

# Healthcare reforms and fiscal discipline in Europe: Responsibility or responsiveness?

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## Abstract

This paper asks how governments across Europe have responded to the dilemma between financial responsibility and political responsiveness against the background of heightened fiscal pressure. Focusing on the domestic politics of healthcare reforms in four contrasted cases (England, France, Hungary and Ireland), we investigate how governments frame and legitimise these reforms. We find that references to input legitimacy vary greatly according to prevailing values of governments and party politics in the respective national realms. With regard to output legitimacy, efficiency and financial sustainability tend to prevail over concerns related to quality in those countries that are more affected by debt. Across all cases, governments rely on an instrumentalist conception of throughput legitimacy, meaning that they use consultation with different stakeholders as a way to prevent adverse politicisation and to support their framing of the reforms.

Keywords : austerity, healthcare, legitimacy, responsibility, responsiveness

## Introduction

Explaining the drivers of healthcare reforms against the background of the recent financial and debt crisis in Europe has proved particularly challenging. 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 in crisis and subjected to wide-ranging reforms long before the outbreak of the European debt crisis (Freeman and Moran 2000). But while the effects of the crisis on healthcare funding and provision seem inevitable, the common pressure for enforcing fiscal discipline has not brought about a convergence of welfare systems as its effects are strongly mediated by domestic politics (Hemerijck et al. 2013).

A myriad of international institutions with specialised research units closely monitor health policy developments and generate extensive comparative data (e.g. Maresso, 2015: 49). They tend to highlight the common challenges in terms of rising needs, especially in times of economic recession where access may become more difficult for some groups. Another 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. 2012) -, marketization through the importance of the pharmaceutical industry and the slow opening of domestic boundaries through increased patient and employee mobility in the framework of the Single Market's regulation. Yet, the high number of potential explanatory factors make it difficult 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 a limited explanatory power as they seem to point to idiosyncratic reform trajectories in response to the crisis (Stamati and Baeten 2014).

EU governments on average spent 15.2% of their total budget on healthcare in 2015, which makes healthcare the second largest programmatic item on their budget after pensions. Correspondingly, attempts at budgetary coordination at the EU level have addressed healthcare. The European Semester, the EU's surveillance cycle which combines stringent rules and procedures on deficits with soft coordination for social policy, 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).

Against this backdrop, the approach adopted here departs from the traditional research agenda that assesses policy change by detecting causal factors and by comparing convergence or divergence across different healthcare systems. 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. Yet, domestic politics and contentious debates surrounding said reforms remain largely an uncharted territory outside of specifically nationally focused contributions. The purpose of this article is therefore to explain how *national decision makers have 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 financial *responsibility* towards international institutions, creditors and international policymaking norms on the one hand, and political *responsiveness* towards their constituencies and people's needs, on the other (Mair 2009, 2011; Mair and Thomassen, 2010). Economic crises affecting interdependent economies, such as those in the EU, exacerbate this dilemma and healthcare is a case in point for illustrating this. The recession and stark rise of unemployment has increased the needs among vulnerable groups, while at the same time, fiscal resources have been reduced as a result of rising deficits, problematic credit, and partly imposed, partly self-inflicted austerity. Moreover, healthcare is a labour- and resource intensive sector where costs are rising secularly, following population growth and ageing. It is therefore a large boat very difficult to manoeuvre and governments cannot expect rapid changes in the short run.

Unlike what Mair and his colleagues have suggested, we argue that it cannot be assumed that governments will strongly prioritise responsibility over responsiveness. 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 by reform proposals at the domestic level. 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.

We use the distinction between input, output and throughput legitimacy to open the black box of domestic politics of healthcare reforms and unpack the way in which European governments have dealt with the responsibility versus responsiveness dilemma. For feasibility reasons, we focus on four country cases, namely France, Ireland, Hungary and Britain (NHS England), which have been selected for their

contrasted features with regard to the institutional characteristics of their healthcare system, and the potential pressure for fiscal discipline exerted by the EU. We look at the most recent major reform plans since 2010. 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.

More specifically, we investigate three hypotheses: 1/ We expect variation among cases with regard to input legitimacy because reforms are heavily affected by the prevailing values in the various national realms 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 adverse politicization, to support their framing of the reforms (*ex ante*), or to diffuse conflict once contention is expressed by particular groups (*ex post*). Our demonstration relies on an analysis of how the respective governments framed the reforms undertaken between 2010 and 2014 to justify them and create political acceptance among the main constituencies.

The article has three sections. The first section explains how legitimizing mechanisms can help governments overcome the dilemma between responsibility and responsiveness. Section 2 justifies case selection and presents the design of the content analysis. Section 3 presents the results of the frame analysis and the way in which the various dimensions of legitimacy were articulated and combined.

