the same conundrum as their Czech counterparts, namely how to satisfy different constituencies and gain political capital from reforming a health system, while balancing health needs with tight public budgets and pressures from interest groups.

Clientelism suggests that parties compete for votes by making narrow promises to groups of voters, offering jobs in public administration, or delivering other narrow resources such as local goods or direct vote buying. However, Bulgaria is not a pure clientelistic system. Parties do not reach 100% of their votes in this manner, nor do

all parties have the same institutional capacity to ensure that clientelistic networks are maintained. Parties therefore still need to compete for votes by making and attempting to keep electoral promises. Parties need to navigate the policy space and decide on policy proposals based on the political capital they expect to receive with key constituencies. For example, some argue that Bulgarian Socialist Party's (BSP[1]) promise to not privatize health was part of the reason why they managed to win the first elections, despite being the inheritors of the communist party (McKee, 1991).

Therefore, it seems that parties have strong incentives to differentiate themselves based on health policy, and compete with each other. The question then is in what way parties choose to structure their different positions on healthcare. This chapter will show that Bulgarian parties mostly conform to ideological patterns visible in other countries. The Bulgarian socialists consistently presented their policies as improving access to healthcare, while right wing parties, most notably the Union of Democratic Forces (SDS[2]), consistently presented their policies as increasing the efficiency of the health system. In doing so, the BSP attempted to cater to its base of mostly rural, older, and lower income individuals, while the SDS and subsequent center-right parties attempted to cater to younger, more educated and wealthier voters. When enacting (or attempting to enact) their policies, both groups of parties attempted to convince a broader majority of voters, beyond their constituencies, that their prescriptions and solutions are adequate.

[1]BSP has run in elections as single party (1990,1991), or as a coalition leader in coalitions named Democratic Left (DL,1994,1997), or Coalition for Bulgaria (KB,2000-2014).

[2]The SDS ran as a single party (1990,1991,1994) and as a coalition leader under the United Democrated Forces (UDF, 1997-2005) and the Blue Coalition (BC,2009). For simplicity, I will only refer to the main parties in the coalitions, the BSP and SDS, in the analysis.

8.1 Bulgaria: Health Partisanship Under Mixed Linkages

The comparison between Bulgaria and Czechia shows that health system outcomes do not match directly with the state-market dimension in other policy areas. If one looked at the two systems in the early 1990s, when Czechia was undergoing market reforms in all sectors under a stable right-wing government and Bulgaria was seemingly maintaining its Semashko public system with a strong socialist party and an opposition in disarray, one would have expected the Bulgarian system to emerge as more protective of marginalized individuals. However, through various policies that protected access for vulnerable individuals, Czechia achieved a strongly decommodified system that nonetheless saw some form of competition and other market and pricing elements. The Bulgarian system, while on paper seeming more state-oriented, nonetheless became severely commodified through neglect and a strong reliance on direct payments.

Table 8.2 shows the major health reforms in Bulgaria since 1990, as well as notable policy failures and cases of policy neglect[3], structured along party ideology and political constraints. The first thing to notice is the fact that right-wing parties have been more active in consequential health policy-making, as well as overall attempts at policy-making.

Two reasons are explored for this. The first is the fact that right wing parties have had more time in power, and under more stable and less constrained coalitions (see table 8.4 for a full list of cabinets and composition). The second reason relates to the

[3]Policy neglect is defined as a lack of reform attempt in cases where policies are deteriorating. The two instances in Bulgaria relate to the deterioration of financing in the 1990s and the subsequent rise of informal payments, and the rise of the uninsured rate following reforms to social insurance, both of which are discussed in more detail in the chapter.

Table 8.2: Policy Outcomes, Ideology and Constraints - Bulgaria

	Unconstrained	**Constrained**
	Updating Policies	*No Change/Neglect*
Left	1. Videnov (BSP/DL): 1995 Pharmaceutical Privatization 1996 Failed Social Insurance Reform	1. Popov(BSP/BZNS/SDS): Neglect of informal payments 1991 Partial Decentralization 2. Stanishev(BSP/NDSV) Neglect of uninsured 2009 Loosening insurance requirements
	Retrenchment Policies	*Layering Policies*
Right	1.Kostov(SDS/ZNS) 1997 Financing - Fees Introduced 1998 Social Insurance Voluntary Insurance 1998 Reduction Hospital Beds Outpatient Care Privatization 2. Saksoburg. (NDSV) Neglect of uninsured 2004 Hospital Financing Reform	1. Borisov I(GERB) 2012 Failed inpatient and outpatient reform 2. Borisov II(GERB): 2015 Hospital reform 2016 Dualization benefits package 2016 Failed hospital privatization

motivation of the two parties, The relative dominance of right-wing parties can explain part of the overall health system outcome. However, the comparison with Czechia shows that Czech right-wing cabinets also had an advantage of forming longer-lasting and more coherent coalitions. Nonetheless, these coalitions were more restrained in retrenchment, while the Czech socialists put health policy at the forefront of their agenda, in both proposing and blocking or reversing reforms. The chapter therefore focuses on the reasons for this discrepancy and argues that linkages represent the reason.

Ultimately, what emerged was the most commodified health system in the EU, with spiraling out-of-pocket payments and the largest rate of uninsured individuals. Conservative parties managed to dominate and ultimately succeed in the policy arena first through reforms, and later through a policy of neglect and privatizing risk (Hacker, 2004a). What made the difference in the Bulgarian case was a socialist party which

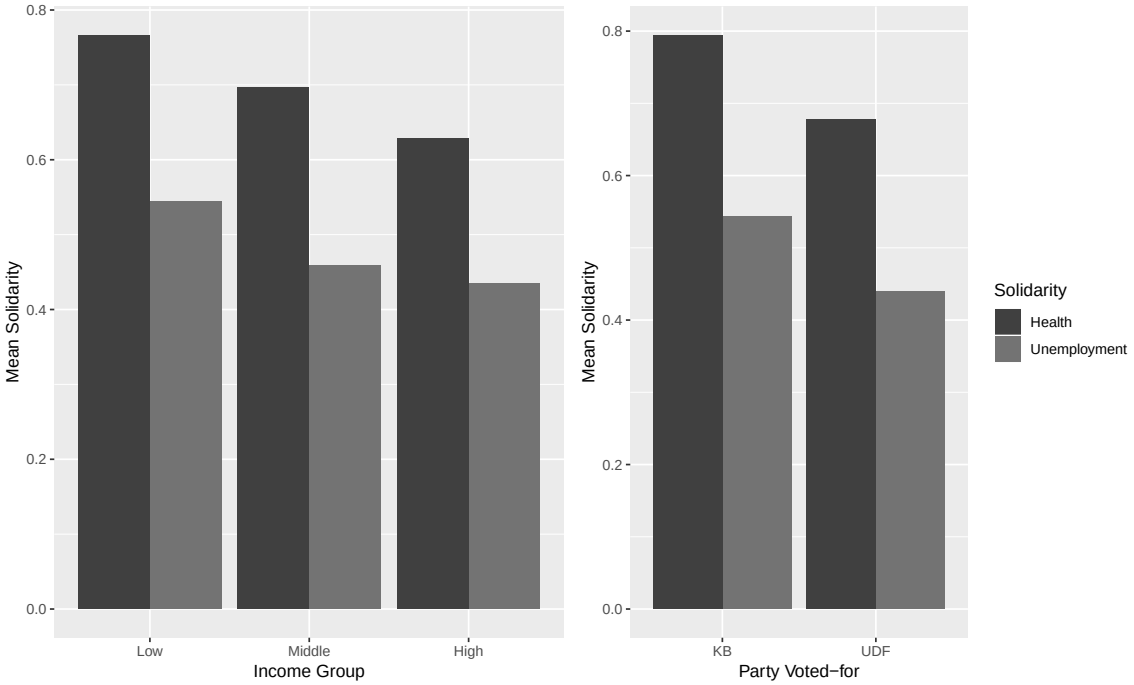
lacked deep programmatic linkages to its core constituencies. Instead, being the successor to the communist party, the BSP inherited its structure and electorate, and could, at least in the beginning, divorce electoral result from performance and catering to voters (despite its promises).

8.2 Bulgarian Attitudes to Healthcare

Bulgarian attitudes to healthcare are similar to those in Czechia and corroborate the results of the pooled sample analysis in section 7.1. Figure 8.1 shows that health solidarity is high in Bulgaria. The figure uses data from the 1996 ISSP survey (ISSP, 1999), however, the trends are similar in subsequent ISSP and ESS surveys (ESS, 2008; ISSP, 2015). While solidarity is overall high, it is considerably lower for high income earners, suggesting a social stratification component to solidarity. The right side of the graph further shows that voters for the socialist party (BSP, running in the 1994 election under a coalition, KB - Coalition for Bulgaria) show more solidarity than voters for the right-wing SDS (running under a coalition, UDF - United Democratic Forces). The figure, and subsequent analysis, suggests that Bulgaria displays a similar dynamic of lower and middle class voters, and voters for the left-wing party, showing higher health solidarity compared to higher income and right-wing voters. The second dynamic seen in the table is the considerably lower extent of solidarity for unemployment, suggesting that healthcare occupies a privileged status among voter preferences and values.

Table 8.3 shows the same multinational model with data from the 2011 special issue of the ISSP applied in the previous chapter, this time specifically to Bulgarian parties. The table shows the odds ratios for voting for the two right-wing parties GERB and SDS, and the ethnic party DPS, as compared to the BSP (z-values are shown

Figure 8.1: Bulgarian Health and Unemployment Solidarity - 1996



Source: ISSP (1999), author's compilation

in parentheses). The comparison between BSP and the more ethnic-oriented DPS shows that voters are not structured between the two parties in economic positions or health policy preferences. Rather, the social-stratification dynamic seems to be present when distinguishing between BSP and the two right-wing parties. Solidaristic individuals were 42% less likely to vote for the new center-right GERB party in the 2009 elections, and 65% less likely to vote for the more established conservative SDS party, compared to the BSP. This effect is comparable to that of income, standardized coefficients showing that voters are 33% more likely to vote for GERB than BSP, while solidaristic voters are 25% less likely to do the same.

The combination of the income stratification of solidarity, as well as the effect of income on voting for right wing parties, suggests that Bulgarian right-wing parties face a similar dilemma between their middle and higher income voters that Czech parties do. An analysis was also conducted for the 1996 ISSP survey (ISSP, 1999), the only

Table 8.3: Multinomial Regression. Predictors of Voting for Parties Compared to BSP, Odds Ratios, Z-values and Significance Levels

	DPS	GERB	SDS
Solidarity	1.063	0.582**	0.355**
	(0.157)	(−2.019)	(−1.996)
Fairness	1.566	0.967	2.064
	(0.972)	(−0.112)	(1.352)
Income	1.000	1.001**	1.002***
	(−0.044)	(2.212)	(4.649)
Education	0.823***	1.016	1.269***
	(−3.664)	(0.425)	(3.778)
Age	0.929***	0.940***	0.958***
	(−7.453)	(−7.399)	(−2.868)
Female	0.728	0.915	2.005
	(−0.912)	(−0.361)	(1.362)
State of Health	0.495*	0.553**	1.117
	(−1.785)	(−2.250)	(0.201)
(Intercept)	204.616***	56.860***	0.013***
	(19.324)	(7.086)	(−43.260)
AIC		806.572	
BIC		952.192	
Log Likelihood		-367.286	
Deviance		734.572	
Num. obs.		422	
Note:		*p<0.1; **p<0.05; ***p<0.01	
		Data from ISSP 2011	

other wave which contained Bulgaria, showing similar dynamics holding up between the BSP and right-wing parties (table shown in appendix D). These analyses show that the first part of the mechanism for health partisanship is present in Bulgaria. If Bulgarian voters have a similarly structured preference for solidaristic health policy and a similar demand for policy from parties (as suggested by voting dynamics), why do Bulgarian parties behave differently than their Czech counterparts? The latter two parts of the mechanism, party policy-formation and institutional constraints, will contain the answer.

The next section explores Bulgarian party positions on health policy in order to see if parties pick up on cues from their voter bases, while subsequent sections explore party linkages and other political dynamics in determining health policy outputs.

8.3 Party Positions on Healthcare

Parties frame their positions on healthcare in order to avoid electoral backlash and to maximize political capital. To analyze party positions I took a systematic analysis of all party manifestos available since 1990, as well as several parliamentary debates surrounding health policy proposals.

What is clear is that Bulgarian parties employ frames in the manner expected, with left parties framing their positions in terms of increasing equity, and right wing parties in terms of increasing efficiency. This suggests that Bulgarian parties are, to a degree, responsive to voters. Where this breaks down is when parties actually need to expend resources and political capital towards such responsiveness. At the very least, what this tells us is that parties pick up on their voters' preferences. However, framing employed by parties also has a role in policy formation and the chances of policies succeeding. The SDS managed a systemic retrenchment of access to health by framing

its policies as solutions to the problems of under-funding and waste in the Semashko system.

Table 8.4 shows all Bulgarian cabinets from 1990 until 2014, with characteristics of the cabinet, governing parties, ideology and the salience of healthcare during that time (only available from 2002 onward). The table shows important similarities between Bulgarian and Czech political outcomes (for Czech parties see table 7.7). The first is the relative instability of the system. Governments tend to be short lived, often operating without parliamentary majority, while coalitions are often incoherent - formed by parties of different ideological orientations and having divergent policy positions on health. The second similarity is the relative dominance of right-wing parties both in terms of the number of years they were in power, as well as having more stable and coherent cabinets. The third similarity is the high salience of healthcare, with an average of over 20 percent of voters citing it among the top two most important issues facing the country. One important difference is the trajectory of right-wing parties. While the Czech ODS maintained their dominant role on the center-right until 2014, the Bulgarian center-right was in turn dominated by SDS in the 1990s, the NDSV in the early 2000s and the more populist GERB in the 2010s.

