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THE ROLE OF IDEAS IN WELFARE REFORMS IN CENTRAL-EASTERN EUROPE

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IN CENTRAL-EASTERN EUROPE**

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The underlying idea is that implementing forms of “civilized” politics is desirable as well as feasible. And, as far as the Italian political system is concerned, it is also urgently needed, since the system appears to be poorly prepared to deal with the challenges emerging in many policy areas: from welfare state reform to the governance of immigration, from the selection criteria in education and in public administration to the regulation of ethically sensitive issues.

In order to achieve this end, LPF adopts both a descriptive-explanatory approach and a normative one, aiming at a fruitful and meaningful combination of the two perspectives. Wishing to foster an informed public debate, it promotes theoretical research, empirical case studies, policy analyses and policy proposals.

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Welfare Policy, Reform,
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ABSTRACT

**THE ROLE OF IDEAS IN WELFARE REFORMS
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In the 2000s, in two Central Eastern European (CEE) countries - Slovakia and Hungary - governments proposed plans for welfare reforms that entailed radical shift from a state- to a market-oriented healthcare system. This paper focuses on the following question: Why did the governments in the two countries propose these reforms when support for the state-run healthcare in these two post-communist countries is still high? The paper shows that the healthcare policy reforms of the two Central Eastern European countries cannot be explained by the dominant accounts of policy change that assign key role to the characteristics of the government, such as its political orientation. Instead, the paper argues that the emergence of market-oriented reforms in the two countries is best explained by neoliberal ideas that strongly influenced government healthcare agenda. The neoliberal ideas built upon belief in the superiority of the market over the state and strongly influenced the CEE governments' plans for healthcare reforms offering solutions for two core policy problems - the healthcare sector-specific deficits and the increased pressures for budgetary control in the context of Europeanization.

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1. INTRODUCTION

Hungary and Slovakia, two Central Eastern European (CEE) countries, proposed strikingly similar plans for healthcare reforms in the 2000s. These plans were radical and market-oriented, as they implied substantial changes to the existing public healthcare systems, including privatization and commercialization of public hospitals, introduction of competition in the health insurance sector and privatization of healthcare costs through user fees and co-payments for a large range of medical services. This turn toward privatization and marketization of healthcare is puzzling since in both countries, similar to other countries in the CEE region, public opinion strongly supported the state role in the healthcare sector (Lipsmeyer 2003; Lipsmeyer and Nordstrom 2003; Wendt et al. 2009). This paper analyzes these reforms by addressing the following question: what explains these rather radical and unpopular plans for market-oriented health reforms in the two CEE countries?

According to the dominant approaches in the literature on policy change, political orientation of the government explains its policy choices. However, the two CEE cases show that strikingly similar market-oriented reforms were pursued by governments of different political orientation: right-wing in Slovakia and left-wing in Hungary. In this paper, I argue that rather than by the political orientation, the emergence of the market-oriented healthcare reforms is best explained by the influence of neoliberal ideas. The neoliberal ideas that built upon belief in the superiority of market over state strongly influenced government plans for healthcare reforms as they offered solutions for two core policy problems - healthcare sector-specific deficits and the increased pressures for budgetary control in the context of Europeanization.

From a theoretical point of view, the paper contributes to the literature on policy change by analyzing the influence of ideas on policymaking process and also by investigating under which conditions ideas are able to influence policymaking process. Analyzing the two CEE cases, the paper shows that neoliberal ideas shaped healthcare reform as they provided both a diagnosis of existing problems and suggested solutions, but also emphasizes the important role of context specific factors - actual deficiencies of the healthcare system and pressures generated by

Europeanization - that facilitated ideational influence on policy change. Empirically, the paper contributes to the development of a still relatively under-researched topic of welfare reforms in post-communist countries.

The two CEE countries represent excellent cases for the probing of the ideational argument given that the same policy ideas about the role of market in healthcare were present, despite the different government orientations in the two countries. Therefore, the paper uses the most different systems design (Przeworski and Teune 1970; Della Porta and Keating 2008) as its methodological approach. In terms of research technique, it relies on process tracing (George and Bennett 2005) in order to describe how neoliberal ideas become dominant in policymaking circles and how they influenced concrete policy initiatives.

