ORDERING FROM THE MENU: 
HOW CENTRAL AND EAST EUROPEAN STATES COPE 
WITH EU DEMANDS FOR INSTITUTIONAL REFORM 

Wade Jacoby 

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Author address: 
Dept. of Political Science 
Brigham Young University 
745 SWKT 
Provo, UT 84604 

Tel: 801-378-1711 
Email: wade.jacoby@byu.edu 

Abstract: 
This paper analyzes key Central and Eastern European (CEE) states’ efforts to return to 
Europe by trying to become members of the EU. It takes a somewhat different slant by 
looking at one specific aspect of these preparations. Specifically, it highlights the ways 
CEE elites often emulate existing institutions from Western Europe or, as the title puts it, 
“order from the menu.” The paper breaks down the concept of emulation, looking at 
reasons for elites to pursue emulation and their varied techniques for doing so. Those 
techniques vary with respect to the degree of voluntarism the CEE states enjoy in 
different policy areas and the also the degree of “faithfulness” they choose in pursuing 
emulation. It also argues that both the density of the acquis and the density of actors 
 surviving from the communist period play important roles in determining the outcomes 
of emulation. While the paper’s central purpose is to offer a richer set of heuristics than 
simply “imitation,” it also contains case studies of policy domains where the EU has 
leaned heavily on CEE states (e.g. regional policy) and cases where the EU has had a 
much lighter touch (e.g. health policy). In both these areas, it uses data from the Czech 
Republic and Hungary, two enlargement front-runners. 

Note: The author thanks Matthew Jennejohn and Steve Page for their research assistance.
In 1989-90, the communist regimes of Eastern Europe fell. In a few countries, social movements had challenged and eroded communism; in other places, the regimes seemed to collapse of their own weight. In either case, however, the new governments that emerged looked to distance themselves from many communist-era practices and institutions. Many elites and citizens characterized these changes as part of a “return to Europe.” Even those who argued that one could not “return” to a place (Europe) that one had never left, still acknowledged the need for radical changes. Within a few years, elites and citizens also came to a broad consensus that their states should aspire to join the European Union (EU) and the North Atlantic Treaty Organization (NATO); many subsequent institutional changes were pursued with these goals in mind.

This paper analyzes key Central and Eastern European (CEE) states’ efforts to return to Europe by trying to become members of the EU. 1 But there are many works that look at EU enlargement. Why produce another? The justification is that this paper takes a somewhat different slant, looking at one specific aspect of these preparations. Specifically, I highlight the ways CEE elites often emulate existing institutions from Western Europe or, as I put it in the title, “order from the menu.” 2 Why do the attractions of foreign designs sometimes outweigh the attractions of indigenous innovation? How faithfully do CEE elites attempt to reproduce West European designs in their own societies? 3 When do they simply “approximate”? How much do external

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1 I pursue the same set of questions for the expansion of NATO, and intend to publish some papers – not this one – that make this comparison explicit.

2 Because my central interest is in emulation, I have focused on it no matter what the “object” of emulation – whether formal institutions, practices, rules, or norms. I shall have something to say about the role of emulation in the spread (or not) of all of these things. This paper’s dependent variable is the type and character of emulation pursued, not institutional change more generally.

3 For a focus on the design aspect, see Heather Grabbe. 1999. The transfer of policy models from the EU to Central and Eastern Europe: Europeanisation by design? Unpublished paper. Institute for German Studies, Birmingham, England.
pressures or incentives from the EU shape their choices? The answers to these questions have rich implications for scholars of globalization, development, international organizations and of institutional change in a variety of policy areas.

Table one, adapted from Schimmelfennig and Sedelmeier, charts the broad range of mechanisms available to states looking to modernize policy sectors and to the EU in efforts to promote compliance with its preferred form of governance. It uses the well-known heuristic of “appropriateness” and “consequentiality.” The table further divides the appropriateness logic into cognitive and normative dimensions, and the consequentiality logic is divided into mechanisms of social influence and material influence. Using this terminology, the current paper is situated on the far lower-left cell termed “imitation.” That said, I will talk instead of “emulation” because that term has less of a connotation of blind mimicry and more a connotation of reflection and adaptation – two themes I stress below. I also move beyond the cognitive logic and discuss the importance of social and material influences on emulation. At its core, I will argue, emulation has a political logic every bit as significant as its cognitive one.

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<th>Activity of EU</th>
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<td>Activity of CEE candidates</td>
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But first, in order to focus on emulation we must first clear up some misconceptions. These misconceptions are common in discussions of institutional change in CEE. Some see emulation as a straightforward tool used by well-informed elites to quickly set up the right institutions following prevailing “best practices”; others see it as the mindless and unreflected mimicry of clueless “new elites” who lack any authentic institution building capacities. Still others emphasize precisely the robust institutional visions of the CEE opposition leaders who emerged from the communist era and deny that these elites had any use for emulation at all. On the question of timing, the myths are also quite varied. For some observers, emulation was used only in a brief flurry after 1989 while others take roughly the opposite approach and suggest it was not used until the EU “forced” the CEE states to adopt its practices.

I label these ideas misconceptions not because they are simply wrong – for all of them contain an element of truth – but because they are all far too simplistic to capture the range of things going on under the deceptively simple cover of “emulation.” The main task of this paper is to unpack the concept and, in so doing, to say something important about the broader process of institution building. To do so, I will break down emulation into questions of “why?” and “how?” And I will offer two simple heuristics that help us account for variation over time and policy areas.

**WHY WOULD CEE ELITES EVER EMULATE EU MEMBER STATES?**

What motives could CEE elites have for emulation? Why would politicians so recently freed from Soviet constraints (and in areas with a legacy of the imposition of foreign practices under
the Habsburg Empire), now be willing to order from a menu set in Western Europe? My central assumptions are that their motives result from the confluence of three factors: the collapse of communist domination and the subsequent opportunity to embrace Western practices, the political benefits that accrue to CEE politicians through modernizing rapidly, and elite desires to demonstrate (through certain symbolic acts) to outsiders and to voters that they embrace needed reforms. In the interests of space, I will not defend these assumptions here, but will only note that they flow from three separate research paradigms. The first part of the claim, building on historical institutionalism, is that full sovereignty means the end of an obligation to pursue the policies of an imperialist power and the chance to “catch up.” The second part, building on rational choice institutionalism, is that CEE ministerial elites face some specific political incentives to adopt the institutions and practices of foreign powers. The third part, drawing on sociological institutionalism, is that some Western “best practices” are at least partially self-legitimating in CEE and that their widespread use and acceptance helps explain the desires to emulate them.

