Humanising Healthcare: Volunteered caring and the free gift in Czech hospitals

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The past decade has seen a marked proliferation of volunteering programs in Czech hospitals. These have been established with the help of national and international funding and take various organisational forms. For the most part, these programs enable lay citizens to provide hospitalized patients with company and social support for a few hours per week. This article considers the ways in which hospital volunteering is promoted and understood as a free gift, in anthropological terms (Parry 1986, Laidlaw 2000). Specifically, I probe why it is possible and desirable for participants on volunteering programs to think about volunteering in this way. I argue that the social construction of volunteering as a free gift promotes a particular ideology of autonomous personhood, which, when considered alongside other political and economic developments in Czech healthcare over the past two decades, can be thought of as part of its neoliberal transformation. I use the latter term advisedly here, concurring with recent scholars who argue that the concept of neoliberalism is unhelpful when it is too general, or when it is presented as an omnipresent or omnipotent force in the world (Kingfisher and Maskovsky 2008). Instead, neoliberalism is best seen as a combination of political projects which link ideologies of personhood and moral authority to those of the market and efficiency (Clarke 2008). I aim to reveal how these projects are historically bound up with each other in the case of hospital volunteering, and how they maintain an ideological and material coherence. In pursing this aim I focus upon the ideological framing of this type of volunteering, and give less attention to the complicated and sometimes contradictory negotiations of it within daily practices and interactions. I therefore draw attention to the ideologies that frame everyday practices, whilst not denying the role of the latter in reproducing and sometimes challenging the former.

The findings of this article are based on a six month ethnographic study of hospital volunteering which I conducted in 2008. I carried out fieldwork at programs based at hospitals in three urban sites in the Czech Republic: Prague, Ustí-nad-Labem, and Ostrava. In each case, the recruitment, training, and supervision of volunteers was managed by paid volunteer coordinators. The Ustí and Prague hospitals funded the volunteer programs, which meant that they paid for the coordinators' salaries and provided office space, materials and equipment for a volunteer center at the hospital. In Ostrava, volunteer programs were organized by the Czech branch of an international NGO, which charged the hospital for coordinating volunteer programs. Alongside conducting a series of detailed interviews with volunteers, coordinators, hospital staff and patients, I also observed volunteer training and supervision workshops across the sites, and collected a range of manuals and booklets produced by the volunteer centers on these topics. It is with these training workshops that I begin, since these were occasions in which prospective volunteers received orientation in how to approach volunteering and how to conduct their relationships with patients on the wards they visited.

Orientating volunteers: the importance of autonomy

Training sessions consisted of a series of exercises aimed at encouraging participants to engage in self-reflection about their personal qualities, their motivations for volunteering, and what they hoped to be able to offer in these roles. The methods of tuition utilized by coordinators were intended to be non-hierarchical. Everyone was encouraged to ask questions and share their thoughts during what was usually a day-long workshop, which took a fairly

standard format across the different sites. Participants began the day by sitting in a circle and introducing themselves to the group, usually by saying a few words about themselves (e.g., family circumstances, hobbies) as well as talking a little about their motivation to volunteer. Participants' accounts of the latter often varied; from wishing to gain insight about particular wards (with a view to a future career in nursing, psychology, medicine or social work), to wanting to work with certain 'deserving' categories of patients (particularly hospitalized children or the elderly), to wanting to feel useful or try out hospital volunteering, having already volunteered in another context. This range of responses was further explored in the next exercise, in which participants were invited to develop their reflections on both the benefits and risks of volunteering for 'the volunteer' in an abstract sense. Typically, participants considered these issues in pairs at first and then fed back their responses to the whole group, whilst the coordinators made notes of the key words on a clipboard. The benefits to the volunteer typically included the following: personal satisfaction, broadening horizons, gaining new experience, perfecting communication skills, reappraisal of personal values and habits, self-education/self-training, making new contacts, and gaining a different perspective on life. The risks included: powerlessness, fear of a patient dying, anxiety about misunderstanding patients or hospital staff, and personal problems getting in the way of volunteering.

