ENLIGHTEN Working Paper 6/2017

Healthcare reforms in times of crisis. From responsibility vs responsiveness to legitimacy and conflict avoidance

Amandine Crespy, ULB

Imre Szabo, Central European University

Introduction[1]

Explaining the drivers of healthcare reforms against the background of the recent financial and debt crisis in Europe has proved particularly challenging. While the effects of the crisis on healthcare funding and provision seems inevitable, notably through a diffuse pressure to enforce fiscal discipline, it is difficult to detect a change in ideas and policies following the 'fast burning' and 'slow burning' phases of the crisis. All European countries have faced similar challenges in terms of ageing population, slow productivity gains, and reduced public resources over the past three decades. Insofar, healthcare systems had been going through a slow burning crisis long before the outbreak of the European debt crisis. Furthermore, the common pressure of austerity does not bring a convergence of welfare systems as its effects are strongly mediated by domestic politics (Hemerijck et al. 2013).

While there is a vast literature dealing with healthcare reforms, it is mainly concerned with describing and evaluating policy developments and outcomes while the fundamentally political dimension of policy making remains undertheorized. On the one hand, there is a myriad of international institutions - such as the OECD or the WHO -, including the EU institutions, and specialised research units which closely monitor policy developments and generate extensive comparative data (e.g. Maresso, 2015: 49). They tend to highlight the common challenges in

[1] Funding for this piece has been supported by the European Commission Research Director General, Horizon 2020 Framework Program, 'European Legitimacy in Governing through Hard Times (#649456-ENLIGHTEN)' project, see http://enlightenproject.eu/ for more details.

terms of rising needs, especially in times of economic recession where access may become more difficult for some groups. They shed light on various reform trajectories and outcomes which often reflect the long term robustness and fragilities of various healthcare systems. On the other hand, an important string of the academic literature has focused on the Europeanisation of healthcare. A number of broad, common trends include the shift from the *dirigiste* state controlling all aspects of healthcare funding, regulation and provision to the rise the regulatory state (Helderman et al. 2013) - which often combines decentralization with an increase of state control over societal autonomy -, rampant marketization through the importance of the pharmaceutical industry and the slow opening of domestic boundaries through increased patients' mobility in the framework of the Single Market's regulation. Yet, the number explanatory factors as well make it very hard to distinguish consistent patterns of reforms. Typologies of established institutional healthcare models – for example the distinction between Beveridgean national healthcare systems (NHS) and Bismarckian social health insurance –SHI) - have limited explanatory power as many accounts seem to point to rather idiosyncratic reform trajectories in response to the crisis (Stamati and Baeten 2014).

A main question has been to what extent the new EU rules for a tighter coordination of national budget and fiscal policy has had an impact on healthcare policies. The European Semester, the EU's governance cycle which combines stringent rules and procedures on deficits with soft coordination can be regarded as a main issue through which healthcare policy agendas are being 'reframed' from the top (Azzopardi-Muscat 2015:53, Helderman, 2015:54). Typically, the country specific recommendations issued by the European Commission and the Council have admonished several Member States to make their healthcare system more efficient, that is to contain unsustainable costs while guaranteeing satisfactory levels of quality and access. While the European Semester has certainly strengthened the diffuse influence of the EU agenda on healthcare policy at the domestic level, the 'EU leverage' is exerted at differentiated degrees depending on whether given countries are under programmes of financial assistance – thus submitted to conditionalities which can affect healthcare directly –, whether they are members of the Eurozone – thus submitted to stringent deficit rules – or they remain fairly distant from the EU's constraint outside of the Eurozone (Stamati and Baeten, 2014).

Against this backdrop, the approach adopted here departs from the research which aims at assessing policy outcomes by detecting causal factors explaining convergence or divergence in healthcare reform trajectories. While the bulk of the comparative research recognises that domestic political factors – such as individual agendas, politics and national cultures – play a key role in shaping healthcare reforms, domestic politics and contentious debates surrounding said

reforms remains largely an unchartered territory outside of specifically nationally focused contributions. The purpose of this paper is therefore to tackle the following question: *how have national decision makers responded to the crisis with regard to healthcare policy?* Our point of departure is the idea, put forward by Peter Mair, that European governments face a dilemma between responsibility towards international institutions, creditors and policymaking norms on the on hand and political responsiveness towards voters' needs on the other (Mair 2009). We believe that economic crises affecting interdependent economies exacerbate this dilemma. Healthcare is a case in point for illustrating this dilemma. The recession and stark rise of unemployment increased the needs among vulnerable groups while, at the same time, fiscal resources have been drastically reduced as a result of rising deficits, problematic credit, and self-inflected austerity. Moreover, healthcare is a work and resources intensive sector where costs arise mechanically from the growth and ageing of population. It is therefore a large boat very difficult to manoeuvre and governments cannot expect rapid changes in the short run.

This being said, it cannot be simply assumed that governments will automatically and strongly prioritise responsibility over responsiveness. Even when doing so, there are several ways in which governments can deal with the involved trade-offs and the expected costs inflicted to different social groups. Typically, decisions relate to funding (who among tax payers, users or professionals should bear the costs of fiscal discipline), regulation (the relative autonomy of professional and markets actors vis-à-vis the state), and provision (shaped by state-market relations and centralisation-decentralisation trends).

Adopting a constructivist-ideational perspective, we assume that the pressure for fiscal discipline emanating in a diffuse manner from creditors, the markets and the EU institutions do not have a mechanistic effect on policy choices. Rather, they are strongly mediated by processes of contention, framing and political discussion triggered my reform plans. We argue that, given the societal relevance and political salience of healthcare, the nature of reforms is strongly shaped by the ability of governments to legitimise their reform plans. The distinction between input, output and throughput legitimacy serves as the analytical framework which helps us to open the black box of domestic politics of healthcare reforms and unpack the way in which European governments have dealt with the responsibility vs responsiveness dilemma. For feasibility reasons, we focus on four country cases, namely France, Ireland, Hungary and the UK (NHS England), which have been selecting for their contrasted features with regard to a) institutional characteristics of their healthcare system, and b) the potential pressure for fiscal discipline enforcement exerted by the EU. We look at recent major reform attempts targeting different areas of health care in the four countries. In all four countries, the reform went beyond cost

cutting and aimed at a more fundamental restructuring of the healthcare system: in France, the extension of access to health insurance, in Hungary the re-centralization of health provision, in Ireland the attempt to introduce universal health insurance and in England the decentralization of the National Health Service.

We explore three hypotheses: 1/ We expect great variation among cases with regard to input legitimacy because reforms are heavily affected by prevailing values and ideologies of governing parties. 2/ Among the different dimensions of output legitimacy, we expect the prevalence of the financial sustainability dimension in those countries that are more affected by austerity (Hungary and Ireland). In less heavily affected countries, we expect to find more arguments around the quality of services (England and France). 3/ Across all cases, we expect governments to rely on an instrumentalist concept of throughput legitimacy, meaning that they use consultation with different stakeholders as a way to prevent an adverse politicization and support their framing of the reforms (*ex ante*) or to diffuse conflict once contention is expressed by particular groups (*ex post*). Our demonstration is based on a two-fold methodology. First, we explore the three dimensions of legitimacy through a process-tracing oriented case studies using the specialized literature, official documents, reports, press material, etc. Then, we conducted a qualitative content analysis (assisted by N-Vivo) of all speeches held by Health Ministers that were related to the main reforms decided since 2010 in the four countries examined in order to demonstrate how the legitimacy of the reforms were constructed discursively.

The paper has four sections. The first section explains legitimizing mechanisms can help governments navigate around the responsibility vs responsiveness dilemma. Section 2 presents the methods underpinning our demonstration. Section 3 gives a sketchy overview of the way in which the three strings of legitimacy have been used to legitimize healthcare reforms in England, France, Ireland, and Hungary. The last section presents the results of our content analysis and the way in which the various dimensions of legitimacy were articulated in public speeches.