These three forces operate, with lulls and lags, across the whole decade of reforms in the 1990s. A fourth force, the EU itself, becomes crucial when we talk of institutional and policy changes in the second half of the decade. In the early part of the decade, the EU held the aspirant members in CEE at arm’s length, and it generally avoided giving them meaningful membership targets. That changed in the second half of the decade as the EU moved slowly toward accepting the idea of some kind of Eastern enlargement. For purposes of exposition in this paper, I divide the decade around the Essen summit meeting of December 1995, at which point the EU issued a White Paper that obliged aspirant members to transpose the 1,000 or so directives that stood at
the heart of the internal market. Before that date, for my purposes, emulation was generally voluntary on the part of the CEE states. After that date, an important note of “conditionality” begins to enter the calculus.5

When we understand motives and the growing leverage of the EU, we also can explain one profound difference between Western Europe and CEE in terms of the EU’s effects. In Western Europe, there are far more national constraints on EU effects than in CEE.6 The EU has become an agenda setter, shaping the choice sets of the CEE governments in profound ways. This agenda setting power derives, in turn, from CEE states’ strong motivations to gain EU membership. These motives limit choices, and they promote particular processes of institution building over others. For this reason, I focus on emulation, acknowledging from the start that much emulation occurs under less than fully voluntary conditions.7 At times, this EU leverage has been very much a blunt instrument while at other times – e.g., screening – the Commission has been able to wield it in a more precise way.8

THROUGH WHICH PROCESSES DO ELITES ATTEMPT EMULATION?

Though the EU’s Eastern enlargement has not yet occurred, the Commission has warned prospective member states that they will have to perform as full members right from the outset of membership. Preparation, therefore, has required getting the institutions right. Historically, the

6 This is a vast literature. A good overview is Goetz, Klaus. 2000. European integration and national executives: A cause in search of an effect? *West European Politics* 23(4), pp. 211-231.
EU allowed new members long transitions, letting them develop their capacities gradually. When the EU admitted Greece, Spain, and Portugal, it limited its pre-accession demands because member states had decided to use EU membership to solidify post-authoritarian democracies. But in the early 90’s, the member states emphasized the prospective costs of taking on states that were “not ready.” Thus, it has made prospective membership difficult. With Essen (and then only slowly), policy shifted to move towards enlargement, but the EU warned it would insist on a high degree of performance from day one. The EU’s demand for immediate performance thus raised the bar for membership and generated enormous efforts to change CEE institutions and practices. These efforts come in various guises, such as the Europe Agreements, the White Paper, the Pre-accession Strategy, Phare, National Programmes for the Adoption of the Acquis, annual Commission reports, screening, and the ongoing negotiations. Rather than recover this ground, I will focus on the element of emulation that is part of this larger picture.  

I argue that “emulation” and “imitation” are metaphors that cover several different, but related phenomena. What appears to be one messy complex of borrowing Western structures is better understood as four analytically separable processes (see Table 2). The typology derives from two analytical continua: the degree of faithfulness in replication and the degree of pressure brought to bear externally. In any given case, CEE national governments largely determine the first value, and EU officials largely determine the second.  

Scholars of “diffusion” and “policy borrowing” have long tried to understand the macrosociological and network factors that promote the voluntary and reasonably faithful  

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spread of institutions from one place to another. Often, there are virtually no changes as the policy travels from one state to another.¹⁰ Such cases fit the upper left cell of Table 2 (here labeled “copies” for shorthand), but I wish to describe three other processes that occur alongside. First, as communism collapsed, some CEE elites voluntarily looked to Western Europe for what I deem general “templates” – those in which the West European model is more a loose functional outline, an approximation rather than a detailed blueprint. Second, in other cases, the EU set “thresholds” that were typically approximations – i.e., “we can’t tell non-members how to design their institutions…” – and less voluntary – “…but if you eventually want to join, you’ll need to consider…” The Commission’s annual reports are full of these warnings. Finally, and more recently, in the upper right cell of Table 2, the screening and negotiation process has required mandatory and faithful “patches” as CEE states’ membership has drawn nearer. In these cases, specific legislative holes indicated by specific EU directives are often filled as quickly as is feasible by taking on very exact legal language of directives or by looking to a specific Euroconform law in a current member state.

| Table 2: Types of emulation that are part of the design of post-communist institutions |
|--------------------------------|------------------|------------------|
|                      | More Voluntary | Less Voluntary   |
| Faithful             | Copies          | Patches          |
| Approximate          | Templates       | Thresholds       |

Of course, CEE fears about being denied membership determine which kinds of institutional deficiencies they will admit and which kinds they will obscure. Accordingly, the macropolitics of membership (i.e., who seems likely to get in and under which conditions) strongly condition the way elites make these institutional changes. So, for example, if CEE elites read the Nice Treaty as a strong indication that enlargement is definitely going to happen, they may be more forthcoming about weaknesses they’d like to address sooner rather than later. On the other hand, if they read Nice as a fiasco indicating that enlargement may require EU reforms that are too painful for existing members, they may wish to avoid any indication that the picture in their country is less than rosy. Such a silence would at least deny opponents of enlargement any additional ammunition in a campaign to brand them unfit for membership.\footnote{This dilemma was much sharper in 1997-98 when the Council had made far fewer commitments to enlargement. Jacoby. “Priest and Penitent.”}

VARIATION ACROSS POLICY AREAS

These forgoing considerations are important, but very general. Yet the impact of the EU, and hence the amount and character of emulation, clearly varies across policy areas. In this paper, of the many possible dimensions of that variation, I focus on two: the density of the \textit{acquis communautaire} (leverage), and the density of policy domain actors prior to the onset of reform (legacy). Though these operationalizations are crude, I find them a useful starting point. I hypothesize that the likelihood that EU practices will be adopted follows from two questions. First, is the policy area one in which the EU has a large body of legislation that either have direct effects or that it expects the prospective new members to approximate? If it is, I expect so see more emulation, even if the job of taking on large numbers of new norms and rules simultaneously might severely tax actors
in that policy domain. Second, is the policy area one in which well established actors already are present? If so, I expect well established actors to have their own procedures and institutions against which they would measure the acceptability of those from the EU. Without denying that the pressure to adopt EU practices may be significant, my expectation is that well established actors may show more skepticism—openly or covertly—about the appropriateness of the new practices to their situation.  

