Health Politics in Hungary and Romania

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Abstract

Recurring economic crises, slower growth, changing demographics and accelerated globalization have put immense pressures for change on welfare systems. However, these systems appear remarkably resilient as governments employ (or delay) a diverse set of reforms. Given that governments shape policy, it is important to understand the politics of reform in order to understand welfare states. Additionally, it is important to extend our knowledge of welfare states beyond well established capitalist democracies in order to understand different mechanisms of change in social policy. This thesis aims to contribute to this understanding by examining the politics of health reform in Hungary and Romania. Process-tracing on a single policy dimension across two similar cases is employed in order to discern the mechanics of reforms. This thesis emphasizes the role of governments and social actors as key players in determining the nature and success of reforms. Political instability, minority governments, the presence of internal veto players and pressures exerted by outside veto players are found to be the main factors which explain the nature and the success or failure of reforms. The main mechanism is found to be the interaction between political actors seeking cost containment and health workers seeking to preserve the status quo.

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1. Introduction

Peter Gourevitch argued that "[p]olicy requires politics", explaining that "[i]deas for solving economic problems are plentiful, but if an idea is to prevail as the actual policy of a particular government, it must obtain support from those who have political power" (1986: 17). It is often the case that scholars neglect the role of politics when discussing policies, thus failing to connect macro phenomena, such as a crisis, to actual political decisions and outcomes. Therefore, in order to truly understand the nature of policy one must also understand the nature of the policy process. The filter of the process not only shapes the chances of policies to succeed but more importantly limits the nature of the policies that can be advanced. In this sense, policies are not adopted based on quality but rather by managing to fulfill necessary majorities and to bypass veto players. Accordingly, in order to improve the quality of social policies, it is vital to understand the process of policy adoption.

This thesis sets out to contribute to the vast debate on welfare states by focusing on the politics of welfare state change. It also seeks to contribute to this debate by extensive analysis into less researched cases. Most of the research carried out thus far has focused on the three broad "worlds of welfare capitalism" of Anglophone countries, Continental Europe and Scandinavia (Esping-Andersen, 1993). Not only does the literature attempt to explain the origins of these systems (Briggs, 1961; Estevez-Abe et al., 2001; Korpi, 2006; Skocpol, 1995) but there are several theories which attempt to explain its patterns of change (Pierson, 2001; Häusermann, 2010; Hacker, 2009). However, when turning to the new democracies of Eastern Europe, we are still faced with many gaps in our understanding of the welfare state.

This presents itself as an important problem. The welfare state is inextricably linked with the structure of a society, and presents itself both as a product and a as a shaper of that society. It denotes the understanding of social justice and of the fundamental view on politics.

Moreover, understanding its patterns of change, or its resistance to it, can provide invaluable knowledge for policy making.

The welfare state is of particular importance in these post-communist countries as it was an important element in the path towards democracy and the free market. In this sense, the welfare state can be seen in these countries as the compromise of transition. Vanhuysse (2006) reasons that elites in these societies used welfare policies to "pacify" the population during the transition. Accordingly, understanding how these welfare states emerged from the economic and political transformation and how they continue to be shaped can tell us much about the politics of these countries and about what we can expect from them in the future.

Therefore, the aim of this research is to broaden the understanding of welfare states in Eastern Europe, and more precisely to attempt to uncover patterns of change within them. Over the past twenty plus years this region has faced a triple transformation of political structure, economic structure and in some cases national identity (Offe 1991). This has produced not only difficulties in the economic sector, which is struggling to keep up with the previously covered needs of the population, a troubled political scene that often lacks transparency and is prone to instability, but also changes in social relations, such as a decline in social capital. These transformations therefore present additional pressures and perhaps different challenges for these countries. Accordingly, welfare state change in these countries is likely to present particular problems.

In order to understand the workings of these phenomena and other in the shaping of East-European welfare states, this paper will analyze a single sector of the welfare system, namely the health system, in two countries - Hungary and Romania. The period taken under analysis will be that between the change in regime in 1989, until 2012. While both states had welfare systems during and even before communism, this time limitation allows a more in

depth look at a period when politics allowed for a multi-polar model of change of the system. Moreover, as mentioned above, this most recent period is also most relevant for the future of policy making in these countries, the understanding of which this study aims to contribute to. This being said, the characteristics of the system before transition will be considered in terms of policy legacies and their possible impact in the analysis of change during the following period.

The mentioned gap in our understanding includes not only certain countries but also many policy dimensions which are avoided for reasons of either simplicity or availability of data. Health care presents itself as one of these often neglected policy dimensions. It is one of the most salient policies in a society in which a variety of social actors are interested, that presents the dependencies of the previous system and that also faces severe practical challenges in terms of funding and coverage. It is also considered more sensitive to the pressures both for change, usually fiscal constraints, and for continuity. It therefore presents itself as a very appropriate subject of analysis in order to understand the particularities of these systems.

The two countries were chosen because they present many similarities in terms of common heritage, common challenges and similar policy directions, while showing some striking differences. As I will show, the timing and speed of implementation, the nature of policies and outcomes but also more fundamentally the mechanisms of change tended to differ across the period but also between the two countries. In this sense, it is expected that this comparative analysis will yield a complex picture of health policy change. The countries were also chosen because their cases have received less attention than most West European but even East European cases in the literature. While Hungary has been present in many studies looking at Central and Eastern Europe (Inglot, 2008; Kornai & Eggleston, 2001; Marrée & Groenewegen, 1997; Roberts, 2009; Vanhuysse, 2006; Mihalyi, 2007), the topic of

health care was rarely addressed in detail, while Romania has been much more absent even in the literature on East European Welfare States (some of the exceptions are Sotiropoulos and Neamtu, 2003; Haggard and Kaufman, 2008).

2. Theoretical Background and Research Design

2.1. Hypotheses and main argument

The main puzzle which motivates this research is the discrepancy in reforms across the two countries and across time, given similar pressures and needs of the population. In accordance, the main question this research tries to answer is: *Which are the most important factors which constrain or enable governments to enact changes in the health care system?* It may further be asked through which mechanisms these changes are achieved, namely what is the process through which different factors have disparate influence on the scope, speed and direction of change.

In order to answer these questions, this thesis evaluates competing forces and actors in order to reach a parsimonious account of policy change. Given the similar strong pressures for both continuity and change faced by both systems, I expect that actors in the political process have a larger role to play. More precisely, politicians and social actors (physicians and other health workers) make up the two interested parties in the process of health reforms. It is through their interaction, as mediated by institutions, that different policies emerge and succeed.

Therefore, the basic model presented here is that, under conditions of pressure, reforms are initiated and their outcome is dependent on the political competition between social actors and politicians. This expectation leads to the following hypotheses:

H1. Reforms depend on political factors rather than being a direct outcome of pressures for reform and continuity.

The main broad expectation of this work is that while changes in the socio-economic environment spark the need for change, the ultimate outcome of reforms depend on political

factors such as government composition. This directly contradicts deterministic models of social policy change. This hypothesis will be tested by considering the outcome of reforms compared to severe episodes of fiscal pressure.

H2. Reforms are more likely to pass and more likely to be comprehensive when governments are stable and there are few internal and external veto players.

The main political explanation for the success of reforms, in line with the broad literature on the politics of reform, is that more stable governments are able to pass reforms in the face of weak opposition from social actors. What this work is expected to add is a detailed explanation of the interaction between actors and an explanation of the type of reforms reached by different configurations of political actors. This will be directly tested through the developed models.

H3. Government stability rather than political color determines policy outcomes.

This expectation goes against most partisan accounts of social policy change (such as Korpi, 2006; Lipsmeyer, 2002; Finseraas and Vernby, 2011), which emphasize political ideology and the link between social groups and political parties, in explaining types of reforms. This will be tested by looking at reform proposals and outcomes and the color of political parties.

These expectations are based on previous studies of the region (Crowley, 2004; Marrée & Groenewegen, 1997; Mihalyi, 2012) as well previously developed models for other regions (Hacker, 2004; Immergut, 1992; Roberts, 2009). These expectations also present two main departures from these theories. The first is that in contrast to West European States, politics is expected to play a much larger role. The second is that the main mechanism of politics is not partisanship, but rather the composition of the government. These two

departures are more in line with a recent study emphasizing political factors in the study of other welfare areas in four Central and East European countries, by Makszin (2013), on which this work builds.

Previous studies have highlighted the role of politics in the new democracies of Eastern Europe. Besides demonstrating that interest groups are much weaker in this region (Crowley, 2004), previous work has also argued that elites have much fewer constraints in determining cleavages (Enyedi, 2005) and in creating social policy (Vanhuysse, 2006). Moreover, previous studies have also shown that partisan effects can be very different (Tavits & Letki, 2009) and that linkages between politicians and voters are not of the programmatic type, necessary for translation of traditional socio-economic cleavages into political ones (Kitschelt, 2000; Volintiru, 2010). These studies lead to the expectation that while politics should play a greater role in this region, it does not do so through the classical social cleavage approach emphasized by approaches such as the power resource theory (Korpi, 2006). This is the main reason why I expect that government unity rather than political color is a more reliable predictor for both the nature of reforms and their chances of success.

The main argument of this research builds on previous works by Immergut (1992) and Roberts (2009) which emphasize institutional veto points and enabling points as responsible for blocking and enabling reforms, respectively. In terms of conceptualizing governments, I build on the work of Makszin (2013) who distinguishes between coherent and non-coherent governments. The argument developed here emphasized the construction and consolidation of political coalitions as explaining success of reforms. In this sense, political coalitions act as political rather than institutional veto or enabling points. The same can be said for other social actors - bureaucrats and physicians. Table 1, discussed in more detail in chapter 4, illustrates be basic model that I will use to explain the adoption of policies.

Table 1. Model encompassing government stability and veto players

	Presence of Veto Players	Absence of Veto Players
Stable Government	Non-systemic change for stabilization	Systemic change for stabilization
Non-stable Government	No reform/ No reform attempt	Patch-style reforms

Therefore it is expected that politicians would seize the process in the face of little opposition from social actors or that these actors would block this process when faced with a weak government. As will be shown, each set of actors has different preferences. A distinct advantage of such an approach is that it takes into account both actual reforms and failed attempts. The following two chapters develop the theoretical framework of this argument, followed by a presentation of the methods, a description of the cases, and the analysis.

2.2. Pressures for change and continuity

Given the vast literature which deals with the subject matter of this thesis, this section only reviews the literature dealing with the impact of different pressures on the system and on the actors. The following section deals with theories that emphasize processes of social policy change. Pressures are important to understand the context of the decision-making process, to understand which factors ignite the need for reform and which ones slow reforms down.

When describing West European welfare states in the late 1990's, Pierson stated that they were being shaped by the action of "irresistible forces [on] immovable objects" (1998). By this he meant that the systems were facing great pressures both for reform and for continuity. This section will review these pressures as applied to the two countries while focusing on the health care system. As will be seen, Romania and Hungary appear to be quite an extreme example of Pierson's statement. These pressures are important both as a cause of

change and as shaping changes. Accordingly, given the difficult nature of passing reforms, it is pressure caused by change in the environment that usually ignites reforms. Moreover, these pressures both constrain and enable the actions of interested actors. It is the interaction of various pressures that allows actors more comprehensive or more limited scope for reform. Hacker argues that because politicians face the urgency of cutting costs but do not want to face the wrath of voters, they often resort to less visible types of change through drift (2004: 698).

I will first discuss pressures for change. They can be delimited into outside and domestic pressures. The most often discussed of outside pressures is globalization. The globalization thesis holds that with liberalization of trade and job markets, there is a "race to the bottom" in terms of cutting welfare entitlements to boost competitiveness (Schwartz, 2001). This thesis has been discussed thoroughly for Western Europe, being criticized that it does not present direct mechanisms of affecting welfare state structure and that it mainly relates to spending rather than types of benefits (Pierson, 1998 and, 2001; Schwartz, 2001). Indeed countries with strong entitlements such as Sweden and Germany retain high competitiveness. In considering it for Romania and Hungary, it is important to take into account their position in the world economy. In transitioning from a centrally planned economy to a market economy opened to international trade and competition, such pressures might have been felt more strongly, especially in the beginning of the 1990's. However, the previous criticisms still holds, namely that at most, this opens the door for policy makers to choose among competing policy directions. What is more, due to lower wages in Hungary and Romania (compared to Western countries), competitiveness operates differently through a tradeoff between low wages and skill level.

The alternative thesis in the literature is called the "compensation thesis". Bonoli (2007) and Swank (2010) discuss empirically and theoretically how globalization can be

linked to increase in welfare services as new risks associated with it necessitate more comprehensive policies. Iversen (2001) offers a powerful counter-argument, linking the increase in welfare services in Western Europe to de-industrialization, through the same risk perspective. However such perspectives are more powerful in explaining certain sectors of welfare such as employment protection, the link being ever weaker when it comes to health care. Therefore, it is not expected that forces of globalization alone account for any distinct policy direction.

A second outside pressure is more particular to East European welfare states. This refers to more direct pressures from international organizations such as the European Union, the International Monetary Fund and the World Bank. The last two, along with other financial institutions, played a role in shaping social policy in the region "both directly by providing intellectual templates and indirectly by pressing for fiscal adjustments" (Haggard and Kaufman 2008, 343). However, these influences were mediated by domestic circumstances: the depth of crisis, and domestic politics, namely the will of governments to ask for foreign consultancy and implement requirements. Moreover, institutions such as the IMF set as requirements not necessarily structural reforms in welfare but rather set financial targets which have a more diffuse and indirect effect. Accordingly, this external influence will be considered as adding to domestic fiscal pressures. Considering the European Union, while it can be argued that the prospect of EU integration gave the institution some leverage, this was mostly used in pushing for judicial and market reforms. Indeed the requirements of EU integration refer to democratization and a functioning market economy, not particular targets in social policy. Therefore it not expected that international organizations have a relevant role in influencing domestic struggles over policy.

Therefore, as with West European welfare states, it is likely that domestic pressures play a greater role. Indeed, they are generally the same broad pressures, namely demographic

change and fiscal pressure (Pierson, 1998; Schwartz, 2001; Swank, 2001). The health care sector is especially sensitive to demographic changes. Simply put, on the entire European continent there is a growing share of people who "are living longer, retiring earlier, and demanding more medical care" (Schwartz, 2001: 26). Moreover, an aging population presents extra pressure on medical care as they are the main beneficiaries of the system and also account for most of the expenditure. Demographic changes also influence the welfare state in general by changing dependency ratios therefore bringing in ever less revenue for an ever increasing number of dependents. Appendix 3. contains a table describing the dependency ratios for the two countries. Vanhuysse (2006) argues that this problem is much greater for Eastern Europe which saw a surge of early retirees in the early 1990's as an elite strategy to pacify possible protests resulting from job loss and unemployment.

