Housing and Health in Fast- and Slow-Burning Crises

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1. Problem and research questions

Universal health care and affordable housing have long been corner stones of European welfare states, and both are in deep crisis. In a recent article on the Greek debt crisis, the Guardian concludes that "of all the damage, health care has been hit the worst".[1] Five years into austerity, the Greek healthcare sector is in meltdown. While the Greek crisis is arguably the most acute in Europe, healthcare sectors have for decades been under enormous financial pressure everywhere on the continent. The global financial crisis (GFC) has struck a further blow to them. Cash stripped governments have slashed health budgets, chopping entire services, raising charges for drugs or medical services, or excluding large number of patients from health service. Reforms have occurred primarily for fiscal reasons rather than health care. Inevitably, universal healthcare is being challenged through recent and more distant reforms.[2]

Cash stripped governments are also increasingly called upon to find solutions for the "housing question", which has become as burning an issue in the early 21st century as it had been in the late 19th century. Decades of housing privatization have depleted the social housing stock across the EU, and done away with non-market forms of housing provision. While governments have promoted private home ownership, they have also relaxed mortgage lending standards and deregulated mortgage markets in order to allow lower income groups access to private homes. The GFC has however turned housing privatization into a debt trap for many homeowners. On the one hand, in the wake of the crisis - especially but by far not exclusively – millions of "subprime" borrowers find themselves over-indebted and in danger of losing their homes. On the other hand, historically low interest rates provoke many people to invest in housing in their search for some return. As a consequence, affordable housing has, once again, become exceedingly scarce.

The crisis in health care tests the limits of the "old", publicly provided welfare system, while the crisis in housing tests the limits of the "new" welfare, provided by markets rather than states. In Paul Pierson's apt formulation, in both cases "irresistible forces" meet "immovable objects" (Pierson 1998), albeit forces and objects differ. In the healthcare sector decades of policy experimentation have shown how difficult it is to decrease costs via marketization, corporatization, and other forms of market-oriented reforms (e.g. Kahancova and Szabo 2015, Galetto et al. 2014). Given that reforms have more often than not also led to increasing shortages, longer wait lists, and higher requirements for co-finance, they are also hugely unpopular. The irresistible pressure exerted by further need for austerity thus meets the immovable

[1] http://www.theguardian.com/world/2015/jul/09/greek-debt-crisis-damage-healthcare-hospital-austerity. See, in particular, the work of Alexander Kentikelenis on this topic, Kentikelenis et al. 2011; Economou et al. 2014.

[2] http://www.economist.com/news/international/21606314-after-years-painful-cuts-spending-health-care-rising-again-laying-down

popular preference for universal and affordable healthcare. In contrast, privatization and individualization of home ownership has effectively shifted popular preferences for private rather than publicly financed homes. This is because debt-laden home-owners prefer low inflation and are hostile to increases in tax-funded collective services. As Herman Schwartz has stated, "To rework an old phrase, cheap mortgages are financing the trenches defending against new demands for social protection" (Schwartz 2009: 29). In the case of housing, therefore, the immovable object are popular preferences for private homeownership, whereas the lack of affordable housing in the wake of the crisis has brought about irresistible pressures on reinventing the public provision of housing.

Against this background, this work package within the ENLIGHTEN project answers three major questions:

- How have the relevant (national and European level) actors sought to address the (fast and slow burning) crises of affordable and universal healthcare and affordable housing?
- How have they generated ideas for policy reforms?
- How have they tried to square the circle of undertaking unpopular reforms while also building legitimacy?

These overarching questions break down into a number of sub questions:

- How has the financial crisis affected the respective policy fields?
- Who are the relevant actors in the respective policy fields?
- How have the relevant actors defined the problems affecting healthcare and housing before and after the GFC?
- What is the role of EU, national and subnational levels in the respective policy fields, and how do they interact? Has the role and interaction of the multiple levels changed since the GFC?

2. Conceptual tools

WP 3 builds on conceptual tools central to the ENLIGHTEN proposal that trace European modes of governance and how different expert networks respond to what is depicted as 'fast-burning' and 'slow-burning' crises (Seabrooke and Tsingou, 2014, 2015, 2016; Schmidt, 2015). The section below introduces the concepts, discusses how they can be applied for our specific cases, and spells out some expectations.