These two hypotheses suggest four clusters of policy cases from the different combinations of leverage and legacy. First, if one can expect relatively little emulation of EU practices in areas where EU norms are few and domestic actors are well established, then health policy would surely be an example of such a case, for the *acquis* is fairly light, and many actors – parties, providers, patients – all are capable of weighing in on proposed reforms. Second and third, we can expect a somewhat more emulation *either* where preestablished actors are weak (e.g., consumer protection, where the *acquis* is, however, fairly modest) *or* where the number of EU norms are high (e.g., agriculture, where the acquis is enormous, but many interest constellations remain intact from the communist era). In each of these two cases, one variable tends to promote the use of emulation to spread EU practices while the other tends to suppress it. Finally, only where both variables point to the potential utility of emulation as a tool to prepare for membership (e.g., regional policy, where EU demands are substantial and CEE interest

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12 This expectation is a hypothesis to be explored more fully below. I can imagine situations in which the opposite hypothesis—that preexisting actors could help promote more norm adoption or faster institutional emulation—might also hold. Thomas Risse’s work on “argumentative communicative action” is very suggestive in this regard. Risse, Thomas. 2000. Let’s argue! Communicative action in world politics. *International Organization* 54 (1): 1-39. I have also argued that a well-established “civil society” is a propitious condition for the transfer of institutions from one country to another. Jacoby, Wade. 2000. *Imitation and politics: Redesigning modern Germany*. Ithaca: Cornell University Press.
associations quite weak) should we expect the emulation of EU practices to play a
dominant role. The predicted result, in terms of volume of emulation and the amount of
renegotiation required, is mapped in Table 3.

Table 3:
Expectations of the volume and faithfulness of EU-driven emulation across policy areas

| Density of actors prior to onset of post-communist reforms |
|---------------------------------|----------------------------|
| Low density of acquis           | High density of acquis     |
| Consumer Protection             | Health Policies            |
| (Low volume, low renegotiation) | (Low volume, high renegotiation) |
| Regional Policy                 | Agriculture                |
| (High volume, low renegotiation)| (High volume, high renegotiation) |

In the rest of the paper I subject these predictions to a limited empirical test. I do so
during two periods divided by the aforementioned Essen Summit: from the late 1980s
through 1995 and 1996 to the present. Because this task involves detailed qualitative
research, I have focused my study on two countries, Hungary and the Czech Republic. I
chose these two countries because they share several important features: Both have had
long experience with broader European institutional developments and have relatively
high levels of economic development. Both are unitary states with long term integration
into the Germanic law sub-family of civil law traditions. Both have had alternations of
government from center right to center left inside parliamentary regimes with similar
party spectrums and electoral thresholds. Both have had a domestic consensus that
joining the EU was the central foreign policy goal. The countries are about the same size (with populations around ten million), and inside CEE both have been among the front-runners for EU membership. In short, if there is any place in CEE where conditions for emulation are propitious, it is here.


The rest of the paper compiles a picture of elite use of emulation in the two policy areas likely to have the most extreme outcomes: regional policy, a “best case” scenario for finding EU-driven emulation because the acquis is dense and actors are sparse; and health policy, a “worst case” in which any emulation found is much more likely to be voluntary since the EU has little leverage and the obstacles are likely to be high. In order to focus on emulation efforts, it will be necessary to say less about parallel indigenous reforms. My account is a probe of one particular category of reform rather than an overall picture of all reforms in these two policy sectors. In phase 1, we look at emulation under conditions of voluntarism. The two forms of voluntary emulation are copies and templates, depending on whether emulation is faithful or approximate. In phase 2 of each policy, we look at the less voluntary emulation that occurs in the wake of the Essen Summit. The two forms here are implementing patches and responding to thresholds, again depending on the same distinction between faithful and approximate. I start with regional policy in the two states and then move to health policy.
REGIONAL POLICY: THE EU’S STRUCTURAL AND COHESION FUNDS

The structural and cohesion policies are the second most expensive component of the EU’s budget, trailing only agriculture. The EU’s structural and cohesion funds contribute financially to the regional policies (RP) of the member states as they seek to create appropriate conditions for investment and job-creation. While the member states retain the responsibility for defining their development priorities, the co-financing role of the EU requires that individual projects respond to three priorities set by the Commission: regional competitiveness, social cohesion and employment, and the development of urban and rural areas. Access to these funds is predicated on planning competence and administrative mastery of complex procedures. These controls are sufficiently strict that many subnational governments in longtime member states are unable to gain access to monies to which their region is nominally entitled. That is, certain administrative competencies and the ability to follow a dense set of rules are a prerequisite for receiving structural funds.

Hungarian Regional and Cohesion Policy: A Brief Overview

Hungarian regional policy began changing even before the end of communism. A 1985 Resolution marked the first effort for systematic regional (as opposed to sectoral) development in Hungary, and further foundations of Hungarian RP were laid with the

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13 Depending on the pace of enlargement, by 2006 up to 30% of total EU structural fund spending could flow to CEE countries. European Commission, Agenda 2000, 63.

As we shall see, however, a burst of activity in the mid and late 1990s has led to a situation in which Hungarian regional policy stands on reasonably sound footing. Hungary addressed the fundamental concerns over centralization and underfunding in 1996 with the passage of the Law on Regional Development and Physical Planning (Act XXI). This law also serves as the primary referent for “screening” Hungarian policy with EU directives, and Act XXI was a site of direct EU influence on Hungarian RP development. Its main principles are decentralization, subsidiarity, partnership, programming, additionality, transparency, and concentration.\footnote{Horváth. \textit{Regional and cohesion policy in Hungary}, p. 16.} 1996 also brought the formation of Regional Development Councils and, as subsets of the councils, Regional Development Agencies. These bodies respond to EU demands by devolving decision-making and management control to the regional level and are the key actors in implementing regional development programs in Hungary. EU involvement continued with the National Programme for the Adoption of the Acquis (updated in 2001) and the National Development Plan (2001).
Czech Regional and Cohesion Policy: A Brief Overview

Though Czech privatization and transitional economic policies differed from Hungarian ones, both states faced the decline of state-owned heavy industry, the decline of the collectivized agricultural sector, the very low mobility of the work force (due in part to lack of accessible housing), and pollution and environmental problems.\(^\text{18}\) In the early 1990s in the hardest hit Czech regions, such as North Bohemia, some officials began to call for policies to address RD, retraining and restructuring. Rising unemployment figures revealed a growing cleavage between regions.

Through the early 1990s, overall Czech unemployment was remarkably low, but aggregate unemployment and regional disparities grew sharply throughout the second half of the 1990s. In July 2000, the unemployment rate had reached 9.0%, but in the worst affected areas of North Bohemia, unemployment had reached 20.7% (Most district) and in North Moravia, it reached 18.4% (Karviná district).\(^\text{19}\) Early on, the government chose not to use regional policy to buck the unemployment trend. The Klaus government did focus on some industrial crisis points but neglected both interministerial coordination at the central level and coordination with actors at the regional and municipal levels. As such, early Czech regional policy tended more toward “bailouts” than development.