An important goal of these training exercises was to orientate participants' perceptions of volunteering. Most crucially, as I have indicated, volunteering was identified by volunteers and coordinators alike as a vehicle for improving the self in various ways, particularly for expanding personal knowledge, understanding, and skills and thereby promoting greater fulfilment and self-realization. One consequence of this notion of volunteering as beginning and ending with the self is that it ruled out alternative ways of thinking about the activity. For instance, during the socialist period in Czechoslovakia, voluntary social and political participation was officially presented as an element of a more general social contract. Every citizen had an obligation to occasionally provide time and labour to 'society' for free, in return for certain benefits and forms of social protection, such as free education and healthcare and guaranteed employment (Read 2010). As I have discussed elsewhere however, organizations promoting volunteering in the Czech context over the past decade have been keen to distance themselves from any association with the widely perceived 'non-voluntariness' of organized voluntary work during socialism (Read 2010). Volunteering organizations have highlighted that 'genuine' volunteering is an activity which individuals choose to enter into freely, without pressure or coercion from state institutions.

Alongside benefits, the risks of volunteering were discussed extensively throughout training days. In relation to concerns about how best to relate to hospital staff, coordinators recommended that participants develop a respectful relationship with nurses and doctors on the wards they visited, for example by always signing in and out on the wards, asking for nurses' recommendations about which patients to visit, and enquiring what particular patients were physically able to do (whether they could go outside, what games they could play, etc.). They should also be attentive to daily routines on hospital wards, not impede or intervene in the work of medical staff, nor ask questions about the nature of a patient's diagnosis. Their role was to engage individual patients in conversations or activities which provided a temporary distraction and relief from the hospital environment.

Much advice was also provided to participants on how to manage the risks inherent to making relationships with patients. Prospective volunteers were urged not to become too involved in patients' personal lives and concerns, as this could lead to 'burn-out'. Volunteers needed to be clear with patients about the limits of their commitment, devote only what time they could afford to volunteering, not feel obliged to visit a particular patient more often than they would normally, simply because the patient asked them to, and not offer or accept gifts

or money from patients. Volunteers could also request to change the ward or patient they visited at any time if they so chose. The manual used to train volunteers in the Prague based hospital stated:

> A volunteer can only attend to the patient in the moment that s/he is with them. Even though a volunteer's activities may result in considerable familiarity with the patient's life story (the patient's past or his fears about the future)... it is important to remember that
> - the volunteer is not responsible for making the patient better
> - the volunteer cannot change the patient's past or present
> - the volunteer can only influence what s/he offers the patient from him/herself, and leave it to the patient to make the most of this, either now or in the future
> (Lékořice, undated, 8).

Potential volunteers were thereby strongly encouraged to set their own limits to their activities in terms of the times, places, and people they visited, and only to take on what was personally manageable. An incident at the Prague hospital training day further illustrates this point. The group of trainee volunteers were asked to enact a series of scenarios consisting of typical problems they might encounter whilst volunteering. One such scene consisted of two people pretending to be child patients on a children's ward, and two others playing the volunteers who visit them. The 'children' were asked to try to persuade the 'volunteers' to stay longer than they had planned, and when this request was refused, to physically cling to the 'volunteers' and become increasingly upset and tearful. The task for the 'volunteers' was to negotiate their exit. During the feedback after the scenario had ended, they stated that they had found it difficult to keep the situation under their control. What excuse should they give for leaving? After some discussion amongst the group, the coordinator's advice was that volunteers should be able to leave without providing reasons or excuses. Volunteers should not threaten not to come back when patients try to persuade or manipulate them to stay, but equally, they should not make firm promises that they will come back. They should simply repeat that they need to leave, and then leave. The bottom line, she said, was that volunteers should not allow any obligations or dependencies (*závazky*) to develop in their interactions with patients.

Autonomous volunteers and the free gift

This attempt to prevent the development of longer-term obligations and reciprocity between volunteers and patients can be elaborated in the light of anthropological debate on the free gift. At first glance, it may seem odd to view this activity as a free gift, given the explicit discussion of its benefits to volunteers during training days. If volunteering is truly a free gift, then shouldn't volunteers receive nothing in return for their efforts? The problem with such a proposition is that it presupposes that there can be such a thing as a 'pure free gift'. The inherent capacity of gifts to generate and transform social relationships, as observed by Mauss and many of his commentators, makes it unlikely that such a concept of free giving could exist in social relations. However, following Laidlaw (2000), I argue that the problematic existential status of the free gift need not deter us from trying to understand human endeavours to imperfectly create it in particular historical settings. In the case of volunteering, it is precisely the avoidance of ties that bind that enables volunteers to give their time and attention to patients 'freely'; that is, not simply 'without payment' but more importantly 'without obligation'. Volunteers were free to choose which wards they work on, the times of their visits, and (to some extent) the patients whom they visit. In principle, they