Fast and slow burning crises, hot and cold knowledge, and politics

A distinction between fast and slow burning crisis forms the backbone of the ENLIGHTEN project. Schmidt (2015) as well as Seabrooke and Tsingou (2014, 2015, 2016) divide the developments that have taken place after 2008 into two phases, and in their framework the fast burning phase of the crisis precedes the slow-burning one. Seabrooke and Tsingou (2014) describe the fast-burning phase of the global financial

crisis as a period of noise, when actors still had not grasped the nature of the troubles and had to build their own crisis narratives. In the slow-burning phase, the nature of the crisis is already more clearly established – even if each professional or political group has its own, competing definition. Following the work of Callon (1998), different crisis phases are also linked to different forms of knowledge. In the fast-burning phase, knowledge is hot, meaning that it is difficult to separate facts from values and the production of knowledge from its application in the decision-making process. In cold situations by contrast, "actors are identified, interests are stabilized, preferences can be expressed, responsibilities are acknowledged and accepted […] calculated decisions can be taken" (Callon 1998: 260). In the fast/slow framework, the two phases are not only associated with different forms of knowledge, but also with different political struggles. In the fast burning phase, there are interest-based battles around resources. Knowledge is more often used for direct political purposes, or at least expert opinion is more clearly tied to specific interest groups (such as in the case of financial experts in Seabrooke and Tsingou 2014). In the slow-burning phase, expert knowledge enjoys more independence and there is an opportunity to engage in more thorough, scientific debates on issue definition (Seabrooke and Tsingou 2015; Seabrooke and Tsingou 2016).

How can these concepts be applied to the selected areas of public health and housing? As mentioned in the first section, the crisis in healthcare is one of underfunding, which manifests itself in a shortage of (affordable) provision of healthcare services.[3] Potentially it therefore morphs into a crisis of universal healthcare. In housing, the crisis is one of over-indebtedness and a shortage of publicly provided social housing. What sets our policy sectors apart from some of the other ones analyzed in the ENLIGHTEN project is that both of them experienced slow burning crises already before the GFC hit. Compared to the general framework outlined above, which pairs up fast-burning crisis with hot knowledge and slow-burning crisis with cold knowledge, in the areas of health and housing these pairs might be more difficult to construct. To be more specific, in many countries the health care sector has experienced major shortages ever since the 1990s, and important reform steps have been taken before the GFC. The GFC has reinforced the problem of underfunding, but might not have led to a fast burning crisis in most cases[4]. According to the general ENLIGHTEN framework we should therefore expect some continuity, in the intensification of cold knowledge and politics during and after the GFC. This would mean that issues become overall more clearly defined and rational-scientific debates can emerge around them.

However, based on our initial intuition, we propose an alternative scenario, namely one in which knowledge never cools down entirely. Issues might become less urgent as the crisis enters a slow burning phase, but their definition might remain as contested and fuzzy as in the fast phase. This proposition is consistent with Callon's who warned that *hot situations are becoming the norm rather than the exception* due

[3] …and can be measured for instance in waiting lists, and self-reported unmet medical need. In some cases it is also due to a shortage of qualified workforce, mostly due to emigration.
[4] with the obvious exception of Greece

to the increasing complexity of human societies and the increasing reliance of specialists on "non-specialist" knowledge. In his words: "it is becoming exceedingly difficult to cool them [hot situations] down, i.e., arrive at a consensus on how the situation should be described and how it is likely to develop."(Callon 1998: 263). Seabrooke and Tsingou's (2015, 2016) analyses on the emerging professional discourse surrounding low fertility also implies that a professional consensus on definitions and distinctions might be impossible to reach even in a slow-burning situation. We submit that this case can be made in health care, too. This is a slow-burning issue but debates around it are still fuzzy, burdened with a lot of definitional issues. For example, advocates of privatization might define shortages as a result of the insufficient involvement of private capital and the inefficiencies of bureaucratic coordination (following Kornai 1980). On the other hand, the shortage of public services can also be conceptualized as the state's reluctance to invest in areas which are essential for long-term economic success but where the involvement of private capital would undermine the principle of needs-based access. Likewise – even those taking the second view might be further divided on whether they think shortage can be alleviated by a rearrangement of public expenditure from hospital-based care to prevention and outpatient care, or whether they think that the entire system needs more resources – resembling the fractal divisions among experts on different issues described by Seabrooke and Tsingou (2014, 2015).

