Legitimating Health Care Reforms across the EU: Government Narratives of Health Restructuring in England, France, Hungary and Ireland

Amandine Crespy, ULB

Imre Szabo, Central European University

Introduction*

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 (Seabrooke and Tsingou 2016). 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

This research was funded by the European Commission Horizon 2020 project "European Legitimacy in Governing through Hard Times" (#649456-ENLIGHTEN).

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 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 longüterm 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 article 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. 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. 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 versus 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 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 the nvivo-assisted content analysis of speeches held by Health Ministers on the main reforms decided between 2008 and 2014 in the four countries. We have coded the different elements of the three dimensions of legitimacy and we have looked at their combination to establish the main features and the coherence of legitimating narratives.

We have found that only the French case corresponds to a coherent, egalitarian vision of social policy-making with a combination of social justice and quality of provision as main themes in ministerial speeches. In all the other cases a more incoherent narrative strategy emerges. Ireland and England both attempted market-

oriented reforms, but in England the reform was justified by a combination of references to freedom of choice and to quality of service, while in Ireland markets were argued to bring social justice and more efficiency at the same time. In Hungary, a reform that increased the power of the central government was justified by the same frames as the market-oriented reforms in Ireland: social justice and efficiency. At the same time, we find strong evidence in support of the hypothesis on the instrumental use of throughput legitimacy across all the four cases.

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 content analysis and the way in which the various dimensions of legitimacy were articulated and combined.

Explaining reform dynamics: from dilemmas to legitimizing strategies

The main purpose of this article is to advance our understanding of how policy choices are made against the background of slow-burning and fast-burning crises. 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 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 legitimizing narratives. Siding with more recent, power-based formulations of

discursive institutionalism, we highlight governments' capacity to independently formulate legitimizing narratives 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 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, 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 measurable 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*).

Case selection and research design

This comparative study relies on a contrasted cases design. We selected four EU countries which exhibit divergent characteristics along three main lines which are considered key dimensions in the recent literature on the effects of the recent 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 of the countries, we have selected one reform or reform attempt that was the most salient in public debates in the period after 2008. Table 1 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 1: Context and content of the reforms

	England	**France**	**Hungary**	**Ireland**
Regime	Universal	Bismarckian	Formally universal, informally dualized	Formally dualized
Fiscal pressure	Moderate	Weak	Strong	Strong
EU pressure	Weak	Moderate	Moderate	Strong
Reform	Marketization of NHS	Extension of access	Centralization	Introduction of universal insurance

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 reforms 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 constitute the legacies with regard to the British NHS.

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. 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.

In terms of access, Hungary has a universal system, which however suffers from long waiting lists and other issues of insufficient provision. Therefore, many better-off patients opt-out by seeking private and semi-private alternatives, including the prevalence of informal payments to doctors. 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, giving ample leverage to directly influence providers through financing arrangements (Gaál et al. 2011: 78).

Irish healthcare has a multipayer, two-tier 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 which in effect allows a dualized access to the system.

Figure 1 displays trends in per capita government health care expenditure in our four country cases over the years 2000-2014, giving an overview of the fiscal pressures experienced by health care in the four countries. The graph documents that 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 the UK and Ireland austerity kicked in later. In the UK, this meant a relatively moderate adjustment of -4.8% from 2009 to 2011, and a stagnation since then. 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.

