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Determining policy priorities in a devolved health system: An analytical framework

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Authorship Declaration

I certify that the thesis I have presented for examination for the MPhil/PhD degree of the London School of Economics and Political Science is solely my own work other than where I have clearly indicated that it is the work of others (in which case the extent of any work carried out jointly by me and any other person is clearly identified in it).

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Abstract

This dissertation develops an analytical framework for studying the effects of health system devolution on the health policymaking process and policy choices made by subnational governments. It addresses two research questions: (1) How does devolution change the structure and agency of the health policymaking process? (2) What is the resulting impact on health policy priorities? A critical literature review covers decentralization, devolution, and interest-based approaches for analysing the policymaking process, structure and agency. An analytical framework for upper-middle- and high-income countries is constructed by integrating (i) a modified version of Bossert's decision-space approach for decentralized health systems; (ii) Blom-Hansen's combined policy network and rational-choice institutionalist approach, which analyses the intergovernmental relations within the national health policymaking environment; and (iii) an original conceptualisation and analysis of informal intergovernmental policymaking at the subnational government level. Empirical evaluation uses information on Spain's 2001 health system devolution reform, focusing on the regional cases of Extremadura and Madrid. Primary data from stakeholder interviews and secondary data are analysed primarily using qualitative, case study and content analysis methods. The decision space granted to regional governments in Spain is examined before and after the reform, developing a decision-space map for Extremadura and Madrid and showing the shifts in the range of choice allowed for each health system function over time. Next, the compositions of the national and subnational health policy networks are determined for before and after devolution, and the policy priorities for each are estimated *ex ante*. Finally, the dissertation analyses the *ex post* priorities and results of health policy decisions made by Spain, Extremadura and Madrid in the period after devolution. Overall results show that the analytical framework is only partially successful in anticipating health policy priorities. Suggestions for improving the framework are proposed, and policy implications and lessons are drawn from the case studies.

For Gabriele

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Abbreviations

Abbreviation	*Español*	English
CISNS	*Consejo Interterritorial del SNS*	Inter-territorial Council of the NHS
CPFF	*Consejo de Política Fiscal y Financiera*	Tax and Finance Policy Council
EA	--	Expenditure Advocates
EG	--	Expenditure Guardians
GDP	*Producto Interior Bruto, PIB*	Gross Domestic Product
GHL	*Ley General de Sanidad*	General Health Law
INE	*Instituto Nacional de Estadísticas*	National Statistics Institute
INGESA	*Instituto Nacional de Gestión Sanitaria*	National Health Management Institute
INSALUD	*Instituto Nacional de Salud*	National Institute of Health
K	--	Kentrocrats / health-sector Kentrocrats
LCQ	*Ley de Cohesión y Calidad del SNS*	Law of Cohesion and Quality of the NHS
LOFCA	*Ley Orgánica de Financiación de las Comunidades Autónomas*	Organic Law for Financing the Autonomous Communities
MIR	*Médicos Internos Residentes*	Internal Medical Doctor Residency
MOEdu	*Ministerio de Educación y Cultura (antes de 2000), Ministerio de Educación, Cultura y Deportes (después de 2000)*	Ministry of Education and Culture pre-2000, Ministry of Education, Culture and Sports, post-2000
MOF	*Ministerio de Economía y Hacienda (antes de 2002), Ministerio de Hacienda (después de 2002)*	Ministry of Economics and Finance pre-2002, Ministry of Finance post-2002
MOH	*Ministerio de Sanidad y Consumo*	Ministry of Health and Consumer Affairs
MOL	*Ministerio de Trabajo y Asuntos Sociales*	Ministry of Labour and Social Affairs
MOPA	*Ministerio de Administración Pública*	Ministry of Public Administration
MP	*Diputado*	Minister of Parliament
MPC	*Comisiones Mixtas Paritarias*	Mixed Parity Commissions

Abbreviation	*Español*	English
NBL	*Ley de Presupuestos Generales del Estado*	National Budget Law
NHS	*Sistema Nacional de Salud, SNS*	National Health System
PP	*Partido Popular*	People's Party
PSOE	*Partido Socialista Obrero Español*	Spanish Socialist Workers' Party
RFM	*Consejería de Hacienda*	Regional Finance Ministry
RHM	*Consejería de Sanidad*	Regional Health Ministry
RHS	*Servicio Regional de Salud*	Regional Health Service
RULEQ	*Registro Unificado de Pacientes en Lista de Espera*	Unified Patient Registry for the Reduction of Surgery Waiting Times
SEA	--	Subnational Expenditure Advocates
SEG	--	Subnational Expenditure Guardians
SGP	*Pacto de Estabilidad y Crecimiento*	Stability and Growth Pact
T	--	Topocrats
US	*Los Estados Unidos de América*	The United States of America
WHO	*Organización Mundial de la Salud*	World Health Organisation

1. Introduction

There is a growing interest in devolution across the globe, especially among European health systems. The existing literature has primarily focused on the issues concerning fiscal and political federalism, examining the effects of the allocation of taxes and power to subnational authorities. However, such literature has so far provided a very limited framework for analysing its effects on policymaking processes and on subsequent policy actions. Most frameworks that examine devolution do so under the umbrella concept of decentralization, despite the significant conceptual and practical differences between the two. Devolution, also known as political decentralization, entails a distinctive political arrangement in which multiple levels of government are autonomous in their decision-making yet interact interdependently (Rhodes 1986; 1992; Blom-Hansen 1999; D. Toke et al. 2013). Whereas decentralization refers to a wider phenomenon that encompasses devolution processes as well as reflects other forms of decentralization (e.g. administrative autonomy and power delegation) (Cheema and Rondinelli 1983; 2007). The distinctive political arrangement of devolution uniquely structures the relationships between actors and, therefore, influences the policymaking process (Kontopoulos 1993; Hedlund 1994; Ansell 2000). Health policy priorities in a devolved health system may then be estimated from the changes in the structure and agency of the policymaking process. To date more of the research has gone to examine the political and fiscal effects of devolution, but we know very little about policy processes and priorities following devolution. Furthermore, health care is a main policy area that is often devolved to subnational governments.

1.1. The Research Puzzle and Questions

The present study develops a comparative analytical framework for studying health system devolution and its effects on the health policymaking process and, consequently, the policy priorities after devolution. The framework uniquely comprises three components, which are modified or developed from the decentralization literature (which encompasses devolution) and public policy literature and then examined empirically on two regional cases in Spain that obtained health service responsibilities during the period of study.

This doctoral dissertation aims to answer two main research questions: *How does health system devolution change the structure and agency of the health policymaking process? What is the resulting impact on health policy priorities?* I hypothesise that, in a devolved health system, policy priorities are the result of the relative influence of key actor groups in intergovernmental health policy networks within the national and subnational policymaking environments. The independent variable here is the relative amount of influence possessed by each actor group within these policy networks, which is partially defined through devolution; the dependent variables are the health policy priorities and decisions generated.

Ideally, a comparative analytical framework for analysing health system devolution should use concepts that can be defined, measured and applied to all health systems or, at least, to the cases being compared. It should represent the policymaking process as structured by the institutional rules and intergovernmental aspects of devolution, including an actor behaviour model that identifies the relative influence of the actors and considers the balance of power between them, their main goals and their interdependencies. The framework should identify the main actor groups in the process and the relationships between them. The actor behaviour model should contain behavioural assumptions for the actors involved. Furthermore, the framework should be examined to substantiate its effectiveness in representing the policymaking process and in anticipating policy priorities in a devolved health system.

The analytical framework of this dissertation addresses all of these aspects, drawing from mainstream models and theories for decentralization[1], devolution, and policymaking and adapting them to the specific policymaking situation created by devolution in the health sector. Specifically, to make it applicable to upper-middle- and high-income countries it modifies Bossert's (1998) decision-space approach to defining and measuring health system decentralization (defined as the level of discretion granted for managing functions of the health system at the subnational level). The framework then integrates the analysis of intergovernmental policy networks within the national policymaking environment explicated by Blom-Hansen (1999), which incorporates concepts of rational choice institutionalism. For this

[1] The broader decentralization literature is examined in addition to the literature on devolution because it offers more theories, frameworks and empirical examples to pull from; overall, there is more published literature on decentralization than on devolution and it tends to have more depth.

environment, it improves on Blom-Hansen's method by newly defining an index for assessing the strength of topocrats in their intergovernmental policy network. Finally, building on Blom-Hansen's approach, the dissertation theorises and develops an approach for analysing intergovernmental policy networks within the subnational policymaking environment of a devolved health system. The decision-space approach and the intergovernmental policy network analysis are particularly important for examining decentralization, including its several forms devolution, and policy processes, respectively. Together, they offer a unique perspective on the institutional relationships that constitute the structure and agency of the policymaking process in a devolved health system and its effects on health policy priorities within both the national and subnational policymaking environments.

This doctoral dissertation attempts to make four major contributions. First, it develops the first analytical framework for understanding health system devolution from a policy process and public management perspective. Second, it modifies Bossert's (1998) decision-space approach for health system decentralization in developing countries so that it may be applied to upper-middle- and high-income countries.[2] Third, it uses intergovernmental health policy networks and corresponding actor behaviour models in a way that facilitates analysis of the policymaking process and subsequent policy priorities within devolved, subnational policymaking environments. Fourth, it creates indices for two of the major actor groups. Fifth, it evaluates the framework's effectiveness empirically by means of two retrospective, longitudinal, regional case studies from a single country that has relatively recently devolved health service competencies. The method of subnational comparison helps to overcome the potential limitation of too much dependence on aggregate, national-level data.