Explaining reform dynamics: from dilemmas to legitimizing strategies

The main purpose of this paper is to advance our understanding of how policy choices are made against the background of slow-burning and fast-burning crises (Seabrooke and Tsingou 2017). In doing so, we also intend to give a more empirically grounded understanding of the concepts used in the debate around governance and legitimacy. In the introduction, we have identified two strands of the literature that informs this debate. First, Peter Mair's concept of the dilemma

between representativeness and responsibility and second, the theory of different dimensions of legitimacy as formulated by Vivien Schmidt (Mair 2009, Mair 2013, Schmidt 2013). To repeat, what Peter Mair pointed out is the growing incompatibility between two facets of governance: acting responsibly in a dense web of rules and expectations set by multiple principals (including international organizations and market forces), and being responsive to the - increasingly illegible - preferences of the electorate (Mair 2009). While using it as a relevant point of departure, we would like to sharpen the notions of responsiveness and responsibility by bringing them closer to the actual practice of policymaking in the specific area of healthcare. In this paper we therefore seek to demonstrate how governments navigate the narrow space still afforded by the trade-offs between responsibility and responsiveness.

We claim that in this navigation exercise, governments' main asset is the active use of legitimizing discourses. Siding with more recent, power-based formulations of discursive institutionalism, we highlight governments' capacity to independently formulate legitimizing discourses around specific reforms (Carstensen and Schmidt 2016). Furthermore, the active agency of governments in the formulation of legitimizing discourses also leads to a variation in the elements constitutive thereof, both across policy areas and across countries. To be more specific, we take the different dimensions of legitimacy – input, throughput and output - as building blocks and we investigate the presence of each of them in government framings and the relationship between them.

We rely on the three-pronged concept of legitimacy as developed by Vivien Schmidt (2013, 2015), building on earlier work by Fritz Scharpf. Scharpf defines the "input dimension" of democratic legitimacy as the reflection of popular will and of the preferences of the governed ("government by the people"). In contrast, output legitimacy refers to the effectiveness of the same policies in increasing the welfare of the governed or solving major societal issues ("government for the people") (Scharpf 1999:2). Vivien Schmidt has elaborated this framework by opening the black box between the input and the output side and introducing *throughput* legitimacy as a connecting element. The throughput dimension highlights the quality of the governance process that in itself has an impact on the public's perception of governments. 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). In the following, we outline our expectations, regarding these three dimensions of legitimacy, taking into account the characteristics of healthcare as a specific policy area, the nature of the reforms under investigation against the background of fiscal discipline across Europe. We also summarize these expectations in three hypotheses.

When it comes to healthcare reforms, framing around input legitimacy are probably the most firmly tied into the national political landscape, while output legitimacy is built around similar framing across all the cases. Input legitimacy – which we find closely related to the concept of representativeness as defined by Peter Mair– is to a large extent about the government's ability to read and aggregate the preferences of voters (Mair 2009: 13). We argue that these preferences are not readily given in a society but they are to a large extent generated through different ideological platforms and values of governing parties. As we will see healthcare in general is a valence issue around the importance of which there is societal consensus, specific reforms can have a strong ideological and value-based underpinning, such as the role of markets and private actors in insurance and provision, the autonomy of the healthcare profession and managers. In the content analysis part of this paper, we decided to focus on mentions of values that are connected to the specific reforms but that are broad enough to be comparable across the cases, such as freedom (including consumer and patient choice through competition) and also social justice (including social and intra-generational equity).

Output legitimacy of healthcare reforms are expected to be uniform across cases mostly for the reason that healthcare is a valence issue. Voters tend to have very similar preferences around broad issues of outputs– in general, they would like to see better healthcare services (Stokes 1963:373, Bélanger and Meguid 2008:12). A counterexample would be social benefits or tax policies, where voter preferences are much more controversial and more clearly guided by socio-economic cleavages – some social groups want more social benefits while others would like to see lower taxes instead.

However, the relatively uncontroversial preference for healthcare among the electorate does not mean that governments' hands are untied to introduce any reform they claim would benefit the public. Not only are there fiscal constraints, but exactly due to the encompassing nature of healthcare - it is difficult for governments to isolate or compensate the losers of reforms, which increases uncertainty and the chances of major electoral losses in case of policy failure. Therefore, output legitimacy will be a salient dimension of framing around reform but one that is expected to be uniform across all cases.

Finally, due to the complexity of healthcare, throughput legitimacy will be a significant part of government framing. References to a transparent policymaking process which involves all the stakeholders - will also be a major part of government framing across all the cases.

H1: Output and throughput legitimacy will feature equally importantly in governments' legitimizing discourses of reforms across countries. Within public speeches of health

officials, we expect to find similar proportions of references to output and throughput legitimacy in all four cases. References to input legitimacy will exhibit more cross-country variation.

To give a more specific and measureable definition to output legitimacy, we separate it to quality and efficiency (including fiscal sustainability), and we expect that in countries which are more affected by the sovereign debt crisis, efficiency arguments will trump quality arguments.

H2: Among the different dimensions of output legitimacy, we expect the prevalence of financial sustainability in those countries that are more affected by austerity (Hungary and Ireland). In less heavily affected countries, we expect to find more arguments around the quality of services (England and France).

We extend the concept of throughput legitimacy beyond the question of whether the government plays by the rules and instead focus on the government's willingness and ability to bend the rules in its own favor. While the original formulation of throughput legitimacy takes consultative institutions as given, we emphasize the government's capacity to use throughput procedures such as consultation and dialogue with experts and stakeholders in order to strategically support the initiated framing of the reform or to alleviate conflict with the groups who are critical of the reform. The use of throughput legitimacy can therefore be built by making access easier to groups that are closer to the government (*ex ante*) or exclude those who are critical (*ex post*). The same is true for the mobilization of expert knowledge. Health policy making relies heavily on expert knowledge, also in the sense that it is health care professionals who implement reforms on the ground and can transmit government framing to citizens, therefore they are key actors in assisting (or hindering) the government in building the discursive frame around reforms. However, knowledge can also be used as an instrument for fine tuning and enhancing their throughput legitimacy of reforms which are primarily ideologically motivated. We expect this type of throughput legitimacy to be present in all cases.

H3: Across all cases, we expect governments to rely on an instrumentalist notion of throughput legitimacy, meaning that they use consultation with different stakeholders as a way to prevent adverse politicization and support their framing of the reforms (*ex ante*) or to diffuse conflict once contention is expressed by particular groups (*ex post*).

Methods

Case selection

This comparative study relies on a contrasted cases design. We selected four EU countries which exhibit divergent characteristics along two main lines which are two key analytical dimension in the literature which tries to assess the effects the recent financial and debt crisis on healthcare reforms: the institutional features of the healthcare regime, on the one hand, and the degree of pressure which may be expected, on the other.

England is the archetype of the Beveridgean regime financed by tax revenue and available to all on a universal basis and free at point of use. Since the path-breaking reform of the early 1990s, the NHS has a long record of internal marketization relying on the commissioning mechanism by practitioners and provision by a variety of public or private providers. The incremental extension of marketization and the role of private actors, along with persisting issues of quality, waiting times, and insufficient funding as a result constitute the legacies with regard to the British NHS. Irish healthcare has a multipayer, two-tier structure finance, where the first tier is a national health service maintained from general taxation. At the same time, the public system does not cover many essential services (including GP visits), for which non-exempted users have to pay on the spot (Irish Medical Organisation 2010). Health insurance companies make up the second tier, offering partly complementary, partly overlapping services with the public sector.

France belongs to the Bismarckian social insurance based model where healthcare is funded through contributions from employers and employees. The French regime is highly fragmented regime which relies on the complementarity between a basic coverage by the "social security" system and optional complementary insurance schemes. A free universal coverage is provided by the State to the most vulnerable. Furthermore, provision is shared between independent GPs (called 'liberal practitioners') who operate with a degree of autonomy in various contractual frameworks, and a diverse hospital sector including public, private, and private 'non-for-profit' institutions. Inefficiency due to a lack of coordination, gaps in coverage, and inequality in access (including the unbalanced access between urban and rural areas) are long-stating challenges in France. Although originally contribution-financed with a single state-run insurer, Hungary has recently shown major signs of deviation from the Bismarckian system. The soaring deficit of health insurance was balanced from the state budget and by 2011, more than half of health insurance fund revenue came from the central government, giving ample leverage to directly influence providers through financing arrangements (Gaál et al. 2011: 78).

Regarding the degree of pressure to enforce fiscal discipline coming from the EU which can be expected to come from the EU, our cases exhibit again contrasted features. As a beneficiary of a bail-out from the EU, Ireland has been submitted to strict conditionality defined in the Memorandum of Understanding settling the conditions for the financial rescue programme. Insofar, the fiscal margin for manoeuvre was extremely reduced, which had a direct impact on healthcare.

