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CHAPTER FOUR

Local Institutions of Health Service and Social Welfare

Ivo Řezníček

4.1 INTRODUCTION

Since 1989, the societal transformation that has been taking place in the Czech Republic has assumed the form of gradual changes

- from state paternalism and centralized decision-making toward individual and communal responsibility of citizens;
- from untraceable redistribution of wealth toward transparent tax, insurance and assistance systems;
- from aggregate economic and social policy-making toward a clear distinction between autonomous institutions of market economy and the welfare state.

These three processes of political, social and economic transformation can be seen as a single undertaking with uneven effects on the society. *In the economy*, private involvement has become widespread as a result of partial de-etatization of enterprises and the rise of independent businesses. *In politics*, plurality of interests found expression in the existence of a number of political parties operating in the parliamentary system. However, the restructuring of communal and county *administrations* has been less pronounced. In the areas of education, health and social welfare, most institutions have remained public, and their transformation from unresponsive bureaucracies into agencies accountable to their clientele has been slow.

The processes of political and economic transformation have been described relatively well in the Czech press as well as abroad. Comparatively less attention has been paid to changes of public policies, particularly at the local levels. In order to describe this process, we have focused our attention on the systemic reform of social welfare and health policies. Their transformation is being realized at several levels, beginning with new legislation and restructuring of ministries, through creation of new governmental and nongovernmental institutions,

and ending with changes in county-- and community-based administrations and facilities. In order to see the impact of the reforms at a regional level, we have intended to observe and describe the transformation of the institutions of the social welfare system (including health services) in the locality of *LITTLETOWN* where the parallel study of the *DOMUS FACTORY* was conducted.

Any attempt at understanding social welfare reform should begin with the realization that the process has only begun and is in its initial stages. Until 1990, the communist government had been developing and administering a centrally directed welfare state in Czechoslovakia that had provided several distinct "social guarantees":

a) universal guarantee of employment (albeit compromised by a de-facto compulsory nature of employment);
b) employment-related guarantee of old-age and disability pensions, vacation and recreation benefits, childbirth benefits and childrens' allowances;
c) employment-related guarantee of health services provided without pay, and associated sickness and maternity leave benefits;
d) guarantee of social and health services and financial benefits for specific categories of people (such as orphans and neglected children, the disabled, the aged, and the "socially unadaptable");
e) universal guarantee of education provided without pay (although of limited access at secondary and university levels);
f) guarantees of rent subsidies and supports for self-constructed or employer-constructed housing.

All these guarantees were financed from the state budget, which was saturated by draining profits of state enterprises or cooperatives where practically all of the adult population was employed. All were provided through highly hierarchical, Communist Party-directed, heavily bureaucratized, state-owned systems of employment, social, health and education programs. Run by individual ministries, these systems were relatively independent of one another and centralized to different degrees. All were, however, subjected to policy directives of the Communist Party. Their financing, channeled by the Party through the state budget, was hidden from the general public and professionals alike and their redistributive impact was difficult to trace and influence.

This situation was further complicated by the fact that the more profitable and/or more influential enterprises and industries had begun to offer their own health and recreation services, child care, educational subsidies and subsidized housing. The state-provided health and social care was thus complemented by corporate benefit schemes but both were under the administrative control of state, regional and local bureaucracies. The corporations neither owned nor ran these facilities. However, by providing financial support for their operations,

they could individually strengthen the benefit provisions tied to the employment status of their workers.

Nevertheless, the standards of care provided and the relative value of available benefits had expanded in the 1950s and 1960s. However, they began to stagnate in the 1970s and deteriorate during the 1980s. While the health care system as a whole continued, its operation under relatively solid professional standards, philosophies and practices of educational and social welfare systems had considerably eroded. None of these systems, however, received adequate funding and neither was primarily committed to clientele satisfaction. The strongest guarantees of well-being of citizens were thus vested in the corporate employment and the entitlement to benefits related to employment. People outside the labor force (the elderly, the disabled, nonworking mothers, students) were less adequately covered and often had to rely on the support and care of their family members.

Already during the 1980s, transformation of the health and social service sector had begun or was being planned as the professionals and politicians sensed their deterioration. Various participants in the process, particularly the professional experts from the so called "grey zone" (neither committed communists nor dissidents) were instrumental in paving the way for the changes that have taken place in the 1990s.

Subsequent attempts to theoretically explain this change in the post-communist societies have been mostly derived from studies and empirical analyses of cultural, social and professional human capital. They can be divided into

- theory of replacement, assuming a decline of the previous entitlement-oriented communist elites and their substitution by merit-oriented non-communist groupings in the decentralized market (Nee);
- theory of continuation of interrupted development according to which the bourgeoisie suppressed in the socialist era is now regaining its legitimate position (Szelenyi); and
- theories of transfer of social and cultural capital into new conditions presupposing cooperation among all those interested in gaining and maintaining advantageous status in the society (Szalai, Možný).

From the developmental perspective, the most characteristic feature of the local government and the health, education and social service sector prior to 1990 was that it had been constituted as an integral part of the communist bureaucracy. Party membership and discipline was almost a necessary condition for pursuing professional career in these occupations. This, of course, is now no longer necessary but habits and practices of the previous era have a certain inertia and are in competition with new economic realities and management approaches that are being introduced in the public sector.