In terms of research design, this thesis creates an analytical framework for analysing the policymaking processes and, subsequent, policy priorities in a devolved health system. Then, using the case study method (Gerring 2004; Merriam 1992; Van Evera 1997; Exworthy, Peckham, and Powell 2012), it applies the framework of the thesis to the case of Spain and two regional case studies. Finally,

[2] The framework developed here is not applicable to lower- and lower-middle-income countries, because it does not account for two factors that are prominent in those nations: (i) the strong policymaking influence of international actor groups (the United Nations, the World Bank, NGOs, etc.) and (ii) the significantly different impact of decentralization on lower- and lower-middle-income countries, e.g. due to their lack of capacity. These considerations lie beyond the scope of the thesis.

it examines and evaluates the results of the framework, which anticipate the direction of health policy priorities for the case studies, with a retrospective analysis of a select number of actual health policies.

Spain was chosen for analysis because it underwent a significant devolution reform of health service competencies to a subnational level of government. It is also a high-income country, whose health system and, in particular, health system devolution reform has been used as a model example for other countries, in particular "newly industrialised" ones (Rodríguez, Gallo de Puelles, and Jovell 1999; Levaggi and Smith 2005; López-Casasnovas 2007; Carnicero and Rojas 2010; Simon-Cosano, Lago-Peñas, and Vaquero 2012; Walter 2012). Spain's most recent health system devolution occurred after 2001 (effective in 2002) and granted authority over health service responsibilities to ten of its autonomous communities (or regions) (Costa-Font 2013). This doctoral dissertation focuses on two of these regions, Extremadura and Madrid, while at the same time incorporates relevant and available information on other regions in Spain to provide a richer analytical context.

The uniform background and contextual conditions of Spain create a semi-controlled environment for the regional cases and thereby limit the impact of potential confounding variables (especially the role of national-level legislation) by holding them constant. The regions of Extremadura and Madrid in particular have three main features in common: (i) both are among the ten regions that received health service competencies in 2001, (ii) neither had active nationalist or separatist groups during the period of study, and (iii) in each region, one major political party[3] controlled the government throughout the study period. The study period of the thesis was retrospective and longitudinal, spanning a decade (1996 to 2006); however, each empirical chapter focuses on a different, smaller period within this range of years, according to the objectives of their analysis. I employ the method of temporal variation, which is useful in dealing with issues of sequencing and contingency in causal analysis (Pierson 2004).

The use of qualitative interviews of institutional actors constitutes a major contribution of this dissertation. In general, in-depth interviews provide first-hand

[3] Specifically, the Spanish Socialist Worker's Party (*Partido Socialista Obrero Español*, PSOE) governed Extremadura and the People's Party (*Partido Popular*, PP) governed Madrid.

information on events that took place during the period under examination (Marshall and Rossman 1995). They also facilitate the compilation of large amounts of data rather quickly, with the potential for subsequent follow-up and clarification (Saldaña 2012). For the regional and country case studies, I collected original primary data through 48 in-depth, semi-structured interviews with key stakeholders and key informants involved in the intergovernmental health policymaking process in Spain and particularly in Extremadura and Madrid. I designed the questions of my semi-structured interview guide based on a stakeholder analysis, following mostly the works of Brugha and Varvasovszky (2000; Varvasovszky and Brugha 2000).

Careful selection of the interviewees based on their professional background and experiences was essential to obtain a fair and accurate portrayal of the Spanish situation. Key informants included university professors and lecturers of health policy, public health and health economics, as well as a few representatives of non-governmental organisations and interest groups (e.g. one actor recounted his experience with Spain's physicians association and another worked for a private health policy foundation). Key stakeholders interviewed included a variety of Spanish national and regional politicians and bureaucrats, who held positions in the political system or the National Health System (NHS) and participated in the health policymaking process before and/or after the 2001 health devolution reform. Initial interviews were obtained using the procedures of key informant and snowball sampling techniques, following the recommendations of Patton (2002). This led to the identification of a small but impressive network of experts on the topic. I personally requested interviews via email and followed them up when necessary, scheduled them and sent out thank you letters.

I performed these interviews in three waves. The first wave consisted mainly of preliminary interviews mostly with key informants and took place during the period December 2005–March 2006. Then, I consolidated and began employing my semi-structured interview guide in the second wave, which took place during the period March–July 2007. The third and final wave took place in October 2007.

To complement the interviews, throughout my preparation of the thesis, I collected secondary data from a variety of sources including research reports, most of which were published as peer-reviewed articles, newspapers, government bulletins and public documents, including relevant parliamentary debates,

regulations and legislation, and tertiary data, e.g. from the INEbase (a database for Spanish statistics).

In terms of data handling and analysis, I used the scientific method of content analysis to analyse systematically the text from the primary, secondary and tertiary data that I collected. This method is commonly used in the social sciences, including political science and public policy (Abrahamson 1983). As a reliable, discreet and context-sensitive technique, it allows researchers to process and analyse relatively unstructured data in order to recognise meanings, patterns, systems, institutions, etc. and make valid inferences from them to the contexts of their use (Krippendorff 2012). It is also constructive for answering policy questions regarding organisational phenomena, like decentralization. To carry out this method, I employed the assistance of the qualitative data analysis software program NVivo 9 to collate, code, categorise and analyse the interview transcriptions and digital recordings, simultaneously, as well as some secondary and tertiary data. I followed di Gregorio and Davidson (2008) for designing and conducting my qualitative research in the Nvivo 9 software environment and for implementing the research design. I used Saldaña's (2012) coding manual as a guide. Data not analysed with Nvivo 9 were processed and analysed in the traditional way of employing the content analysis method. The result of the content analysis was that I could draw inferences from it and validate them. In particular, I juxtaposed and triangulated inferences that stemmed from the primary interview data with the secondary data; when not available, I crosschecked and compared the information provided by different interviewees and informants. Finally, I used these inferences to give a narrative in the three empirical chapters of the thesis.

1.2. The Organisation of Chapters

This dissertation is structured as follows. Chapter 2 provides an extensive and up-to-date literature review in two main sections. First, to set the stage for addressing the research questions of the thesis, it critically reviews the literature on decentralization to locate devolution within it and to find a comparative and measurable definition for it. The review argues that Bossert's (1998) definition and measurement of the decentralization of health systems are the most advanced theoretical and empirical tools in the literature for comparatively analysing these organisational reforms; however, since they have never been applied to upper-

middle- and high-income countries, they require some modification for use in this thesis. Second, a suitable model for analysing the policymaking process and its structure and agency in a devolved health system is identified through an examination of the theory and empirics behind interest-based policymaking approaches. In its review of interest-based policymaking, this chapter examines the policy network approach, rational choice institutionalism, game theory, and the principal-agent model, among other literature. It does so to understand which of these best represents the structure and agency inherent in a devolved government setting. It concludes that Blom-Hansen's (1999) intergovernmental policy network approach, which incorporates concepts of rational choice institutionalism, is most appropriate for analysing the power structure of a devolved system and the interactions among significant intergovernmental policy actors as well as for explaining different policy outcomes. The policy network approach and rational choice institutionalism overlap in their emphasis on actors and their behaviour and interests. At the same time, they complement each other because the policy network approach highlights the additional value of including a relationship-based perspective when studying the policymaking process and its outcomes, while rational choice institutionalism stresses the importance of institutions. Consequently, Blom-Hansen's approach provides a robust empirical analysis of intergovernmental relations within a decentralized policymaking environment and demonstrates its practical usefulness by applying it to the health, economic and childcare sectors of Scandinavian countries. Third, this literature review chapter closes by proposing the integration of Bossert's decision-space approach and Blom-Hansen's intergovernmental policy network approach as a suitable way forward for analysing health policy priorities in a devolved system.

Chapter 3 presents the analytical framework of the thesis, which in addition to modifying and combining the two-aforementioned analytical approaches identified in the literature, develops an additional tool for analysing policymaking at the subnational level of government. Specifically, the framework modifies Bossert's approach to define the level of discretion (or range of choice) allowed for functions of the health system at the subnational level by adjusting it for use with upper-middle- and high-income countries. The range of choice is categorised as narrow, moderate or wide. For a narrow range of choice at the subnational level, the framework turns to the national policymaking environment, incorporating Blom-

Hansen's approach, which identifies three types of actor groups—expenditure advocates, expenditure guardians and topocrats (topocrats are the representatives of subnational governments that seek to influence national policymaking)—whose abilities to pursue their self-interests are hampered and facilitated by the structure of their intergovernmental policy network. The thesis presents a novel index for measuring topocrat strength as well. For a wide range of choice at the subnational level, the framework examines the subnational policymaking environment using my original contribution to the literature: an intergovernmental health policy network with actor groups and assumptions for their behaviour that stem from Blom-Hansen's approach but are specific to the subnational policymaking environment in a devolved system. This new intergovernmental policy network extends the concept of expenditure advocate and guardian actor groups from the national to the subnational level. In addition, it uniquely identifies a new institutional actor group, which I call the *kentrocrats* and define as the representatives of national-level government who seek to influence the subnational policymaking. It also presents an original index for measuring the stewardship of health-sector kentrocrats, stemming from the literature on health system stewardship. For a moderate range of choice at the subnational level, the national and subnational intergovernmental policy networks share power and will need to be examined more closely with respect to the affected policy to understand whether one supersedes the other or if the two should be described as fully interrelated (which I believe is rather rare empirically). Consequently, the corresponding intergovernmental policy network and policymaking environment is then examined.

In summary, Chapter 3 constructs an analytical framework that (i) provides a comparable definition and method of measuring health system devolution in upper-middle- and high-income countries; (ii) provides a thorough description of the policymaking process in a devolved health system; (iii) analyses this process more precisely and accurately, using two new indices for measuring actor strength, to determine the effects of devolution on policymaking; and (iv) anticipates the policy priorities in a devolved health system. Chapter 3 closes with a presentation of the research design and methods employed in the three empirical chapters that follow it.