entered into and opted out of relationships with patients as they wished. For some volunteers, this autonomy, which stood in marked contrast to their obligations to their children, parents, other relatives, friends, and colleagues, was key to the attraction of volunteering. For instance, Jana[1] and Zuzka, two young female student volunteers I interviewed who visited a geriatric ward together, contrasted volunteering with paid work on the basis that the former did not require you to be somewhere for a set period of time. They related one occasion when they had met up as usual before a planned volunteer visit, and then spontaneously decided to cancel it. They particularly enjoyed having the freedom to make this decision. Similarly, Stefan, a young man and Eva, a woman in her mid-seventies, who visited the same children's ward, both expressed that they were glad that the hospitalized stay of children was short, which meant that even though they visited the ward on a weekly basis, it was extremely rare for them to see the same child twice. Eva commented that it made her happy to play with the children and see that they enjoyed this. In particular, she was always glad to see that patients with whom she had spent an hour or so were going home refreshed and revived. At the same time, her relationship with these children didn't feel like a sacrifice to her, nor did it cause her anxiety or worry. She had no lasting attachment to the children beyond the two hours a week she volunteered.

There were, of course, moments when volunteers struggled to maintain this level of autonomy from patients. The care and concern volunteers felt for patients was not always compatible with sustaining relationships from which it was possible to walk away, physically or emotionally. Helena, for example, felt extremely upset when an elderly lady she had been visiting for several months died, and no one from the hospital called her to convey the sad news. Equally, Jan felt he needed a break from volunteering after several of the patients he regularly visited passed away. Even those volunteers who had shorter-term or one-off interactions with patients sometimes struggled to maintain control over the duration of a visit. Sitting with Jana and Zuzka on their visit to a geriatric ward, I watched them work hard to engage an elderly woman in conversation. Initially she seemed indifferent or reluctant to talk with us, leaving this to the patient in the next bed. After an hour, however, she became curious about the volunteers and began to ask questions enquiring into their views and knowledge on wide-ranging topics. Ignoring their polite signals that they now needed to leave, she eventually obliged them to stand up and bluntly announce that they had to go.

The view of the autonomous person emergent in volunteering discourse and practice can be seen as a component of Western individualism, which has its roots in Enlightenment thought and has taken various historical formations over the past two centuries. MacFarlane depicts individualism as "the view that society is constituted of autonomous, equal units, namely separate individuals and that such individuals are more important, ultimately, than any larger constituent group" (in Kingfisher 2002: 18). There is a large body of social science literature which considers Western personhood and individualism in its historical development and cultural specificity (see for instance Morris 1991; Strathern 1988; Spiro 1993; Pateman 1988). My purpose here, however, is not to trace how the autonomy ascribed to volunteers as persons might be historically located in philosophical debates about Western individualism. Instead I ask more prosaically, what does this formulation of personhood achieve for the subjectivities of volunteers? And how might it be seen as part of the neoliberal transformation of health care in the Czech context?

In his commentary on Mauss' essay on the gift, Parry sees the creation of a realm of free giving as arising in complex, state societies with advanced commercial sectors. In these societies, the disembedded nature of economic transactions from other social relationships helps sustain an ideological antagonism between the activities associated with commercial and non-commercial realms:

> Those who make free and unconstrained contracts in the market also make free and unconstrained gifts outside it. But these gifts are defined as what market relations are not - altruistic, moral and loaded with emotion [Parry 1986:466].