As a member of the Eurozone and signatory of the Treaty on Convergence, Stability and Governance (TCSG), France is subjected to all the stringent rules stemming from the new EU governance framework (the European Semester) which converted the deficit rules of the Stability and Growth Pact into hard law, potentially leading to financial sanctions. Thus, with deficit levels over the settled 3% GDP, France has been continuously subjected to the 'Excessive Deficit Procedure' since 2009. Yet, it has consistently used its political weight to negotiate new extensions of the deadline to correct its budget trajectory and avoid sanctions. Finally, the UK is likely to be least sensitive to the pressure coming from the EU. While it is included in the surveillance procedures of the European Semester and has been under and EDP since 2008, it did not sign the TCSG and the stringent nature of the EU rules (including the potential sanctions) do not apply to the UK.

Our case selection is in tune with the 'EU leverage' index conceived by Stamati and Baeten (2014, p. 92). Taking into account a range of criteria (including financial programmes, Eurozone membership, open EDP, and the number of country specific recommendations related to healthcare), they evaluate the 'EU leverage' as strong for Ireland, moderate for France and weak for the UK.

A two-fold investigation of legitimizing mechanisms

Our empirical investigation of input, output, and throughput legitimacy occurs through a two-step methodology which combines a process-based and a discourse-based analysis.

First, we conducted country case studies to investigate the three strings of legitimacy. We identified the main reforms adopted and implemented in at stake after the break out of the crisis in 2008-2009 thus leading to slightly different and case dependent time frames. In terms of input legitimacy, we focused on whether and how healthcare was a salient issue during election campaigns and which kind of pledges the elected parties made with regard to the inherited legacies and the effects of the crisis. Regarding output legitimacy, we provide for a brief account of the nature of the reforms with regard to funding, regulation, and provision. Typically, reforms will affect the respective role of and relations between society (tax payers, patients), markets

(private providers, the pharmaceutical industry), and public authorities (at central or regional level). We also look at the expected effects of the reforms and the types of outcomes can already be observed. We are especially interested in throughput legitimacy. Our central claim in this paper is that reforms are strongly shaped by immediate responsiveness of governments to the reception of reform plans, whether these are more of a consultative or of a conflictual nature. To assess throughput legitimacy, we therefore focused on the interactions between governments and various categories of actors including medical professionals, experts, market actors, or patients and civil society.

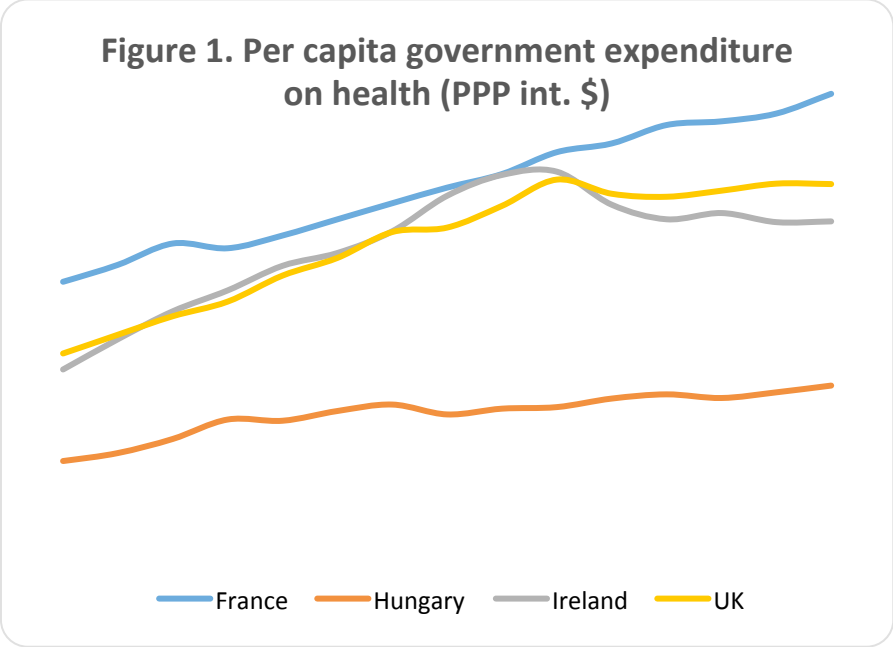
The second step of our analysis consists in looking at legitimizing discourses and how input, output, and throughput legitimacy were articulated by domestic politicians in charge. Drawing from the insights of discursive institutionalism, we assume that national institutional settings (including inherited policy legacies and party politics) will contribute to forge 'communicative discourse'. Our empirical material is an exhaustive database of speeches by the Health Ministers focused on the main reforms in the respective relevant time frames. Thus, we analysed 20 speeches or media reports on speeches for England, 25 for France, 62 for Hungary and 32 for Ireland. They were retrieved from various websites, mainly official government archives and in one case (France) the personal blog of the Health Minister. They are mainly press releases, public speeches, or speeches in the Parliament and, as such, they can vary greatly in length. In terms of methods we use a framing methodology. Widely used in the literature on public policy as well as on collective action, frames are broad ideas which connect more specific sections of discourse and provide the relevant meaning context. While frames can be cognitive or normative, we were interested in broad frames related to the relevant values and the relevant frames connected to input, output and throughout legitimacy (see table in appendix). Unlike lexicometry, which focuses on word occurrence, we coded either words, sentences or whole paragraphs. When sections of texts contained several frames, they were therefore coded several times. Our analysis was assisted by the software N-Vivo.

Austerity, restructuring and conflict avoidance

This section first provides a general overview of the choices made by governments with regard to healthcare funding and its budgetary implications. This gives a first indication of the extent to which they have prioritised (or not) fiscal discipline over policy needs. We provide a sketchy account of the input, output and throughout legitimacy dimensions in all four cases.

Healthcare expenditure and budgetary dilemmas

Figure 1 displays trends in per capita government health care expenditure in our four country cases over the years 2000-2014. This time frame allows us to compare developments before and after the outburst of the global financial crisis. The period before 2008 shows steady gains in the three „old" member states, with France modestly increasing expenditures starting from an already high position in 2000, and with the UK starting from a lower point but growing at a faster pace. Among these three countries, Ireland had the most dramatic expansion, overtaking the UK in 2002 and reaching the spending level of France in 2008. Hungary – as the lowest spender over the entire 15 year period – was slow to catch up to the other three cases already in the 2000s.



Hungarian health care experienced austerity already in 2007 with a 7.4% drop in spending compared to 2006. Health care was in the forefront of a socialist-liberal government's attempts to stabilize the country's deteriorating fiscal position (Gaál et al. 2011:3,61). In this sense, Hungarian healthcare has been affected by permanent austerity ever since 2006. In the UK and Ireland, developments are more typical: they reflect the crash of 2008 and the subsequent turn to austerity. In the UK, this meant a relatively moderate adjustment of -4.8% from 2009 to 2011, and a stagnation since then. While the Conservative-liberal colaition elected in 2010 had made the increase of the NHS funding a main pledge, said increase remained very limited. Ireland on the other hand slashed its healthcare budget by 13% over the same two-year period, and kept

spending firmly below pre-crisis levels since then. France is the only country among our four cases where healthcare budgets continued to expand after 2008, meaning that on an average, per capita basis, the French government spent more than 3500 PPP-adjusted dollars on healthcare. It should nevertheless be stressed the government under Hollande has made unprecedented efforts to contain the continuous rise of healthcare expenditure and was thus successful in reducing the deficit of the social security. Data on total -as opposed to government- spending from the same source (WHO) suggest that private sources follow the same trend, albeit with some lags and with less volatility.