Equity Frames - BSP

Messaging on health policy in terms of increasing or maintaining equity can be seen in the manifestos of the Bulgarian Socialist Party, going back to 1990 and the first free elections. Healthcare was at the forefront of social policy in nearly all BSP manifestos, suggesting that the party perceived health to be salient among voters. Framing can be seen in two ways. The first is the actual words that politicians and party manifestos use. Words act as cognitive shortcuts in order to activate certain ideas and values in voters' minds. The second way in which framing is seen is in the

Table 8.4: Bulgarian Cabinets and Characteristics 1990-2014

Start date[i]	**Prime Minister**	**Government Type**	**Governing Parties**	**Ideology**	**Salience**[ii]
21.09.1990	Lukanov (BSP)	Majority Single-Party	BSP	Center-left	-
22.12.1990	Popov (ind.)*	Majority Incoherent Coalition	BSP, BZNS, SDS	-	-
08.11.1991	Dimitrov (SDS)*	Minority Single-Party	SDS	Center-right	-
30.12.1992	Berov	Caretaker	-	-	-
17.10.1994	Indzova	Caretaker	-	-	-
25.01.1995	Videnov (BSP)*	Majority Coherent Coalition	BSP/DL	Center-left	-
12.02.1997	Sofijanski (SDS)	Minority Single-Party	SDS	-	-
21.05.1997	Kostov (SDS)*	Majority Coherent Coalition	SDS, ZNS	Center-right	-
24.07.2001	Skskoburg. (NDSV)*	Majority Coherent Coalition	NDSV, DPS	Center-right	18.42
16.08.2005	Stanishev (BSP)*	Majority Incoherent Coalition	KB, NDSV, DPS	Center-left	34.07
27.07.2009	Borisov (GERB)*	Minority Single-Party	GERB	Center-right	22.08
13.03.2013	Raykov	Caretaker	-	-	19.63
29.05.2013	Oresharski (ind.)*	Caretaker	Ind.; BSP; DPS	-	19.63
06.08.2014	Bliznashki	Caretaker	-	-	23.33
07.10.2014	Borisov II (GERB)*	Minority Coherent Coalition	GERB, RB, ABV	Center-right	23.33

[i] All party data taken from the ParlGov data-set (Armingeon et al., 2002). Government type and ideology computed by author, see chapter 6 for details.
[ii] Salience calculated from Eurobarometer surveys 2002-2016 (Commission, 2019), as percentage citing healthcare among top two most important issues facing the country.
* Cabinets formed as a result of an election.

focus on particular problems. At any given time health systems have a multitude of problems. A party's focus on a specific issue as opposed to others, tells us which types of issues parties believe they can derive political capital from, and which voters it targets.

For the first open elections in 1990, the newly renamed if not yet reformed Communist Party, campaigned as the Bulgarian Socialist Party and emerged as the largest political group, though short of gaining a majority of votes. The BSP campaigned on promises of maintaining public healthcare, explicitly arguing against privatizing the system, and vowing to prevent healthcare from turning into "a commodity on the market" (BSP, 1990). There was no mention of reforming the system towards social insurance, but rather of maintaining free-of-charge public health while allowing private providers. What this amounted to was a mildly reformed maintenance of the existing Semashko model. The next elections were held in 1991, following the adoption of the new constitution. The BSP's overall platform promised protection from the risks associated with the transition. For healthcare, the party moved to a position proposing social insurance, with free delivery of services and cost-sharing for pharmaceuticals. Overall they maintained the need for a strong role of the state in policy-making, and provision of services (BSP, 1991).

The 1995 elections saw the first return to power of the socialists, forming their only coherent majority coalition after transition. Their manifesto adopted a similar position to their 1991 promises on healthcare. They campaigned on a promise to introduce social insurance while maintaining the public character of the health system, by promising subsidies to drug prices and protections for vulnerable individuals (BSP, 1994). With the electoral victory came the opportunity to implement the promised reforms. The process, and its failure, are analyzed below. What is notable is how the party positioned its stance on social insurance, and how vastly it differed from the

SDS stance at the time and one year later when they attempted a different version of the same policy.

The main voice of the BSP in the debates was the Minister of Health, Vitkova. The minister framed the reform as a solution to under-funding and access barriers that had emerged during transition. The minister took care to point to the continuation of important principles from the Semashko model: "the proposed bill adopts the principles of obligatory provision of citizens, solidarity between insured persons, universal accessibility of the medical assistance..." (National Assembly, 1996). Considering the problems of the system at the time in addition to access barriers, such as chronic under-funding and low quality of services, it is revealing that the party focused its messaging in terms of increasing equity.

During the 1997 debates on the more regressive form of social insurance proposed by the SDS, several BSP members of parliament attacked the bill by defending the Semashko model or proposing a mixed system, or a more gradual transition away from state funding of healthcare. They argued that SHI, while broadly adopted in the rest of Europe, was ill-suited to Bulgaria, due to its social stratification and high rate of poverty (National Assembly, 1997). MP Marangozov put forward that it would impede access to healthcare of Bulgarians living in poverty, and would destroy the solidarity and equity principles which allowed access to healthcare to be based on needs rather than income (National Assembly, 1997). Other coalition members argued for more proportional contributions. Other MPs appeared to exaggerate the extent of marketization that the law promoted, by comparing it to the private system in the United Stated, citing the uncertainty and vulnerability of US citizens, for example the position of MP Stoilov (National Assembly, 1997). The ways in which the MPs attacked the law, suggests that they believed they could gain electoral capital by tapping into exiting voter values of health solidarity.

In the 1997 elections that preceded that debate, the BSP manifesto had promoted their previous version of SHI, adding the need for additional protections, such as subsidizing drug costs and advocating for a system according to needs, not income: "The health of the Bulgarian should not depend on the thickness of his wallet." (BSP, 1997). This highlights the party's attempt to appeal to the broad health solidarity values among their voter base and the general population.

The 2001 manifesto of the party saw it reacting to the aftermath of the 1997 reform and the accelerating problem of uninsured individuals. The socialists were the only party to seize the issue of the uninsured, promising to create funds from municipal and state budgets for the uninsured and socially vulnerable. More broadly, they promised to "preserve the public character" of the health system and argued against treating healthcare as a commodity (BSP, 2001). The way the BSP positioned itself against the previous reforms and as seeking solutions to its emerging problems broadly fits what might be expected of a socialist party seeking to expand access to healthcare. However, as we will see, when it did manage to form a government four years later, it did not apply these principles, although the 2005 manifesto also advocated for the "special fund for state health solidarity" (BSP, 2005). The special fund, which was never implemented, came back as an electoral promise in the 2013 manifesto. In addition, the manifesto proposed covering prescription drugs for the chronically ill, reducing co-payments for pensioners, introducing subsidies and incentives for hospitals and doctors to maintain access in remote areas (BSP, 2013).

Overall, the policies proposed by the BSP in the years after the introduction of regressive social insurance, sought to address the problem of spiraling out of pocket payments, and the increasing rate of uninsured individuals. The party used equity frames, citing the need for solidarity, and increasing access for vulnerable groups. In the end, however, these policies were never seriously attempted, either in government

or opposition. The next section explores the reasons for this, by looking at the cabinets in question.

Efficiency Frames - SDS/NDSV/GERB

The more fragmented center-right of Bulgarian politics saw three major parties taking turns in occupying the space. The SDS (and its coalition umbrella UDF), followed by the NDSV and GERB, took up similar positions on healthcare.

In the 1990 elections the SDS campaigned on a platform of promoting social health insurance, allowing private voluntary insurance and promising free-of-charge access to pharmaceuticals for those in need. In diagnosing the problems of the existing structures, the SDS focused on the state monopoly over the different aspects of healthcare as a source of inefficiencies. It argued for a pluralistic structure combining state, private and voluntary/cooperative elements, as well as emphasizing patient choice and promoting a vision of using pricing systems to evaluate activities in the health sector (SDS, 1990). The 1991 elections saw a similar positioning of the party.

In the 1995 elections, similar to the BSP, the SDS manifesto contained references to social insurance, but did so in a context of emphasizing problems with state monopoly and promising to develop private medical services. The same messaging was adopted in the debates over the BSP social insurance proposal citing the increased financial pressure on businesses and the problems with low autonomy of the fund and no competition (National Assembly, 1996).

Its 1997 manifesto pointed to some of the reforms and principles it was to implement by referencing again the need to implement SHI, the need to develop the private sector, while patient choice and financial security was to be achieved through a mix of private and public insurance (SDS, 1997). These principles were echoed in a draft policy agenda from the Ministry of Health in 1999, *Better Health for a Better Bulgaria*, which

cited the need for a public-private mix in financing and self-governing institutions (Hinkov, Koulaksuzov, Semerdjiev, & Healy, 1999).

In the ensuing parliamentary debate over social insurance, the SDS MPs and government officials framed the law as a break from the communist past. The problems of the system were characterized mainly in terms of inefficiencies which resulted from central planning under the Semashko model, which they deemed inappropriate to a market economy (National Assembly, 1997). Indeed, some MPs referred to these inefficiencies as "vices", to be fought with through market mechanisms, for example the position of Blagoy Dimitrov. Others referred to the distributional principle inherent in the tax-based Shemashko as the "Achilles' heel of orthodox socialism", arguing that it was the main source of inefficiencies in the system and that it was to be replaced in order to "make money effective", for example the position of Grigor Shishkov (National Assembly, 1997). This reflected the broader concerns among SDS and other MPs that underfunding of the system was not the primary problem, but rather mismanagement of funds and over-utilization of services (National Assembly, 1997).

The Minister of Health, Petar Boyadzhiev, argued that the autonomy and independence of the fund would assure greater quality of services, claiming that the law created incentives for competition between the insurance fund and healthcare providers (National Assembly, 1997). A similar claim was made by MP Maria Brainova, that spending based on contracts with providers would restructure the organization of healthcare provision, as the money would follow the patients. Strangely enough, the bill itself did not set up incentives or structures in order to promote competition between providers, or a fee-for-service system (or equivalent) that would ensure that money follows the patient. Nonetheless, SDS MPs used claims of efficiency and market-type arguments in order to justify the introduction of social insurance.

Shifting the debate towards the inefficiencies of the system and framing their policy as a means to achieve higher efficiency, allowed the SDS to mask retrenchment policies which ended having profound negative effects for health access, through spiraling out-of-pocket payments and a rising uninsured rate. The party lost the following elections to a new competitor on the right, the NDSV. In their manifesto preceding the 2001 election, the SDS maintained their message of continuing efficiency measures in the health system, suggesting that the party believed it could gain electoral capital from the reforms, at least with their own electorate. The health policy proposals revolved around extending market principles by promoting private investment and privatizing health institutions, as well as building up the health information technology sector. It also promised to lower drug costs through negotiations (SDS, 2001).

The party that ultimately won the 2001 elections, the NDSV, initially lacked clear policy positions on healthcare. Their 2001 manifesto showed a degree of incoherence of principles. On the one hand it promised to increase access to health services "with special attention to children, mothers, the elderly and socially disadvantaged" (NDSV, 2001). On the other hand, it proposed an escalation of privatization of public health facilities, except those of "national importance". It moreover proposed the reforming the insurance fund into multiple competing insurance bodies.

The 2005 NDSV manifesto, before the elections which they ultimately lost to the socialists (becoming their junior coalition partner), the party defined their stance more clearly. It explicitly argued for introducing competition among hospitals in order to achieve higher quality and to efficientize the use of funds. The party also proposed developing voluntary health insurance (a layering policy) as a means to increase funds (NDSV, 2005).

The NDSV vote share, like that of SDS, collapsed in the 2009 elections which were won by a new center-right populist party, GERB. The initial 2009 GERB manifesto

contained only vague references to healthcare, such as improving quality of care and management (GERB, 2009). The 2013 and 2013 manifestos contained pledges to increase public spending, while also promising to increase the efficiency of funds, and develop competition in hospital care (GERB, 2013, 2014). Ultimately, the GERB cabinets implemented layering policies, creating a two-tier health system where higher income individuals could pay for additional services, while continuing to neglect out-of-pocket payments and the uninsured.

8.4 The Politics of Neglect - Clientelism and Responsiveness

If voting dynamics suggest that voters want public healthcare, what explain the relative neglect of the BSP and the ability of ring-wing parties to pass retrenchment policies without (perceived) electoral cost. This section proceeds by looking at linkages between the main Bulgarian parties and voters, and then using this framework to understand the politics of neglect in the 1990s.

Table 8.5 shows the major Bulgarian parties and a set of characteristics relating to linkages to voters, taken as the average response of expert ratings from the DALP data-set (Kitschelt, 2013). The differences between Bulgarian and Czech parties (shown in table 7.6) are stark, across the many dimensions of linkages. While Czech left and right parties are evaluated to have the expected ties to unions and business, the BSP is evaluated to have ties with both, ties to business having greater consensus among respondents.

The following five items break down the relevant dimensions of clientelism which parties can use to gain support from groups. These range from offering goods directly, to offering targetted social benefits, employment in public positions, offering prefer-

Table 8.5: Bulgarian Party Linkages Characteristics

	SDS[i]	GERB	BSP	NDSV
Ties to Unions[ii]	0.333	0.091	0.538	0.000
Ties to Business[ii]	0.667	0.727	0.692	0.667
Clientelism Goods[iii]	2.500	3.000	3.154	3.333
Clientelism Benefits[iii]	2.273	2.667	3.308	3.083
Clientelism Employment[iii]	2.818	3.300	3.615	3.417
Clientelism Contracts[iii]	2.500	3.333	3.692	3.417
Clientelism Regulations[iii]	2.333	3.167	3.231	3.250
Target Poor[iv]	0.083	0.154	0.692	0.167
Target Middle[iv]	0.750	0.385	0.231	0.583
Target Rich[iv]	0.167	0.462	0.692	0.500
Target Loyals/Strategic[v]	1.667	1.800	1.615	1.750

[i] Data from Democratic Accountability and Linkages Project (Kitschelt, 2013)
[ii] Mean expert evaluation, 1=Ties Present
[iii] Mean effort level 1=Negligible, 2=Minor,3=Moderate,4=Major
[iv] Mean evaluation, 1=Target Group
[v] Target loyalists=1, Both loyalists and strategic=2, Target strategic voters=3

ential contracts to firms, and offering preferential regulations. Where Czech parties were evaluated to make only minor efforts across all dimensions, Bulgarian parties are evaluated to make moderate to major efforts, with the BSP showing the highest scores, and the SDS the lowest. What is interesting is that the two newer parties, the NSDV (formed in 2000) and GERB (formed in 2009), are also evaluated to use moderate to high efforts. This suggests the presence of a structural problem, since new parties need to adapt to clientelistic practices in order to gain and maintain support. It also suggests a catch-22 problem where parties cannot gain electoral support from apathetic voters and resort to clientelistic practices, while voters grow more apathetic due to parties breaking programmatic promises (Keefer & Vlaicu, 2007).