Chapter 4 empirically applies the first of three components of the analytical framework to the case of Spain: defining and measuring decision space for health system devolution. In particular, it employs the modified decision-space approach

to Spain's 2001 devolution of health service competencies, which affected 10 of its 17 autonomous communities (or regions). While I provide some information on all ten regions, the primary focus of the study is on the regional cases of Extremadura and Madrid. This analysis examines the *de jure* decision space systematically for the periods before and after devolution: 1996–2001 and 2002–2006, respectively. It results in a decision-space map for each period, which illustrates the range of choice allowed for specific functions within five health system functional areas. The maps demonstrate how the 2001 devolution reform changed the decision space at the regional level in Spain. It also discusses some *de facto* results that the analysis reveals.

Chapter 5 empirically applies the second and third components of the analytical framework to the case of Spain: the integrated intergovernmental policy network approach for both the national and subnational policymaking environments. The chapter begins by describing the structure of the intergovernmental health policy networks and the model of actor behaviour in the Spanish national and subnational (informal) policymaking environments. Primary interview data are used to validate the appropriateness of identified actor groups in Spain. This chapter, then, analyses and establishes the positions of these actor groups within the intergovernmental health policy networks at both the national and subnational level for Spain and the regions of Extremadura and Madrid. Finally, it discusses the resulting power-sharing situations, showing the trade-offs in intergovernmental health policymaking at both levels of government before the 2001 health system devolution reform and after it for the period 2004–2006.

Chapter 6 evaluates the analytical framework empirically, combining the results from Chapters 4 and 5 (specifically, the *de facto* decision-space maps and the *ex*-ante trade-offs in intergovernmental health policymaking) and examining whether these health policy priorities hold for Spain and the regional cases of Extremadura and Madrid for the period 2004–2006. This chapter analyses three health policies within the subnational health policy network—waiting time guarantees, common health benefit package expansions, and paying medical specialists in hospital ambulatory settings—, each of which belong to a different functional area of the health system. Additionally, it analyses the policy for increasing health financing to the regions within the national health policy network. Although the analysis may be applied to health system functions with different

amounts of decision space, this chapter focuses the analysis on these policies, which belong to health system functions with a moderate amount of decision space after 2001. Moreover, the time-period of this part of the study ensures that the regions are fully in the implementation phase of their health service competencies and responsibilities. It also guarantees—through a stable institutional architecture for both the health and finance sectors—that the balances of power within the intergovernmental health policymaking environments in Spain are unchanging. Once more, the focus of this analysis is on the degree to which *ex-post* health policy in these two regions reflects the *ex-ante* privileged position and goals of key actors in the decision-making process. My assessment of this employs three different measures of the effectiveness of intergovernmental policy (as described in chapter 3): policy efficiency, policy strategies and policy failures.

In Chapter 7, I discuss the empirical findings of this doctoral thesis and present conclusions. Limitations of the intergovernmental policy network approach are highlighted and possible improvements to the application of the analytical framework are outlined. Overall, the findings suggest that the analytical framework of the thesis is adequate to define the decision space and policymaking process in a devolved health system and partially successful in anticipating *ex-post* health policy priorities. Ways to improve the framework further are presented, along with potential areas of further research, policy implications and lessons learnt.

2. Decentralization, Devolution and the Policymaking Process

This chapter reviews the literature on decentralization, including devolution, and its relationship to the policymaking process, structure and actors. The first subsection reviews the history behind decentralization reform, conceptualises it and discusses how it can be defined and measured. Where appropriate, it incorporates details specific to the devolution-form of decentralization. Because there is no established framework for analysing decentralization and devolution reforms in more economically developed countries (i.e. upper-middle- and high-income countries), the goal of this subsection is to present a broad summary of the general and health-specific literature on decentralization and devolution with the hope that it provides direction on how to create one. To complement this subsection, Appendix A reviews the literature on the theoretical effects of decentralization in the governance and political literature. Overall, this first subsection buttresses the second subsection because decentralization and devolution are institutional reforms that affect the policymaking process and policies that follow it.

The second subsection reviews the public policymaking process and different theories, approaches and models for the classical concepts of structure and agency. Specifically, it covers the literature from the interest-based perspective, describing the theoretical and empirical literature on rational choice institutionalism and presenting the principle-agent model and the policy network approach. This subsection addresses the current literature on the research questions of the thesis: (1) How does devolution change the structure and agency of the health policymaking process? (2) What is the resulting impact on health policy priorities? This subsection is also purposely broad in nature, narrowing to a discussion on the analytical approaches in the literature that have the greatest potential to offer insight into the "black box" of policymaking within a devolved health system.

The final subsection of this chapter collects the most salient research emerging from the previous two literature reviews, and combines them to form a framework for the analysis of the research questions in upper-middle- and high-income countries.

2.1. Decentralization Reform

2.1.1. A Brief History of Decentralization

Decentralization, and its specific form of devolution, is a relatively recent phenomenon in unitary states; that is, in non-federal states. Prior to the 1950s and 1960s, the governance trend in unitary states for centuries has favoured centralization (Treisman 2007b; Saito 2011). Indeed, since the beginning of mankind, centralising power was the prevailing answer to the age-old question of how governments should be organised (Faguet 2012). With the development of European welfare states around the mid-twentieth century, countries began to centralize some policymaking authority further from national to supranational unions, such as the European Union, though maintaining their sovereignty; for the most part, however, public and social policy remained at the national level of government. Nonetheless, with the democratisation of several European countries (sometimes labelled the "third wave of democratisation") and the increasing need for reform to adjust to new economic conditions, a new trend of decentralizing functions and powers to subnational and local governments arose.[4] This doctoral dissertation focuses on the consolidation of this new, important, but less understood period of decentralization.

Over the next half-century, the countries that decided to decentralize public and social policy and services, including health care, hoped to achieve efficiency improvements and address broader institutional needs. By the early 1960s, centralized, industrialised democracies were challenged by increased, often heterogeneous, demands from their citizens, especially with regard to the provision of services (Saito 2011). In such cases, advocates deemed administrative decentralization the solution to issues that could be managed locally (J. M. Cohen and Peterson 1996). In the 1980s, economies began to stagnate, central bureaucracies began to show increased inefficiency, and reducing the size of the central government through decentralization of responsibilities to subnational governments seemed the best way to reverse these trends in industrialised and developing countries alike (Saito 2011; A. L. Schneider 2003). For the Reagan administration in the United States (US), this meant modernizing the public sector

[4] Faguet (2012, 3) provides a thorough and concise account of the historical context of centralization and decentralization.

(including the health), accompanied by administrative decentralization and privatisation of public services (Saito 2011). Meanwhile, international aid agencies piped and pushed decentralization strategies as a better way for developing countries to reach their urban and rural poor and increase their participation in the development process. The most notable and effective of these strategies were included in the structural adjustment programs of the International Monetary Fund and the World Bank (Saito 2011). By the end of the Cold War, democratisation took a front seat on the world's development agenda, and decentralization, particularly political decentralization, seemed to be a means to advance it (Cohen and Peterson 1996).

During the same period, domestic voices also pressured for decentralization, although with a different goal in mind: increased local control and autonomy (B. C. Smith 1985). Subnational politicians and civil society actors desired a higher stake in local affairs and thus were amenable to power and resource transfers. Left-wing parties generally backed decentralization as a means to distribute more power following a democratisation agenda, while right-wing parties supported it because of its potential to make government more efficient by bringing some interjurisdictional competition. In Spain, for example, decentralization was responsive to the demands of regional governments and their populations for more autonomy after decades of living under a dictatorship. Other countries, such as Denmark and Sweden, maintained a decentralized organisational structure to continue allowing adjustments to specific local needs and coping with the heterogeneous demands of the population.

In addition, central governments looked to decentralization as a way for off-loading their sometimes burdensome management responsibilities for public services and, yet, still be able to offer them to their populations (A. L. Schneider 2003). Consequently, central government politicians looked to exchange power and resources for more support from subnational governments. Trade liberalisation and international treaties (e.g. the European Economic Community) also affected the decisions of central governments to transfer some of their public service responsibilities and authority to subnational governments.

In the 1990s, many industrialised countries viewed political and fiscal decentralization or devolution in unitary states as a way to achieve greater choice without harming social equity. Modernisation reforms and the privatisation trend

continued through this decade (Tanzi 2008). Countries, such as Italy, that had already devolved their national health system and were providing access to services based on citizenship (and thereby experiencing reduced social inequities) turned to administrative decentralization to improve their effectiveness (France and Taroni 2005). Overall, then, since the 1950s, decentralization has been seen as a panacea for numerous systemic issues in unitary states.

2.1.2. What is Decentralization?

Decentralization fundamentally means the dispersion or distribution of functions, powers and authority from a centre (Wolman 1990). This definition, however, does not provide sufficient precision when applied to government. Indeed, whereas the literature has a generally agreed-upon definition for centralization as "the concentration of power, resources and authority in a single head or center" (A. L. Schneider 2003, 34), it emits several definitions for decentralization. Bennett (1990, 1) describes decentralization as "a single term … [that] disguises a complex and highly varied set of phenomena." The real issue, however, is not with the varied meanings but rather that scholars need to proceed cautiously to avoid over- and under-specification (A. L. Schneider 2003).

Until recently, decentralization has been studied differently in various countries. The three largest distinct pools of literature on decentralization comprise (i) the development literature, which targets developing and transitioning countries, (ii) the more general literature, primarily on industrialised countries outside the US, and (iii) the US literature. Saito (2011, 285) writes, "Attempts at comparative cross-national analyses have been further fragmented by specific regional focuses. For instance, while Western Europe has been relatively well studied, only recently have limited pioneering attempts been made to integrate assessments of industrialised countries with those of developing countries (e.g. Wibbels 2005; Rodden 2006)."