Density of Acquis, Sparseness of Actors

One of the main tasks in this policy sector has been to build up actors at regional levels who are competent enough to engage in the demanding tasks of planning and implementing RP. While the number of formal laws that must be transposed is actually small – RP is a policy area where “direct effects” dominate – the rules and norms around the EU structural and cohesion funds are many and strict. In this sense the acquis – construed broadly – can be said to be dense while the actors needed have been, at least at the outset, quite sparse. As noted, the EU has pushed the creation of new regional and local actors. The Czechs had more to build and less to start with because, unlike Hungary, there had been no efforts to regionalize politics in the waning years of communism.

The Czechoslovakian regional governments were merely an extension of the central communist government, and they were abolished in 1990. The resulting lack of regional authority was apparent in comparison with many EU member states, even strongly unitary states. But this Czech-EU difference hardly bothered Václav Klaus, whose ODS Party emphasized the defense of the nation state as the only source of identity and vigorously fought against efforts to create strong Czech regions. The Social Democrats (ÈSSD) saw growing unemployment in structurally weak regions as a potential source of votes, however, and they responded with a stronger RP emphasis. In contrast to the ODS, pro-EU arguments began to appear in the ÈSSD election campaigns and found a prominent spot in the party program.20

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An important lever for challenging central ODS control lay latent in the Czech Constitution of 1992, whose Article 99 foresaw the creation of a layer of self-administered regional governments (also called higher territorial administrative units) between the existing central and municipal levels. But the authors of the constitution left vague the provisions for regional governance. The stalemate dragged on throughout the entire first period covered in this paper. Despite the constitution's call for regional governments and the EU Commission's not so subtle warnings that some form of regional planning competence was required of all members, the Czechs made few changes. The EU paid a Czech regional planning group for three separate studies of foreign systems of regional policy formation, but ODS dominance continued to block the space for such a transfer.

To this point, it may sound more like there are too many actors than too few. Recall, however, that my causal logic is that actor density matters on the presumption that the actors have staying power. It remained the case that there were almost no established RP actors. Indeed the Czech case is significant for the way privatization cut off and allowed to atrophy those networks that had existed. Thus, when the ODS left the government, things shifted. And when the stalemate finally came apart, EU actions played an important role. In January 1996, the Czech Republic applied for EU membership, and as noted above, the Commission prepared the required opinion on the readiness of the Czech

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21 Constitution of the Czech Republic (Prague, 1992).
Republic to join. As a consequence of the lack of interest in regional policy by the ODS-led government, the Commission's initial assessment in this area was blunt: “Currently, the Czech Republic has no regional policy. Indeed, regional development initiatives are implemented through sectoral policies at national level.” The Commission pointed at the functional necessity of authorities able to formulate regional development priorities. They were further able to specify the need for some kind of partner on the Czech side able to develop and articulate such plans. On these points, the Commission noted that “Czech authorities still have to introduce important reforms to comply with EC's structural policies. ... Financial resources at the disposal of regional policy should be increased and efficient instruments need to be created. ... Czech authorities have to determine the future legal basis of a Czech regional policy in order to provide the appropriate legal structure for the actions envisaged to counteract regional disparities and for financing structural policy expenditure.”

**Phase 1, Voluntary Emulation, 1989-1995**

We have just seen that the Klaus government allowed little space for any emulation of West European practices in this policy domain during the period through the Essen Summit. In Hungary, there is more of a story to tell. As noted, voluntary emulation of western RP models began in Hungary even before 1989. The 1985 Act on “Long Term Tasks of Regional and Settlement Development” is a clear case of a template. Though Hungarian reformers were looking to the west for ideas, integration into the socialist bloc

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meant that direct copies were not acceptable. The Act incorporated the following key western elements: first, “cooperation between settlements instead of a hierarchical relations;” second, “wider use of local resources, together with the strengthening of local independence;” and third, “a new, decentralized financing system of settlements.”

With the collapse of state socialism in 1989, voluntary emulation of western European models continued to play some role. Lawmakers slowly began to adapt the centralized, poorly funded communist era RP. As in 1985, Hungarians used some templates to work through these reforms. Templates allowed the Hungarians to introduce more EU principles and ideas but also allowed them to mold the policies to their specific circumstances. One example that could stand for others is the government introduction of the Regional Development Fund in 1991. The Fund used EU financing guidelines, but it retained management with the central government in Budapest. Here we see an echo of the Czech case: the EU RP practices were appealing if they promised techniques (or resources) for dealing with growing unemployment. But those same practices were threatening if they seemed to erode central state authority. In neither state then can we point to substantial and sustained use of templates during the period in which any emulation would have been strictly voluntary.

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26 The socialist government even established a parliamentary office in the late 1980s to check the compatibility of Hungarian legislation with EU law.
Phase 2, Less Voluntary Emulation, 1996-present

The EU begins to use RP thresholds in earnest at the time of the first Commission Report in 1997, and each subsequent Regular Report contains a multitude of such thresholds. For instance, in the 2001 Regular Report on Hungary, the Commission calls for improvements in interministerial cooperation, technical preparation for fund management, partnership structures and local participation in policy-making, project evaluation, financial management, and regional statistics. These are thresholds because the Commission demands reform but doesn’t prescribe the measures Hungary must take.

Hungary has been quite responsive to such suggestions. For example, the Commission’s 1999 Regular Report noted that Hungary needed to reform its mechanism for RD financing. In response, in 2000 the parliament’s Budget Law introduced two new regional financing tools. The Commission sets a threshold by warning implicitly that if the regional financing system is not fixed, Hungary might not be eligible (ultimately) for accession. In a less blunt way, the EU can also decide not to fund “pilot programs” if the policy instruments are not acceptable to the Commission. The Hungarians, in meeting this threshold, chose a funding mechanism that follows the EU insistence that regional approaches take priority over sectoral ones.

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29 1999 Regular Report on Hungary, 71
30 2000 Regular Report on Hungary, 63
Some experts worry that “The theoretical basis [of Hungarian RP development] was ‘imported’ and used without the necessary adjustment to given conditions.” It is true that when faced with EU leverage, some Hungarian emulation is quite close to legislation in current member states. In some cases, the fixes are so faithful that they merit the label of patches. Some are contained in Hungary’s Act XXI (1996), which classifies regions as mandated by the EU. With Act XXI, several different levels of regions, with multi-county regions (equal to EU dimensions) were introduced. The Act also set up an EU-mandated “national regional development conception,” “a national regional development programme,” and “a national regional development plan” (terms native to the EU and not used in Hungary prior to the Act). Also, the Act stipulates that the parliament must organize and legislate the decentralization of Hungary’s regional policy-making and implementation, something it had avoided to that point. Also introduced in this Act are requirements for the regional development plan to take “spatial ordering” and environmental factors into consideration. Finally, the Regional Information System appears to be a patch. In many cases, Hungary dealt with EU thresholds not by innovating on existing institutions or policies, but by quickly adopting Euroconform patches learned about through screening or the vetting of draft Regular Reports.