The health care sector is also particularly sensitive to fiscal pressures. In general, health care, alongside pensions, accounts for most social spending. Technological advancements alongside population change have meant that health care is the fastest growing expense in most countries. Hungary and Romania are no exception. Indeed, between 1995 and 2010 nominal spending increased threefold in Hungary and tenfold in Romania, the latter seeing also a doubling of the proportion of the GDP spent on health care (World Health Organization, 2013). For a more detailed look at expenditure, see Appendix 3. Although both countries, especially Romania, started from extremely low spending, this surge in expenditure meant a great fiscal pressure on the system. While facing different economic challenges than Western Europe, the initial transformational recession and subsequent economic slumps have also put pressure on the system. Modest economic growth directly affects health care expenditure by reducing available government funds (Pierson, 1998). As a more extreme case than the West, East European countries did not have mere fiscal, but systematic problems with welfare entitlements. The 1990's transformation recession greatly reduced economic

output and government revenue in countries where all citizens had universal access to health care, irrespective of employment. The growth years of the late 1990's and early 2000's were followed by the 2008 crisis thus putting East European states alongside their West European counterparts in a state that Pierson (1998) called "permanent austerity", namely continuous fiscal pressure on the system. This is also present in the discourse of policy makers which continuously argue for the need to cut benefits.

Despite all these "irresistible forces", while there has been change, it has often been limited and has maintained the basic principles of the systems. The pressures for continuity appear therefore to be equally strong. Unlike the pressures for change, pressures for continuity are only domestic. They can be divided into electoral pressures and institutional path dependence (Pierson, 2001; Inglot, 2008). The problems of changing a system have been obvious even for centuries. Machiavelli hints at both these problems when he says that:

> *"It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than a new system. For the initiator has the enmity of all who would profit by the preservation of the old institution and merely lukewarm defenders in those who gain by the new ones." (1988, [1532]: 44)*

Machiavelli seems to capture a still present reality. The communist universal model of healthcare produced first of all dependencies but possibly more importantly it produced support for such a system and shaped the ideas of citizens about what is a 'normal' and just system. As I will show, across many policy changes, certain basic principles such as universality have survived. Indeed, even in 1996 more than 95% of people in these countries agreed that it was the duty of the state to provide healthcare (Haggard and Kaufman, 2008: 310). Seeing as reform is a political process which depends on building and retaining popular support, it is no wonder that reforms were difficult to implement. Indeed, voters in Hungary and Romania, as those in most countries, are attached to the welfare state which has legitimacy as a "source of social stability and guarantor of basic rights of citizenship"

(Pierson, 1998: 552). Connected to this are of course the aforementioned dependencies. Therefore a first trade-off that the governments of Romania and Hungary had to face was that between popular demands and availability of finance, coupled with international agreements. The pressure from voters is not only in terms of continuity but also a desire for the expansion of benefits.

This connects to the second aspect which presents resistance to change, namely institutional path dependence. Simply put, because of commitments and dependencies but also because of the logic of bureaucracies and organization, institutions and policy courses are hard to change once started. Once a path has been established, the institutions and actors receive increasing returns from the path and reversal costs become higher (Pierson, 2000). Accordingly, institutional legacies themselves dictate much of the direction of further change. Inglot (2008) presents a very elaborate analysis emphasizing path dependence when considering the evolution of the welfare states of Czechoslovakia, Hungary and Poland from the inter-war period until 2004. He takes a macro perspective looking at the major characteristics of these systems. He argues that institutional inertia has been their driving force with their differences being explained by the moment of establishment of the basic structure and the time of completion of coverage (Inglot, 2008). His main argument for continuity since the transition is that "[s]ince 1989 the new democratic governments inherited not only laws, rules, and norms of the communist-era welfare state but also its institutional resources, bureaucratic capacities, organizational structures, personnel, and networks of expertise" (Inglot 2008, 297). Indeed what he seeks to explain is this remarkable continuity in the face of extreme political change. However, in choosing such a broad perspective, he does not address the actual mechanisms through which change is achieved and patterns of change are established.

As argued by this chapter, the problem with perspectives which only consider varying forces, is that they lack the micro-logic necessary to understand policy change. While pressures of either kind influence policy makers, their sheer diversity means that they cannot dictate a single outcome. This being said, their impact is not negligible and they do often constrain actors in particular direction. Fiscal pressures drive policy makers towards cutting costs. Public support and public pressure constrain the types of reforms that politicians can attempt while path dependence also sets important limitations on the direction and scope of reforms. This being said, the variation in terms of reforms between the two countries, and within the same country across time, shows that actors still have considerable freedom. The next section considers theories that explain patterns of change, emphasizing different actors and mechanisms.

2.3. Mechanisms of change

Having discussed the main factors which put pressure both for change and continuity on the system, I now turn to possible mechanisms of change and related theories. More precisely, I turn to how these mentioned pressures are mediated resulting in change by considering the major theories in the field, as well as their limitations.

As with the pressures, mechanisms for change can also be delimited into outside and domestic. Outside mechanisms usually emphasize the importance of the same institutions or transnational actors. Jacoby (2006) distinguishes between three approaches: "inspiration" - policy diffusion across countries and elites, "coalition" - outside elites using domestic minorities to attempt changes, and "substitution" when outside actors impose policy. Stallings (1992) and Dobbins et. al. (2007) develop similar frameworks, emphasizing the interests and power of outside actors as opposed to domestic ones. Given the low saliency of health policy

for outside actors, the only likely channel to apply in this case is that of "inspiration". Indeed, it can be argued that part of the reason why both countries chose social insurance reforms and decentralization, was because of similar models in other European countries.

In terms of domestic channels, there are many factors and mechanisms which might play a role in social policy change. Among them are "socio-economic factors, political competition, public beliefs and popular and interest group preferences, ideational diffusion and gendered political decisions" (Cerami and Vanhuysse, 2009). A general framework, not discriminating between the relative importance of these factors is explained by Cerami and Stanescu (2009) where change in environment leads to misfit and then through mediating factors (ideas, interests and institutions) and through enabling factors (socio-economic situation, cleavages and policy diffusion), change in the welfare system is achieved.

The issue of course is which factors are more influential and which mechanisms they operate through. One of the best elaborated theories concerning Western European welfare states is that of the power-resource approach (PRA). This is the classic approach considering the importance of interest groups and how they influence policy making through political parties (Korpi, 2006). The approach not only refers to formal interest groups such as associations and non-government organizations but to voters with different interests as composing interest groups competing in democratic politics. In this sense, considering the saliency of health care and how it relates to different groups - rich and poor, young and old - we might expect such an approach to be revealing.

However, there are also many reasons why such an approach might not be as relevant in East European societies. Firstly, because of the nature of the previous regime, it is unlikely that a traditional cleavage system will appear and form itself in the political sphere. As Offe (1991) argued, these societies had not been subject to the market forces that create the

classical divisions and cleavages necessary for democratic politics. Indeed as Vanhuysse (2006) and Enyedi (2005) argue, in these societies it is likely that political leaders can shape cleavages and have a much more direct influence because of the lack of traditional cleavages. Kitschelt (2000) argues that these societies do not have the traditional programmatic linkages with elites that transform the interests of competing groups in society into political battles.

Moreover, for the same historical reasons, these societies present small and often inactive trade unions and other civil society organizations, which are considered to be the main actors shaping change in Western societies (see Crowley, 2004; Vanhuysse, 2006). Despite this, it is possible that other actors can operate through different channels to influence decision making. Those who benefit from a health system are not only patients but also bureaucrats, doctors and administrators who might favor certain institutional arrangements. Doctors, for example, are assumed to favor higher wages and greater autonomy, usually preferring a system of multiple private insurers with a fee for service payment (Roberts, 2009; Immergut, 1992). Their main mechanisms of action are protest and bureaucratic capture, the latter representing an instance where doctors come to lead the bureaucracy or relevant ministries (Roberts 2009).

A competing theory aiming to explain the emergence of the welfare state for Western European states is that of Varieties of Capitalism (VoC, see Hall and Soskice, 2001). This approach revolves around production regimes where different structures of skill requirements such as general or specific skills, prompt different levels and types of social insurance (Estevez-Abe et al., 2001). VoC also presents many limitations. By looking only at production and therefore employment, this approach neglects other aspects such as health care. Moreover, the approach has many times been criticized for being able to explain only situations of equilibrium and not reform patterns. What is more, stemming from the fact that the approach only explains equilibriums, it lacks a sociological explanation for change,

namely thorough what institutional processes the equilibrium is reached. What it can explain is how systems reach institutional complementarities which further constrict possibilities for change.

In both of these approaches, as well as most theories explaining policy change, institutional perspectives are always present. In general terms institutions "provide and restrict opportunities for resistance to unwanted policy change" (Swank, 2001: 206). Two major ways they do so are by affecting the structure and abilities of interest groups and secondly by either concentrating or diffusing government power to act. Roberts (2009), for example, emphasizes the manner in which institutions filter the influence of doctors and their ability to capture the policy making process by considering first the unity of a government and secondly the strength of the bureaucracy.

Accordingly, when it comes to interest groups, it is the institutions that affect the relative power of such groups and therefore their ability to negotiate and persuade policy makers. The power of votes, the number of seats they receive, the type of organization they are allowed to make and their cohesion and concentration are influenced by the institutional makeup (Swank, 2001). One major aspect here is the union system and whether it is a united system such as a social corporatist one or a pluralist system of interest representation (see Schmitter, 1974). Unity and concentration greatly affect the relative power of such groups.

Another important aspect is the absence or presence of veto points. Veto points refer to the possibility of actors, sometimes minority groups, to block legislative process and therefore reforms. In the absence of such measures, government have much more flexibility and ease in passing reforms, especially unpopular ones. I will highlight, for example, the difference between Hungary's fragmented government in the 1990's and the recent period of government unity and decision power. This ability of governments is therefore also shaped by

government structure. Accordingly, coalition governments are generally less able to garner necessary support and political will than unitary governments. More importantly, governments which enjoy parliamentary majority have much more power to implement desired policies. Moreover, it has been argued that parliamentary type systems also have more decisional power than separation of powers systems (Bonoli, 2001). This is because there is greater power concentration and greater ease of persuading the legislature if government composition reflects it. In the second case there are many more opportunities for institutional blockage and for individual actors to stop the process. A strong version of this argument is provided by Immergut (1992) who uses veto points as the main explanatory element in order to understand why different developed market-economies chose different health systems. In countries were actors had more opportunities for blocking reforms, universal systems could not be put in place, whereas in countries with few veto points, policy makers managed to implement comprehensive systems.

An interesting counter-perspective to the traditional veto points argument is presented by Gehlbach and Malesky (2010) in discussing veto players and reforms in Eastern Europe and the former Soviet Union. They emphasize that veto players can actually help economic reforms by weakening special interest actors. More importantly they emphasize that veto players also make policy reversal less likely. This can be seen across the two cases studied here, that while Romanian governments managed fewer and less comprehensive reforms due to veto players, their relative absence in the Hungarian case permitted policy reversal.

A further aspect to consider is political agency. One way elite agency can explain welfare change is through the elites themselves as actors with more freedom in EE than others countries. Vanhuysse (2006), when considering change since 1989 emphasizes their role in using social policy as a means to avoid political losses. He reasons that while initially politicians used social spending to "pacify" possible protests, this resulted in a skewed

political process that gave a greater voice to certain elector groups, most notably the elderly (Vanhuysse, 2006). This shows of course that this liberty that elites can assume still must face the constraints of the society in which they operate. For instance, a major reason why so many countries show continuity is also related to public opinion, which remained consistently in favor or universalistic welfare measures after 1989 (Haggard and Kaufman, 2008: 310). Therefore, there are many factors which elites cannot themselves manipulate and therefore must work with.

A second perspective would view politicians as having a distinct type of policy preference, as an interest group competing with others. In this perspective, which is argued to be especially powerful in times of crisis, politicians are assumed to desire more control over spending by keeping a centralized control over funds and over salaries of physicians (Roberts 2009). In this perspective, their preferences would directly collide with that of physicians. This interaction forms the basis of the argument presented in this work. Actor preferences and their possibilities for action will be developed in chapter 4, specifically in sections 4.3 and 4.6.

A third perspective can look at the structure of parties and governments. Lipsmeyer (2002) explores pension change in ECE in the context of economic hardship and budgetary shortfalls. Her analysis reveals a distinct role of right parties in government in achieving pension reform. This approach too might prove deficient for the reasons stated above, namely the possible ideological inconsistency of parties which do not have traditional social bases. The role of parties is then likely to be different. Indeed, as argued above, there is a stronger case for institutional structures to shape behavior and possibilities of parties of passing reforms. If we consider the financial circumstances which these countries have faced then any government would be constrained to seek reforms. It would then depend more on the type of

government and the possibility of actors blocking the institutional process, whether policies could pass.

Another interesting perspective to be looked at is that of informal networks and practices. This approach has not yet been fully integrated into the research on welfare states. Despite this, especially in post-communist states which in theory present many legacies of this kind, such an analysis could prove valuable in understanding pressures for continuity and change. These practices can vary between leaving informal payments as a means of direct financing of doctors and nurses, to the power of clientelistic networks to influence policy outcomes. Concerning the first, these informal payments, a legacy of the communist period found throughout the region are a response to under financing of the system (Gaál et. al. 2010). Accordingly they can be viewed as a pressure for continuity as they allow the system to continue under low budget or simply low spending conditions. Moreover, certain groups of physicians might even prefer them to restructuring which in the best scenario would mean salary increases which would not reach the level of informal payments.

An even more interesting, and perhaps more elusive perspective is that of informal networks. There is a growing literature on the channels of interaction between citizens, bureaucrats and politicians which would suggest different models of interest aggregation and interaction (see Aasland et al 2012, Kitschelt 2000, Volintiru 2010). One of these, which might characterize the region is that of informal patron-client type relations. This is especially relevant for systems which require the distribution of funds, such as public services. While such a perspective is beyond the scope of this thesis, the analysis presented here can offer valuable insights into future areas of study regarding social services and informality.

2.4. Methodology

In order to answer the research questions posed, this thesis will employ a comparative historical analysis as its main method. In looking at developments in Romania and Hungary between 1989 and 2012, the variation between countries and across time will be used to explain reform processes. An informal model will be built regarding actor preferences and in depth process tracing will be used as a method of assessing those preferences. This method will allow the disentangling of complex interaction on the outcome of reforms. Indeed, as the literature discussion has pointed out, one of the major problems in this type of research is the untangling of complicated interactions of factors. By tracing the process of reforms across different periods and governments, the analysis will more convincingly separate the effect and autonomy of actors in the political process. Additionally, interviews will be used to strengthen the analysis.

