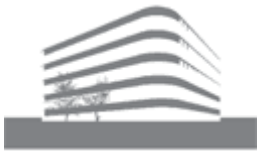

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POWER RATHER THAN PATH?
THE DYNAMICS OF INSTITUTIONAL CHANGE UNDER HEALTH CARE FEDERALISM

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Abstract

Proposals for government decentralisation rank high in the political reform agenda of health systems worldwide. Their impact on welfare state performance and change is however still under theoretical scrutiny. This paper examines from a political economy standpoint the dynamics of devolution in the Spanish National Health System to shed some light on this debate. Against widespread claims of path dependence, we argue that the specific nature of the devolution model developed in Spain fostered policy innovation and institutional change. Consolidation of an NHS system was compatible with some regional diversity. Despite concerns for social cohesion, health care federalism apparently prevented the rise of significant territorial inequalities. The Spanish experience of devolution highlights that the resulting horizontal cooperation and enhanced bottom-up political accountability had a significant influence in fostering the organisational efficiency of the system, although it also brought about substantial policy coordination and cost-control difficulties.

Keywords: devolution, welfare state, federalism, health care reform, path dependence, institutional change, accountability, National Health Service, health inequalities, Spain.

1. Introduction*

Two simultaneous macro-institutional reforms took place in Spain during the 1980s; namely, the set up of a devolution process and the transition to a NHS system – which still rank high in the political agenda. This makes Spain an interesting case to investigate health policy change, given claims of generalized path dependence (PD) within the sector. In particular, the PD framework highlights the prominence of federal and devolved institutions as powerful constraints on health reform. The causal mechanisms which link federal institutions, political actors, and policy change are however not adequately explored in the PD literature.

The article examines the effects of devolution upon the building of the Spanish NHS with the aim of shedding some light into this debate. Our main analytical goal is to evaluate the relative explanatory power of political institutions (and history) versus actors (and the political process) in explaining health policy reform. Given its characteristics, the case of Spain offers excellent opportunities to test previous theory. Against the predictions of PD theory, the case of Spain stands as a deviant case-study (DCS). Previous research suggests that the building of the Spanish NHS has not apparently been impeded but rather fuelled by the parallel process of federalization (Bovens et al. 2001; Rico et al., 1998). DCSs consist of the in-depth analysis of a case from an international comparative perspective, and constitute a traditional methodological tool in the social sciences to detect inconsistencies in received theory and help build new hypotheses (Ragin, 1991). In addition, the specific design of institutions in Spain, based in asymmetric federalism, offers specific quasi-experimental advantage. And, in contrast with other federal or devolved countries, there is a relative wealth of published evidence available on the Spanish case.

* The working paper presents an updated, refined summary of Ana Rico's (1997) PhD dissertation (financed by, and available from, the Centre for Advanced Study in the Social Sciences of the Juan March Institute). We wish to thank Elias Mossialos, Adam Oliver and all the participants in the European Health Policy Group based at LSE Health and Social Care for their excellent discussion of previous drafts. We are grateful to David Wilsford, Adam Oliver, and two anonymous referees for their editorial comments to the current version of the paper, which is under submission to the *Journal of Health Politics, Policy and Law*. The usual disclaimer applies.

The article is structured in five sections. Section 2 presents the theoretical framework. Section 3 describes the empirical case. Section 4 contains the analytical discussion of the Spanish experience in the light of theory; and proposes new theoretical hypotheses to explain health care policy change in federal and devolved states. The paper ends with some conclusions.

2. Path dependent or action-based explanations?

The concept of PD comes from economics. It was originally coined to describe a particular type of market failure, characterized by the early random adoption and posterior lock-in of a relatively inefficient technology (e.g. David, 1985). For others, PD is rather a quality (or a consequence!) of institutions (e.g. North, 1990). What both interpretations have in common is that new institutions, as some market technologies and products, require extraordinary initial investments, and therefore once adopted are difficult to change. In spite of its intuitive appeal, the PD framework has been heavily criticised based on its dubious conceptual consistency and predictive power (Mahoney 2000; Liebowitz and Margolis 1995). As some of its advocates recognize, "PD has been a victim of what Sartori (1970) called *concept stretching*" (Pierson 2000: 252). Most importantly, PD theory is unable (by definition) to explain institutional change. In this section, we argue that both problems derive from the association of PD with institutions. Instead, we defend that PD directly derives from power and preferences.

The concept of PD enters policy research via neo-institutionalist economics. This has two important implications. First, its meaning is blurred by its association with institutions, another concept subject to various interpretations. Rules, values (or culture), and organizations are all regarded as institutions by different social research streams (Scott, 1995). In economics, the concept of institution has been applied to formal regulation; to the contractual codes which regulate behaviour within and between organizations; and lately (and following classic sociology) to values and culture as informal rules of the game. Modern

political science further stretches the concept to include also organizations as collective actors. Understanding collective actors merely as institutions represents a radical departure from mainstream social sciences, which maintain a sharp distinction between organizations as *ruled arenas* (i.e. as sets of rules = as institutions), and organizations as actors (= capable of independent action). It therefore creates conceptual confusion. It also leads to institutional determinism.

In fact, the association of PD with neo-institutionalism brings determinism as a second negative consequence. In economics as in politics, institutionalist theorists defend that actions are either heavily constrained or fully determined by institutions. Hence the lack of change. As Scharpf (2000: 770) emphasizes, "In the light of empirical research, however, both of these positions appear much too deterministic". In fact, policy research shows that some institutions change, while other prove more resilient. PD theorists have tried to solve that problem by resorting to institutions themselves as the main determinant of institutional (policy[1]) change: following an *unusual conjuncture* (i.e. an internal crisis or an external shock), the likelihood of changed policy depends on the facilitating versus constraining effects of previous institutions. Again, determinism reappears and actors disappear from the picture.