What we wanted to find out was the extent to which the centralized, inflexible and bureaucratic habits ingrained in the public sector at regional and local levels since the 1950s have been affected by the societal changes since 1989.

4.2 METHOD

The process of reform begun in 1989 is expected to result in changes of property ownership that will affect, among other things, provision of various benefits and services previously provided to the citizens by the state. Privatization of businesses and decentralization of government will change the nature, extent and balance of goods and services that in the past had constituted the "social certainties", i.e., guarantees of a basic standard of living, full employment, free medical care and education, and equitable wage levels. They are expected to be replaced by a less equitable, merit-based system of deserved benefits. In order to understand the nature of these changes, our study has focused on *LITTLETOWN,* a small town with a major employer, the *DOMUS FACTORY,* and its administrative background in the county seat of *HIGHLAND.*

In particular, we have focused our attention on selected areas of the organized public and social sphere, i. e., local government, labor market, social security and assistance, social service and health institutions. These are the bodies that are expected to mediate the impact of the economic reform at the local and regional levels.

In our analysis, we have mostly left aside the system of social benefits as such, although attention was paid to institutions that administer these benefits. We also have not covered educational, judicial, law enforcement and military institutions because they lie outside the realm of health and social programs. Although they are important institutions in their own right, they were difficult to access, in part because they were still under full or substantial control of the old communist leadership. Because the operation of local agencies in *LITTLETOWN* cannot be understood without regard to their organizational context at the county level, we had done an extensive research at relevant county offices and institutions as well.

Several leading research questions formed the study: *What changes in the mission, content, structure and management have taken place in the institutions? What personnel changes and how motivated they were? What changes in the budget? What changes in the clientele? What changes in the sanction and accountability? How did the institutions fit into the the local public networks? How were the public institutions related to local businesses? What was the general character of the institutional changes? How did their clientele perceive these changes?*

Our primary methodology were structured interviews of management and staff, complemented by brief surveys of clients.

Interviews were conducted with managers and personnel of the health and social service network in *LITTLETOWN*, the location of the *DOMUS FACTORY*, the *DOMUS FACTORY* itself, and in the town of *HIGHLAND*, the seat of the county where *LITTLETOWN* belongs administratively.

4.3 FINDINGS

4.3.1 The Health Sector

Of the three areas of our analytical concern (health sector, social security and services, services provided by the corporate sector), the medical system is currently undergoing the most profound transformation. Theoretically, the reform of the health system aims to "increase life expectancy to the European level, decrease illness and disability rates and increase the quality of life". In practice, the state is giving up its monopoly in the provision of health care while guaranteeing its universal availability.

Previously, the Ministry of Health controlled the provision of health care centrally, through its budgetary and regulatory authority, down to its regional and county or municipal Health Committees (bureaucracies) and its Institutes of National Health (care providers). Administrative decentralization will now gradually transfer the health facilities to the most feasible extent to county, municipal and communal ownership. Privatization will enable physicians to establish private practices. State control of the health sector will be replaced by professional accountability and management by nationwide professional associations and elected local health boards. Financing of health care will be based on market mechanisms, i.e., true health insurance. The most radical changes in the provision of medical services thus involve financing of health care and ownership of health service facilities.

Until 1992, the financing of health care and social care came from general state revenues contributed to by employers at the level of 50 percent of wages paid to their employees. From the beginning of 1993, a bona fide health insurance system has been in operation, based on combined and obligatory contributions of employers (9 percent of wages) and employees (4.5 percent). These health funds are collected by the General Health Insurance Company and 15 other regional, industry branch and corporate insurance companies, all of which are independent of the government. These compulsory contributions represent a slightly smaller proportion of the national budget than before. They finance actual health care, wages of personnel, and investments.

What is of paramount importance is that in parallel with the establishment of the health insurance system, individual practitioners began privatizing their professional practices within state-owned facilities, mostly local clinics and spas. (There were neither private health practices nor facilities in Czechoslovakia prior to 1990.) In practice, this means that doctors and nurses purchase space and equipment from municipal and county Health Departments or purchase them on their own, on credit. Then they make arrangements for reimbursement of their services to clients by the local branches of health insurance companies.

Furthermore, during the course of 1993, physicians, communities and possibly corporations will be able to privatize also, selected primarily outpatient health facilities as a whole. The privatization of individual and group practices is already under way while privatization of larger health facilities has not been legislated yet and its implementation has been stalled for political reasons. Parties of the coalition government have not yet agreed on the definition and extent of facilities to be privatized.

Principal vehicles of these changes are the insurance companies. They are nongovernmental bodies established independently according to parliamentary legislation, and technically under parliamentary supervision. By virtue of collecting insurance contributions from employers and their employees, and disbursing finances to doctors, clinics and hospitals according to the number and nature of services provided, they in fact influence the type, quantity and quality of provided health care. The *General Health Insurance Company* is the largest if not universal insurer, covering about 92 percent of the population. Its accounting therefore has a strong impact on health care. The others are special trade and corporate insurers.