The paper is structured as follows. The next section focuses on the theoretical framework and the key argument of the paper. The third section provides a comparative analysis of the two cases. The fourth and final section summarizes the paper's main findings and suggests directions for future research.

2. EXPLAINING POLICY REFORMS

2.1. *The dominant approach: partisan politics*

The literature on policy change considers governments as key players in policymaking process. Given that the governments are not only in charge of proposing and drafting new legislation, but also of passing the latter in parliament and implementation in practice, they are seen as main actors responsible for both inputs and outputs of the policymaking process. In the comparative welfare state analysis, this government-centered approach translates into the understanding that the variation (or similarity) in government's characteristics would be key explanatory factor for variations (or similarity) in social policy reforms across countries. One of these characteristics, emphasized by the traditional partisan politics approach (see e.g. Tufte 1980; Castles 1982), is the political orientation of the government. Put simply, the partisan politics approach argues that since policymaking is motivated along political party lines, left-wing governments foster policies with more expansive welfare programs and strong role of the state, while governments of right-wing orientation favor programs of welfare retrenchment and market-oriented welfare provision (see also e.g. Hicks 1999; Allan and Scruggs 2004; Iversen and Cusack 2000).

Explanations focused on partisanship as key determinant of policy reforms have been originally coined and tested on welfare policy change in the Western European countries (e.g. Hicks 1999; Iversen and Cusack 2000; Huber and Stephens 2001). However, more recent studies on social policy in the post-communist context suggest that these types of explanations are equally successful in explaining welfare policy change in the post-communist Eastern Europe. Careja and Emmenegger (2009), for example, found that like in the West, the political composition of governments in the East has very robust effect on welfare expenditure,

since left-wing governments are associated with high levels of social spending (see also Schmidt 2012). Jahn and Müller-Rommel (2010) similarly found a positive correlation between the left-oriented government in Eastern Europe and spending for social policy programs. Tavits and Letki (2009), in contrast, found that while government orientation matters, there is a rather inverse pattern of its influence on policy in the East compared to the West. They show that the Eastern European left-wing parties, when in government, pursue policies of fiscal responsibility, including limiting spending for sectors such as health and education, while right-wing parties spend more in order to alleviate economic hardship.

If partisan explanations successfully travel to the East, in either identical or reverse form, as suggested by Tavits and Letki, one would expect them to explain the two cases of CEE healthcare reforms. Yet, this is not the case. The expectation that government's political orientation would be important factor driving policy change fails the empirical test since, as we show later, similar healthcare reforms in the two countries were pursued by governments of different orientation - left-wing in Hungary and right-wing in Slovakia. Given that the two governments were so different, why did they pursue similar healthcare reforms?

This paper argues that the emergence of market-oriented healthcare reforms on the agenda of CEE governments cannot be explained by partisanship, but rather by the influence of neo-liberal ideas on governments' policy choices. Neo-liberal ideas had independent causal influence on policy choices as in both countries governments acceptance of these ideas went against the public preference for the state role in healthcare sector, and even, as shown by the Hungarian case, against the expectations based on government's own political orientation (see Larson and Goul Andersen 2009). The paper also argues that, while the neoliberal ideas had a key role in shaping governments' healthcare policy choices, the capacity of these ideas to influence policy making was dependent on two important contextual factors: i) specific deficiencies of the healthcare system; ii) the accession of the two countries to the European Union (EU) and its institutions. The next section provides the theoretical framework of the ideational approach and further elaborates this core argument of the paper.

2.2. The argument: ideas

Ideational approaches to policymaking assume that one of the key tasks of the government is figuring out how to solve social problems. According to Hecló (1974), government affairs are not only about power but also about puzzle. "Politics", argues Hecló, "finds its sources not only in power but also in uncertainty – men collectively wondering what to do [...] Policymaking is a form of collective puzzlement on society's behalf." (ibid. 305-6). Assuming that the policymaking process implies puzzling about collective problems, ideas take the central stage in this process as tools that offer solutions to policy problems (Campbell 2002; see also Hall 1993; Hay 2001; Schmidt 2008; Mehta 2013). Programmatic ideas are one type of ideas that drive policy change by providing solutions to policy problems

(see Berman 1998; Campbell 2002; Schmidt 2008). They are defined as programmatic beliefs that supply guidelines for practical activity and formulation of solutions for everyday problems (Berman 1998). Programmatic ideas shape policy not only because they are practical, but also because they are systematic in that they offer not only problem definitions, but also analytical tools, norms and principles that allow identification of the policy problem and help elaborate strategies of response (Schmidt 2008).