Wilsford's (1995) analysis of health policy change is a good example of those caveats of the neo-institutionalist framework. His central empirical puzzle is why attempts at health reform following a severe financial crisis succeeded in some countries (the UK and Germany, according to his interpretation), while they failed in others (France and the USA). He mainly relies on the degree of centralization of national government institutions to explain the different fate of reforms. As the framework results clearly unconvincing to explain the relative success of the federal Germany over the highly centralized French state, Wilsford implicitly turns to interest groups and other collective political actors to explain the puzzle, by including them within the undefined term *structures* (taken as equivalent to institutions).

[1] On the equivalence between institutional and policy change in this context, see Pierson (2000).

Similar ad-hoc adjustments to the concept of institutions are used to accommodate citizens' preferences and values in the analysis.

Since the mid 1990s, there are signs of renewal in the PD paradigm. Within political science, the relevance of political actors for PD processes starts to be slowly recognized, but often against a framework dominated by institutional determinism (e.g. Putnam et al, 1993; Pierson, 1996). Two later contributions to the PD framework represent more explicit departures from neo-institutionalist assumptions: Scharpf (2000) defends the centrality of political action as the proximate cause of policy change, and the secondary causal role of institutions as more remote influences (a traditional claim of action-based[2] research); and Pierson (2000) convincingly argues that PD in politics is a result of asymmetries of power and other characteristics of collective action (as the power resources approach[3] does). Together they inspire our central claims, namely that institutional change is widespread; the direct result of political action, and ultimately reflects the evolving balance of power in society. And that, likewise, PD is also a consequence of political dynamics, and ultimately derived from the inherited distribution of power in society (which is protected by, but not equivalent to, the institutional framework!).

Figure 1 maps out the proposed causal process underlying institutional change. First, we defend that the distribution of informal political power (IPP) resources is the ultimate cause of institutional change. Following Hugher Tuohy (1999), in modern societies there are three main sources of IPP: ownership, knowledge and (social or political) support. They can have both (a) independent and (b) mediated effects upon the policy process. For instance, citizens' support can be directly influential via political demonstrations or opinion surveys; and also exert mediated effects (via the electoral system) upon the selection of government actors. In fact we defend that institutions matter precisely because they allocate formal political power (FPP) among competing actors; more specifically, they translate actors' IPP

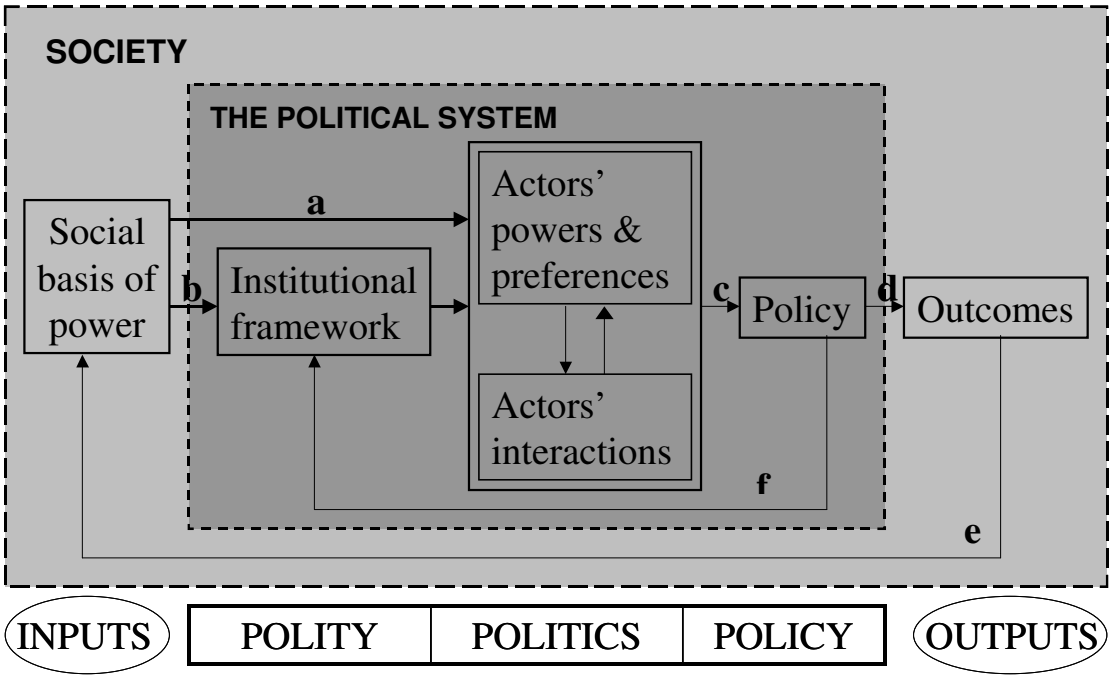
[2] We use the term action-based research as antonymous of neo-institutionalist research, given that both sustain opposite claims about the relative explanatory power of institutions versus actors.