According to Parry, it is Christianity, above all of the world religions, that has most thoroughly universalized disinterested giving as a moral requirement of all, which has in turn historically shaped the development of a separate economic sphere "where self-interest rules supreme" (1986*:*469). Following Parry, I see one of the important consequences of volunteering as helping to sustain the coherence of moral oppositions between self-interested actions on the one hand and selfless free giving on the other. Volunteers, and others linked to volunteer programs, frequently cast volunteering as selfless, moral activity which both contrasts and counter-balances other spheres of contemporary life that require either self-interested or self-centered behavior, or which appear valueless and devoid of ethical purpose. For instance, Ana, an experienced volunteer who visited a geriatric ward, told me that she got involved in volunteering partly because her job was unfulfilling. According to her, it entailed "administration, just numbers, nothing else. I really wanted to do something meaningful, something [where I would get] an immediate reaction, or simply a feeling of being useful". Andrea, whom I met on a volunteer training day, wished to get involved in volunteering because she felt it encouraged non-materialistic values. She added that, in other areas of her personal and professional life, it was necessary for her to behave in an essentially selfish, "materialistic" way. By becoming a volunteer she hoped to restore a personal sense of balance and equilibrium between these opposing principles. On a different training day, volunteer coordinator Iveta promoted volunteering to participants by emphasising its potential to foster precisely this 'balance' (*vyrovnani*) between selfish and unselfish behavior. Some healthcare professionals also cast volunteering in this light. The head nurse at one of the hospitals I focused on, who had been particularly instrumental in establishing the volunteer center and program there, described the conditions of contemporary life as hectic and stretched, making most people preoccupied with their own interests, troubles, and the need to make ends meet. In her view this made volunteers admirable people, because they were prepared to give up their time to work for the benefit of others without any direct personal reward.

The broader significance of this point is that the notion of volunteering as a free gift only becomes intelligible in relation to a wider series of historical conditions, in particular those which insist on the necessity of self-interest as an organizing principle of economic relations. This is important, because at first glance volunteer programs may appear to be somewhat marginal, consisting of a loose and transient group of people whose impact upon large scale transformations in healthcare and Czech society generally is limited. Nevertheless, I argue that volunteering both gives expression to these transformations and provides a morally coherent means of processing and constituting them. As I have already shown, the idea of volunteering as a free gift becomes ethically compelling in relation to the acknowledged self-interested character of social life outside of volunteer programs. I will now move to a discussion of volunteering as part of a series of specifically neoliberal transformations in healthcare.

Volunteering and neoliberalism

As indicated above, recent work has addressed the problematic character of neoliberalism as an analytical concept. Neoliberalism has been associated with a range of related processes, from the rise of a global capitalist class and the reach of corporate capital into new areas of life (Harvey 2005), to the dismantling of the welfare state (Kingfisher 2002), to the evolution of new forms of governing populations (Rose 1999). In spite of the

extremely broad scope of these processes taken together, Clarke (2008) and Kingfisher and Maskovsky (2008) warn against the tendency to see neoliberalism everywhere, as this risks overstating its dominance and making its power rather too inevitable. Instead, they argue for the need to specify how neoliberalism emerges through its connection with other political projects in particular times and places. Clarke sees mutability and appropriation as key characteristics of neoliberal projects – the tendency to re-articulate the objectives of other political movements in neoliberal terms (Clarke 2008: 139). What, then, are these terms? Clarke identifies four elements which, *in combination*, provide neoliberalism's coherence. These are a "logic of market rationality" which seeks to universalize market principles as a way of organizing social life; a conception of personhood which is "a model of the self-possessed and self-possessing individual"; a framework of efficiency which "establishes norms and ways of calculating value" and lastly, the fusing together of "different forms and sites of authority" (Clarke 2008: 141). Taken individually, there is nothing especially new or neoliberal about these different elements, it is rather their combination which "marks the distinctiveness of neoliberalism, and…their co-existence that enables neoliberalism's flexibility in processes of appropriation/articulation" (Clarke 2008: 141).

I hope to show that Clarke's model is useful in elucidating how volunteering is connected to other processes of change in Czech healthcare over the past decade. Having already discussed at length how a notion of autonomous, self-possessing personhood is elaborated in volunteering practices, I now move to consider how this relates to the other three elements associated with neoliberalism. This entails considering Clarke's last point first, and examining how the establishment of volunteering was part of the challenge to and reorganization of medical authority in the decade following 1989 that included significant Czech healthcare reform.

Fracturing medical authority?

In describing the emergence of hospital volunteering programs, research participants depicted Czech hospitals of the recent past as closed institutions, run by medical personnel who exerted total authority. Take for instance the following description of the head nurse at one of my hospital field sites:

> I think that because [Czechoslovakia] was such a closed society, this helped perpetuate the roles of dominant medic and submissive patient, or submissive client. Generally, the Czech population…was not very well educated in matters of health and health problems. So the patient was not able to assert his rights. And he didn't have any rights in Czech hospitals during totalitarianism [i.e., socialism]. There was no reason to let them [volunteers] into hospitals, to communicate with them. Why complicate the sterile daily routines? It was very simple. Visiting hours were from two to three, then they shut the doors and that was that…The main thing was that doctors and nurses didn't want anybody to look too closely under their fingers.