As practical and systematic solutions to policy problems, programmatic ideas shape policymaking performing two important functions. First, they provide '*diagnosis*' of the policy problem (Schmidt 2008; Larsen and Goul Andersen 2009; Béland and Cox 2011). Ideas are capable of providing diagnosis of problems because, in their essence, they are beliefs, products of cognition that draw upon specific principles and assume causal connections between different phenomena, such as for example a connection between government spending and economic growth (see Béland 2005; Béland and Cox 2011). By creating beliefs about causes and effects in the case of specific policy issues, ideas help policymakers to identify policy problems and provide a common understanding of their causes (see Larsen and Goul Andersen 2009). As causal beliefs, however, ideas do not only diagnose problems, they also suggest '*therapies*' i.e. offer guidance for policy action by providing both specific content for policy reform and legitimacy to new policies. Ideas provide content for reforms by offering blueprints for the design of new policies and institutions. This makes them particularly attractive tool for policymakers who are expected to make decisions under time constraints and therefore prone to draw upon already available blueprints and developed reform proposals (see Blyth 2001, 2002; see also Weyland 2008). While providing content, ideas also grant *legitimacy* to policy change. They legitimize proposals for new institutional or policy setting by diminishing legitimacy of the principles at the basis of existing policies and institutions, which they diagnosed as the source of the problem at the first place (see Hall 1989, 1993; 1993; Blyth 2001, 2002; Berman 2013). This delegitimization implies interpretation of existing policies and institutions as not capable of solving policy problems of the day and therefore as obsolete. This helps new ideas dismantle the authority of beliefs and principles underlying the existing institutions and policies and replace it with the authority of their own beliefs that are to be used as a basis for the new institutional or policy setup (see Hall 1993).

The theoretical framework that accounts for ideas' influence on policy change is particularly helpful in explaining the radical market-oriented plans for healthcare reform in the CEE context. In both Slovakia and Hungary, neoliberal ideas profoundly shaped the government proposals for healthcare policy change by providing solutions for the problems of the healthcare sector. In both countries, the proposals for healthcare reforms focused on the most pressing problems of the healthcare systems: high levels of corruption and large debt in hospital and insurance sector. They argued that these problems could be easily solved by replacing the existing state-dominated healthcare systems, characterized by public financing and predominantly state-owned delivery of healthcare services, with the market-oriented model of healthcare provision. Similar to the neoliberal frameworks that

attacked the welfare state in the West, neoliberal ideas used in the CEE context drew upon a more general belief in the self-regulating capacity of the markets and their superiority over the state. This was a causal belief according to which the markets, if left to operate freely, will provide healthcare to the citizens in a more efficient and organized way than the state. The neoliberal ideas hence built strongly on the criticism of the existing state-run system of healthcare, blaming it as the cause of inefficiencies and distorted incentives, supporting the culture of passive dependence and weakened personal responsibility for their own health and for the use of the available healthcare resources (see Ferrera 2013).

However, the neoliberal ideas used in the context of CEE healthcare reforms provided not only diagnosis of the problems in the healthcare sector, suggesting the link between the inefficiencies of the healthcare system and its state-run character, but also offered very concrete solutions. The well-developed reform proposal inspired by neoliberal ideas offered very precise guidelines on how to introduce specific market instruments into the existing healthcare system, such as for example through privatization of healthcare costs or competition between health insurance funds and healthcare providers and legitimized these instruments by efficiency gains. Interpreting inefficiencies of the healthcare system as consequences of state failure in delivering healthcare, neoliberal ideas dismantled the authority of the state as a guiding principle of healthcare policies and replaced it with the authority of the market as key instrument of the new and more efficient policy setup.