## Explaining reform dynamics: from dilemmas to legitimizing strategies

### Theoretical approach

Two strands of the literature inform our understanding of how national decision makers have responded to the policy challenges in the healthcare sector against the background of diffuse pressure for more fiscal discipline. First, Peter Mair's concept of

the dilemma between responsibility and responsiveness (2009, 2011) and, second, the different dimensions of legitimacy as formulated by Vivien Schmidt (2013). Peter Mair pointed out the growing incompatibility between two facets of governance: acting responsibly in a dense web of rules and expectations set by multiple principals, on the one hand, and being responsive to the - increasingly illegible - preferences of the electorate (Mair 2009), on the other. More specifically:

‘Responsiveness is generally identified with the tendency, and indeed the normative claim, that political parties and leaders – for reasons that range anywhere from self-interest to re-election, organisational discipline, ideological commitment – sympathetically respond to the short-term demands of voters, public opinion, interest groups, and the media’ (Bardi et al. 2014: 237).

In contrast,

‘Responsibility is identified here with the necessity for those same parties and leaders to take into account (...) the claims of audiences other than the national electoral audience, including the international markets that ensure their financial alimentation, the international commitments and organisations that are the root of their international credibility, and, in the European context in particular, the heavy transnational conditions of constraint that are the result of a common currency and common market.’ (Ibid.)

While the responsibility vs responsiveness dilemma has been mainly explored by scholars of party politics, a few contributions have sought to apply it to questions of political economy, public policy and EU politics. Bohle (2014), for instance, provides a historical account of how policy makers in the Weimar Republic have solved the dilemma between responsibility and responsiveness through cheap credit, then having to turn to harsh austerity as a result of the Great depression. Looking into the EU regime for fiscal discipline set up in the aftermath of the 2008 financial crisis, Laffan (2014) argues that responsibility has become the prevailing norm for European governments due to the stringent and deeply intrusive nature of the external constraints stemming from EU governance. Using these approaches 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 article 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 legitimising strategies. Siding with strategic constructivism (Jabko, 2006) and with recent, power-based formulations of discursive institutionalism (Carstensen and Schmidt 2016), we highlight governments' endeavours to strategically frame specific reforms in order to create acceptance. Thus, the active agency of governments in the formulation of legitimising frames leads to a variation in its constitutive elements, both across policy areas and across countries. In that perspective, 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, as well as the nature of the reforms under investigation against the background of fiscal discipline across Europe.

Analytical framework and hypotheses

Our analytical strategy rests on a matrix which combines legitimization strategies in the face of the responsibility vs. responsiveness dilemma. This has implied analytical choices which reduce the complexity of discourses and separates frames which are hard to disentangle. As reported in table 1 below, we categorized the frames based on an assessment of broad public philosophies on how healthcare resources should be allocated, which actors should be involved in health policymaking and what

normative goals health care should serve. However, some of these categories are fundamentally ambivalent. Justice, for example, can be regarded both as a normative endeavour but also as an outcome of healthcare reforms. Furthermore, in the practice of political discourse, ambiguous combinations of these concepts can occur. For example, freedom of choice may also feature in speeches as a proposed way to improve the quality of services.

#### TABLE 1 AROUND HERE

While we are aware of these difficulties, our strategy has been to detect inductively the main justification themes in terms of values, objectives and processes, and then code deductively the more specific elements related to these broad themes during the empirical analysis.

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. Healthcare reforms 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 frame analysis part of this article, 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.

Three main values are part of the decision makers’ discourse aiming at addressing constituencies’ demands in the realm of healthcare policy refer to: a) freedom: this can refer to market freedom, the freedom of patients to use the health services they want under the label ‘patient choice’ or the freedom of healthcare professionals in the conduct of their activity, mostly freedom vis-à-vis public and regulatory authorities; b) social justice or fairness in terms of the extent of access for all social groups to quality services, the reduction of inequalities, and inter-generational equity; c) democracy in terms of the involvement of patients’ associations in healthcare policy making, or the possibility for patients to be fully informed and associated with the individual decisions regarding their health. This is sometimes labelled as ‘sanitary

democracy'. Thus, we formulate a first hypothesis as follows: we expect variation among cases with regard to input legitimacy because reforms are heavily affected by the prevailing values in the various national realms and ideologies of governing parties (H1).

Output legitimacy of healthcare reforms are expected to be more uniform across cases primarily for the reason that healthcare is a valence issue. While political values and ideologies matter for the specific content and design of the reforms, voters tend to have very similar preferences around broad issues of outputs. In general, they all would like to get high quality and easily accessible 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 reflective of socio-economic cleavages – some social groups want more social benefits while others would like to see lower taxes instead. We also assume that there is a consensus about the need to contain rising health care costs. Citizens are not only users of healthcare services but are also taxpayers financing the services and beneficiaries of other social programs which compete with healthcare for funding.