Moreover, decentralization is a common term in many academic disciplines (Cohen and Peterson 1996). Indeed, it has been studied in accountancy, administration, anthropology, economics, history, law, management, philosophy, psychology, political science, public and social policy, sociology, and theology. However, because of the different meanings of the word in these various disciplines, decentralization has been studied mostly in silos and not in an inter-disciplinary way. Additionally, the term has been modified to fit the concepts associated with it.

For example, decentralization permeates the conceptual literature on agency theory (also known as principal-agent theory), central-local relations, public choice theory, and fiscal federalism. Moreover, often the literature in a discipline uses different terms for the same concept (Peckham et al. 2005); for example, the term "central-local relations" can refer to the organisational structure created by decentralization. Other terms may appear at first glance to also refer to decentralization but actually refer to only one form of decentralization (e.g. regionalisation), may embody key differences in meaning (e.g. regionalism), or may be interpreted in divergent ways within the literature (e.g. federalism). Finally, decentralization is often linked with many related concepts, such as autonomy, power, and localism (Peckham et al. 2005).

The result is considerable confusion and misunderstanding about *what decentralization is*. Because of this, researchers from different disciplines often talk past each other (Schneider 2003). For example, on the one hand, economists tend to centre on the view of decentralization as a way to enhance competition at the subnational levels of government (Oates 1972; Tiebout 1956). As such, governments are assumed to compete for regulatory power and resources (e.g. the right to make expenditures and levy taxes) and the beneficiary of such competition is the citizen who pays fewer taxes and/or receives more-efficient services. This research is categorised according to the terms and sub-fields of the economics discipline, such as public choice, fiscal local choice and fiscal federalism. Meanwhile, political scientists focus more on the effects of decentralization on governance and political values, such as responsiveness, accountability, diversity and innovation at the subnational level, or policy stability at the national level. Only recently have some researchers begun to cross the disciplinary divide, achieving a fuller understanding of decentralization and its processes (Smoke, Gomez, and Peterson 2006; Faguet 2012; Exworthy, Peckham, and Powell 2012; Costa-Font and Greer 2013).[5] There remain, however, many unresolved questions regarding the conceptualisation, definition and measurement of decentralization and devolution, especially regarding health systems.

[5] See also Oliver's (2013) account of the importance of interdisciplinary research.

2.1.3. Conceptualizing Decentralization

Scholars have reached a consensus on few issues related to decentralization. It is the antagonist of centralization, but not an alternative to it (UNDP 1998). Nor do decentralization and centralization form a simple dichotomy; rather, they are opposite ends of a continuum (Wolman 1990). In addition, centralization and decentralization can co-exist in the same national system, as some functions seem most logically to belong at different levels of government – e.g. foreign policy with the central government and solid waste management with the local government (UNDP 1998).

While decentralization refers to a specific structural arrangement of government, it also describes a *process*, or a means to an end. Peckham et al. (2005) describe decentralization as "a process – one of a number of factors – that can be employed for achieving particular goals rather than an end in its own right". Decentralization has no general normative implications; that is, it does not inherently produce good or bad governance (see Appendix A).

Decentralization is often interchanged with the terms regionalisation, regionalism or federalism; and regionalism and regionalisation are often confused with one another (Tuñon 2013). To disperse this confusion, I discuss how these are the same and/or different terms. Regionalism is a political ideology, referring to the organisation of a community and focusing on the interests of a particular region (B.C. Smith 1995). Caciagli (2006, 12) defines regionalism as a "process, first cultural and afterwards, but not always, political, produced by a community endowed with a strong feeling of territorial membership". The goal of regionalism centres on increasing a region's influence and political power. This is usually done to gain greater competencies because of anthropological, historical, cultural or social factors. Regionalism is ascending from the bottom-up; therefore, if anything, it is the centralization of powers and authority but without destabilizing a state (Albina and Khasson 2008). Often, states have pursued regionalism in conjunction with neighbouring states for the purpose of greater regional economic integration, such as in the formation of the European Union. Therefore, regionalism cannot be understood as a synonym for decentralization.

Regionalisation, in politics, is a process wherein "the state initiates a devolution process mobilizing the region to bring government closer to the

citizenship" (Tuñon 2013, 5). It is a process of dividing a country into smaller subnational territories—particularly 'regions'—and transferring power and authority to them from the central government. Similar to decentralization, but contrary to regionalism, regionalisation is a top-down process, involving "a territorial planning based on already existing state powers" (Petschen 1992). Different from decentralization—which does not specify the level of government to receive the transfers, which for example could be moved to a regional or a municipal level—, regionalisation transfers functions and authority from a central to a regional government. Thus, regionalisation is a particular variety of decentralization and, as we will see later in this review, there are several varieties of decentralization.

Federalism also has many variations in the literature. It is generally agreed, though, that federalism describes a system of government in which sovereignty (and political power) are constitutionally divided between a central authority and subnational authorities (e.g. states). Although by definition it has a decentralized polity and the same structure as a politically decentralized unitary state (B.C. Smith 1985), a federation may be established through either a decentralization or a centralization process. The more commonly known type of federalism is centrist, creating a federation from the bottom up when a "stronger central authority is sought by regions loosely allied in a confederation" (B. C. Smith 1985, 56). The US, Australia and Mexico are examples of federations created by centralizing power. On the other hand, federations can be created through "a move from a unitary state to one in which constituent territories are given constitutional safeguards" (B. C. Smith 1985, 55), or "decentralist federalism" (King 1982). One such example is Germany after World War II. In sum, not all federations have experienced decentralization and a decentralized national system is not necessarily a federation. Furthermore, the difference between centralization and decentralization is not equivalent to the difference between federal and unitary states, as "unitary states may be characterized by decentralization while federal states may be characterized by centralized decision-making" (Wolman 1990, 30).

Like decentralization, a federation may be symmetrical or asymmetrical, with all subnational governments having the same or varying power and status, respectively. In a federal system, self-governing subnational governments share sovereignty with the central government, who cannot unilaterally change the existence or powers of the subnational governments. In contrast, subnational

entities in unitary systems are not self-governing but may be changed – broadening or narrowing their powers – or abolished by the central government, which holds the supreme authority. Biela, Hennl, and Kaiser (2013, 6–7) argue that federalism and decentralization are "two different dimensions of territorial organisation of state activity, i.e. multilevel systems which exhibit independent as well as interdependent effects".

2.1.4. Finding a Comparative and Measurable Definition for Decentralization

Before addressing any one particular definition or measure for decentralization, I present here the most widely accepted typology for decentralization in the literature: Rondinelli's (1981) public administration "type-function framework" of administrative, political and fiscal forms of decentralization. In an attempt to simplify the explanation of the different structural arrangements of decentralization, Rondinelli developed this typology and it has permeated the literature ever since, though, at times with modifications. For example, Rondinelli, Nellis and Cheema (1984) included political, administrative, spatial and market forms of decentralization; Wolman (1990) included administrative, political and economic forms; Cheema and Rondinelli (2007) included administrative, political, fiscal and economic forms. Thus, I will discuss each form in detail separately to understand what it represents and how it differs from the others.

The forms of decentralization most frequently mentioned in the literature are administrative and political decentralization. Administrative decentralization is the hierarchical and functional distribution of powers and functions between central and subnational government units. It has three variations, often called types in the literature: de-concentration, delegation and devolution. First, the *de-concentration* type of administrative decentralization is the redistribution of decision-making authority and management responsibilities among different levels of government, but still under the jurisdictional authority of the central government. Second, the *delegation* type of administrative decentralization is the transfer of responsibility for decision-making and administration of public functions from the central government to semi-autonomous organisations not wholly controlled by the central government, but ultimately accountable to it. Third, the *devolution* type of administrative decentralization means the transfer of authority for decision-making, finance and management to quasi-autonomous units of subnational government with corporate

status granted under state legislation and accompanied by underlying political decentralization (Rondinelli, Nellis, and Cheema 1984; Cheema and Rondinelli 1983; J. M. Cohen and Peterson 1996).

Political decentralization, also referred to as 'devolution'[6], is the transfer of decision-making power from central to subnational governmental units or to citizens and their elected representatives (Rondinelli, Nellis and Cheema 1984; Cheema and Rondinelli 1983; Cohen and Peterson 1996). As Cheema and Rondinelli (2007, 7) indicate, it "includes organizations and procedures for increasing citizen participation in selecting political representatives and in making public policy".

The remaining forms of decentralization are fiscal, economic (or market) and spatial. Fiscal decentralization is the transfer of financial responsibilities from central to subnational levels of government (Rondinelli, Nellis and Cheema 1984; Cheema and Rondinelli 1983; Cohen and Peterson 1996). It "includes the means and mechanisms for fiscal cooperation in sharing public revenues among all levels of government" (Cheema and Rondinelli 2007, 7). Economic or market decentralization focuses on "market liberalization, deregulation, privatization of state enterprises, and public-private partnerships" (Cheema and Rondinelli 2007, 7). Spatial decentralization is the transfer of excessive urban concentration in a few large cities to regional growth locations with the potential to become centres of manufacturing and agricultural marketing (Cohen and Peterson 1996; UNDP and Government of Germany 1999).

In practice, these forms of decentralization are not (and cannot be) entirely discreet. For example, fiscal decentralization should follow political and/or administrative forms of decentralization; otherwise, having little to no control over their revenue function, the subnational governments receiving the political and administrative competencies may not be able to execute effectively their newly acquired power, authority and responsibilities. Moreover, political decentralization (or devolution) is the most complete form of decentralization and must be supported by fiscal and administrative decentralization to be successful.