While the cases of interest are countries, the unit of analysis is each government episode of Romania and Hungary, starting from 1990 until 2012, the last year where data is available for all key variables. Within each government episode, each instance of reform attempt will be considered. This will be the dependent variable of the study. More precisely only reform attempts which advance to the floor of the legislative will be considered. Of these, the study will be limited to those that qualify under Hall's second and third order changes, of changing policy instruments and paradigm shifts, and not first order changes of "satisficing, routinized decision making" (1993: 278).

As the discussion section in chapter 4 highlights, there were no third order reforms in either country across the period studied. However, the second order changes uncovered are further conceptualized in two categories as systemic and non-systemic changes. Second order systemic changes refer to reforms which change the instruments by changing the

organizational or financial structure of the health system. Such reforms include decentralization attempts, privatization attempts and the separation of the insurance fund from national budgets. These changes do not qualify under third order changes as although the change affects the entire system, it continues to operate under the same major principles of universal public provision and financing. Non-systemic changes refer to changing of instruments without affecting the entire system. Such change attempts include the introduction of a copayment or other alternative financing, expanding or retrenching benefit packages and creating legal frameworks for voluntary private insurance. The main source for the data used to operationalize this variable will be national legislative archives. The advantage of such a data source is that it allows to look both at successful and unsuccessful reforms - both of which this study seeks to explain. Moreover, detailed records allow for tracing the reform across time, governments and parliament discussions.

In choosing reforms as the operationalization of welfare state change, this study also addresses the "dependent variable problem" (see Green-Penderson, 2004; Makszin, 2013) of studies of welfare state change. Welfare state change can be understood in terms of inputs, outputs and outcomes. The selection of the type of measure needs to reflect the question raised. As I am interested in the effect of governments, I will be seeking a measure of change which can be connected as clearly as possible to policy-making.

The measure used most often is outcomes, usually in terms of expenditure, inequality measures or actual health outcomes of the population. This is also the most problematic as these measures, while influenced by government decisions and policy, are in fact highly dependent on many exogenous factors such as the state of the economy or individual characteristics such as education. Paul Pierson (1994) argues in favor of using this measure when he conceptualizes "retrenchment" as being not only active policy-making but also government inaction when external factors change policy outcomes. However, in doing so he

assumes not only knowledge on part of policy makers of these effects, but also that policy makers have the capacity to act and choose not to. This is important as conceptions such as "retrenchment" require intentionality on part of governments, which is impossible to prove by using outcome measures. Therefore, this measure would not be appropriate when trying to discern the effects of governments.

Another often used measure is that of outputs. This refers to the specifications of reforms and their implementation in terms of coverage, requirements or restrictions. The strength of this approach lies in its sensitivity to implementation. Hacker argues that the implementation part is where most changes take place, when he notices that changes in welfare follow the pattern of "reform without change and change without reform" (2004: 709). The limitations of this approach consist of its insensitivity to the political process and the extent of the reach of governments. Although compared to output measures, outcomes are closer to the control and responsibility of policy makers, they are also dependent on many exogenous factors such as the bureaucracy, technological or other limitations. Moreover, they are especially hard to quantify in the health sectors as often coverage and payment remain the same while the nature of the system can change and have wider reaching impact.

Therefore, for the purposes of this study, the most appropriate conceptualization of reforms is in terms of inputs. This refers to considering reforms in terms of legislative acts. These are the closest approximation to what can be considered direct effect of governments and social actors in political struggles over changes to the health care system. The obvious limitation of such an approach is that there can be a very large discrepancy between legislation and implementation. However, having examined qualitative reports on the systems (such as Chevreul et. al. 2012; Gal, 2012, Mihalyi, 2007 and Zaman, 2012), the only major discrepancies found were delays in implementation. Moreover, reforms which are under-

specified in terms of implementation are considered patch-style reforms and their adoption by non-stable governments in fact strengthens the argument presented.

Although the dependent variable is considered in the context of parliament deliberation, the *main independent* variable that assesses the structure of political actors consists of governments rather than parliaments. The main reason for this is that in both the parliamentary system of Hungary and the semi-presidential system of Romania, governments depend on parliamentary majorities. Moreover, in both cases it is governments that initiate legislative projects. Therefore, the main independent variable considered for the study is government stability. This conceptualization builds on Makszin (2013) which develops a measure of government coherence. The main difference is that stability does not include ideological proximity of parties. Rather, stability is understood as representing the degree to which governments are united as opposed to fragmented. This will be operationalized by considering legislative seats, the number of parties in the coalition and the nature of the government. A government is considered stable if it has majority in parliament, if there are four or fewer coalition partners and if the government is not a caretaker one. All other governments are considered non-stable. The first characteristic is most vital as minority governments have greatly impaired governing capacity as they can be voted out. The number of parties is expected to affect the reform process as negotiations are likely to weaken legislation while caretaker governments are usually not expected to pass any sort of reforms. The main data-sources used for this variable will be the Comparative Political Data Set III. The complete table of governments and their characteristics, is presented in Annex 1.

The second main independent variable used in this study is that of veto players. These are delimited into internal and external veto players. As chapter 4 will discuss in more detail, internal veto players are represented by the presence of physicians in the health ministry, which varies across countries and country years. External veto players represent other health

workers and actors outside the process. The data for internal veto players was obtained by consulting health ministry records in both countries, while the latter was obtained from other studies discussing episodes of social contention in the two countries (Mihalyi, 2012; Zaman, 2012).

Several control variables are used. These refer to the pressures for reform and continuity discussed in the literature evaluation. The main one is the balance of the health budget in each country, presented in Figure 3 in chapter 4. Institutional characteristics in terms of institutional veto points will also be considered. In this sense, Romania presents more institutional veto points as actors have more opportunities to block reforms in the dual chamber, semi-presidential regime. Data for these variables was obtained from Eurostat and national statistical offices.

The model employed considers the interactions between competing actors. Simply put, this refers to the interaction between different kinds of governments with internal and external veto players, within two countries with different veto points. The model is discussed and applied in chapter 4.

In order to strengthen the causal claims as well as supplement analysis, three interviews have been conducted. These are anonymous, unstructured interviews with a former Romanian health minister, a Romanian union leader of health workers and a Hungarian policy maker. The interviews with the two Romanian officials were carried out in Romanian. Translations of quoted fragments were done by the author. The interview with the Hungarian official was carried out in English. These were carried out because interviews offer a dimension of understanding that is not at reach through formal data and can accordingly strengthen the analysis. They are summarized in Table 2 below.

Table 2. Summary of Interview Details

Reference Title	Title of interviewee	Interviewer	Interview Type	Date	Location
Interviewee 1	Former Health Minister of Romania	Author	Tape Recording	08.04.2014	Bucharest, Romania
Interviewee 2	Union Leader, Romania	Author	Tape Recording	09.04.2014	Bucharest, Romania
Interviewee 3	Policy Maker, Hungary	Author	Written Recording	16.04.2014	Budapest, Hungary

The limitations of this research are quite straightforward. By analyzing only the health care system it does not attempt to offer a full explanation of social policy change. In this sense this research is based on the assumption that different social policies have different mechanisms through which they are achieved and therefore can be taken into separate explanations. Moreover by employing an in-depth small N study this research cannot infer past it's two countries to the wider region. However, it can offer valuable insight as to how to study the matter in these countries which do have common legacies and past experiences.

The main contribution of this research will be to add to the existing knowledge of East European Welfare states. It seeks to narrow the gap in our understanding of social policy implementation. It also seeks to contribute to existing literature by attempting to implement previous approaches to these new cases. Moreover, by looking at this often neglected policy dimension it also seeks to challenge these approaches that were usually applied to pension reform or employment protection.

3. Major Health Reforms in Romania and Hungary

This chapter will develop a descriptive understanding of the two health systems by mapping reforms since 1990. First I will look at the broad policy legacies and how they differed in the two countries. Secondly, I will consider the major policy reforms. Both countries had similar broad timing in implementing reforms. Therefore, I will look at three major waves of reform. Indeed, the fact that we observe similar periods of change hints towards Tuohy's (1999) understanding that change comes only within a "window of opportunity" which once passed limits change to follow initial changes. This also relates to what Cerami and Vanhuysse (2009: 7) called “critical realignments” in social policy. They develop the concept and hint at the possible circumstances which ignite them as being “significant changes in the power equilibrium between political elites and key welfare state actors, especially unions, peasants and popular political parties” (2006: 8). This is also similar to the "critical juncture" approach which emphasizes special periods when the constraints on policy reform are significantly relaxed (Capoccia and Kelemen, 2007). However, we must also understand the contingent factors which lead to these changes as well as the social factors which call for change.

3.1. Legacies of social policy

As mentioned, the two countries face similar broad policy legacies. This is to be found in the choice for a social insurance, Bismarckian type of health insurance system before the Second World War followed by a Soviet, Semashko model of universalistic state-central model (Inglot, 2008; Cerami and Stanescu, 2009).

The Bismarckian model was based on the insurance principle, emphasizing work-related accidents, where contributions were directed to a central fund from which provision was financed (Marree and Groeneweger, 1997). We will see a return to this broad model in both states after regime change.

By contrast, the model that followed, the soviet one, was characterized by a centralized state monopoly both on provision and finance. It was also characterized by strong paternalism which meant no patient choice. Provision was universal and financing was direct from the state budget. The main effects of such a system are characterized as being "defenselessness of patients, low quality of care, and sluggish scientific and technological development" but also "security, solidarity, and equality, albeit at an extremely low level" (Kornai and Eggleston, 2001: 139). I will show how problems of cost containment and performance from lack of competition put pressure for initial reforms.

These broad similarities being stated, defining differences become clear once we look more closely at the timing of these models, their completion and possible reforms they underwent before the regime change.

Hungary established its first health care law already in 1891 (ISSA, 2012) and continued to form it's system based on the Bismarckian model. The next step of the soviet model provided in addition to the previous one a centralized system of financing and delivery. It expanded coverage which was completed in the late 1970's (Inglot, 2008). What makes Hungary stand out from its neighbor is the fact that it had started making changes towards market economy from previous decades, giving it a head start. Accordingly, near the end of the regime it permitted technocratic rule (Tokes, 1996). As a result of this they already allowed a commission to bring forth policy proposals in 1987 which were followed to allow doctors to be paid per diagnosis and therefore in a way performance based. The same

commission was to provide proposals after 1989 (Roberts, 2009), a legacy which relates directly to bureaucratic strength. What is more, a Social Insurance Fund (SIF) was established in 1988 as a preliminary measure to separate these finances from the state budget (Mihalyi, 2012). However, entitlements remained linked to citizenship rather than contributions.

Romania also followed the establishment of a Bismarckian system in 1930 (ISSA, 2012) with soviet principles of centralization. Completion of coverage to include the peasantry was only achieved in 1960 and the system continued to lag behind and face increased pressures with economic downturn (Cerami and Stanescu, 2009). The deep crisis of the 1980's, coupled with the disastrous policies of Ceausescu meant a system tethering on the brink of collapse with a weak bureaucracy.

These systems thus presented several problems to be inherited after the regime change, namely the "absence of a regular inflationary adjustment of benefits, lack of transparency in social security financing, relaxed disability rules, severely skewed relations of benefits to earnings ... and a long history of instability in sickness insurance" (Inglot, 2008: 109). In terms of outcomes and policy reform these legacies set the stage for "semi-permanent emergency, excessive bureaucratization, and deep contradictions between the ambitious goals of the socioeconomic development and the actual day-to-day tasks of social policy" (Inglot 2008, 127). This "permanent emergency" can be seen both in political discourse and policy practice, and it shapes the main policy direction in both countries, namely cost containment.

What is most relevant for this study is the particular legacy of presence or absence of reforms and the continuity of the bureaucracy. While Hungary maintained the reforming bureaucracy there was nothing similar to speak of in Romania.

3.2. Early reforms

After 1989, among many challenges facing these countries was that of stabilizing health care. In doing so both moved forward by moving towards the past, namely reinstating the Bismarckian system of social insurance. This system maintained basic principles such as universalism and the change was far from radical privatization which was expected at the time. This indeed presents itself as the first puzzle of health care reform in Romania and Hungary, namely why under severe fiscal pressures and under international advice, they did not seek the policy of gradual privatization. Section 4.5 deals with this puzzle.

A second puzzle is to be found in the time difference of implementation of the reform of the two countries, considering their similar pressures. This is even more interesting as the pressures for Romania were even higher given the depth of the economic crisis that persisted well into the 1990's. This issue is discussed within the framework of this work in section 4.6.

The first major reform in Hungary was the Act LXV of 1990 on local government. The main feature of the law was decentralization, the ownership of hospitals and responsibility of provision being passed down to local authorities. Very few hospitals were privatized and for the most part the staff, nurses, doctors and other hospital workers remained salaried public servants. Decentralization brought more efficiency as it provided more incentives by local government to invest and improve facilities and services but it also resulted in cheating in invoicing, increased corruption, malpractice and the hiding financial problems, among others (Mihalyi, 2012: 176-178).

Between 1990 and 1992, the Social Insurance Fund managed both health and pension funds. It was then divided into the Health Insurance Fund (HIF) and a separate fund for pensions. From 1993 the HIF was put under the charge of the independent National Health Insurance Fund Administration (NHIFA) who had the task of pooling financial resources and

could contract state and private healthcare providers (Mihalyi, 2012: 177). Since it was a single fund this new system basically meant a monopsony operating with competing providers. It also meant mandatory membership and resulted in a large part of the population benefiting without payment: non-working spouses, children under 18 and pensioners, which at the time made up 62% of beneficiaries with only 38% contributing (Mihalyi, 2012). This would spell future problems that would amount to new pressures for reform.

Such an attempt at reform was that of 1995-1996 under the then socialist finance minister Lajos Brokros. The package of reforms named after him sought general retrenchment efforts on welfare state and more specifically an introduction of partial fees to health services. What followed was a backlash from the Constitutional Court, popular protests and divisions within the government. This spelt doom for the program which was not even introduced fully before being repealed. The Bokros package is an example of a policy attempted by a government without meaningful participation of trade unions or other social groups (Inglot, 2008: 291).

In Romania there was an initial continuation of the old system, centrally coordinated by the Ministry of Health through 41 districts. It was financed by the state budget and through external resources. This was done through the establishment of a special state fund for health through the Government Ordinance 22 of 1992 and through loans from the World Bank as well as other external funds and programs.