When we left the Czech RP story, the Commission Delegation in Prague was looking for appropriate partners in the Czech administration in order to implement Phare projects aimed at preparing the ground for RP reform. When the Klaus government fell, the

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32 The Commission allows the candidate countries to have drafts of the reports some months in advance and in many cases will soften the final language if convinced the candidate is ready to make more progress in a specific area. Obviously, what I am calling patches can be quite beneficial in these circumstances.
Tošovský government unblocked the RP issue and paved the way for future reforms. Most important, in late 1997 the Constitutional Act on the Formation of the Higher Territorial Administrative Units was passed by both chambers of the Parliament. This represented the first major step toward fulfilling the provisions of Article 99 of the constitution. When a Social Democrat minority government, emerged from the April 1998 elections, it quickly adopted “The Principles of the Government Regional Policy,” a document that reflected the principles of regional policy of the EU. It used bona fide EU parlance to identify two types of problem regions according to the classification of structural funds: economically weak regions (what the EU calls objective 5b regions) and structurally weak regions (objective 2). The new government hewed closely to EU norms on its definitions of these regions: The structurally weak regions were defined by a high concentration of traditional industry and a high level of urbanization and unemployment. Economically weak regions comprise mostly rural areas with lower levels of urbanization and economic development. In the Commission's eyes, these moves constituted real progress—the first they'd seen in a while.

Based on this change, the Delegation started a Phare-financed pilot project for North Bohemia. This project was run by the MRD, which now began to develop a regional policy according to the EU framework. The Ministry's First Regional Operational Program involved not just the central government, but also actors from the regional and municipal levels. Before the creation of the higher territorial units in January 2000, these regional actors were mainly mayors and representatives of Regional Development Agencies, some of whom also were set up with Phare financial support. In 1999 the

regional actors formed special Regional Coordination Committees (RCC), which also included representatives of the state administration. These committees assumed the de facto role of informal, non-elected governments on the subnational level. With regional elections in fall 2000 leading to the establishment of the higher territorial units on January 1, 2001, the regions then incorporated the RCC into their administrative structures. Thus did Commission thresholds, Phare seed money, a latent constitutional provision, and a change of government produce new momentum for Czech RP.

As in the Hungarian case, we can name the key RP thresholds the Czechs faced. First, the EU presumes that states have in place formal regional actors who have the authority to formulate regional policy objectives. Second, the EU promotes the coordination of regional policy between the central government and the regions concerned. Third, the EU pushes the expectation that the allocation of structural funds will be based on competitiveness among regions. Fourth, the EU insists that states separate management and monitoring of regional policy. And fifth, the EU understands regional policy as an instrument of job-creation and investment incentives, instead of a mere redistribution mechanism.34

Once the EU’s opening appeared, how precisely did the EU exploit the chance to affect Czech practices? Once the Commission launched the negotiation process with the first group of candidate countries in March 1998, the acquis was divided into thirty-one chapters, and each became subject to a screening process. During this period, the

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Commission explained to the candidate countries the amount the *acquis* contained in the individual policy areas. The candidate countries, in turn, responded by describing the extent to which they already complied with EU law and further specified time periods over which they could likely achieve full compliance. After completion of screening in 1999, substantial negotiations began on each chapter, but the macropolitical complexities of RP have meant that the negotiations have not yet been provisionally closed.\(^{35}\)

Both exercises—screening and the negotiations—have been instrumental in establishing a reform agenda and timetable in the candidate countries.\(^{36}\) In its regular reports the Commission assesses the progress of each country in meeting the norms and the institutional requirements it has laid out. And besides mere explication of the *acquis* in this highly structured process, the EU made substantial funds available to support the development of necessary administrative structures for a successful implementation of EU policies and also to start concrete work by financing pilot projects. To be sure, none of this is “imitation” in the everyday sense of the word that connotes voluntarism. Yet when one looks closely, the elements of emulation are unmistakable, whether by approximation in responding to “thresholds” or by faithful implementation of very specific “patches.” In short, a more diverse and self-confident regional political layer of government is emerging in the Czech Republic—a development difficult to imagine without the influence of norms from the EU.

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\(^{35}\) These membership negotiations are not negotiations in the narrow sense of the word. Rather, they are meetings of ministry and Commission officials, who assess and document progress in individual areas and countries. The eventual result will be an accession treaty that takes account of exceptions and possible transition periods a country may need in order to achieve full compliance with the *acquis*. As of December 20, 2001, both the Czechs and Hungarians have provisionally closed 24 of 29 chapters.

STRUCTURAL AND POLICY CHANGE IN HEALTH CARE

Health policy is also an arena where CEE élites have looked to Western models, yet the EU has played a relatively minor role. Here, emulation has been mostly voluntary and almost exclusively approximate, rather than faithful. The diversity of institutional practices in Western Europe and the obvious struggles the various national systems have in controlling costs have meant that no model has been an unambiguous favorite. Further complicating the use of Western templates has been the incommensurability of advice on broad social policy given by a range of international organizations, including the World Bank, International Labor Office, International Monetary Fund, OECD, the Council of Europe, and the EU.\textsuperscript{37} As a result, the institution building process has included more cases of isolated, adaptive borrowings from different Western models.

Unlike in regional policy, which has been built nearly from scratch, the overall picture in health care is of modest reforms. I will argue that one important reason for this modesty is the lack of EU interest in and leverage over the health policy sector. That is not to say there has been no reform. Some have asserted that the reform of the Hungarian, Czech, and other CEE health care systems made the move “back to Bismarck.” That is, these states had Bismarckian health care systems until the Soviets imposed their model through the national communist parties. Today, these states seek to implement models based on the same Bismarckian system.\textsuperscript{38} While this image is somewhat overstated -- as we will see, the German model is not the whole story -- it serves as a useful starting point.

CEE states have not seen the precipitous and alarming drops in public health that plague some post-communist states, including Russia. Modest reform has gone hand in hand with a general increase in health (longer lifespan, lower incidence of disease, lower infant mortality rates). On the other hand, there has been an actual increase in the incidence of some diseases (e.g. cancer, diabetes), and Hungary lags behind the Czech Republic in all indicators shown except viral hepatitis. Of course, these morbidity figures are affected by many factors, of which the institutional features of health care are only one cluster. Table 4 gives some major indicators.

