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Reforms of Czech Hospitals in Multiple Streams Perspective: The Cases of Success and Failure

ABSTRACT: *The Czech Republic experienced a significant transformation of health care as a consequence of society-wide changes which started 30 years ago. The article aims to identify factors of successful and unsuccessful processes in giving a legislative anchor to the new organisational–legal form of Czech hospitals after 2000. There were several attempts to change the organisational–legal structure of hospitals. Just two of them succeeded to enter the decision-making phase in the Parliament, and only one led to successful approval of the Act.*
In the article, we use the Multiple Stream Framework (MSF) to explain how different streams (policy, politics and problem stream) couple and open a policy window that allows a policy change. We chose modified MSF, which broadens the concept by including the agenda-setting as well as decision-making processes and offers two coupling processes. In a comparison of two cases of the policy process, we identified the factors that cause closing the window before the agenda is set.

KEYWORDS: health policy, Multiple Streams Framework, decision-making, policy process.

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INTRODUCTION

Hospital care is an essential part of the healthcare system due to its impact on the general health of the population and as a recipient of a substantial portion of the funds reserved for health care. In 2017, in the Czech Republic, two-fifths of the funds for health care were aimed at hospital care (CSU 2019). Hospitals also perform other important functions such as creating an environment for teaching and research, generating employment opportunities or indirectly fulfilling social functions (McKee, Healy 2002).

In this respect, it is not surprising that the post-communist Czech Republic experienced competing framings as to how to change the organisational and legal status of Czech hospitals, particularly in the last 20 years. Consequently, there were many attempts to transform it (Angelovská, Hanušová 2005, CSU 2019). However, it is paradoxical that despite many attempts, only one succeeded in 2006 (Act No. 245/2006 Coll., on Public Non-profit Institutional Health Facilities). Even this Act was repealed in 2011 without any real impact because no hospital was transformed according to this law.

Existing literature does not address sufficiently the rarity of the policy change in this domain during the last 20 years. Increased interest in the hospital care field was found in the 1990s and early 2000s in response to healthcare reforms as a result of post-Soviet transformation in Central and Eastern European countries (McKee, Healy 2002, Preker, Harding 2003, Edwards, Wyatt, McKee 2004). Later, the separate topic of the transformation of hospitals rarely appeared (Saltman, Durán, Dubois 2011, Dubas-Jakóbczyk et al. 2020). Currently, the authors mention hospitals in their analyses of reforms, problems or challenges for the whole health sector (Romaniuk, Szromek 2016, Mastromarco, Stastna, Votapkova 2019, Nemec et al. 2020).

Our article compares two policy processes within two attempts to change the organisational and legal form of Czech hospitals in the new millennium. Better inquiry of the related policy process helps us better understand the resistance to the policy change and this policy domain and the nature of its policymaking process. A closer examination from the policy process perspective, and particularly from the Multiple Streams Framework (MSF), fills the gap in the healthcare field as well as tests current conceptualisations in post-communist settings of the Czech Republic and enlarges applications to the healthcare domain.

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For this purpose, the MSF (Herweg et al. 2018) represents a salient perspective because assuming ambiguity fits well to the post-communist country with transforming health care and competing framings of hospitals' transformation. We follow the recent MSF literature (Herweg et al. 2015, 2018, Zahariadis 2014) and address agenda-setting and decision-making processes that accompanied the change of Czech hospitals in the new millennium. More particularly, we aim to identify the contextual factors of success or failure of opening and exploiting the agenda and decision windows of opportunity to change the organisational–legal form of hospitals within the reporting period.

To fulfil this aim, we shortly present the MSF first. Second, we discuss our methodology. Then, we focus on the context of the reforms and inquire into the case of health policy in the Czech Republic from the MSF perspective. To emphasise this rare successful adoption, we contrast it with one more attempt to change the organisational and legal arrangement of hospitals when politicians tried to replace the legislation in the form of contributory organisation with a new legal form. We follow two periods (successful attempt in 2002–2006 and unsuccessful attempt in 2014–2017). Finally, we discuss our findings.

THEORETICAL BACKGROUND

The specificity of the health system is often highlighted in the context of the debate on the degree of public and private, mainly for-profit sector's participation. The controversy over the appropriateness of applying market principles to the provision of health care stems from the lack of consensus on whether or not health care is a common good. It was not until the middle of the 20th century that economic theory became more focused on health services. The understanding of health care, or its availability as a basic human right, began to be reflected in the institutional set-up of the health systems in many developed countries. It is often emphasised that the healthcare provision differs from other commodities. Therefore, most western democracies guarantee a minimum basic level of health care (Cukier and Thomlinson 2005, Arrow 1963, Culyer 1971, Stiglitz 2000).

According to a World Health Organisation (WHO) report (2000), three generations of health reforms can be identified in the period since World War II. In the third stage, from the 1990s onwards, political pressures, such as the transition of Central and Eastern European countries to market economies and economic pressures, led to market-oriented reforms and increased patient participation (WHO 2000).

Since the mid-20th century, European countries have fluctuated between state regulation and the market and chosen measures that have strengthened the role of one or the other sector (Saltman, Bankauskaite, Vrangbæk 2007). Several hybrid variations exist between the purely public and private provision of health services.

Since the 1980s, there has been a clear trend in European health systems to reduce the state's role and introduce market-based measures to reinforce the principle of competition in health services. Saltman, Bankauskaite and Vrangbæk (2007) cite several factors that have influenced this trend. They mention globalisation, new public management strategies, management changes influenced by information technologies with pressure for more transparency in public organisations, resource-based strategic management and pressure from voters for lower taxes, among others, which have forced governments to look for other ways to cover the rising costs of the health system.