In addition to the healthcare sector specific problems that facilitated promotion of neoliberal ideas, Europeanization was another contextual factor that helped their rise to the government agenda. In the CEE, the late 1990s and early 2000s were marked with unique historical event – the entry into the European Union (EU) and its institutions. EU membership as key event of Europeanization implied acceptance of the *acquis communautaire*, which lacked regulation regarding healthcare policy because of the EU's rather minor competencies in this policy domain. Nevertheless, Europeanization created a macroeconomic environment characterized by competing priorities and imperatives of adjusting to the single market, which generated increasing pressures for the control of public spending, an important portion of which was related to healthcare (see McKee et al. 2004; see also Ferge 2001; Lendvai 2004). In both Hungary and Slovakia, during the first transitional decade, the growth of healthcare expenditure was not seen as a problem due to the previous tradition of chronically underfunded healthcare sector under communism (see Kornai and Eggelstone 2001). However, healthcare spending became one of the key issues on the government agenda in the context of EU entry and, subsequently, these countries' efforts for entering the Eurozone. In this context, the idea of an efficient and well-performing healthcare system based on market instruments became particularly attractive to policy makers as it was seen as a solution not only for the healthcare sector specific problems, but also for more general macroeconomic pressures. Europeanization, in other words, helped emphasize the problems of the healthcare sector by presenting them as potentially obstructive not only for the functioning of the healthcare sector but also for the for the counties' membership to the EU.

In sum, this section provided theoretical framework for ideational approach to policy change and argued that neo-liberal ideas played a key role shaping healthcare policy reforms in the two CEE countries. The neoliberal ideas attributed inefficiencies of the healthcare sector to its state-dominated character and proposed market instruments in financing and delivery of healthcare services as solutions for these sector-specific problems. The problem-solving character of these neoliberal ideas was additionally emphasized in the context of increased macro-economic pressures coming from the countries' membership in the EU institutions. The next section provides empirical evidence for this argument by providing a more detailed description of the two cases.

3. NEOLIBERAL IDEAS AND HEALTHCARE REFORMS IN CEE

After the fall of communism in 1989, Slovakia and Hungary underwent series of systemic reforms, marked by the shift from the communist so-called 'Semashko' model of healthcare provision to a 'Bismarckian' system of social health insurance (Marrée and Groenewegen 1997). The shift to the insurance system implied several large-scale changes, shift from tax-based model of healthcare financing to health insurance contributions, establishment of health insurance funds (as bodies in charge of collecting health insurance contributions) and introduction of purchaser-provider split. Parallel to this systemic change, the two countries introduced some market-oriented mechanisms in their healthcare sector, including partial privatization of primary care, and competition through, for example, free choice of healthcare providers (see Roberts 2009). The outcome was that healthcare underwent systemic changes, though remaining predominantly public and featuring strong role of the state.

3.1. Slovakia

In Slovakia, the neoliberal ideas of healthcare marketization were first brought into policy discussion through a document titled "Strategy of Healthcare Reforms - A True Reform for a Citizen", published by the think-tank *MESA 10* in 2001 and authored by a group of experts (Pazitný et al. 2005). As an elaborated proposal for healthcare sector reform, this document outlined the main ideas for health reform placing emphasis on identification of the key problems of the Slovak health sector and analysis of their causes. The paper dedicated special attention to what it saw as core problems of the healthcare system - high debt in the insurance and hospital sector. As the main causes of these problems it blamed central management, financing and supervision of the system that were described as still having "a socialist form" (ibid.). Strictly defined and centrally managed network of healthcare facilities and controlled prices for healthcare services were seen as generating poor flexibility and inadequate responses to problems, low motivation of healthcare providers, nurturing passive attitudes among patients and,

on a system level, grossly distorting price mechanisms and suppressing competition. In order to solve these problems, the proposal specified a concrete five-steps reform plan. The plan included measures aimed at substantial restriction of state's role in healthcare provision through the introduction of pluralism and competition of purchasers of healthcare services, decentralization of collection and redistribution of healthcare funds, introduction of the voluntary pillar of healthcare financing and transformation of public hospitals and insurance funds into joint-stock companies (*ibid.*).