In contrast, while affordable housing has experienced a slow burning crisis before the GFC, the solutions provided by "expert knowledge", namely further privatization of housing, liquid mortgage markets, relaxation of borrowing standards, and subsidization of "subprime" lending were oftentimes directly responsible for the GFC, and have thus entered into a fast burning stage once the GFC broke out. In line with the framework of the project we therefore expect discontinuity in knowledge, expertise and politics during the hot phase of the crisis. This is because in contrast to the health sector, in housing the GFC crisis has not brought about more of the same problems, that is a quantitative increase of the problem load; but has in a dramatic fashion revealed the flaws of previous policies. Hence, it calls for a qualitative shift in discourse, knowledge and networks. However, an interesting question is whether in the slow burning phase after the GFC we indeed see a qualitative shift, or rather a return to earlier recipes of how to solve the crisis. Overall therefore our cases are ideally suited to test and develop further our understanding of long-term crises processes, which alternate between fast and slow burning phases, and with interesting variations among the two sectors.

Based on the discussion above we can formulate the following expectations on slow and fast burning crises and their link to knowledge, politics and policies:

a/ If the fast burning crisis only deepens existing problems we expect a normalization of "hot" knowledge and policy making both during slow and fast burning phases of the crisis. The fast-burning phase will only reinforce the type of policy recipes which have prevailed in the earlier slow-burning past.

B/ If the fast burning crisis reveals fundamental flows of existing knowledge and policies, we expect hot knowledge and politics during the fast burning phase. An open

question remains whether and under which conditions the ensuing slow burning phase will build on the hot knowledge generated during the crisis, or will return to previous knowledge and policies.

Input, output and throughput legitimacy in health care and housing

The ENLIGHTEN project relies on the three-pronged concept of legitimacy as developed by Vivien Schmidt (2013, 2015), building on earlier work by Fritz Scharpf (e.g. 1999). Scharpf defines an "input dimension" of democratic legitimacy as reflecting the popular will. "In the input dimension, governors may be held accountable for policy *choices* that are in conflict with the politically salient preferences of their constituents" (Scharpf 2011: 3). In contrast, the output legitimacy derives from the fact that policy outcomes reflect politically salient concerns of the governed. Vivien Schmidt has redefined legitimacy by making *throughput* the central element. The throughput dimension highlights the quality of the governance process that in itself has an impact on the public's perception of governments - and international institutions. Throughput legitimacy includes efficacy, accountability, transparency of information, as well as inclusiveness and openness to consultations with experts, interest groups and civil society (Schmidt 2015:6).

How relevant are these three dimensions of legitimacy for our policy sectors? We submit that – partly in contrast with other areas studied in the ENLIGHTEN project, output and input legitimacy might be as important (or possibly even more important) than throughput legitimacy. This is because we are dealing with policy areas where national governments rather than the EU are in the driving seat. In both areas, citizens are represented through political parties, who can potentially offer policy choices, this way responding to citizen's concerns. In addition, in some countries, major health care reforms have been subject to referendums.[5] This is different to the process governing – let us say financial reforms – where the EU and other international organizations are in charge of policy making, and consequently there is little room for input legitimacy. One interesting question for our sectors is whether the input dimension of legitimacy is becoming less important, or whether – especially during fast burning crises – its significance even increases.

The output dimension of legitimacy is important too. While people certainly do not understand all the intricacies of let us say health-care output – for instance patients might not be able to judge whether they were "overtreated" or not, or whether a cheaper and shorter alternative therapy would have been available - they can judge easily more general forms of output, such as the length of wait lists, the quality of service, and the costs of healthcare and housing.

[5] A perfect example of the significance of input legitimacy for healthcare reforms is the Hungarian case, when the Socialist government's attempt to privatize hospitals and introduce co-payment fees was defeated in a referendum organized by the then opposition party. In terms of housing, during the crisis new political parties such as PODEMOS are putting alternative social housing models at center stage of their electoral platforms.

