Discursive imaginaries and cultural codes in post-communist health policies

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I. Introduction

Health policy debates are a laboratory for broader shifts in the role of the state in welfare provision (Pierson 2002; Rothgang 2010). For the last couple of decades, health care systems of developed states have been subject to permanent reform attempts. Just in the last decade, the United States Congress passed a health care reform, the government of Germany worked on a reform of its national system, the Health and Social Care Act 2012 made provisions for several changes to the British National Health System (NHS), and in France, François Hollande promised in his electoral campaign to protect the national health service, expand complementary coverage, lower the price of medicines and fight against health disparities. Health care has become a battle zone in which it is being fought for the character of modern welfare state – and discursive and cultural aspects have been the best part of these battles. Although almost all political parties agree on the importance of medical innovations and fiscal responsibility, they differ in their explanations of why and how to achieve those goals.

The unfolding narratives of health care reforms in the Czech Republic, caught in between the promising discourses of Western medicine and the fiscal limits discourses of contemporary welfare state, provide the best ground for exploring these questions. It is for this reason that my case study focuses on health care in the Czech Republic after the fall of communism. I intend to classify, chart, and compare patterns of argumentation and narration. I map alternative and competing narratives as constructed by key stakeholders in health policy networks, and explore how these narratives are modified and deployed in the process of forming storylines to promote particular policy solutions. Indeed, I look at the ways in which these storylines are embedded in a broad complex of thought and cultural codes. The Czech Republic is an ideal case for this study because the regulatory paradigm is still unfolding and there is a

great deal of debate. This enables me to understand the shifting narratives and alliances in a relatively fluid policy arena.

Since the fall of the communist regime, the institutions of politics and health care in the Czech Republic have undergone a period of rapid change. Between 1990 and 1994, the first period of transformation focused on basic market-oriented reforms such as to establish public health insurance or to improve health care facilities (Rokosová et al. 2005; Potůček 1999). Although health care changed significantly in the two decades after the fall of communism, a second major reform was proposed in 2006. Post-communist reforms of health care have usually been interpreted using structural or agent-based explanations, either from an economic perspective (Rechel, McKee 2009; Kutzin et al. 2010; Björkman and Nemec 2013) or from an institutional perspective (Roberts 2009; Saxonberg and Sirovátka 2009; Sitek 2010). Less has been written about the narrative facets of the reforms. The institutionalists usually describe post-socialist health care systems as an unbalanced combination of pluralist health insurance with tight state control over the system and poor patient participation. The historical-narrative approach employed in the present thesis seeks to explain why the system has evolved in this way and how its institutional characteristics have been influenced by broader discursive and cultural patterns.

I follow the dynamics between sustainability constructions and cultural codes in narratives of heath care reforms. I analyse three main periods in the history of post-socialist health care: (1) transformation, (2) consolidation of rules and (3) neo-liberal reform. The analysis includes newspapers and weekly magazines, and allows me to explore the role of discourses of medicalisation; the role of discourses of fiscal limits in defining policy goals; and the ways policy narratives are embedded in more general codes of regulatory cultures. Consequently, the narrative dimension of post-socialist institutional change can be elaborated.

Interrogating the ways in which public policy is narratively constructed allows us to better understand how contemporary governments justify themselves. It helps us contemplate policy making

not only as a process of solving public problems but also as a means of defining and disputing the legitimacy of institutional arrangements. Furthermore, it prompts us to understand political competition differently. To reveal the narrative character of public policy means also to question the political character of public policy. "While fundamental public issues such as social inequality remain generally insoluble, continuously renewed activities show that some solution can contribute to resolving them, even partially, and are not only at the centre of political activity, but assemble what holds society together: politics." (Zittoun 2014: 11)

II. Theoretical background

Policy narratives is sequences from equilibrium through disequilibrium to re-establishing equilibrium (Propp 1962; Todorov 1972; Greimas and Cortés 1982). Disequilibrium is created by labelling a situation as a problem, identifying victims, designating causes and predicting an apocalyptic future, on the other hand, re-establishing equilibrium involves labelling solutions, identifying their consequences and beneficiaries, coupling solutions with problems to resolve, and integrating them in a broad complex of public policy and in a referential framework (Zittoun 2014). Narrative practice selects newsworthy elements from a multiplicity of events, statistics or rules, and constructs which aspects of life are newsworthy and, on the contrary, which ones are largely ignored.

From the linguistic point of view, a narrative is a story with a temporal sequence of events organized in a plot characterized by dramatic moments, symbols and characters that concludes in a moral lesson. The essence of a narrative lies in the temporal dimension: it has a beginning, a middle, and an end. Policy narratives "provide a credible principle upon which to read past, present and future events, and capture people's hearts and minds" (Torfing 2005: 15). At its simplest it can be defined as "the representation of real or fictive situations and events in a time sequence" (Prince 1982: 179). Narrativisation involves "the distanciation of the saying in the said" (Ricoeur 1981: 134) – in other words, abstraction from particular situations, virtualisation with respect to time, and potential inscription of a speech act in text. Narratives work as causal stories which describe how world works and prescribe

responsibilities of different actors (Stone 1988). They create cognitive schemas for describing and understanding an otherwise chaotic and complex series of situations, events, and behaviours.

The narrative mode represents the core of political communication. French philosopher Jacques Rancière (1999) points out that political speech relies upon poetic, world-opening devices, such as stories, through which collective subjects are articulated. Politics means contesting the very definition of the community and resisting the domination resulting from the exclusion from political arena. Political action involves forcing an opposing side to acknowledge not only demands for inclusion but also the speech of those making the demands. For Rancière, in contrast to rational oriented policy, the objects of politics and the status of its actors are aesthetic and can never be determined logically. Politics starts with conflicts, different meanings, multiple perspectives and inequalities. For these reasons, political accounts are inherently narratives.

One can distinguish organizing and communicative functions of a narrative. The organizing function of narratives includes naming the problem and scripting the identities and roles of various actors involved in it. Narratives play an important role in organizing (White 1992; Kabele 2010), including both planned and unplanned reorganisation (Kurtz, Snowden 2007; O'Connor 2002). In this way, narratives "fulfil an essential role in the clustering of knowledge, the positioning of actors, and, ultimately, in the creation of coalitions amongst the actors of a given domain." (Hajer 1997: 63) On the other hand, the communicative function of policy narratives means the ability to persuade a broader audience of the legitimacy and appropriateness of a particular version of a situation (Schmidt 2002). The communicative function emphasizes the importance of expression, argumentation, and persuasion in generating and validating interpretations of the situation. This often involves a sort of narrative competitions, as individual actors or organizations construct and project their own interests in ways that position them in the field (Golant, Sillince 2007).