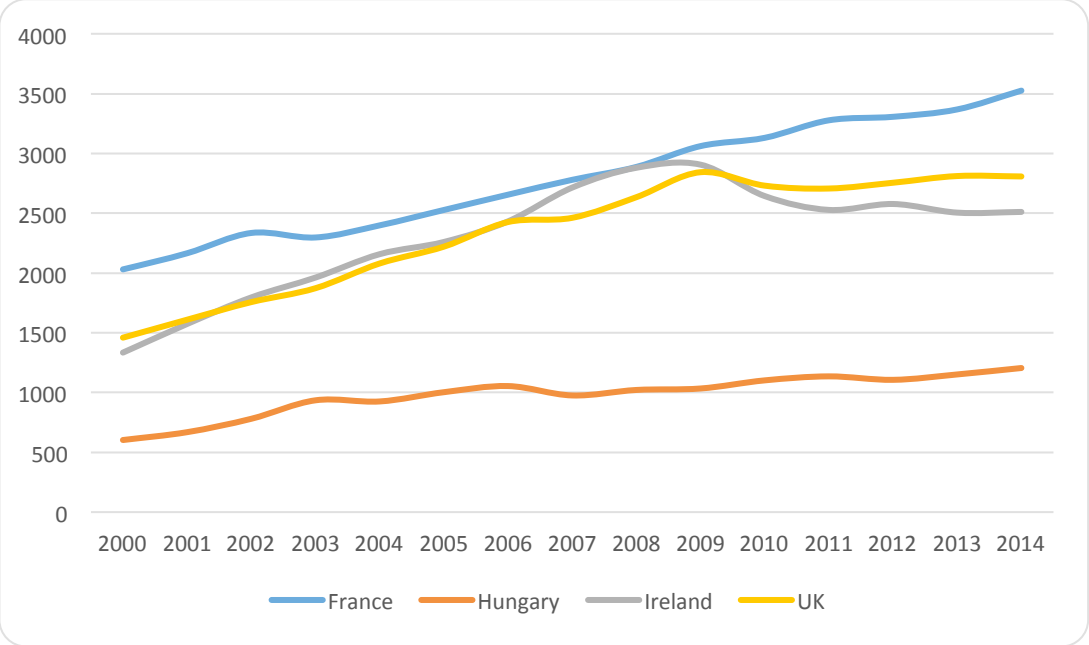

Figure 1: Per capita government expenditure on health (PPP int. $) Source: WHO Global Health Expenditure Database

Regarding the degree of pressure to enforce fiscal discipline coming from the EU, our cases again exhibit 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. 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. Hungary has a controversial attitude to EU fiscal regulations. The country is not a member of the Eurozone, but due to lax public finances and exchange rate volatility, Hungary was under surveillance in the Excessive Deficit Procedure since 2006 and it had an IMF-EU-World Bank assisted bailout in 2008. The conservative government coming to power in 2010 made it a priority to minimize institutional pressures coming from the EU, while keeping the deficit rules. In turn, Hungary substantially lowered its deficit levels and was released from the Excessive Deficit Procedure in 2013 (Council of the European Union 2013: 3).

Our case selection corresponds to 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. We categorize Hungary as a country that experiences moderate pressures coming from the EU.In each country, we have selected the most salient reform over the period 2008-2014. In England, the thrust of the – eventually failed - reform proposal consisted in extending competition among health services providers. This would have occured 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. (Vizard and Obolenskaya, 2015, p. 24-26).

The most important reform package of the Hollande presidency in France extended basic public universal insurance as well as private complementary insurance schemes to people not covered so far. 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, as well as the reorganisation of care provision at the local level aiming at a better coordination between public and private hospitals, between

hospitals and ambulatory care. Finally, the reform package was complemented by a set of measures for improving patients' rights and preventive public health.

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 centers. 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 – a process in which hospital were turned from budgetary institutions into independent corporations. As already mentioned, within each country we focus on specific reforms that went beyond simple retrenchment measures. Even if a major or final the final – as we will see – in many cases the final cost-cutting and intended to restructure one or many substantive parts of the healthcare system.

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. We constructed a database that consists of 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 in the format of press releases, transcript 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 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 value-based frames related to input, output and throughout legitimacy (see table in appendix 1). Unlike lexicometry, which focuses on word occurrence, we coded statements, that could cover parts of a sentence, a single full sentence or multiple sentences. We hand-coded the statements by indicating which narrative concept the given statement makes a reference to. A statement could be linked to multiple concepts. When sections of texts contained several frames, they were therefore coded several times. Our analysis was assisted by the software N-Vivo.