Actual reform of the system came only in 1997 through law nr. 95 of 1997. This established a similar system of compulsory insurance financed by contributions and government subsidies. A separate fund was created for this purpose, the National House for Health Insurance (NHHI). As in the case of Hungary, this was a return to the interwar Bismarckian system of insurance. The monopsony and universal coverage under tight

budgetary constraints meant similar problems and shortcomings for the Romanian system as well. New institutions were also created, such as the College of Physicians of Romania which regulates the profession of physicians. This was followed by the law on Local Public Finance in October 1998 which decentralized finance and provision of health care to local government (Haggard and Kaufman, 2006). However, the ownership of the hospitals remained in government hands, and their administration was appointed directly by the Minister of Health. Moreover, although partly decentralized, the NHHI fund remained in practice a single fund.

3.3. Second wave of reforms

A second wave of reforms in the two countries occurred during the mid-2000's. As the systems established in the 1990's had serious misgivings and even issues of sustainability, reforms for finance and coverage were needed. In Romania they were mostly sparked by the inconsistencies of the patch-style reform of 1997, while in Hungary, an early financial downturn beginning with 2005 ignited the reform process.

Hungary made minor reforms with attempts at major change resulting again in backlash. In 2006, the HIF was integrated into the central budget with administration still in the hands of the NHIFA and the Ministry of Health. The socialist-liberal coalition re-elected in 2006, represented the first government continuation in Hungary. Under fiscal pressure they first passed a small copayment (300 HUF equivalent to ~1 euro). Further negotiations resulted in a proposal for a mixed system with partial privatization of health-care insurance management funds which regulated competition among them. The HIF responsibilities were to be taken over by 22 non-profit sickness funds. A second step was conceived to privatize them. In this process, they had to acquire 500.000 customers or merge with bigger companies

which would ultimately result in 5-8 large private insurance companies (Mihalyi, 2012: 178-179).

There was great opposition to this plan from opposition MP's, to citizens, to the Hungarian Medical Chamber. The main opposition party initiated a referendum on the copayment which was passed with over 80% of support. In the aftermath, the socialist Prime Minister dismissed the liberal Health Minister, thus breaching the coalition pact (Chevreul et. al., 2011: 165). The coalition split, leaving MSzP as a minority cabinet, the single non-stable government in the Hungarian case. The insurance law, after initially being passed, was put to a vote for repeal in May, with all socialist MP's voting against it (Edelenyi, 2008).

In Romania, the socialist minority government - Nastase I, initially attempted many small law packages, most of which did not survive the legislative process. They did however, pass law nr. 212/2004, allowing for voluntary private insurance, above the public mandatory one. The following center-right coalition government - Tariceanu I passed law nr. 95 of 2006 which replaced the previous social insurance law. This act was more comprehensive, detailing and specifying many of the issues left open before. It detailed the provision of a minimum package of emergency services for those uninsured. It also provided greater autonomy for hospitals whose administration could decide on its own budget. Moreover, financing regulation was changed, allowing for a contract approach between hospitals and insurers. However, hospitals were still state owned, and the act further increased the power of the Health Ministry in relation to hospitals and the NHHI. More importantly, the act itself was incomplete as negotiations required many initial elements to be dropped. Issues such as instating a co-payment or decentralization were left in continuous debate, to be decided many years later (Zaman, 2012: 19).

3.4. Third wave of reforms

The global financial crisis started in 2008 had severe impacts on the budgets of Romania and Hungary. Its aftermaths presented ever increasing pressures on the system and therefore required new reforms.

In Hungary change was required due to accumulated strains on the budget which were coupled with the shock of the crisis. In 2009, contribution revenues made up to 70% of the public health budget supplemented with 25% through government transfers which changed to 49% and 46% respectively by 2011 (Mihaly, 2012: 181).

In 2010 Fidesz was elected with a strong majority. This allowed it to implement several drastic changes. The Ministry of Health was abolished after 59 years of existence and it's attributes were distributed. The constitution changed and removed references to the link between contribution and entitlements as the Constitutional Court had previously interfered with government plans. In this sense the government was eliminating possible "veto points" in the system. Responsibilities of local government were taken over with no compensation paid to the investments of local administrations. Moreover, all hospitals and polyclinics were taken over by the state. Therefore, the government again became "the owner, the manager, the fund provider, the financial controller, and the quality assurer of virtually all medical services" (Mihalyi, 2012: 180). It thus reversed almost all policy changes since the change of the regime, turning the Hungarian system into a mix of social insurance and single payer. A new plan, called the Semmelweis Plan was announced in October 2010 and accepted in June 2011. It established regions of care encompassing 1.2 mil people on average. Not only was this a reversal of all previous policy but it was a complete turn-around of the reform ideas of 2006-2008.

In Romania, the first government during the Great Recession was a grand coalition. It passed the 542/2009 Decentralization Law which was later implemented by the minority right-wing government after the coalition split. Major reforms were again delayed and proposals to instate a copayment from 2006 only passed in November 2011 when the parliament adopted the Law 220/2011. The major change in this law was the instatement of this limited copayment. A more contentious issue at the time was the general austerity package adopted by the government which slashed state employee salaries. Moreover, an attempted reform towards privatization of emergency services sparked immense protests which ultimately let do the government quitting and new elections being drawn (Ciutacu, 2012).

New reforms are under way in Romania with one of the most interesting developments being the first formation of a unified doctors association from the previously dispersed organizations.

An interesting aspect in Romania following the second wave of reforms was the growth of the private sectors. Private health developed rapidly was expected to reach EUR 1 billion in 2013. The most recent survey concluded that 20% of the population used in April 2011 private medical establishments. For 70% of them, a better quality of services represents the main reason for this option (Zaman, 2012). This represents another major difference in the Romanian system.

4. Explaining Reforms and Non-Reforms

This chapter will detail the explanatory model for both attempted and completed reforms in the area of financing and organization for the health systems. The major finding is that political instability and the number of veto points and actors shapes not only the chances for policy success, but also the nature and degree of the policy. This broad picture will be broken down in the following sections. The first one presents the theoretical models. The second presents the argument on a macro scale, followed by developing the micro argument - the interactions between policy makers and those within the system. The chapter concludes with a discussion of the findings.

4.1. The basic models

This thesis uses a form of the most similar systems design. Given the initial policy but also political similarities between the two countries, the similar bureaucratic structures, and the legacies and challenges, it would be expected that they present similar outcomes. The fact

Table 3. Characteristics of the Political Systems

Characteristic	Hungary	Romania
Decision-making Structure	Predominantly Veto-Free	Predominantly Veto-Ridden
Party System	Stable/Entrenched	Unstable/Changing
Cabinet-Formation	Predictable/According to Parliament Majority	Unpredictable/Tied with Presidential election
Structure of Medical System	Decentralized(from 1990-2010)	Centralized (Until 2010)
Outcome	Few large scale, usually successful reforms	Many patch-style reform attempts, few successes

Data on decision-making structure, party system and cabinet formation composed from Comparative Political Dataset III - See Appendix 1 and 2.

that they present both similar and dissimilar outcomes, suggests that there are certain differences. Table 3. highlights these differences and outcome in terms of types of policy-making. Section 4.3 details these differences.

The main goal of this research is to explain these large reform outcomes and their processes using a more detailed micro-level explanation of policy-making. In doing so, it is necessary to work down from broad models. One such model comes from Cerami and Vanhuysse (2009) and is reproduced in Figure 1.

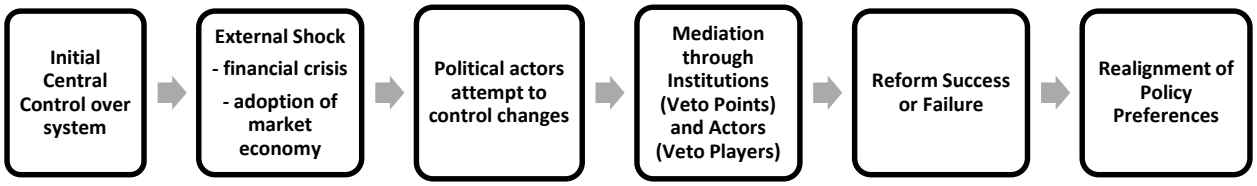
Figure 1. Cerami and Vanhuysse (2009) Model of Welfare State Change

In their framework, Cerami and Vanhuysse (2009) expect that in general, changes in the welfare state are initiated when outside pressure renders current institutions less compatible. This sparks the need for reform, which is mediated through the current ideas, shaped by the main actors' interests and filtered through political institutions. Policies are further constrained or enabled by socioeconomics, political conflicts and diffusion from other policy areas or from other countries. While their model does not explicitly state it, it rests on the fact that actors' preferences are shaped by the nature of the system at the initial time. In her analysis on Western European transitions to public health systems, Immergut's (1992) analysis starts from a status quo of private insurance. She attributes the resistance of physicians to change as indicative of their preference for private systems. However, evidence

suggests that their preference is for the status quo, whatever it may be - as section 4.3.2. will detail.

Accordingly, the initial system shapes actors' preferences which then get translated through institutions and into actual policies. As section 6.1. outlined, while Romania and Hungary had several differences at the beginning of transition, most notably the early reforms and peaceful transition in Hungary, in large terms they both started from underfinanced centrally controlled health systems. Accordingly, politicians, physicians and other social actors were likely to have similar interests at the initial time. These interests are likely to adapt to changes in the status quo, as the last box indicated. Considering this, an adapted version of Cerami and Vanhuysse's model is presented in Figure 2:

Figure 2. Adapted Model of Health Care Change



This model will be further detailed when applied in sections 4.5 and 4.6 Several changes are striking from the broad model. First is the specification of actors' preferences. Politicians, given their control and responsibility (and accountability) over the system will always seek stabilization of the system through various levels of reform. It can be expected that social actors will resist these attempts, and it is this interaction as played through institutions that will spell the success or failure of reforms. Moreover, once certain policies are passed, such as decentralization of hospital ownership, it is clear that actors' positions will change regarding further developments. Another important issue to notice is feedback

mechanisms. Namely, once the policy-making process is stabilized, policy preferences will also be shaped by known limitations, both political and socio-economical.

Table 1. on page 8 presents the model and expected outcome, given the two main explanatory variables: stability of the government, adapted from Makszin (2013), and the number of veto points and players, adapted from Immergut (1992). Once actors' preferences are discerned, their ability to carry them through depends on these two main factors, as presented in Table 1. on page 8.

This research looks both at long-term directions of change while looking to explain the micro processes that shape it. This broad model seeks to capture all important reforms in the two countries. The trade-off for such simplicity is the fact that it will not perfectly describe each case. The complexities of policy making being much broader, non-fitting cases will be individually discussed.

4.2. The big picture - political (in)stability

In the big picture, simply put, the single most important difference between the two systems is instability. When considering the long term coherence of the health systems, the instabilities present in Romanian decision-making appear to tell the most important story. From 1990 to 2012, Romania had 15 separate governments with an average tenure of 18.8 months, while Hungary only had 9 governments with a mean tenure of 31.7 months (Comparative Political Dataset III, 2013). More strikingly, Romania had a total of 23 health ministers with an average tenure of 12.1 months, while Hungary had only 12, with an average tenure of 23 months (Comparative Political Dataset III, 2013). Such a discontinuity of governments and health ministers in the case of Romania is the main culprit for delayed and

often incoherent decision making. This not only prevents policy continuity across ministers but impacts their policy strategy directly. As a former minister detailed, when he got into office, he knew that he likely had only months to implement his goals (Interviewee 1, 2014). It is no wonder that Romanian governments were better suited for small-scale changes to overcome immediate problems of financing, rather than introducing large-scale reorganizations. The Romanian health system even lacked multi-annual budgets. As the same former minister explained, he had to spend time bargaining with his own coalition partner in the Finance Ministry each year. This applies to other areas such as hospital organization. Therefore, Romanian ministers were more preoccupied with what Hall called "incrementalism, satisficing, routinized decision making" (1993: 279) of the system, rather than attempting larger changes. When these changes were attempted, due to the political incapacity of decision making, they were either small changes or incomplete reforms.

While not enjoying full political stability itself, Hungary exhibited more consistent patterns of government formation, and therefore political capacity, which allowed coherent policy change. With more political stability, they were better able to propose and implement more systemic reforms. However, the relative lack of veto players resulted in a different kind of instability as policy reversal also became easily possible.

The big story told here is that while given these particular systems, change is ignited by external shocks, it is internal politics that translate the need for change into actual policies. The actors' ability to enact such changes is limited by the government structure and institutions. However, the story of instability as presented above, is incomplete. Political actors do not operate in a void, and are not stopped by instability alone. Rather, instability gives other actors from outside or even inside the political system, the opportunity to influence policy making. The outcome is therefore based on their interaction. To understand

this interaction, it is necessary to understand the preferences of different actors and their ability to push those preferences through. It is to this process, that I now turn.

4.3. The political process of reforms

The big story presented in the previous section hides within its simplicity complex mechanisms which are the result of the interaction of competing actors. After all, even with immense instability, Romanian governments passed specific reforms when they had the chance. At times they made many reform attempts, while at others they made none. This hints to a more nuanced and complex picture to be uncovered at the actor level - a micro-logic of policy making.

The health system is quite peculiar when concerning the interested actors. As opposed to other social policy areas such as pensions or unemployment benefits, citizens tend to be less responsive to changes, due to the complex causal chain going from reforms, to their implementation and to personally felt outcome. Moreover, as systems that maintain broad coverage, minute or even large scale finance changes are not directly and immediately felt by consumers. Major reforms such as decentralization are likely to be felt less than minor changes such as the introduction of a 300 ft (1 euro) copayment. This is reflected by the fact that in both countries, social movements started from minute changes such as a small co-payment in the Hungarian case ("Hundreds of Protesters", 2008) or the firing of a popular minister in the Romanian one ("Solidary cu Arafat", 2012).

The most important actors in such a system are those whose livelihoods or careers depend directly on it. These are the political elites, physicians, and other health workers. While citizens do not feel every extra leu or forint in the system, every leu or forint spent is

one earned by a health worker, and lost from the state or fund budget. Indeed, as a former Romanian minister explained, "the reason why the system is hard to reform is simply because it engages with so many actors, just the hospitals (in Romania) employing over 220 000 doctors, assistants, nurses and other staff" (Interviewee 1, 2014). These actors have strong incentives to try and influence decision-making. On the other side, political elites depend on the well functioning of the system for their political careers. Moreover, the decisions regarding the health system are not only meant to stabilize it, but also to assure their decision-making power for future problems.

The interaction of the two actors shapes not only policy adoption but also policy proposals. Policies are attempted - reaching the floor of the legislative, when there are no inside veto players. They are subsequently passed if the political majority manages to overcome external veto players.