New public management strategies emerged in healthcare provision, and they shifted the operation of healthcare facilities from a passive 'administrative' model to a managerial one (Pollitt, Bouckaert 2017). The most common model has been the restructuring of public hospitals into public enterprises with semi-independent management (e.g. UK, Portugal, Italy), but public ownership and accountability to the public in the provision of health services has been maintained (Saltman, Durán and Dubois 2011). Other new public management strategies have also been applied in the health sector. A typical example is contracting, where the management of health centres is entrusted to private non-profit and for-profit firms (e.g. in Sweden). Another approach appeared in long-term care, where patients were assigned a fixed budget from which they could draw to pay for selected services that they could choose themselves. Initially aimed at the most expensive patients, that is 5-10% of patients usually with multiple chronic conditions who consume around half of health care spendings, active disease management has gradually expanded to moderate-risk patients and healthy populations (e.g. in Germany) (Figuears and McKee 2012).

Generally, the hospitals may be divided by ownership into private for-profit, private non-profit and public ones. In the last decades, a considerable number of empirical studies on ownership of hospitals mainly targeted the financial measures including costs, profits and responsiveness to financial pressures (Sloan et al. 2001, Rosenau, Linder 2003). It covers the not only case of USA (Rosko

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2004, Bayindir, Schreyogg 2021), but also a large spectrum of European countries like Poland (Sielskas 2021), Slovakia (Nemec, Meričková, Štrangfeldová 2010), Germany (Herr, Schmitz, Augurzky 2010, Tieman and Schreyogg 2009), Austria (Czypionka 2014), Italy (Barbetta, Turati, Zago 2007), Hungary (Kornai 2009), the Netherlands (Krabbe-Alkemade, Groot, Lindeboom 2017) and Switzerland (Farsi, Filippini 2008).

Property rights theory, agency theory or public choice theories presume the positive effect of private ownership (Domberg, Jensen 1997, Sloan 2000, Tiemann, Schreyöggand Busse 2011). However, the evidence of different studies is unclear in this aspect and does not prove causal effect. The chosen methodology also plays a role. Different results illustrate it despite using the same dataset of German hospitals, but different variables and methods. As the most efficient ownership, Tieman and Schreyögghreyogg (2009) and Herr (2008) claimed public ownership to be the one, while Weblow et al. (cited in Tiemann, Schreyöggand Busse 2011) found the private for-profit firm to be the one.

Several systematic reviews confirmed the unclear relationship between ownership and performance of hospitals (Eggleston et al. 2008, Herrera et al. 2014, Hollingsworth 2008, Currie, Donaldson, Lu 2003, Tiemann, Schreyöggand Busse 2011) and pointed out that public ownership does not have to lead to lower efficiency compared to the private one, or the differences between the types of ownership is not statistically significant. The reasons lie partly in the character of the health market, which deviates from the ideal competitive market (Arrow 1963, Krabbe-Alkemade, Groot, Lindeboom 2017). Private for-profit hospitals try to reach better economic results and generate higher profit by cream skimming, that is, their specialisation in more profitable treatment and choosing of low-severity patients (Duggan 2000, Barro, Huckman, Kessler 2006, Street et al. 2010), or skimping, that is, providing fewer services and cutting the quality of care (Glaeser and Shleifer 2001).

Also, Nemec, Meričková and Štrangfeldová (2010) claimed the ownership form of hospitals not to be the primary determinant of their performance because of the important role of the concrete environment of the policy. The effect of the ownership depends on other factors, for example, subsidisation (Farsi, Filippini 2008), budget constraint (Duggan 2000), procurement (Nemec et al. 2021), reimbursement principle (Tiemann, Schregogg 2009) and the institutional context (Tynkkymen, Vrangbek 2018).

Following the changes in the hospital sector, we intended to offer a better understanding of the changes in the legal form of Czech hospitals in the new millennium. We decided to bring a new perspective and focused our research on the policy process. To explore it, we chose MSF as the core theoretical approach. The idea of multiple streams brought considerable benefit for the study of public policy in the field of policy process research (Weible, Sabatier 2018, Baumgartner 2016). Kingdon (1984) innovated the idea of garbage can model (Cohen et al. 1972) and introduced the concept of multiple streams to explain the functionality of the US health and transport policy agenda setting and specification of alternatives at the federal level of the USA. Although the number of studies based on Kingdon's multiple streams approach has been decreasing in American literature in recent years, an increasing trend in the number of studies can be seen in Europe and Asia (Rawat, Morris 2016). Different authors have operationalised or tested Kingdon's multiple streams concept (Jones et al. 2016). They often applied it to other levels of public policy in different countries and to a variety of other areas (Jones et al. 2016, Cairney and Jones 2016), mostly using qualitative perspective (Rawat, Morris 2016). The quantitative approaches still appear only in a minimum number of cases (Novotný, Satoh, Nagel 2021). Even though similar methodology and data are used to a certain extent across countries and policy areas, the authors agree that expanding research areas requires adaptation of the multiple streams concept when it is applied outside Kingdon's original scope (Kane 2016, Mukherjee, Howlett 2015).

The MSF is stemming from Kingdon's original ideas, but it turned the multiple streams concept into a full-fledged policy process framework addressing ambiguity in policymaking (Zahariadis 2003, 2014, Herweg et al. 2017, Ackrill et al. 2013). The main idea of the MSF is based on the coupling of three streams. It does not occur automatically that all three streams are ready for the connection, that is, the problem is recognised, the solution is identified and the political atmosphere favours a policy change. The right time comes when the 'window of opportunity' opens. Only then, the topic becomes a recognised problem on the governmental agenda and there is a chance that the policymakers and decision-makers start to solve it. The MSF assumes that particular policy subsystem (policy community) participants, policy entrepreneurs, use the window of opportunity to speed up the agenda they care about. Because the MSF assumes that the window opens for a relatively short time, the policy entrepreneurs play a key role at the moment, as they try to connect the three streams, linking the problems and their pet solutions with the political support, respectively. The more successful ones are usually more persistent and have closer access to policymakers (Herweg et al. 2017). At the same time, there is a risk that the problem will not be solved or it will be even worsened if they use an inappropriate window of opportunity for their goals (Avery 2004).