To give a more specific and operational definition of output legitimacy, we separate it to a) quality: this involves for instances themes such as low mortality rate, shorter waiting times, patient satisfaction, as well as to technological innovation and e-health; and b) efficiency which refers to the capacity to maintain a high level of services while reducing costs, either by raising productivity, avoiding waste or reducing the cost of management. This is related to concerns over long-term sustainability of healthcare systems under regimes of fiscal discipline. In a comparative perspective we expect that in countries which are more affected by the sovereign debt crisis, efficiency arguments will trump quality arguments. Our second hypothesis is therefore that among the different dimensions of output legitimacy, we expect efficiency to be present across all cases, but it should be prevailing over other concerns in those countries which are submitted to greater fiscal discipline (Hungary and Ireland). In less heavily affected countries, we expect to find more arguments around the quality of services (England and France) (H2).

Due to the complexity of healthcare, throughput legitimacy will be a significant part of government framing. References to a transparent policymaking process that

involves all the stakeholders will also be a major part of government framing across all the cases. While the original formulation of throughput legitimacy takes consultative institutions as given, we emphasize governments capacity to use throughput procedures such as consultation and dialogue with experts and stakeholders in order to strategically support the initial conceptions of the reforms 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 the throughput legitimacy of reforms which are primarily ideologically motivated. We expect this type of throughput legitimacy to be present in all cases. In our study, throughput legitimacy therefore refers to the involvement of four categories of actors: a) market actors, that is the representatives of large health services firms and insurance companies; b) experts who may be either bureaucrats within the state apparatus or experts from the private sector including international consultancies; c) representatives of the profession, meaning either from professional associations or unions or individual personalities from the top management in the sector; d) civil society, i.e. patient advocacy groups, NGOs, or more occasionally individual personalities, for instance academics who act as advisors on a particular issue. Against this background, we hypothesize that across all cases, governments rely on an instrumentalist notion of throughput legitimacy, meaning that they use consultation with different stakeholders as a way to support their framing of the reforms (*ex ante*) to diffuse conflict once contention is expressed by particular groups (*ex post*).

The last step in building our framework consists in explaining how we connect input, output and throughput-related frames with responsibility and responsiveness. With regard to input legitimacy, we associate freedom and efficiency with responsibility because the prevailing policy paradigm is built around the belief that markets allocate

resources more efficiently, and therefore market freedom and freedom of choice leads to fiscal discipline. In contrast, the values of sanitary democracy and social justice aim to respond to voters' basic concerns related to the underpinning philosophy of their national healthcare system. Output legitimacy seems more straightforward as efficiency shall allow financial responsibility while quality shall respond to people's concerns about the performance of health services. Finally, we also have a differentiated approach to throughput legitimacy. We expect that market actors and experts involved will tend to favour marketization and point to financial sustainability against the background of scarce public resources. This is mostly articulated together with freedom and efficiency which feeds into responsibility concerns. In contrast, governments involve representatives of the medical profession and civil society groups to express responsiveness to those who are directly affected by the organization of healthcare provision.

Our empirical investigation of input, output, and throughput legitimacy and their constitutive elements is built on the analysis of speeches that health ministers held on the given reform. While they may have been addressed to a specific audience, they are all public and publicized speeches.

We collected an exhaustive corpus of 139 speeches<sup>1</sup> or media reportage of speeches directly related to the reform at stake in each country and retrieved from official government archives, and in one case (France), from the personal blog of the Health Minister. They are mainly in the format of press releases, transcript of press interviews or of speeches in the Parliament or in front of the larger public, and, as such, they can vary greatly in length. In terms of methods we use a software-assisted (N-Vivo) frame analysis methodology. Originating in the work of the sociologist Erving Goffman, the study of framing constitutes a well-established approach to policy analysis and policy change (Schön and Rein, 1994; Fischer, 2003). Frames are broad ideas which connect more specific sections of discourse and provide the relevant context of meaning (Creed et al. 2002: 37).

Unlike lexicometry, which focuses on word occurrence, frame analysis requires to identify packages of meaning. We therefore coded statements that could cover parts

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<sup>1</sup> 20 for England, 25 for France, 62 for Hungary and 32 for Ireland.

of a sentence, a single full sentence or multiple sentences and identified the frames it referred to. This methodology is partly inductive and partly deductive since, besides the expected frames (such as justice), the manual coding allows for identifying further frames which may be salient. When sections of texts contained several frames, they were therefore coded several times. The quantification of the frames displayed in the figures has no other purpose than to measure the relative salience of different frames.

## Four contrasted cases of healthcare reforms: England, France, Hungary and Ireland

### Case selection

This comparative study relies on a contrasted cases design. We selected four EU countries exhibiting different characteristics along three main lines which are considered key dimensions in the recent literature on the effects of the financial and debt crisis on healthcare reforms: the institutional features of the healthcare regime, the degree of fiscal pressure which may be expected, and the degree of pressure coming from the emerging EU economic governance regime (Stamati and Baeten 2014). Rather than looking at healthcare in general, in each country, we have selected one reform or reform attempt that was the most salient in public debates in the period between 2010 and 2016. Table 2 summarizes the main institutional features of the four cases, the fiscal and EU-policy context, as well as the content of the reform that we focus on.