England

Input legitimacy. The issues faced by the English National Health Service (NHS) are typically very salient in the British public debate. Problems causing public distress relate mainly to deficient quality to availability issues (waiting times) and the lack of funding for tackling these problems. In their coalition programme agreed in the aftermath of the 2010 General election, the Conservatives and the Liberals (under the leadership of David Cameron) committed to increase funding for the NHS each year as well as "stop the top-down reorganisations of the NHS that have got in the way of patient care".[2] At the same time, they committed to general principles such as making the NHS more accountable and transparent and improve patients' choice. Against this background, the coalition initiated one the most far-reaching reorganisation of the NHS since its path breaking marketization in the early 1990s. As early as July 2010, that is only two months after the general election in May 2010, the Health Secretary Andrew Lansley published the White Paper "Equity and excellence: Liberating the NHS" which presented the substance of the envisioned reform plans of the healthcare system. According to Timmins (2012: 25-27), the type of reforms entailed in what would become the Health and Social Care Act had been long prepared within the conservative circles as Lansley served as a shadow health secretary since 2005. At the same time, the reform was broadly in tune with the values

Output legitimacy. The thrust of the reform consisted in extending competition among (private) health services providers. This would occur by abolishing middle-range structures (primary care trusts) and most of the NHS management at regional level and transferring commissioning directly to general practitioners under the control of a unique new regulatory authority (called the Monitor) in charge of promoting competition. The reform put forward was

---

[2] « The Coalition : our programme for government », HM Government, p. 24.

part of a broader vision of public services functioning under the auspices of the regulatory state in which the main role of central authorities is to guarantee that outcomes meet established quality standards, ensures transparency towards patients and oversees competition among various providers which are operating according to patients' and professionals' 'choice in a very decentralized fashion (Vizard and Obolenskaya, 2015), p. 24-26). While the coalition government immunized the NHS from the otherwise harsh cuts in public services, the actual improvement of its financial situation remained limited against the background of rising needs. This repeatedly prompted further public debate on the lack of resources for the NHS over the past few years. While far reaching organisational reforms have been implemented in a short period of time bringing about a reform fatigue within the NHS, the long term effects of the extension of centralisation and the marketization of provision are still expected (Vizard and Obolenskaya, 2015).

Throughput legitimacy. The proposed bill triggered strong resistance within the medical profession with large organisations such as the British medical association, the Royal College of Midwives and the Royal College of nurses opposing the Bill along the public service union UNISON and various associations and citizen groups such as Keep our NHS public and 38 degrees. As the conflict between the medical profession and the very unpopular minister Lansley exacerbated, David Cameron took over in April 2011 and decided to make an unprecedented "pause" in the legislative process. The purpose was to alleviate the discontent among professionals by initiating a so-called "listening exercise". For this purpose, the government set up the "NHS Future Forum" gathering 57 personalities from the medical profession within the NHS (and patients). The Forum produced four reports[3] and its recommendations grounded a number of changes in the proposed bill, notably to attenuate the pro-market effects of the reform.

France

Input legitimacy. The European recession and debt crisis brought about a stark increase of the French deficit up to 7.2 and 6.8 % GDP respectively in 2009 and 2010. Prior to 2012, the government's attempts to contain the deficits brought about only minor reforms consisting mainly in increasing user charges in various ways (Maresso;Mladovsky et al., 2015) and in introducing a voluntary payment contract creating incentives for liberal general practitioners

[3] The reports focused on choice and competition, clinical advice and leadership, education and training, and patient involvement and accountability

practices in terms of prescriptions and tariffs. From 2012 onwards, the new majority in power attempted to square the circle between financial responsibility required by France's commitments in the framework of the EU governance, on the one hand, and the necessary political responsiveness in line the left wing, socially minded political pledges for tackling health inequalities on the rise. In a key campaign speech in Le Bourget as well as in the campaign manifesto, F. Hollande made important pledges for tackling the rise of inequalities in access to quality healthcare, a trend which had been present for some time and accelerated as a result of the economic recession.

Output legitimacy. The Socialist government which took office after F. Hollande's election in May 2012 therefore engaged with a strategy aiming at balancing deficit reduction and needs. The reform package focused on the following measures: a) the extension of basic (public) universal insurance as well as (private) complementary insurance schemes to people not covered so far; b) This implied tightening the constraints on liberal practitioners (in particular limiting the rise in tariffs and the generalisation of the quasi-free access at the point of use whereby doctors); and c) the reorganisation of care provision at the local level aiming at a better coordination between public and private hospitals, between hospitals and ambulatory care (liberal practitioners) and a set of measures for improving patients' rights and preventive public health. The French government clearly pursued a cost containment strategy with some success so far. While user charges have not increased and many patients now improve better coverage by insurance schemes, it remains uncertain whether the restructuring of care provision is able to bring about efficiency gains and general practitioners' tariffs remain difficult to control (Bras, 2016). The savings strategy has targeted market actors, on the one hand, that is the pharmaceutical industry through a stricter regulation of medicines' price, and efficiency savings in public hospitals, on the other hand.

Throughput legitimacy. The government's key legislative initiative, the Healthcare Modernisation Law was adopted in December 2015. It took three years for the government to build the throughput legitimacy of surrounding the reform both in an ex ante and ex post fashion. In January 2013, the government launched the "national strategy for healthcare", a vast round of consultation aiming at shaping the reform. Along the reports emanating from the specialized services within the Ministry departments from the Finance and Social Affairs Ministries[4], from the bodies providing expertise and evaluation such as the *Haut Conseil de la Santé publique,* the Health Minister Marisol Touraine appointed a so-called committee of wise men for

[4] E.g. « Le pacte de confiance pour l'hôpital », report, March 2013.

setting the direction of the reform in February 2013[5]. Furthermore, reports on specific issues - such as, for instance, 'sanitary democracy'[6] were commissioned to well-known personalities from civil society, on the one hand, and a consultation forum called the *Conférence nationale de la santé* held close to thirty debates at national and regional level between October 2013 and February 2014.

Nevertheless, this was not sufficient to avoid conflict and overcome resistance coming especially from liberal practitioners who criticised a "take over by the state" of the French healthcare system. They saw their freedom threatened as the control of the state through tight regulation over care organization and provision at the local level would go hand in hand with more constraints on practices in terms of prices and payment. Under the threat of strikes, the Minister had to engage more actively in a consultation with this section of the medical profession notably by appointing four working groups addressing the issues related to payment to doctors, the organisation of care provision and coordination between physicians and regional health agencies, developments in the realm of medical skills, and the relations between public and private hospitals. Concessions in the related articles of the proposed legislation were made in order to alleviate fears from independent practitioners that they would lose much autonomy vis-à-vis state authorities, i.e. regional agencies[7]. Moreover, the negotiations over general practitioners' tariffs have resulted in an increase rather than a stabilization.

Hungary

Input legitimacy: Even though centralization of the health care system was part of the conservative ruling party's agenda of building a strong state, the measure was mentioned neither in its electoral nor in its government manifesto in 2010. Once prime minister Orbán made this decision, it was consistently implemented through the two main branches of public services that had been predominantly under local government control since post-communist transition: education and health care. It is not possible to directly investigate the question to what extent the centralization procedure reflected popular will or the demands of any electoral group. Healthcare is a salient area in Hungarian politics, and the last major systemic reform attempt by a socialist-liberal government in 2006-2007 failed and this failure was a major part of the electoral defeat of the

---

5 The committee was composed of high level practitioners/researchers who became representatives of the profession and/or high level advisers and bureaucrats. It was chaired by a civil servant from the Finance ministry, former Head of the Paris Hospitals.

6 « Pour l'An II de la démocratie sanitaire », report by Claire Compagnon, 14 February 2014.

7 This implied, among others, to replace the "territorial public health service" by "territorial professional health communities".

governing parties in 2010. Therefore, although there is a popular consensus around the need for improving healthcare quality, systemic reforms are very risky.

Likewise, apart from the statist agenda of the government, it is difficult to associate any specific societal values with the centralization that has little ideological loading as compared to insurance reforms or reforms of access. One value that can be considered part of input legitimacy and that surfaced from time to time in the government narrative was territorial equity, meaning that a centralized system smoothens out the previous differences in access and quality between urban and rural areas as well as between rich and poor areas.

Output legitimacy: while the decision to centralize the hospital system had roots in the conservative-statist values of the ruling party and prime minister Orbán, it became clear early in the process that one of the main goals of the process is to achieve savings through more efficient cost controls. The deal around centralization that was struck between the central government and mostly FIDESZ-affiliated mayors rested on debt consolidation. Local governments gave up control of their hospitals and schools in exchange for a relief of debt that they had accumulated while still controlling these units. At the same time, the acknowledged motivation of the central government was to set hospital finances on a sustainable path by replacing a fiscally irresponsible (spendthrift) owner with a more cost-conscious one. In this argument, local governments were the previous, spendthrift owners, who could always rely on subsidies from the central government. The central government, as the bearer of final responsibility for fiscal matters in a country is therefore more suited to control costs, as it cannot rely on subsidies/bailouts from a higher authority.

A more specific argument – advocated by the health secretary Miklós Szócska - concerned economies of scale in public procurement of utilities and hospital equipment8. As a result of centralization – the argument went – hospitals would form a single, powerful actor against near-monopoly suppliers, who were able to abuse this position in the previous, fragmented system. Finally, as the content analysis part will also demonstrate, the health secretary was also adamant to claim that centralization cannot compromise the quality of health service and that no hospitals will shut down as a result of the process.