The new financing and privatization of health care are engendering several important changes in the system. There is a strong pressure exerted through the mechanism of reimbursement by the *General Health Insurance Company* (GHIC) toward greater effectiveness in the provision of care. GHIC has developed and introduced its List of Activity Fees, an official price list for particular medical services. Through the price standards and through its inspector corps, GHIC controls the cost and extent of provided medical care. Compared to the West, there is overemployment of health personnel in the Czech Republic by an estimated 20 to 30 percent. While it is not excessive, reductions of staff in hospitals and clinics (particularly nurses and support personnel) and limited closings in the local outpatient system can be expected soon because of impending competition and cost controls.

In addition, there is evidence that the GHIC List of Activity Fees has skewed the balance of provided services, left certain services unpaid or underpaid, and caused inflation of reported service deliveries. This has already led to underfinancing of less populated regions and of less politically powerful specialties (such as psychiatry), competition among care providers and medical

branches, and neglect of certain areas of care (such as long-term hospitalization, geriatric care, preventive health care and occupational medicine).

It must be said that, comparatively speaking, the health field has been traditionally the most professional and merit-oriented of all helping professions in the Czech Republic. Even in the communist era, maintenance of educational and services standards had remained a matter of unquestioned professional pride and loyalty. The current systemic transformation is taking place under a vigorous professional control of elected representatives (centrally by the Chamber of Physicians and locally by Municipal or County Health Departments) so that the quality of care does not diminish substantially under the fiscal pressures.

In *HIGHLAND COUNTY*, the pivotal institutions of the health care system are the hospital and the outpatient clinic located in the county seat. Attached to them are two local outpatient clinics in smaller towns, several community health care centers (one in the community where the *DOMUS FACTORY* is located), several corporate health care centers (one inside the *DOMUS FACTORY*), and a dental clinic in the county seat. Privatization projects have been submitted to the Ministry for Privatization in regard to some of these local clinics and centers.

Furthermore, in the process of decentralization, the County Hygienic Service (Public Health), Pharmaceutical Service, and a Home for Disabled Children that used to belong to the former County Institute of National Health, located in the hospital and the clinic, became self-managed independent entities in 1992. Now they are being financed from the county budget outside the health insurance system.

The hospital and the clinic have experienced the impact of the GHIC regulatory and financing procedures immediately after their introduction in mid-1992. First of all, investment and maintenance budgets were slashed. Second, costs incurred by particular units have been subjected to monitoring and inspection. In consequence, certain uneconomic departments are being curtailed and others made more effective. Third, services provided by the hospital and clinic but not reimbursed by GHIC (long-term illness hospitalization, rapid response service) have to be subsidized from the county budget or from charitable sources, forcing their cuts. Fourth, the clinic is now undertaking the privatization of several activities of individual physicians, and the structure of its departments, services provided and personnel is also changing (personnel from rehabilitation was moved to long-term care, geriatric nurses were laid off). In comparison with the highly impacted clinic, the hospital has not suffered much from the changes, in part because its director is a member of national consultative bodies and can effectively adjust to anticipated trends, in part because its competitors are not as powerful as in larger cities, and in part because the hospital is not planned to be privatized.

The GHIC reimbursement system also tends to influence relationships between the hospital and its outpatient clinic on the one hand and the local clinics

and health centers on the other hand. Previously, the local facilities were not forced to behave economically and their determination of need for particular services was based solely on diagnostic criteria. While the small local facilities staffed by general practitioners can be privatized readily, the county clinic, because of its size, complexity and specialization, experiences difficulties.

The competition for clientele is changing the behavior of local practitioners as they tend to provide as many services as possible by themselves. The size of their clientele and the extent of their services simply determines their income and hence their ability to stay in business. Competition for clients may also endanger the relatively redundant local facilities. Moreover, some local doctors and nurses whom we contacted say privately that fiscal pressures may bring or have brought about irregularities in the service delivery. Geriatric services, for instance, have weakened, and outlying localities have experienced longer service delays than was customary before.

Nevertheless, these changes do contribute to overall improvements in health care management. Leadership of the county hospital and clinic was democratically elected by the staff for the first time since the 1950s and enjoys general popularity. The respective roles of various facilities have been divided and redefined, and their accountability to the county government has been strengthened. Government oversight has diminished and the county hospital and clinic have become more autonomous. The situation in local clinics and health centers is less transparent and more uncertain. For instance, there are two competing projects for the privatization of the local clinic in the community where the *DOMUS FACTORY* is situated. If the project of the general practitioners currently employed at the center should lose in the contest, the center would be privatized by dentists from outside the community and the structure of provided services would be radically changed. If the physicians' project is selected, the center could become a strong competitor to the two factory-based clinics in *LITTLETOWN* that cannot be sustained by the employee clientele itself and would have to be either subsidized by the corporate management or opened to the public.

Personnel changes so far have been minimal in the county health system under our scrutiny. They involved departure of several politically compromised managers and a few doctors and nurses charged with documented unprofessional conduct. However, expected changes in the work force that are related to privatization and economization will be much more pronounced than in the past.