### TABLE 2 AROUND HERE

England is the archetype of the Beveridgean regime financed by tax revenue, available to all on a universal basis, and free at the point of use. Since the reforms of the early 1990s, the NHS has had a long record of internal marketization relying on the commissioning mechanism by practitioners and provision by a variety of public or private providers.

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, relying on the complementarity between a basic coverage by the social security system and optional complementary insurance schemes.

Furthermore, provision is shared between independent general practitioners ('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.

In terms of access, Hungary has a universal system, which however suffers from long waiting lists and a proliferation of private and semi-private alternatives. Hungary originally had a contribution-based system of financing with a single state-run insurer, but this system has eroded recently. As of 2011, more than half of health insurance fund revenue came from the central government, therefore the government could directly influence providers through financing arrangements (Gaál et al. 2011: 78).

Irish healthcare has a multipayer, two-tier, dualised system 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 primary care, for which non-exempted users have to pay on the spot. Voluntary health insurance constitutes the second tier, offering partly complementary, partly overlapping services with the public sector.

Figure 1 displays trends in per capita government health care expenditure in our four country cases over the years 2000-2012, giving an overview of the fiscal pressures experienced by health care in the four countries. Hungarian health care experienced austerity already in 2007 with a 9.4% drop in spending compared to 2006. Health care was in the forefront of attempts to stabilize the country's deteriorating fiscal position (Gaál et al. 2011: 3, 61). In the UK and Ireland austerity kicked in later. In the UK, this meant a relatively moderate adjustment of -0.7% from 2009 to 2011. Ireland, on the other hand, slashed its healthcare budget by 5.8% over the same two-year period. France is the only country among our four cases where healthcare budgets continued to expand -albeit moderately- after 2008.

FIGURE 1 AROUND HERE

Regarding the degree of pressure to enforce fiscal discipline coming from the EU, our cases again exhibit contrasted features. Ireland has been submitted to strict conditionality defined in the Memorandum of Understanding which settled the conditions for the financial assistance programme. With deficit levels over the settled

3% GDP, France has been continuously subjected to the Excessive Deficit Procedure since 2009. Yet, it has used its political weight to negotiate new extensions of the deadline to correct its budget trajectory and avoid sanctions. Hungary is not a member of the Eurozone, but due to lax public finances and exchange rate volatility, it was subject to the Excessive Deficit Procedure (EDP) since 2006 and it was bailed out by the IMF-EU-World Bank Troika in 2008. The ruling conservative government since 2010 aims at minimizing pressures coming from the EU and relies on its own measures to reduce the deficit. In consequence, the country was released from the EDP in 2013 (Council of the European Union 2013: 3).

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 an 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. Overall, our case selection is in tune with the 'EU leverage' index conceived by Stamati and Baeten (2014, p. 92). They evaluate the 'EU leverage' as strong for Ireland, moderate for France and weak for the UK. We categorize Hungary as a country that experiences moderate pressures coming from the EU.

#### Nature of the reforms

In each country, we focus on the most salient reform over the period 2008-2014. Even if a major or final goal of the reforms were cost-containment, they aimed to achieve this by comprehensive restructuring rather than by one-off retrenchment measures. In January 2011, the Health Secretary of the UK, Andrew Lansley submitted the Health and Social Care Act, which turned out to be the most controversial reform of the Liberal-Conservative legislature of the UK. After much consultation and amendments, the Act was adopted in March 2012. 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 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, to ensure transparency towards patients and to oversee 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 public debate on the continuous lack of resources for the NHS, and on the far-reaching consequences from an increase in competition among providers and an increase of involvement of the private sector in health provision.

The Socialist government which took office in France after F. Hollande's election in May 2012 engaged with a strategy aiming at balancing deficit reduction and deteriorating access to healthcare. Besides the law on insurance schemes, the reform occurred through the 'Law on modernisation of the healthcare system' discussed from 2013 onwards and eventually adopted in January 2016. 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); 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 enjoy 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 targeted the pharmaceutical industry, on the one hand, and efficiency savings in public hospitals, on the other hand.

The eventually failed reform proposal in Ireland – which was the most comprehensive attempt of restructuring between 2010 and 2014 - 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

arrangement was often referred to in the literature as the Dutch model, as it would have copied the emblematic healthcare reforms in the Netherlands in the mid-2000s (Enthoven and Wynand 2007, Kelleher et al. 2014 WIN 2014; 22(3): 28-29).

Centralization was the main structural reform that took place in Hungarian health care after the crisis. Between 1990 and 2011, public services in Hungary (including health care and education) were provided to citizens through a decentralized system. Local governments owned and operated the majority of hospitals and outpatient care centres. From 2011 on, the central government took back ownership of hospitals from local governments and curtailed the financial autonomy of university hospitals as well. The government also reversed functional privatization – it restored the legal form of hospitals from corporate undertakings into budgetary units. On November 21, 2011, the Parliament 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). 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.