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We consider MSF as a scientific research programme (Ochrana, Novotný, Angelovská 2022), and our article follows the actual MSF conceptualisation (Herweg et al. 2015, 2017, Zohlnhöfer et al. 2015), which modifies the framework, revises the basic conceptualisation and specifies agenda as well as decision process (for more, see Herweg 2017:36). The underlying MSF logic of coupling the three streams by an entrepreneur within an opportunity window remains, but the configuration of MSF structural elements differs in particular processes and windows. We try to apply this new conceptualisation to test its salience in the settings of post-communist countries.

METHODOLOGY

Our methodology reflects the qualitative nature of the research, similar to a majority of MSF studies (cf., Jones et al. 2016, Rawat and Morris 2016), because it seems to be more appropriate to capture peculiarities of our cases.

We adopted a case study design (Gerring 2006), intending to gain in-depth insight into the policy process surrounding the new organisational–legal form of hospitals within two periods in the new millennium. Thus, the case study is designed as diachronic. There were several attempts to change the organisational–legal structure of the hospitals, but only one was successful. Therefore, we choose and examine two cases, one successful and the other one unsuccessful in two respective periods during which the change aimed at the non-profit form of hospitals. Following the policy cycle and Herweg's (2017) MSF modification, we divided both periods into agenda-setting and decision-making phases. The first period is related to a successful attempt. It covers the period January 2002–May 2006 because in 2002, the sector of hospitals experienced significant changes due to public administration reform and it started the agenda-setting phase. In May 2006, Act No. 245/2006 Coll. on Public Non-profit Institutional Health Facilities was passed and it completed the decision-making phase.

The second period is related to a most mature, unsuccessful case. It covers a 3-year period and starts in January 2014 when after an autumn election, the President appointed the Prime Minister, and the Government got the confidence of the Chamber of Deputies. In June 2017, the Chamber of Deputies suspended discussion of the Government Bill in general debate and did not open it again till the next election. It closed the possibility for coupling.

The choice of the second case took into account the most similar initial conditions to better identify why the policy change was successful in only one case. The main characteristic for the selection of the second case was to choose the public policy proposal as similar as possible, that is, a proposal based on a non-profit form of hospitals. It led to a presumption that the actors would hold similar roles and positions and allowed better identification of the key factors that played a role in the approval of the proposals.

The selected cases also exhibited other similar features. None of the studied cases started on account of an unexpected critical event. The composition of the political scene corresponded to the centre–left coalition, which had a majority in Parliament (101 votes in 2002 and 111 in 2013). The basic definition of the public policy problem in both cases studied was based on the unsatisfactory economic situation of hospitals, with many hospitals struggling with debt in both periods.

We collected data during spring 2019 through content analysis of media, legislative documents and other types of documents like a press release or official statement of involved actors (e.g. Czech Medica Chamber, Association of Czech and Moravian Hospitals [AČMN]). The search was based on core search term, 'hospital', in close combination with terms 'non-profit', 'contributory', 'public' or 'university'. Media analysis covers 20 periodicals (including six nationwide dailies, three economic and political titles, two social and nine health domain titles), four nationwide TV stations, one nationwide radio station and three Internet servers. We covered two time periods – from January 2002 to May 2006 and from January 2014 to June 2017. Data cleaning narrowed the relevant records in the Newton Media Search electronic archive to 2087. See code book in Appendix.

The direct legislative data we analysed included law proposals (Bill 810/2004 on Public Non-profit Institutional Health Facilities, Act No. 245/2006 Coll. on Public Non-profit Institutional Health Facilities, Bill 1054/2017 on University Hospitals) and five Constitutional Court resolutions. The other documents covered 12 stenographic records of parliamentary sessions, eight parliamentary papers, strategic documents (mainly of the Ministry of Health) and policy documents (e.g. the partisan document 'Blue Chance' made by Civic Democratic Party [ODS], coalition agreements).

We acknowledge that it would be more appropriate to have interviews with policymakers, because the MSF assumes their subjective perception of issues. We considered this direction, but we found it very difficult to access them because of longer time

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distance. However, the media data provided us with opinions and statements of the involved policymakers, and although it is not ideal, they still represent a relevant subjective perspective of policymakers on the issue.

We analysed the data by thematic analysis. We used the concept-driven codes derived from the MSF, and it allowed us to build results around major and minor elements of the framework.

We defined the MSF indicators following Herweg (2017) and Herweg et al. (2017).

To better understand the policy process of hospital reforms, we focus on the general part of the MSF explanation which assumes that 'Agenda change becomes more likely if (a) a policy window opens, (b) the streams are ready for coupling and (c) a policy entrepreneur promotes the agenda change' (Herweg et al. 2017, p. 30).

First, we inquired the agenda window in our cases. Within the problem stream, we work with both attention and interpretation. In our case, it covered the topic stressed out by the actors to catch attention. The thematic analysis helped us to identify the problematic issues which appeared in the public arena, that is, attention (in our case, hospitals' debt, risk of privatisation, a double track of health and education sector within university hospitals) as well as their framing, that is, interpretation necessity of the change of the new organisational–legal form of hospitals (framed as a bad economic situation or risk of transfer to business companies). We identified problem brokers according to their attempts to raise attention to the problem or to change the framing. We also focused on the negative change of indicators, harmful focusing event and negative policy feedbacks from the previous governmental programme because it helps a problem broker to more likely frame a condition as a problem (Herweg et al. 2017, p. 30). In this stream, we also paid attention to the opening of policy windows which can be caused both by the change of indicators, focusing events or feedback related to the condition and by putting decision-makers' re-election at risk.