Throughput legitimacy: the reform was the result of a top-down process, which was initiated by the prime minister's close circle, with no public consultation before the reform was passed in the legislature. The municipal lobby –as the previous owners of hospitals – had a noticeable

---

8 Szócska Miklós: előbb vagy utóbb intézményi törvényt kell alkotni. MTI. August 30, 2012.

impact on the process, while and the medical expert community (including the department of health) played a secondary role.

FIDESZ held a closed party meeting on September 9, 2011 which decided on public service (school and hospital) centralization9. Shortly afterwards, on November 21, 2011, the legislature passed Act 2011/CLIV on the consolidation and transfer of ownership of county-level public service institutions and Budapest hospitals. The process of hospital centralization was completed by 2013, but due to the resistance from the local government lobby within FIDESZ, outpatient centers were eventually not taken back into government control (Gaál 2016)10. While the political decision on centralization was made following negotiations within the governing party between the prime minister's circle and local power brokers, the health administration's role was limited in the process.

The available evidence suggests that the medical profession - including the health secretary - had an ambiguous attitude towards the process, in general supporting state-led solutions but being more skeptical about the benefits of centralization11. Taking back central government control over the hospital system did not feature in the discussion paper version of the Semmelweis plan, a semi-official health care program published in October 2010 by medical experts with close links to the health secretary (Beneda et al. 2010; Mihalyi, 2012). However, in the second, professional concept version of the plan, published in May 2011, the nationalization of Budapest hospitals was already mentioned (Beneda et al., 2011).12

The government not only relied on its legislative power, but used consultative institutions in a proactive fashion. For example, health secretary Szócska toured the country to inform local hospital managers about the new system. Here, we have to emphasize that the words consultation and information are used interchangeably in government-issued reports and statements, but as the main decision on centralization had been taken beforehand, there was little

---

9 Orbánék döntöttek: az államhoz kerülnek az iskolák és a kórházak. September 9, 2011 [Orbán and his party have decided: schools and hospitals return to the state]http://www.medicalonline.hu/eu_gazdasag/cikk/orbanek_dontottek__az_allamhoz_kerulnek_az_iskolak_es_korhazak

10 The details of how local governments were able to fight off the central government`s attempt to take over outpatient clinics needs to be further analyzed as well. At the same time, local governments' motivation for sticking to these institutions may have had to do with the fact that compared to hospitals they are easier to manage, as they provide definitive care for a variety of conditions at a low cost (Gaál 2013).

11 Peter Gaál, a renowned expert of health management claimed that by concentrating administrative capacities on ownership change, the government to some extent neglected the more pressing need of functional integration of hospitals (Gaál 2013:10).

12 Egyetértenek a kórházszövetségek az államosítással. [Hospital Associations agree with nationalization] HVG online. 23 April 2012.http://hvg.hu/itthon/20120423_korhazi_szovetsegek_allamositas

room for effective consultation at these meetings. Furthermore, critiques of the reform argued that hospital managers were put under pressure and intimidated by administrative measures, namely they had to re-apply for their position in connection to new pension regulation introduced in 2011 (Mihalyi, 2012).

Ireland

Input legitimacy: The reform proposal analyzed in this section would have introduced Universal Health Insurance (UHI), based on compulsory participation of all citizens in a system of competing insurers, and a state-run compensatory mechanism assisting the most vulnerable groups (Thomas and Burke 2012: 9). The proposed new arrangement is often referred to in the literature as the Dutch model (Enthoven and Wynand 2007, Kelleher et al. 2014 WIN 2014; 22(3): 28-29).

The introduction of Universal Health Insurance featured as a key promise in the electoral manifesto of both the center-right Fine Gael and the center-left Labour Party in 2011. The two parties formed a coalition government after Fine Gael had won the elections. Based on an overview of electoral manifestos in 2016, all the major parties criticized the current 2-tier system as unfair, and this probably reflects the overall public opinion. Therefore, in the sense of a consensus around the need for change, reforms had input legitimacy. On the other hand, the content and the direction of the change was a matter of political debate, but this debate did not correspond to traditional left-right cleavages of the party system: a coalition of the center right and the center left stood behind a reform that would have combined needs-based access to health care (a left-wing principle) with competition among insurance companies (a market liberal principle).

Output legitimacy: the universal health insurance concept relied heavily on input legitimacy deriving from the need to address injustices of the two-tier system. The output legitimacy of the reform was weaker from the beginning. First, it was not clear to what extent the plan could address major bottlenecks in the public system, such as insufficient primary care coverage. The major blow to the plan however came from the cost efficiency side. The plan failed due to the expert community's resistance to a plan whose costs were not calculated. Although in public speeches efficiency was a main theme, this was insufficient to convince experts from both state-run and independent research institutes and consultancy firms.

Moving on to *throughput legitimacy*, compared to the rest of the country cases, the Irish government was the least effective of using consultative processes as an instrument. The policymaking process in the Irish case was relatively inclusive and transparent – and also very long. More than three years had passed between the inauguration of pro-UHI minister James Reilly in March 2011 and the publication of the White Paper on Universal Health Insurance in April 2014. However, after the publication of the White Paper, it took barely a few months till the most prominent advocate of the UHI model, James Reilly resigned, and the plan was subsequently shelved by his successor, Leo Varadkar. 13 This happened shortly after the publication of two negative assessments on the potential costs of the system, one published by KPMG and the other by the Economic and Social Research Institute (Wren et al. 2015., KPMG 2015).

The composition of actors that had access to policymaking had changed over the successive stages of the reform process. In the first and longest stage - between the inauguration of the new minister in March 2011 until the publication of the white paper in 2014 – only a narrow circle of health bureaucrats and experts had been formally consulted. Even within this narrow circle, health bureaucrats and experts within state institutions outnumbered external actors. From the ten positions available in the main forum of the preparatory phase, the Implementation Group on Universal Health Insurance (set up in February 2012), seven were reserved to people working for government departments or for the Health Service Executive14. Not having been invited to the Implementation Group, representatives of insurance companies were consulted separately, in the Health Insurance Consultative Forum (Department of Health, 2012: 8).

The next milestone in the reform process was the publication of the white paper on the reform on April 2, 2014, which also marked the beginning of the public consultation period. Upon the end of the open call submission period, the Department commissioned Crowe-Horvath - an international consultancy firm - to analyze the results. Crowe-Horvath grouped comments on the white paper around 19 themes, the following three coming on top: (1) the

---

13 Statement by Minister Varadkar following Cabinet discussion on UHI. 18.11.2015

14 Two were directly employed by the Department of Health, one had close links to it as an adviser. One member came from the Department of Public Expenditure and Reform. The Health Service Executive (HSE) was represented by two members. One member was a hospital manager, formerly directing an HSE-project on health costing. Another member was a senior health manager who also had been involved in earlier reforms by the Department of Health and HSE. Two international health experts were acting as alternates to fill one position within the group. The health minister also invited one senior academic (lecturer) from Trinity College to the group (Minister for Health announces the Establishment of an Implementation Group on Universal Health Insurance. 24-02-2012). The group was later expanded by a practicing physician (Department of Health, 2012: 7).

timetable for the proposed reforms, (2) the debate regarding universal health insurance versus other funding structures, and (3) the costs of the system both at the individual (household) level and at the level of the government budget (Crowe and Horvath, 2014: vii.).

The last step in the fate of UHI was the publication of two reports on the costs of the new system. As we mentioned previously, the three main concerns raised during the public consultation was timing, the equation of universal health insurance with universal healthcare and cost issues in general. It was the third element on which the reform eventually failed. A market oriented consultancy firm (KPMG) and an independent research institute (ESRI)15 have arrived at similar conclusions in their reports, namely that the costs of the new system would overburden the state budget. After the publication of the reports, Minister Varadkar announced that although UHI is still the government's preferred option, the ESRI report [therefore] vindicates the Government's decision not to rush the implementation of UHI."16

Legitimizing discourses

In the following, we report the results of the content analysis, structured around the three main dimensions of legitimacy (input, throughput and output) and interpreted along the lines of cross-country variation. Figure 2 lays out the distribution of references to the three main analytical dimensions, namely across the four countries. Corresponding to our first hypothesis, we see the least variation in the dimension of throughput legitimacy. Throughput legitimacy features in roughly equal portions in the texts across the four cases, moving in a narrow range from 22.8% of all references in Ireland to 32% in Hungary.