Table 4: Comparison of Incidences of Disease and Causes of Death

<table>
<thead>
<tr>
<th></th>
<th>Life Expectancy at Birth in years</th>
<th>Infant Mortality Rate per 1000 live births</th>
<th>Tuberculosis Incidence all forms per 100,000</th>
<th>Viral Hepatitis Incidence per 100,000</th>
<th>Cancer prevalence percentage</th>
<th>Diabetes prevalence percentage</th>
<th>Standardized Death Rate, Disease of Circulatory System per 100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>CR</td>
<td>72.06 (’91) 74.94 (’99)</td>
<td>10.38 (’91) 4.62 (’99)</td>
<td>20.17 (’91) 15.61 (’99)</td>
<td>20.74 (’91) 22.39 (’99)</td>
<td>1.79 (’91) 3.09 (’98)</td>
<td>4.76 (’91) 6.07 (’99)</td>
<td>615.65 (’91) 487.17 (’99)</td>
</tr>
<tr>
<td>Hu</td>
<td>69.46 (’91) 70.75 (’99)</td>
<td>15.64 (’91) 8.43 (’99)</td>
<td>35.36 (’91) 35.08 (’99)</td>
<td>22.68 (’91) 13.52 (’99)</td>
<td>Na 3.09 (’98) 4.76 (’91)</td>
<td>Na 6.07 (’99) Na</td>
<td>638.17 (’91) 588.45 (’99)</td>
</tr>
</tbody>
</table>


The Hungarian Case: A Brief Overview

Since the 1980s, many Hungarian officials have been troubled by the declining health of the Hungarian population, the poor quality of health care, and the shortage of financial
Economic reform helped drive more reforms in the 1990s. Yet while some important changes have occurred, the reforms have fallen short of expectations, and some inefficiencies and shortcomings of central planning are still visible in Hungarian health care. The argument that Hungary has turned “back to Bismarck” rests on the decision to recreate insurance-based systems and place major social groups, including unions and employers, into top management positions. As Marrée and Groenewegen argue,

Since the Second World War, the social health insurance system has slowly been replaced by a national health system. [But since 1990] the Hungarian health care funding has been modified into a social insurance system again. . . . In addition, the financing methods in the health care sector have completely changed; since 1990 a point system, a DRG system, per diem remunerations and per capita payment have been introduced.

On the other hand, much has not changed. A 2000 OECD study concluded that further reform of the Hungarian health care system is badly needed. The study notes the system is “broadly in line with that of other OECD countries,” but that it “remains in serious

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need of reform.” Hungarians have the OECD’s lowest life expectancy, and “the effectiveness of the nearly universal national health insurance system is greatly reduced by systemic inefficiency, perverse incentive structures and perennial over-spending in pharmaceutical expenditures.” The report goes on to suggest that Hungary has an “excess supply of specialists” that results in an “excessively hospital-centric and specialist-based pattern of treatment.” In addition, the study also noted that difficulties also plague the payment systems for inpatient (DRG) and outpatient hospital (points) care. As we shall see, both these systems owe something to the inspiration of specific western models.

**The Czech Case: A Brief Overview**

In the Czech case, there has been a more significant overhaul of health care. The Klaus government claimed at its main priorities decentralization, privatization, autonomy for providers, freedom of choice for patients, and compulsory social health insurance for essential services. Scheffler and Duitch note that

The reforms were designed to achieve solidarity, decentralisation, and privatisation through three major elements: (i) mandatory health insurance for all citizens, financed by a national health insurance fund to which the government and, via a payroll tax, workers and employers contribute; (ii) creation and promotion of competition among non-profit, employment-based health insurance plans in the private sector; and (iii) movement of physicians and other health care workers into private practice and the transfer of some hospitals to decentralised private control.

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42 All quotations in this paragraph are from Orosz, Éva, and Andrew Burns. 2000. *The healthcare system in Hungary*. Economics Department working papers no. 241 Organization for Economic Co-operation and Development. Economics Department.


To this end, the government transferred control of some specialized facilities to the Ministry of Health and allowed other facilities to become legally and financially independent. Also, it permitted patients a free choice of providers. It seems the Czech people have realized some benefits of reform as consumers, for “reform has also elevated the voice and stature of consumers with respect to choice of providers and treatments.”

Additionally, three independent professional health chambers (Act No. 220/1991 concerning the Czech Medical Chamber, the Czech Chamber of Dentists and the Czech Chamber of Pharmacists), to which all health care providers are obligated to belong, were formed to register health care providers and to establish ethical standards. In January 1992, a General Health Insurance Company was formed. In 1993, the GHIC became an autonomous insurance fund, roughly analogous to the German funds. Subsequently, several other autonomous insurance funds (e.g. Škoda-Volkswagen) were formed. By 1995, however, most of these privatized insurance funds faced severe financial difficulties. The GHIC then took over many of them. In the mid-90s there were as many as 27 funds. In 2000, there were only nine.

Density of Actors, Sparseness of Acquis

This paper has argued that we should see the least EU-mandated emulation in cases where the pre-existing networks of interested actors are most dense and where the

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45 Scheffler and Duitch. “Health care privatisation.”
substance of the acquis is lightest. The former proposition speaks to veto positions of established actors, and the latter proposition highlights the role of EU leverage. Health care reforms (of lack thereof) illustrate the general point, for the many interest associations present there make it far from a tabula rasa, while the EU’s very sparse health policy acquis provides the EU little leverage.

Several actors play key roles in reforming the health care system of Hungary and the Czech Republic. Internally, in both states the Ministry of Health and the Ministry of Finance actively participate in health care reform as they seek to balance health and fiscal reform. Also, health care providers, though they are often divided (e.g. primary care versus specialized care, specialties, private practice versus public-sector employment) are key actors. Unlike in regional policy, the multiplicity of reasonably well-established actors have made reforms quite complex. The World Bank remarks upon the “highly fragmented nature of health policy in the Czech Republic….There is no clear leadership in the sector, and the myriad of amendments to the original Act is testament to the lack of clear vision.” Meanwhile, in Hungary, efforts to address health care problems have “been hindered by endemic conflict between the Ministry of Health (previously Welfare), the self-government of the health insurance fund, the HIFA and the Ministry of Finance who have [had] overlapping responsibilities in the financing, policy preparation and

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administration of healthcare. A major challenge will be to introduce reforms in a way that reduces these tensions and increases co-operation between agencies.”

In both countries, moreover, democratization affects reforms. As Nelson argues that citizens will accept top-down decision making in some areas more than others: “On the issues they believe they understand in greater degree, and where there is no obvious reason for rapid action, citizens in democracies are much more likely to expect open debate and consultation. Social-sector issues in general fit this description.”

As in the section on regional policy, I turn now to a more explicit consideration of emulation. The next section describes two main phases: the first phase, which runs up to the Essen White Paper, covers the period in which the EU took no special interest in CEE health care reform. Any emulation that occurred in the period was very likely motivated by factors internal to each state or in “anticipation” of pleasing the EU or other outside agencies. In either case, such moves were voluntary by the definitions used here. In the second phase, from the publication of the White Paper on, however, the priority of preparing for eventual EU membership means that we are best advised to code the cases as “less voluntary.” This does not mean CEE states were “forced” to make the reforms but does recognize that membership was the country’s number one foreign policy goal.