The same typologies have been applied to the literature on health system decentralization. Building on Rondinelli's forms and types, Mills et al. (1990)

[6] Not to be confused with the devolution type of administrative decentralization, despite the same name; though, these often go hand-in-hand.

determined that four types of decentralization are most common in the health sector: de-concentration, delegation, devolution and privatisation (also known as divestiture, and related to economic or market decentralization). Any given country may have one or more of these types in its health sector at once (A. Mills 1994). Bossert (2004) describes the example of the Chilean health system, where different types of decentralization co-exist: while Chile's Central Ministry of Health ensures the constitutional right to health protection and performs a stewardship role over the whole system; it has *de-concentrated* responsibilities for health service delivery to its Regional Health Offices, *devolving* the network of primary health care facilities to the municipalities; in addition, it has *delegated* responsibility for collecting, administering and distributing fiscal resources for the system to the National Health Fund, and it has *privatised* health insurance plans.

Despite all the scholarly attention, this type-function framework provides little comparative utility and has never seemed to advance the literature much. In fact, some authors have argued that this over-specification of decentralization has led more often to confusion and even stagnation (Peckham et al. 2005; Treisman 2007b; Peckham et al. 2008; Faguet 2012; Costa-Font and Greer 2013). Faguet (2012, 196) considers this approach to be a case of "definitional failure":

> Instead of articulating a clear definition of decentralization from the start, many authors allowed themselves to be led conceptually by the phenomena they encountered. The quasi-spontaneous definition that so emerged is opaque, malleable, and ultimately unstable. It ranges from the de-*concentration* of central personnel to field offices in authoritarian systems, via the *delegation* of managerial responsibilities to organizations outside the regular bureaucratic structure, and the wholesale *divestiture* of public functions to the private sector, to the *devolution* of resources to autonomous, elected subnational governments. … All of these phenomena often find themselves jostling together under the rubric *decentralization*. But these are instead fundamentally different institutional reforms that establish systematically different incentives and thus prompt government officials to different behavior.

Costa-Font and Greer (2013, 4) illustrate this definitional failure with an empirical example:

> This definition creates a remarkable level of confusion: simply put, creating a Scottish Parliament, selling British Telecom, and moving the drivers' license agency out of London are three profoundly different kinds of actions, and lumping them together does not make them easier to understand.

It is, however, possible to find an accurate, precise and measurable definition of decentralization in the literature. While the common-sense definition for decentralization may be too ambiguous, here I discuss a few of the many example definitions of decentralization in the scholarly literature. Faguet (1997) considers several general definitions of decentralization and highlights this one by Rondinelli (1981):

> The transfer of responsibility for planning, management, and resource-raising and allocation from the central government to (a) field units of central government ministries or agencies; (b) subordinate units or levels of government; (c) semi-autonomous public authorities or corporations; (d) area-wide regional or functional authorities; or (e) NGOs/PVOs [i.e., non-governmental organizations and private voluntary organizations].

This definition specifies the different responsibilities that may be transferred through decentralization as well as the various units or authorities that may receive the transfer of such responsibilities. The definition may seem comprehensive, but decentralization has many more dimensions. Later in his writings, Faguet (2012, 2 bold in original) underscores the importance of having a clear definition for decentralization and uses the following definition in his study *Decentralization and Popular Democracy* in Bolivia:

> **Decentralization** is the devolution by central (i.e., national) government of the specific functions, with all of the administrative, political, and economic attributes that these entail, to democratic local (i.e., municipal) governments that are independent of the center within a legally delimited geographic and functional domain.

In both this definition and the following passage from a publication by the United Nations Development Programme (UNDP) and Government of Germany (1999, 1), the many dimensions of decentralization are apparent:

> Decentralization is a complex phenomenon involving many geographic entities, societal actors and social sectors. The geographic entities include the international, national, subnational and local. The societal actors include the government, the private sector and civil society. The social sectors include all the development themes – political, social, cultural and environmental. … Decentralization is a mixture of administrative, fiscal and political functions and relationships. In the design of decentralization all three must be included.

These definitions together highlight the multiple aspects or dimensions that may be present in a particular definition of decentralization. The first dimension is the geographic or territorial aspect of decentralization. The second dimension

regards the actors involved in the process, such as entities in the government, private sector or civil society. The third dimension is the sectoral aspect of decentralization, which may have a significant bearing on the process because one form and type of decentralization may be more appropriate for some sectors than for others, and decentralization of a specific sector competency may be more appropriate to one subnational level of government rather than another. The fourth dimension regards functions within a sector, which may be decentralized to different extents and to different subnational governments. For example, Rondinelli's (1981) definition included some of these functions: "planning, management, and resource-raising and allocation". The fifth dimension includes the different forms of decentralization—administrative, fiscal and political—as defined by Rondinelli (1981). The sixth dimension includes the relationship aspect, which varies according to the form and actor dimensions, shedding light on an often-overlooked aspect of decentralization: the intergovernmental relationships resulting from the decentralization, and particular devolution, process. See Table 2.1 for a summary of these dimensions.

Table 2.1. The Main Dimensions of Decentralization

	Dimension	**Description**	**Examples**
1	Territorial/ geographic	What major geographic entities are involved in the process?	International, national, subnational (e.g. regional, provincial), local (e.g. municipal)
2	Actor	What main actors are involved?	Government (central, subnational, local politicians or bureaucrats), private sector, civil society
3	Sector	Which sector is involved in the process?	Health, education, environmental, economic
4	Function	What sectoral functions are involved in the process?	Planning, management, resource-raising, allocation, service provision
5	Form	What form(s) of decentralization is (are) involved?	Political, administrative, fiscal
6	Relationship	What is the newly created intergovernmental relationship that results from the process and how has it changed the incentive framework among the main actors and the behaviour we should expect from them?	E.g. an administrative delegation of functions to subordinate units or levels of government could imply a principal-agent relationship

Nota bene: These numbered dimensions do not suggest any order of importance.

Thus, unlike the existing literature which focuses on one of these six dimensions (i.e., the form of decentralization), a good definition of decentralization for the thesis would have to consider most, if not all, six of these dimensions and be focused on the devolution type of political decentralization.

In the following, I explore the most salient analytical frameworks of decentralization in the general works and health-specific literature that improve on or go beyond the type-function framework, comparing them against these six dimensions to understand their comprehensiveness and looking for the one that provides the most comparable measurement for decentralization. Cohen and Peterson (1997) proposed an "Administrative Design Framework," which focuses on administrative decentralization, and its three types, in order to help developing countries improve governance, accountability and performance. Their framework studies the concentration of organisational and institutional roles and public sector tasks and identifies three administrative design strategies: *institutional monopoly* (or centralization); *distributed institutional monopoly* (or administrative decentralization with roles within one organisation); and, *institutional pluralism* (administrative decentralization with roles shared by two or more organisations). Compared to our six dimensions of decentralization, the administrative design framework only addressed the territorial/geographic (or spatial) dimension, the actor dimension and the form dimension. For the form dimension, it only focused on administrative decentralization and not political decentralization (or devolution). Thus, despite reducing some confusion around decentralization by centring its analysis on only one form, this framework does not improve on the definition and measurement of decentralization much and not at all of devolution.

Gershberg (1998) proposed rather a framework for analysing performance accountability in "decentralizing" social service delivery systems, considering the following seven aspects: finance, auditing and evaluation, regulation and policy development, demand-driven mechanisms, democratic mechanisms, service provider choice/mix, and civil service and management systems. His framework emphasises determining who is responsible for providing services, what incentives exist for motivating effective service provision and how well the actual services function. Gershberg applied his framework to the education and health sectors of Mexico and Nicaragua and recommended that lessons derived from these experiences should emphasise contingent recommendations (i.e., if X, then Y) rather

than blanket evaluations. Compared to our six dimensions of decentralization, Gershberg's framework examines the actor (the '*who'*), sector and function dimensions. It does not specify a form of decentralization but rather points to, but does not elaborate on, the use of degrees of decentralization for appropriate definition and measurement of decentralization. At the same time, Gershberg discourages using existing tools in the literature to determine this measure. Admittedly, Gershberg acknowledges that his framework does not result in a road map for decentralization.

With the shortcomings of the above frameworks and our six dimensions of decentralization in mind, I find Bossert's (1998) decision-space approach to analysing the decentralization of health systems in developing countries particularly useful. Bossert's main objective was to design a comparative analytical framework to determine the effectiveness of decentralization in achieving health system goals. Quite different from most of the approaches for analysing decentralization that we have discussed already, Bossert emphasises the *degree of discretion allowed* through decentralization as being more important than *who* gets the greater range of choice at the local level. He sought to establish a consistent means of defining and measuring decentralization in different national systems, settling for this purpose on the concept of "decision space," which maps the range of choice (or degree of discretion) that the central government has granted to local authorities for a series of key health system functions. The map depicts the range of choice on its horizontal axis and defines it as narrow, moderate or wide. On the vertical axis, it places a series of functional areas of the health system, including finance, service organisation, human resources, and access and governance rules (Bossert 1998); subsequently, logistics systems were added (Bossert, Bowser, and Amenyah 2007). For each functional area, Bossert suggests indicators that could be examined for a rigorous, comparative mapping of the decision space. For example, for the functional area of finance, he displays four key functions. One of them is *sources of revenue*, which he measures by the indicator of intergovernmental transfers as a percentage of total local health spending, with 'a high percentage' indicating a *narrow* range of choice. A second example is *income from fees*, which he measures by the range of prices that local authorities are allowed to establish, with 'no limit' implying a *wide* range of choice (Bossert 1998, 1518). Importantly, Bossert's definition and measurement approach allows decentralization to be conceptualised

not as a single transfer of a block of authority and responsibility, but rather as a series of functions, for which different levels of discretion may be transferred to the local level.