References to input and output legitimacy are more unevenly distributed. In England and Ireland they cover equal parts of the speeches (36.4% input to 38.3% output in England and 40.1 to 36.3% in Ireland). However, in France and Hungary, input and output legitimacy are competing themes in the speeches. In France, input legitimacy covers almost half (49%) of all references, whereas output legitimacy comes up in less than a quarter (23.5%) of them. In Hungary, output legitimacy dominates with more than every second coded statement linking to the output legitimacy node. By contrast, input legitimacy appears in only 13.2% of all statements.

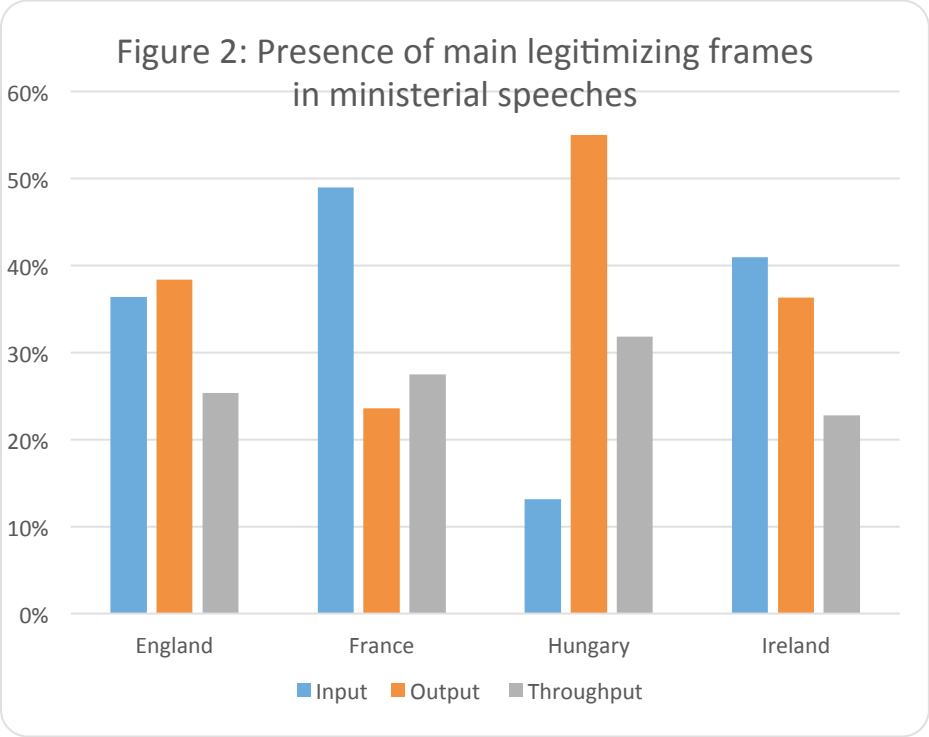
This gives further evidence to the value (or ideology-) based motivations for the reforms in France, while in Hungary, despite the conservative-statist values associated with the

---

15 http://www.irishexaminer.com/ireland/universal-health-insurance-report-found-policy-would-cost-four-times-original-predicted-price-365539.html

16 Statement by Minister Varadkar following Cabinet discussion on UHI. 18.11.2015

centralization process, in public speeches the minister applied a narrative highlighting the alleged positive outcomes of the reforms both in terms of efficiency and quality of service. In England and Ireland we see a more hybrid narrative frame around the reforms, with input and output legitimacy equally represented.

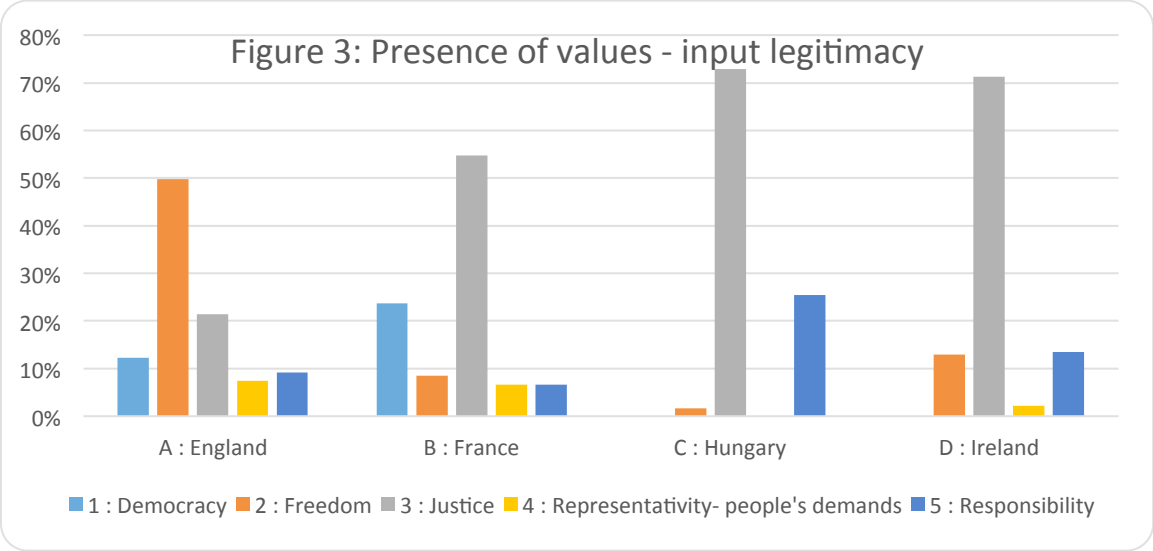


Input legitimacy

Having presented the relationship between the three main dimensions of legitimacy, we proceed to outline the results on the constitutive elements of each of these dimensions. Regarding input and output legitimacy, we are looking at the consistency of frames around specific values in different countries. When it comes to output legitimacy, we would also like to figure out whether the results correspond to hypothesis 2 – namely that ministerial speeches in countries affected by austerity will contain more references to efficiency and financial sustainability than to the quality of services, while in countries less affected by the crisis the reverse will be true. Finally, in terms of throughput legitimacy, we aim to identify the main alleged partners of the government during the policymaking process – whether they are health care professionals, experts or market actors.

As figure 3 demonstrates, from among the values associated with input legitimacy, social justice is the most prominent theme of the speeches in France, Hungary and Ireland (54.8%, 72.9 and 71.3% of all references). This serves to articulate responsiveness with the rise of inequalities with regard to access to quality services and unmet needs for financial reasons, a long-term trend across European countries, which has only been exacerbated by the crisis. In France, for instance,

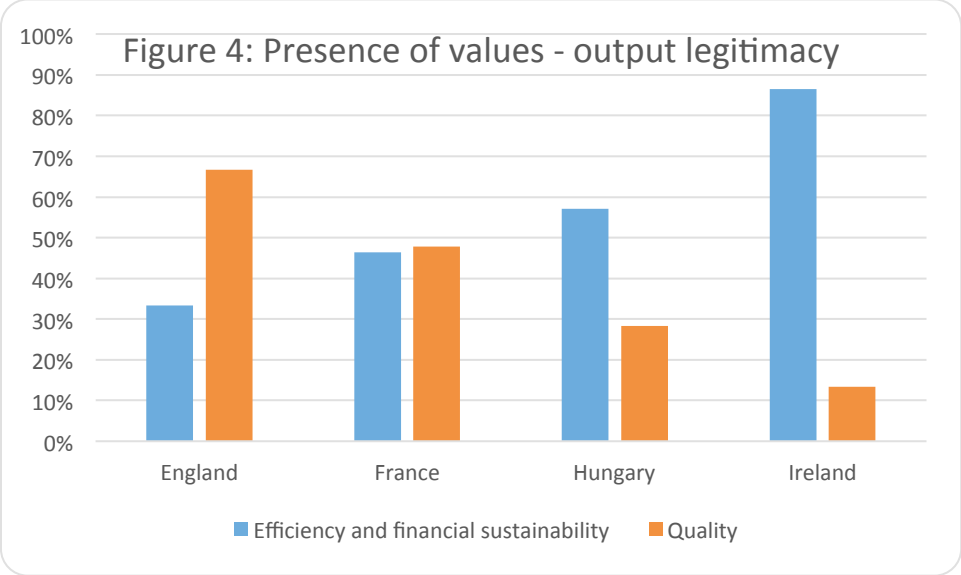
the emphasis put on social justice by the Socialist government serves to address the discrepancy between acute issues regarding access (including lacking insurance coverage, out-of-pocket amounts, as well as poor availability in rural areas) and the self-picturing of the French welfare State as strongly egalitarian. In contrast, justice only loads on 12% of the references in England. This may be explained by the fact that the NHS is totally free at point of use, which makes unequal access for financial reasons less a problem.