4.3.1 Political actor preferences

After 1989, both Romanian and Hungarian politicians saw themselves in charge of a system they had little control over. Ministers, cabinet members, and supporting MP's, were faced with a system nearing bankruptcy, the declining health of the population, and little political will from their colleagues, caused by and coupled with other more pressing economic difficulties. In Romania, until recently, health reform was never a platform issue for any major political party, neither of which has had a coherent health care strategy. Indeed, the health ministry was often delegated to physicians within the party or to junior coalition partners. In Hungary, more pressing economic problems took precedence in the 1990s. In both countries, it was not until the mid-to-late 2000's that health care became very politicized.

Nevertheless, governments had concrete interests in dealing with the initial health system crisis. Soaring budget deficits continued to be a concern, especially important during economic hardship. Solutions therefore had to be found to make the system more efficient. However, as outlined in section 4.5, many options were off the table. Privatization was not an option due both to public opinion and political interest. As Immergut (1992) argues, politicians can better control costs through public financing and provision while seeming to maintain or improve benefits. A different set of incentives also makes politicians in these two countries prefer state, as opposed to market control. In both countries, public services are also a means of gaining political influence. This happens through clientelistic networks which characterize countries such as Romania and Hungary (Kitchelt, 2000; Volintiru, 2010). As a former Romanian health minister revealed, he had the discretion of appointing all major hospital administrators, who were then under his influence (Interviewee 1, 2014). A Hungarian policy-maker echoed this view when he talked about how this discretion in the Hungarian system meant that administrators were changed with the governing party, which they knew they had to support in order to get funds (Interviewee 3, 2014). The political incentives for capturing the bureaucracy give politicians in both countries distinct incentives to maintain control over the system.

Politicians therefore have what may be seen in a sense as conflicting interests. On the one hand, they prefer public control of financing and provision in terms of systemic structure, while preferring retrenchment of benefits and raising dues in administration. This is not as puzzling when considering their overall goal of cost-containment, to which this appears the easiest solution. These two preferences are themselves constrained by two factors. Control over costs comes at the cost of increased responsibility and therefore possible public reproach (Hacker, 2004: 703). This can, and was, ameliorated by diffusing responsibility through creating an insurance fund separate from the ministry and state budget and through handing

hospital administration to local authorities. Concerning administrative reform, any retrenchment attempt can be met with harsh public reactions, which is why politicians have an incentive to create what Pierson (1994: 19-22) called "obfuscated" changes. Therefore, minute (first order) changes in the system were achieved through government ordinances, which did not have to pass through the legislative decision making process.

In line with the above, when crisis hits, politicians attempt to stabilize the system within the bounds of public provision and financing, yet attempting more minute change. The characteristics of the political system shape their freedom to act, where a stable system would allow them to attempt more systemic changes. This is done in competition with physicians and other actors, to which I now turn.

4.3.2 Physician preferences and tools

It is a peculiarity of East-European countries, and within them a peculiarity of the health system, that the practitioners in the system tend to also be present during policy making. While most health ministers have been doctors, the same is not true for education or other ministries. The general high social prestige that doctors have in these countries might be part of explaining this phenomenon. Another might be the high status of doctors within their own community and their perception as legitimate actors of change. Yet another might be connected with the power-politics relating to clientelism, with doctors possibly acting as mediators between political actors and public servants. The reason is unclear, and it is outside of the scope of this thesis. What is important is the main consequence of this, namely that the interests and incentives of these individuals affect policy making from within as well as from without.

Two major hypotheses emerge from major works regarding the preferences of physicians. The most prevalent and well emphasized one is explained by Immergut (1992), as well as Roberts (2009), who emphasized doctors' preference for private systems which optimize their salary with the fee-for-service payment method, and their autonomy by giving them control over their practice and their time. This seems quite plausible considering the immediate goals of physicians. However, it is subject to two limitations. Firstly, such an option might not exist, as I will argue in section 4.5. Secondly, the questionable implementation of any new system might leave them at a disadvantage. For example, as a union leader argued, the reason they feared decentralization of hospital property was because they thought that some of the property would be taken over through corrupt practices (Interviewee 2, 2014). Uncertainty plays a big role in how actors negotiate in weak political and bureaucratic systems.

The second main perspective is exemplified by Gingrich (2011). She emphasizes that entrenched actors will always benefit more from the system in place. While this might seem to be a sweeping generalization at first, it is supported by both the theoretical arguments and empirical evidence in the health systems of the two countries. In theory, entrenched networks and practices at least appear more appealing to the actors within a system than an uncertain new system. This can be seen as a particularized version of the path dependence argument (Pierson, 2000), where physicians have increasing returns in a familiar system with entrenched networks. In practical terms, in Romania, none of the systemic changes were carried out during physician tenures in the health ministry. In Hungary, more far reaching reforms were attempted during tenures of economists or other non-involved health specialists. In both countries, reforms aimed at privatization of either the insurance system (Tóth and Neumann, 2008) or hospital ownership ("Descentralizarea", 2010) were met with harsh criticisms and opposition from professional associations of physicians.

A vital distinction to make here, which perhaps for reasons of simplicity no author does, is which doctors have power within the system. The most influential physicians, those with the highest salaries and positions in hospitals, holding chairs in professional associations but also in parliament and sometimes at the head of the ministry, will likely have different interests than the rest. Since they are the most influential, it is likely that their policy preferences will be most closely observed. These are the same individuals that are most likely to benefit from the current system and therefore resist any major changes to it.

A further feature to be emphasized is that physicians in political positions have more constraints than other types of actors. Simply put, they are part of networks of peers who can exert pressure on them. Given the short tenure of health ministers or of political positions in general, they are likely to not attempt many changes, and even to resist possible changes. In this sense, they act as internal veto players in the process.

More interestingly, yet harder to discern, influential physicians are likely to also benefit more from informal payments than they would otherwise in a more transparent, institutionalized system. While it makes great intuitive and theoretical sense, this point is difficult to prove, yet there are studies that show that senior medics and especially surgeons receive the bulk of informal payments (Farcasanu, 2010; Ungureanu et. al., 2010, Chevreul et al., 2010). This point was also highlighted by a health policy-maker when attempting to explain the resistance of physicians towards policies that would seem to benefit them (Interviewee 3, 2014). The answer here would be that the influential decision-makers are already benefiting more from non-taxed informal income.

This would also explain another puzzling element. While physicians are part of professional associations, they do not join unions that could enable them to bargain collectively or voice preferences. A connected reason is the great salary dispersion between

health workers, with senior physicians receiving the bulk of payments. In Romania, only a couple of hundred physicians are part of the largest health workers' union, Sanitas, while over 100 000 medical assistants - who are more wage sensitive and have tighter wages - are part of it. This is also in line with the fact that the recent mass exodus of health workers from both countries concerns most prominently medical assistants and recent graduates. These are the individuals most vulnerable in the current system, with the lowest salaries and most difficult working conditions. In Hirchmanian terms this leads to a vicious cycle where those most likely to want to reform the system are the ones who most quickly leave a declining system, a scenario when the increased exit options undermine voice in the system (Hirschman, 1970: 51).

This leaves physicians without proper unions and therefore no bargaining, lobby power or organized protest power. However, their strength comes from their direct political involvement. In Romania, 15 of the 23 health ministers were physicians, while in Hungary the number is 10 out of 12. Moreover, in the Romanian Parliament they average around 50 MP seats in the lower chamber. They therefore have entrenched power to influence the system.

4.3.3 Other actors

The other main actors in the system are the other health workers. Theory, interviews, and empirics suggest that they have quite limited influence. In terms of preferences, while physicians are more interested in the systemic structure, other health employees are more interested in direct financing measures, budgets, salaries and jobs. However, their possibilities for achieving these goals are quite limited. One of the leaders of the largest Romanian health workers union complained that they are rarely consulted and almost never

listened to, more specifically none of their hundreds of proposed amendments to the ongoing Health Law (45/2006) were put forward (Interviewee 2, 2014). He continued by stating that they have no legal framework for lobbying, for which they could be prosecuted. Moreover, he complained that the judicial system was also too cumbersome to achieve change. Their final tool is protest and disruption, which can have varying degrees of success. In Hungary, a well executed campaign reversed privatization measures in 2008 (Edelenyi, 2008) while in Romania, four-month long protests returned a reform package ("Sanitas Suspenda Greva", 2013). However, protests did not prevent a 25% across the board budget cut in Romania in 2010 ("Legile Privind Reducerea cu 25%...", 2010).

4.4. Major systemic differences

Before moving on to the major reforms, this section will develop on the differences in the key explanatory variables between the two countries, namely: government stability, veto points, and veto players.

The first three are linked in the case of Romania and can be traced to the choice of political system. The semi-presidential system of Romania combines parliamentary oversight of the cabinet with a separate election of the President. Moreover, the President decides on the nomination for the Prime Minister, who then forms the cabinet which must be approved by Parliament. What this means in practice is that the party that obtains the presidency has the upper hand to shift parliamentary coalitions, despite not having won a majority. Combined with the highly fragmented nature of the party system, this has led to Romania having only 6 stable governments out of 15, over the period studied (mostly due to the minority status of the governments), compared to Hungary's 8 out of 9. It is also the cause for the large government instability. It was the case in the 1996 and 2004 (both right

governments) elections that the party that won the presidency had fewer seats won than the opposing coalition yet still managed to make a minority government. This was possible by gaining the support of MP's of national minorities and independents. In effect these cabinets were minority cabinets. Although the party that won the presidency in 1992 and 2000 also won the highest vote share in the elections, opposition parties together still gathered more seats yet a minority government was formed in these cases as well. Only in 1990 was a clear majority won, while in 2008 a grand coalition was formed. This contrasts starkly with Hungary's clear system of cabinet formation, although this led in the Hungarian case twice to the formation of the seemingly incompatible coalition of socialists and liberals.

One similar characteristic, that is expressed in different ways, is the dominance of the executive in both systems. While in both, parliament can technically dissolve the government, in Hungary this is prevented by having parliamentary majority; while in Romania it is prevented by the presidential nomination mechanism. In Romania, executive dominance is strengthened by the use and abuse of Emergency Ordinances which take the form of legislative acts. In fact, many of the reforms considered were legislative proposals to formalize governmental emergency ordinances.

Romania also has more veto points than its neighbor. Besides the separate election of the president, which in Hungary is done by parliament, Romania also has a dual chamber legislative. This was especially problematic in passing the first comprehensive reform bill which took 3 years to reach the second house, in 1997. Commissions and amendments in both chambers complicate and stall the process.

4.5. Explaining lack of reforms

Over the studied period, lack of reform appeared to be in fact the norm. These non-reform outcomes can be broken down into episodes that lacked legislative initiatives altogether and episodes where initiatives failed. This logic can also be applied across reform types in order to understand why certain types of reforms were not even attempted.

In Nelson's (1993) framework, reforms were attempted when external pressure hit the system, and they were successful when reformers were insulated from opponents and there was diffuse public support. What this framework adds is the importance of veto players. Accordingly, reforms are attempted when external pressure hits and there are no internal veto players. They are successful when outside veto players are defeated.

Given the ample possibilities in both systems for actors to block or prevent initiatives, it is no wonder that in the Hungarian case only 5 out of 9 governments managed to attempt and to succeed in passing reforms and in the Romanian case 10 out of 15 governments attempted with only 6 governments succeeding at passing reforms. The next section will discuss those attempts.

It is also important to consider why certain types of reforms were not attempted. Easier to explain is the lack of comprehensive expansionary reforms. The economic hardships faced by both countries over most of the period of study, coupled with the shortage of funds in the health system, meant very few opportunities to comprehensively expand eligibility and basic services. Another type of reforms that was not attempted was comprehensive privatization of provision and insurance - one exception being the 2008 Hungarian Insurance Reform, which was later repealed due to the same reasons that make these reforms difficult to put forward. At first, privatization would seem to be a viable solution to all involved parties. Politicians would no longer face budget problems if insurance

was taken over by the private sector and investment in hospitals was done by private actors, and health workers could expect higher salaries that could not be kept artificially low by governments.

Several reasons conspired to take comprehensive privatization efforts off of the reform table. First of all, as previous chapters have shown, a vast majority of the population in the two countries preferred public systems. These societal norms and expectations were one important limit to policy making. The second important limit is political capacity and credibility. Roland argues that political actors need to have "credibility of transfers" (2002: 33) in order for those affected by reforms to be supportive. What this means in practice is that involved actors need to believe that the government can implement reforms in a transparent way that is also advantageous to those actors. In the Romanian case, the union leader explained how governments had lost credibility due to deferring promises and delaying agreed pacts, while also fearing corruption in implementation of reforms (Interviewee 2, 2014). This lack of credibility is coupled with general uncertainty in new systems and thus makes big steps towards privatization much more unlikely.

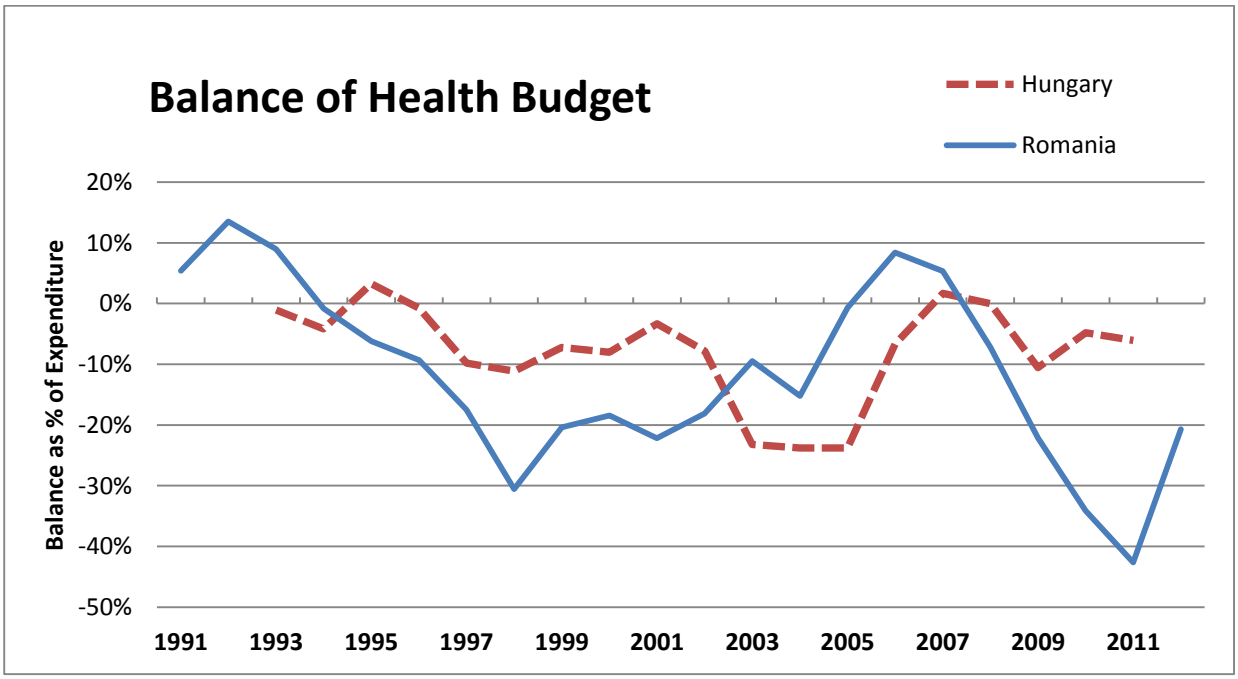
4.6. Explaining reform episodes

This section will apply the above developed framework to the major legislative changes in the systems of the two countries. The major reform episodes this work has uncovered are in the case of Romania: the 45/1997 Health Insurance law, the 43/2006 Health Law and the 542/2009 Decentralization Act. In the case of Hungary, these are: the X/1990 Social Security Benefits Act, the LXV/1990 Local Government Act, the 2008 Health Insurance Act, and the CLIV 2011 also known as the Semmelweis Plan. The main similarities to be explained are the common choices for social insurance and decentralization, while the

main differences to be explained are the Romanian delay in implementing both social insurance and decentralization, the stalling of the reform process with the 43/2006 Health Law in Romania, the rejection of the 2008 Health Insurance Act in Hungary, and the policy reversal in Hungary in the form of the Semmelweiss Plan. Other non-systemic changes and proposals are included in the model.