"The Strategy for Health Reforms" was refined and included into the official proposal for healthcare reforms under the government of the Prime Minister (PM) Mikuláš Dzurinda. Dzurinda's government was formed after the September 2002 elections, which were marked by the victory of the Slovak Democratic and Christian Union (*SDKU*) over its main opponent - the conservative Movement for Democratic Slovakia's (*HZDS*) that witnessed significant drop in electoral support compared to previous elections (Deegan-Krause 2013). Since the *HZDS*, led by Vladimír Mečiar, was the strongest party on the country political scene during the 1990s, the results of the September 2002 elections suggested new dynamic on the country political landscape. After the elections, the *SDKU* formed a majority center-right government with three other parties, the conservative Christian Democratic Movement (*KDH*), the liberal Alliance of the New Citizen (*ANO*) and the moderately center-right Party of the Hungarian Coalition (*SMK-MKP*), with the *SDKU*'s leader Dzurinda as PM.

The official government proposal for healthcare reform was based on the 2001 reform proposal and was presented as a White Paper titled "Healthier Health in the Service of Citizens: Story of Reforms from Conception to Implementation" (Pazitný and Zajac 2004) in August 2004. The fact that the official reform proposal drew upon the 2001 document was not very surprising since one of the members of the expert team that had prepared the initially proposal, Rudolf Zajac, became the Minister of Health in the Dzurinda's second cabinet. Similar to the initial proposal, the White Paper justified the need for change of the healthcare policy in the market-oriented direction criticizing the poor state of affairs of the existing healthcare system and its state-dominated character. As the overall aim of the reform it specified creation of stable conditions for the operation of the healthcare sector, which would stop the rising debt and establish a balance between revenues and expenditure. It argued that the shift to a market-oriented system would prompt users of healthcare services (labeled as 'consumers') to take greater responsibility for their healthcare, discourage them from seeking unnecessary care and encourage them to make cost-benefits calculations in healthcare consumption (*ibid.*; see also Hlavacka et al. 2004). Drawing upon the five-step reform plan, the government proposal also provided an outline of six healthcare laws that specified legal changes needed to transform the existing system into its market-oriented counterpart that would lead to improved efficiency of the system and prevent debt creation. These laws entailed four key changes: i) introduction of co-payments and user-fees for healthcare goods and services; ii) creation of voluntary health insurance; iii) transformation of health insurance funds

into for-profit joint-stock companies; iv) changing the legal status of hospitals from state institutions (through a process described as 'de-etatization') to joint-stock companies and non-profit organizations (Pazitný and Zajac 2004; see also Fisher et al. 2007; Verhoeven et al. 2007).

These plans for the transformation of the Slovak healthcare sector were presented as part of a larger neo-liberal reform by the Dzurinda's government. The plan entailed not only reforms of the healthcare sector, but also of the pension sector, as well as tax and fiscal decentralization reform (Spectator 2004a; Haughton and Rybál 2008; Fisher et al. 2007). The main aims of these reforms, according to the government, was the reduction of the public deficit below 3 per cent of the GDP by 2006 in order to conform to EU's criteria. In addition, the reforms aimed to increase competitiveness and promote investment, with the idea of achieving a more rapid economic growth that would help Slovakia catch up more quickly with the other EU member states (Fisher et al. 2007). This focus on the fulfillment of EU criteria was emphasized as a leitmotif of the government's reform agenda, and had been already encapsulated in the Dzurinda's *SDKU*'s election slogan - 'We'll finish what we've started. We are on the right path' and 'Blue is good' - that stressed the persistence of the government efforts to make Slovakia a fully-fledged member of the European community (Haughton 2004).

As first reform step, the Ministry of Health issued ordinance introducing user fees - flat payments of 20 Slovak Crowns (0.5 €) per physician visit and drug prescription, and 50 Crowns (1.24 €) for a day spent in hospital. The opponents of the fees, however, criticized the fees as unconstitutional and submitted them for review to the Constitutional Court. However, the Court ruled that the fees are not in conflict with the Constitution, arguing that they do not endanger the elementary right to healthcare (Spectator 2004b). As a next step, the government introduced a package of six healthcare reform bills in June 2004. These bills drew upon the six laws proposal outlined in the White Paper and were successfully passed into law in September the same year. Law on Health Insurance and Law on Health Insurance Companies specified the legal status of health insurance companies as for-profit joint-stock companies and defined their competences, management and organization. Law on Healthcare, Law on the Scope of Healthcare Services Covered by Social Health Insurance, Law on Healthcare Providers and Law on Emergency Services reorganized healthcare provision and limited state's role in it, restricted benefits covered by the mandatory health insurance and defined procedures for the transformation of hospitals into joint-stock companies (Hlavacka et al. 2004).