[3] As we define power and resources as actors' characteristics, we treat the power resources approach as a variety of actor-based explanations.

resources into FPP (an intuitive example is the electoral system). This explains why they are resilient: political actors purposefully design institutions which protect and amplify their own social basis of power; and then use their FPP rights to prevent change. However, in democracies actors with FPP will constantly be challenged not only by internal competition, but most critically by external pressures from actors with independent IPP resources. In addition, the social bases of power can be expected to evolve partly independently of politics and institutions, as a result of social and economic interactions (e.g. through the emergence of a brand new private health care sector as a result of economic growth). Therefore as time passes the correspondence between historically inherited institutions and evolving social bases of power weakens and resisting change will become increasingly costly for the incumbent. As a result, policy shifts might occur (c), which could modify outcomes (d). There are two main feed-back effects. Changing outcomes affect the initial distribution of IPP resources (e); and changing policy effects institutional change (f). An important research variable, not displayed in the figure, is the *capacity of the state* (Orloff and Skocpol, 1984) to change policy in response to evolving societal pressures, and against internal and external opposition. We use the term *reform capacity* as synonymous. Analytically, it is equivalent to *political effectiveness*, as it represents the degree to which reform goals are accomplished.

Let's now examine the black box of the political process. Preferences as power are likely be only partly conformed by institutions. Following Scharpf, (2000), we use the term to refer to actors' orientations. Cognitive orientations include policy legacies (protected by inherited institutions) as well as innovations and reform models (as products of interaction-based policy transfers and learning). Normative orientations can be directed by narrow, corporative self-interests (changing with changing actors); or by broader group or societal interests (partly based on resilient values, but partly on changing interactions). A third critical element from an action oriented perspective (closely linked to preferences and power) are the dynamic interactions among actors. These can be broadly divided into cooperative and competitive. In federations, a distinction can be made between vertical (across government levels) and horizontal (among sub-national units) competition/cooperation.

Figure 1. The explanatory model



PD advocates from different fields of research (Nelson 1994; Scharpf 2000) have recently claimed that understanding institutional change requires investigation of the causal mechanisms linking institutions, actors, and policy responses, which are likely to be country- and sector-specific. In our case, this implies the need to examine the impact of federalism on health policy. The classical view is that federal institutions reduce the accountability of policy-making and increase the veto points which allow vested interest to block policy change (Orloff and Skocpol, 1984). This blocks welfare expansion and facilitates retrenchment, and ultimately decreases accountability and responsiveness (Pierson 1996). For some PD theorists, institutional change would be altogether less likely in federations due to expanded transaction costs and veto-players under joint-decision making, what results in inefficiency (Scharpf 2000). For others, the likelihood of policy change will differ across units within a federation depending on their social capital endowments (collective action resources and values, which are heavily dependent on the path of economic development); hence a gap might open between rich and poor regions in terms of government performance, exacerbating inherited territorial imbalances (Putnam et al. 1993).

Our research is founded on the controversial proposal that federal and deeply devolved states like Spain can be treated as analytically similar, because they share the critical feature of breaking the monopoly governance power of central government and opening it up to a number of sub-national governments. Other stated differences between federal and devolved countries are from our view of little relevance. In Europe, the progressive federalization of formerly unitary states via political devolution during the 1950s, 1970s and 1990s have resulted in quasi-federal structures which often only present little institutional differences with older federations. Many of these countries (like Germany, Austria, Switzerland, Italy or Spain) had been confederations during long historical periods, therefore resembling the supposedly unique federalism which emerged in America out of pacts among the previously independent states. And in any case, formally federal states are institutionally and politically very diverse, and there is a wide agreement in the literature that there is no such thing as a federal model (Lijphart, 1984). The proposal of treating federalism and devolution as similar, however, only laterally affects our analysis; as in any case the results would hold within the more restricted (but currently growing worldwide) sphere of political devolution.

3. The evolution of health policy in Spain (1982-2002)[4]

The aim of the case-study is to investigate the causes of health policy change in federations. In particular, we want to test the relative explanatory power of institutions versus actors. Our main dependent variable are health reforms during 1982-2002. We also (if only laterally) explore the connections between policy change, state capacity, and policy outcomes.

[4] Unless otherwise specified, this section is based on a previous, comprehensive literature review on Spanish health care reforms (Rico and Sabés, 2000)

3.1. Institutions and actors in Spanish health care

The political institutions of the new Spanish state

The territorial structure of the Spanish state was originally instituted during the transition to democracy along the lines of a rather uncommon model of *asymmetric federalism*, which initially mirrored the model adopted during the II Republic. The 1978 Constitution defined two types of regions-states, termed Autonomous Communities (ACs). As for health care, the central government retained exclusive powers in some key areas (financing, benefits, human resources and pharmaceuticals). In the rest of areas, it only remained in charge of framing health policy; while the remaining powers were asymmetrically devolved. Seven 'special' ACs comprising two-thirds of the Spanish population were entitled to exercise a significant degree of power in health care (close to the Canadian provinces, and above the German länders). The remaining ten 'ordinary' ACs, only received powers in the field of public health, ambiguously regarded in the Constitution: domestic policy was to be fully devolved to all ACs (done during 1978-1986); but the central state retained full powers in the undefined field of international public health. During 1981-1994, health care was transferred to the special regional governments; with regional health expenditure representing from then on more than 80% of total public health expenditure, and over 30% of their regional budgets.

Power asymmetries were also instituted in education and social care, but not in other devolved, sensitive areas, like industrial development. The Constitution also introduced additional asymmetry in financing, by recognizing the historical rights of two special ACs (the Basque Country and Navarra) to exercise almost full fiscal powers. In the remaining ACs, tax collection and regulation remained initially centralized. These asymmetries of power were lately reduced in two steps. As for political federalism, in 1992 education and social care were transferred to the ordinary regions in 1992; and in 2002 full health care transfers followed. This required the amendment of the constitutional framework, protected under a qualified majority clause. As for fiscal federalism, two government pacts in 1991 and 2001 devolved the management of some 40% of taxes to the fifteen ACs previously under central financing.