In accordance with the initial framework, Figure 3. highlights that changes were attempted during periods of great financial troubles for the system. The numbers show the balance of the health budgets as a proportion of total health spending. The numbers were personally computed in this way in order to make them comparable, as the Romanian data changed its formula in 2005. In the Hungarian case, the deficit represents the amount spent over the Health Insurance Fund's budget, that was covered by the government. In the Romanian case, until 1997 it represents the amount spent over the total allocated sum that was further provided by the government. After 1997 it represents, as in the Hungarian case, the percentage that had to be covered by the government directly.

Figure 3. Balance of Health Budget as % of total Health Expenditure



As can be seen, the major Romanian reforms were ignited by the budget crisis in the late 1990's (which was partly due to the financial crisis at the time), and the 2009 financial crisis that put similar strains on the budget. In the Hungarian case, the initial transition phase prompted the initial measures. The economic downturn and the increasing HIF budget deficit in the early 2000's ignited the 2006-2008 wave of reforms, while the most recent wave was ignited by the financial crisis of 2008-2009. However, economic downturns or health budget deficits do not create reforms by themselves. The inconsistencies and time lags across countries and country years highlight the importance of political factors.

As Table 4 shows, in the Romanian case, despite enormous fiscal pressures, reform was not achieved before 1997 mainly due to the combination of non-stable governments and the presence of physicians in the health ministry and parliament, the first acting as internal and the latter as external veto players. The 1997 Insurance Law was passed under a Liberal Minister during a non-stable right-wing government. The seemingly non-fitting case is the complete lack of reform or attempt at reform during the first two (non-caretaker) post-communist governments, both of which were stable and ideologically coherent. Given the presence of veto players, the model would have expected a non-system change for stabilization. The presence of physicians within the ministry can explain the lack of even an attempt (putting forward a legislative proposal) of passing reforms. Physicians, who preferred direct state financing, which they could influence, to financing from a fund, which they could not, used their internal veto power to prevent the initiation of proposals. More importantly, while technically stable, both governments were short lived, the Roman III government having a six month tenure, and the Stolojan I Government having a 13 month tenure. This was due not to unstable parliamentary majority but to factions within the party itself caused by and coupled with the general political turmoil during the early 1990's, characterized by protests and political violence.

Table 4. Romanian Health Reforms

Romania	Presence of Veto Players	Absence of Veto Players
Stable Government	*Non-System Change for Stabilization:* NA	*System Change for Stabilization:* **542/2009** Decentralization Act
Non-stable Government	*No Reform/Rejected Proposals:* No attempts prior to 1994 Proposal 215/1994 Proposal 527/2000 Proposals701,239,206,315,654/2000-2004 Proposal 372/2003 Proposal 386/2005 Proposal 62/2008	*Patch-Style Reforms*: **145/1997** Health Insurance Law **212/2004** Private Insurance Law **43/2006** Health Law **220/2011** Copayment Law

The Decentralization Act of 2009 was the only one passed under a stable, albeit non-coherent grand coalition. As such, it was the only full reform passed quickly and fully implemented. This can be considered as a system type change, where in order to stabilize finances, hospitals and later financing was decentralized to local authorities which were responsible for nominating leadership positions, for investment and the running of the system. The other two major reform cases were both stalled, incomplete reforms. While the 145/1997 insurance reform took three years to pass and a further two to implement, the 2006 Health Reform took only months to pass, yet it has still not been fully implemented. Moreover, these pieces of legislation were continuously amended by further governments, the 2006 Law gathering hundreds of article amendments. The 2004 Private Insurance Law is also a patch-style reform as it simply creates the legal framework for extra voluntary insurance outside the system. The 2011 Copayment Law is also a patch-style reform since it is firstly far from comprehensive, and secondly as the 2006 Law it is still not fully implemented.

The many failed legislative attempts in the Romanian case are also in line with expectations. They are the result of having few or no insider veto points while having many outside ones. What this means is that most of them were initiated under non-physician ministers that were part of non-stable government. These ministers and their cabinets attempted reforms which could then not make it though the legislative political process. The Romanian case also exhibits learning effects. Actors within the system are aware of the political, institutional and electoral limitations of reforms. Therefore, the incomplete reforms and the patch-style acts were not simply a result of amendments, but were rather created as such to be able to pass.

The Hungarian story differs markedly. Stable governments, of which the most important characteristic was having parliamentary majority, in Hungary were coupled with increased party discipline and fewer veto points. Therefore, most reforms were comprehensive and systemic. Both of the acts of 1990 which market the return to a Bismarckian social insurance system and the turn to decentralization were passed quickly under a coherent government with little internal or external opposition. The 1995 and 2006 reforms went towards retrenchment, in the first case cutting benefits, excluding certain services and including a transfer payment, while the second introduced a co-payment and cut some services from the minimum package. The veto players in both cases were external societal actors (including health workers) that resisted change.

The 2008 comprehensive MSzP-SzDSz plan aimed at reorganization and privatization was, on the other hand, repealed after initially being passed. Vehement opposition from social actors as well as opposition parties ended that reform episode. Fidesz, once it had reached power in 2010 adopted an opposite tactic to SzDSz, opting first to centralize power and remove veto points before attempting reforms. By removing constitutional provisions and centralizing power on the one hand (Mihaly, 2012), and abolishing the health ministry, on the

other, they managed to remove the few veto points and players remaining in the system. As a result, they managed to easily pass the single policy reversal of all the studied governments. This is perhaps part of the explanation of why this reversal was possible. Their choice of recentralization of the administration made immediate sense from a cost-containment perspective

Table 5. Hungarian Health Reforms

Hungary	Presence of Veto Players	Absence of Veto Players
Stable Government	*Non-System Change for Stabilization:* **XLVIII/1995** Stabilization Act **CXV/2006** Health Reform Act	*System Change for Stabilization:* **X/1990** Social Security Act **LXV/1990** Local Government **XCVI/1993** Voluntary Insurance Act **I/2008** Health Insurance Act **CLIV/2010** Health Law
Non-stable Government	*No Reform:* NA	*Patch-Style Reforms*: NA

As Table 5 further shows, there were no reform attempts in Hungary which were rejected (the 2008 Health Insurance Act passed parliamentary vote and was only later repealed through the same parliamentary procedure). This is mainly due to the fact that most Hungarian governments were stable. In fact, as the parliamentary records show, Hungarian governments average an overall over 90% bill adoption rate. Moreover, in accordance with expectations, the single non-stable Hungarian government did not attempt any reforms. However, this was most likely also due to the fact that is was considered a caretaker minority government which would have had no legitimacy to attempt reforms, especially considering that it came after the socialists had lost the reform battle.

The interesting case in the Hungarian story is that of the I/2008 Health Insurance reform by the MSzP-SzDSz coalition. While it was expected that the coalition could pass its unpopular reform, two puzzles remain to be explained. Firstly, it is unexpected for the coalition to go against its immediate political interests and pursue on the one hand an unpopular policy, and on the other, one that would limit its own further maneuverability for action to contain costs. Part of the explanation is provided by Makszin (2013), who categorized the MSzP-SzDSz coalition as un-coherent, due to the ideological inconsistencies between the two parties. In this case, as well as others she studied, policy was delegated to independent technocrats. Indeed, a reform committee was established, which was composed mainly of financial and health managerial experts. This explains both the liberal-technocratic nature of the proposed reforms but also the lack of political constraints. In Nelson's (1993) terms, this is a form of policy making by isolating the reformers, thus removing ex-ante constraints. This also helps to understand the second puzzle, of policy repeal. By isolating the reformers from social actors, the coalition removed ex-ante constraints but increased the ex-post constraints as the opposition and social actors desired reversal. In fact, the same policy expert noted that they wanted to push reforms fast because they were expecting reversal attempts (Interviewee 3, 2014).

The issue of ideological coherence remains an open question. In the Romanian case it is clear that it plays no role as a grand coalition managed to pass reforms while others did not. Even in the MSzP-SzDSz case it is not clear as a discussion with a member of the committee revealed that the differences between the two parties were not so much ideological but immediately political in terms of who should bear the costs for reform (Interviewee 3, 2014).

4.7. Discussion

What this chapter has first highlighted is the importance of long-term political stability. Without continuity in government (and the health ministry), there is little chance for comprehensive stable reforms in health policy. High political instability has led not only to periods of no reform for Romanian governments, but when reforms were attempted, they were incomplete. Higher stability allowed Hungarian governments to pass more comprehensive reforms, yet coupled with a relative lack of veto points, this also led to policy instability in terms of policy reversal. In both countries, reforms were not determined by sheer pressures alone, rather these pressures were mediated through political factors, as expected with hypothesis one.

In the short-term perspective, each episode of reform, or lack thereof, can be explained by the interaction of political and medical elites as mediated through institutional veto points - the possibilities for opponents to block reforms through lengthy policy-making procedures - and political veto points - the possibility of preventing attempts or blocking reforms from non-stable governments. This is in line with the expectations of the second hypothesis stated in the second chapter. The number of veto points in a system also shapes the type of reform. In systems with many veto points, such as the Romanian one, political actors propose less comprehensive and more compromise-oriented reforms. However, even in the Hungarian case, comprehensive and contentious reforms were also weakened by the process. The 2008 Insurance reform wanted 100% privately owned insurance initially but the reformers were forced to accept a compromise of 49% private and 51% state owned shares in the new proposed (but never implemented) regional insurance funds (Interviewee 3, 2014).

In terms of reforms, the empirical data on proposals and laws has revealed no attempt at third-order changes - a paradigm shift, completely discontinuing previous practices (Hall,

1993: 279). Not even the turn to the social insurance model can be viewed in these terms as it maintained the basic long-standing principles of public provision and coverage of the entire population. Viewed on this dimension, Inglot's (2008) argument of surprising policy continuity even across political regimes, due to path dependence, find evidence here as well.

Changes are however located at lower levels. While this work has focused on second-order changes, it has also distinguished system oriented reforms from non-system ones. Both of these qualify as a changing of instruments, being distinguished by whether the reform affects the organization of the system or not. In fact, as was noted, non-systemic changes were often more contentious due to the fact that they were more immediately felt by those involved.

Another interesting finding present in this chapter is that there were almost no clear reforms that could be considered expansive. This is in line with the overall argument of the thesis that cost-containment within a public system is the main goal of political elites. It appears that Pierson's argument that welfare states have entered a period of "permanent austerity" (1998: 550), due to fiscal pressure, stand for Eastern Europe as well. This gives support to argument presented here as opposed to the explanation on partisan effects. Accordingly, in line with hypothesis three, it is not the color of governments that gives the direction of reforms but rather its composition. This is also in line with Immergut's explanation that class theories cannot tell us which policies are adopted, but only the moments when they are discussed (1992: 17). It is unclear whether even the latter part of the statement remains valid in the case of Romania and Hungary.

Another important issue uncovered mostly through discussions with officials, is the importance of informal practices and networks. While informal payments to physicians might have influenced their preference for the status quo, political elites' control over civil servants

likely influenced their preference for maintenance of public delivery systems. As the Romanian union leader emphatically highlighted, corruption and informality goes very deep: "I tell you, politics is the cancer of the Romanian health system, because even the cleaning lady needs to have a party ID if she wants to have a job" (Interviewee 2, 2014). The importance of these networks suggests a promising area of study, in combining the study of welfare states with that of good governance.

5. Conclusion

This work set out to understand the political factors which shape welfare state reforms. It doing so, it focused on the health care sectors of Hungary and Romania for the period 1990-2012. Important legislative proposals and health laws were analyzed in order to discern the effects of governments and social actors. By specifying actors' preferences, an informal model was created to understand the interaction between politicians and health workers, and the ways in which this shapes health reforms. Several control variables were used: the number of veto points in the system, health spending and fiscal pressure.

The main finding is that political stability determines the chances of policy success. This happens because non-stable governments cannot push through reform in the face of both internal and external veto players. Government composition moreover affects the nature of the reform as reforms themselves are shaped in such a way as to survive the political process by being compromise-oriented and therefore less substantive. More specifically, non-stable governments were more likely to attempt non-systemic reforms.

Furthermore, the nature of the reforms was shaped more by the interests of political elites - to contain costs - than by their stated political color. Besides emphasizing the importance of government composition, a further theoretical contribution of this work was in developing a more accurate model of actor preferences within the health system. In terms of methodology, the main contribution was in developing a means to look more directly at change, by looking at policy proposals rather than outputs or outcomes. This work also contributed empirically by considering two understudied cases on a specific policy dimension.

The main limitations present are spatial and temporal. By only looking at a short period, by policy standards, larger trends in the two health care systems were not fully

considered. Moreover, given the similarity in context of the two cases, it is not clear how far the findings can travel. Lastly, by looking only at policy inputs, this work cannot address the mechanisms which shape policy implementation or policy results.