First, the county health system, riddled with inefficiency and overemployment, will have to eliminate up to 30 percent of superfluous personnel. According to the director of the county Health Department, the most feasible alternative is to freeze hiring. If implemented as expected, new graduates of medical schools will find it difficult to get employed in the county. Second, privatization of physician's activities, both as independent practices and as practices within

the outpatient clinics, has led and will continue to lead to layoffs among nurses and other medical and support personnel in order to cut costs. Bankruptcies of new practices are also possible. As a result, quality of care and professional time spent per patient may diminish as a result. Access to medical care may also change and patients from distant areas may experience complications and delays. At the time of the study, however, patients interviewed in the hospital and the clinics mostly did not perceive any changes for the worse when specifically asked about service delivery.

The health care professions had been highly hierarchized before and little change has taken place in that respect in the last three years. Physicians still enjoy substantially more power than the other health and support personnel and clientele is not involved in providing feedback, except for being able to complain about malpractice more effectively. Apart from the greater threat of layoffs to nursing and technical personnel than to doctors, this also means that the relatively impersonal standard of patient care by doctors continues from the previous period. Most of the questioned hospital and health center patients nevertheless expressed satisfaction with the quality of received services and perceived no changes in the extent of their provision.

In sum, the health sector is being strongly influenced by changes in health insurance and privatization of facilities. Although it is too early to give clear evaluation of current developments, it appears that there is relatively less financing available for health care in the county than before. As a result, competing pressures for greater effectiveness and a greater amount of provided services lead to increasing competition among providers and imbalances in the provision of care. Nevertheless, the health sector continues to be managed professionally and has remained most stable in terms of service standards and personnel qualification as well as universal delivery. Staffing can be expected to decline, however, particularly among nursing and support personnel, and access to care may become more difficult for patients living at greater distances from the population centers.

4.3.2 Social Security and Social Services

In social policy (social insurance, social assistance and social services), the changes that have taken place in the Czech Republic since 1990 have not affected existing institutions as much as those in the health care. In 1994, the system of social benefits will undergo an overhaul similar to the establishment of the *General Health Insurance Company* but their financing will come from both insurance contributions and general revenues. Social services have been undergoing decentralization since 1991 and their privatization is also expected, although to a lesser extent than in the health sector.

Underlying this transformation is a new conception of social policy formulated in 1990. According to it, social programs will be restructured into a) social security (insurance-based pensions, illness and caretaking benefits, motherhood benefits and unemployment compensation) and b) social support to certain categories of beneficiaries (guaranteed income benefits, child allowances, birth and death cash benefits and armed servicemen cash benefits).

In addition, c) the state will provide financial benefits and social services to certain persons who may need them (such as the frail elderly, neglected and abused children, persons returning from prisons, the disabled) but without the categorical entitlement (the state is not stipulating eligibility criteria and provides benefits on a case-by-case basis). Private charities are invited to provide facultative benefits and services as well (to whomever they themselves decide to offer them).

A three-tier system of social policy is thus being created, consisting of obligatory and comprehensive insurance, categorical assistance, and facultative social assistance and care. The corresponding institutions responsible for implementation of this policy will be county and municipal *Administrations of Social Security, Social Departments* and various social agencies. The *Social Departments* have been created out of previous Social Affairs Administrations at county and city levels. The *Social Security Administrations* have been established as separate new institutions that have taken over the most of the accounting and pension provision functions from the previous social affairs administrations. Social service *agencies* (for the aged, the disabled, children, and other persons in need) have been emancipating themselves from the previous social affairs administrations or are being created anew. Some are nongovernmental non-profit institutions built upon the interrupted traditions of pre-war social welfare.

In *HIGHLAND COUNTY*, an autonomous *Administration of Social Security* (ASS) was created in 1992, but it is still being funded from general governmental revenues rather than from bona fide insurance contributions. There is as yet no social insurance office, and the transformation of ASS into an insurance–like company is expected to take place in 1994. Organizationally, however, ASS has already been completely withdrawn from the system of the county government to which its functions previously belonged and on whose personnel it has drawn. ASS has begun to function as a provider of entitlements (pensions and compulsory benefits) and is no longer involved in provision of need-tested (voluntary) benefits and services.

Essentially, it is being built as an impersonal, client-shy, legalist and effective financial bureaucracy. Although its administrative leadership includes former CP members from the previous county government, the office has already hired new personnel from the outside. ASS does not have an advisory board yet but otherwise all legal instruments set up for its functioning are post-communist.

Its clientele is almost universal, including all employed persons without long-term disability. A substantial change in comparison with the pre-1990 past involves a steady rise of the insured from private businesses and from self-employment. Cost to the employer is relatively higher than it was before and it is also higher than in most Western European countries (34 percent of gross wages).

The budget is allocated centrally by the Czech government but administered locally according to standard actuarial criteria. One important characteristic of the emergence of ASS is that it has apparently become personally and organizationally isolated from other county institutions of the health and social sectors. Locally, ASS mostly acts as an impersonal institution delivering financial benefits to entitled persons by mail. One exception is its duty to monitor the illness and recuperation status of its clients in their own homes.

A substantially different picture has emerged at the new county *Social Department* (SD). This is an institution that has previously concentrated in its purview all essential social programs in the county. By design, the former Social Office (and before it, the Health and Social Office) of the County National Council (local communist government) ascribed and distributed pensions and other financial benefits, dealt with all social clientele in the county and controlled all social service agencies in the county.