Looking across all parties, experts judged that they make moderate to major efforts to bribe voters. When asked whether these efforts grew or decreased in the 10 years prior to the response, experts judged that the efforts were greater in 2009 than in 1999 (Kitschelt, 2013).

Neglecting a system in crisis

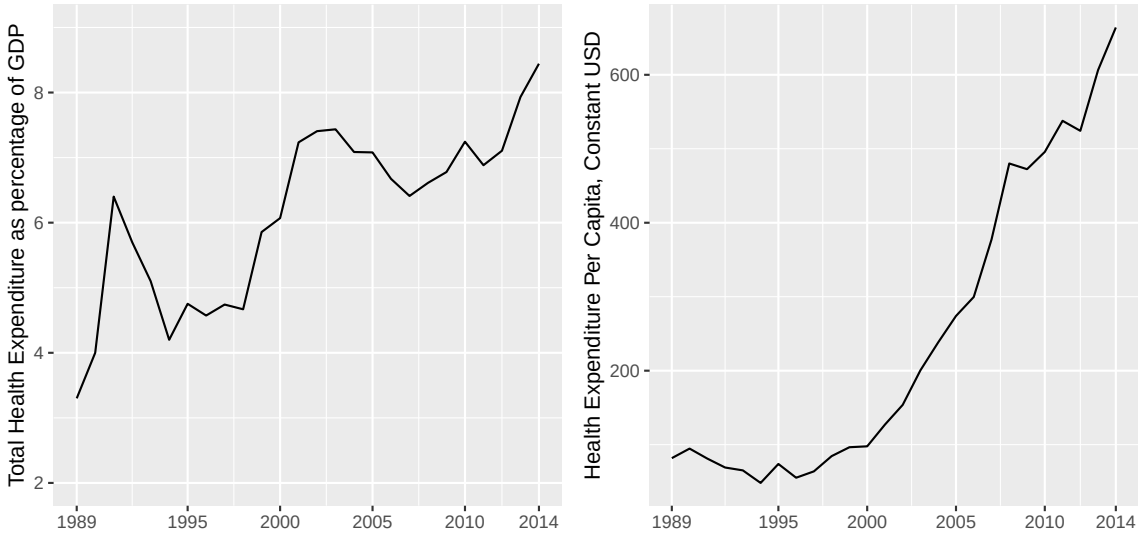
Bulgaria, together with Romania and Poland, represent the reform laggards in EE[4]. Bulgaria is a particularly puzzling case of stalled reforms. Despite the need for solutions to the deteriorating system, popular opinion which was in favor of social insurance, political consensus that at least some form of social insurance was desirable, and support from interest groups such as doctors' unions, there was no reform until 1997, and no attempt at a reform until 1995.

What is the cause of the Bulgarian reform paralysis? Before delving into possible explanations, it is worth further exploring the reasons why some type of reform would have been expected. Firstly, with the exception of Romania and Poland, the entire region had been swept by the reform (or return) to Bismarckian Social Insurance (Marrée & Groenewegen, 1997). The reasons for this were a mix of practical considerations, such as separating health funds from the state budget so as to increase spending, and ideological reasons including a desire to break from the communist past and embrace (or seeming to embrace) new market principles. Ultimately, SHI was the norm at the time, as Bulgarian MPs from both the left and right acknowledged and argued for in parliamentary headings surrounding the later SHI proposals (National Assembly, 1996, 1997).

Secondly, the health system was going through a severe crisis. Funding, both per capita and as a proportion of GDP, was extremely low. The state budget was under severe strain from the ongoing transformational recession. The centralized and inefficient communist health system started facing immense pressures during the transition. The low level of funding was exacerbated by the ensuing and long-lasting

[4]All three countries introduced Social Health Insurance in 1997, as a means of increasing funding and efficiency in healthcare. Bulgaria started with a proposal in 1995, while Romania first introduced a bill in Parliament in 1994, but the efforts were discontinued until a government turnover. (Sotiropoulos et al., 2003).

Figure 8.2: Bulgarian Health Spending



Source: WHO (2019), author's compilation

recession. Collapse of industry and increasing unemployment meant decreased revenue for governments. At a time when the population was becoming more vulnerable, the health budget and capacity of the health system were shrinking. Figure 8.2 shows the evolution of health expenditure as a percentage of GDP and per capita.

These issues were seen at the time to be linked to structural deficiencies in the health system, such as centralized mismanagement, shortages due to planning, overutilization of hospital services, lack of price incentives, competition and innovation, and low pay and morale of health workers (Borissov & Rathwell, 1996). Social insurance, decentralization and separating purchaser and provider functions, were seen as the solution to chronic underfunding and low efficiency - despite the fact that insurance was tied to employment and therefore problematic in transition (Ensor, 1993).

These problems only got worse over the transition years. What resulted was a deterioration of the public healthcare provision, and a marked increase in informal payments

to physicians as a means of gaining access to services (Atanasova et al., 2011). In a 1994 survey among 1000 respondents, 43% reported to have paid for an officially free service in a public facility in the previous two years (Hinkov et al., 1999). Overall this meant a large increase in vulnerability of marginalized social groups, deteriorating solidarity and lower overall access to services. Simply put, inaction at the time resulted in a stark increase in commodification of the health system - and can be seen as a means of privatizing health risk through neglect rather than official policy.

The third reason reform was expected was public opinion. At the time, a majority of the population was in favor of maintaining a free, broad access system that protected health needs. The ensuing economic collapse and insecurity only made this more pressing. A 1995 study showed that health was the top concern for Bulgarians, ahead of personal finance, and 50% of the population supported free universal provision by the state, with virtually 100% agreeing that the state should at least cover vulnerable groups (Balabanova, 2001). Public opinion and solidarity values among the population therefore stood in stark contrast to the realities at the time. Beyond patients, doctors also showed strong support for reform, specifically for SHI. Similarly to their counterparts in Czechia and other EE, they saw SHI as a means of increasing funding, and therefore their own salaries.

The last important reason that reform would be expected was the fact that there was broad political consensus on the need for reform. Indeed SHI was on the agenda, in the manifestos of all major parties. In the three elections held before the 1997 snap elections, the SDS had promised SHI reforms in all 3 manifestos (having won and formed a minority government in 1991), while the BSP promised the same in its 1991 and 1994 manifestos (having won the latter), and simply promising to protect public healthcare in 1990, when they also emerged as the main party.

Therefore, there seemed to have been a perfect set-up for reform: immense pressure,

saliency, a favorable ideational-diffusion context, support of relevant stakeholders and political consensus.

Existing explanations for lack of reform

The first, and likely strongest existing explanation for this puzzle is political instability. From December 1990 until May of 1997, the country went through 6 different cabinets, with only the last cabinet, the BSP-led Videnov coalition, holding a firm parliamentary majority. The other cabinets were either broad incoherent coalitions or minority governments which relied on the informal support of smaller parties (Döring & Manow, 2010). Adding to this was the general instability of the party system. The transition years of the 1990s saw a flurry of new parties and coalitions appearing. Coalition governments were, however, dominated by either the BSP or SDS. However, their junior coalition partners were often of diverse or even opposite ideological orientation.

Instability provides a fairly strong reason for why reform could be impeded. Indeed, the first attempt at introducing social insurance came during the more stable BSP-led Videnov government, while the actual law came in the next stable government of Kostov. However, political instability, as an explanation for policy failure or delay, usually implies strong policy disagreement. Akin to "veto-points" explanations, political instability presumes that social actors or opposition parties leverage their power against a weak government in order to prevent reform - or that self-aware governments do not attempt reform when they know that repercussions await. However, as we saw, there was overwhelming consensus on the need for reform and SHI as the only acceptable solution.

A second explanation relates to the limited reform capacity due to other priorities of transition, most notably managing the collapse of the economy. Indeed, Bul-

garia suffered one of the harshest and longest transformational recessions in EE, with double-digit unemployment and triple-digit inflation into the late 1990s, while the real wages in the mid to late 1990s were approximately half of their value from 1989 (Sotiropoulos et al., 2003). However, during the period when health reforms were actually attempted and enacted, in 1995-1999, the crisis was at its highest, therefore suggesting that this was not an impediment.

A third, and related argument suggest that SHI was postponed due to its direct impact during a deteriorating state of the economy. The argument suggests that due to rising unemployment, failing firms, and increased informal economy, employers and employees had a more limited capacity to generate the envisaged revenue from contributions to an insurance fund (Koulaksazov et al., 2003; Borissov & Rathwell, 1996). Indeed, such concerns were expressed at the time by political commentators (Pavlova, Groot, & van Merode, 2000), as well as in the first reading of a proposal for SHI in 1996 - opposition SDS members expressed concerns over sustainability due to unemployment (National Assembly, 1996).

However, there are two problems with this explanation. The first is that state funds, the existing source of financing, also heavily relied on the state of the economy, and general taxation. The second, and much more important, reason was that when SHI was actually introduced, the crisis reached its peak. Recession, inflation, and unemployment were at their highest in 1997 (Valev, 2004). It therefore does not seem that this was an important reason in stalling reforms.

Linkages and lack of reforms

Political instability, priorities and reform capacities do play a role. But they ultimately do not do enough to explain the neglect seen in the first seven years of transition. Another possible explanation is that parties simply did not form coherent

positions on health, that they did not seek to differentiate themselves and politicize health. However, as the previous section has shown, parties not only differentiated themselves, but did so in a manner that suggests that they took into account public opinion and the preferences of their voters.

If parties did have specific policy goals concerning the health system, part of the reason for the lack of reform during this period is that parties did not prioritize healthcare because they had other avenues of gaining support, and perceived that they could gain electoral capital from other policy areas. Specifically, the BSP, who had both more time in power and formed more stable governments at the time, as well as being expected according to their own manifestos to prioritize expanding access to healthcare, could rely on previous formal and informal networks in order to gain electoral support.

The reforms that were passed during these first governments were not addressing the urgent needs of the system. The Socialist Lukanov government reestablished the medical association in 1990, while the following Popov government enacted a partial decentralization of administration and allowed private practice in 1991 (Hinkov et al., 1999). However, no efforts were made to incentivize private practices or reform primary care, as the first Czech governments had done.

8.5 Ideologically-shaped Social Insurance Reforms

By the mid-1990s, the Bulgarian health system was nearing a collapse, with spiraling unregulated payments and an emerging black market for health services (Hinkov et al., 1999). The deteriorating state of the health system had already exacerbated serious inequities by 1997. A study conducted at the time, based on self-reported health, concluded that health inequalities were strongly influenced by social stratification.

The association was strongest with self-perceived financial hardship, a measure of material deprivation more sensitive to informal economic exchanges than reported income (Balabanova & McKee, 2002b), suggesting that informal payments in the health sector had an influence on access to treatment. The study found that those reporting the highest financial difficulties, and thus the most sensitive to informal payments, were up to ten times more likely to report worse health than the high income group. The study concluded that "[i]t is likely that the divisions in society will widen in the coming period of macro-economic stabilization" (Balabanova & McKee, 2002b, p. 311).

The BSP and SDS attempts at social insurance reform in 1996 and 1997, respectively, offer a unique possibility of counterfactual analysis on the effect of ideology on the same policy - the switch to social insurance. Both coalition cabinets had similar circumstances: stable coherent majorities which had the possibility to implement their preferred policy, only an external shock preventing the BSP from implementing theirs. This is therefore a perfect test of partisanship in clietelist systems. Does partisanship still matter for policy making when linkages between voters and politicians aren't strictly programmatic? Given that Bulgaria is not a pure clientelist system, we would expect parties to still seek to gain votes and electoral capital from social policy, by offering solutions demanded by their constituencies.

In short, this is exactly what we see. The BSP proposal would have basically maintained the old Semashko model, while shifting most of the financing from the state budget to a social insurance fund. The lack of independence of the fund meant that the proposal would have mostly amounted to a special tax on employers and employees for healthcare, in order to raise more revenue. The SDS version of the bill included fewer protections for vulnerable individuals, a greater burden of payment on employees, the introduction of user fees, and the separation of the insurance fund

from state control. The former closely aligns with the interests of lower and middle-income voters, who are more cost-sensitive, desire greater social protection and have higher levels of health solidarity, while the latter is more in line with higher-income voters who desire higher quality services and greater privatization even at the cost of increasing user costs.

Socialist attempt at social insurance

The 1995 elections saw the first stable and long-lasting government formed under the BSP. The Videnov cabinet brought forward a proposal for SHI the same year, with debates being held in 1996. At this first reading of the proposal, both the left and the right agreed that the introduction of social health insurance is the only viable way to reform the healthcare system (National Assembly, 1996). However, the SDS (in opposition) criticized the lack of independence for the insurance fund, which was to be put under the Social Insurance Ministry. It also decried problems with financial sustainability given high unemployment. The BSP, mostly through the voice of Health Minister Vitkova, defended the proposal by arguing that it would increase funding and access to healthcare by gaining additional revenue in the form of social insurance contributions at a ratio of one to three between employees and employers.

The BSP version of the law would have implemented a social insurance system where the state would maintain its dominant role in all three areas of healthcare: financing, provision, and regulation. The absence of other provisions, and the subordination of the fund to the government, meant that the reform mostly amounted to a specific tax for health, on employers and employees, in the form of insurance contributions. The law passed with a large majority. However, a second reading was never reached due to the ensuing financial crisis (Datzova, 2006).

Ultimately, the economic crisis of 1996 led to mass protests in the winter of 1996-1997,

and the resignation of the Videnov cabinet. An interim government was appointed and early elections were held and won decisively by the SDS opposition (Spirova, 2008).

Right-wing social insurance

The new government of the United Democratic Forces (UDF) was headed by SDS with Prime Minister Kostov, while containing many smaller parties. It was the first cabinet to implement systemic changes in the Bulgarian health system. The series of reforms that followed were argued as a means of increasing efficiency but ultimately resulted into a retrenchment effort.

As the first stable, majority government of the pro-market opposition, the Kostov government initiated reforms in a number of areas. In order to stabilize the economy, it introduced a Currency Board, and pegged the Bulgaria Lev to the German Mark, and later to the Euro (to which it is still pegged, at the time of writing). It also accelerated the process of privatization and began accession efforts to the EU and NATO (Stolarov-Demuth, 2019). Countering ideas of limited reform capacity due to prioritizing the economy, the Kostov government also engaged in comprehensive reforms of the health system.