These being said, Romania and Hungary share a set of features with many other understudied polities, for which this approach can potentially be useful. It can be argued that in fact most countries share Romania and Hungary's lack of transparency, the phenomenon of political bureaucratic capture, as well as non-programmatic linkages between citizens and politicians, to varying degrees. Accordingly, the mechanisms emphasized here can potentially travel to other such countries. The findings of this work suggest that governance is related to social policy not only at the level of implementation and outcomes, but also at the level of policy making. Accordingly, policy makers are likely to consider their influence through informal networks when designing policy. Likewise, social actors such as physicians are likely to consider their benefits from a non-transparent system when opposing or supporting reforms. More research is needed in this area as it is clear that these factors can have an enormous impact on social policy.

6. Bibliography

Aasland, Aadne, Åse Berit Grødeland, and Heiko Pleines. 2012. "Trust and Informal Practice Among Elites in East Central Europe, South East Europe and the West Balkans." *Europe-Asia Studies* 64 (1) (January): 115–143.

Armingeon, K., Romana Careja, Laura Knöpfel, David Weisstanner, Sarah Engler, Pana-jotis Potolidis, Marlène Gerber. 2013. "Comparative Political Data Set III 1990-2011". Bern: Institute of Political Science, University of Berne.

Bonoli, G. 2001. "Political Institutions, Veto Points, and the Process of Welfare State Adaptation". in Pierson, Paul (ed). 2001. "The New Politics of the Welfare State." Oxford University Press. Oxford.

——— 2007. "Time Matters: Postindustrialisation, New Social Risks, and Welfare State Adaptation in Advanced Industrial Democracies", *Comparative Political Studies*, 40(5): 495-520.

Briggs, Assa. 1961., 'The Welfare State in Historical Perspective', *Archives Européennes de Sociologie*, II, 221-58

Capoccia, G. and Kelemen, R. D. 2007. "The Study of Critical Junctures: Theory, Narrative, and Counterfactuals in Historical Institutionalism", *World Politics*, 59(3): 341-369.

Cerami, A. and Stanescu, Simona. 2009. "Bulgaria and Romania" in Cerami, A. and Pieter Vanhuysse (eds). 2009. "Post-communist welfare pathways : theorizing social policy transformations in Central and Eastern Europe". New York : Palgrave Macmillan.

Cerami, A. and Pieter Vanhuysse (eds). 2009. "Post-communist welfare pathways : theorizing social policy transformations in Central and Eastern Europe". New York : Palgrave Macmillan.

Chevreul, K., Durand-Zaleski, I., Bahrami, S., Hernández-Quevedo, C., & Mladovsky, P. 2011. Health system review. *Health Systems Transition*, *12*(6), 1–291.

Ciutacu, C. 2012. "Cabinet resigns as social partners oppose austerity measures" EIRO Report available at http://www.eurofound.europa.eu/eiro/2012/02/articles/ro1202029i.htm

Constantinescu, M. 2013. "S-a format coalitia profesionistior din sanatate". 18.07.2013. Pagina Medicala available at http://www.paginamedicala.ro/stiri-medicale/S-a-format-Coalitia-profesionistilor-din-sanatate.-Proteste-in-strada_-din-septembrie_19011/

Crowley, Stephen. 2004. "Explaining Labor Weakness in Post-communist Europe: Historical Legacies and Comparative Perspective." *East European Politics & Societies* 18 (3): 394– 429.

"Descentralizarea, o incercare de a transfera responsabilitatea". 2010. Agerpres. 02.07.2010 Retrieved from http://www.agerpres.ro/sanatate/2010/07/02/vasile-astarastoae-descentralizarea-o-incercare-de-a-transfera-responsabilitatea-18-12-39 last accessed on 10.12.2013

Dobbin, F, Simmons and Garret, G. 2007. "The Global Diffusion of public Policiers: Social Construction, Coercion, Competition or Learning". *American Review of Sociology. 33.*

Edelényi *M.* (2008). Government performs unexpected U-turn on health reform bill. EIRO Report available at http://www.eurofound.europa.eu/eiro/2008/06/articles/hu0806029i.htm

Enyedi, Zsolt. 2005. "The Role of Agency in Cleavage Formation." *European Journal of Political Research* 44 (5): 697–720.

Esping-Andersen, Gosta. 1993. "The three worlds of welfare capitalism", Cambridge, UK : Polity Press, 1993, c1990

Estevez-Abe, M., Torben Iversen, and David Soskice. 2001. "Social Protection and the Formation of Skills: A Reinterpretation of the Welfare State. In: Peter Hall and David Soskice. "Varieties of Capitalism. The Institutional Foundations of Comparative Advantages". Oxford, Oxford University.

Farcasanu, D. O. 2010. Population perception on corruption, informal payments and introduction of co-payments in the public health system in Romania. *Management*, *14*(1), 8–13.

Finseraas, H., & Vernby, K. 2011. "What parties are and what parties do: partisanship and welfare state reform in an era of austerity". *Socio-Economic Review*, *9*(4), 613–638. doi:10.1093/ser/mwr003

Gál, R. I. 2012. Annual National Report 2012. Retrieved from http://www.socialprotection.eu/files_db/1239/asisp_ANR12_Hungary.pdf

Gehlbach, S., & Malesky, E. J. 2010. The contribution of veto players to economic reform. *The Journal of Politics*, *72*(04), 957–975.

Gingrich, J. R. 2011. "Making markets in the welfare state: the politics of varying market reforms". Cambridge ; New York: Cambridge University Press.

Gourevitch, P. 1986. *Politics* in Hard Times. Comparative Responses to International Economic Crises. Ithaca & London: *Cornell University Press*.

Green-Penderson, Christoffer. 2004. "The Dependent Variable Problem Within the Study of Welfare State Retrenchment". Journal of Comparative Political Analysis: Research and Practice 6 (1): 3.

Hacker, J. S. 2004. Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform. *British Journal of Political Science*, *34*(4), 693–724. doi:10.1017/S0007123404000250

Hacker, Björn. 2009. "Hybridization Instead of Clustering: Transformation Processes of Welfare Policies in Central and Eastern Europe." *Social Policy & Administration* 43 (2) (April): 152–169.

Haggard, Stephan and Robert R. Kaufman. 2008. "Development, democracy, and welfare states: Latin America, East Asia, and Eastern Europe". Princeton, N.J. : Princeton University Press.

Hall, P. 1993. Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain. *Comparative Politics*, *25*(3), pp. 275–296.

Hall, P. and David Soskice. 2001. "Varieties of Capitalism. The Institutional Foundations of Comparative Advantages". Oxford, Oxford University Press.

Häusermann, Silja 2010. "The politics of welfare state reform in continental Europe : modernization in hard times", Cambridge : Cambridge University Press.

Hirschman, A. O. 1970. "Exit, Voice, and Loyalty. Responses to Decline in Firms, Organizations", and States. Cambridge: Harvard University Press

"Hundreds of Hungarian protesters clash with police" 2008. USA Today. Retrieved from http://usatoday30.usatoday.com/news/world/2008-03-15-hungary-protests_N.htm last accessed 08.12.2013

Immergut, E. M. 1992. "Health politics: interests and institutions in Western Europe". Cambridge [England]: Cambridge University Press.

Inglot, Tamasz 2008. "Welfare states in East Central Europe, 1919-2004", New York: Cambridge University Press.

International Social Security Association (ISSA) 2012 data. Available at http://www.issa.int/Observatory/Social-Security-Observatory. Last accessed on 10.04.2013

Iversen, T. 2001. "The Dynamics of Welfare State Expansion: Trade Openness, De-industrialisation, and Partisan Politics", in Pierson, P. (ed.) *The New Politics of the Welfare State*, Oxford: Oxford University Press.

Jacoby, Walter 2006: "Inspiration, Coalition and substitution. External influenced on Post-Communist Transformation". *World Politics 58 (July 2006)*

Kitschelt, H. 2000. "Linkages Between Citizens and Politicians in Democratic Polities." *Comparative Political Studies* 33 (6-7) (September 1): 845–879.

Kornai, János. 1994. "Transformational Recession: The Main Causes". Journal of Comparative Economics 19, 39-63.

Kornai, János and Karen Eggleston. 2001. "Choice and Solidarity: The Health Sector in Eastern Europe and Proposals for Reform". International Journal of Health Care Finance and Economics, Vol. 1, No. 1 (Mar., 2001),pp. 59-84

Korpi, Walter. 2006. "Power Resources and Employer Centered Approaches in Explanations of Welfare States and Varieties of Capitalism. Protagonists, Consenters, and Antagonists". *World Politics* 58.2 (2006)

Legile privind reducerea cu 25% a salariilor bugetarilor şi recalcularea pensiilor, publicate în MO. 2010. Mediafax. 30.06.2010. Retrieved from http://www.mediafax.ro/politic/legile-privind-reducerea-cu-25-a-salariilor-bugetarilor-si-recalcularea-pensiilor-publicate-in-mo-6465980 last accessed on 10.12.2013

Lipsmeyer, Christine S. 2002. "Parties and Policy: Evaluating Economic and Partisan Influences on Welfare Policy Spending During the European Post-Communist Transition." *British Journal of Political Science* 32 (04) (September 17): 641–661. doi:10.1017/S0007123402000261.

———. 2003. "Welfare and the Discriminating Public: Evaluating Entitlement Attitudes in Post- Communist Europe." *Policy Studies Journal* 31 (4): 545–564.

Machiavelli, N. 1988 (1532). "The Prince". Cambridge: Cambridge University Press.

Makszin, Kristin. 2013. "Reforming East Central European Welfare States: Governments, Technocrats, and the Patterns of Quiet Retrenchment," PhD dissertation, Central European University.

Marrée, J., & Groenewegen, P. P. 1997. "Back to Bismarck : Eastern European health care systems in transition". Aldershot, Hants, England: Brookfield, Vt. : Avebury,.

Mihalyi, P. (Ed.). 2007. "Health insurance reform in Hungary". Budapest: EUROPE Ltd.

——— 2012. "Spending cuts and centralization in Hungarian healthcare as a response to the international financial crisis". *International Journal of Healthcare Management*, *5*(3), 173–186. doi:10.1179/2047970012Z.00000000025

National Institute of Statistics, Hungary. Accessible at http://www.ksh.hu/?lang=en, last accessed on 05.03.2014

National Institute of Statistics, Romania. Accessible at http://www.insse.ro/cms/, last accessed on 05.03.2014

Nelson, J. M. 1993. The politics of economic transformation: Is third world experience relevant in Eastern Europe? *World Politics*, *45*(03), 433–463.

Offe, Claus .1991. "Capitalism by Democratic Design? Democratic Theory Facing the Triple Transformation in East Central Europe", *Social Research*, 58(4), 865–92.

Pierson, C. 1994. *Beyond the welfare state? : the new political economy of welfare / Christopher Pierson*. Cambridge, England : Polity Press.

Pierson, P. 1994. *Dismantling the welfare state? : Reagan, Thatcher, and the politics of retrenchment / Paul Pierson*. Cambridge : Cambridge University Press.

——— 1998. "Irresistible forces, immovable objects: post-industrial welfare states confront permanent austerity". *Journal of European Public Policy*, *5*(4), 539–560.

——— 2000. "Increasing returns, path dependence, and the study of politics". *American Political Science Review*, 251–267.
——— 2000a 'Three Worlds of Welfare State Research', *Comparative Political Studies*, 33(6- 7): 791-821.
———. (ed). 2001. "The New Politics of the Welfare State." Oxford University Press. Oxford.
Roberts, A. 2009. "The Politics of Healthcare Reform in Postcommunist Europe: The Importance of Access". *Journal of Public Policy*, *29*(03), 305. doi:10.1017/S0143814X09990110
Roland, G. 2002. "The political economy of transition". *The Journal of Economic Perspectives*, *16*(1), 29–50.
Sanitas suspendă greva generală. Guvernul a aprobat deblocarea posturilor din sănătate şi plata dublă pentru munca în weekend a personalului medical. 2013. Alba 24. 27.11.2013. Retrieved from http://alba24.ro/sanitas-suspenda-greva-generala-guvernul-a-aprobat- deblocarea-posturilor-din-sanatate-si-plata-dubla-pentru-munca-in-weekend-a- personalului-medical-253144.html last accessed 10.12.2013
Schmitter, Philippe. 1974. "Still the Century of Corporatism?" *The Review of Politics*, Vol. 36, No. 1,(Jan.), pp. 85-131.
Schwartz, Herman. 2001. "Round Up the Usual Suspects! Globalization, Domestic Politics and Welfare State Change" in Pierson, Paul (ed). 2001. "The New Politics of the Welfare State." Oxford University Press. Oxford.
Skocpol, Theda. 1995. "Social Policy in the United States". Princeton, NJ: Princeton University Press, pp. 136-167
"Solidari cu Raed Arafat. Mai mulţi bucureşteni au protestat faţă de noua lege a sănătăţii" 2012. Antena 3. 11.01.2012 Retrieved from http://www.antena3.ro/romania/solidari-cu-raed-arafatmai-multi-bucuresteni-au-protestat-fata-de-noua-lege-a-sanatatii-150989.html last accessed 08.12.2013
Sotiropoulos, Dimitri A., Ileana Neamtu, and Maya Stoyanova. 2003. "The Trajectory of Post-communist Welfare State Development: The Cases of Bulgaria and Romania." *Social Policy & Administration* 37 (6): 656–673.
Stallings, B. 1992 "International Influence on Economic Policy: Debt, Stabilization and Structural Reform." In Haggard, S. and Kaufman, R. R. eds., *The Politics of Economic Adjustment: International Constraints, Distributive Conflicts, and the State*. Princeton: Princeton University Press: 41-88.
Swank, D. 2001. "Political Institutions and Welfare State Restructuring". in Pierson, Paul (ed). 2001. "The New Politics of the Welfare State." Oxford University Press. Oxford.
——— 2010. "Globalization", in Castles, F. G., Leibfried, S., Lewis, J., Obinger, H. and Pierson, C. (eds.) *The Oxford Handbook of the Welfare State*, Oxford: Oxford University Press.
Tavits, M., & Letki, N. 2009. "When Left Is Right: Party Ideology and Policy in Post-Communist Europe". *American Political Science Review*, *103*(04), 555. doi:10.1017/S0003055409990220
Tóth A. and Neumann L. 2008 "Health insurance bill passed despite nationwide protest strikes". EIRO Report available at http://www.eurofound.europa.eu/eiro/2008/02/articles/hu0802029i.htm
Tökés, R. L. 1996. "Hungary's Negotiated Revolution: Economic Reform, Social Change and Political Succession" (Vol. 101). Cambridge University Press.
Tuohy, C. H. 2011. "American Health Reform in Comparative Perspective: Big Bang, Blueprint, or Mosaic"? *Journal of Health Politics, Policy and Law*, *36*(3), 571–576. doi:10.1215/03616878-1271279

Ungureanu, M. I., Litan, C. M., Rus, I. A., & Chereche S, R. M. 2010. "A brief insight into the study of informal health care payments in Romania. Retrieved from http://rtsa.ro/en/files/tras-39E-2013-13ungureanu,%20litan,%20rus,%20chereches.pdf

Vanhuysse, Pieter. 2006. "Divide and pacify : strategic social policies and political protests in post-communist democracies". Budapest, Hungary : Central European University Press.