Several months after the passing of the reform package, Slovakia's President Ivan Gašparovic vetoed all six healthcare reform laws. However, his veto was effectively overturned by the parliament and all six laws were passed for a second time in their original form (Spectator 2004c). However, despite the government reform success, the opinion polls showed that the healthcare reforms were very unpopular. Public opinion about the reform under the Dzurinda's government was the most negative about the healthcare reform. An opinion poll from 2006 showed that 74 per cent of respondents disagreed with healthcare reforms, com-

pared to 35 per cent who disagreed with the pension reform (Jevcák 2007).

3.2. Hungary

In contrast to Slovakia, plans for healthcare reforms in Hungary emerged in a very different political context. In the early 2000s, Hungarian politics was characterized by the growing polarization between two party blocks dominated by the two main political parties - the Hungarian Socialist Party (*MSZP*) and the Hungarian Civic Alliance (*FIDESZ*) (Palonen 2009). The results of the April 2006 elections confirmed this polarization, as the *MSZP* and the *FIDESZ* won 43 per cent and 42 per cent of the votes, respectively. The post-election period also led to no surprises, given that the government was formed by *MSZP* - i.e. the Socialists and its loyal minor coalition partner, the liberal *SzDSz*. This resulted in a majority government led by Ferenc Gyurcsány, leader of the *MSZP*, as the first government in the post-communist Hungary to serve two consecutive terms.

After government formation in autumn 2006, the Socialists-Liberal coalition announced its radical plans for healthcare reform. Similar to Slovakia's, Hungary's plan for healthcare reform was based on a previously prepared policy document titled "What is Right Has to Be Done", which was published in 2005 and authored by an expert and a party member from the *SzDSz*, Lajos Molnár, who became the Minister of Health in Gyurcsány's second government. Molnár's proposal criticized the existing system of healthcare provision as filled with deficiencies and wrong incentives - which it called "system errors" - that generate phenomena such as corruption and debts in the healthcare system. It argued that these deficiencies could only be solved through a large-scale reform capable of "correcting the system". The proposal also outlined the content of these reforms through a vision of a reform path that would dismantle the monopoly of the state and establish a competitive insurance system that would rely on the freedom of choice. It also suggested other changes such as definition of basic benefit package and widening of the scope of co-payments (Mihályi 2008).

The official government proposal for health reform, which drew upon this document, was published just three months after the government formation and titled "The Green Book of the Hungarian Health Care". The proposal entailed the introduction of a large-scale reforms that would involve creation of a decentralized, competitive insurance system with private healthcare facilities and user fees for services. These reforms, it argued, would weaken the incentives for the excessive use of healthcare services, rationalize the use of available capacities and improve the transparency of the system as a whole. Putting user fees at the forefront of the reform plan, the government argued that the fees would significantly contribute to the increase the efficiency of healthcare provision. They would reduce the unnecessary demand, raise additional revenue for the insurance sector and, most, importantly, help solve one of the key problems of the healthcare sector: corruption i.e. informal payments for healthcare services, remaining from the socialist period (Gál 2009; Baji et al. 2011).