Narrative practice relies on an underlying structure of discourse and cultural codes. This underlying structure results from long-term processes and forms a basis through which goals and means of policies

are articulated. Michel Foucault (1985) defines discourse as a wide set of social practices. He is concerned neither with the truth nor with the meaning of actual statements, but with their conditions of possibility. Feindt and Oels (2005) highlight four characteristics which distinguish Foucaultian discourse analysis from other types of discourse analysis: (1) the focus is on the productive function of discourses; (2) power relations are present in all forms of social interaction; (3) discourse enables and constrains them by shaping their field of opportunities and by limiting their freedom; (4) the realm of power relations extends to the construction of subjectivity. Foucaultian genealogical description provides us with an account of how current perceptions of individual and state regulatory responsibilities are embedded historically and how history is internalized in current debates and current discursive practice. According to Gavin Kendall and Gary Wickham (1999), genealogy (1) describes statements with an emphasis on power; (2) introduces power through a history of the present; (3) describes statements as an ongoing process; (4) concentrates on the strategic use of archaeology to answer problems about the present. Nikolas Rose (2000: 57–58) suggests that we should consider the genealogies of issues as answers, and we should seek for questions behind them.

"Political argument does not have the systematic and coherent character of theoretical discourse. Nonetheless, we suggest, it is possible to specify and differentiate political rationalities in terms of the relatively systematic discursive matrices within which the activity of government is articulated, the particular languages within which its objects and objectives are construed, the grammar of analyses and prescriptions, the vocabularies of programmes, the terms in which the legitimacy of government is established." (Miller, Rose 2008: 30)

This approach posits an important question, how discourse can systematize incoherent policy arguments. A response to this problem involves the concepts of nodal points and social imaginaries (Howarth and Stavrakakis 2000). They are privileged signifiers or reference points that bind together a system of meaning or chain of signification. Nodal points are always open and somehow empty. The social field can never be closed, and political practice seeks to fill this void. "In other words, even if the

full closure and fullness is not realizable in any actual society, the idea of closure and fullness still functions as an (impossible) ideal. Societies are thus organised and centred on the basis of such (impossible) ideals." (Howarth and Stavrakis 2000: 8) Nodal points are central to establishing social imaginaries. Ernesto Laclau (1990: 63) defines social imaginary as a horizon or an absolute limit which structures the field of intelligibility. He introduces the distinction between myths and social imaginaries. A myth constructs new spaces of representation that attempts to join the dislocated space in questions. From their emergence to their dissolution, myths can serve for the inscription of a variety of social demands and dislocations. However, when a myth has proved to be successful in neutralising social conflicts and incorporating a great number of social demands, then it has been transformed to an imaginary. "The term 'imaginary' is reserved for those cases where a particular group succeeds in moving beyond its particular interests onto a universal terrain." (Norval 2000: 229) Myths and social imaginaries, in this sense, act as horizons of imagination through which most societal demands can be articulated. Foucaultian genealogy is partly the method in which a trajectory from myth to imaginary can be reconstructed, analysed and criticized.

In contrast to discourses as social imaginaries, cultural codes provide a critical basis though which different imaginaries are ordered, organized and reconciled within a single social order. Using the cultural theory developed by Mary Douglas (Douglas 1993; Thompson, Ellis and Wildavsky 1990), narratives can be defined according to how they articulate societal constraints for individual members and how they defy or circumvent the rules and boundaries of their social environment. Cultural codes organise narratives along specific classification schemes of basic assumptions in which each code is defined in contradistinction to the narratives based upon other codes. Each code proposes a different grammar of policy narratives as well as a different theory of regulation, which differently explains the origins of regulation. They act as grammars representing different dimensions of how policy might be problematized or articulated. In each of this dimension, different criteria can be used to evaluate the regulation and different questions can be raised. From the institutional point of view, cultural codes

propose different institutional tools modelling market, hierarchical or egalitarian relations. Under some circumstances, they can also produce the feeling of fatality, which postulates no institutional change or passively accepts external pressures.

Analysis of cultural codes starts with the assumption that a culture is grounded in an interpretative grip comprising distinctions about what is good and bad, moral and immoral, natural and cultural, rational and emotional, and so on (Balkin 2002). The interpretative grip that informs, mediates and constitutes our social relations becomes the basis for both factual assessments and moral judgments (Alexander and Smith 1999). For Balkin (2000), cultural codes operate as software that provides a set of nested oppositions trading on each other to create hierarchies that privilege one side at the expense of another.