By contrast, freedom covers half of the references to input legitimacy in England. The core argument was that competition among various (public and private providers) would be fostered by the Health and Socila Care Act only insofar as it would increase patient choice without being imposed upon practitioners for the sake of it. Freedom – mostly the freedom of choice on the insurance market for consumers – also comes up as a prominent theme in Ireland (12.9% of references). Responsibility features in 13.5% of input-legitimacy related references in Ireland and in 25.4% of them in Hungary. In the former case the issue of responsibility comes up in relation to compliance with the EU regulation of insurance markets. In the latter case, the minister makes statements to the responsibility that hospital directors have to bear in terms of fiscal rules and new rules of employment. The democracy frame covers here two dimensions, namely the transparency and accountability of the healthcare system, and an enhanced patient involvement in everyday decision making. It features as an emerging value in France (23.6% of references), where it is referred to as 'sanitary democracy', and to a lesser extent in England (12.3%) where politicians in charge used the motto 'no decision about me without me'. In contrast, the democracy frame does not appear in the Hungarian and Irish discourse.

Output legitimacy

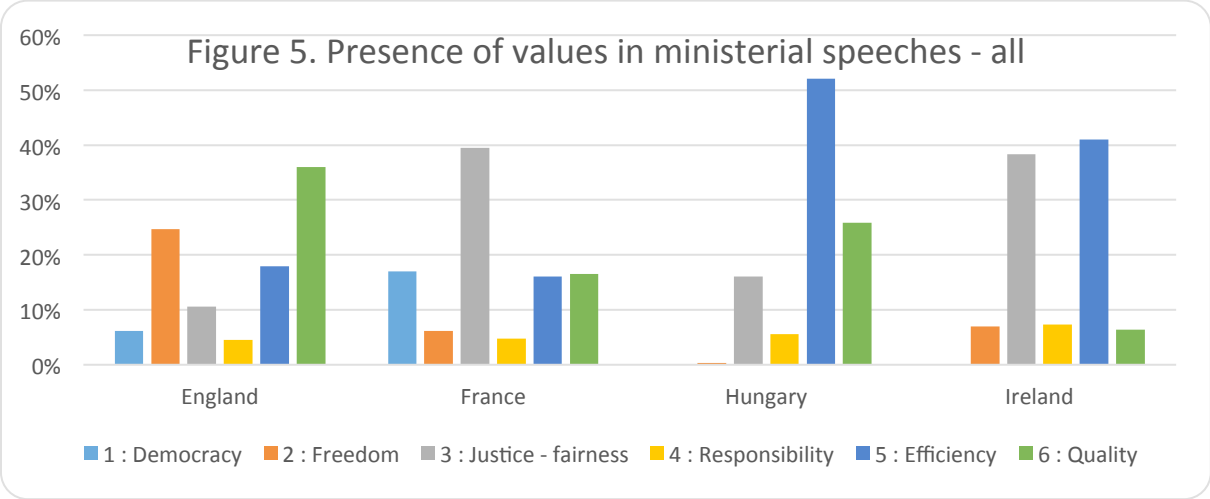
Figure 4 looks at the output legitimacy dimension, comparing the relative presence of efficiency (also including financial sustainability) as opposed to quality in the analyzed speeches. In short, hypothesis 2 gains support, as in the "crisis countries" (Hungary and Ireland), efficiency features more often than quality (57.1% versus 28.3% in Hungary and 86.65 versus 13.4% in Ireland). Efficiency is a strong theme in the less affected countries (England and France) as well, but it is either on par with quality (as in France) or actually quality is a more important theme than efficiency. The important focus on quality in England reflects the fact that poor quality of the NHS and major failures in some hospitals regularly made the headlines.



Thus, a central claim of the reform was to address quality issues as central authorities would focus on stimulating, controlling and evaluating 'outcomes'. In France, the quality frame was often associated with that of justice ('quality services and innovation for all'). Efficiency featured on an equal foot as Marisol Touraine insisted that the excellence of the French healthcare system should be made financially sustainable in the long run through efficiency gains.

If we interpret the results on input and output legitimacy- related values simultaneously (see figure 5), we find that probably the most consistent case is France, where the reform is presented in a patient-centred narrative, with the main building blocks of social justice, democracy, and quality of services. The English case can also be described as a relatively coherent one, in which competition and freedom of choice for GPs and patients will result in better delivering and go hand in hand with a stricter control of quality. However, in both England and France, efficiency and fiscal sustainability is present as a strong subtheme, although the pledge by

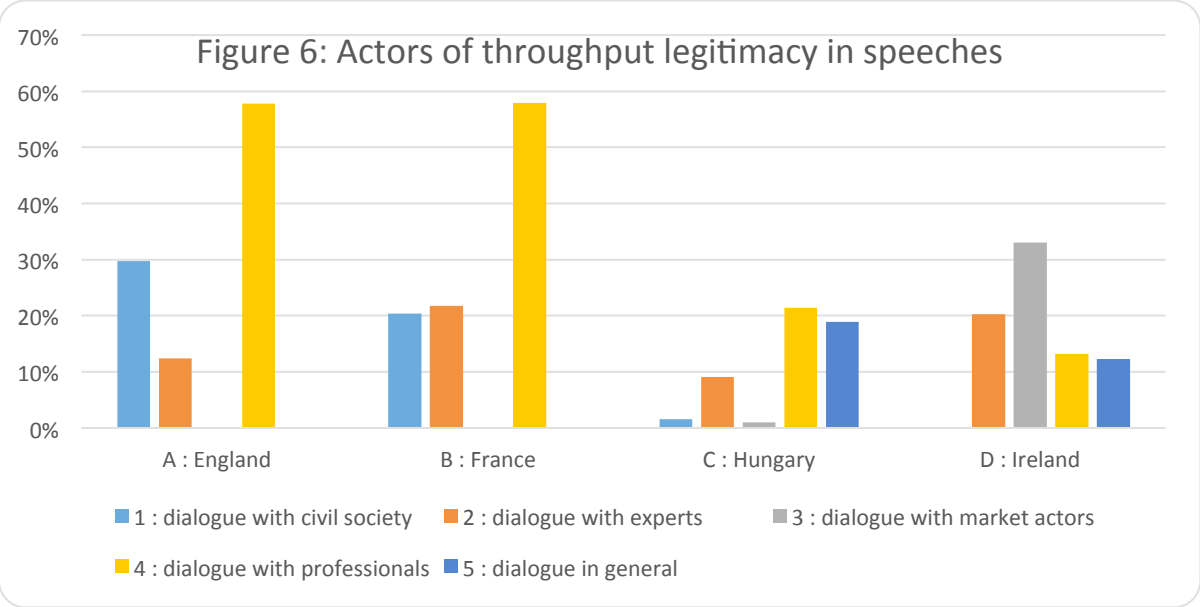
the British coalition government to not submit the NHS to austerity cuts explains that this theme was not much emphasized in the British discourse. Framing in Hungary and Ireland is less coherent. In Ireland, we can observe a combination of the drive towards efficiency on the insurance market, while exhibiting a similarly strong reliance on values of (mostly inter-generational) solidarity and social justice. In Hungary, the dominant value frame - covering more than 50% of the references which is exceptional among the cases – is efficiency. At the same time, the combined proportion of quality and fairness is also above 40%, which calls into question the claim that the Hungarian government would have justified the centralization process only with financial considerations.



Throughput legitimacy

Finally, Figure 1 has provided evidence that throughout legitimacy is an important dimension of legitimizing discourses accounting for a quarter to a third of all legitimizing frames. In terms of values, throughput legitimacy relies on the idea of dialogue, or consultation, with various stakeholders who may provide the government with input for (re-shaping its reform plans). Going one step further, we looked into the different categories of actors which were referred to as providers of throughput legitimacy. References to agency feature in a similar way in England and France, with a focus on the dialogue with professionals, which reflects the fact that the reform plans have triggered contestation from within the medical profession in both countries. In France, dialogue with experts and dialogue with civil society feature on the second place in terms of the frequency of references, while in England, dialogue with the civil society turned out to be more important to mention in public speeches than the dialogue with experts. However, it should be noted that it is often difficult to disentangle the various types of agency as civil society actors, professionals and bureaucrats are often all considered as providing relevant expertise through

mixed for a or consultation processes. In Hungary, references to dialogue or consultation in general, without mentioning any specific actor appear almost as often as references to the dialogue with health care professionals. Finally, in Ireland, due to the type of reform (the restructuring of the insurance market), dialogue with market actors comes to the fore.