Democratically elected parliaments and governments were created in all ACs, which designed and approved their own constitutional *statutes*. They are constitutionally at the same jurisdictional level than central ones. Hence, a Constitutional Court mediates in disputes across levels. The Senate was made weak by design, and only indirectly (through provinces) representative of regions. This is however typical of some formally federal states (Liphart, 1984). The electoral system adopted at the centre (and reproduced in most ACs) mixes up majority and proportional features: it clearly favours the winner, but it also over-represents territorial minorities in rural provinces (versus national parties in urban areas).

Historical legacies in health care

The Spanish social health insurance (SHI) system, initially based on mutual funds, was designed during the II Republic (1931-1936). General Franco's coup-de-etat ended the short democratic experience. In spite of it, the Republican SHI reform was passed in 1942. In 1975, at the onset of the democratic transition, the SHI system covered 80% of the population, was organized around a network of modern state-owned hospitals, and its financing and management were public and centralized. This was coherent with the statist standings of the Francoist regime. The private sector was small and ambulatory care paid a prominent role; with the quality of private hospitals perceived as lagging behind public sector standards, according to a sample of physicians surveyed in 1978.

The power and preferences of political actors

Although 96.6% of the population agreed in the polls that the state should guarantee health care for all, the 1978 Constitution only ambiguously recognized citizens rights to health care. This should be understood as the result of the delayed but severe impact of the economic crisis. Likewise, plans of health reform were postponed during the democratic

transition, also due to the absence of a consensual reform model. While the government favoured an extension of the existing SHI system, the opposition as well as most of the population favoured a NHS model instead. The overwhelming electoral victory of the social-democratic party PSOE in 1982 opened a lengthy process of institutional design of the NHS, which led to the approval of the 1986 General Health Care Act. The strong initial commitment of the social-democrats with welfare state expansion gradually eroded during 1982-1986, as a result of the economic turndown and the failure of neo-keynesianism in France during the early 1980.

The PSOE stayed in power until 1996. During the Socialist period, the main opposition party was the centre-right Popular Party (PP), which programmatically supported an enlarged role for the private sector, and a more prominent role for physicians in the health care scenario. The party won the national elections in 1996, and in 2000 renewed mandate with a majority of the votes. Other relevant parties have been the Catalan and the Basque Nationalists, in power in their regional governments since the onset of democracy, which at the central level played a strategic role as critical allies of several governments during the nineties. The Constitutional Court and the judiciary occasionally played a critical political role in settling high-level disputes between central and regional governments and between health professionals and the state.

Professional associations are rather fragmented and only occasionally have been influential in policy making. Class-based unions, together with the post-communist party IU have shown considerable mobilization muscle in leading demonstrations and public campaigns in favour of a strong public sector. Public sector professionals conducted several strikes on salary and work conditions. Private providers are only weakly organized, and except in Catalonia, they have had a marginal role. In contrast, insurance and pharmaceutical companies are represented by a powerful central association. Regional media and civil associations rapidly developed, initially only in some ACs, but lately in most. Some national political actors (such as political parties and professional associations, as well as to some extent unions) also suffered rapid regionalization, with open strategic disputes between central and regional elites becoming frequent.

3.2. The policy process and the institutional development of the Spanish NHS

The stated reform objectives of the social-democrats at the start of their term in office included the institution of a NHS (based on tax-funding, universal coverage and free access), and the expansion of the public primary and community care sector. These programmatic commitments were only partly fulfilled by the majority government. Most importantly, the 1986 Act incorporated a shift from universalisation to a mere means-tested expansion of coverage, and left the door open for increased private financing and provision. The incumbent (under heavy pressure of the Ministry of Finance and the SHI Treasury against universalisation) defended these departures from programmatic goals by resort to the fiscal and economic crisis. It counted with the lay support of the right opposition, which justified its support as a way of protecting the role of the private sector. Ironically, therefore, only the communists defended the extension of coverage to affluent non-social security members. In addition, the Basque and Catalan centre-right nationalists obtained important amendments to the originally foreseen central coordination powers.

The half-hearted commitment of the social-democrats towards the expansion of public health care was also reflected in delayed implementation of the 1986 Act, as well as in a drop in public expenditure between 1982 and 1987 (obtained through decreases in real salaries and reductions in the private contracted-out sector). The general strike against the social-democrats in 1988 pushed them to draft an agreement with unions which resulted in the gradual extension of tax-based funding. Some months before, the Basque Health Minister (a social-democrat) made effective the extension of coverage to non-SHI members subject to means test. The promptness of the Basques was against central government's plans of delaying implementation of this measure. The Socialist trade-union mediated in the conflict, and managed to prevent the central government from appealing the Basque measure before the Constitutional Court. A few months later, other regions and the central state passed similar decrees, partly as a result of trade-union pressures. This is an example of a more general trend of inter-territorial diffusion of reforms and innovations which presides over health care policy-making in Spain and is typical of federations (Lijphart, 1984).

The Basque example also illustrates the important role of ACs in the implementation of the 1986 reforms. In addition, regional governments pioneered the introduction of new public management reforms during the 1990s which, in the absence of framing legislation, required considerable innovation and experimentation. Basque politicians also pioneered other processes of reform implementation in Spain, such as the expansion of community mental care, and the extension of full dental coverage to children. Andalucia and Navarra pioneered primary care reforms, another area of low priority for the central government. Catalonia created in 1988 an innovative program of integrated long-term care for the elderly, which represented a significant policy innovation, and a further extension of coverage (Rico et al., 2003).