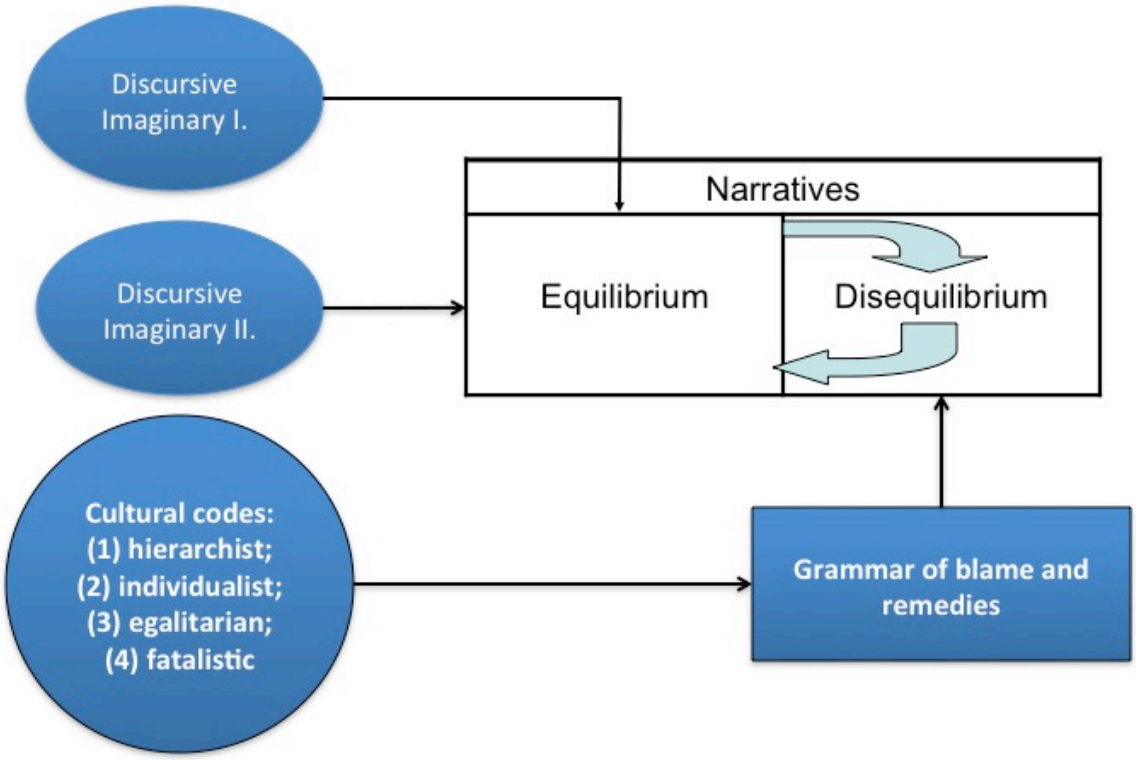
Cultural theory developed by Mary Douglas (1992) points to four rival world-views, with their contrasting and competing diagnoses and solutions to regulatory problems (see Table 2). These views emerge from distinctions on two dimensions: (1) grid which defines the extent to which individual behaviour is bound by rules; (2) group which defines the extent to which an individual regards herself or himself as being embedded within group processes. In line with logics, Douglas identified four cultural types: hierarchism, individualism, egalitarianism, and fatalism. The former two types are much more associated with processes in modern societies whereas the latter two can be found in more traditional societies or they cover more traditional aspects of social life. For example, modern trends such as centralization, integration, standardization, specialization, economic efficiency, and incentivization can be associated with hierarchism and individualism but less with egalitarianism or fatalism (Baldwin et al. 2012: 51).

Different cultural codes also construct different types of disorder. Whereas crisis in the individualist code relates to lack of incentives, crisis in the hierarchist code is associated with lack of reputation. Both dominant regulatory codes used in the transformation period proposed a model of patient deficit. The individualist code depicted patients as rational actors who need to learn skills to work in the new model

of health care. In contrast, a deficit of knowledge is articulated in the hierarchist code, calling on professional authorities to protect patients' interest because patients are not able to do so themselves.

Classification of narratives based simultaneously upon discursive imaginaries and cultural codes allows me not only to grasp the horizons anticipated by policy narratives, but also to grasp the way in which these horizons can be reached and responsibilities can be distributed within the medical field. Using Alfred Schutz's (1966) terminology, the broad discursive imaginaries represent future-oriented *in-order-to motives* and cultural codes represent *because motives*. Particular policy narratives rely both on policy discourses defining goals and on cultural codes defining actors' and tools' positions within the moral order of society.

Policy narratives is sequences from equilibrium through disequilibrium to re-establishing equilibrium. Disequilibrium is created by labelling a situation as a problem, identifying victims, designating causes and predicting an apocalyptic future. On the other hand, re-establishing equilibrium



involves labelling solutions, identifying their consequences and beneficiaries, coupling solutions with problems to resolve, and integrating them in a broad complex of public policy and in a referential framework. In this process, important roles are played by category-making as a way of claiming the boundaries of a problem and identifying victims and beneficiaries, and metaphors as a way of embedding narratives in the broader context. Narrative practice selects newsworthy elements from a multiplicity of events, statistics or rules, and constructs which aspects of life are newsworthy and, on the contrary, which ones are largely ignored.

Discursive practice is an ordering practice putting the possibilities and rooms for manoeuvre determined by discourse as an underlying structure together with various elements of regulation narratives such as facts, norms, competing discourses, rules and interests. Discourses are understood as broad complexes of nodal points with their genealogies and materiality constructed to create subjectivities and collective imaginaries.

A narrative can stem from one imaginary nodal point or emerge from a combination of different nodal points. Indeed, some nodal points conflict with each other, while others may reinforce each other. Discursive imaginaries act as horizons that determine the future orientation of policy narratives. In contrast to discourses as social imaginaries, cultural codes provide a critical basis though which different imaginaries are ordered, organized and reconciled within a single social order. In cultural codes, the rules of society as whole are involved. With respect to elements of narrative, cultural codes determine the ways causes, victims and beneficiaries are identified.

III. Methodology

The analysis examines the frames of health policies in the Czech Republic between 1990 and 2008. It uses the discursive approach and the cultural codes theory. I put emphasis on the factor of time – how regulation narratives evolved throughout the period analysed. Methodologically, my approach could be described a discursive historical institutionalism. I borrowed from historical institutionalism an emphasis on time and historical specificity as well as a focus on dynamics in public policy. However, in

contrast to most historical institutionalists, who have been strong proponents of positivist social causation, I focus more on ideational aspects of institutional life. I study how the language of regulation has evolved and how it has shaped the institutional framework.

The corpus includes articles in newspapers and weekly magazines. With respect to the historical character of my study, I decided for media articles because they represent a coherent corpus of data written in the same genre and covering the entire period. Using Newton Media Search, 785 articles were extracted and coded along the conceptual lines developed in the previous theoretical chapter. The search covered the period from the beginning of 1990 to the end of 2008. The final corpus contained a broad range of genres – news articles, features, interviews with policy makers and practitioners, letters to the editor, etc.

The entire corpus also comprises the transcriptions of 14 debates on health care broadcast on Czech public TV in the weekly political debate series, "Questions of Václav Moravec". This series features representatives of political parties, relevant stakeholders and experts and provides them with a relatively sufficient space for discussion (each session lasts around 120 minutes), representing the main arena for public debates among top-level politicians in the Czech Republic. The entire corpus of transcribed discussions was coded to identify what categories were used, what elements made them belong together, what meanings they signalled, and what was the point of view which made them meaningful together. TV debates represent an ideal unit of analysis because they require politicians to explain their proposals to their opponents and the general public.

I analyse three main periods in the history of post-socialist pharmaceutical regulation: (1) transformation (1990-1996), (2) consolidation of rules (1997-2004) and (3) neo-liberal reform (2005-2008). The analysis includes newspapers and weekly magazines, and allows me to explore the role of discourses of medicalisation; the role of discourses of fiscal limits in defining policy goals; and the ways policy narratives are embedded in more general codes of regulatory cultures.