Findings

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, 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 in France.

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 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.

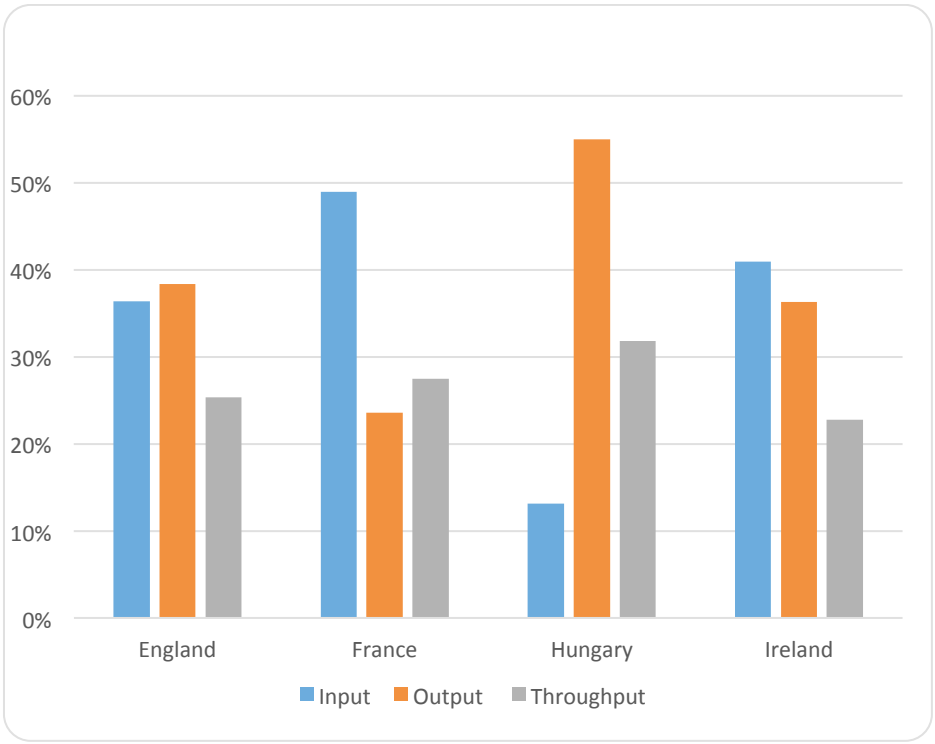

Figure 2: Legitimizing frames in ministerial speeches

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.

Input legitimacy

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 a concern of policymakers with the rise of health inequalities which has been present as a slow-burning issue, but on the short-term 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. 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.