Moreover, Catalan politicians pioneered the second wave of reforms (Cutler, 2002), based on a modified version of the managed competition and new public management reforms (independent public agencies in charge of purchasing and management, contracts, and flexibilization of the organizational and managerial structure of providers and purchasers). The Catalan proposals were lately adopted in several ACs, and subsequently included within central legislation (Gonzalez et al., 2001). The central government also tried, mostly unsuccessfully, to push some measures to promote the role of the private sector, against strong citizens' opposition, led by the unions and the communists. During 1997-9, private insurance paid by employers received tax discounts, and the management of sickness leave was partly privatised; in parallel, however, the tax break previously granted to out-of-pocket payments and voluntary insurance was suppressed. Controls of the prices and profit margins of the private pharmaceutical sector were applied at regular intervals since the late 1990s, but a lacked a systematic strategy, and generally did not succeed in containing the rocketing trend in expenditure (Rodríguez et al., 2000).

The regional resource allocation system in health care evolved partly independently of health reform, as it was commissioned by the Constitution to a committee of regional and central Finance Ministers. This was only made effective in 1994. Up to then, it was mainly based on historical expenditure, and relied on scarcely transparent bilateral agreements. Political discretion, coupled with recurrent overspending by central governments, led to

rising regional health expenditure and mounting public deficits (López-Casasnovas, 1999; Reverte-Cejudo and Sánchez-Bayle 1999). In 1994, the government made a firm commitment to put into force a simple capitation system that linked expenditure growth rates to GDP. Tight controls started to be applied upon public salaries and pharmaceuticals. The principle of capitation was later broken in 1997 to include a supplement for those regions which decreasing population (most notably Catalonia) (Pellisé et al., 2001). From then onwards, and specially during the bilateral negotiations with the 10 ordinary ACs, political discretion tended to increase (López-Casasnovas and Rico 2003).

3.3. Policy change and policy outcomes: accountability, responsiveness and the equity/efficiency trade-off

Policy change and state capacity

Today, the Spanish NHS is the result of a still incomplete if substantially advanced transition from the former SHI system. On the one hand, the consolidation of the basic features of the NHS model has proceeded further than in other similar, but centralized countries like Portugal and Greece. The system provides nearly universal coverage to all citizens regardless of wealth, and mostly free at the point of access. A new publicly staffed network of primary teams has been slowly implemented since 1986 (Larizgoitia and Starfield, 1997), which in 2000 covered some 80% of the population. Since 1999, taxes represents 97% of public financing. Co-payments have a marginal role, compared with Italy or the Nordic countries; and against the general trend, their share over total financing decreased during 1980-2000. Private health expenditure increased by 3% between 1981 and 1996, while in Sweden, Italy, Portugal and the UK it increased by 5-10 percentage points (OECD, 2002).

This suggests a relatively high reform capacity (and political effectiveness) of the Spanish state during the period. Only a few institutional features of the previous SHI system

proved resilient. Interestingly, most of them are under the responsibility of the central government. Coverage remained in the hands of the over-powerful SHI. Although some 99%[5] of Spaniards have free access rights, coverage is not linked to citizenship status, and for non-social security members requires a means test. Immigrants' rights to access were only granted in 2000, and also depend on a mean test. The special corporative status of civil servants, established under Francoism, remained untouched. Benefits are formally comprehensive, but in practice some preventive, long-term and dental care services are only covered in some regions. There is evidence that primary care reforms were initially blocked in some ACs but there is a clear tendency for those regions to catch up during the late 1990s.

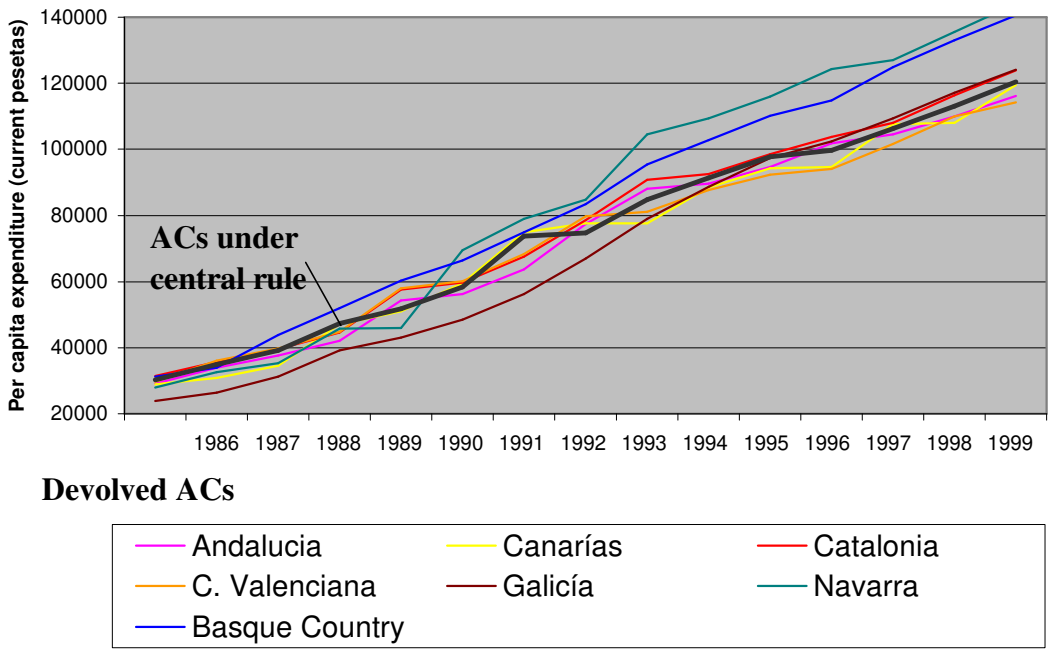
The balance is more mixed for the second wave of reforms. Spain has performed relatively well compared with other NHS countries mainly in terms of the *new public management* reforms: private management and organizational instruments have been introduced to modernize and improve the public sector; and there has been considerable experimentation with new types of private purchasers and providers, as well as with new services not explicitly contemplated by the 1980s reforms, such as long-term care and new preventive programmes. In contrast, managed competition proposals, and most specially attempts at expanding the role of the private sector, have not been successful until very recently, and only at the margins of the system (Rodríguez et al., 2000; López-Casasnovas, 1999).