Conclusion

In this paper, we have investigated the trajectory of four health care reforms in four EU member states after 2008, using a government-centered framework of legitimation strategies. We have argued that governments maneuver through the dilemmas of responsiveness and responsibility through an active use of legitimizing discourses. Democratic legitimacy in the post-war period had been largely built on the provision of universal public services, including health, education and social housing. While the universality and public funding of these services started to unravel long before the current crisis, the post-2010 period represents a new stage, where an EU-wide consensus around austerity inhibits government spending on public services. Those governments that experiment with a more permissive fiscal stance can now expect retaliation not only from global financial markets but also from European institutions.

The main proposition of the research presented here is that in this compressed fiscal space, governments were forced to reinvent and experiment with new combinations of the three elements of legitimacy: input, output and throughput. We aimed at identifying these different combinations across countries and types of reforms. The research focused on healthcare, a complex policy area where the links between government decisions and material outcomes were

not always directly observable to individuals, therefore legitimizing discourses that explain this link had particular importance.

Our research was exploratory, but in the future we plan to link different framing strategies to the causal explanation of success or failure of the reforms. To be able to do so, first we need to build a framework in which these four reforms with very different content become comparable. Second, we need to add a more thorough review of alternative explanations for reform trajectories, such as those that focus on political institutions and veto points or those focusing on epistemic communities (Haas 1991, Immergut 1992).

References

Bélanger, É., & Meguid, B. M. (2008). Issue salience, issue ownership, and issue-based vote choice. Electoral Studies, 27(3), 477-491.

Beneda Attila, Bíró Márta, Burány Béla, Cserháti Péter, Egresits Tímea Gaál Péter, Gui Angéla, Gyebnár Brigitta, Horváth Ildikó, Hankó Balázs, Kadocsa Ildikó, Mészáros Gábor, Mészáros János, Novák Krisztina, Páva Hanna, Pászthy Bea, Mogyorósi András, Mogyorósi Dorottya, Pálinkás Ágnes, Stefka Nóra, Stubnya Gusztáv, Szaszovszky Eszter, Szócska Miklós, Török Krisztina, Velkey György, Vokó Zoltán (eds.) (2011) Újraélesztett egészségügy, Gyógyuló Magyarország Semmelweis Terv az egészségügy megmentésére. Szakmai koncepció. Nemzeti Erőforrás Minisztérium Egészségügyért Felelős Államtitkárság. [Resucitated Health Care, Recovering Hungary: Semmelweis Plan to Rescue Health Care. Professional concept. Ministry of National Capacities, Department of Health.]

Beneda Attila, Burány Béla, Cserháti Péter, Gaál Péter, Hankó Balázs, Páva Hanna, Mogyorósi Dorottya, Stefka Nóra, Stubnya Gusztáv, Szócska Miklós, Török Krisztina, Velkey György (eds.) (2010) Újraélesztett egészségügy, Gyógyuló Magyarország Semmelweis Terv az egészségügy megmentésére. Szakmai konzultáció – vitairat. Nemzeti Erőforrás Minisztérium. Egészségügyért Felelős Államtitkárság [Resucitated Health Care, Recovering Hungary: Semmelweis Plan to Rescue Health Care. Discussion paper for professional consultation. Ministry of National Capacities, Department of Health.]

Bras, P.-L. (2016) 'Politique économique et politique de santé', Les tribunes de la santé, 1673-86.

Carstensen, M. B., & Schmidt, V. A. (2016). Power through, over and in ideas: conceptualizing ideational power in discursive institutionalism. Journal of European Public Policy, 23(3), 318-337.

Crowe and Horvath (2014). Thematic Analysis of Submissions in Response to a Public Consultation on the White Paper for Universal Health Insurance. Final Report to the Department of Health, 3rd October 2014.

Department of Health (2012). The Path to Universal Healthcare. Preliminary Paper on Universal Health Insurance.

Enthoven, A. C., & van de Ven, W. P. (2007). Going Dutch—managed-competition health insurance in the Netherlands. New England Journal of Medicine, 357(24), 2421-2423.

Gaál, P. (2013). Hogyan tovább? Az egészségügyi rendszer fejlesztésének stratégiai irányai a Semmelweis Terv értelmezési keretében [How to proceed? Strategic directions for health systems development within the framework of the Semmelweis Plan]. Interdiszciplináris Magyar Egészségügy XII. Évfolyam, 3. Szám, 2013. Április. Pp 9-14.

Gaál, P. (2016). Recent changes in the organizational structure of the Hungarian healthcare system (2010-2015). Online Health Policy Update on Hungary, 13 January 2016. The Health Systems and Policy Monitor. European Observatory on Health Systems and Policies. http://www.hspm.org/countries/hungary25062012/countrypage.aspx

Hassenteufel, P (2012). Les sources intellectuelles des réformes du système de santé français: la prédominance des forums et des acteurs administratifs. In J. De Kervasdoué (ed.) Carnet de santé de la France 2012, Paris: Economica, 161-183.

Hassenteufel, P(2014). Les systèmes de santé entre conceptualisation économique et reconceptualisation politique. Socio-logos. 9/2014, http://socio-logos.revues.org/2812

Hemerijck, A., Dräbing, V., Vis, B., Nelson, M., & Soentken, M. (2013). European welfare states in motion (Vol. 5). Neujobs working paper.

Hurst, J. (2010). Effective ways to realise policy reforms in health systems. OECD.

Immergut, E. M. (1992). Health politics: interests and institutions in Western Europe. CUP Archive.

Irish Medical Organisation (2010). IMO Position Paper on Universal Health Coverage. Dublin.

Kelleher, S.; Alomari, D.; Azizea, S. O'Sullivan, S. (2014). Going Dutch. Is adapting the Dutch healthcare system to Ireland the answer to our problems, ask four doctor of nursing students from UCC. World of Irish Nursing 2014; 22(3): 28-29

KPMG (2015). UHI Premia Costing Report submitted to the Health Insurance Authority.

Mair, P. (2009). Representative versus responsible government (No. 09/8). Max Planck Institute for the Study of Societies.

Maresso, A., et al. (2015) 'Economic crisis, health systems and health in Europe', XXX

Mihályi, P (2012). Elitváltás, centralizáció és a települési önkormányzatok jogainek csorbítása az egészségügyben. Elite change, Centralization and the Infringement of Municipial Rights in Health Care. Fundamentum / 2012. 2. szám p.39-44.

Pierson, P. (2001). Coping with Permanent Austerity: Welfare State Restructuring in Affluent Democracies. In: Pierson, P. (ed.): The New Politics of the Welfare State. Oxford University Press, Oxford. pp. 410-456.

Scharpf, F. W. (1999). Governing in Europe: Effective and Democratic? Oxford University Press. http://cadmus.eui.eu/handle/1814/21979.

Scharpf, F. W. (2011). "Monetary Union, Fiscal Crisis and the Preemption of Democracy." LEQS Paper, no. 36. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1852316.

Schmidt, V. A. (2002). Does discourse matter in the politics of welfare state adjustment?. Comparative political studies, 35(2), 168-193.

Schmidt, Vivien A. 2013. "Democracy and Legitimacy in the European Union Revisited: Input, Output and 'throughput.'" Political Studies 61 (1): 2–22.

Seabrooke, L. & E. Tsingou, 'Europe's Fast- and Slow-Burning Crises', mimeo, ENLIGHTEN project, February 2017.

Stamati, F., & Baeten, R. (2014). Health care reforms and the crisis. ETUI.

Stokes, D. E. (1963). Spatial models of party competition. American political science review, 57(02), 368-377.

Thomas, S., & Burke, S. (2012). Coping with austerity in the Irish health system. Eurohealth, 18(1), 7.

Timmins, N. (2012). Never again? The story of the Health and Social Care Act 2012. The King's Fund.

Vizard, P. and Obolenskaya, P. (2015) 'The Coalition's Record on Health: Policy, Spending and Outcomes 2010-2015', accessed.

Wren, M., Connolly, S., & Cunningham, N. (2015). An examination of the potential costs of universal health insurance in

Ireland. Economic and Social Research Institute. Dublin, Ireland.