Within the policy stream, the policy community and policy primeval soup are significant for forming proposals and alternatives. In this stream, policy entrepreneurs promote their ideas within policy and expert community to gain support for their alternatives. We focused on compliance of proposals with the MSF selection criteria (technical feasibility, value acceptability, etc.), which indicate the likelihood to gain agenda status and the integration of the policy community because less-integrated communities should allow new ideas to become viable policy alternatives. In this stream, we also identified policy entrepreneurs and inquired their access to policymakers as well as their persistency in the issue (cf., Herweg et al. 2017, p. 30). Within media analysis, we identified actors (e.g. Czech Medical Chamber [CMC]), their connection to the concrete proposal (i.e. the author of the proposal) and the framing of the variant (i.e. opportunity to simplify the complicated organisational and legal form of hospitals) to make clear their role during coupling.

Within the political stream, we focused on the fitness of the policy proposals to the general ideology of government or legislature majority. We were interested in policy positions of political parties and related turnovers in legislature and government. We also paid attention to campaigns of interest groups. During the thematic analysis of data including stenographic records, we not only identified the actors, but also the manner in which they framed the problem within the public and political arena (i.e. governmental proposal farmed by the opposition as a risk of nationalisation). We did not address too much the third indicator, the national mood, due to a lack of data and unreliability of pre-election research. Also, public opinion research covered the health sector, in general, questions and attitudes, and it could not offer the relevant picture of the mood towards the researched topic. In this stream, we also inquired the policy windows which could open here by turnover in legislature and government, interest group campaigns or a change in the national mood (Herweg et al. 2017, p. 30).

Second, we examined the decision window. Here, we focused on the likelihood of policy adoption, which is more likely when a proposal is backed by political entrepreneurs who hold an elected leadership position in the government or by a government or a majority party that is not constrained by other veto actors. We also addressed whether there were some package deals among the participating actors or whether the issue was perceived as salient by voters. We were also interested in a change of the adapted proposals from the original ones, which could be caused by the veto power of actors outside the government or powerful interest group's campaigns against the original proposal. Following these indicators represents foundations of a good MSF explanation of inquired hospital reforms.

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CHANGING POSITION OF CZECH HOSPITALS

Healthcare reforms attracted both lay and professional attention during the last 30 years. Alongside the pension system, this is the second major component of the current welfare state, whether we measure its importance by the volume of expenditure, by the number of workers producing and providing medical goods and services or by subjective citizens' relation to the services of health institutions. Healthcare reforms reflect trends in a welfare state change, with the most notable features of current welfare state reforms being privatisation and the introduction of market principles into welfare (Klenk, Pieper 2013). A growing number of European health systems are in the midst of a long-term structural or organisational reform process. Since the 1980s in most Western democracies and since the 1990s in Central and Eastern Europe, health reforms have become a political priority (Flood 2000, Figueras and McKee 2012).

Over the past decades, the nature of health organisations has undergone a significant transformation (Anderson 2012), in line with general trends, with a decline in the provision of public goods and services by public organisations and an increase in the number of businesses providing public goods for profit.

In 1989, the change of political regime brought about transformation of the other systems as well and caused ambiguity in their development. Czech health care has had to cope with significant changes, and the first transformational period was crucial for its development in the following decades, including the position of Czech hospitals. Already in its programme statement of the Czech Government in 1990, the health system reforms are mentioned, especially organisational changes based on decentralisation and the emergence of new entities, especially professional chambers (Government Program Declaration 1990). The proposed healthcare reform plan was inspired by the WHO principles of maintaining and improving health in society, the principle of state guaranteeing equal access for all citizens to adequate health care regardless of their financial situation and social status. The Czech government approved it by the end of 1990. The main changes took place in three areas – financing and reimbursement of services, the status of health service providers and the public administration system itself (Hanušová 2004). The original financing of health care from the state budget was replaced by multi-source financing of health care, in which the compulsory public health insurance based on the principle of solidarity played the primary role. In addition to the framework for public insurance itself, the Act on General Health Insurance (550/1991 Coll.) also defined the scope for concluding contractual relations between health insurance companies and hospitals.

Since 1991, legal changes have enabled rapid and extensive privatisation of healthcare facilities (Gladkij et al. 2003). With Act No. 160/1992 Coll. on health care in non-state healthcare facilities followed the intention to privatise all hospitals, except the large ones. The right-wing government of Vaclav Klaus favoured the proclaimed 'massive and rapid privatisation' in the context of economic reform (Government Program Declaration 1992), and this created growing pressure for rapid and extensive privatisation of healthcare facilities (Holub, Skovajsa 2006). At that time, the legal framework allowed the transfer of hospitals only to the legal form of business companies because there was no legislation to open up the possibility of nationalisation to non-profit or public benefit (Hanušová 2004). The first alternative appeared only in 1995 together with, albeit quite general, Act No. 248/1995 Coll. on public benefit societies.

Due to the risk of serious consequences, the government stopped privatisation of hospitals in 1996 and only a few dozen small hospitals were transferred to the legal form of business companies (Angelovská, Hanušová 2005). In general, privatisation in health care was limited to transferring assets of lower acquisition value (ambulances, small polyclinics, small hospitals) (Potůček 1998). The problem of privatisation in the field of inpatient care compared to outpatient care is also evidenced by the number of state-owned establishments. In 2002, the state possessed 80% of inpatient care, while in the outpatient sector, it took only a year from the start of privatisation to transfer more than half of the outpatient care to non-state healthcare facilities (mainly general practitioners, paediatricians, dentists, etc.) (Vepřek et al. 2001).