Empirical evidence on Spain also suggests that improved state capacity was mainly the result of the dynamism of some ACs. Their higher reform and innovation capacities spread, if unevenly, across the territory. In contrast, the central state, in this as in other sectors, emerges as a relatively reactive policy actor during most of the period (Bovens et al, 2001). There are signs, however, that a reversal of that trend might start in the early 2000s. The earlier moves of the Ministry of Finance to push political and fiscal federalism forward were later reciprocated by the Ministry of Health, which in 2003 presented a draft framework

[5] There are no reliable data on the extent of coverage in Spain. On the available estimations, see Freire (1993) and Rico and Sabés (2000).

bill on health care coordination to the Parliament. This interesting development (a third reform wave?) lies however outside the domain of this article.

Figure 2. Regional health care expenditure per capita, 1986-2000



Source: Ministry of Health (2002)

The equity/efficiency trade-off

We only shortly summarize here the evidence available on the outcomes of the reformed NHS, which are more extensively covered elsewhere (López-Casasnovas et al. 2004). In contrast with expectations, substantial policy innovation has not apparently been at the cost of inter-territorial equity in Spain. Regional inequalities in health expectancy stayed constant at very low levels during 1980-1998. From an international perspective, inequalities in regional expenditure remained low until 1998, and from them on, started to rise. Interestingly, inequalities in expenditure among the 10 ACs centrally managed were

significantly larger at the end of the period (López-Casasnovas et al. 2004). This suggests that equity in resource allocation has been easier to impose to devolved ACs than to ACs subject to centralized management. Inequalities in the financing and delivery of care decreased during the 1980s and early 1990s (Urbanos 1999; Wagstaff et al. 1999).

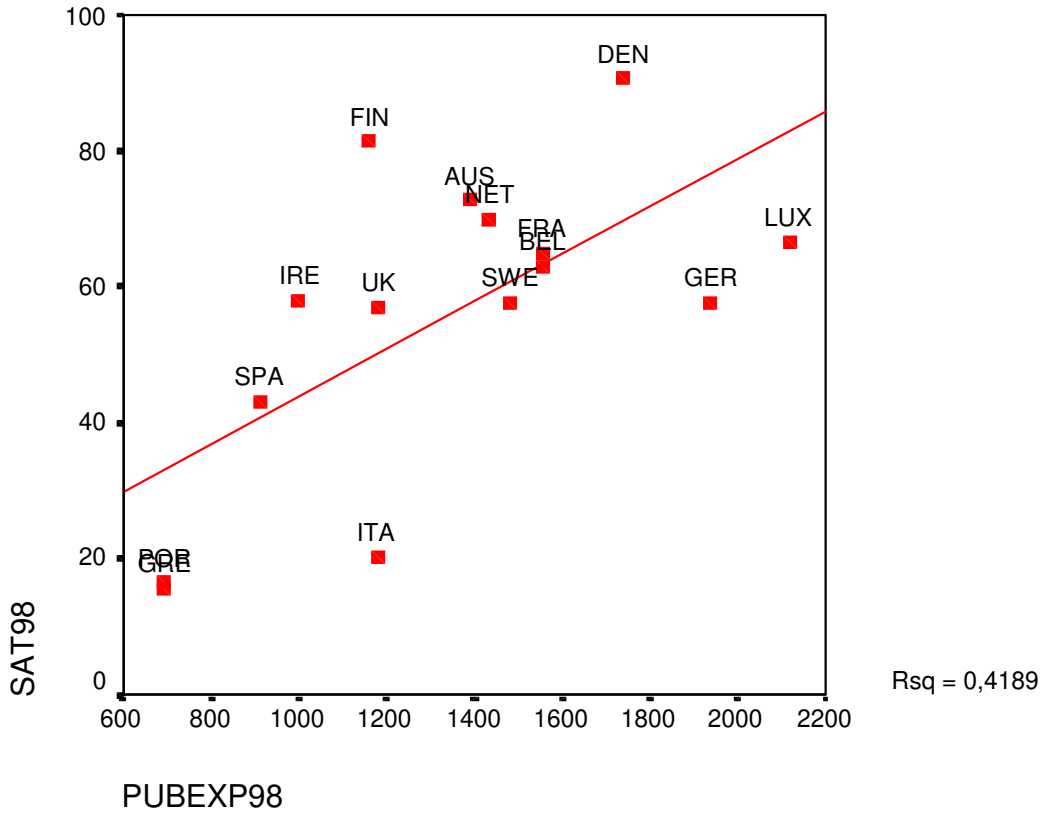
Next we examine the impact of the devolved NHS on efficiency. There is evidence that special ACs have tailored health care resources (e.g. beds) to regional needs (e.g. aging) more rapidly than the central state, and hospital productivity increased in most ACs (González et al.). Pressures on macro-economic stability have sometimes been slightly higher than in other NHS systems, but on average only moderate (OECD, 2002). This, coupled with the considerable rates of policy reform and innovation achieved, points to increased political efficiency. Against this generally positive background, there are a few worrying developments. Interestingly, the major rise within the public budget concentrates in pharmaceuticals, still a central responsibility. Public deficits have been recurrent, and in centrally financed special ACs these have often been made through hidden debt (which makes expenditure figures less reliable for them). According to official data (Figure 2), both the level and the trend of growth in public expenditure have been higher in the two regions with full fiscal autonomy (which are also among the top public sector reformers) than in the rest of ACs. This is consistent with recent evidence about other federations (Banting, 2002).