In my analysis, I aim to reconstruct the trajectories of arguments made by different actors. This type of coding helps me reconstruct the main policy storylines. In analysing utterances, I put emphasis on the ways in which they articulate answers to the following questions: (1) what regulatory failures are identified; (2) what norms justify regulation; (3) what tools are preferred within a regulatory regime; (4) who should benefit and lose from regulation; (5) what are the internal and external limits of regulation; (6) what are the cultural patterns behind regulation. In each of this segment, attention is paid to how blame is prescribed.

Cultural theory's system of four core codes – hierarchism, individualism, egalitarianism, and fatalism – is used as an analyst's compass into the landscape of frames that comprises the patterns of blame and proposed remedies and integrates narratives into a broader moral order of society. My analysis of argumentation I extract claims demanding types of regulatory action, and categorise these claims according to cultural codes (Lodge, Wegrich, and McElroy 2010; Lodge and Wegrich 2011).

The transformation period (1990–1997)

The level of consumption of pharmaceuticals started to rise after 1990, hand in hand with prices and the level of spending on pharmaceuticals. Between 1990 and 1992, both national and regional health institutions were dissolved and health care facilities obtained a high degree of legal and economic autonomy. Even though the 1966 Act on Public Health Care remains the core of health care legislation, it was amended by a series of reforms which either enacted new laws or amended existing laws.

In the period from 1990 to 1997, successful implementation of new medical technologies caused both a declining trend in mortality rates and a growing demand for investment in health. Life expectancy increased from 67.6 to 71.1 for men and 75.4 to 78.1 years for women, while infant mortality decreased from 10.8 to 5.2 per 1000 live births (European Health Observatory 2000: 60). The level of consumption of pharmaceuticals rose significantly during the first transformation years. Hand in hand with a dramatic increase in prices during the same period, spending on health care was rising rapidly. Two main problems were identified by policymakers and supported by the media: a shortage of modern medicaments and a

breakdown of supply from the other socialist countries. The existing choice of pharmaceuticals was presented as insufficient and outdated. Furthermore, problems with supply started to pop up.

Problems with supply were caused by the fact that the Czech system relied too much on domestic production and the domestic pharmaceutical industry had a limited production capacity for certain drugs. On the Czech and Slovak market, a total of 45 drugs – including 11 imported and 34 from domestic manufacturers – were missing.[1] In 1990, over 800 kinds of pharmaceuticals in 1,300 dosage forms were produced in Czechoslovakia.

The health care system was portrayed as rigid, sclerotic and in need of replacement with a new flexible one. This need was also underscored by evidence of widespread public support for changing the previous health care system. Competition was understood as a magic wand which can solve problems. The concept of competition was based upon an important imaginary which followed the dictum of the Washington Consensus: to stabilise, to privatise and to liberalise.

The notion of competition allowed portraying the nascent system in a steep contrast with the hierarchical and sclerotic management of the past. The new moral order was articulated with a strong emphasis on the individualist code, with choice and competition as dominant values. On the other hand, the old system was described as hierarchist one, with a complicated system of rules and unequal access to health (as the communist *nomenklatura* had enjoyed a completely different health care than others). Perverse rules of state socialism were mentioned in contrast to market-based solutions. Individual responsibility and individual rationality were stressed in this code. On the other hand, there was a strong inclination to a social market model based on moral choice and solidarity. "Medication is not like a dress which you can buy when you don't need it. You must buy it. Many of us need our medication daily," the media reported.[2]

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[1] Tomešová L: Proč chybějí léky? Rudé Právo (22 Jun 1990), p. 5.

[2] Tomešová L: Sanitas na lopatkách? Rudé Právo (23 Aug 1991), p. 13.

A new construction of patients' roles was intended to change hierarchical relations between patients and doctors into a partnership of equals. For patients, it also brought free choice of doctor and hospital. "Above all, communism affected the individual level and led to a decline of relations between patients and doctors," Minister Martin Bojar said in an interview for the Respekt weekly. This perspective brought also an emphasis on patients' responsibilities. In relation to patients' constructions, responsibility was also a key word of the first transformation years. This is a very important point. The hierarchical system based upon rules was to be abolished not only for its ineffectiveness but also for its morality, which had ruined the relations between patients and practitioners and produced irresponsible patients.

The competitive character of health care was also mirrored in the dominant construction of patients' roles. The media portrayed patients both as victims of the old regime, when modern care was just for the *nomenklatura,* and as pupils who had to learn how to use the new system. "The public should realise that health care is not for free. People will have to pay at least a part of their prices. However, we are going to categorise drugs. For painkillers and vitamins, citizens will pay more. However, for medicaments which people cannot choose to consume because they are dependent on them, there will be a rather symbolic co-payment," Minister of Health Bojar described the philosophy of the reform in 1991.[3]

This narrative evolved around the construction of co-payment and categorisation of pharmaceuticals as the main regulatory devices of the period. Co-payments were presented as a natural and ideal state in which costs would be shared across the entire society so that modern care could be

[3] Šindelářová M: Bojím se velkého třesku (rozhovor s českým ministrem zdravotnictví MUDr.Martinem Bojarem), Respekt (11 Feb 1991), p. 5.

guaranteed.[4] Co-payments were also presented as a teaching tool for patients to use health care in a responsible way. In relation to their educational significance, co-payments as an institution did not have only their economic meaning but also a moral, symbolic one.

With respect to the stagnating health indicators and the perceived backwardness of socialist health care, the discourse of health hopes also represents an important social imaginary of the period. The dominant imaginary was to shift away from an outdated and inefficient care towards modern and imported care. The legacy of backwards health care was predominantly conceived as a burden to alleviate. However, the costs of health care were not presented as a problem. The primary locus of health care transformation was modernisation, privatisation, competition and innovation as the ways in which health care services could be improved. In terms of future horizons, the original transformation horizon was progressive. "We are not building the health care system for the next year, but for 2000 or rather 2003," Minister Bojar declared.[5]

This narrative relates to the post-communist discourse called "civic enthusiasm" by John Dryzek and Leslie Holmes (2000). The way to a fully developed democratic system is presented as very difficult, but it is worth fighting for because only this system could guarantee us prosperity and the rule of law. It would enable people to live in a normal society, unlike the communist society we have rejected. "While full democracy may take more than a generation to build, such that our children rather than ourselves

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[4] It was expected that co-payments would represent between 10 and 15% of the overall healthcare costs. A poll conducted among doctors in 1991 found 80% in support of this plan (Potůček 1999). A flat user fee of CZK 1 was also introduced for prescription pharmaceuticals. In 1992, the fee was abolished in relation to categorisation of pharmaceuticals covered by health insurance. Re-introducing of this fee was discussed later in 1994 in relation to the urgent need to discipline upward spiralling health care expenses.