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Phase 1: Voluntary Emulation, 1989-1995

Health reform is a complex policy area, and each post-communist country has many actors operating in the field. Moreover, this is an issue that the general public cares about very deeply. Government leaders wish to implement health care systems that reflect the values of the people and provide for their needs. To reach this end, states may occasionally emulate parts of other health care systems, but they are likely to do so much less than in a domain like regional policy. János Kornai invokes a critical starting point for this issue of emulation, namely the lack of a coherent Western model:

There is no “model country” to represent the “developed West,” whose example might be followed without hesitation….Policy-makers would be well advised to consider adopting different aspects from different systems to construct a coherent whole most appropriate for their own country.\(^{54}\)

Nelson argues that absence of such a vision is rooted partly in the complexity of the sector “with its many levels of operation and stakeholders.” She notes that these institutions provide “public goods” but that “the division of responsibilities among public (national and subnational) agencies, private for-profit agents, voluntary organizations, households, and individuals is highly flexible and immensely controversial. It is difficult to reduce the trade-offs among groups and goals to a common denominator.”\(^{55}\) In other words, even if there were a clear model, the complex politics of this policy sector would make its pursuit very difficult. A related difficulty for emulation is that health policy is not an area where the communist states left behind only discredited institutions. Kornai

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notes that the health care mechanism established under socialism “can only be transformed; it cannot and must not be torn asunder before an alternative system can evolve to take its place.”

While the perceived problems of social democratic welfare states in Western Europe makes the wholesale emulation of those models difficult, early in the decade, the Germany and Austrian models were a significant point of reference for CEE reformers. In Hungary, the first step was taken by the last socialist government in 1989, which separated the health system from the general fund and sought to institute quasi-corporatist arrangements for its funding and oversight. This change meant, among other things, that citizens now would pay insurance contributions (usually through their workplace), rather than have medical expenditures covered by the state’s general revenues.

The oversight of these new funds moved to a corporatist structure. As one of the Hungarian Roundtable participants on the committee charged with health policy has recalled, the idea of neo-corporatist oversight “just conquered brains. It was in the air.” Kornai locates the timing of a more general shift in the direction of the German model to 1991 in Hungary and 1992 in the Czech Republic. Both Hungary and the Czech Republic used templates in that they voluntarily implemented certain functional characteristics of the German model. A key functional feature the Czechs and Hungarians approximated from the German model was the aforementioned separation of provision

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58 Interview with Ivan Csaba, Budapest, July 16, 1998.
and financing. The mechanism the two states chose resembles the German model in two ways. First, the social insurance fund for health care has its own source of revenue that lies outside the general fund, and secondly the fund purchases services from health providers, from whom it is institutionally distinct.\textsuperscript{60}

Other steps also have transparent foreign roots. Under the first post-socialist government, a fee-for-service reimbursement system was introduced. Hungary adopted and then heavily adapted the institution of so-called “diagnostic resource groups.” These DRGs, which set insurance fund payments to hospitals for groups of related medical conditions, are widely used in the US, but are also used in Norway, Sweden, Portugal, and Austria. German enthusiasm for DRGs seems to have contributed to their use in Hungary with the German health consultants playing a role in articulating the virtues of DRGs. As with the insurance system more generally, this emulation was not faithful, but approximate. The DRG system was adapted in at least three ways. First, account had to be taken of the much higher use of technology and longer stays in US hospitals than in Hungary. Second, Hungarian hospitals had to build into the DRGs the employment costs of doctors since those charges are typically billed separately in US hospitals, where doctors often have “privileges” without being employees. Third, DRGs were adapted to take account of different epidemiological patterns in Hungary. Again, some adaptations of the DRGs also apparently came by way of German experience. Since DRGs can invite “overcoding,” the German state of Bavaria has used a capped fund for physician fees so that as use rises in a particular category, average reimbursement rates fall. But what was a \textit{regional} system for

\textsuperscript{60} Kornai and Eggleston. \textit{Welfare, choice and solidarity}, pp. 145, 148.
physician fees in Bavaria has been used as the national model for Hungarian DRGs, and has apparently made some contribution to cost control problems faced by the funds.

The European Observatory on Health Care Systems, a partnership between the WHO, NGOs, and several European governments, also notes that Hungary is using models from other western countries, including

- United States: the DRG as a financing and controlling model; the Health Maintenance Organization as a way of combining financing and provision
- Germany: autonomous quasi public sectors owners, strengthening primary care, performance based financing, new management structure
- Scandinavia: health centers (which seem, at the same time, to build on the communist traditions of polyclinics)
- England: patient capitation payments for family physicians

While Hungary’s initial reform steps looked to Western models for some inspiration, those in Czechoslovakia did not. In January 1992, Czechoslovakia initially moved to a General Health Insurance Office with the state as the dominant shareholder. This pattern was far more one of path dependency than of innovation based on foreign models. But as Olga Výborná has argued, such a state monopoly was hard to justify as a “natural” one when cost calculations were so unclear. This criticism opened space for some Czech

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parliamentarians to invoke Western models to suggest that a competition of health insurance companies would be key to dampening cost pressures.\(^6\)

Within a year, the parliament allowed a plurality of private insurers through the “Sectional, Professional, Corporate, and other Health Insurance Offices Act.” The Czechs then introduced fee-for-service methods of payment in which points are distributed for each procedure. Yet unlike in most Western societies where fee-for-service systems are used, there were no provisions made for co-payments, so insurance companies lost an important cost control lever, and health care costs increased dramatically. There is some disagreement among specialists on the origins of the Czech point system. Some argue that it drew so closely on the German one that it might be called a copy.\(^6\) Others emphasize that the new system was consonant with several foreign models:

As the reform plan was originally conceived and implemented, providers were paid solely on a fee-for-service point system for services covered by the health insurance system. This point system is similar to the relative value scale used in the United States, Germany, and Canada.\(^6\)

**Phase II, The EU Enters the Picture, 1996-present**

The previous section sketched those moments in health care reform in which Czech and Hungarian officials relied on voluntary emulation of Western models for specific reforms. These reforms usually merely approximated Western structures and thus used


templates. While a great deal of advice was available on health care reforms, CEE states were perfectly free to take that advice or leave it. We have seen that a similar pattern held in the domain of regional policy and that absent EU pressures, few reforms were achieved. There, we also saw that after the Essen Summit the EU began to take an active role in promoting institutional modifications.

Externally, several actors have had some interest in CEE health care reforms. The EU plays some role in promoting health reform through Commission programs, but there was no really large role either for the Commission or its constituent agencies like Phare.65 Thus, the aim of the following short section is to sketch quickly what the EU has tried to influence and to show that it has not really been a major player in this domain.