After the previous failed attempt of the BSP to introduce social health insurance, the Kostov government attempted its own version. This reflected the consensus for SHI, as it was seen as a solution to funding crisis. What is notable is that the two bills had important substantial differences and were presented and argued for from different ideological standing points. While the BSP argued for SHI as a means of increasing funding and access, the SDS framed it as a move away from communism and a means to improve efficiency in the system, by taking the state out of health management, separating financing and provision and allowing autonomy and some

form of competition.

The SDS bill established the new National Health Insurance Fund (NHIF), a self-governing institution responsible for the management of health insurance funds. What is interesting is that despite talk of introducing competition, the SDS coalition did not seriously consider a Czech model of multiple competing funds (Datzova, 2006).

While the bill had some similarities with the previous BSP bill, it also had important differences. Firstly, the share of contributions paid by the employee was significantly larger, with a ratio of one to one, as opposed to the one to three ratio of the Videnov bill. Secondly, the NHIF was constituted as a completely independent entity, no longer under the administration of the National Social Security Institute. Thirdly, the bill also provided for the development of voluntary health insurance (Georgieva et al., 2007).

The introduction of social insurance was coupled with an introduction of user fees. Patients had been required to pay for certain luxury services since 1995. The new co-payments, introduced by the Kostov government through Ordinance 22 of 1997, applied to inpatient and outpatient care without a referral from the family doctor (Datzova, 2006). These new out-of-pocket fees also applied to general medical services in public facilities, but not private practices (Atanasova et al., 2011). These fees were broadly seen as a means of deterring what the government perceived as overutilization. The end results, however, were a marked increase in the share of direct costs on patients.

In 1999 the same government introduced the Law on Healthcare Establishments. The act aimed to reform the provision side of the health system, and move it from a command-and-control model to a more decentralized structure, while shifting the burden of care from hospitals to primary care and developing private care. The primary care model was changed from polyclinics to the family doctor model, while

the polyclinics were transformed into separate outpatient diagnostic and treatment facilities (Georgieva et al., 2007).

The reforms of the Kostov government were the single largest transformation of the post-communist Bulgarian health system. The policies, and ensuing parliamentary debates, showed a surprisingly clear partisan pattern despite clientelism and other inherent weaknesses of the political system. The SDS clearly positioned itself rhetorically to the right in a state-market dimension in general, and even more clearly in the equity-efficiency dimension in health, by primarily defining the problems of the system as a lack of efficiency caused by mismanagement and waste.

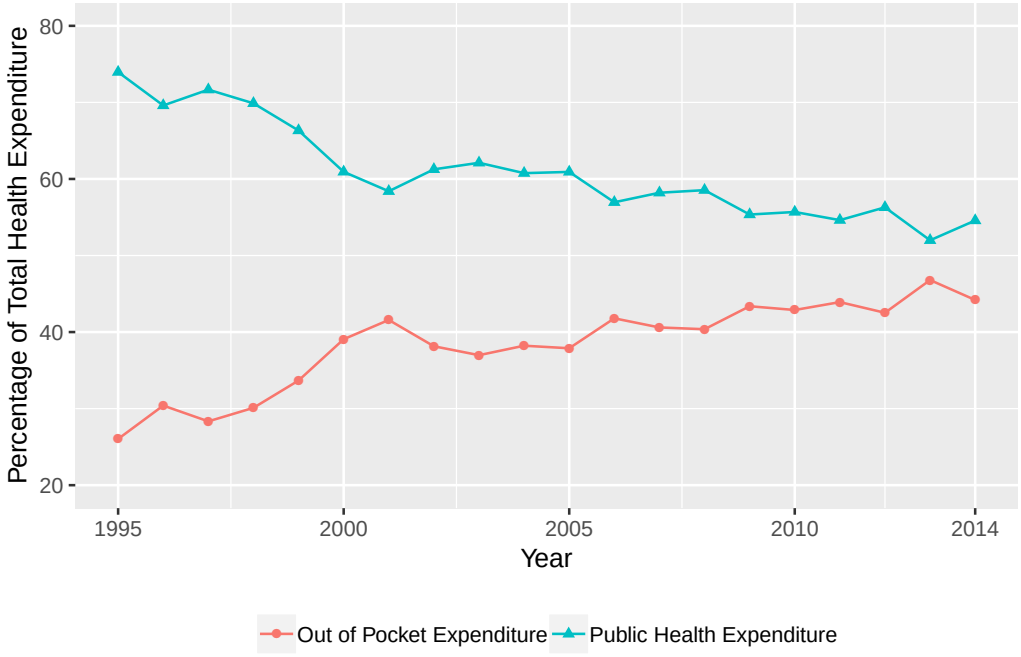
Why did the SDS choose these policies, and this framing? As the next section will show, the policies ultimately ended up benefiting the wealthier individuals making up their constituency, at the expense of lower-income individuals. These regressive policies were passed by appealing to new pro-market values and to the general dissatisfaction with the previous system. Ultimately, the SDS succeeded in framing the problems of the Semashko model as resulting from state control.

Distributional Effects

Initially, the SHI reform were well received. A 2000 survey found that a majority of Bulgarians preferred social health insurance over taxation-based financing, largely stemming from dissatisfaction with the quality of healthcare under the previous system. However, at the same time, over half of respondents supported universal provision that is free at the point of use (Balabanova & McKee, 2004), suggesting that individuals disapproved of user fees and the overall effect of decreasing access.

Indeed, while the reforms were framed as increasing efficiency, they resulted in few efficiency gains, and important reductions in access. Part of the reason for this is the content of the policy. Social Health Insurance is much more regressive in Bulgaria

Figure 8.3: Bulgarian Public and Out of Pocket Spending



Source: WHO (2019), author's compilation

due to the fact that there is an upper limit to contributions, which has a regressive effect as it caps the amount of contributions from wealthier individuals (Dimova et al., 2012).

The second reason why SHI is more regressive in Bulgaria, has to do with its socio-economic problems. Social exclusion of minorities and the maintenance of a large informal economy has meant that a) the state gathers fewer contributions than would be expected given economic performance and b) vulnerable groups are likely to not be covered either by the state or social health insurance. Indeed, data from 2004 show that more than two million people were uninsured in 2003, the vast majority being either Bulgarian citizens living abroad or groups with low socioeconomic status (Dimova et al., 2012).

What this means is that in absence of mechanisms to protect vulnerable individuals (besides the ones whose contributions are already covered by the state), social health

insurance had a net regressive effect in Bulgaria. This is visible in the explosion of out-of-pocket expenditure from 1998 onwards, which has never been contained. Figure 8.3 shows how in the aftermath of the reform, Bulgaria saw a replacement of public expenditure with direct private expenditure, private insurance maintaining an insignificant role. Out-of-pocket expenditure captures the fact that individuals had to increasingly rely on direct payments for medical care. What it does not capture is medical treatment that is forgone due to inability to pay, which is likely to have risen more drastically.

These changes were ultimately visible in public opinion, which five years after the reform, was much more negative about its impact. A survey in 2003 showed that an overwhelming majority of stakeholders (82,6% of patients and 87,9% medical staff) thought that the reforms in the health system led to its worsening (Daskalova et al., 2005).

Ultimately, the reforms by the SDS resulted in a system in which access became more restricted, the uninsured rate skyrocketed, and personal risk and vulnerabilities were exacerbated by the rise of out-of-pocket expenditure. In a sense, the system entered a much deeper crisis than it had been in before. Moreover, public opinion was signaling a strong desire for change. These factors make it even more puzzling that subsequent governments failed to improve access. However, the results of the policy favored the more educated and wealthy voters of the SDS, who now enjoyed increased choice of providers and who could use direct payments to access services.

8.6 The Relevance of Partisanship within Political Constraints

The 2001 election saw the emergence and victory of a new party, formed around the former monarch, Simeon Sakskoburggotski (NDSV, commonly referred to as the Simeon II Movement). The party was based on the charismatic persona of the monarch, therefore lacking a clear ideological orientation and could broadly be characterized as center-right. The coalition government it made with the DPS, the Turkish minority party, lacked a clear policy agenda, beyond promising quick prosperity (Stolarov-Demuth, 2019). It proposed to introduce multiple insurance bodies in order to create competition in insurance. Ultimately, it did not enact these promises. What is even more notable is the lack of action when it came to the increasing number of uninsured individuals.

The NDSV and DPS coalition attempted to implement their privatization promises by introducing three draft laws in parliament, out of which emerged a single amendment to the Health Establishment Act. During public consultations and parliamentary debates, the coalition defended its proposal to shut down inefficient hospitals. The privatization efforts were stalled after the coalition realized the political costs it would incur from the proposal (Georgieva et al., 2007).

In 2002 the coalition also took on the increasing problem of uninsured individuals. Several amendments to the health insurance act sought to curb the uninsured rate. To tackle the problem of Bulgarians living abroad, it decreed that those living for more than 183 days per year abroad were relieved of the obligation to pay contributions. Secondly, it increased to scope of state coverage to pensioners, people with disability from wars, children under the age of 18 and citizens receiving certain kinds of social security benefits (Dimova et al., 2012; Stolarov-Demuth, 2019).

These policies did have a considerable effect in the short term. The number of uninsured decreased from over 2 million to 1.4 million in 2004, and to 1.1 million in 2005. However, the policies didn't address the much more pressing problem of individuals engaged in informal work and still did not provide enough incentives to encourage entrepreneurs and other self-employed individuals to pay contributions. By 2011, the number of uninsured individuals was 1.7 million, or approximately 23% of the population, showing that neither this nor successive governments effectively addressed the issues (Dimova et al., 2012; Rechel et al., 2011).

Ultimately, the NDSV government left a mixed mark on the struggling health system. This, and its failure to keep other promises, including its broad claim to drastically increase prosperity, meant that it saw its vote share plummet from 42% to 19% in the next elections in 2005, trailing the BSP as the second party. It ultimately entered into a broad coalition agreement with the BSP.

Coalition incoherence and neglect

The Bulgarian Socialists won the 2005 elections with 31% of the vote, emerging from a period of severe political crisis. Following the disastrous management of the economy, and the crushing defeats in the 1997 and 2001 elections, it began a process of internal reform. Adding to this pressure was the emergence of a competitor from the left, which had previously been absent. Formed from a splinter group in the party in 1993, the Bulgarian EuroLeft (BEL) had entered parliament in 1997 and offered a more modern social-democratic vision, inspired by third-way politics (Spirova, 2008). Ultimately these pressures led to a shifting of the focus of the BSP. It no longer concentrated on continuing the role of the state in the economy, but rather framed its ambitions as ensuring equality of opportunity within the context of a market economy (Spirova, 2008). Ultimately, this shift to the center and the broad coalition it created

with the NDSV and the right-leaning DPS, resulted in continuing the policy of neglect of the access problems.

Not only did the socialist-led coalition fail to address the problem of the uninsured and expanding out of pocket payments, but most of its policies and proposals were rather characterizable as commodifying. In 2007 it lifted a moratorium on privatization of public hospitals which had been created in 2001 by the NDSV (Stolarov-Demuth, 2019). In 2008, a proposal emerged for creating multiple insurance funds which could compete with each other. The proposal came from the junior coalition partners, the NDSV and the DPS, but was ultimately supported by the BSP. While the proposal never saw the floor of parliament, it did enter the National Health Strategy of 2008-2013 (Dimova et al., 2018). The coalition did make an attempt to curb the uninsured rate. Through an amendment to the Social Insurance Act in 2009, it increased the period after which the failure to pay contributions would result in losing insurance rights from one to three years. Ultimately, since it did not address the more systemic problems of the uninsured, the effect of the amendment proved negligible (Scott, Powles, Thomas, & Rechel, 2011).

Populist right-wing health reforms

The 2009 election saw the emergence of yet another new party which sought to occupy the center right. By this point the SDS, the former dominating right-wing party, had been performing at under 10% of the national vote, and the NDSV party all but collapsed. The Citizens for European Development of Bulgaria (GERB) party, formed previously around the charismatic leadership of Boyko Borisov, won almost 40% of the vote and formed a single party minority government. GERB would go on to from two more governments after a series of protests, resignations and new elections in 2013, 2014 and 2017 (Döring & Manow, 2010).

Generally perceived as populist, the center-right party, GERB, initially lacked a comprehensive view on healthcare. In its three manifestos from 2009 to 2014, it initially advocated for maintaining solidarity, thereafter focusing on attempting to increase competition among providers and creating a two-tier system of health insurance. The latter policy emerged as the main concrete policy goal of the coalition. The proposal came in 2015 and was implemented through a ministerial order in 2016, and later repealed by the Constitutional Court as it was seen to infringe on patient rights (Dimova et al., 2018, p. 176). The policy split the benefit package into a basic part which remained covered by general insurance, and a complimentary part which required additional payments or waiting times. The fact that this layering policy benefited higher income earners, in the same way that the SDS reforms did, suggests some degree of continuity between the SDS and GERB constituencies.

Partisanship in Non-programmatic Settings

Bulgaria shows how left and right parties behave when they have other avenues for achieving political support, such as informal networks of patronage. For the left-leaning BSP, the perception of receiving limited political capital from expanding health access led to neglect during the 1990s and later during the mid-2000s. This moreover allowed it to delegate health policy, in the second period, to junior coalition partners - the NDSV and DPS.

For right-wing parties, clientelistic linkages between voters and politicians resulted in a greater ability to avoid blame from retrenchment policies. Moreover, in the long run this allowed parties to decrease access to healthcare to a much higher degree than was possible by Czech parties. Ultimately, subsequent right-wing cabinets also managed to persuade middle-income voters of the necessity of market reforms, by framing them as efficiency gains for the struggling health system.

9 Conclusion

> *There, comrades, is the answer to all our problems. It is summed up in a single word– Man.*
>
> —George Orwell, Animal Farm

Governments affect the quality of life of their citizens through social policy. They shape how citizens access health services, and at what cost this comes to them. Reducing access to healthcare has drastic consequences for utilization of services, unmet health needs and financial security of individuals. Resulting health inequalities are shaped by, and add to, other social inequalities and vulnerabilities.

This dissertation set out to ask *what the conditions under which governments expanded and retrenched access to healthcare* are. It focused on the role of party ideology and party responsiveness to voters, asking whether *politics requires parties*, that is to say, whether governments still play an important role in policy outcomes. The findings of the dissertation suggests that cabinet ideology and party linkages play a consequential role in shaping health policy. Parties take cues from voter preferences and values in shaping policy positions and pursuing policy outcomes which they believe will gain them electoral capital.