The picture of healthcare in the socialist period offered here exaggerates the interests of medical professionals in keeping hospital visitors out and maintaining their authority over patients. However, this exaggeration appeared to be widely shared, as it was frequently iterated to me in the course of my field work by volunteers and healthcare staff alike. It certainly was the case during socialism that visiting hours on the wards of many hospitals were much more restricted than today, that there were fewer mechanisms by which patients could question or challenge medical judgements, and that there was no organized hospital

volunteering programs. The decentralising reforms to healthcare structures in the early 1990s (to which I return below) were accompanied by the emergence of criticisms of established medical practices from a range of quarters (see also Read 2007, 2010, 2011). One such criticism was that long-term hospitalized patients required more social support and connection to the 'normal outside world'. The first formal volunteering program to be established in the Czech Republic was set up precisely to meet this need. Volunteers were brought onto a large children's oncology ward in a major Prague hospital to engage young patients in painting, drawing, singing, and games. Teresa Pavlova, a pediatrician who had been hired by the director of the ward to improve the social and psychological support of its patients, described how she sought to integrate volunteers into the daily functioning of the ward:

> I was looking for a space for volunteers, where they wouldn't get in the way...where they wouldn't interrupt medical procedures…it is important that hospital staff are convinced…that a volunteer will not compete with them, or take their work from them, or interfere with their activities.

Clarke's identification of a fusion of different forms of authority in neoliberal projects illuminates the shifts I am describing here. The introduction of volunteering in hospitals complicated the previously established authority of doctors and nurses. Volunteer programs were often imposed on wards by senior hospital management, in the process encountering various degrees of objection and resistance from frontline staff. Their introduction required doctors and nurses not merely to recognize additional patient needs (for social activities and support) which they could not meet in context of their normal duties, but moreover to accept the entrance of lay citizens onto wards to work directly with patients; volunteers who would remain outside existing staff hierarchies and be accountable not to them, but to volunteer coordinators. Some nurses I spoke to acknowledged the uncertainty they had initially felt about this transformation, not simply because people from the 'outside world' would see 'under their fingers' as in the head nurse's quote above, but also because of their concerns about patient confidentiality and the safety of both patients and staff. Volunteer training has evolved to address these concerns and to delineate the areas of authority and expertise pertaining to medical professionals on the one hand, and volunteers on the other. As mentioned above, volunteers were urged not to interfere in the daily routines of hospital wards, nor to intervene or even ask about a patient's diagnosis. At the same time, it was also emphasized to them that they should not allow themselves to be pressured to undertake activities normally carried out by nurses (e.g., feeding or washing patients), nor feel under any obligation to work on a ward because staff there indicated that their help was needed.

Through these careful delineations of areas of responsibility, doctors and nurses have had the presence of volunteers thrust upon them in ways which fracture and diversify earlier structures of authority. Yet, informally, they maintain the upper hand. Volunteers and coordinators rely on cooperative hospital personnel for access to patients. Nurses retain the ability to identify appropriate patients for volunteers to visit, and I witnessed and heard of many occasions in which volunteers arrived on wards only to be told that "there is no one here for you" by staff on duty. Whilst there is usually a member of staff whose role includes acting as a point of contact for volunteers, that person may or may not be on duty when volunteers visit, and his or her colleagues can block volunteers' access by claiming to be unaware of any messages or instructions for volunteers, or even ignorance of the volunteering program altogether. Some volunteers described to me how hard they had to work to gain the trust of staff, and show them that their visits had a positive impact on patients' wellbeing.