Commission documents from the late 1990s do worry about “the lack of clear, modern public health policies equal to the challenges facing the health system and the relatively low priority given to this sector.”66 Two main areas of EU effort stand out: institution building and public health issues. Recognizing the multiplicity of demands on state budgets and seeing that some aspects of current system are financially unsustainable, the Commission has noted the “growing gap between the professionally possible and affordable health services.” As a result, “the Pre-Accession Strategy stresses the importance of institutional building, especially related to public accountability and


budgetary control. The health sector is an important user of public funds and institutional building is particularly important here.”

The second key EU priority has been in public health issues, including communicable diseases, the decline in vaccination coverage, increased drug use, the need for better emergency facilities, the low social and economic status of health professionals, the relative lack of involvement of the civil society in health issues, and poor environmental conditions. Among the key institution building tasks are improved surveillance for communicable disease and better integration of CEE health professionals into broader European networks.

The Commission, keenly aware that existing member states guard their prerogatives in health and social policy, must take a cautious approach. The Commission talks of “options [that] could be considered.” The EU has yet to institute a program that explicitly defines steps that states must take to reform their health care systems, both in terms of policy and structure, prior to EU accession. There is some evidence that the Commission conceives its role as speaking for a public health function that has suffered in the transition away from communist era health systems. As the Health and Consumer Protection Directorate argues:

The former health systems in the [CEE] Countries had an important disease prevention and health promotion component. This orientation has evolved into a treatment oriented one. This has led to public health being of low priority, with

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inadequate funding. Activities in health promotion and disease prevention
(including environmental health) are being initiated again through the
establishment and implementation of national programmes, even-though most
Candidate Countries still lack a clear, modern public health concept based on
inter-sectoral action and carefully selected objectives.\textsuperscript{69}

The Regular Reports have had little specific to say about health. The 2001 Czech Report
mentions disarray in the Ministry of Health and problems with fiscal surveillance,\textsuperscript{70} while
the report on Hungary complains of “major shortcomings,” frets about the fiscal demands
of health care, and the over-reliance on hospital stays.\textsuperscript{71} Beyond that, however, the EU
has done little to delineate the changes that the Czech Republic and Hungary must make
before they are admitted to the EU. The EU appears to be most interested in economic
reform vis-à-vis the health care system:

While the transposition of the \textit{acquis} will put little demand on the health sector,
the EU has already expressed concern regarding the health financing system and
its viability over the longer term. As the process of EU accession advances, an
affordable and working health care system that does not compromise the
government’s expenditure envelope is necessary.\textsuperscript{72}

In other words, one of the EU’s primary concerns about health reforms is that if they do
not take place, then the fiscal situation might blow up.

\textsuperscript{69} European Union. \textit{Working paper on health and enlargement}, pp. 11-2. Note, however, that cigarette
smoking has actually decreased in both countries between 1991 and 1999.

\textsuperscript{70} European Union. Commission of the European Communities. 2001. \textit{2001 regular report on the Czech}
Republic’s progress towards accession}. Brussels: European Union. p 69.

\textsuperscript{71} European Union. Commission of the European Communities. 2001. \textit{2001 regular report on Hungary’s}
progress towards accession}. Brussels: European Union. p 32.

To be sure, the Hungarian government is fairly open that templates from other nations play some role in their reforms even during the period in which EU attention has been brought to bear. For instance, the Ministry of Health touts its new program, entitled “For a Healthy Nation: Public Health Program 2001-2010,” in the following terms:

There have been other nations in Europe that were in similar straits not so long ago, and by setting realistic goals, designing good programs to target them, and winning over the entire nation to cooperate, they achieved impressive results. The most often publicized North-Karelia Program was set into motion in Finland in 1972. . . . In other words, there is an existing model that can be adapted to Hungarian conditions, and if it is implemented consistently success is guaranteed. 73

Three points here stand out. First, the government invokes foreign models to promote encouragement and optimism. Indeed, if the model is followed “consistently,” then success is “guaranteed.” Second, the “model” in question has no clear institutional specification at all, rather it is just a “program” implemented in one region of Finland. Third, it comes at a time when the EU’s own process gives the CEE states incentives to pitch their reforms as approximations of processes already extant in the member states.

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CONCLUSION

I have tried to suggest two points: 1) emulation (or imitation) is actually a pretty complex process that includes at least four discrete sub-processes (copies, templates, adjusting to thresholds, and patches), each with their own dynamics. 2) the kind of emulation pursued and the results achieved are likely to vary by policy domain. Specifically, the density of the acquis and the density of pre-existing actors both matter for understanding outcomes. The dense *acquis* and the absence of any policy legacy in the field of regional policy gave the EU both leverage to ask penetrating questions and the space to suggest very detailed answers. By contrast, the light acquis and density of established actors meant emulation took the form of a process of continuously negotiated inspiration in the Hungarian and Czech health care systems. The lack of EU leverage meant that CEE politicians were free to take advice where they chose to, but it’s worth noting as well that there haven’t been very many truly fundamental reforms in CEE health care in the past decade.

The conceptual and empirical findings here have broader implications that can be noted briefly. First, there is are new and growing literatures on “external influences” on both democratization and economic reform in CEE. These two literatures tend to be disconnected from one another now, but they can and should be joined. Both literatures respond to the initial descriptive work and crude typologizing about “transitions,” which emphasized internal political considerations in accounting for political choices (what should the constitution look like? How should institutions be reformed? etc). More recently, some edited volumes have made the point that external influences have often (not universally) been important in some of these choices. I think this is a growth area for
good conceptual work because it addresses questions of multi-level governance and the union of foreign and domestic influences. This latter point is important because I discern a trend toward setting up “external influences” as an “alternative explanation” to domestic considerations. This is exactly the wrong approach because external influences can almost never have any real purchase unless they are joined together with domestic ones (we saw this even in regional policy). Casting external influences as an alternative is empirically wrong (for the reason just stated) and analytically unpromising (because we don’t yet have real theories of external influence and aren’t likely to get them through this route). If CEE specialists can strengthen this ad-hoc literature on external influences, we can say something crucial to the broader field of comparative politics.

We can also improve the well-established conditionality literature. Notwithstanding predictions that the “era of conditionality” ushered in by the debt crisis of the 1980’s had passed, aspirant members have been confronted with a series of tough tests for joining. Indeed, in the EU case, member states have manipulated the very size and shape of the *acquis* in completely unprecedented ways. The CEE states have had to hit a moving target, so to speak. Those who heralded the end of the era of conditionality assumed that the decline of the acute phase of the debt crisis and the end of the Cold War robbed those who set conditions of both the leverage and motivation for doing so. But in these European cases, CEE aspirations to join (not a factor in IMF-World Bank discussions) resulted in a new kind of leverage. If we can better apply an established literature to a new region (CEE), we can reevaluate and correct a trend emphasized in the political economy of development literature.