Accountability and responsiveness can increase in federal states

In democracies, both concepts refer to the extent to which citizen's preferences and power are present in the policy process. There are clear signs that both have increased in Spain as a result of devolution and health reform. More than half of Spaniards agreed in the mid 1990s that responsiveness to citizens' preferences and needs had improved due to the devolution process (Garcia-Ferrando et al., 1994), although the rates differed among regions, with several special ACs showing above-average levels. In addition, general citizens' satisfaction with public health care has steadily improved since the early 1990s, and more

markedly (from 50% to over 75%) in primary care. As a result, as displayed in Figure 3 (which plots government per capita health expenditure in $US-PPP in 1997 against the percentage of citizens which declare to be generally satisfied with the way the health care system works in their countries), Spain had moved up from its previous position within the Southern Europe cluster, showing a clearly higher satisfaction/expenditure ratio than centralized Portugal and Greece and the intermediate case of Italy, federalized 10 years later than Spain.).

Figure 3. Citizens' satisfaction and health care expenditure, 1998



Sources: Eurostat (2001) and OECD (2000).

We define democratic accountability as the relative power exerted by citizens over governments in the policy process vis-à-vis other actors; and defend that it depends on complex interactions between actors' characteristics (powers, preferences and coalitions) and institutions (which allocate formal power –and hence responsibility among competing actors). In section 2 we saw that PD theory expects weakened accountability in federal states. However, based on the Spanish case, we defend that under certain conditions federalism can result in enhanced democratic accountability. As the argument is theoretically loaded, we move it to section 4 below.

4. The Spanish case in theoretical and international perspective

4.1. Bringing actors back in: The centrality of politics to explain institutional change and resilience

The explanatory model presented in section 2 proposes that both reform capacity and institutional stickiness are the direct result of the balance of actors' preferences, powers and coalitions during the policy process. Let us examine each of these in turn. At the start of the transition, citizens' preferences clearly favoured the establishment of an NHS and the concurrent expansion of the public sector. Notwithstanding the effects of values/ideology, the low perceived quality of the existing private sector vis-à-vis the public one was most probably a critical factor here. The private sector formal market power was however protected by the inherited SHI institutions. In spite of that, shifting preferences led to changing government, and ultimately to significant public sector expansion through health care reform during the 1980s and 1990s.

The considerable reform capacity showed by the Spanish state can be mainly attributed to a latent coalition between citizens' majority preferences for an enlarged public sector and considerably dynamic regional governments with vested interests in public sector expansion. In fact, regional governments (together with the communists and the class-based

trade unions) were critical actors in the 1986 reform, despite having little formal political power at the central level. Their critical influence should be interpreted mainly in terms of informal citizens' political support, as illustrated by the extraordinary number of demonstrations and strikes which they led during the democratic period. Later on, regional governments also pioneered the implementation, modernization and further expansion of the new NHS. Satisfaction and perceived responsiveness increased. The critical role of citizens' preferences in the health care process also resulted from relatively weak (and considerably centralized) private vested interests, which were not able to exploit in their favour the increased veto points brought about by devolution.

Understanding institutional change not only requires a static analysis of preferences and powers, but also to examine the political dynamics. Given devolution, the predominant actors' interactions were among governments. The evidence on Spain shows that special ACs both competed and cooperated for improved benefits; that ACs with full fiscal autonomy did not compete with the centre to reduce taxes (but rather the opposite); and that all regions competed among them and with the central government to expand health care expenditure. The resulting balance clearly favoured the expansion of public health care over a reduction in taxes (an effect amplified the higher the fiscal/political autonomy of sub-national governments). Furthermore, the Spanish case shows that the reduction of central government involvement can result in increased democratic accountability in federal states, via reduced tensions between the overlapping bottom-up and top-down accountability lines operating upon sub-national governments. This has however been at the cost of some problems of policy coordination (with especially adverse effects in the field of public health) and expenditure control, exacerbated by excessive vertical competition for power and budgets during the early 1980s. During most of the 1990s, however, cooperative dynamics predominate, and this pushes the reform capacity of the Spanish state up to average European standards (Bovens, 2001).

A central claim of PD political theory is that formal political institutions and actors (understood as institutions) are the main determinants of institutional resilience and change. We have reasons to sustain that formal institutions and powers alone cannot explain the

consolidation of the Spanish NHS. For instance, the central socialist government enjoyed successive electoral majorities, and in spite of that, the 1986 reforms only ambiguously reflected citizens' preferences. However, we indeed accept that the extent to which citizens' preferences drive the policy process is partly dependent on institutions. Devolution is a text-book example of that. Devolved/federal institutions matter because they break government monopoly into a number of sub-national actors, and therefore expand the contestability of the market for formal political rights. And also because they influence the degree of power-sharing, and hence the political visibility of government decisions (who is responsible for what). Contestability and visibility are in fact two critical requirements for accountability and responsiveness. While contestability clearly increases following devolution, visibility is more controversial. As we defended elsewhere (Rico et al., 2001), it can also increase if each level of government receives almost full powers in each policy area, and shared or overlapping powers are minimized. None of these factors are taken into account by PD theory .