The public administration reform became a significant impulse in the area of changes in the organisational–legal status of hospitals. The key source of change was the second stage of reforms when, in 2002, the district authorities were dissolved. The ownership of district properties moved from district offices to newly established regions. This transition covered the area of hospital care as well, and it affected about half of the bed capacity in the Czech Republic (Rokosová 2005), concretely, 82 hospitals out of a total of 203 hospitals, including big state hospitals. At the end of the year 2002, all those hospitals became the property of the newly established regions. The regions at the same time became responsible for the accessibility of hospital health care as a public service (Grospič, Vostrá 2004). The government lost the possibility to intervene in activities of regions (Hendrych 2003) based on the Czech Constitution (Article 101 (4)).

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Several negative aspects followed the transformation. Firstly, it has led to uncertainty and inconsistency of the future development of the organisational–legal form of former district hospitals. It was caused by the considerably underestimated legislation of public administration reform in the field of hospital care (Havlan 2004). Secondly, regions inherited hospitals' commitments, including considerable debts (Vepřek et al. 2001). Thirdly, the organisational–legal form was often politicised and medialised by actors of public administration and other health policy actors in the election campaign in November 2004.

The unsolved problem of hospital debts has been running for several years. Since the end of 90s, the Chamber of Deputies has been discussing it repeatedly. Before the transfer of hospitals in 2002, the Chamber required the Ministry of Health to propose a solution, to which the Ministry responded only by the general concept of medium-term policy, which included, inter alia, a bill on healthcare facilities and their management (Thesis 2003). The Ministry and the government failed to fulfil the plans of the concept. Furthermore, they eliminated hospitals' debt only about 60% (Malý, Pavlík, Darmopilová 2013) despite their previous claims.

The hospitals' debts put the regions in a problematic situation. The regions acquired other property besides hospitals, but they were not allowed by law to use them for purposes other than those originally intended. Therefore, the regions had to offer unnecessary acquired assets back to the state and not to use it to cover the debts of hospitals. It caused a financial crisis in the hospital field.

The regions responded to the difficult situation by looking for other solutions. Because Act No. 250/2000 Coll. on budgetary rules of territorial budgets allowed regions to establish their organisational units, regions began to transform hospitals into business companies. The law did not specify the legal form, which could range from contributory organisations to public benefit corporations or business companies. As ODS, a centre-right party, dominated in most regions after the 2000 elections, it chose the joint-stock company as the most appropriate legal form to address the economic problems of hospitals.

The main reason for criticism of such an approach was the weakening link between health care and the public sector, a decrease in the role of the state, and thus its ability to influence the development of hospital care. The critics perceived it as a risk of lowering access to health care. These new trends in the Czech hospital care and different framing of the issue were the triggers for searching for a new legislative form of regional hospitals.

MULTIPLE STREAMS ANALYSIS

In the following section, we present two cases across the MSF structural elements in both phases, that is, agenda setting and decision-making. Just the first case succeeded in both of them, and we mapped the contextual factors when a similar proposal led to different results.

Case 1 – Act on Public Non-profit Institutional Health Facilities

The first case presents the results of the analysis based on the structural elements of the broadened MSF concept and covers phases of agenda setting and decision-making from 2002 to 2006. We discuss both windows of opportunity.

Case 1 – Agenda setting

Over the past 30 years, the matter of hospitals has repeatedly been coming back to the political arena at intervals of several years, with the attention in the 1990s being mainly related to the transformation of the whole system. Within the MSF concept, the beliefs of actors about the existence of a problem make an essential condition (Herweg et al. 2017:92) for forming a **problem stream**. In our case, the impact of public administration reform on the hospital sector has given impulse to shape the problem stream. Actors including government and opposition politicians, health professionals, academics or experts agreed that the problem existed, although they framed it differently. At the very beginning of the reform, actors framed the issue as a problem of hospital debt. After the hospitals' transfer to the regions in the final stage of the reform, the attention paid to the issue increased and the organisational–legal form became a topical issue of the agenda. Anyway, we did not identify the focusing event in our case. Policymakers identified the problem due to indicators connected to the negative economic results of hospitals. Hospital debts began to affect their insolvency

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and curtailed restrictions on the provision of health care. Thirty district hospitals with debts amounting to 320 million crowns were facing severe financial problems. Distributors had stopped supplying medicines to some of them. On 10 December 2002, the Chamber of Deputies discussed the Government Report on the State of State Hospitals' Indebtedness, on the Solving of These Debts and the Regulatory Compliance of the Transfer of Hospitals to Regions (Háva et al. 2003).

The inclusion of the bill on healthcare facilities among the goals of the Ministry of Health did not provoke such a great response among politicians and media as when centre-right regional county presidents began to transfer regional hospitals to joint-stock companies. It also changed the framing of the problem. The issue of organisational–legal form of hospitals has been given priority at the expense of the topic of indebted hospitals. There existed a consensus on the fact that the form of budgetary and contributory organisations was outdated. On the solution in the form of joint-stock companies favoured by regional county presidents, the centre-left government disagreed completely. It argued by the risk of future privatisation by the private sector, which may cause lower access to health care. The government preferred the non-profit form.

Both regional elections and Senate elections in 2004 influenced the course of the debate, and the issue was used for election struggle. The governing centre-left party chose the topic as a leading one for the regional elections. The Prime Minister retrospectively considered health issues like a poorly chosen topic. Anyway, in the Policy Statement of the government, the plan of law on healthcare facilities was stated.

The **policy stream** represents the possible policy solutions – both the pre-formulated one and the new one. The preparedness of the appropriate solution may significantly shorten the whole process. In the stream, a large group of policy entrepreneurs may participate covering, for example, politicians, experts or academics. Their ideas compete in a 'primeval soup' to win the approval of policy networks (Zahariadis 2014, Herweg 2016). In the case of Czech hospitals, two basic alternatives played a role. The government preferred the one that builds on the non-profit legal form, while the regional county presidents favoured the alternative to business form.