## Framing the legitimacy of healthcare reforms - Findings

### Input legitimacy

As figure 2 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 a concern of policymakers with the rise of health inequalities which has been present as a slow-burning issue, and on the short-run it also has been exacerbated by the financial 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. At the

other end of the scale is England, where justice only loads on 21% of the references. This may be explained by the fact that the NHS is free at point of use, which makes unequal access for financial reasons less a problem.

FIGURE 2 AROUND HERE

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 Social Care Act only insofar as it would increase patient choice without being imposed upon practitioners for the sake of it. Freedom – mostly defined as consumer choice on the insurance market – also comes up as a prominent theme in Ireland (12.9% of references). The democracy frame consists of two elements, namely the accountability of the healthcare system, and an enhanced patient involvement in everyday decision making. It features as a prominent 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.

In tune with hypothesis 1, we observe significant variation across our country cases as far as input legitimacy is concerned. The issue of social justice (and equality in access) is a main concern everywhere, but to contrasted extents. The same is true for freedom, although its high salience seems to be a British peculiarity, thus echoing the claims in the manifesto of the Liberal-Conservative coalition elected in 2010. Furthermore, the idea of ‘sanitary democracy’ and patient involvement is unevenly present in the various national realms. Overall, we conclude that input legitimacy related values reflect a greater concern for responsiveness from the side of governments as it serves to connect policy making to people’s main demands and needs in connection with the most pressing issues and the ideological grounds on which governing parties have been elected.

Output legitimacy

Figure 3 looks at the output legitimacy dimension, comparing the relative presence of efficiency (including financial sustainability) as opposed to quality in the analysed speeches. In short, hypothesis 2 gains support, as in the ‘crisis countries’

(Hungary and Ireland), efficiency features more prominently than quality (66.9% versus 33.1% in Hungary and 86.6 versus 13.4% in Ireland). Efficiency is a strong theme in the less affected countries as well, but it is either on par with quality (as in France), or it becomes a more important theme than efficiency (as in England). At the same time, the 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'.

#### FIGURE 3 AROUND HERE

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 Health Minister Marisol Touraine insisted that the excellence of the French healthcare system should be made financially sustainable in the long run through efficiency gains. This provides evidence that governments under greater pressure for fiscal discipline tend to favour frames which support their concern for complying with fiscal responsibility.

In Hungary, the dominant value frame – covering two-thirds of all the references, which is exceptional among the cases – was efficiency. This high ratio calls into question the received wisdom that reforms increasing state capacity would necessarily be associated with a relaxation of budget discipline. The acknowledged motivation of the Hungarian central government was to set hospital finances on a sustainable path by replacing a fiscally irresponsible owner with a more cost-conscious one. In this frame, 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 was therefore claimed to be more suited to control costs, as it could not rely on subsidies or 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 equipment (Szócska 2012). Because of centralization – the argument went – hospitals would form a single, powerful actor against near-monopoly suppliers, who had been able to abuse this position in the previous, fragmented system. At the same time, when it comes to input legitimacy, territorial equality surfaced repeatedly in the government discourse as a fairness-enhancing aspect of the reform. The Hungarian government claimed 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 regions.

#### Throughput legitimacy

Throughput legitimacy relies on the idea of dialogue, or consultation with various stakeholders in the course of policy making. Figure 4 outlines which actors governments claimed to have consulted with in each country case. In England and France, the focus was on the dialogue with professionals, which is due to 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 in mixed-membership consultation bodies. 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 potential impact of the reform on the structure of the insurance market, dialogue with market actors came to the fore.

#### FIGURE 4 AROUND HERE

In all four cases, throughput legitimacy was used in an instrumental way, meaning that governments were referring to those actors that they deemed potentially crucial allies or veto players whose consent was needed in the reform process. In this respect, the type of reform predetermined which actors were deemed necessary to be involved in the framing of reforms. In England and France, as the reforms more directly affected the medical profession (GPs in England and the liberal practitioners in France), governments either needed their consent and they needed to counterbalance the opinion of the medical establishment with that of civil society actors and health experts. It is worth noting that the consultations happened *ex post* after the main concept of the respective laws were conceived and presented. Therefore, consultation and framing in terms of throughput legitimacy clearly served to alleviate the conflict and discontent triggered by said reforms. In Hungary, the reform was part of a larger agenda about restoring the capacities of the central state, therefore the rhetoric of the reform also

targeted the public in general, rather than any specific professional or civil society group. Finally, in Ireland, an attempted reform of the insurance system necessitated the involvement of the representatives of insurance companies, which explains why market actors feature most prominently in the legitimizing frames.