After the decentralization, SD was deprived of pension provision which was delegated to ASS in the local communities. In addition, several service agencies became legally autonomous (homes for the aged) or subject to national authorities (home for the severely disabled and home for children) while others were newly established (home for disabled children, social foundation). Direct provision of facultative benefits to the poor, although financed from the county budget, has now become the responsibility of local communities (larger village or town defined as "focal commune").

DSA thus became a coordinating and financing body with responsibilities for allocation of social services to persons in need (primarily the disabled, the frail elderly and the solitary elderly). It has retained, however, its own service unit. This is responsible for direct assistance to children at risk and their families (asylum, foster care and adoption), the poor, and the so called "socially unadjustable" (the homeless, former patients of mental hospitals, and persons returning from correctional facilities). SD also finances and administers a *psychological counseling center* in the county seat, *a day home for disabled children and a care service for the elderly* (meals delivery and subsidized housing).

Organizational changes at SD have caused disruption in the coordination of social services in the county. Previously, the relatively tightly controlled county network functioned under relatively clear criteria of service eligibility and service performance. These were based on advice and regulation from the ministry

and a now defunct methodical center in the nearby metropolis of the larger region. Over the last three years, SD administration has suffered from changing ministerial conceptions of social policy, changing legislation, poor coordination among various national and regional policy making bodies less than perfect dissemination of essential information from the Ministry of Labor and Social Affairs. Informal practices, previously an important aspect of social service delivery, seem to have been strengthened by this development.

These difficulties have been exacerbated by political and personal struggles over the division of the former *Health and Social Office.* Before 1990, personnel policy in the county administration was nepotistic, and some persons who had engaged in it are still in positions of power. Moreover, only two persons from the previous leadership of the Office were fired for political reasons, and key positions of its successor institutions are now held by people who had actively supported the communist regime before.

Additionally, the budget of the Social Department has been apportioned relative to the needs of other institutions of the county network, including the *Administration of Social Security* and the *Labor Office.* As a result, the finances available to SD have been diminishing in real terms since 1990. This has affected investment, maintenance and hiring. Although the number of clients in need has grown, the SD personnel has not been enlarged. Casual observation of work at SD revealed that due to increased workloads, crisis resolution plays the central role there while lesser problems cannot always be attended to. When asked, the staff did not mention any radical changes in their way of delivering services since 1990 except for the establishment of the facility for disabled children.

The Day Home for Disabled Children was opened in the county seat due to the personal involvement of a parliament deputy from the region who was able to secure the extra start-up funding from the Ministry and from private foundations. Operating in its second year, the home is serving a small number of mentally disabled children from the county. However, because of transportation costs most of the clientele comes from the county seat rather than from the outlying areas. The waiting list exceeds the capacity of the home. Staff is newly hired and expert and the program was designed according to standards of similar facilities abroad. While administered autonomously, the home is financed from the SD budget and donations. County financing is insufficient and the continued existence of the home is by no means certain. It seems, nevertheless, that the facility is quite adaptive to needs of its clients and their families. It is operating less formally and more enthusiastically than other social institutions in the county. Due to its precarious existence, the home has developed good ties to important county institutions, namely the medical and educational establishment and facilities.

This is less true about the homes for the aged which draw their clientele from the whole county. The homes are in high-rise apartments built in the late 1970s that were converted for their particular purpose, to provide institutional care of aged CP members and former trade union officials of county prominence. Ordinary elderly citizens deemed eligible for institutional care were housed in an older structure before. Only after 1989 has this elitist practice been abolished and the new homes have opened to wider clientele. It is important to note that the eligibility criteria for placement in the homes are a diminished capacity of a client to take care of oneself and the absence of a caretaking family network. Theoretically, most of the incapacitated and the lonely from the outlying area should be placed in the homes but demand exceeds their capacity by about 20 percent. As a result, some eligible do not get placed in the homes.

Apart from the change in the clientele, the most important aspect of the transformation was the administrative emancipation of the homes from the county government, and changes in their financing. Legal autonomy has enabled the management to pursue the purposes of care for the aged more independently. Previously, placement decisions were made by the county social administration, sometimes without regard to the internal conditions in the facility or even to eligibility criteria. Now, the personnel can influence the placements relatively more. In terms of financing, state subsidy ceased to be the only available source at the beginning of 1993. From then on, the county and the clients themselves have also contributed. So far, this change hasmeant that less money is now available to the homes, and as a result, planned investments had to be postponed.

Staff changes have been minimal, and politically substantiated departures were only two. The stability of the personnel is considered an advantage, and the homes appear to have sufficient and expert personnel in terms of medical care, housing and food. The program has not changed its structure since 1990, and compared to standard homes for the aged in the West, clients appear to be passively surviving. Social, therapeutic and reactivation activities are absent from the homes. Upon inquiry, most clients expressed satisfaction with their situation, however.

The institution most closely involved in alleviating the negative impacts of transformation in the locality of *LITTLETOWN* is the municipal government, particularly its *Social Division.* Prior to the dissolution of the county Social Administration, there was no autonomous body dealing with social problems at the community level. Since 1991, all towns and several larger villages (focal communes) have established them. They now have the capacity primarily to assess financial and service needs of their citizens, to provide relevant information to them, and to disburse benefits to them from the social support and social assistance funds.