The dissertation combines insights from welfare studies, health policy and electoral politics literatures in order to advance the understanding of how partisanship affects

policy and what its micro-foundations consist of. The dissertation contributes to understanding the politics of policy making in general, and in particular the specificities of health politics in a set of understudied cases. Methodologically, the dissertation shows how insights from cross-case QCA analysis can be combined with individual-level regression analysis across and within countries, and in depth process tracing.

Summary of Findings

The findings of the dissertation lend support to the *health partisanship* argument, namely that parties are responsive to voters' greater support for healthcare, left and right parties attempting to maximize their electoral capital with their respective constituencies.

The cross-case QCA analysis of the access index and its components shows that left wing cabinets, in combinations with the absence of large deficits, the absence of veto points, the presence of programmatic linkages and already expanded systems, further expand access to healthcare. Right wing cabinets, in combinations with fiscal deficits, predominantly clientelistic linkages and existing restricted access, but seemingly irrespective of veto points, restrict access. The cross case analysis therefore lends support to the idea that left and right wing parties do in fact behave in ways predicted by ideological orientation. However, this behavior is seen only in the presence of, and in combination with, other factors. The necessity of the sufficient terms of programmatic linkages for expanding access, and clientelistic linkages for retrenching access, lends support to the hypothesis that left cabinets try to gain political capital when they are held accountable by expanding access, whereas right parties retrench when they believe they can avoid blame from their middle-class constituents.

These findings stand in contrast to the statistically insignificant effects found in most

quantitative studies looking at the effect of partisanship on spending. As argued in chapter 2, this is partly due to the fact that spending does not capture the effect of health systems on patients, and therefore is not the object of political contestation. This difference is also due to methodological choices. Chapters 4 and 5 have argued that an "average effects" approach to analyzing the impact of party ideology on policy outcome is likely to be inappropriate, since there are several institutional and political factors which shape the role of party ideology. By looking at the combinations of conditions which lead to expansion and retrenchment, the QCA analysis was better able to untangle *when* party ideology leads to policy outcome.

However, the cross-case analysis still shows only associations and does not directly prove or refute particular mechanisms or explanations for the observed relationships. In order to test whether the hypothesized mechanism is present, two approaches were combined: a statistical analysis of individual preferences, values and voting, and process tracing within case studies.

The results of the micro-analysis, both across the sample of cases (section 7.1), and, when looking at the two main cases of Bulgaria and Czechia, show evidence for the specificity of health. One the one hand health is different, having much broader support than unemployment and covering more than two thirds of the population. However, social stratification still persists, higher income earners showing less solidarity. As hypothesized, the highest income earners show a dramatic drop in solidarity, while middle-income earners seem to maintain solidarity in their majority. This lends support to the hypothesis that right wing parties face a dilemma between the two groups of voters. This is further corroborated by the fact that solidarity has a plausible impact in voting behavior, solidaristic individuals being more likely to vote for left-wing parties. Evidence is also found, in the pooled sample, that health solidarity can mediate the effect of income on voting. What it shows is that middle and higher

income voters are more likely to vote for right wing parties if they are not solidaristic.

If health solidarity is broad, and there is evidence to suggest that it influences voting, the question remains as to how parties respond to voters. Analysis of party manifestos, policy documents and parliamentary debates showed that parties position themselves strategically on health policy in order to gain electoral capital (sections 7.2.2 and 8.3). The manner in which parties frame their positions, the left arguing for increased equity, while the right arguing for increased efficiency (as opposed to direct retrenchment), suggests that parties pick up on voters preferences in both clientelistic and programmatic systems. However, political promises and arguments are not policies. The real test is whether parties put their resources into pursuing their stated policy preferences.

It is here that linkages play a crucial role. In more clientelistic systems parties have alternative means of gaining electoral capital, through vote buying, patronage politics and other informal networks. The subsequent weakening of party responsiveness is seen in several ways when comparing Bulgarian and Czech parties. The first is the prioritization of health policy in the 1990s by Czech parties, and the relative neglect by their Bulgarian counterparts. The second is the overall neglect of the uninsured in Bulgaria, contrasted with measures in Czechia to subsidize insurance funds in order to maintain coverage. The clearest example is the different response of the Czech and Bulgarian socialists to user fees and hospital privatization. While the Czech social-democrats turned user fees into their main campaigning issue, going to great lengths to oppose them at the national and regional levels and in the judicial arena, the Bulgarian socialists made only minor and ineffective efforts. The final piece of evidence concerns the depth of retrenchment by right-wing parties. While both sets of voters had similar levels of health solidarity in similar socio-economic and voting patterns, when it came to retrenchment, Czech parties did not go beyond layering

policies, while Bulgarian right wing parties enacted much deeper retrenchment of health access across dimensions of financing, provision and regulation.

This does not mean that countries with more clientelistic linkages cannot expand access to healthcare. Clientelism is a spectrum and none of the cases analyzed here fall squarely in the programmatic or clientelistic camps. Even the best networked parties still need other sources of support, therefore needing at least some degree of responsiveness to voters. As the QCA analysis reveals, there are conditions under which both clientelistic and non-clientelistic left cabinets expand access, given the existing health system and fiscal pressure.

Ultimately, the choices made by Czech and Bulgarian parties, over almost three decades, have put their respective health systems on opposite ends of the access spectrum. These choices were shaped by political realities, institutional constraints and the relationships that parties built with voters and their informal networks. In the end, such choices were never fully determined by their circumstances. Successive governments chose to prioritize or neglect health policy, and chose the reform direction.

Contributions

The contributions of this dissertation span the three areas outlined in the introduction: conceptualizing changes in health systems, theorizing and empirically testing a mechanism of health partisanship, and applying a "complex-causality approach" to studying the effects of partisanship on policy outcomes.

Chapter 2 built an index of health access which was later used in the empirical analysis. The theoretical foundations of the index were built upon literature from welfare studies and health systems classification, and aimed to reconnect healthcare research

to the broader literature of welfare policy change. It did so by adapting concepts such as decommodification, policy drift, layering and neglect, to health policy. By using a deductive approach in building the measure and index, this approach can easily be expanded to include further cases, without affecting the relative scores of the sample. The index is also flexible to including further indicators which can capture dimensions of access. One such dimension relates to informal payments, which plague certain countries more than others. Further research can continue theorizing and including other types of policies, if they are likely to affect patient access.

The classification covers cases in EE and SE that were previously excluded in typologies, which focused more heavily on OCED countries (Böhm et al., 2013; Wendt, 2009). By looking at cases across time, the typology allows a novel way of seeing how health systems move through the policy space in different dimensions of access.

The main theoretical contribution of this dissertation, developed in chapter 4 and tested in chapters 6, 7, and 8, relates to the role of partisanship in health policy change. Using multiple methodological approaches, the dissertation has pieced together a theory of health partisanship starting from voter preferences and ending with parties' ability to pass policy changes.

Ultimately, what the index and subsequent analyses show is that health access is not directly related to macroeconomic indicators such as GDP, or to the amount of health spending directly, but rather to how resources are allocated and how services are structured. The implications are both uplifting and depressing. On the one hand, economics is not destiny - countries do not need to wait for economic development in order to build health systems which protect and serve their populations. On the other hand, economic development is also not a guarantee of increased population health and health security. Political conflict ultimately decides who is covered and to what degree they are covered.

The dissertation therefore contributes to the wide-ranging debate of the role of partisanship. While some suggest that the role of partisanship is reversed in Eastern Europe (Tavits & Letki, 2009), the dissertation argues that left and right parties behave in expected patterns. When it comes to healthcare, uncharacteristic behaviors are seen when healthcare is de-prioritized and given to junior coalition partners, such as the Bulgarian Stanishev cabinet.

The broader implications of these findings for the politics of welfare is that the role of partisanship should be reconsidered. As Castles (2009) and others suggest, the politics of different social policies are likely to be divergent. The implication of the approach used here is that scholars should identify the constituents of different types of policies (those who directly benefit), and the degree to which a policy has broad popular support, in order to see how these groups map onto existing voter groups of parties. The findings of this dissertation suggest that the analysis of constituencies specific to certain policies can explain why parties choose to expend resources on certain policies and not others.

A related theoretical contribution is that the mechanism of partisanship is not unidirectional, from voters to parties, but can travel the other way around as well. Voters can take cues from parties framing health reforms as well as from their perception of parties' ability to deliver on reforms. While more research is needed in order to model these effects concretely, the analysis here suggests that voters are less likely to punish non-programmatic parties which fail to deliver on policy promises. Parties also appear able to avoid blame by framing retrenchment in terms of efficiency gains for the system. Further research can further probe the complex interactions between existing voter preferences and values, and parties' abilities to utilize such values in order to promote policies.

The third area of contribution of the dissertation relates to using mixed methods

in order to answer the question of the roots of health politics from different angles, while taking into account the complex-causality dynamics which characterize policy-making. By using a set-theoretic research design, the dissertation was able to specify the conditions under which left and right cabinets expand or retrench access to healthcare. Statistical survey analysis was able to corroborate the foundations of health partisanship by showing the plausibility of issue-voting and the extent of health solidarity. Case studies then showed how parties pick up on voting dynamics and navigate their political realities and institutional environment in order to reach policy action.

A final contribution is empirical, by studying cases which are less represented in the literature. This begs the question of whether the politics of Eastern and Southern Europe are similar to the more often studied Western European countries. This dissertation has argued that health politics are different from those of other policies, and likely different between the two sets of countries. In addition to the particularities of healthcare, there are political and institutional features that set ESE apart. Political instability, clientelistic linkages and their more limited democratic experience meant that traditional ties between social classes and parties play out different. However, this has not meant that politics is a pure struggle for power. As argued by Roberts (2009b), parties seem to be responsive to voters at least to a degree, and form policy positions accordingly, while allocating resources towards particular policies based on their perceived gain of political capital.

Limitations

Does the argument of this dissertation travel beyond the two case studies, and if so, how far? Several methodological choices were made to ensure that the argument trav-

els across the 17 cases analyzed in the sample. The nesting of causal process tracing within the QCA cross-case analysis lends support to the fact that the partisanship mechanism travels to other cases and explains the subset relations uncovered, namely the role of ideology and its interactions with linkages and other factors. Within this design the micro-analysis was performed on a pooled sample as well as the two case studies, over multiple surveys covering multiple years. This suggests that the results are robust, not being driven by particular samples or time periods, as well as particular countries. These being said, the existence of deviant cases for consistency and coverage suggest that additional factors are necessary to add to the explanatory framework.

Does the argument travel further? Should we expect health partisanship to play out similarly in other cases, and if so, in which cases? This dissertation has argued that the foundation of health partisanship rests on the extent of health solidarity, and the degree of party responsiveness. The variation in these key factors is likely to determine the applicability of the argument in other cases. However, the cases in this analysis were chosen with certain scope conditions in mind, in order to isolate these variables. Membership in the EU, relatively stable democratic practices, having a functioning economy and a middle to high level of economic development, are just a few of the common characteristics of the countries in the sample. Another is the relative ethnic homogeneity and lack of direct ethnic conflict. For ethnically divided societies, Selway (2015) makes a convincing argument that nature of the ethnic cleavage and its interaction with the electoral system best explains whether countries adopt universal health systems. However, even in such cases health solidarity and party responsiveness likely still play a role. What is less clear is how important this role will be, and how it will depend on other factors. As the QCA analysis demonstrates, even among the cases studied here, there is a degree of heterogeneity in the way in which partisanship influences policy.

A second limitation of external validity surrounds the existing health system arrangements. Although there are considerable differences among the health systems analyzed here, there are also certain similarities which set them apart. With the possible exception of Cyprus, all the cases discussed here primarily rely on publicly run and funded healthcare. With the notable exception of Bulgaria, the cases of this study have achieved and maintained full, universal coverage, unlike many countries in Latin America (Pribble, 2013) and elsewhere. As the QCA analysis suggests, existing arrangements of health systems are important for determining future changes. This is also in line with broader research in welfare studies which find that welfare programs can create their own constituencies (Pierson, 1994), and the broader institutionalist arguments which emphasize path dependence (Cerami & Vanhuysse, 2009). This is not to say that past arrangements determine the future, but rather that such characteristics will interact with political factors.

The dissertation also has several limitations surrounding causality. While I trace the mechanism from public opinion, through party preferences and to policy outcomes, direct causality between public opinion and policy outcome cannot be claimed. More detailed data on attitudes to policy across time and countries is needed in order to build convincing cross-level statistical models of the effect of public opinion on policy outcomes.

The QCA analysis has its own set of limitations. The imperfect consistency and coverage scores, and more importantly the cases which are deviant in kind, suggest that further refinement is needed to the theoretical model presented here. Additional conditions and data will be needed in order to separate non-fitting cases and understand what makes them different. An additional limitation relates to time. Data availability limited the analysis to only four time periods as opposed to covering all the cabinets in the time period. Moreover, while consistency scores do not seem

to vary substantially across time, temporal dynamics would benefit from additional modeling.

Related Arguments and Unanswered Questions

Complications to health solidarity and salience

Health solidarity and related measures warrant further investigation and conceptualization. Although useful and comparable, the question as asked by both the ESS and the ISSP likely do not capture all of the underlying attitudes towards healthcare, nor do they tell us how individuals view specific policies. One solution could be to look at survey items regarding specific policies. While this would link public opinion and policy in a clearer manner, it would mean losing comparability across countries and missing out on other dimensions of the attitude. Another approach is to use multiple questions on health attitudes in order to uncover underlying attitudes that any one single question cannot capture. A preliminary factor analysis conducted during this study revealed three such dimensions, using questions from the 2011 ISSP, which focused on health. One dimension seemed to capture the willingness to support public health campaigns. A second dimension seemed to capture values of fairness and solidarity, while a third seemed to capture whether individuals with damaging health behavior and migrants should have access to health services. However, the results were not deemed robust, the three factors forming weak uniform scales. Moreover, lack of strong existing theory regarding such underlying values prevented from incorporating the results in the final analysis. However, further exploration is likely to add to our understanding of values regarding healthcare and their impact.