Bossert's definition of decentralization becomes the foundation of his decision-space approach, which he combines with an interest-based approach to policymaking, namely, the principal-agent approach. In doing so, he inherently focuses on the role of actors, and their relationships and interactions. He uses this approach in particular to examine the principal's use of channels of control (e.g. incentives, sanctions and monitoring compliance) over the agents in order to ensure that the agents work towards achieving the desired health reform objectives. He also looks at how agents given a wide range of choice over a function choose to take advantage of this new decision-making power: do they innovate, do they reject central directives or do they just continue doing what they had done before? Bossert evaluates the impact of these decisions on the performance of local health systems in achieving the national health system's objectives.

Over the years, Bossert and others have successfully applied his decision-space approach, including his definition of decentralization, to several country health systems in developing countries:

- Bolivia (Bossert 2000; Bossert, Larrañaga, and Ruiz-Meir 2000);
- Chile (Bossert 2000; Bossert, Larrañaga, and Ruiz-Meir 2000; González-Rossetti and Bossert 2000);
- Colombia (Bossert 1998; 2000; González-Rossetti and Bossert 2000);
- Ghana (Bossert, Beauvais, and Bowser 2000; Bossert and Beauvais 2002; Bossert, Bowser, and Amenyah 2007);
- Guatemala (Bossert, Bowser, and Amenyah 2007);
- the Indian state of West Bengal (Bossert et al. 2009);
- Mexico (González-Rossetti and Bossert 2000);
- Nigeria (Adebusoye 2009);
- Pakistan (Bossert and Mitchell 2011);
- Philippines (Bossert, Beauvais, and Bowser 2000; Bossert and Beauvais 2002);
- Uganda (Bossert, Beauvais, and Bowser 2000; Bossert and Beauvais 2002);
- Vietnam (Bossert, Mitchell, and Blanchet 2009); and
- Zambia (Bossert, Beauvais, and Bowser 2000; Bossert and Beauvais 2002).

Notably, Bossert and Mitchell (2011) modified Bossert's original decision-space approach, combining it with the concepts of institutional capacities and mechanisms

of accountability – which, they suggest, are responsible for producing improved outcomes – and measuring these factors in an empirical study of Pakistan.

Bossert's definition of decentralization and his approach to measuring it are the most advanced tools, both theoretically and empirically, in the health system literature today. Bossert's decision-space approach incorporates all six dimensions of decentralization. It also offers a means for measuring decentralization, which can be applied to political decentralization or devolution. However, since Bossert's approach was designed for (and, prior to this thesis, has been applied only to) developing countries, the functional areas and functions needed in a developed country may not be directly applicable to a health system in an upper-middle- or high-income country.

2.2 The Policymaking Process, Structure and Agency

> In the process of public policymaking, problems are conceptualized and brought to government for solution; governmental institutions formulate alternatives and select policy solutions; and those solutions get implemented, evaluated, and revised (Sabatier 2007, 3).

Understanding the complexities of the policymaking process requires knowledge of actors, institutions and issues over extended periods. As such, analysts have developed different theories, approaches and models to simplify the process in order to understand it better.

In this subsection, I review existing literature in search of the best theory and approach to employ in considering the following questions: (1) How does devolution change the structure and agency of the health policymaking process? (2) What is the resulting impact on health policy priorities? To answer these questions, it is important to use a theoretical approach that simplifies the policy process and focuses on the essential features of the empirical case. The scholarly literature is full of theoretical approaches that do this; they can be categorised according to their predominant perspective on the policy process, as either macro-view (or structure-based), meso-view (or institution-based) or micro-view (or interest-based). After a more expanded critical review of the literature on all three perspectives (Appendix B presents a review of the literature on structure-based and institutional-based approaches), I centre on the micro-view and its interest-based approaches to policymaking. I introduce each approach with reference to the general public policy literature and then present its development with respect to the health policy

literature. The review is purposely broad—and not Spain-specific—as it looks to find a comparative analytical approach to studying and examining the policymaking process in a devolved health system.

To understand the relationship between this review and the overall goals of my thesis, I kindly remind the reader of the key features of the policy process on which this thesis focuses. My first research question concerns the influence of devolution (the independent variable) on (i) the structure and (ii) agency of the health policymaking process (dependent variables). With regard to the independent variable and recalling the importance of a clear definition and our six dimensions for defining decentralization, the study uses the following definition for **health system devolution**:

> The transfer of power and authority over specific health system functions from the central government to subnational government units, with all the administrative, political and economic attributes and relationships that these entail, including the discretion to engage effectively in decision-making regarding health policies within their legally delimited geographic and functional domain.

Thus, a key element is the transfer of decision-making power and authority over health system functions to the subnational government actors, who become new players in the policymaking process. Consequently, the research focuses not only on the policymaking process itself but also on institutions and actors, as well as the relationships between them. Accordingly, this subsection reviews the theoretical and empirical literature on interest-based approaches and models to policymaking, which pay particular attention to institutions and actors involved in the policymaking process and the structure of their relationships, of which the latter delimits actor behaviour and interactions with each other.

2.2.1. Interest-based Approaches to Policymaking

Interest-based models to policymaking focus on the role of actors, their relationships and interactions, and their respective policy preferences and strategies, offering a micro-level explanation of the policy processes and changes. These models differ in three main ways. First, they focus on specific types or groups of actors; for example, some models centre on the strategic actions of elites, others on bureaucrats and still others on private-sector interest groups (e.g. physician associations, unions, lobbyists, businesses). It is important, then, to determine which actors are the most

significant players for a given policymaking scenario and issue. Second, each model contains a way of representing actor interest and behaviour. Generally, there are three major perspectives: *homo recipricans, homo sociologicus* and *homo economicus*. Underlying many interest-based models are behavioural assumptions based on rationality. Third, interest-based models address the links between actors, i.e., their relationships. In these relationships, whether informal or formal, actors interact differently and design strategies for contributing to the process of policymaking. The literature is well stocked with models and frameworks that can be used to analyse the strategic decision-making interaction between two or more actor groups and, depending on the strategies they employ and the choices they make, to determine possible policy outputs and outcomes.

2.2.1.1. Actors in Policy: Actors in policymaking are "(groups of) individuals who participate in policy processes and whose preferences will ultimately determine the policy choice" (Knill and Tosun 2012, 40); see (Scharpf 1997) for further discussion). These actors may work independently, as individuals, or with others in a group. Relatively few individuals (e.g. the president) are likely to have a significant influence on policy by themselves, so most work together in groups to coordinate their policy influence. Accordingly, in the political science literature, the term "actor" usually denotes a group of individuals bound to each other by shared interests or common goals.

These groups of actors are usually categorised as collective or corporative actors. According to Laumann and Marsden (1979, 717), a collective actor is a group of individuals "who (1) share an outcome preference in some matter of common concern, and (2) are in an effective communication network with one another". Typical examples of collective actors are social movements, interest groups, social classes or ethno-religious groups who are united politically but not legally (L. C. Freeman, White, and Romney 1992). The literature also supports the notion of government as a collective actor because it "is composed of persons who have preferences regarding the policy area they are responsible for and which they express in front of the other actors (mostly the legislature) in order to turn their preferences into public policy" (Knill and Tosun 2012, 41). This description emphasises that actor preferences in government play a larger role in policymaking than the government's internal organisation. The collective actor, however, faces two weaknesses in its ability to act. First, it often confronts changes in perceptions,

preferences and interest; thus, collective actors have a relatively shorter duration and their form of action is considered unstable (or changeable). Second, it faces Olsen's (1965) "free-rider" problem, whereby it can be an individual's advantage not to invest effort in attaining a desired goal but rather to benefit from the efforts of others who are pursuing it already. However, this problem describes the situation of individuals within a group, not an overall group or collective actor. To circumvent these weaknesses, societies and organisations have developed ways to carry out collective action in a more stable fashion. This generally has meant the institutionalisation of collective groups from purely political entities into legal ones, based on contractual arrangements. When this happens, the actor group is considered a corporate actor. Flam (1990, 6) refines Coleman's (1974) original definition of corporate actors as "those organized actors which participate directly in (policy-oriented) decision-making, are formal organizations, have a real constitution and a real membership, but … can be said to also pursue autonomous, member-independent interests." Scharpf (1997, 56)) adds that they are "typically 'top-down' organizations under the control of an 'owner' or of a hierarchical leadership representing the owners or beneficiaries." A firm is the prominent example of a corporate actor in the literature.

Actors can also be characterised as public or private, with regard to whether their preferences and actions are on behalf of the state or their own interests, respectively. In representative democracies, public actors are elected individuals who represent citizens through policymaking and appoint other actors to do the same in the different aspects of the policymaking process. Key public actors include those in the executive, legislative and judicial branches who share power horizontally, as well as with the bureaucracy and political parties. There is also a vertical division of power within a state and across levels of government (e.g. decentralization or federalism). In addition to national institutions, supranational (e.g. EU or UN) and intergovernmental organisations increasingly influence domestic policymaking. Finally, there are private actors, interest groups and experts. Private actors are not elected or appointed government officials, but they offer policymakers valuable information and potential solutions to social problems. Key private actors in policymaking are interest groups (including lobbyists, interest associations, pressure groups and non-governmental organisations) and experts.

In a presidential system, the president as sovereign executive selects the cabinet and decides autonomously how much to rely on cabinet members' opinions in his or her decision-making. In parliamentary systems, the executive branch is more complex, as the head of the government (prime minister or chancellor) and ministers from the legislature form the cabinet. Depending on their ability to garner support from a parliamentary majority, a cabinet is formed in one of two ways. It may consist of members from only one party if that party has an absolute majority in parliament, but if there is a multi-party governing coalition, the cabinet usually has members from more than one party.