In all countries, concerns for financial responsibility is reflected in the framing through involvement of experts, mostly concerned with financial sustainability, while reference to market actors remain more marginally circumscribed to the Irish case. In contrast, more frames related to throughput legitimacy serve to display responsiveness in a strategic way. The virtue of consultation and dialogue in general is an emerging frame in Hungary and Ireland, while dialogue with civil society is more specifically articulated in France and Britain. This is a way for governments to show that they are listening to people's concerns and grievances and that they are involved in decision making. More importantly, dialogue with the medical profession features most prominently everywhere. Clearly, governments need to appear responsive to grievances in the face of planned reforms since the profession is the category of actors which is most structured in terms of representative organisations, and is the most powerful veto player due to its ability to engage action to block or slow down the adoption or implementation of the planned reforms.

It is also important to stress here that throughput legitimacy is not simply a discursive device. In all cases except Hungary, the involvement of non-government actors effectively led to non-negligible changes in the bills discussed or led to the government completely abandoning its reform plans as it happened in Ireland. Framing that feeds into throughput legitimacy therefore shows that responsiveness is key in the ways in which governments conceive, discuss, amend and eventually adopt (or not) healthcare reforms.

## Conclusion

This article contributed to the literature on the politics of policymaking by connecting the dilemma of responsibility and responsiveness to the different dimensions of legitimacy and the ways in which governments frame reforms when they address their constituencies at large. Overall, our findings do not support the general claim that governments favour responsibility over responsiveness to a great extent or in a

systematic way. Rather, we argue that in a compressed fiscal space, governments are forced to reinvent and experiment with new combinations of the three elements of legitimacy: input, output and throughput. While input legitimacy tends to vary across countries according to national culture and party politics (H1) we find that amongst its elements, social justice features in all four countries prominently. In terms of output legitimacy, the main legitimising frame supporting a responsibility driven policy making is efficiency, related to a claim to maintain or even improve the quality of health services while containing or reducing their costs. Our findings also support the claim that the greater the pressure for enforcing fiscal discipline, the more salient the efficiency frame (H2). Finally, the way to generate throughput legitimacy also depends on the nature and unfolding of national debates and the nature of the reform at stake, but dialogue with professionals and civil society seems to be important for creating reform acceptance and for avoiding protracted conflicts (H3). Finally, we also find that responsiveness and legitimizing frames which display governments' responsiveness is unescapable as far as healthcare reforms are concerned. A crucial avenue for future research is to understand how adopted and implemented reforms are being evaluated by various constituencies and how this feeds back into governments' ability to manage the responsibility vs responsiveness dilemma.

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Tables and figures

*Table 1 – Analytical matrix*

	<b>Input legitimacy</b>	<b>Output legitimacy</b>	<b>Throughput legitimacy</b>
<b>Responsibility</b>	Freedom	Efficiency	Market actors Experts
<b>Responsiveness</b>	Democracy Justice	Quality	Professionals Civil society

*Table 2 - Context and nature of the reforms*

	<b>England</b>	<b>France</b>	<b>Hungary</b>	<b>Ireland</b>
<b>Regime</b>	Universal	Bismarckian	Formally universal, informally dualized	Formally dualised
<b>Fiscal pressure</b>	Moderate	Weak	Strong	Strong
<b>EU pressure</b>	Weak	Moderate	Moderate	Strong
<b>Nature of Reform</b>	Marketization of NHS	Extension of access	Centralization	Introduction of universal insurance

Figure 1 – Per capita government expenditure on health (PPP USD, 2010)  
 Source: WHO Global Health Expenditure Database