In 2004, a Member of Parliament (MP) Krákora submitted a bill on Public Non-profit Institutional Health Facilities, when the proposal had been already widely discussed. Originally, the proposal was initiated and prepared by the CMC. Because under the Constitution, the CMC has no right to submit bills, the Ministry of Health took charge of it. To speed up the process of preparation and approval compared to a possible government draft, the Minister of Health charge, MP Krákora, proposed the bill as a parliamentary initiative. After the submission of the bill, the Minister of Health claimed her dissatisfaction with it. The government took a neutral stance on the bill, and the Minister announced an intention to put forward the ministerial version.

Concerning softening up of the proposal, although many actors agreed that there was a need for special legislation for public hospitals, they considered the proposed law to be incomplete. The Ministry of Health criticised the fact that the submitted law deviated from the recommendation of the Legislative Council of the government that it had significant legal and legislative shortcomings. The Union of Employers' Associations disagreed with the proposed method of management, the automatic contractual obligation of insurance companies and the tax advantage. The proposal received support from the CMC and the Medical Trade Union Club.

There was a disagreement in value acceptability. The regional county presidents perceived the bill as questioning the function of the private sector not only in health care, but generally. The Czech Social Democratic Party (ČSSD) representatives criticised such an idea of health care as being 'a business like any other, and that is a fundamental clash of ideas with us'.

In addition to this major initiative, a centre-right opposition politician and shadow minister of health Julínek (ODS) presented in the partisan document Blue Chances for Health (2004) his idea of a healthcare system with hospitals as joint-stock companies. The market would run and manage hospitals, while the state would keep control and regulatory functions. The centre-left party (ČSSD) responded by setting up an expert group to which the World Bank experts (led by Mukesh Chawla) were invited, but no results of the group's activities were published.

The **politics stream** differs from the policy stream in its nature, which is based rather on negotiation and power play than on argumentation. The national mood and the current political climate in society are mirrored in the political stream. Personnel changes in executive and legislative power or interest group campaigns may play a significant role and change the direction of the stream (Mukherjee, Howlett 2015).

The outcome of the elections strongly influenced the politics stream. After the 2002 elections, the winning ČSSD with two other coalition partners reached a one-vote majority in the Chamber of Deputies. The mood within the government was generally supportive of the new organisational–legal form. The situation changed among representatives because in the 2004 elections, the number of coalition senators declined. The coalition also lost many representatives in the municipal elections. Within the interest groups, the strongest support came from the CMC. Regional county presidents made the most substantial opposition.

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Two factors influenced the political scene. The first was a delay in the preparation of the Act on Public Non-profit Institutional Health Facilities. The second mirrored the reaction of the regional county presidents to the preparation of the law, who tried to speed up the started transfer of hospitals to commercial companies. The decreasing number of hospitals in contributory and budgetary organisational form weakened the reasonability of the bill. The government party ČSSD attempted to stop the transfer run by regions in the Chamber of Deputies through a blocking mechanism as an amendment to the Environmental Noise Assessment and Reduction Act. It was formulated in one paragraph prohibiting the transfer of hospitals to companies. The aim was to prevent the increase in the number of hospitals in the form of business companies until the enactment of the non-profit form of healthcare facilities. The initiative was not successful when the Chamber of Deputies managed to overvote the Senate veto, but not the President's veto of Vaclav Klaus.

In December 2004, the first reading of the bill took place in the Parliament despite several governmental objections. The potential success of the change was supported by the hospitals´ debts as a negative indicator as well as by the general ideological majority in the Parliament. The window started to open in the problem stream because of the negative indicators.

Case 1 – Decision-making

The key issue has not changed in the **problem stream**, and it has remained defined as an unsatisfactory organisational–legal form of hospitals. The attitudes of the actors remained the same. On the one hand, the ruling coalition and some actors in the health sector stressed the need for a new law to prevent the transformation of hospitals into a business companies form, which could lower access to health care and increase the risk of misappropriation of hospital assets. On the other hand, the centre-right politicians and regional county presidents began to compare the situation to the situation in the 1950s. They framed the bill as a re-nationalisation of property. The discussions escalated compared to the agenda setting.

Within the **policy stream**, the bill followed up a parliamentary initiative in the form of the Parliamentary Paper 810 on public non-profit institutional healthcare facilities. The proposal has undergone a fundamental change. In this specific case, we do not call it as a process of softening up because it was not negotiated with stakeholders and has triggered protests by many actors. The new Minister of Health previously held the position of CMC president. He input into the proposal the obligation to transform former district hospitals into a non-profit form, including those already transferred by the regions to the form of business companies. This change proved to be a significant weakness of the technical feasibility, as was later confirmed after its approval. Regional county presidents pointed out this shortcoming. They also protested against the proposal with the argument that the monopoly of non-profit hospitals might emerge and declared their plan to work on their proposal of hospitals in the form of joint-stock companies. However, they did not manage to present the proposal before the Parliament passed a law.

Due to the current composition of the Parliament, the **politics stream** has become the most important stream in the decision-making phase. In its Policy Statement, the new government confirmed the necessity to create a law on healthcare facilities (Government Policy Statement April 2005). The mood within the government stayed supportive.

The situation, as in the agenda-setting phase, repeated. The delay of the law approval led to another attempt to stop the transfer of hospitals through another blocking mechanism. This time, the initiator was the Communist Party, and it included a paragraph in the amendment to Act No. 258/2000 Coll. on the protection of public health. The attempt could improve the technical feasibility of the proposal. The Chamber of Deputies succeeded to outvote the Senate and the presidential veto. However, the blocking mechanism had no real effect since the regions had changed most hospitals into business companies (mainly joint-stock companies). The regional county presidents immediately responded by announcing that they would file a complaint with the Constitutional Court and were about to take advantage of the legal loophole and circumvent the concept of 'change in legal form' by setting up new companies.