The legislature functions primarily to enact policies but also provides legitimacy for the political system and, mainly in parliamentary systems, carries out oversight and control functions over the executive branch. Legislatures can act positively to formulate and amend policies or negatively to block and delay policymaking (Kreppel 2011, 128). Generally, the executive is more active in policymaking than the legislature, and legislatures in presidential systems are more active than in parliamentary systems. In addition, there is usually little policy-related disagreement between the executive and the legislature in parliamentary systems, whereas marked conflict between the two is typical in presidential systems. In addition, the legislature is responsible for facilitating communication between citizens and the government and representing citizens' preferences in policymaking. This is how it imparts legitimacy to the political system. Regarding its oversight and control activities in parliamentary systems, the legislature has an arsenal of tools for monitoring and evaluating the executive's activities and controlling the budgetary process. Examples of such activities include committee hearings, investigative committees, special inquiries and hearings, ombudsmen, and the preparation of reports for particular subjects. In presidential systems, such activities are more limited.

Judicial actors in policymaking are primarily the constitutional court judges, who affect the design and content of public policy in a profound way through their authority to interpret and apply the constitution and other laws. Constitutional judges can influence policy directly through judicial review or by declaring a piece of legislation or a policy unconstitutional. They become agenda setters when lawsuits addressing the neglect of social problems by the executive and legislative branches come before them (e.g. lawsuits on the harmful effects of smoking on

public health; see Daynard, Hash, and Robbins 2002). In some countries, constitutional judges can even ban certain actors from participating in the policy process. More generally, they can play a political role, as they usually have their own political preferences and have been nominated or selected by certain governments. For example, the US Supreme Court justices are nominated by presidents and ratified by the Senate. Presidents usually make Supreme Court nominations based not only on professional merit, but also on ideological compatibility and political support from the President and her cabinet.

Bureaucratic actors are generally the implementers of policy, but they can also play a role in formulating policy due to their procedural and specialised knowledge (Knill and Tosun 2012, 60). Bureaucrats are known for their technical capacity and autonomy in relation to elected politicians (Scartascini 2008, 64–65). Traditionally, they have been appointed based on their political loyalty rather than their experience or expertise (giving them low autonomy and low capacity). However, in most advanced Western democracies, bureaucrats are appointed according to experience and expertise and generally are self-governing in their actions; thus, enjoying high capacity and high autonomy. This situation varies between countries and over time, and some bureaucracies are transitioning between these, meaning that they may have high autonomy and low capacity or vice versa.

While not a branch or function of government, political parties also play an influential role in policymaking from the very beginning by recruiting, nominating and seating their members in political offices, and sometimes also in bureaucratic positions. Parties coordinate many political functions including, most importantly, electoral campaigns. They also structure competitions by selecting candidates for elections and appointed offices, represent their members within government institutions and society, and play a role in policymaking by influencing the ideas and beliefs of citizens about certain public policies, affecting electoral decisions and defining the strength of their party in the executive and legislative branches (Gilardi 2010). Political parties are generally defined by their ideological views.

Private actors include a variety of interest groups and experts. Interest groups are organisations that work to align government policy with the interests of their members. As opposed to social movements, they are formally organised actors that interact with and access institutions in different decision-making arenas on a regular basis (Kriesi 2011). They can also be a part of a social movement.

According to Wilson (1974), individuals join interest groups to pursue their specific goals, enjoy the benefits of group membership and/or make a political statement. Regarding the first of these three, interest groups can pursue the *private* interests of their members, which are often financial in nature, or *public* interests, whose benefits extend beyond its members. Private interest groups usually represent the interests of professions, such as associations of doctors or teachers. *Public* interest groups are not-for-profit organisations that pursue public issues such as the environment, health, or human and civil rights. Interest groups affect policymaking primarily through lobbying politicians and exchanging resources—such as policy-relevant knowledge on an issue—for access to politicians.

While interest group members can also be experts, experts as understood here are distinguished by their unbiased influence on policymaking. They are, according to Haas (1992, 5), epistemic communities or "networks of recognised specialists with policy-relevant knowledge in a particular issue area." Examples of such communities in the health arena include the Global Health Council and the Global Health Network. Individual experts, including scientists, consultants and practitioners, can also influence policymakers' decisions with their knowledge and information on a particular issue (Howlett 2009). Often, individual experts serve as political advisers to a prime minister or to the cabinet (Eichbaum and Shaw 2007; 2008). Once experts accept such a position, their impartiality is often questioned.

2.2.1.2. Actor Behaviour: Homo Economicus and Rational Choice: In addition to a focus on key actors in policymaking, the policy literature presents models for actor behaviour. The three major perspectives on how to best represent actor behaviour are *homo reciprocans, homo sociologicus and homo economicus* (Dahrendorf 1968). Both *homo reciprocans* and *homo sociologicus* take a mainly sociological theoretical perspective. *Homo reciprocans,* or "reciprocal man", characterises human behaviour as primarily motivated by reciprocity and a desire to improve one's environment through cooperation. *Homo sociologicus*, or "sociological man", portrays human behaviour as fulfilling social roles and norms. These two perspectives, particularly the latter, are applied in structure-based and institutional-based approaches to policymaking (cf. Appendix B).

The *homo economicus* perspective on human behaviour is the one most aligned with this section's focus on interest-based approaches to policymaking. *Homo economicus*, or "economic man", is a concept widely utilised in economic

theories and other social sciences, representing human behaviour as rational and self-interested because humans seek to attain specific, pre-determined goals to the best of their ability and at minimal cost.[7] This motivation subjectively influences judgements and decision-making. In the policy literature, this perspective is more commonly referred to as the rational choice perspective, wherein rational actors seek to fulfil their preferences. In contrast to other human behaviour perspectives, *homo economicus* takes more of a calculated rather than a cultural approach, seeing humans' main objective as to maximise utility as a consumer and economic profit as a producer.

The words *rationality* and *self-interest* in this human behavioural perspective describe how a decision is reached, rather than the result or object of that decision. More specifically, rationality describes the fact that choices are made to serve a certain purpose; it explain how actors seek to realise their desires and preferences. Self-interest does not mean being selfish or egotistical, but rather self-centred (Shepsle and Bonchek 1997, 16). For example, rational actors are self-interested in the sense that they "view the world from their own perspective and form preferences based on their interpretation of it" (Dowding and King 1995, 13–14).

Moreover, a person acting rationally and with self-interest has ordered desires and preferences, and acts to fulfil them. According to Hindmoor (2006, 182; Tsebelis 1990, 18), an actor's desires and preferences can be modelled as *axiomatic* and *optimizing*. The axiomatic approach means that people compare all their desires and preferences, rank them in a hierarchical order of importance, and pursue them in that order (Griggs 2007). Given this understanding, the rational choice perspective in decision-making requires a top-down logic and deductive reasoning so as to link premises with conclusions in a transitive way—e.g. if A is preferred to B and B to C, then A is preferred to C. Adding to this foundation, the *optimizing* approach suggests that actors also pursue their preferences in an optimal way, with perfect information and no limitations in expertise or ability. This premise characterises the *fully rational* actor as it is often used in microeconomics and sometimes in political science.

[7] This does not mean that the actual goals of the actor are rational in a larger ethical and social sense, but that the behaviour used to attain them is rational.

As an approximation of what happens in reality, the idea of the fully rational actor is somewhat implausible, especially for policymakers, who lead potentially busier lives than most people do. Behaving with full rationality would be impossible in view of the great number of decisions that they make every day. It would be particularly hard for policymakers to obtain all the information and knowledge necessary to understand the policy alternatives comprehensively and determine which one is most likely to serve their own agenda.

To this end, Herbert Simon (1957) amended the concept of full rationality previously used to model human behaviour to *bounded rationality* – bounded, most importantly, in the amount of information that people can gather and cognitively process in a meaningful way within the finite amount of time available to make a decision. The concept of bounded rationality still assumes that people are goal-oriented, but in a "satisficing" rather than optimizing way. Simon (1947) first posited the term *satisficing* to explain the behaviour of decision makers when an optimal outcome cannot be reached, indicating that they seek satisfactory solutions to issues rather than optimal ones. Thus, a decision made with bounded rationality does not require top-down, transitive logic. Rather, it can be based on the imperfect information available and the decision maker's assessment of the outcome that is most likely to be satisfactory.

Rational choice theory is based on the assumption that individuals employ either full or bounded rationality in their decision-making.[8] It applies this axiom and other theoretical tools advanced in economics to produce models that depict the essential features of political processes in the real world, along with likely human behaviours and their consequences. It boils down individual decision-making behaviour to its very essence under particular conditions in order to create a model for predicting aggregate human behaviour. Then, it combines these models with detailed assumptions regarding how individuals relate to one another in specific institutional settings and what their preferences are. Finally, it runs these models to examine the extent to which they can confirm or refute assumptions and predictions and, ultimately, to explain socio-political outcomes by establishing causality.

[8] This is as opposed to other motivations in decision-making such as "habit, tradition, or social appropriateness" (MacDonald 2003, 552).

The assumptions for individual preferences can be either simple or complex, "thin" or "thick". A thin set of assumptions, for example, might include that actors optimise, their preferences are ranked by priority and they are transitive. A thick set of assumptions is more detailed and offers specific assumptions for preferences and beliefs (Tsebelis 1990, 30). For example, Sheple and Bonchek (1997, 17–18, 33–35) modelled the effect of uncertainty and imperfect information on an individual's ability to pursue his or her preferences. As another example, Hindess (1988, 69, 80) modelled uncertainty while taking into consideration bounded rationality, which emphasises "satisficing" rather than optimisation. These assumptions can also be described as either weak or strong, depending on the consistency of preference. In the end, however, the discussion about assumptions for individual preferences comes down to the same trade-offs as in other fields: either explaining a lot with a little or a little with a lot – the choice between the law of parsimony (Occam's razor) and the law of miserliness.