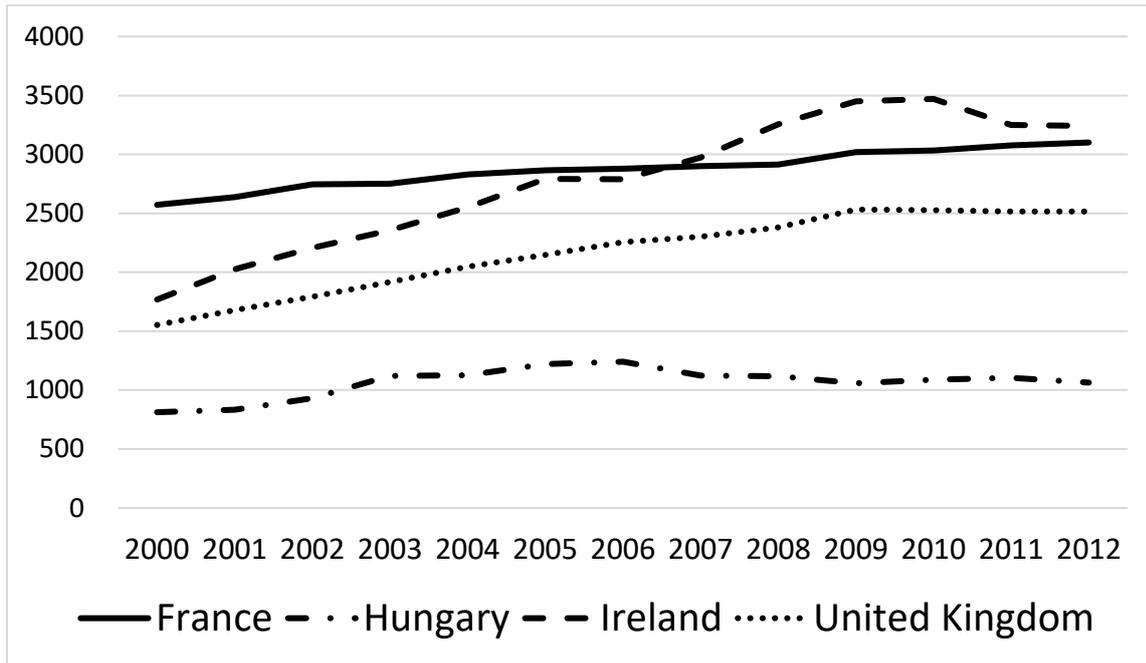
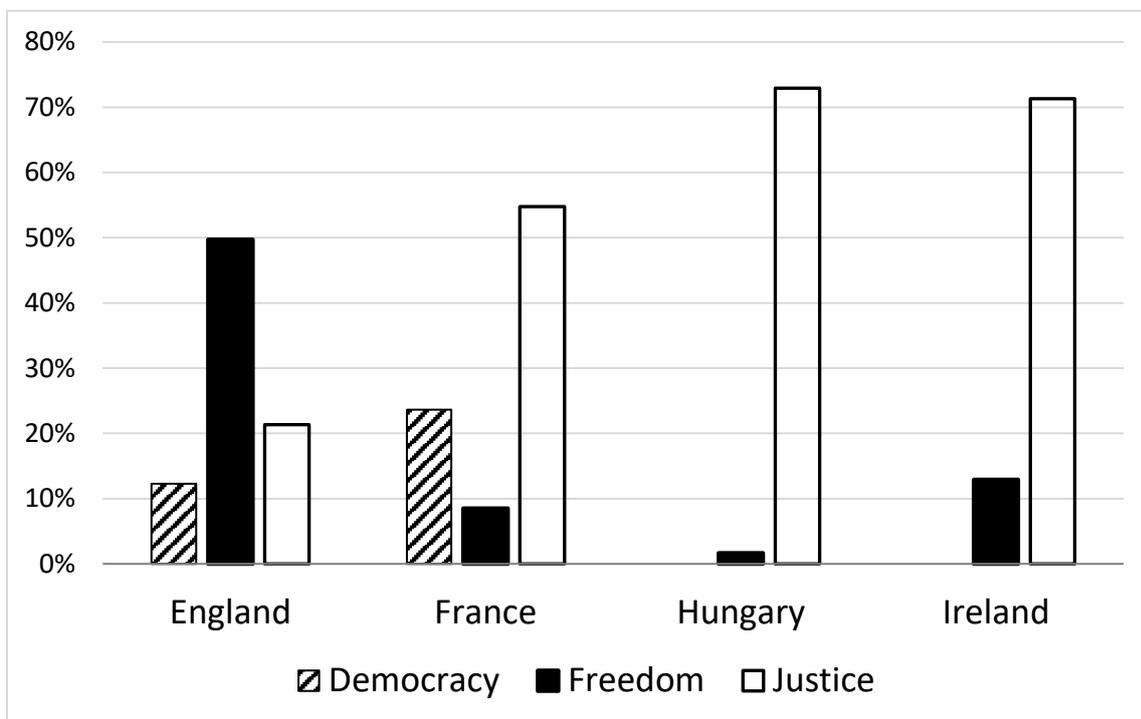
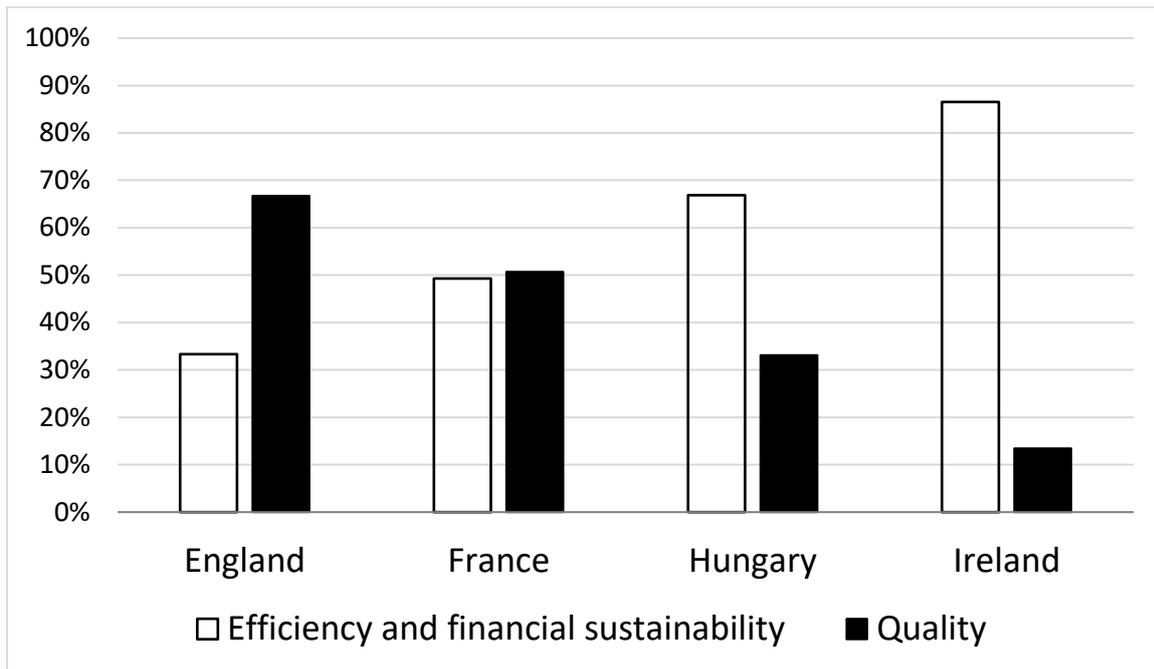