[5] Šindelářová M: Bojím se velkého třesku (rozhovor s českým ministrem zdravotnictví MUDr.Martinem Bojarem), Respekt (11 Feb 1991), p. 5.

may see the true benefits, we should not wait for either economic reform or equality to pursue democracy," Dryzek and Holmes (2000: 1057) describe such a discourse.

In 1993 and 1994, alternative narratives questioning the reform and criticizing the government appeared in the public discourse. Since such critical reflections of the starting reforms were underpinned by a strong individualist code, an "interpretive cacophony" emerged. In this period, what had been homogeneous policy narratives from the beginning started to scatter along different lines. Nevertheless, those different accounts did not question dominant social imaginaries as public policy horizons but rather they served to correct the dominant individualist code or for actors to build their positions.

Some expert groups, for example, used the hierarchist code to establish their position within the regulatory setting. Representatives of medical associations claimed that specific expert knowledge was needed to prescribe medicines, general practitioners did not have that knowledge, and indeed, a hierarchic order was needed. Because of their pressure, prescription restrictions were established to control pharmaceutical spending. Only specialists could prescribe some of the most expensive drugs, and the most expensive drugs required approval by a physician reviewer. These limitations were discussed in the categorisation committee with representatives of medical associations.[6] This case illustrates that different cultural codes can operate under the same system. Whereas the individualist code was the order of justification within public, the hierarchist code was used as a principle of ordering by particular, in this context professional, communities.

Using the egalitarian code as a challenge to the dominant individualist worldview, some critics pinpointed the negative social impacts of co-payments. An increase in co-payment for pharmaceuticals

[6] According to Prokeš (2012), there are two reasons for such a tool: (1) guaranteeing appropriate diagnosis; (2) knowledge of both desirable and undesirable effects of the drug. It is supposed to increase cost effectiveness and patient safety. On the other hand, it may hinder health care accessibility and lead to overusing (more expensive) specialist health care.

was criticised by the Czech Helsinki Committee, which warned against its possible impact on the financial situation of seniors. Minister of Health Luděk Rubáš dismissed this appeal regarding an official statistic showing that the average Czech pensioner was spending 15 CZK for reimbursed medicines and 178 CZK for over-the-counter medicines.[7] The minister strictly refused to reflect social factors such as age or income in his co-payment policy. Health status was to be the only factor taken into considerations. Co-payments were also legitimised, in a fatalist sense, as inevitable. "There is no country in Western Europe where citizens do not directly contribute financially to their care," the Minister of Health declared.

Healthcare providers, on the other hand, still criticised bureaucratisation and a lack of communication. A physician complained in the Czech media: "I cannot imagine that in case of every medicine I prescribe I will be skimming through the two heavy books released by the ministry (in order to know the level of reimbursement). ... The question therefore is not whether or not doctors inform patients about the number of co-payments for drugs, but whether they are able to do so because of the incompetent work of the staff of several ministries."[8]

However, in the beginning of 1995, increases in health care expenditure began to be discussed intensively and fiscal sustainability was foregrounded. Ministry representatives initially did not blame anyone. In line with the fatalist code, they considered a steep increase in expenditures as an inevitable and natural consequence of transformation of a post-communist health care system and as a proof of their success. In some way, this narrative could still be tied to narratives stressing the fact that the benefits of reform would be consumed by next generations. However, the fatality of this narrative made room for further regulation. Immense progress had been made in catching up with Western countries

[7] Pergr, V.: Loni důchodce zaplatil za léky na recept 15 a bez receptu 178 Kč, Rudé Právo (13 Dec 1994), p. 3.

[8] MUDr. Ludvík Kychler, Valtice, Lékař neřekne pacientovi, kolik doplatí za léky, protože to neví, Z redakční pošty, Rudé právo (18 Apr 1994), p. 3.

and modernising the system, and now came the time for regulation. The government's narrative used one of the advantages of the fatalist code – to justify changes without blaming anyone.

In relation to the steep increase in the expenditures, Minister of Health Ludek Rubáš from the right-wing Civic Democratic Party (ODS) declared faster and more intensive reforms of health care, including unpopular steps, to make health care provision much more effective. "The period of pressure from the left-wing advocates of gradual and slow changes to health care, too mild to citizens, has come to an end. The changes will influence even the community of medical professionals. The Civic Democratic Party criticised existing policy and is calling for much intensive and faster reforms now," Rubáš said.[9]

The original apolitical narrative, based upon shared discursive imaginaries of the individualist code, was newly reframed as a political struggle between the left and the right. The right-wing Minister Rubáš labelled some measures such as lower co-payments for the elderly as a leftist solution and put it in contrast to his plans. His proposed changes included prescription limits – the same solution was labelled as a left-wing proposal a decade later – and individual health insurance accounts. He expected to increase co-payments of patients to 20 or 25% of the overall health budget.[10]

In 1995, a reference pricing system was introduced in the Czech Republic, setting maximum prices for reimbursement by the health insurance funds. At the end of 1995, health insurance companies owed pharmacies almost 320 million CZK. According to the Czech Pharmaceutical Chamber, six insurance companies owed more than 20 million to pharmacies (in average 250,000 CZK per pharmacy) and the biggest pharmacies had each up to three million CZK in accounts receivable[11] In general, pharmacies and hospitals owed almost one billion CZK to pharmaceutical distributors because of delays in payments

[9] Pergr, V.: Rubáš chystá razantní změny i za cenu nepopulárních kroků, Rudé Právo (21 Feb 1995), p. 1.

[10] Pergr, V.: Rubáš: Za dva tři roky by pacient měl přímo hradit až čtvrtinu zdravotní péče, Rudé právo (15 Mar 1995), p. 3.