Healthcare, markets and efficiency

I take together Clarke's remaining two points in considering the location of volunteering within the broader post-1989 reforms to Czech healthcare. As I have elaborated elsewhere, these reforms entailed the introduction of quasi market mechanisms to what was, during socialism, a highly centralized set of organizations offering health services which were funded directly and exclusively from tax revenues (see Read 2007, 2010). There were three key elements to the reforms. Firstly, healthcare provision was to be decentralized; hospitals, clinics and other providers were provided with significant autonomy from local and regional health authorities, such as the ability to manage their own budgets. Secondly, health services were to be funded from health insurance companies, who paid for them on a fee for service basis, thereby reinforcing a market-imitating separation between the payers and the providers of health services. Thirdly, patients were to be treated as consumers, endowed with the individual freedom to choose their own doctor and the right of direct access to specialists. Since these radical transformations to Czech healthcare were pushed through in the early 1990s, there have been a series of further waves of reform, perhaps most notably to the health insurance system.[2]

Nevertheless, the key principles of the early 1990s reforms remain in place in the present. In these transformed conditions, hospital directors and senior management faced contradictory sets of pressures. On the one hand, there have been new demands for changes and improvements to the quality of patient care their institutions provided, as I have already alluded to above. Patients were now consumers of health services, and could (at least in theory) choose the hospital in which to be treated, with direct consequences for 'competitor' hospital funding in the fee for service system. On the other, directors were charged with keeping a tighter rein on their budgets and controlling costs. Pressure in this area has increased further in recent years, as some Czech hospitals have been transformed into shareholder run companies (*akciové společnosti*). In these circumstances, hospital directors have become increasingly open to working with NGOs to establish volunteering programs (in spite of opposition from their own staff in many cases), because these programs provide a means of improving patient care without incurring greater costs.

To provide an instance of this process, I return to the head nurse who played an important role in establishing the volunteering program at the Prague hospital where I conducted research. She described to me how she had long supported volunteering before the program formally began, but faced opposition from colleagues and lack of support from her boss, the hospital director at the time. Nevertheless she felt that, on certain wards, there was a distinct need for forms of care and support which doctors and nurses were unable to provide, particularly in a context in which there was (and still is) a nationwide shortage of nursing staff. This need was most acute on the children's neurology ward, where patients were hospitalized for long periods of time and lacked activity. In response to this need, she began to employ a play therapist on that ward, which made a significant improvement to patients' well being. After some time, she began to push for a budget to employ such therapists elsewhere, particularly on the geriatric ward, which also accommodated long-term patients. However, as the costs of employing these therapists began to increase and become less palatable to senior colleagues, she raised again the possibility of a hospital volunteering program, which this time received renewed support. As she described, "In these circumstances the money for an office and a [volunteer] coordinator raised no objection, because next to the cost of the annual salary of ten therapists, this was peanuts."

It was also agreed that the hospital would support the formation of an NGO based at the volunteer center, which would be eligible to apply for external funding to further develop volunteering activities and projects. Hospital volunteering thus becomes both possible and

desirable in the context of the contradictory pressures created by the quasi market of health services, and the calculating models of efficient cost-containment employed by hospital management to juggle pressures and maintain their position within this system. Volunteer centers, for their own part, help sustain these forms of evaluating efficiency by keeping close records of the number of 'volunteer hours' contributed annually (via signing in and out books kept on hospital wards where volunteering takes place). This enables the centers to quantify the overall impact of their programs on patient care, and thereby justify the need for, and impact of, volunteer programs to managers, patients, volunteers, and the broader public.

Conclusion

In considering this last point, we might recall Parry's insight on the interdependency of the spheres of self-interested exchange and disinterested giving. We have seen this interdependency recur at various structural levels in the case of Czech hospital volunteering. Individual volunteers become attracted to volunteering as a way of temporarily escaping from (and thereby finding a 'balance' with) the self-centeredness, consumerism, and materialism of modern existence. Hospital managers praise the moral virtue of volunteers' disinterested giving on the one hand and view it highly instrumentally on the other as a low-cost way of adding 'value' to patient care in a quasi competitive market for hospital services. These processes take specifically neoliberal form in their relation to (and reliance upon) two other conditions. The free gift of volunteers' service requires the perpetuation, in volunteer training and supervision, of an ideology of autonomous personhood. It is the very autonomy of the (unpaid, non-medically trained) volunteers which fractured and complicated structures of authority and accountability on hospital wards.

[1] I use pseudonyms throughout the article in referring to individual research participants.

[2] Prior to 1991, health services were free for all national citizens and funded from taxation revenues. In 1991, the General Health Insurance Act led to the creation of a series of non-profit health insurance companies. Hospitals, clinics, and other health providers form contracts with health insurance companies and claim reimbursement from them on a fee-per-service basis. During the mid-1990s the number of health insurance companies rapidly increased to 27, until further government reforms reduced the number to nine by 2000. Health insurance is compulsory, but funded from a combination of contributions from individuals, employers, and the state.

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