Finally, throughput legitimacy plays an important role, too. Thus, in the case of health care, one of its specificities feeds well into the debates on throughput legitimacy, namely its labor intensity. Labor intensity makes the involvement of trade unions and professional associations arguably a key requirement of throughput legitimacy in health policy making. If health care reforms do not have the support or at least the consent of professionals, it might be very difficult to implement them, not to mention to secure their desired outcomes. As much of health care quality hinges on the relationship between patients and professionals (including nurses and assistant staff, not only doctors), professionals play a major role in securing output legitimacy for reforms. Therefore, their involvement in throughput processes might be essential too. In a similar fashion, professionals in health care have a strategic position as they can participate not only in the coordinative discourse on reforms (as experts) but also in the communicative discourse, as they have direct access to the targets of the reforms (patients). Finally, patient organizations' contribution to the policy making process might also generate legitimacy. In the case of housing, throughput legitimacy is likely to be generated through the input of NGOs and civil society actors that represent over-indebted homeowners, the homeless etc. In addition, housing experts are crucial for providing expertise and securing output legitimacy for reforms.

At the same time, throughput legitimacy is endangered by what Culpepper (2011) calls the "quiet politics of business power", or private interest governance. To put it simply, Culpepper argues that when an issue is not politically salient, that is when the issue at hand is of little immediate interest to voters, business normally gets what it wants. This is because of business' power resources, namely their lobbying capacity, expertise, and their capacity to frame and influence public opinion. In particular, policy makers prefer to rely on business' expertise if they can, as it is very costly to gather independent expertise. While we have argued above that both affordable health care and housing are politically salient issues, the same does not necessarily hold for particular aspects of healthcare and housing. Thus, voters will not necessarily care much about the exact drug and therapy they are prescribed, and will also not necessarily be very much concerned with the price-value ratio of their treatment. In this case then, pharmaceutical industry is likely to provide important input for policy makers, potentially undermining throughput legitimacy. A similar case can be made for financial instruments that make housing (seemingly) affordable. Voters normally do not care about the concrete credit instruments, nor the fine print on their mortgage contract, as long as a credit is available. In subprime and prime mortgage finance, business is therefore likely to influence policy making, potentially undermining throughput legitimacy. The quiet politics argument serves as a warning sign that cold knowledge should not be equated with unbiased scientific knowledge that is free of interest group pressure. Quite the contrary, the cooling down of knowledge makes debates less salient in the eyes of the public, enabling powerful interests to stabilize their own position. As a debate becomes less politicized and can garner less and less publicity, there are less opportunities to challenge existing power relations, which are also supported by a normalized, scientific discourse. A large part of (re)gaining control over a policy area is exactly by setting the boundaries of what is considered expert knowledge and what is not.

An important question for our investigation is how slow and fast burning crises affect the three forms of legitimacy. Our expectations are as follows:

During slow burning crises, output legitimacy is most crucial. This also means that policy makers have to make sure that whatever reforms they undertake, the results must be perceived as compatible with the common good. Health care must stay affordable, and housing must be accessible to most. During this phase, while throughput legitimacy might matter, it is simultaneously being undermined by the reliance on quiet politics and business "expertise". This however is bound to change during the fast burning crisis phase. Here, politics starts to matter both in terms of input legitimacy and in the way how the sphere of quiet politics is being dragged into the open and becoming politically salient. In light with our expectations above on the different sequences of slow and fast burning crises in the two sectors, we expect that overall in health care, output legitimacy will remain most relevant, even during the hotter phase of the crisis, while in housing policy makers will have to address issues of input, throughput and output legitimacy simultaneously during the hot phase of the crisis. [6]

Emerging new forms of European governance in health and housing?

As we argued above, our sectors are still primarily governed by national government rather than European governance. At the same time, however, we do see an increasing awareness of European level actors of these two policy issues. In addition, the new European economic governance mechanism is likely to have an influence on our policy fields, in particular through the European semester. We therefore expect an increasing "Europeanization" of our policy fields, and will need a close monitoring of how this affects the issue of legitimacy.

3. Cases, comparisons and research strategy

The research to be conducted in this work package will rely on case-based comparisons across policy areas and across countries. The two selected policy areas within public services are health care and housing, which are both riddled with long-term issues of shortage of provision and marketization of services, further magnified by the GFC. Besides, the two policy areas fundamentally remain the competence of nation states – which calls for the cross-national dimension of the comparison. Pressures from the EU on these areas traditionally came indirectly, through demands for deficit reduction in the general government budget, but with the introduction of new EU governance mechanisms after 2010, these pressures have become more direct and specific.

[6] An interesting twist of the legitimacy issue is brought in by one of our cases, Hungary, which has turned from a full-fledged democracy into a hybrid regime recently. Hybrid regimes tend to rely less on input and throughput legitimacy, and more on output legitimacy.