[11] Pechová, R.: Lékárny chtějí platby v hotovosti. Lidové noviny (11 Nov 1995), p. 5.

from health insurance companies.[12] At the same time, a different problem emerged on the supply side: particular medicaments were running out in pharmacies. In order to get their products on the top of the list of fully reimbursed drugs, pharmaceutical companies pushed their prices down drastically. However, the demand was higher than expected and the companies were unable or not willing to deliver such a large amount of packages.

The period of consolidation of rules (1997–2001)

From the point of view of theory of regulation, whereas the first phase of transformation was framed mainly in the individualist code, the second phase, which began in 1996, was marked by negotiations between the individualist and hierarchist codes. In the first phase, a lack of competition was considered as the main problem by proponents of policy reforms, whereas in the second phase, a lack of order started to be considered as a problem, too.

This construction of policy rationales was shared across the political spectrum. Any increase in co-payment was considered unacceptable because of risk of losing voters, and policymakers focused their attention on the need to consolidate rules. This shift may have related to a change in the general discourse about post-communist democracy, when the previous dominant discourse of civic enthusiasm was replaced by what Dryzek and Holmes (2000) called "disaffected egalitarianism". People were dissatisfied with the individualist code based upon choice and competition, concepts they considered as facets for new hierarchies and inequalities. "Disaffected egalitarianism in the Czech Republic represents disillusion with the post-communist order, which is a democracy in name only, that masks growing social, economic and political inequality, as well as hierarchy, corruption and bureaucracy. This discourse was perhaps bolstered by the corruption and money politics that became central issues in Czech politics in the mid-1990s." (Dryzek and Holmes 2000: 1059) The change of discursive

[12] Pergr, V.: Nemocnice dluží za léky miliardu Rudé Právo (4 Aug 1995), p. 2.

environments made room for policy narratives describing abuse of power and clientelism, based upon the egalitarian code, and narratives describing the necessity of expertise and rules, based upon the hierarchist code.

In this period, important changes took place in the legal area. The main changes were connected with the accession of the Czech Republic to the European Union. The legal system was harmonised with EU law. Dlouhy and Hava (2003) called this period "the era of regulation" when an open system was quickly replaced by tight regulation. Changes in the reimbursement system ensured the essential modification of economic incentives for health providers. In particular, the fee-for-service system with its incentives for over-utilisation[13] was replaced by motivations to make it economically rational for physicians to minimise the volume and cost of services. Negotiations between health insurance funds and organised groups of providers at the national level were also introduced. The objective of the negotiations was to set fees and certain growth of expenditure ceilings.

Europeanisation also appeared in the public discourse,[14] bringing to life various examples of nationalisation of patients. In 2000, the discussion culminated when the Cabinet submitted an amendment of the patent law extending the protection of original products by five years. Domestic manufactures, therefore, asked for compensations and a possibility of testing generic drugs even in the period when the original patent was still valid. On the other hand, representatives of foreign pharmaceutical companies were, indeed, strong advocates of the new regulation. From the narrative

[13] Specialists in outpatient services were still paid through the fee-for-service system, but with tight time limits and expenditure ceilings, which in practice meant budgeting of these services. (Dlouhý and Háva 2003)

[14] For example: Náklady na léky musí růst pomaleji, Hospodářské noviny (29 Dec 1999), p. 5; ČR slaďuje ochranu patentů, Zdravotnické noviny (19 Nov 1999), p. 12; Speváková, Š: Česká kúra pro léčiva, Ekonom (25 Mar 1999), p. 14;

point of view, however, the media did not frame this controversy as a battle between domestic and foreign producers but rather as one between the national interest and the EU.

The period of chaos around categorisation (2002–2005)

In 2002, the process of categorisation came under fire from different stakeholders. The Ministry led by Social Democrat Bohumil Fišer changed arbitrarily the committee's decision on reimbursement levels and was met with a wave of protests by both pharmaceutical firms and expert bodies.[15] In a nutshell, the committee decided which pharmaceuticals would be fully covered from the health insurance system, and for this reason, it came under careful scrutiny and critique of a variety of stakeholders in pharmaceutical policy. This controversy brought attention to the way in which the reimbursement decisions were produced. In 2002, Marie Součková replaced the dismissed Bohumil Fišer, but the critique continued. In 2003, pneumologists complained about a delay in categorisation of tiotropium for patients with chronic obstructive pulmonary disease (COPD). This medicament had been waiting for inclusion in the list for three years. Every time the Committee recommended putting this drug onto the list of fully reimbursed medicines, the Ministry ignored its recommendation. The chaos culminated in mid-2005 when experts counted 86 categories in which fully reimbursed drugs were either totally missing or not available for different reasons.[16]

The entire period was marked by the ongoing controversy between experts in the categorisation committee and the ministry. The representatives of the ministry used the egalitarian code of "taking the social dimension into consideration" to justify their attempts to correct the committee's decisions. They considered the experts' view as reductionist, following medical criteria only. On the other hand, the discourse coalition of opponents, including experts and representatives of foreign pharmaceutical firms,

[15] Cikrt, T.: Kategorizace léčiv: Výrobci protestují, ministerstvo ale považuje svůj postup za správný, Zdravotnické noviny (15 Mar 2002), p. 8.

[16] Kučera, P.: Statisíce pacientů si od července připlatí za lék, Lidové noviny (18 Jun 2005), p. 1.

put emphasised a different side of the egalitarian code, namely the private capture narrative, and accused the ministry of being under the influence of lobbyists. They identified the Czech system with corruption and clientelism and put it in contrast with the transparency of European law. Discursively, this period can be characterised as a battle over justifications of who can act on behalf of patients. Patients did not have their own voice but their interests were mobilised for different reasons and they were represented in different ways. Their social interests were represented by the Ministry, and with regard to their health, expert medical groups spoke on behalf of them. All claims were justified by public interest and criticised from the perspective of private capture.

As a result, the political narrative about the Ministry correcting the committee's decisions for moral reasons was outvoiced by narratives about the Ministry ignoring expert advice in favour of stakes held by pharmaceutical companies. The latter construction was also underlined by the rapid succession of ministers. The hierarchist narrative of expert communities definitely prevailed. It was supported by an increasing dissatisfaction of the Czech citizens with politics (Linek 2010) and a relatively high prestige of medical professionals and scientists in the Czech media (Čada et al. 2006).