Many actors, including, for example, Trade Union of Healthcare Employees, Czech Pharmacy Chamber or the Association of Health Insurance Companies, had objections to the Act on Public Non-profit Institutional Health Facilities. Therefore, it did not successfully pass the third reading in the Chamber of Deputies until February 2006. All three streams of policy coupled in the window of opportunities in May 2006, when the Chamber of Deputies outvoted the presidential veto. The Act came into effect on 31 May 2006. Generally, the government played an important role in adopting the law. The veto actors postponed the process, but did not succeed to stop it.

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Case 2 – Act on University Hospitals

De facto elections in 2013, which resulted in a coalition of three political parties, led to the birth of the University Hospital Act. In their coalition agreement, the parties pledged to adopt a law on public non-profit (public) health facilities that would create a backbone network of hospitals. The law should also include the positioning of teaching hospitals with the participation of universities in their management.

Case 2 – Agenda setting

Within the **problem stream,** there appeared two main topics. The first topic of the economic situation of hospitals remained in the limelight for only the first few months. Some hospitals were still struggling with the unbalanced economy, but the situation was not as alarming as the start of the millennium. However, the situation worsened. In 2013, the Constitutional Court abolished hospital patient fees. The fee was CZK 100 per day of hospital stay, and this step caused a loss in hospital income of approximately CZK 2.1 billion per year. Before he was appointed the Minister of Health, Němeček considered as the crucial issue in the short term to ensure full compensation for the approximately CZK 2 billion loss of hospitals.

At the same time, politicians began to discuss inadequacy of budgetary and contributory organisations as an organisational and legal form of hospitals. The potential new legal form was presented as suitable not only for budgetary and contributory organisations, but also for teaching hospitals and regional hospitals in the form of joint-stock companies.

Within the **policy stream**, several options appeared in the game. In addition to the announced proposal of the Ministry of Health, the CMC also informed about the preparation of the bill. The situation reminded the 10-year-old case in which the ministry or the parliamentary initiative would have to take over the proposal. The left-wing Communist Party of Bohemia and Moravia also adopted the new legal form and proposed to renew the law of 2006, which was abolished in 2011 by the centre-right government. The centre-right deputies welcomed the announced change in the current unsatisfactory situation, but they had a different idea of the final form of hospitals. They preferred a joint-stock company.

The Ministry of Health was behind schedule with the bill. Instead of the bill, the Ministry sent a document entitled 'Thesis of the Bill on Public Health Organizations' to tripartite partners in April 2015. The AČMN participated in the process of preparing the law at the Ministry's request. It evaluated the presented theses as 'fragmentary, ill-considered, unrelated, and therefore incomplete summaries of opinions in which this bill lost its meaning and purpose'. Two months after its introduction, experts criticised the bill, pointing out that up to a 'third of hospitals are in danger of going bankrupt'. They mentioned 'the bill de facto introduces two categories of providers'. The Ministry of Finance stated not to support the actual version of the bill. The Ministry of Justice evaluated the bill as 'confusing', 'unsystematic', 'inaccurate' or 'inappropriate'.

Two conflicting streams began to appear in the media. The centre-right parties compared the proposal to the 2006 Act and tried to frame the Ministry's efforts negatively. The centre-left wing parties distanced themselves from the original, resulting law, but endorsed the basic idea of non-profit. The Ministry of Health itself acknowledged the inspiration of the previous law: 'We have taken over certain elements from Rath's law, but we are smarter in that we know the Constitutional Court's finding'. It did not, therefore, include a mandatory changeover to the new form or claim conclusion of contracts with insurance companies. The proposal went through a process of softening up. During the discussions of the Act in 2015, several significant features emerged, and after criticism, the Ministry modified them. It was the case of, for example, tax relief for non-profit hospitals or a limited number of hospitals that could be transformed into non-profit hospitals. The proposal highlighted the role of university hospitals. The Ministry sent the proposal for interdepartmental comment procedure in October 2015.

Although the ruling coalition put the law into a coalition treaty, a split appeared in the ruling coalition after the proposal was introduced. The mood within the government was not cohesive. While the Czech Social Democratic Party, to which both the Prime Minister and the Minister of Health politically belonged, supported the bill, the ANO 2011 (ANO), led by the Minister of Finance, began to criticise the law intensively. Concerning the **politics stream**, the third coalition party did not initially form a definite opinion. Apart from the KSČM, which openly supported the proposal, the other opposition parties remained neutral. Some professional organisations (e.g. the Czech–Moravian Confederation of Trade Unions, the Trade Union for Health and Welfare)

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demanded withdrawal of the law. The CMC required modification of the proposal and criticised the Ministry for not using CMC's proposal. University hospitals, which were also significantly influenced by the proposal, supported it in the present version.

Case 2 – Decision-making

With the elections approaching, the framing of the **problem** began to change. Indicators connected to the economic situation of hospitals started to be overshadowed by the topic of privatisation. Since the second half of 2016, the law supporters have started to frame the bill as a safeguard against privatisation of health care. They stressed the aspect of the better position of faculty hospitals too. At the same time, there appeared increasing criticism that the law would not pass in a given election period. Opponents framed such a situation as a government failure to fulfil the coalition programme.

The **policy stream** experienced the important softening up. Concerning the interdepartmental comment procedure, the proposal returned with many comments (over 370). A large part of the comments incorporated, for example, many accounting changes, the guarantee of the state for the obligations of hospitals and the possibility of judicial review of the registration of hospitals as non-profit hospitals. The proposal thus experienced significant changes compared to the 1-year-old version. The Ministry handed over the bill in its new form to the government and the Legislative Council of the government, which rejected it. The Ministry had objection to the way the Legislative Council discussed it because the discussion revolved around academic topics instead of specific provisions that the law addresses.