Partisanship and Linkages

Another open question for healthcare partisanship is how health solidarity relates to shifting electoral constituencies. Recent literature on developed capitalist economies suggests that the cultural dimension to voting is gaining increasing importance over the economic dimension, shifting working class voters to right wing populist parties and educated wealthy voters to left-wing parties (Häusermann & Kriesi, 2015; Gingrich & Häusermann, 2015). The implications of such a shift are as of yet unclear for healthcare politics. Nor is it clear if such a shift is taking place in the cases studied here. What the findings of this dissertation suggest is that overall shifts in electoral bases of parties might not matter as much as which voters are solidaristic, since healthcare attitudes seem to have a separate effect on voting that parties can pick up on. However, it is likely that these two phenomena interact, as parties try to keep account of both their base and potential issue-voters on healthcare.

A further area of exploration relates to party responsiveness. As documented in this dissertation, there are multiple factors which affect party responsiveness. While linkages seem to be the most relevant factor for the cases studied here, it is likely that other factors play a larger role in other cases. Other factors likely play a role even in the cases studied here. For example, Binzer Hobolt and Klemmensen (2008) suggests that political competition increases responsiveness. And indeed, the analysis here suggests that another important difference between the Czech and Bulgarian socialists is that the Czech ones faced competition from the communists on the left, while the BSP had far less competition from the left. Clientelism itself opens up several additional avenues of research in healthcare. Afonso et al. (2015) show that clientelistic parties are more resistant to austerity because they would lose control of resources they need for patronage. Healthcare resources can also, in principle, be used for patronage. Allocating funding for providers and appointing administrative staff are just

some of the ways in which parties can use health policy to reward loyalists. We would therefore expect clientelistic parties to be more reticent to decentralize such decisions to local government. The evidence here is so far mixed - while the Czech system is more decentralized than the Bulgarian one, so is the more clientelistic Romanian system (Vladescu, Scintee, Olsavszky, Hernandez-Quevedo, & Sagan, 2016).

Interest Groups

Healthcare is mostly comprised of services rather than cash benefits, unlike policies such as unemployment or pensions (Bambra, 2005b). This means that the effects of a particular policy can be less clear and less visible to most voters. While citizens can be sensitive to some types of changes, other healthcare changes are often more technical than changes to unemployment or pension benefits and the effects are often delayed and harder to spot; for example, privatizing hospitals, or decentralization of insurance funds, or the introduction of DRGs, produce results that are not immediately visible for patients, with unclear winners and losers. Therefore, in several types of policies, interest groups like epistemic communities (Löblová, 2018), doctors (Roberts, 2009a), or other interest groups (Oliver & Mossialos, 2005) can take over the policy process. Often, they design policy themselves, something that workers' unions or pensioners organization usually do not have the privilege of doing. The same dynamic can also allow parties greater leeway to pass policies with effects that are hidden to citizens. This is most clearly seen in Czechia, where medical professionals took initial command over the health reforms after 1989.

The role of doctors deserves special attention. Particularly in Eastern Europe, doctors seem to have large influence on policy making, holding many parliamentary seats and often holding top positions in the Ministry of Health (Vladescu et al., 2008). The role of doctors is, however, not well understood. The common assumption is that doctors

prefer private insurance systems and fee-for-service payments in order to maximize their autonomy and income (Roberts, 2009a; Immergut, 1992). While this seems to hold for WE, it seems that the evidence is mixed for the cases studied here. In Czechia doctors initially pushed for competition and privatization of outpatient care, while later opposing user fees and hospital privatization. In Portugal and Romania it seems that they mostly blocked changes towards privatization (Oliveira et al., 2005; Vladescu & Astarastoae, 2012). What is the cause of such different behavior? One reason might be that doctors are divided between insiders, who benefit from existing systems and prefer centralized public healthcare, while outsiders would prefer marketization.

Fiscal pressure and conditionality

Fiscal pressure can operate not only through domestic pressure, but also through external institutions, such as the IMF. Indeed, many of the cases of this study have received loans and bailouts from institutions such as the European Commission and the International Monetary Fund, which came with harsh austerity measures as conditions. Greece, Portugal, Cyprus all had Economic Adjustment Programs which set macroeconomic targets and sometimes explicit policies. While conditionality affected public salaries, including in the health sector, as well as the fiscal policy and a range of other economic policies, conditionality did not directly affect health access policies (Greer, 2014). While there is evidence for an effect of austerity on population health (Schrecker & Bambra, 2015; Kentikelenis et al., 2011), there is less evidence that conditionality directly affects health systems. While such programs can make recommendations (Fahy, 2012), they are not imposed in the manner that economic policy is. Ultimately governments have discretion over whether to retrench access to healthcare as a response to budget crises. The variety of responses from cases in this study are further evidence of the existence of discretion. However, the impact of

conditionality can still benefit from further research.

The Future of Health Politics

The conclusions of this dissertation are troubling in the current context. Existing research tells us that health solidarity is based, at least to a degree, on uncertainty (Jensen & Petersen, 2017). Indeed, the life-course risk literature tells us that individuals support health insurance because they do not know what risks they face. Therefore, even healthy or wealthy individuals choose to pool their risk. This mechanism will be increasingly threatened by two developments in healthcare technology. The first is the advent of personalized medicine. Detailed personal data, including genome data, can reveal (only imperfectly for now) diseases to which individuals are predisposed (Prainsack, 2018). Greater knowledge of individual risks can make healthier individuals less willing to contribute to social insurance, while decreasing the uncertainty of middle and higher income individuals and therefore their propensity to contribute to general insurance.

The second threat to solidarity is posed by the costs of new medical technologies. As genome sequencing, gene editing, targeted treatments, and sophisticated medical devices become widespread, they will increase the salience of the equity-efficiency trade-off. Public health systems will not be able to adopt new and expensive technologies while maintaining full access. As real and perceived health needs diverge among income groups, solidarity among those who can afford expensive treatment will decrease towards those who cannot. Health systems will need to adapt and parties will need to make decisions based on the trade-off. If they choose to maintain access, they will risk losing wealthier voters who seek expensive new technologies. If they choose to adopt new technologies and maintain wealthier contributors, they will

need to restrict usage of such treatments by erecting financial and regulatory barriers to access. This dynamic is already at play, as this dissertation has argued. The risk is that the speed of medical innovation will outpace political responsiveness to voters.

The implications of eroding solidarity are stark. Health policy may begin to resemble unemployment policies in the future, less progressive and more residual. Health insecurity is likely to increase. One possible solution is to build new bases for health solidarity, though it is unclear what they may look like. A second troubling trend the findings of this dissertation points to is that of eroding linkages between voters and parties. Data from the DALP project suggest that in many of the countries of Easter and Southern Europe, clientelistic practices are more prevalent now than they were 10 years ago (Kitschelt, 2013). Populism, democratic backsliding and a shift of political conflict from the economic to the cultural dimension are likely to add to this, making parties less responsive to voters on social policy issues.

Healthcare will further be impacted by two related trends: automation and population aging. As the demographics of Europe shift to an ever larger proportion of elderly, healthcare and particularly long-term care will grow as sectors. Coupled with the growing automation of manufacturing sectors, this will push more and more individuals into service jobs related to healthcare (Oh, 2017). What this means is that we are likely to see a growth of the salience of health policy and a more direct involvement of worker groups.

These developments are not unavoidable. This dissertation has argued that political parties can be held to account on health policy. Voters, civil society, and opposition parties have multiple avenues of contesting policy and putting pressure on decision makers. Ultimately, when parties face competition and see their voting base erode, they need to adapt to popular demand for social policy.

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A Ideal Type Scores Full Table

Table A.1: Ideal Type Analysis, Full Table Fuzzy Set Scores

Country	Year	Fin	Prov	Reg	FPR	FP∼R	F∼P∼R	F∼PR	∼FPR	∼FP∼R	∼F∼P∼R
Bulgaria	1999	0.26	0.76	0.66	0.26	0.26	0.24	0.24	0.66	0.34	0.24
Bulgaria	2003	0.18	0.69	0.33	0.18	0.18	0.18	0.31	0.33	0.67	0.31
Bulgaria	2007	0.13	0.70	0.00	0.00	0.13	0.13	0.00	0.00	0.70	0.30
Bulgaria	2011	0.09	0.64	0.00	0.00	0.09	0.09	0.00	0.00	0.64	0.36
Croatia	1999	0.81	0.70	0.33	0.33	0.67	0.30	0.30	0.19	0.19	0.19
Croatia	2004	0.67	0.68	0.33	0.33	0.67	0.32	0.32	0.33	0.33	0.32
Croatia	2008	0.76	0.73	0.33	0.33	0.67	0.27	0.27	0.24	0.24	0.24
Croatia	2012	0.76	0.69	0.33	0.33	0.67	0.31	0.31	0.24	0.24	0.24
Cyprus	2003	0.05	0.21	0.33	0.05	0.05	0.05	0.05	0.33	0.21	0.67
Cyprus	2008	0.05	0.20	0.33	0.05	0.05	0.05	0.05	0.33	0.20	0.67
Cyprus	2012	0.05	0.22	0.33	0.05	0.05	0.05	0.05	0.33	0.22	0.67
Czechia	2000	0.86	0.49	0.66	0.49	0.34	0.34	0.51	0.14	0.14	0.14
Czechia	2004	0.85	0.61	0.66	0.61	0.34	0.34	0.39	0.15	0.15	0.15
Czechia	2008	0.72	0.59	0.66	0.59	0.34	0.34	0.41	0.28	0.28	0.28
Czechia	2012	0.75	0.53	0.66	0.53	0.34	0.34	0.47	0.25	0.25	0.25
Estonia	2000	0.60	0.48	0.33	0.33	0.48	0.52	0.33	0.33	0.40	0.40
Estonia	2004	0.58	0.38	0.00	0.00	0.38	0.58	0.00	0.00	0.38	0.42
Estonia	2008	0.63	0.71	0.00	0.00	0.63	0.29	0.00	0.00	0.37	0.29
Estonia	2012	0.65	0.69	0.00	0.00	0.65	0.31	0.00	0.00	0.35	0.31
Greece	2000	0.10	0.87	0.66	0.10	0.10	0.10	0.10	0.66	0.34	0.13
Greece	2004	0.17	0.87	0.66	0.17	0.17	0.13	0.13	0.66	0.34	0.13
Greece	2008	0.16	0.87	0.66	0.16	0.16	0.13	0.13	0.66	0.34	0.13
Greece	2012	0.34	0.84	0.33	0.33	0.34	0.16	0.16	0.33	0.66	0.16
Hungary	1999	0.45	0.67	0.33	0.33	0.45	0.33	0.33	0.33	0.55	0.33
Hungary	2004	0.42	0.64	0.33	0.33	0.42	0.36	0.33	0.33	0.58	0.36
Hungary	2008	0.36	0.62	0.33	0.33	0.36	0.36	0.33	0.33	0.62	0.38
Hungary	2012	0.31	0.58	0.33	0.31	0.31	0.31	0.31	0.33	0.58	0.42
Italy	2000	0.44	0.89	0.66	0.44	0.34	0.11	0.11	0.56	0.34	0.11
Italy	2004	0.54	0.88	0.66	0.54	0.34	0.12	0.12	0.46	0.34	0.12
Italy	2008	0.58	0.88	0.66	0.58	0.34	0.12	0.12	0.42	0.34	0.12
Italy	2014	0.56	0.86	0.66	0.56	0.34	0.14	0.14	0.44	0.34	0.14
Latvia	2000	0.06	0.95	0.66	0.06	0.06	0.05	0.05	0.66	0.34	0.05
Latvia	2004	0.12	0.94	0.66	0.12	0.12	0.06	0.06	0.66	0.34	0.06
Latvia	2008	0.20	0.94	0.66	0.20	0.20	0.06	0.06	0.66	0.34	0.06
Latvia	2010	0.20	0.94	0.66	0.20	0.20	0.06	0.06	0.66	0.34	0.06
Lithuania	2000	0.39	0.68	0.66	0.39	0.34	0.32	0.32	0.61	0.34	0.32

Table A.1: Ideal Type Analysis, Full Table Fuzzy Set Scores

Country	Year	Fin	Prov	Reg	FPR	FP∼R	F∼P∼R	F∼PR	∼F∼PR	∼FPR	∼FP∼R	∼F∼P∼R
Lithuania	2004	0.29	0.68	0.33	0.29	0.29	0.29	0.29	0.32	0.33	0.67	0.32
Lithuania	2008	0.42	0.65	0.33	0.33	0.42	0.35	0.33	0.33	0.33	0.58	0.35
Lithuania	2012	0.33	0.65	0.33	0.33	0.33	0.33	0.33	0.33	0.33	0.65	0.35
Malta	2000	0.33	0.83	0.66	0.33	0.33	0.17	0.17	0.17	0.66	0.34	0.17
Malta	2004	0.34	0.84	0.66	0.34	0.34	0.16	0.16	0.16	0.66	0.34	0.16
Malta	2008	0.23	0.82	0.66	0.23	0.23	0.18	0.18	0.18	0.66	0.34	0.18
Malta	2014	0.35	0.81	0.66	0.35	0.34	0.19	0.19	0.19	0.65	0.34	0.19
Poland	2000	0.35	0.93	0.00	0.00	0.35	0.07	0.00	0.00	0.00	0.65	0.07
Poland	2004	0.39	0.93	0.00	0.00	0.39	0.07	0.00	0.00	0.00	0.61	0.07
Poland	2008	0.47	0.39	0.00	0.00	0.39	0.47	0.00	0.00	0.00	0.39	0.53
Poland	2012	0.46	0.35	0.00	0.00	0.35	0.46	0.00	0.00	0.00	0.35	0.54
Portugal	2000	0.42	0.94	0.66	0.42	0.34	0.06	0.06	0.06	0.58	0.34	0.06
Portugal	2004	0.45	0.94	0.66	0.45	0.34	0.06	0.06	0.06	0.55	0.34	0.06
Portugal	2008	0.39	0.94	0.66	0.39	0.34	0.06	0.06	0.06	0.61	0.34	0.06
Portugal	2011	0.36	0.94	0.66	0.36	0.34	0.06	0.06	0.06	0.64	0.34	0.06
Romania	2000	0.66	0.82	0.33	0.33	0.66	0.18	0.18	0.18	0.33	0.34	0.18
Romania	2004	0.76	0.82	0.33	0.33	0.67	0.18	0.18	0.18	0.24	0.24	0.18
Romania	2008	0.69	0.77	0.33	0.33	0.67	0.23	0.23	0.23	0.31	0.31	0.23
Romania	2012	0.65	0.75	0.00	0.00	0.65	0.25	0.00	0.00	0.00	0.35	0.25
Slovakia	1999	0.85	0.40	0.66	0.40	0.34	0.34	0.60	0.15	0.15	0.15	0.15
Slovakia	2005	0.51	0.39	0.33	0.33	0.39	0.51	0.33	0.33	0.33	0.39	0.49
Slovakia	2008	0.38	0.34	0.33	0.33	0.34	0.38	0.33	0.33	0.33	0.34	0.62
Slovakia	2011	0.46	0.31	0.33	0.31	0.31	0.46	0.33	0.33	0.31	0.31	0.54
Slovenia	2000	0.67	0.95	0.00	0.00	0.67	0.05	0.00	0.00	0.00	0.33	0.05
Slovenia	2004	0.64	0.95	0.00	0.00	0.64	0.05	0.00	0.00	0.00	0.36	0.05
Slovenia	2009	0.66	0.95	0.33	0.33	0.66	0.05	0.05	0.05	0.33	0.34	0.05
Slovenia	2011	0.66	0.95	0.33	0.33	0.66	0.05	0.05	0.05	0.33	0.34	0.05
Spain	2000	0.46	0.91	0.33	0.33	0.46	0.09	0.09	0.09	0.33	0.54	0.09
Spain	2004	0.49	0.91	0.33	0.33	0.49	0.09	0.09	0.09	0.33	0.51	0.09
Spain	2008	0.54	0.90	0.33	0.33	0.54	0.10	0.10	0.10	0.33	0.46	0.10
Spain	2012	0.47	0.91	0.33	0.33	0.47	0.09	0.09	0.09	0.33	0.53	0.09

B QCA Tables and Additional Analysis

Financing Analysis

Table B.1 shows the solution for expanding financing. The third is identical to the general decommodification path, suggesting that the cases were driving the results in both. The similar configuration of left-wing and large deficit-free programmatic cabinets is present. However, now the Czech cases are deviant - they do not show the outcome.