Of all the institutions that we had an opportunity to visit, the local government in *LITTLETOWN* appeared least reformed. All previously appointed management have remained in their positions since the communist era. While some of the newly elected officials came from other than the traditional Communist and Christian parties, informal information that we were able to collect suggested that autocratic methods of work were still present at the town hall, despite democratic appearances. (Town meetings, by admission of elected officials, do not fulfill the function of feedback and are often taken as a mere formality by the citizens. There is also talk of corruption and heavy-handedness.) If there were any hidden agendas among the local officials (privatization of communal property, building permits, business licenses), however, they probably did not involve the social sector.

The Social Division is small, with one official and two employees who should be technically social workers but are in fact nurses who were laid off from hospitals and hired by the municipality. Their work description includes monitoring the poor and unattached elderly, poor families with children, managing the local *House of Care and Service* (subsidized housing for the aged without relatives), establishment of eligibility for and disbursement of financial benefits, and monitoring the communal health clinic.

It appeared that the Division did not have firm guidelines for operation. Its data base was on computer but not kept up-to-date. Indeed, no precise information was available upon asking. There was no outreach and information about potential clientele was gained mostly informally. When asked, the staff admitted that if a neighbor or a relative does not inform them about an apparent need, they themselves may not detect it. No clientele was present during our two visits.

Being new, the Division and its employees seemed in part uncertain about their roles and functions. Eligibility determination and benefit disbursement was done for them at the county level and the division followed the county regulation. Administering the House of Care and Service was routine. However, maintenance of the subsidized House is too costly for the community and the town hall thinks of privatizing it. Monitoring of the health center, another communal institution that will undergo privatization, appeared to be in the hands of the magistrate's secretary rather than the Division. Coordination with other institutions of the county human and health service network was done mostly by telephone through the County Office rather than by mutual contacts of personnel.

An interesting case of transformation is that of the *Home for the Severely Disabled* in a village adjacent to the locality of *LITTLETOWN*. This facility serves the region of the former District that encompasses six counties. As such, it was created and administered by the District National Council that also provided it with technical advice and monitored it. After the District was abolished

in 1990, the Home became a part of the county system for a brief period and then became an institution responding directly to the Ministry of Labor and Social Affairs. Compared to the preceding era, this has meant an improvement.

The most beneficial change at the Home was receiving direct financing from the Ministry. Because of lowered overhead and direct access to Ministry officials, the home could obtain and allocate funds to substantially renovate the interior and improve the living conditions of clients. Additionally, one part-time and four full-time professionals could be added to the staff. Salaries were increased and staffing became more stable. Most of the previous professional personnel remained at the facility. Addition of a psychiatrist meant the first-time introduction of basic therapeutic and counseling services.

The second change, more gradual and reaching back into the late 1980s, involved clientele. Because of the establishment of another facility for relatively less disabled persons, the home has become an institution serving primarily clients with more severe diagnoses. This has made the work of the personnel more difficult and partially worsened the overall social environment. The majority of clients use wheelchairs or are confined to beds.

Previously, the home was able to secure work for its clients from nearby factories. Although it was mostly assembly work, the clients favored it as a way to make their lives less clinically and more socially oriented and as a means of complementing their disability pensions. Changes in taxation and insurance laws, however, made the work almost profitless for the enterprises and the home has had a difficult time preserving the occupational opportunities for the clients.

Although the service content of the home has not changed much, about one-third of the clients appreciated what they perceived as improvements in their living quarters. The management would like to add special educators, a psychologist and a social worker to the team but finds it difficult to attract them to this distant locality. The future of the home, as the management sees it, may be in privatization and use of its property (Artesian well with high-quality aquifer water) for raising the funds necessary for modernization.

Fundraising for charitable purposes is becoming an integral part of the social service network. An innovative development in the county seat was started in 1992 by a private foundation *Assistance to the Needy.* Basically a one-person operation in a former Commmunist Youth League club, the foundation conducts a variety of educational and cultural activities for clients of social agencies. The clients include single mothers and their children, the disabled and the aged. Although it operates on a shoe-string budget, the foundation has improved the lives of clients of social agencies in the county by operating in a nonbureaucratic, personal manner and bringing them in touch with the outside world. This is in contrast to the traditional functioning of the established residential institutions.

To summarize, changes in social policy are causing uneven developments in counties and communities. Decentralization and compartmentalization of programs, together with the emergence of new programs, cause disruptions in coordination among them. On the other hand, the variety of programs and the number of clients served is increasing, although the apparent need is not met by existing facilities. Social agencies show a strong inertia and have been changing only slowly, both in terms of staffing and service content. On the other hand, the clients of social institutions, long accustomed to the *dirigisme* of the old-style institutions, are barely aware of new possibilities in the social services sector and never demand them. It is actually the enlightened professionals who have been responsible for changes toward greater accountability and humanization of the services.

4.4 LABOR MARKET AND CORPORATE WELFARE

Changes in the Czech labor market and its institutions since 1990 have been substantial. Until the late 1980s, employment was guaranteed, and virtually compulsory for all men of productive age. More than two-thirds of adult women also participated in the labor market, and their jobs were reserved for them for a period of two years after the birth of a child. In the second half of the 1980s, however, this de-facto overemployment became unsustainable. At first, high school and university graduates began to experience unemployment. Then women of childbearing age began to feel the pressure of a tight labor market. Still later, in connection with the economic reform, the structure of production and employment has been transformed and unemployment has become a reality.