Volintiru, Clara. 2010. "Clientelism and Democratic Accountability." In *Political Studies Association Graduate Network Conference*.

World Bank Data Repository, 2014. Available at http://data.worldbank.org/indicator/SP.POP.DPND last accessed on 22.01.2014

World Health Organization Data Repository 2013. Available at http://apps.who.int/gho/data/view.main. Last accessed on 10.04.2013

Zaman, C. 2012. Annual National Report 2012. *Romania*. Retrieved from http://www.socialprotection.eu/files_db/1283/asisp_ANR12_ROMANIA.pdf

A. Appendix 1: Summary of Romanian Government Characteristics

Table 6. Summary of Romanian Government Characteristics

Government	Parties	Period	Government Type	Stability	Coherence*	Health Minister
Roman I	FSN	Dec 89 - Jun 90	Caretaker	Non-stable	-	(FSN)Dr. D. Enachescu
Roman II (1990)**	FSN	Jun 90 - Apr 91	Single Party Majority	Stable	High	(FSN)Dr. B. Marinescu
Roman III	FSN	Apr 91 - Oct 91	Single Party Majority	Stable	High	(FSN)Dr. B. Marinescu
Stolojan I	FSN, PNL, Ecologists, PDAR	Oct 91 - Nov 92	Surplus Coalition	Stable	Low	(IND)Dr. M. Maiorescu
Vacaroiu I (1992)	FDSN/PDSR + PUNR	Nov 92 - Dec 96	Minority, Multi Party	Non-stable	Low	(PDSR)Dr. I. Mincu/ Dr. D. Bartos
Ciorbea I (1996)	PNTCD+PNL+PD+UDMR+PSDR	Dec 96 - Apr 98	Minority, Single Party	Non-stable	Low	(PNL) Dr. S. Dragulescu/(IND) Dr. I. Bruckner
Vasile I	PNT+PNL+PD+UDMR+PSDR	Apr 98 - Dec 99	Minority, Multi Party	Non-stable	Low	(UDMR) F. Baranyi, G. Hajdu
Isarescu I	PNT+PNL+PD+UDMR	Dec 99 - Dec 00	Surplus Coalition	Stable	High	(UDMR) G. Hajdu
Nastase I (2000)	PSD+PUR	Dec 00 - Dec 04	Minority, Single Party	Non-stable	Low	(PSD) Dr. D. Bartos/Dr. M. Beurean/I. Blanculescu/O. Branzan
Tariceanu I (2004)	PNL+PD+UDMR+PUR+PC	Dec 04 - Apr 07	Minority, Multi Party	Non-stable	Low	(PNL) Dr. M. Cinteza/E. Nicolaescu
Tariceanu II	PNL+UDMR	Apr 07 - Dec 08	Minority, Multi Party	Non-stable	Low	(PNL) E. Nicolaescu
Boc I (2008)	PDL+PSD	Dec 08 - Dec 09	Minimal Coalition	Stable	Low	(PSD) Dr. I. Bazac/M. Videanu
Boc II	PDL+UDMR	Dec 09 - Feb 12	Minority, Multi Party	Non-stable	Low	(UDMR) A. Cseke/Dr. L. Ritli
Ungureanu I	PDL+UDMR+UNPR	Feb 12 - May 12	Minority, Multi Party	Non-stable	Low	(UDMR) Dr. L. Ritli
Ponta I (2012)	PSD+PC+PNL	May 12 - Dec 12	Surplus Coalition	Stable	Low	(IND) Dr. V. Cepoi/(PSD) V. Ponta + (IND) Dr. R. Arafat

Source: Comparative Political Dataset III, National Archives

*Coherence was coded with the criteria of Makszin (2014)**The years in brackets represent election years.

B. Appendix 2: Summary of Hungarian Government Characteristics

Table 7. Summary of Hungarian Government Characteristics

Government	Parties	Period	Government Type	Stability	Coherence*	Health Minister(s)
Antal (1990)**	MDF, KDNP, FKgP	May 90 - Dec 93	Surplus Coalition	Stable	High	(KDNP) Dr. László S.
Boross	MDF, KDNP, FKgP	Dec 93 - Jul 94	Surplus Coalition	Stable	High	(KDNP) Dr László S.
Horn (1994)	MSZP - SZDSZ	Jul 94 - Jul 98	Surplus Coalition	Stable	Low	(MSZP)Dr. Kovacs P. / Szabo/Dr. Kokeny
Orban I (1998)	Fidesz+MDF+FKGP	Jul 98 - May 02	Minimal Winning Coalition	Stable	High	(Fidesz) P. Harrach
Medgyessy (2002)	MSZP - SZDSZ	May 02 - Sep 04	Minimal Winning Coalition	Stable	Low	(MSZP) Dr. Csehák J.
Gyurcsány I	MSZP - SZDSZ	Sep 04 - Jun 06	Minimal Winning Coalition	Stable	Low	(IND) Dr. Jenő Rácz
Gyurcsány II (2006)	MSZP - SZDSZ	Jun 06 - Apr 09	Minimal Winning Coalition	Stable	Low	(SZDSZ) Dr. L. Molnar/Dr. Horváth Á./ (Ind)T. Székely
Bajnaj	MSZP	Apr 09 - May 10	Minority, Single Party	Non-stable	-	(IND) Dr. Tamas Szekely
Orban II	Fidesz+KDNP	May 10 - May 14	Single Party Majority	Stable	High	(IND) DR. M. Réthelyi+ (Fidesz) Z. Balog

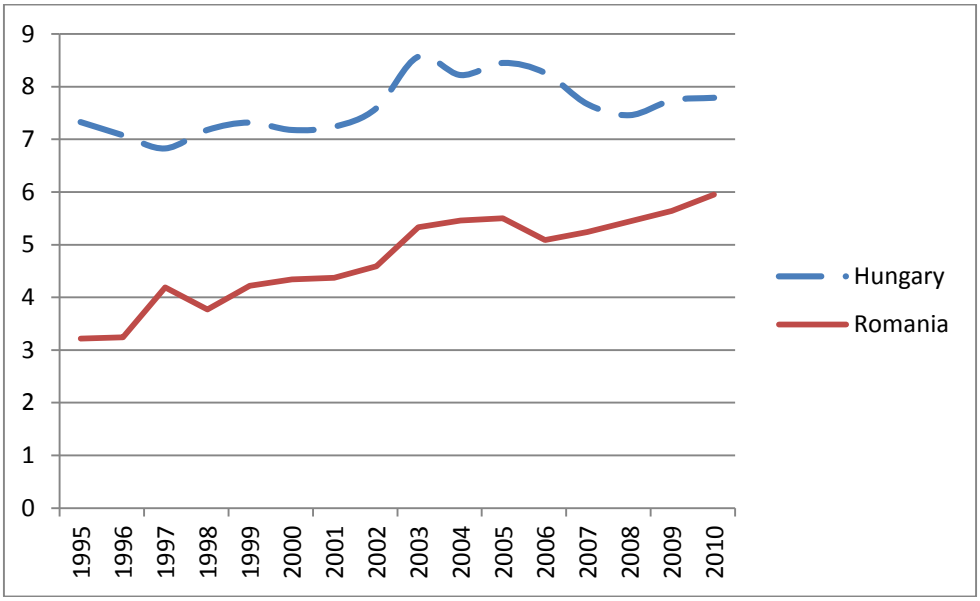
Source: Comparative Political Dataset III, National Archives
*Coherence was coded with the criteria of Makszin (2014)**The years in brackets represent election years.

Both the Romanian and Hungarian data on government type, period in office, and parties, was obtained from the Comparative Political Dataset III. Data regarding health ministers and their political affiliation were obtained from national parliamentary archives and individual websites of the ministries.

C. Appendix 3: Summary of Health Expenditure and Other Data

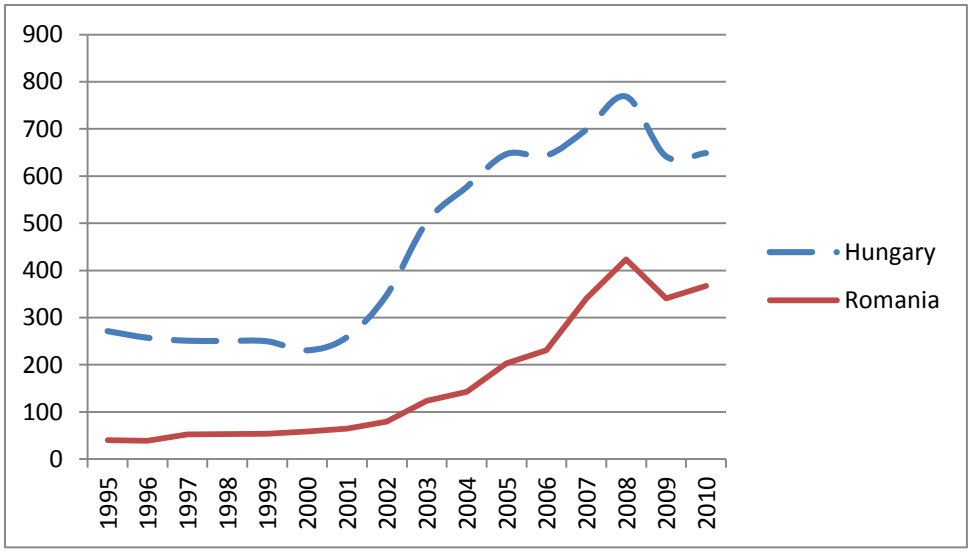
Figure 4 represents health expenditure in the two countries, as a proportion of GDP. Figure 5 represents per capita health expenditure in 2011 $.

Figure 4. Health Expenditure as % of GDP



Source: World Health Organization, 2013

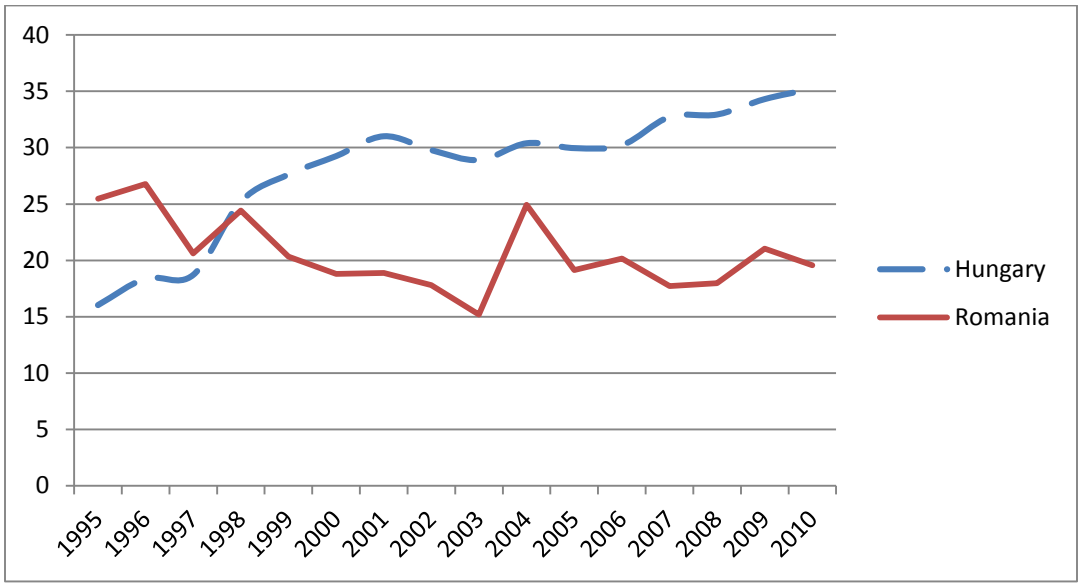
Figure 5. Per Capita Health Expenditure



Source: World Health Organization, 2013

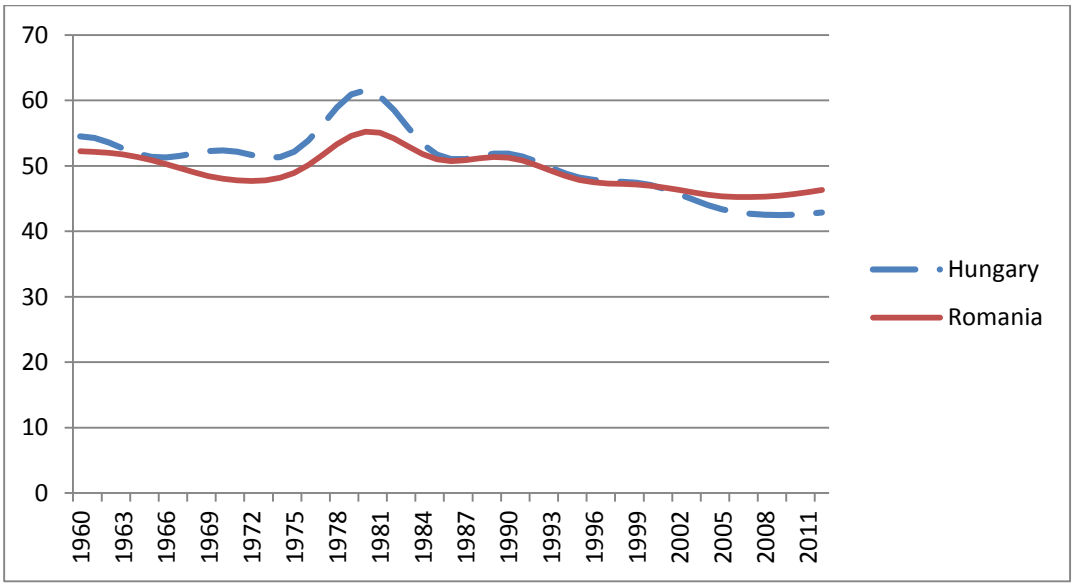
Figure 6 shows all sources of private expenditure (private insurance, out of pocket payment etc) as a proportion to total health spending. Figure 7 shows the ratio of dependents, those not contributing to the insurance systems, to the working-age population, namely those ages 15-64. Data are shown as the proportion of dependents per 100 working-age population.

Figure 6. Private expenditure as % of all expenditure



Source: World Health Organization, 2013

Figure 7. Ratio of Dependents as % of Contributors in Insurance Budgets



Source: World Bank Data Repository, 2013