The first two solutions terms overlap with the third, yet have more deviant cases (seen in the lower consistency scores). They suggest that veto-free systems and existing expansive systems are an INUS conditions in combination with left-wing governments and absence of large deficits. The fourth solution term has considerably lower coverage and contains the Meciar VI cabinet, who is in fact a deviant case in degree.

Table B.2 shows 4 paths leading to retrenching access in financing. The first two, which overlap considerably, contain combinations of right-wing cabinets with existing low levels of financial access and clientelistic systems, while the last shows right-wing governments in combination with veto-ridden systems and presence of large budget deficits.

Table B.1: Sufficiency. Expanding Financing Access

	cons.	PRI	covS	covU	cases
FINDEC*right*def	0.85	0.58	0.54	0.03	Milanovic,Racan I,Prodi II; Zeman, Spidla,Drnovsek V,Drnovsek VI, Pahor I,Zapatero I; Nastase I
veto*right*def	0.81	0.50	0.57	0.03	Papadopoulos II,Christofias IV, Simitis II,Simitis III,D'Alema I, Brazauskas I,Kirkilas I; Milanovic, Racan I,Prodi II; Zeman,Spidla, Drnovsek V,Drnovsek VI, Pahor I,Zapatero I
right*def*PROG	0.89	0.62	0.52	0.01	Miller I,Fico I; Zeman,Spidla, Drnovsek V,Drnovsek VI, Pahor I,Zapatero I
FINDEC*veto*DEF*PROG	0.91	0.50	0.35	0.05	Meciar VI
Solution	0.81	0.55	0.70		

Figure B.1: Sufficiency Analysis - Expanding Access in Financing

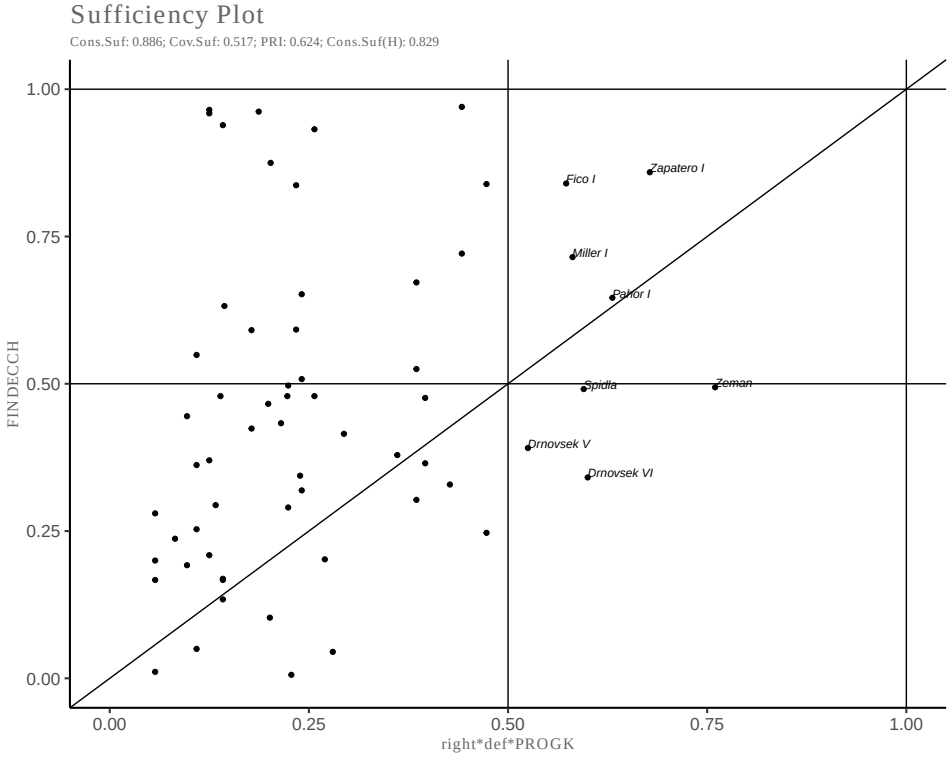


Table B.2: Retrenching Access in Financing

	cons.	PRI	covS	covU	cases
findec*RIGHT	0.81	0.60	0.63	0.09	Klerides IV,Kubilius,Kubilius III; Berzins,Repse,Godmanis II,Aznar I, Aznar II; Karamanlis Kos II, Papademos; Dombrovskis I,Rajoy; Borisov,Kostov,Sakskoburggotski, Orban I,Orban II,Barroso; Buzek I, Kaczynski,Tusk I,Radicova I
RIGHT*prog	0.82	0.61	0.61	0.07	Klerides IV,Kubilius,Kubilius III; Karamanlis Kos II,Papademos; Borisov,Kostov,Sakskoburggotski, Orban I,Orban II,Barroso; Sanander I, Sanander II,Monti,Berlusconi II; Vasile,Tariceanu III; Boc III
findec*VETO*prog	0.87	0.68	0.46	0.04	Stanishev,Guterres II,Socrates I; Medgyessy,Gyurcsany II,Socrates II; Borisov,Kostov,Sakskoburggotski, Orban I,Orban II,Barroso
VETO*RIGHT*DEF	0.92	0.65	0.39	0.02	Boc III; Dzurinda II
Solution	0.80	0.60	0.79		

Table B.3: Retrenching Access in Provision

	cons.	PRI	covS	covU	cases
prodec*VETO*PROG	0.95	0.84	0.30	0.01	Fico I; Kaczynski,Tusk I, Radicova I; Dzurinda II
prodec*RIGHT*PROG	0.94	0.81	0.34	0.04	Laar II,Kalls; Kaczynski, Tusk I,Radicova I; Dzurinda II
VETO*RIGHT*prog	0.94	0.75	0.50	0.12	Borisov,Kostov,Boc III, Orban I,Orban II,Barroso,Vasile, Tariceanu III; Sakskoburggotski
VETO*DEF*prog	0.96	0.73	0.38	0.03	Medgyessy,Gyurcsany II, Socrates II; Boc III
Solution	0.92	0.76	0.64		

Provision and Regulation Analyses

The analysis of the subdimensions of provision and regulatin contain only the analysis of retrenching access. The small number of observations showing expansion of access in provision and regulation meant that they cannot be explained with current data.

The first path in table B.3 shows three Slovak governments (two right wing and one left wing) along with two of the Polish cabinets. Together with second path, these show instances of programmatic left and right wing governments retrenching access in provision. The third shows the familiar set of Bulgarian, Slovak and Romanian governments: non-programatic, right-wing in veto-ridden systems, while the last shows non-programatic cabinets in veto-ridden systems under a large fiscal deficit. Figure B.2 shows the third path in more detail. What can be seen si that there are 4 cases that are true logical contradictions - that do not present the outcome.

Table B.4 shows the solution covering four out of the seven governments who retrenched regulation access.

Figure B.2: Sufficiency - Retrenching Access in Provision

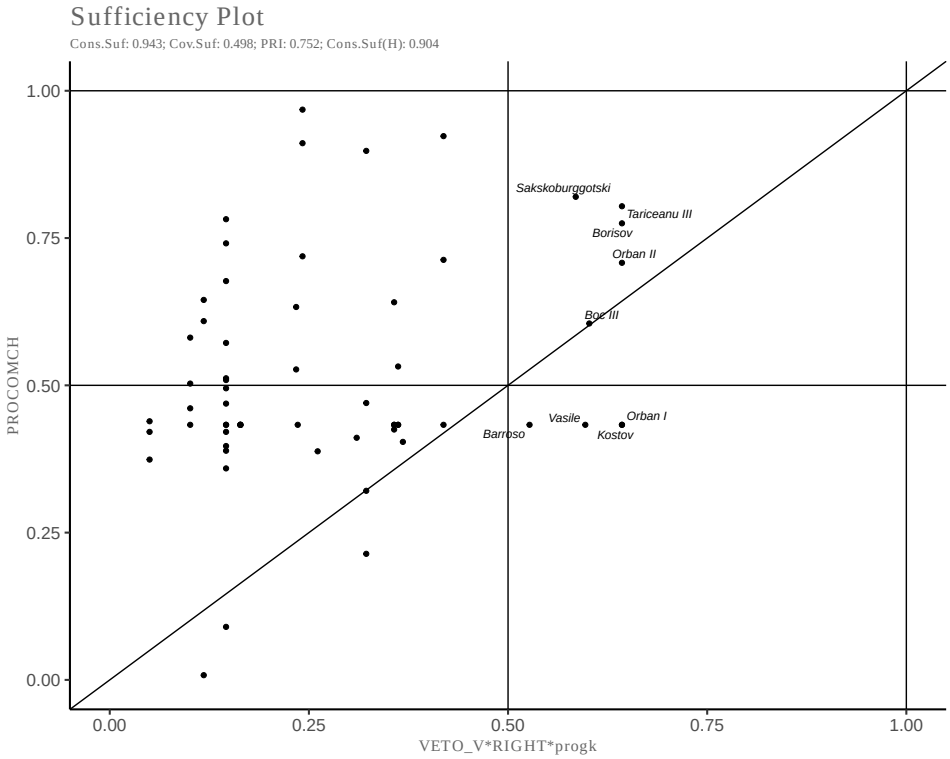


Table B.4: Retrenching Access in Regulation

	cons.	PRI	covS	covU	cases
regdec*VETO*RIGHT*DEF	0.97	0.80	0.50	0.05	Boc III; Dzurinda II
regdec*RIGHT*DEF*prog	0.98	0.87	0.52	0.07	Papademos; Boc III
Solution	0.97	0.81	0.58		

Panel Structure Tests and Truth Tables

Table B.5: Consistency Distance Scores for Main Analyses

Analysis	Pooled Consistency	Distance Between to Pooled	Distance Within to Pooled
Necessity - Change towards Decommodification	0.911	0.026	0.026
Necessity - Change towards Regulation Commodification	0.9	0.037	0.026
Sufficiency - Change towards Decommodification	0.868	0.022	0.048
	0.920	0.033	0.030
Sufficiency - Change towards Commodification	0.915	0.039	0.020
	0.901	0.020	0.027
	0.949	0.024	0.018
Sufficiency - Change towards Financing Decommodification	0.854	0.046	0.034
	0.807	0.037	0.041
	0.886	0.041	0.027
	0.907	0.017	0.029
Sufficiency - Change towards Financing Commodification	0.812	0.071	0.039
	0.823	0.06	0.034
	0.869	0.043	0.03
	0.919	0.030	0.027
Sufficiency - Change towards Provision Commodification	0.953	0.03	0.021
	0.942	0.022	0.02
	0.943	0.025	0.021
	0.962	0.007	0.02
Sufficiency - Change towards Regulation Commodification	0.969	0.02	0.01
	0.981	0.012	0.009

Table B.6: Consistency Scores Across Time Periods

Analysis	Pooled Consistency	Period 1 2000	Period 2 2004	Period 3 2008	Period 4 2012
Necessity - Change towards Decommodification	0.911	0.983	0.884	0.927	0.857
Necessity - Change towards Regulation Commodification	0.9	0.789	0.888	0.962	0.941
Sufficiency - Change towards Decommodification	0.868 0.920	0.959 0.902	0.819 0.816	0.972 0.904	0.950 0.849
Sufficiency - Change towards Commodification	0.915 0.901 0.949	0.915 0.901 0.949	0.935 0.916 0.943	0.948 0.867 0.877	0.790 0.861 0.961
Sufficiency - Change towards Financing Decommodification	0.854 0.807 0.886 0.907	0.742 0.755 0.789 0.897	0.833 0.744 0.855 0.870	0.914 0.849 0.949 0.954	0.949 0.885 0.968 0.912
Sufficiency - Change towards Financing Commodification	0.812 0.823 0.869 0.919	0.896 0.833 0.852 0.915	0.674 0.701 0.850 0.867	0.719 0.772 0.783 0.860	0.944 0.968 0.990 0.997
Sufficiency - Change towards Provision Commodification	0.953 0.942 0.943 0.962	1 0.963 0.867 0.98	0.862 0.886 0.945 0.961	0.956 0.927 0.959 0.942	1 1 1 0.966
Sufficiency - Change towards Regulation Commodification	0.969 0.981	1 1	1 1	1 1	0.909 0.944