Julinek's Reform (2006–2008)

Czech health care changed significantly in the two decades following the fall of communism, with the second biggest reform proposed after the parliamentary elections in 2006. A reformist program was one of the highlights in the election campaigns of the two biggest Czech parties: the right-wing Civic Democratic Party and the left-wing Czech Social Democratic Party. Although the Czech Social Democratic Party won, it was unable to find any coalition partner to form government. Thus, the election resulted in a right-oriented coalition, which decided to bring the proposed reform into being. "Mutual relations between insurance funds, medical facilities and citizens do not motivate any one of them to use health care economically," Minister for Health Tomáš Julínek noted while justifying his proposed

steps.[17] He referred to his reform as a "revolution". In line with his election promises, the Minister prepared several new proposals aiming both at the privatisation of large hospitals and health insurance funds and at cost containment in health care provision. His reform program was originally articulated strongly in the dominant individualist code. He stressed the need to enhance individual responsibility and motivate patient self-regulation through flat user fees and higher co-payments. He also stressed market-based solutions, modernisation of health care, and the need to innovate and shift away from inefficient care. The Minister declared two goals when the reform was being launched: "The two main goals of the reform are to improve the status of the patient and to deal with the effects of ageing of society. The Czech Republic is one of the most vulnerable countries in the European Union. In 2050, there will be public funds for less than half the care needed. In 2015, we will miss at least thirty billion."[18]

The discussion gradually boiled down to the fiscal responsibility goals. Controlling healthcare costs became top priority in the discourse, which was driven by a combination of factors, including arguments over resource scarcity, population ageing and patient responsibility. The prevailing focus on savings was mirrored in the way that the reform's achievements were presented to the general public. Pharmaceuticals played a very important part in this process. "Since we introduced the reform, the consumption of prescription drugs has decreased significantly and more prescription drugs have been sold. As a result of the new system, nearly two billion CZK were saved in the last quarter of the year," Minister for Health summed up.[19] Savings became a key measure and wasting of money was attributed mainly to choices made by individual patients who allegedly over-consumed healthcare because of insufficient financial motivation. "The main rationale for the reform was to reduce public expenditure;

[17] T. Julínek představil svůj program, Medical Tribune (18 Sep 2006), p. 1.

[18] Otázky Václava Moravce, Česká televize (4 Nov 2007)

[19] Otázky Václava Moravce, Česká televize (8 May 2008)

moreover to achieve a psychological breakthrough and make the patient aware that health care costs money and it is necessary to weight one's actual needs," the Minister explained.

The reform's proponents justified savings in some sectors as a way to ensure more spending or stability in other parts. They were trying to put under one umbrella two imaginaries – the discourse of health hopes and the discourse of fiscal responsibility. When the reform was being debated, the issue revolved around two general regimes of care: health efficiency and economic efficiency. The first regime represented modern treatment, which was promised to be guaranteed regardless of the costs, while the second regime represented a domain where more expensive drugs could be replaced by cheaper products and patients could pay more for their care. While outpatient care was associated with cheap and generic drugs, hospital care was associated with expensive and unique medicaments.

Six main categories of health care have been identified: (i) uniqueness; (ii) novelty; (iii) origin; (iv) price; (v) indication; and, (vi) way of distribution (see Table 8). In the health efficiency regime, care was associated with the concepts of originality, novelty, foreign medicaments, acute states, and cancer treatment. This type of care was in the hands of professionals in hospitals, who distributed it reasonably. Julínek's reform proponents argued that strict regulation was not needed. On the other hand, the economic efficiency regime associated care with standard quality, domestic products, chronic illnesses and outpatient care. This regime was seen as wasting money and in need of regulation. This categorisation replicated the dominant media representations of professional medicine as a way to treat sickness competently and successfully by doctors in hospitals using latest technology and fast-acting drugs (Lupton 2003: 57).

Table 8: Architecture of health care categories and their dimensions in Julínek's reform

Dimension	Health efficiency regime	Economic efficiency regime
Uniqueness	Unique	Standard
	Original	Generic

Novelty	Modern	Old
Origin	Foreign	Domestic
Price	Expensive	Cheap
Indication	Acute	Chronic
	Cancer	Unspecified
Way of Pharmaceuticals Distribution	Hospital care	Outpatient care
	Professional responsibility	Individual responsibility

The alternative narrative of a coalition of the oppositional Social Democrats and representatives of the domestic manufacturers producing mainly generic drugs stressed a worsening access to medicines and extensive support for foreign pharmaceutical companies. Health effectiveness was questioned and modern treatments were associated with the profit of foreign companies. "Modern, new and expensive drugs are the flagships of the pharmaceutical companies, bringing them huge profits. It is, therefore, abundantly clear in whose name the Minister is playing."[20]

In the health reform, the individualist code associating the wasting of money in health care with inadequate financial motivation of patients and outpatient care prevailed. In this economic discourse, out-of-pocket payments and user fees were considered to be a magic wand which would turn passive patients into active consumers. In the elections following the reform, however, Czech patients refused to be identified with wasting in the health care system and voted against parties standing behind the discourse.

[20] Sýkorová, V., Křenková, K.: Léková politika v ČR, Haló noviny (4 Jun 2007), p. 8.

In autumn 2008, the Czech Social Democratic Party focused on user fees as a central issue in the regional elections campaign. The electorate refused to be blamed for health care costs and governmental right-wing parties lost significantly in this election. Consequently, major government reforms were stopped and the author of these reforms, Minister of Health Tomáš Julínek, was dismissed. Two years later in the 2010 parliamentary election campaign, health care played just a marginal role (Sedláček and Herot 2011). Regarding Down's (1972) theory of attention cycles, a period of intensive organisational activity was replaced by a decline in interest by the main political parties caused by the public refusal of the last reform attempt. The consequences of the health reform were devastating for the Minister of Health and his reform team. The opponents appeared to score a great political victory but the policy itself did not fail completely. Even if the government gave up the next steps of the planned reform, the changes that had already been implemented still prevail.

V. Discursive imaginaries and cultural codes

Contemporary biomedicine interlinks a diversity of hopes, generates a diversity of possible futures, and offers us various choices we can make to enjoy a good quality of life. This discursive imaginary of health hopes is connected with promises of better care, medical innovations, shifting away from an outdated and inefficient care, and increasing life expectancy and quality of life. It urges us to think that modern medicine makes our lives better and longer. This imaginary structured significantly the first period of post-socialist transformation and neoliberal reform after 2006. In both cases, this imaginary was contrasted sharply to the hierarchical and sclerotic systems of the past (firstly the communist regime, later fiscally responsible socialist governments) that were too inflexible to react to acceleration of the biomedical field. However, under the same imaginary, hierarchies of knowledge and a superior position of medical experts were constructed and maintained. From the institutional point of view, this imaginary put into being tools to enhance the implementation of medical innovation and responsibility in the medical sense.