Despite the similar context, we expect struggles around knowledge forms, reform processes and legitimacy to play out differently in the two areas. In line with the earlier discussion on different knowledge forms, it can be claimed that the GFC had a more pronounced fast-burning phase in housing and therefore produced more hot knowledge than in health care. In housing, the relationship between governments, professional interest groups and civil society are expected to be more antagonistic, and the knowledge used in their struggles more politicized and less formalized, which in turn impinges on throughput legitimacy. It might be already difficult for actors to agree on problem definition and on a common procedure for discussing possible solutions. Throughput legitimacy is difficult to achieve not only because the relationship between existing actors are unclear but also because of the emergence of new actors - for example civil society groups representing victims of evictions or protesting against unfair lending practices of financial institutions. Finally, output legitimacy is also hindered by the conflict between the strong consensus around home ownership and the reality that more and more people are excluded from or even cannot enter into this system.

By contrast, in health care the fast burning phase of the crisis only produced more of the same in terms of the problem load. Correspondingly, knowledge was not heated up to the same extent as in housing. If the proposition about the existence of a colder ("less hot or normalized hot") type of knowledge in health care is true, this should be documented through the less politicized nature of debates, the continuity of policy forums and the continuity of the participating actors. A colder type of knowledge does not mean a more harmonious relationship between actors, but rather the existence of a shared understanding of problems, let them be shortage of labor or expanding waiting lists. The proposed solutions can still be fundamentally different.

The purpose of the research project is to comparatively assess developments in these two policy areas on the level of nation states and also to explore how emerging European governance mechanisms affect them. The country cases as listed in the table below are France, Netherlands, the UK, Denmark, Spain, Ireland and Hungary. The selection covers cases from the European economic core and periphery, from within and from outside the EMU, under financial assistance programs or without such schemes. The case selection represents the diversity of crisis experiences across Europe - from lightly to very badly affected - and also the different attitude of national policymakers to the EU, from markedly Eurosceptic governments to the most consistent supporters of further integration.

	In the Eurozone	Outside the Eurozone
Core	France, Netherlands	UK, Denmark
Periphery	Spain, Ireland	Hungary

Diversity of the selected cases allows for generalizing the argument, but also makes the research process challenging as there are only a few variables that can be held constant and controlled for across all the cases. Traditional differences among national health and housing systems prevail, and getting an overview of how each of these regimes were affected by the crisis and by the emergence of new European forms of government would be too ambitious to start with. Therefore, the research team plans to carry out pairwise comparisons first, which can be built around most similar or most different systems designs. For example, Hungary and Ireland can be portrayed as most similar cases when it comes to housing crises: they both saw the collapse of mortgaged housing markets as a result of the GFC in the years 2008-2009. In spite of the similar starting point, government policies and the discourses surrounding them went into opposing directions in the two countries: there was a radical break with earlier policies in Hungary while Ireland by and large stayed on the same track as before the crisis. This divergence in policy outcomes cannot be explained by the different magnitude of crisis in the two cases: if anything, the plunge was deeper in Ireland, so we should have expected a more radical break with existing policies there (e.g. Bohle and Greskovits 2015).

In other dimensions however, Hungary and Ireland could be portrayed as most different cases that still produced similar outcomes. Health care policy for example faced very different fiscal environments in the two countries, especially after 2010, when Ireland got under Troika supervision. While Hungary also remained committed to deficit reduction, it was playing alone after 2010, quitting previous IMF-EU assistance scheme. Nevertheless, in health care both countries ended up shifting the burden of medical costs to patients, either through directly increasing charges (Ireland) or indirectly through attrition: letting informal practices and private providers flourish while underfunding public providers (Hungary). WHO data shows that from 2008 to 2012, the public share of total health expenditure remained stable in EU-28 (76.9% → 77.3%), but it fell by 7.8 percentage points in Ireland (75.4% → 67.7%) and by 4.5 percentage points in Hungary. Moreover, if we count that Hungarian health care had to endure a longer phase of austerity that already started in 2006, the decline becomes the same magnitude as in Ireland (7.5 percentage points, from 70% in 2005 to 62.5% in 2012).

The puzzles introduced above can serve as tentative starting points for comparative analysis, as they highlight that despite similar structural challenges two countries can end up pursuing very different policy courses. Likewise, governments with different attitudes towards EU governance procedures can opt for similar policy solutions in the specific fields of health and housing. These are the situations where discourses and legitimacy processes can play an important explanatory role.

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