Alongside the rising joblessness caused primarily by a steadily decreasing demand for goods, pressures have arisen to make production more efficient. The efforts to cut costs have been undermined by continuously rising wages and the uneconomic use of labor, energy and materials. However, there has been a visible effort on part of some businesses to reduce their commitment to providing corporate welfare, i.e., health, recreational, educational and housing services for their employees.

The Czech government reacted to the rise of unemployment in 1990 by establishing county-based *Labor Offices* under the Ministry of Labor and Social Affairs and by entrusting them with the implementation of the so-called passive and active employment policy. Passive policy involves provision of unemployment benefits and information about available job vacancies. Active policy includes subsidies for newly created job opportunities, creation of public work schemes, for counseling and retraining. Since 1990, the ministry has determined the relative weight of its policy components by allocating its available resources to each of them. However, the directors of Labor Offices were able to develop

their programs relatively independently, according to local and regional conditions. As with other social security programs, funding of Labor Offices and its activities still comes from general revenues but establishment of a true unemployment insurance system is under preparation, to take place in 1994.

In *HIGHLAND COUNTY*, the emerging *Labor Office* (LO) was staffed by personnel from the former Office of Labor Forces at the County National Committee, the local government of the communist era. Most of them were CP members but its director came from the dissident Civic Forum. This arrangement, together with the relative autonomy of the LO, gave it a post-communist outlook which has been strengthened by young staff hired later. However, LO found it difficult to find capable lawyers and economists who prefer to work in the private sector and have to be lured from other public institutions in the county. After the county hospital and the health insurance company, LO is the most professionally staffed and managed institution of the helping sector. By virtue of its mission, it is also an active participant in the county institutional network.

The activities carried out by LO depend on the situation in the labor market and its interpretation by the Ministry. With the decline of unemployment across the Czech Republic at the end of 1992, the Ministry has substantially cut the funds for the activ2e employment policy regardless of regional differences. This has lessened the effectiveness of the Labor Office in the *HIGHLAND COUNTY*. LO functioning is further hampered by the low level of coordination in the county network, including the employers. Unreliability of information about job vacancies is a notorious fact of life as is the employer disrespect for regulations concerning the employment of disabled workers. In this situation, the 38 clients interviewed by us at random expressed general satisfaction with the work of LO but dissatisfaction with the results.

While LO representatives ascribe the decline of unemployment in the county to their active employment policy, it is probable that the expanding private sector provided many of the new jobs and would have done so even without the LO support. The true test of LO effectiveness may come when unemployment will grow. This is expected to happen in the second half of 1993 when the law on bankruptcy, enacted by the Parliament recently but rendered ineffective for fear of its possible domino effect, will be enforced. In current conditions, the main problem for the Labor Office in *HIGHLAND* is the growth of long-term unemployment which disproportionately affects women and the disabled. In the near future, the county is expected to experience losses of jobs in the agricultural sector due to privatization of land and loss of production subsidies. This will also contribute to long-term unemployment because jobs lost in the agriculture will be irreplaceable, as it happened in the West during the postwar years.

An important aspect of social policy under the communist regime was corporate social welfare. It used to be extensive, providing benefits such as day

care for employee children, health clinics, subsidized food facilities, subsidized recreation, summer camps for children, paid education, subsidized housing, retirement bonuses, etc. These were offered beyond the universal health and social benefits provided by the state and represented an incentive for employment in disadvantaged geographical regions, industrial branches and enterprises. Some of these benefits and services were provided from the corporate income, and as such, represented an above-standard social welfare. Others were in fact paid for by special subsidies from the state budget, as a part of the overall policy of industrial development implemented by the CP in a given region.

To take a concrete example, the *DOMUS FACTORY* has been the leading institution of corporate welfare in *LITTLETOWN*. Another factory there is smaller and has provided relatively less benefits. The township itself provided still less of communal social welfare.

Stability of employment at *DOMUS FACTORY* is of primary importance both to the management and to the workers. Skilled labor that the factory employs would be difficult to replace if laid off. The management has therefore instituted a variety of mechanisms to bridge its workers over periods of seasonal slack of demand: substitute work in factory maintenance, postponement of overtime pay to fallow months, even distribution of forced unpaid vacations among employees, early retirement with bonuses, flexible worktime, part-time work. This is in line with the past pro-labor orientation of the original owners, and workers consider such policy as their traditional right. Because at times of high demand it is necessary to work on weekends, the factory pays for or arranges transportation for the overtime workers. Production costs are too high because the afternoon shift, which has fewer workers, uses the same amount of energy as the morning shift. The management has launched a campaign to lay off unmotivated workers and abolish the second shift. This has caused considerable anxiety among workers and passive resistance among workshop foremen who were given responsibility for the selection.

A certain number of benefits is provided at present universally to all workers from factory profits at the level equal to 2 percent of paid wages under the agreement betweenthe management and the trade unions. This funding is slightly smaller than it was in the 1980s. The social fund so created provides for subsidizes meals, recreation in factory facilities, cultural events and organized trips and use of a nearby recreational facility for childrens' summer camps. The factory has already turned its recreational chalets for adult workers over to the trade union and intends to stop subsidizing them within a year.