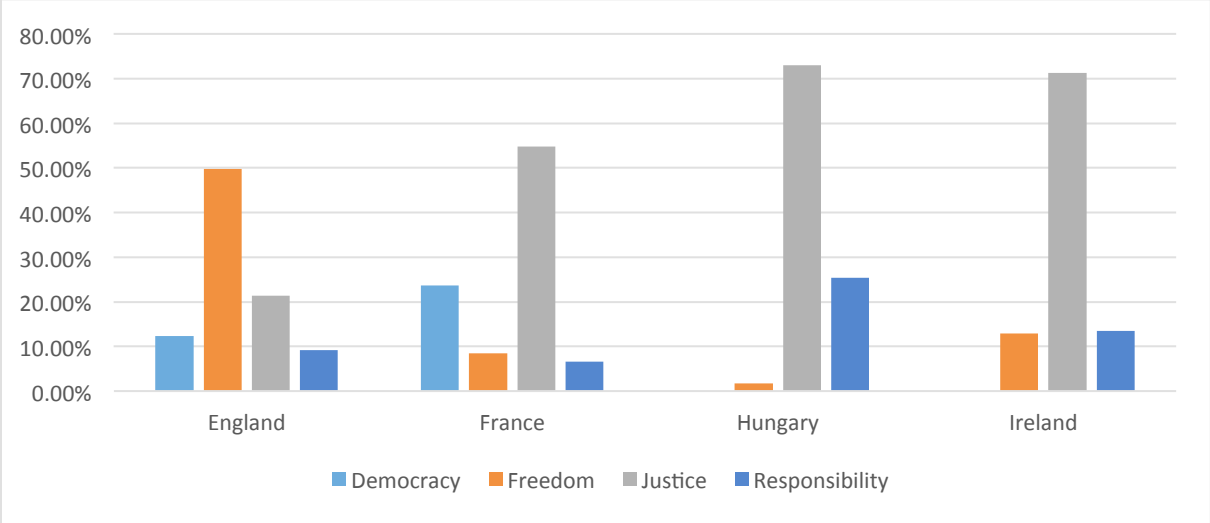

Figure 3: Values within input legitimacy

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 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 (Mihalyi, 2012). 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 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 (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 as well, but it is either on par with quality (in France) or quality is a more important theme than efficiency (in England). At the same time, in the UK, 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.

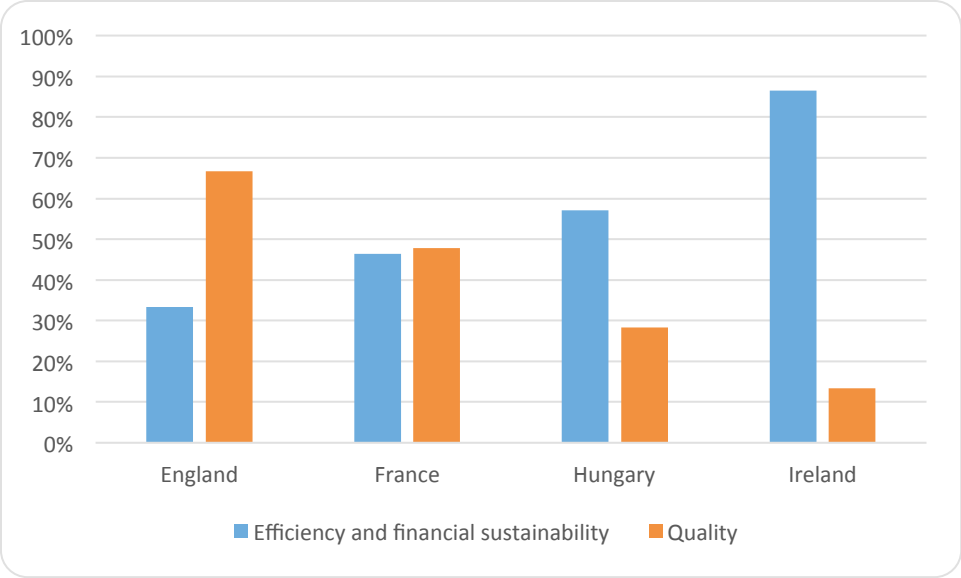

Figure 4: Values within output legitimacy

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.

Table 2 presents the values associated with either input or output legitimacy that occurred most frequently in the ministerial speeches in each country. the constitutive values, thereby enabling us to interpret the combination of these different values. We find that the most consistent case is France, where the reform is presented in a patient-centred narrative, with the main building blocks of social justice and quality of service. Efficiency also features in the French case, but it does not dominate efficiency in the speeches.

Table 2: The most prominent values within legitimating narratives across countries

	England	**France**	**Hungary**	**Ireland**
Input	Freedom	Justice	Justice	Justice
Output	Quality	Quality -	Efficiency	Efficiency

		Efficiency		

The framing of reforms in the remaining three cases was less coherent. While both the English and the Irish reforms were market-oriented, the narrative that surrounded them relied on different combinations of values. In England, markets were invoked to bring competition and freedom of choice to GPs and patients, and it was claimed that this freedom of choice will result in better quality. In Ireland, the extension of markets was presented in an entirely different frame. The process of market-making was on the one hand claimed to enhance fairness because the dualism of the extant system would have been eliminated. On the other, however, the minister referred to markets as efficiency-enhancing tools in the context of the fiscal crisis of the country

In Hungary, the dominant value frame - covering more than 50% of all the references which is exceptional among the cases – was efficiency. This 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/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[1]. 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.