4.2. Assessing and re-defining path dependency

. In its simplest version, PD theory predicts that major institutional change is not to be expected. More refined predictions (see section 2) indicate that institutional change is altogether less likely in federal than centralized countries, due to hindered accountability and higher vulnerability to vested interests. Neither the predicted policy outcomes nor the stated causal mechanisms apparently apply in the case of Spain. We defend that the development of the NHS in spite of its limits, represented a major institutional change. In fact, Spain can be considered both a high achiever in terms of NHS consolidation, as compared with Portugal and Greece; and a relatively pro-active, innovative country within the second wave of reforms compared with other NHS countries of Western Europe.

At first sight, the transition to tax-financing and the expansion of the public ambulatory sector might seem minor reforms relatively coherent with the nationalization of hospitals and insurance funds during Francoism. This is however ill-conceived. In fact, this

allocation of market power (the state in charge of hospitals, and private doctors in charge of ambulatory care) is at the core of the SHI model in all Continental Europe, and it reflects the historical power equilibrium between the state and the medical profession. Nationalizing the sector can be therefore interpreted as a radical redistribution of market power. Likewise, the transition to tax-funding required to overcome the opposition of powerful stakeholders such as the SHI Treasury, as well as to override the informal (and profitable), doctor-run insurance schemes used to complement restricted public coverage.

The global image which emerges from the Spanish picture is one of major institutional change compatible with a few (but key) resilient institutions. Some features of the previous SHI framework remained unchanged, and attempts at expanding the private health care sector during the 1990s resulted relatively unsuccessful. The PD framework cannot explain why some institutions changed and others not under similar institutional and conjunctural circumstances. We propose that these results are indicative of *selective* PD (SPD). In the light of the explanatory model traced in the article, the Spanish case can be used to formulate a few hypotheses for further research. First, SPD is likely to be nationally and sector-specific; and to reflect the extent to which the interests protected by the former institutional framework still keep their fair share of informal power resources. Second, SPD might explain why similar international reform models result in institutional hibridization rather than convergence across nations (Bouguet, 2003). Third, SPD can be understand as the result of the distribution of power and the resulting degree of actors' competition and cooperation, so that the more concentrated power is, and the less competition and cooperation (versus collusion) occurs, the less policy change and innovation is to be expected.

5. Conclusions

In contrast with other countries of Southern Europe, Spanish health care has experimented relative radical institutional change during the 1980s and 1990s, involving the consolidation and modernization of an expanded NHS. This was achieved in parallel with the

progressive federalization of government institutions. The specific type of federalism which characterizes the Spanish state did not apparently block, but rather fuel, policy innovation and reform. Although regional differences in state capacity (or government performance) have been interpreted as a source of potential territorial inequalities in the accessibility and delivery of care, in Spain there is evidence of informal cross-regional policy diffusion processes working in the medium and long run. It is true that there have also been instances of excessive vertical competition for public power and budgets, and insufficient horizontal cooperation. There is however evidence of slowly convergent regional health budgets and outcomes during most of the period. All in all, these developments directly challenge the predictions of received PD theory.

Due to its quasi-experimental features and deviant status, the Spanish case can be used to formulate some hypotheses for further research. Against current PD theory, our central claim is that formal institutions play a subsidiary role vis-à-vis political actors in explaining policy change. Deeply entrenched in institutions, but analytically distinct from them, the social basis of power (ownership/income, knowledge and social/political support) can be considered the ultimate causal force behind institutional change and resilience. The evolution of Spanish regional health policy also emphasizes that the resulting balance of competition and cooperation among government levels (and other actors) during the policy process directly conditions policy responses in federal countries. And that this balance depends more on actors' preferences and informal power resources than on institutions.

It is true, indeed, that the degree of competition and cooperation (as well as actors' orientations: towards corporate/self-interest or majority/social interests) can be *managed* by modifying the incentives embodied in the institutional framework, and ultimately by redistributing formal political power among actors. For instance, the evolving model of power-sharing across government levels in Spain, which was characterized during most of the period by non-overlapping jurisdictions (with regions in charge of health policy and the central state in charge of fiscal responsibility), is clearly partly responsible for the evolution of health politics, policy and outcomes. Hence, questioning the causal relevance of institutions does not imply underestimating its critical policy relevance. In fact, the social

bases of power are PD not only because they are protected by formal institutions, but mainly because they depend on the initial distribution of informal power resources among collective actors, which might well be more resistant to political reform than the formal institutional framework. Institutions therefore become key, but sharply in contrast with the assumptions of PD theory, as decision variables rather than as ultimate or direct causes.

The global image which emerges from the Spanish picture is one of significant institutional change coupled with a few, key instances of resilient institutions. This suggests that selective PD rather than generalized PD might be the rule, which is coherent with the general hibridization (rather than convergence) of welfare systems as a result of common pressures. The Spanish case also emphasizes that increasing hibridization seems compatible with convergent outcomes, a result also obtained in the field of European welfare state reform (Bouguet, 2003). It suggests that different countries might reach similar goals through different institutional trajectories. And it also points to the important role of financial and knowledge transfers vis-à-vis policy as determinants of outcomes and changing social bases of power. We only laterally addressed these issues in the article, which focused instead on the dynamics of political power and policy change. The challenge of studying the relative impact on policy outcomes of changing institutions, shifting powers and evolving resource transfers therefore remains open for further research.

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