Less than a month later, the new Minister of Health withdrew the bill from government meeting. Due to fundamental disagreement with the proposal among coalition partners, he sent a new proposal. The proposal covered only university hospitals. Compared to the original one, the law would apply to 15 healthcare facilities instead of the original 39. For the most part, it copied the part of the previous proposal that was devoted to university hospitals. At the same time, the Ministry requested an abridged comment procedure, which lasted only 5 days and was the subject of sharp criticism. At the same time, the Regulatory Impact Assessment (RIA) was not drawn up to the Act.

In the **politics stream**, the dispute between the coalition parties continued, in particular, between the Minister of Health (ČSSD) and the Minister of Finance (ANO). The Prime Minister (ČSSD) tried to resolve the situation by a personal replacement of the Minister of Health. The situation did not improve with either the new minister or the new bill. With the forthcoming elections, the discussion between the two sides became more personal and sharper, as Ministry of Finance´s claim illustrates: 'It is a comical proposal, the material perhaps reached a record in contradiction. I cannot imagine a compromise solution that ANO would support'. The Ministry of Finance has refused to eliminate hospitals' debt despite previous indications that it will. It led to criticism from the university rectors who otherwise supported the law.

After the presentation of the new proposal, there was a reallocation of powers in the Chamber of Deputies. While from the beginning, the KSČM supported the original proposal on non-profit healthcare facilities, it distanced itself from the new proposal. In addition to the content, it also criticised the fact that the law will not be passed in the given election period. The window of opportunity began to close. Nevertheless, the bill was finally passed at the first reading, supported, besides ČSSD, also by the coalition ANO and two opposition parties. One of them, TOP09, compared the law to its own several-years-old bill on university hospitals. In June, the Parliamentary Committee on Health Care postponed its proceedings until the end of September and failed to discuss the law before the next election.

DISCUSSION AND CONCLUSION

The modified MSF afforded a useful structure for the study of agenda setting and decision-making in the health policy field. Empirically, we followed most of the MSF studies and chose the case study. Such an approach has well-known limitations regarding generalisability, but it offers a better understanding of the reform processes in the Czech hospital sector and helps us to identify the contextual factors of policy change.

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We compared two similar cases. In either case, the change did not respond to a focusing event, but hospitals were struggling with the economic problems. The window of opportunities in the agenda-setting phase opened up in different streams. The window opening in the first case fits the traditional MSF scenario and began to open up in the problem stream with a minimal potential for opening in a different stream. It was a result of identifying hospital debts as a public policy issue within political and media discourse. Ten years later, the preconditions for change appeared in the stream of politics because of the composition of political representation in the Parliament and a political will to make the change claimed in the governmental programme. The dominance of the stream of politics made it impossible for the CMC to repeat its success in getting its bill passed.

The decision-making phase confirmed the assumption of many authors (Zohlnhöfer, Herweg and Rüb 2015, Zahariadis and Exadaktylos 2016) that the policy stream makes the main stream in this phase. Both cases fulfilled assumption of such an opening window of opportunity due to the composition of the Parliament, although in the second case, the window started to close faster.

There was no change in the actors themselves between the two cases, except the new political movement ANO. However, differences can be traced in support of the actors. These changes affected the political scene itself (e.g. ODS or KSČM) and professional associations (e.g. CMC). The changes in positions mirrored the potential impact of the proposed public policy on the actors. We consider the most important change in the coalition's position and cohesion. We agree with the authors of the MSF concept, and our analysis has also shown that the politics stream is the most important in the decision-making phase, and if the policy promoter has sufficient support from legislators and enough time, it is able to push through the policy regardless of the opposition of other actors. It is illustrated by the first case when the composition of the Chamber of Deputies made it possible to overvote the Senate and presidential veto, even though the bill had undergone significant changes criticised by the expert community. Another key factor was the importance of the position of policy entrepreneurs and their links to the political representation.

The important factor affecting the streams' coupling was elections, whether to regional councils or the Parliament. With the upcoming elections, media and political discussions began to intensify, framing the policy escalated and entrepreneurs strengthened their efforts to speed up approval processes. It was more evident in the second case when the proposal was submitted to the Chamber of Deputies after a comment procedure abridged to 5 days without the RIA.

The article sought to apply the MSF to explain the different results of similar cases within the Czech health policy. Following Weible´s (2018:366) statement, our purpose of applying MSF was to ´describe and explain the intricacies of a case study´. We see the main contribution of our research in the validation of the modified MSF application in another institutional setting than it was originally set. Furthermore, the application confirmed the importance of distinguishing agenda-setting and decision-making phases because the coupling of the streams significantly differs. The cases confirmed the broad applicability of the MSF for policy process analysis and the usefulness of concepts such as streams, policy windows and policy entrepreneurs for interpretation of policymaking processes.

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APPENDIX 1

Code book

Descriptive variables

- ID number
- Headline of the article
- Author of the article if available
- Date in which the article was published
- Type of the article (e.g. news, interview)
- Page

Analytical variables

- Problems of the hospital sector (e.g. debts, unsuitable legal form)
- Practice mentioned in the article
  - Practice (e.g. Act from 2006, limited companies)
  - Mentioned as positive × neutral × negative
- Proposal mentioned in the article
  - Proposal (e.g. government proposal, CMC proposal)
  - Mentioned as positive × neutral × negative
- Aspect of the proposal
  - Policy aspect (e.g. better legislative form, the risk of privatisation, lower access to health care, risk of nationalisation)
  - Positive × neutral × negative
- Aspects of politics
  - Politics aspect (e.g. critics, blocking mechanism, cooperation)
  - Positive × neutral × negative

Policy actors in case they are mentioned in the text with the previous information

- Person – if the actor is mentioned by their name, both as a single individual or as a representative of the organisation (e.g. David Rath, Andrej Babiš)
- Position in the organisation (e.g. minister, president of the Czech Medical Chamber)
- Name of the organisation to which the actor belongs, or it is mentioned without an actor (e.g. the Ministry of Health, the CMC)

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