Similar to healthcare reforms in Slovakia, the healthcare reforms in Hungary

were part of a bigger plan that aimed on reforming not only healthcare, but also higher education sector. Announcing its plan for the reform of the two sectors, the government argued that the reforms would modernize the welfare state and rationalize its spending. This, in turn, would help the country reach the aims of the Convergence Program (Hungarian Government 2006) - decrease the deficit of the government budget - that would enable the country to meet the criteria for joining the Euro zone (Mihályi 2008; Baji et al. 2011). Emphasis on the European dimension of welfare reforms helped the government to make a strong case for healthcare reform stressing that these changes were to be achieved under the restrictive conditions of the convergence programme. After the parliamentary discussion on the "Green Book" proposal, the government introduced a series of healthcare laws. The first was Law on the Establishment of Health Insurance Supervisory Authority introducing the Supervisory Authority as a first step toward the establishment of the competitive healthcare insurance market. The second law amended the existing Law on Healthcare Insurance by introducing user fees - a fee of 300 Hungarian Forints (1.40 €) for a doctor and hospital visit. The third, Law on Hospital Development and Restructuring, allowed for hospital privatization, and the fourth, Law on the Management of Health Insurance Funds, put in place legislation for the establishment of decentralized, competitive insurance system (Mihályi 2008; Gál 2009).

Similar to Slovakia, in Hungary the President, László Sólyom, vetoed the legislation. However, in February 2008, the Parliament overruled the President's veto and passed the laws successfully for the second time (Mihályi 2008). In stark contrast to the Slovakia, this was not the end of the healthcare reform in Hungary. In face of rising popular criticism of the reform, the inter-coalitional disagreements within the government resulted in the replacement of Minister Molnár with the new Minister of Health, Ágnes Horváth, also member of the liberal *SzDSz*. Additionally, reform opponents started campaigning for a referendum on the cancellation of user fees. After the Constitutional Court in June 2007 approved the referendum call, the popular vote was held in March next year. Witnessing a significant turnout of 50.5 per cent of eligible voters, by an overwhelming majority of more than 80 per cent of votes the referendum abolished the user fees (Gaál et al. 2011). Frightened by the outcome of the referendum, the parliament revoked another law on the transformation the Law on the Management of Health Insurance Funds in May 2008. Hugely successful anti-reform initiatives soon led to enough friction in the coalition for the *SzDSz* to give up their government positions (Toka and Popa 2013). The political outcome of the reform failure was then, unsurprisingly, both PM's dismissal of the Health Minister Horváth and the subsequent break-up of the government coalition (Baji et al. 2011; Gaál et al. 2011).

4. CONCLUSION

This paper analyzed market-oriented welfare reforms in two post-communist countries of Central Eastern Europe - Slovakia and Hungary - and argued that

neoliberal ideas were key drivers of these reforms. The neoliberal ideas of efficient healthcare system based on market elements influenced reforms as governments considered them solutions for two specific problems - the weaknesses of the healthcare sector, such as debt and corruption, and the external pressures on the public budget in the context of EU accession. As solutions to these problems, neoliberal ideas provided not only content for reforms, offering blueprints for policy change, but also legitimacy to the government reform agenda that focused on replacing the state with market-oriented models of healthcare.

The findings of this paper are in line with previous research on the role of ideas in policy change, which suggests that ideas can have an independent causal influence on policymaking, irrespective of public preferences and/or government's political orientation (Larsen and Goul Andersen 2009). The findings are also in line with previous research, such as for example the study by Frisina Doetter and Götze (2011), which shows that specific deficits of the healthcare sector or welfare state more generally can help promotion of ideas as drivers of large-scale policy change (see also Vis and Van Kersbergen 2013). Lastly, the findings are in line with some of the most recent literature on policy change in the context of global economic crisis that provides evidence on the increased impact of neoliberal beliefs and ideas on the restructuring and transformation of social policy programs in Europe (Farnsworth and Irving 2015; Blyth 2013; Navarro and Muntaner 2016).

However, the study of the two cases of the CEE reforms also points to some limitations of ideational approach. As indicated in the empirical section of the paper, the market-oriented healthcare reforms in Hungary and Slovakia were similarly based on neo-liberal ideas, but the outcomes of the reform process were significantly different. In Slovakia, the government managed to implement its reform plans relatively smoothly, despite the opposition to the reforms, while in Hungary the government had to reverse the reforms under the strong public pressure. Further research therefore remains to be done in order to account to what extent the outcomes of the healthcare reforms were determined by other, non-ideational factors, such as for example interests and institutions. As suggested by previous research (see Béland 2009, 2016), insights about the other factors driving policy change might not necessarily point to the limitations of the ideational approach, but could rather complement it, providing better insights into the mechanism shaping the different phases of the policymaking process.

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