Table B.7: Truth Table - Expanding Health Access

	DECOMM	VETO_V	RIGHT	DEF	PROGK	OUT	n	incl	PRI	cases
18	1.00	0.00	0.00	0.00	1.00	1.00	5.00	0.93	0.66	Spidla,Drnovsek V,Drnovsek VI,Pahor I,Zapatero I
10	0.00	1.00	0.00	0.00	1.00	1.00	2.00	0.92	0.38	Miller I,Fico I
25	1.00	1.00	0.00	0.00	0.00	1.00	3.00	0.88	0.50	Guterres II,Socrates I,Nastase I
17	1.00	0.00	0.00	0.00	0.00	1.00	6.00	0.87	0.46	Milanovic,Racan I,Simitis II,Simitis III,D'Alema I,Prodi II
27	1.00	1.00	0.00	1.00	0.00	0.00	1.00	0.90	0.31	Socrates II
24	1.00	0.00	1.00	1.00	1.00	0.00	2.00	0.88	0.30	Dombrovskis I,Rajoy
16	0.00	1.00	1.00	1.00	1.00	0.00	1.00	0.87	0.15	Dzurinda II
23	1.00	0.00	1.00	1.00	0.00	0.00	1.00	0.87	0.24	Karamanlis Kos II
11	0.00	1.00	0.00	1.00	0.00	0.00	2.00	0.86	0.21	Medgyessy,Gyurcsany II
6	0.00	0.00	1.00	0.00	1.00	0.00	4.00	0.86	0.35	Ansip II,Laar II,Kalls,Ansip IV
15	0.00	1.00	1.00	1.00	0.00	0.00	1.00	0.86	0.20	Boc III
7	0.00	0.00	1.00	1.00	0.00	0.00	1.00	0.86	0.19	Papademos
5	0.00	0.00	1.00	0.00	0.00	0.00	2.00	0.84	0.28	Klerides IV,Kubilius III
21	1.00	0.00	1.00	0.00	0.00	0.00	5.00	0.84	0.35	Sanander I,Sanander II,Monti,Berlusconi II,Kubilius
9	0.00	1.00	0.00	0.00	0.00	0.00	1.00	0.84	0.24	Stanishev
14	0.00	1.00	1.00	0.00	1.00	0.00	4.00	0.84	0.18	Buzek I,Kaczynski,Tusk I,Radicova I
22	1.00	0.00	1.00	0.00	1.00	0.00	8.00	0.83	0.38	Topolanek II,Necas I,Berzins,Repse,Godmanis II,Jansa I,Aznar I,Aznar II
29	1.00	1.00	1.00	0.00	0.00	0.00	4.00	0.83	0.33	Kostov,Barroso,Vasile,Tariceanu III
1	0.00	0.00	0.00	0.00	0.00	0.00	4.00	0.83	0.25	Papadopoulos II,Christofias IV,Brazauskas I,Kirkilas I
13	0.00	1.00	1.00	0.00	0.00	0.00	4.00	0.79	0.20	Borisov,Sakskoburggotski,Orban I,Orban II
2	0.00	0.00	0.00	0.00	1.00	1.00	0.00	-	-	-
3	0.00	0.00	0.00	1.00	0.00	0.00	0.00	-	-	-
4	0.00	0.00	0.00	1.00	1.00	0.00	0.00	-	-	-
8	0.00	0.00	1.00	1.00	1.00	0.00	0.00	-	-	-
12	0.00	1.00	0.00	1.00	1.00	0.00	0.00	-	-	-
19	1.00	0.00	0.00	1.00	0.00	0.00	0.00	-	-	-
20	1.00	0.00	0.00	1.00	1.00	0.00	0.00	-	-	-
26	1.00	1.00	0.00	0.00	1.00	1.00	0.00	-	-	-
28	1.00	1.00	0.00	1.00	1.00	0.00	0.00	-	-	-
30	1.00	1.00	1.00	0.00	1.00	0.00	0.00	-	-	-
31	1.00	1.00	1.00	1.00	0.00	0.00	0.00	-	-	-
32	1.00	1.00	1.00	1.00	1.00	0.00	0.00	-	-	-

Table B.8: Truth Table - Retrenching Health Access

	DECOMM	VETO_V	RIGHT	DEF	PROGK	OUT	n	incl	PRI	cases
16	0.00	1.00	1.00	1.00	1.00	1.00	1.00	0.97	0.80	Dzurinda II
15	0.00	1.00	1.00	1.00	0.00	1.00	1.00	0.96	0.78	Boc III
7	0.00	0.00	1.00	1.00	0.00	1.00	1.00	0.95	0.74	Papademos
23	1.00	0.00	1.00	1.00	0.00	1.00	1.00	0.95	0.70	Karamanlis Kos II
14	0.00	1.00	1.00	0.00	1.00	1.00	4.00	0.94	0.71	Buzek I,Kaczynski,Tusk I,Radicova I
13	0.00	1.00	1.00	0.00	0.00	1.00	4.00	0.93	0.74	Borisov,Sakskoburggotski,Orban I,Orban II
5	0.00	0.00	1.00	0.00	0.00	1.00	2.00	0.91	0.60	Klerides IV,Kubilius III
27	1.00	1.00	0.00	1.00	0.00	0.00	1.00	0.95	0.66	Socrates II
11	0.00	1.00	0.00	1.00	0.00	0.00	2.00	0.94	0.65	Medgyessy,Gyurcsany II
9	0.00	1.00	0.00	0.00	0.00	0.00	1.00	0.92	0.65	Stanishev
10	0.00	1.00	0.00	0.00	1.00	0.00	2.00	0.92	0.47	Miller I,Fico I
1	0.00	0.00	0.00	0.00	0.00	0.00	4.00	0.90	0.60	Papadopoulos II,Christofias IV,Brazauskas I,Kirkilas I
29	1.00	1.00	1.00	0.00	0.00	0.00	4.00	0.90	0.61	Kostov,Barroso,Vasile,Tariceanu III
24	1.00	0.00	1.00	1.00	1.00	0.00	2.00	0.90	0.45	Dombrovskis I,Rajoy
6	0.00	0.00	1.00	0.00	1.00	0.00	4.00	0.88	0.51	Ansip II,Laar II,Kalls,Ansip IV
25	1.00	1.00	0.00	0.00	0.00	0.00	3.00	0.86	0.44	Guterres II,Socrates I,Nastase I
21	1.00	0.00	1.00	0.00	0.00	0.00	5.00	0.86	0.47	Sanander I,Sanander II,Monti,Berlusconi II,Kubilius
17	1.00	0.00	0.00	0.00	0.00	0.00	6.00	0.83	0.35	Milanovic,Racan I,Simitis II,Simitis III,D'Alema I,Prodi II
18	1.00	0.00	0.00	0.00	1.00	0.00	5.00	0.81	0.19	Spidla,Drnovsek V,Drnovsek VI,Pahor I,Zapatero I
22	1.00	0.00	1.00	0.00	1.00	0.00	8.00	0.81	0.35	Topolanek II,Necas I,Berzins,Repse,Godmanis II,Jansa I,Aznar I,Aznar II
2	0.00	0.00	0.00	0.00	1.00	0.00	0.00	-	-	-
3	0.00	0.00	0.00	1.00	0.00	1.00	0.00	-	-	-
4	0.00	0.00	0.00	1.00	1.00	0.00	0.00	-	-	-
8	0.00	0.00	1.00	1.00	1.00	0.00	0.00	-	-	-
12	0.00	1.00	0.00	1.00	1.00	0.00	0.00	-	-	-
19	1.00	0.00	0.00	1.00	0.00	1.00	0.00	-	-	-
20	1.00	0.00	0.00	1.00	1.00	0.00	0.00	-	-	-
26	1.00	1.00	0.00	0.00	1.00	0.00	0.00	-	-	-
28	1.00	1.00	0.00	1.00	1.00	0.00	0.00	-	-	-
30	1.00	1.00	1.00	0.00	1.00	0.00	0.00	-	-	-
31	1.00	1.00	1.00	1.00	0.00	0.00	0.00	-	-	-
32	1.00	1.00	1.00	1.00	1.00	0.00	0.00	-	-	-

C Chapter 7 Additional Analysis

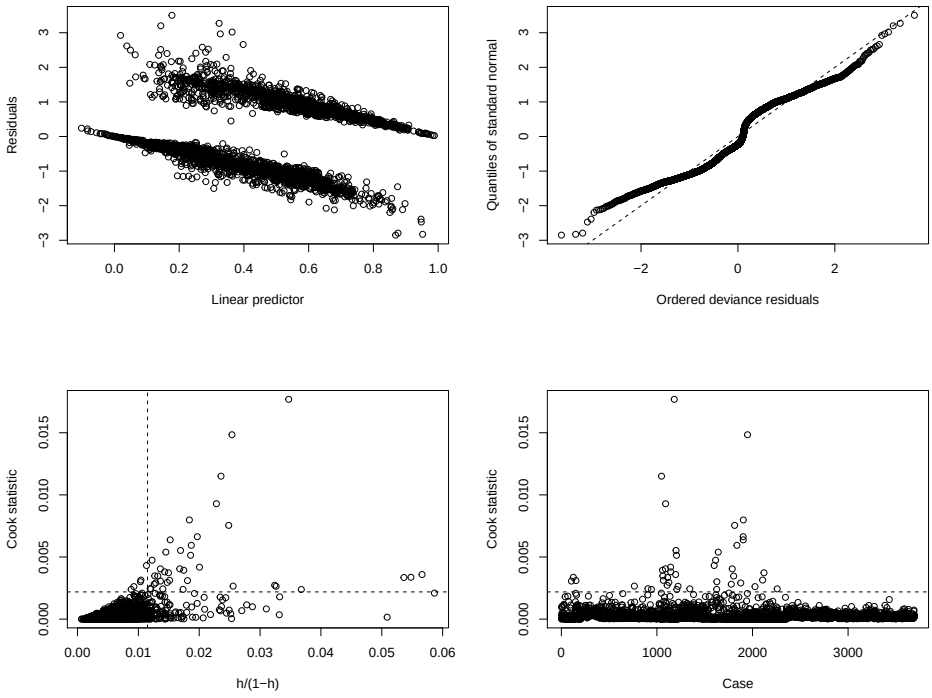
Additional Analysis and Diagnostic Plots

Table C.1: Multinomial Regression. Predictors of Support for CSSD Compared to Others, Odds Ratios, Z-values, and Significance Levels

	1996				2006				2016				
	KCSM	KDU-CSL	ODA	ODS	KCSM	KDU-CSL	ODS	SZ	ANO	KCSM	KDU-CSL	ODS	TOP09
	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(1)	(2)	(3)	(4)	(5)
Solidarity	1.019***	0.759	0.222**	0.556***	1.426**	0.938	0.788**	0.923	0.804*	1.254	0.737*	0.653***	0.800
	(4.768)	(−0.980)	(−2.319)	(−2.757)	(1.978)	(−0.377)	(−2.395)	(−0.589)	(−1.884)	(1.117)	(−1.740)	(−3.065)	(−1.470)
Income	1.423	0.599	6.875*	0.925	0.679**	1.475*	1.289**	0.981	1.195	0.673**	0.910	1.437**	1.403*
	(0.645)	(−1.295)	(1.794)	(−0.252)	(−2.371)	(1.865)	(2.103)	(−0.120)	(1.370)	(−2.249)	(−0.443)	(2.198)	(1.948)
Education	0.703*	1.273**	1.190	1.098	0.941	0.991	1.069	1.068	1.139**	0.827**	1.185**	1.218***	1.225***
	(−1.741)	(2.366)	(1.268)	(1.108)	(−0.991)	(−0.124)	(1.529)	(1.124)	(2.294)	(−2.033)	(2.010)	(3.034)	(2.961)
Age	1.059	1.005	0.977	1.002	1.014	1.034***	0.984**	0.965***	0.979***	1.048***	0.970**	0.981*	0.951***
	(1.251)	(0.217)	(−0.775)	(0.112)	(1.509)	(2.643)	(−2.362)	(−3.843)	(−2.603)	(3.659)	(−2.386)	(−1.912)	(−4.522)
Female	0.352	1.732	7.135**	0.988	0.950	1.401	1.280	1.284	0.837	0.839	1.184	0.779	1.188
	(−0.980)	(1.020)	(1.998)	(−0.028)	(−0.184)	(0.898)	(1.154)	(0.863)	(−0.762)	(−0.568)	(0.447)	(−0.864)	(0.572)
Union Member	0.598	0.145***	0.270	0.339***	1.429	1.115	0.794	0.739	0.843	1.570	0.317	0.427	0.187
	(−0.581)	(−3.435)	(−1.580)	(−2.649)	(0.726)	(0.162)	(−0.578)	(−0.540)	(−0.380)	(0.876)	(−1.064)	(−1.253)	(−1.571)
Solidarity:Income	1.018	1.481	2.681	0.777	1.211	1.005	0.922	0.841	0.836	1.166	0.896	0.949	0.954
	(0.056)	(1.062)	(1.378)	(−0.911)	(1.080)	(0.028)	(−0.774)	(−1.248)	(−1.429)	(0.767)	(−0.597)	(−0.362)	(−0.301)
(Intercept)	0.018	0.012**	0.008*	0.403	0.445	0.004***	1.336	0.986	0.473	0.244	0.030**	0.085**	0.222
	(−1.631)	(−2.404)	(−1.861)	(−0.604)	(−0.796)	(−3.738)	(0.406)	(−0.015)	(−0.828)	(−0.965)	(−2.515)	(−2.311)	(−1.352)
Akaike Inf. Crit.	445.540				1,683.823				1,792.474				

Note: *p<0.1; **p<0.05; ***p<0.01
Data from ISSP (1999, 2008, 2018)

Figure C.1: Diagnostic Plots - Pooled Model, Comparing Left to Conservative Vote



D Chapter 8 Additional Analysis

Table D.1: Likelihood of Voting for SDS as Opposed to BSP, Odds Ratios, Z-values and Significance Levels

	SDS Vote - 1996
Solidarity	0.558**
	(−1.999)
Income	0.958
	(−0.286)
Education	1.101**
	(2.087)
Age	0.953***
	(−4.672)
Female	0.485***
	(−2.814)
Union	0.895
	(−0.323)
Unemployed	1.570
	(0.769)
Religious	2.232***
	(3.057)
Intercept	24.504***
	(3.382)
Observations	444
Akaike Inf. Crit.	423.259
Note:	*p<0.1; **p<0.05; ***p<0.01
	Data from ISSP (1999)