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

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

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. Figure 5 outlines which actors governments claimed to have consulted with most often in each country case. In England and France, the focus was 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 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 type of reform (the restructuring of the insurance market), dialogue with market actors came to the fore.

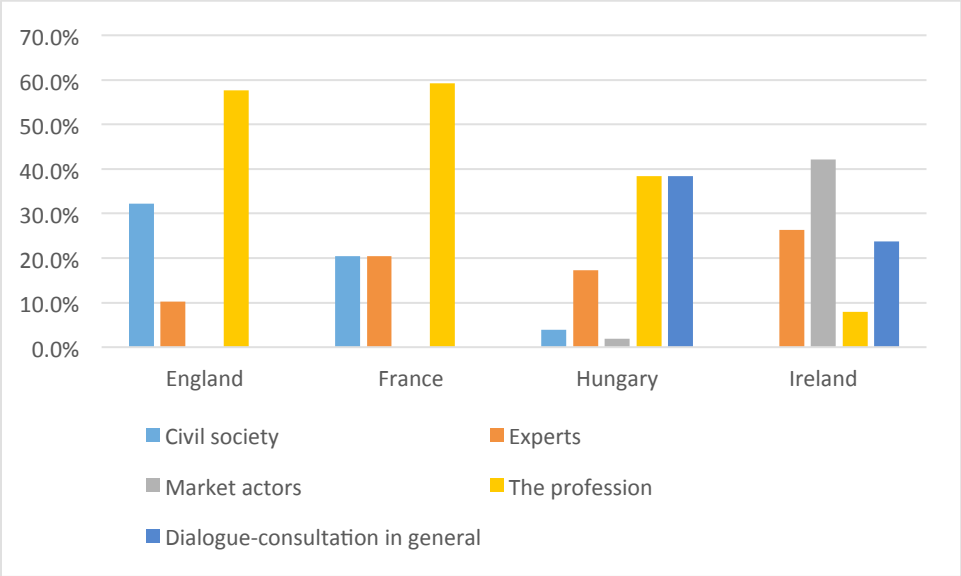

Figure 5: Throughput legitimacy: dialogue with specific actors

In all four cases, throughput legitimacy was used in an instrumental way, meaning that governments were referring to those actors that they deemed crucial potential 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 or they needed to counterbalance the opinion of the medical establishment with that of civil society actors and health experts. In Hungary, the reform was about restructuring more generally, therefore the references also targeted the general public. Finally, in Ireland, an attempted reform of the insurance system necessitated the involvement of the representatives of insurance companies.

Conclusion

In this article, 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.

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.

Council of the European Union (2013) Council Closes Excessive Deficit Procedures for Italy, Latvia, Lithuania, Hungary and Romania. *Press Office of the European Council.* http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ecofin/137561.pdf

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

Seabrooke, L. and E. Tsingou (2016). Bodies of Knowledge in Reproduction: Epistemic Boundaries in the Political Economy of Fertility, New political economy 21 (1), 69-89.

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.

	Input legitimacy	Output Legitimacy	Throughput legitimacy
Relevant agency	Voters' preferences People's demands	The markets International organisations The EU	Dialogue with experts Dialogue with civil society (NGOs and patients) Dialogue with professionals Dialogue with market actors
Relevant values	Freedom (incl. competition and choice) Justice (incl. fairness and market regulation) Democracy (incl. patient involvement, transparency) Responsibility (of government, practitioners, patients)	Efficiency Financial sustainability Quality (incl. outcomes, results, delivering) Investment (rise in funding) Working conditions	

Appendix 1 – Concepts and coding