Figure 2 – Values feeding into input legitimacy (% of all references)



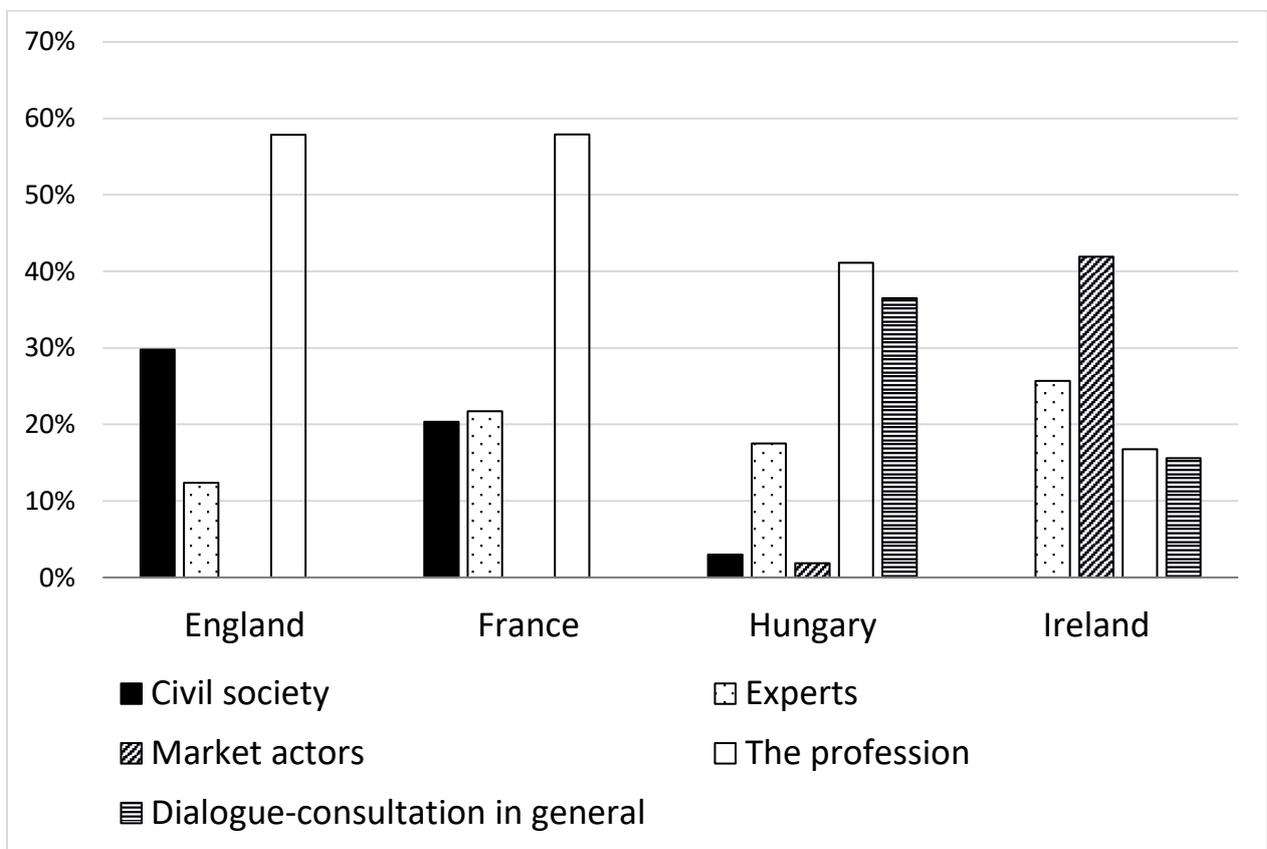
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Figure 3 – Values feeding into output legitimacy (% of all references)



(Total number of references: 427)

Figure 4 – Throughput legitimacy: dialogue with specific actors (% of all references)



(Total number of references: 203)