However, since the 1980s, the health budgets of Western European countries have been under constant pressure. At the same time, patients' expectations have been rising and, in turn, expenditures have been rising as well. The tendency of doctors to overuse medicines and the monopoly power of pharmaceutical companies are both long-standing justifications for public policy efforts to reduce the prices of pharmaceuticals. During the period up to 2009, all OECD countries saw their health spending outpace economic growth. This excessive spending is believed to produce unbalanced public budgets and make budgets more prone to fiscal crisis; but it allegedly also ruins temperance and prudence as the fundamental moral principles of the modern capitalist state.

The policy narratives of post-socialist fiscal reforms since 1996, have been framed not only as a way in which public budgets can be cured but also as cures to moral order, renewing responsibility, transparency and rule of law. Under the same imaginary, one can encounter either depictions of corrupt individuals consuming health care irresponsibly, or with images of greedy pharmaceutical companies which are able to capture policymakers to act in their interest. This imaginary has been connected with concepts such as increasing government debt, healthcare spending, insecure fiscal future and economic responsibility. From the institutional point of view, these discursive imaginaries justified the tools that limited expenses and enhancing responsibility in the economic sense.

These transnational imaginaries directly influenced the Czech policies but also steered them through supranational structures such as the EU. National policy makers reflect on institutional development in other member states, and the EU itself has some powers over pharmaceutical regulation. With emphasis on making modern pharmaceutical products accessible in the European market, the European Commission can be counted as a strong institutional promoter of the social imaginary of health hopes, namely in its biomedicalised mode. Besides, the European Union promotes also the elements of fiscal stability through the European Central Bank or the euro convergence criteria. The Union, however, produces these contradictory discursive imaginaries as institutionally separated. Because there is no common European budget for pharmaceuticals, conflicts between medical innovations and fiscal

responsibility do not have to be reconciled at the European level and are left by the European commission, as an institutional actor, to individual states.

After 1989, the first period of transformation was characterised by a dominant individualist code, focusing mostly on basic market-oriented reforms such as a pluralistic health insurance model to guarantee up-to-date treatments. It resulted in a growth of total health care expenditure. In the context of accession to the EU in 2004, as reforms of public administration and transposition of European norms were being conducted, a hierarchist code stressing the need to consolidate rules prevailed. The last complex reform was proposed after the parliamentary elections in 2006. The reform plan corresponded with a global shift towards a neoliberal paradigm in health care, focusing on consumer-oriented services obtained in the market and patients as responsible and rational actors.

In the Czech context, the individualist code served predominantly to articulate a combination of the health hopes imaginary and the fiscal responsibility imaginary. On the contrary, the hierarchist code was often employed to express the fiscal responsibility imaginary. This historical configuration marked significantly the character of post-socialist welfare, because the positive imaginary of modernisation of health care was always associated with the individualist discourses of market-driven reforms. Efforts to strengthen rules and hierarchies, on the contrary, were much more underscored by fiscal doomsday scenarios.

However, unsuccessful neoliberal reform demonstrated that the hierarchist code resonated much more with actual public perceptions of health care. Czech public opinion was strongly convinced that health care is a public good that should be guaranteed by the state (Buchtik 2013). This case illustrates the fact that policy narratives are read with respect to the ways the public understands the workings of democracy and the role of government.

In this case, the shift away from a discourse of civic enthusiasm, typical for the first transformation years, towards disaffected egalitarianism seemed to be a crucial one. Disaffected egalitarianism represents disillusion with the political system, a “democracy in name only, that masks growing social

inequality, as well as hierarchy, corruption and bureaucracy" (Dryzek and Holmes 2000: 1059). Supported by increasing dissatisfaction of Czech citizens with politics, this discourse made the pharmaceutical regulation untrustworthy and gave rise to different private capture narratives.

However, it seems that policy makers did not echo this egalitarian code in their narratives but rather they translated it into narratives structured by the hierarchist code. Instead of enhancing of public participation or public oversight through third parties, such as NGOs, they intended to solve the problem by writing new rules and further increasing the complexity of the system. Complex rules such as the categorisation practice led to an increase in the share of private cost and co-payments without making it publicly visible and disputable. The technicality of the rules displaced them from the public political arena. Even though the Czech public refuted the individualist approach of Tomáš Julínek's reform, the steady increase in private expenditure, as evidenced by economic statistics, was well understood by the public. Inscribed in the system's technical rules, however, such trends were not reflected in the policy narratives and broad discussions.

Conclusion

Cultural theory uses cultural codes for classification of different societies. My analysis proposes to consider them rather as orders of justification, which define boundaries within society. For example, even in periods of dominance of the individualist code, the medical field continued to be described in the hierarchist code. At the same time, the political arena distinguished itself from the expert arena by using the egalitarian code, and the requirements of European law were displaced from the political arena using the fatalist code. From this perspective, cultural codes are not only used to blame perpetrators, identify victims and categorise solutions, but they serve also to construct the position of author and to define different moral orders for different realms of society.

This interplay between different codes under one umbrella can explain the categorisation rules underlying the distinction made during neoliberal reform between the regimes of health efficiency and economic efficiency. Whereas health efficiency was articulated in the hierarchist code with emphasis on

specialized knowledge of medical professionals, the economic efficiency regime relied on the individualist code. It seems that where discursive imaginaries are in conflict, cultural codes play a crucial role in defining boundaries between different orders of justification of evaluation.

Survival abilities of modern organisations do not rely on their organisational efficiency, but rather on their ability to incorporate socially legitimated elements in their formal structure. Consequently, such incorporation relies on a narrative practice which constructs, through interconnecting the past with future imaginaries via cultural codes, specific disequilibria and ways in which new equilibria can be established. These constructions of disorder formed the foundation of specific rights and authorities for particular institutional changes. The explanatory model based upon an interplay between paradigmatic discourses and cultural codes in narrative structures provides us with a key to critical examination of institutional dynamics in modern societies. My analysis attempts to demonstrate that a combination of Foucaultian discursive analysis with cultural sociology might provide the explanatory model to grasp this interplay in its complexity and with respect to the main structural elements.

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