More than two decades ago, the factory also opened its own health and dental clinic for workers on its premises. It has been staffed by physicians and nurses who are technically employees of the county hospital and clinic. However, under the changing conditions of health care financing, the clinic cannot survive by providing care only to the workers. It will either have to be opened to

local inhabitants or operated only on a part-time basis. The other option that the management does not favor is to subsidize the clinic. The clinic is due to be privatized but it is not clear whether this will happen as a part of the county clinic privatization process or idenpendently from it. The final decision concerning the factory clinic will be made by the county Health Department and the factory management. Because the *LITTLETOWN* community clinic is already a privatized project, the factory clinic will lag behind. The community clinic has a better, central location, and may attract most of the local clientele while the factory clinic clients may in fact dwindle.

The factory currently owns over sixty apartments and a small house for single persons that are rented at subsidized prices to its employees. This arrangement is highly unprofitable. The factory management has decided to divest itself of its housing and is waiting only for the passage of the law on houses and apartments in order to sell the properties. The price and the method of the sale have not been determined yet.

Together with three other local enterprises, the factory had financed construction and operation of a nearby kindergarten. This was a part of the previous regime's policy of "joining resources" among communities and production companies, instituted in the 1980s. The kindergarten, designed for children of factory workers and local inhabitants, has never been filled to capacity and was closed in 1988 as unprofitable. Its building now stands unused.

Previously, the factory used to encourage and pay for work-related education of its workers. Since 1991, the management has only provided retraining for workers of one department free of charge. Any other educational endeavors now have to be paid by interested workers themselves.

Finally, the factory had been a strong supporter of local sports clubs and sporting events. Lately, its sponsorship has changed its beneficiaries. The factory is giving more to charitable causes, particularly in areas of regional health care and care of the disabled, and has practically ceased to support adult sports. It still does give, however, to annual athletic games for children.

4.5 CONCLUSIONS

In the three and half years since the transformation of the Czech society began, changes in the sector of health and human services have taken place at different rates in different institutions. Our study of one locality and its wider environment shows that movement from autocratic to participatory forms and provisions of service has been relatively slow in institutions where old personnel remained and continued in their old-style practices (lack of accountability, poor management, lackadaisical attitude). In contrast, the newly established in-

stitutions and the health facilities, first exposed to the competitive pressures of the market, have undergone more rapid transformations.

The two joint reasons that can explain this inertia are absence of experienced professionals who could take over existing institutions or establish new ones without unnecessary disruptions, and absence of examples of effective democratic practices in service provision. Habit, rather than professional efficiency, invention and innovation, still determines how key institutions in the social welfare network function in the county. The third reason is lack of finances. However, on the whole, more services and assistance are now available to more clients under more transparent criteria of eligibility.

In our opinion, it is not only the vested interests of the past hierarchy that play an important role during the transformation period. A comparative lack of alternative personalities and approaches explains more than anything the maintenance of certain customary nonstandard approaches (networks of friends, families and acquaintances that support their members) and a lack of coordination after the demise of autocratic control.

Although the institutional environment in the county is monopolist rather than pluralist, it is exposed to substantial pressures that should force it to become more cost-effective. New organizations that must rely on nongovernmental resources have been most forthcoming and innovative in meeting the needs of their clientele for adequate services but they experience greater financial difficulties than the traditional institutions.

We can conclude that the process of democratization in local institutions of health and social welfare is only in its beginning phases. Formal accountability procedures are missing in many cases, and client interests are being taken into account only after the institutional and professional survival concerns are satisfied. Lines of authority, sanction and control remain unclear. Vested political and group interests in management, personnel hiring, client eligibility and interprofessional relations still tend to prevail over objective selection, evaluation and monitoring standards. Client influence and feedback is still rare although client advocacy by individual professionals is growing.

Yet, when the magnitude of the transformation is taken into account, it is obvious that it is being handled with certain professionality, particularly in the health sector. One is being reminded time and again that the informal and paternalistic approach of institutional leadership, carried over from the past, has as its counterpart the relative absence of citizenry interested in exercising real democratic control through interest groups and associations, activism and ballot.

It seems that the existing public institutions are not fully prepared to handle the impact of severe economic depression, should it come. As it is, the current financial capacities of most surveyed institutions are below need, and may not increase in times of budgetary constraints. As far as the the corporate welfare

system is concerned, our mocal example confirms the trend toward its withering.

Consequences for those affected are multifaceted. If the current belt-tightening is only temporary, to be followed by economic improvement, the health and social services will be squeezed only for the time being, and can be gradually brought up to Western standards later. If the economic depression strikes deep and wide, those in great need, served relatively poorly in the past, will continue to receive poor service, and possibly less of it. Universality of benefits, although marred by corruption and special selectivity in the past, appears to be giving way to greater partiality and selectivity based on one's employment position.

All in all, however, if changes are currently being recognized at all by the public and the clientele in the health and social sector, they are not necessarily perceived as a process of democratization about the form of which there is no consensus. Rather, they are being perceived as attempts to realistically cope with the past impoverishment and recent onslaught of market-like competition.