Rational choice theory does have its critics. Some authors (Laver 1997, 4–10) have contrasted it with methods that employ inductive reasoning and generalise from observed patterns of behaviour, such as Immergut's (1992) study of health politics in France, Sweden and Switzerland. Other authors have critiqued its "degree of variation of characterization of actor behavior in the different models" (Stoker and Marsh 2002, 6). Many have argued that its models have little to do with reality and real-world actor behaviour (Green and Shapiro 1994; 2005; Udehn 1996; S. Parsons 2005). These authors, however, tend to hold rational choice theories to higher standards than most other theories face (Laver 1997; John 1998; Ward 2002; Hindmoor 2006).

Despite these critiques, rational choice theory has proven to be particularly useful in answering questions about institutions, especially how people manoeuvre within them. It can demonstrate a tendency towards a particular behaviour or at least provide a convincing explanation for why it occurs (Hindmoor 2006, 212). In this sense, models of rational choice theory can offer conditional predictions of policy outcomes (Dowding 2001, 92; Hay 2004, 57). Rational choice theory also has an advantage over other approaches (such as inductive reasoning): it requires simplification of the real world in its model building. This is where some critics have misinterpreted the value of simplifying reality. Such simplification forces researchers to formalise their argument, clarify their assumptions and choose the

aspects they consider most relevant and worthy of study (Ward 2002). At the very least, a rational choice theory model is useful in enabling a comparison between its results and the real-world situation (Dowding 1991). Ward (2002, 70) agrees and further adds that the "instrumentally rational[9], self-interested self" can actually be utilised as a standard point of reference to actual human behaviour.[10] Furthermore, rational choice theory contributes to the understanding of questions about behaviours that it cannot address directly, such as "why individuals have the interests they do, how they perceive those interests, and the distribution of rules, powers and social roles that determines the constraints on their actions" (Ward 2002, 65).

The issues raised by rational choice theory inform most aspects of public policy, including the rules of government formation, the power of bureaucracies, and the extent to which institutions can be used to solve collective action problems. Rational choice theory can therefore fulfil a normative role, dealing with questions such as "How can we hold people accountable when they deliver public services?" It is often utilised in situations regarding public goods, such as communicable diseases in public health, where everyone needs to work together towards a joint policy but where "free riding" can also occur (Cairney 2012, 134; Ostrom 1990). Moreover, rational choice theory has been used to explore government solutions, which are often far from optimal, and may be costly and produce unintentional consequences. For example, Ostrom (1990) demonstrated that non-market and non-institutional solutions to collective action problems could be more cost-effective and efficient.

2.2.1.3. Actor Relationships and Interactions: Interest-based models of policymaking focus on the different types of actors and their behaviour, addressing the relationships among them. Actors are influenced not only by the institutions that surround them but also by the presence of other actor groups. To understand policymaking fully, it is necessary to model and examine how actors interact with one another. There are various representations of the relationships and interactions of rational actors in situations of strategic decision-making; the most basic of these

[9] Instrumentally rational individuals fulfil their preferences according to their beliefs regarding the most appropriate means to achieve them. This is intentional behaviour based on the goals of the individual (Elster 1985, 8) and not motivated by "habit, tradition, or social appropriateness" (MacDonald 2003, 552).
[10] Laver (1997, 9) does this with the alternative "socially-oriented, norm-driven self".

is game theory. After discussing game theory and its relation to rational choice, I will discuss the main aspects of community power and influence.

Game theory allows the researcher to consider more than one rational actor or actor group in isolation while also paying attention to the interactions between actor groups and the institutions that surround them. It represents decision-making as a game in which the actors choose between two or more possible strategies and the outcomes depend on those choices. As in chess, each strategy tells the actor which choice to make in response to the actions of other players, the anticipated choices of other actors and the expected "payoffs" for all actors (Hindmoor 2006, 106–7). In addition, each game defines the information available to each player when he or she makes a decision, especially whether it is perfect (fully rational) or imperfect (boundedly rational) information (McCarthy and Meirowitz 2007).

The main purpose of game theory is to "identify points of equilibrium when actors make a choice and stick to it, such as the 'Nash equilibrium' when players have made their best choice and there is no incentive to change behavior" (Cairney 2012, 138). "The 'best choice' refers to the 'best co-strategy to what one expects the other person(s)' choice will be' rather than a choice which necessarily produces the best overall outcomes" (Chwaszcza 2008, 145). In the realm of public policy, game theory furthers the principles of rational choice institutionalism in particular by looking at how institutions and public policies are created to address collective action dilemmas. By finding the equilibria of games, game theory helps to predict how actors will behave in similar policymaking situations.

One well-known example of game theory with imperfect information is Albert Tucker's "prisoner's dilemma", which demonstrates how two fully rational individuals might still not cooperate, even if it seems to be in their best interest to do so and achieve the optimal collective outcome (Poundstone 1992).[11] This is not a realistic representation, however, of how policymakers might interact. Modelled after the prisoner's dilemma, Hardin's (1968, 1247) "tragedy of the commons"

[11] "Puzzles with the structure of the prisoner's dilemma were devised and discussed by Merrill Flood and Melvin Dresher in 1950, as part of the Rand Corporation's investigations into game theory (which Rand pursued because of possible applications to global nuclear strategy). The title 'prisoner's dilemma' and the version with prison sentences as payoffs are due to Albert Tucker, who wanted to make Flood and Dresher's ideas more accessible to an audience of Stanford psychologists. Although Flood and Dresher didn't themselves rush to publicize their ideas in external journal articles, the puzzle attracted widespread attention in a variety of disciplines" (Kuhn 2011). See also Flood (1952; 1958).

presents a scenario that is more widely applicable, especially to situations with limited common resources. In this scenario, individuals act out of rational self-interest and use common resources (e.g. air, pastures, public health resources) for their own gain and with no regard for others; if they do this without any regulation of the common resources, then they are likely to consume more than their fair share of the resources (free-riding) to the point where these resources are eventually depleted. This may be a particular problem when a collective group is large and the potential to free ride is greater. Olson (1971, 2 emphasis in orginal) commented, "Unless the number of individuals in a group is quite small, or unless there is coercion or some other special device to make individuals act in their common interest, *rational, self-interested individuals will not act to achieve their common or group interests*". As a result, the literature suggests that larger groups should make collective agreements with selective (or members-only) benefits or incentives to reduce the negative externalities of free riding.

While the prisoner's dilemma and the tragedy of the commons portray structural decision-making situations addressing conflict and cooperation among actors, they still tend not to accurately portray the real-life situations faced by policymakers—who can speak and interact directly with each other, gather more information and additional resources on the issue at hand and make decisions based on more than a limited number of choices. Elinor Ostrom's (1990) study on *Governing the Commons* criticised Hardin's work and provided empirical evidence of how common concerns requiring collective action can sometimes be solved by voluntary organisations and not only by state or market solutions. In her Nobel Prize Lecture (2009), Ostrom stated:

> The classic models have been used to view those who are involved in a Prisoner's Dilemma game or other social dilemmas as always trapped in the situation without capabilities to change the structure themselves. This analytical step was a retrogressive step in the theories used to analyse the human condition. Whether or not the individuals who are in a situation have capacities to transform the external variables affecting their own situation varies dramatically from one situation to the next. It is an empirical condition that varies from situation to situation rather than a logical universality. Public investigators purposely keep prisoners separated so they cannot communicate. The users of a common-pool resource are not so limited.

From these examples of game theory, we should keep in mind that when assumptions are changed, the nature of the problem also changes. For example,

Capraro (2013) posits that when given the opportunity, individuals prefer to form coalitions and cooperate in order to achieve the most optimistic forecast in a one-off social dilemma. Another example is the extended "iterated" version of the prisoner's dilemma, where a "tit for tat" strategy is employed when the game is played repeatedly with the same prisoners (Axelrod and Hamilton 1981; Axelrod 1984). Furthermore, still considering the "iterated" game, Tsebilis (1990, 2) proposes that, if the number of rounds is known, then it may actually be an optimal strategy for a prisoner to act irrationally in the short term to achieve a longer-term goal. This means that institutions, defined as the "rules of the game" by Ostrom (1986), are many and may affect actors' behaviour differently (Dowding and King 1995, 10). Thus, it is important to define the type of institution at the centre of one's research.

Just as in the original prisoner's dilemma and other games emulating rational choice, an institution (or an institutional solution) does not always result in an optimal outcome for all persons. When policymakers make policy choices, inevitably, some people's preferences are satisfied and others are not. Governments cannot solve everyone's problems; "they solve some, ignore some, and make others worse off" (Cairney 2012, 143). Therefore, the basics of game theory as described above may not be enough to explain policymaking processes. Indeed, there is evidence that actors are not only influenced by the presence of prior or anticipated choices and the strategies of the actors around them (as suggested by game theory), but also by other factors, most importantly the amount of power (i.e., authority, resources and information) and influence (i.e., exerted power) of other actors in the decision-making situation. This point was famously stressed by Machiavelli (1513) and more recently by Hunter (1953; 1980), Mills (1956), Dahl (1958), Bachrach and Baratz (1962; 1963), Lukes (1974; 2005), and Flyvbjerg (1998).

The concept of power pervades the political science literature and is central to the decision-making process. Power is often an explanatory factor of policy instability and change; policymakers, for example, often exercise their power to obtain the policies they desire or resist the efforts of others. Elitism and pluralism are two of the most common interpretive models of community power in the literature; the two assume very different understandings of where power is held. Elitism treats power as "concentrated in the hands of a small number of people or organizations that control policy processes", whereas pluralism views power as

being diffuse, fragmented and specialised, with no actors holding overall control of the policy process (Cairney 2012, 46–47). Accordingly, some authors theorise a "ruling elite" (Hunter 1953; Mills 1956) while others believe that actor power varies depending on the policy issue (Dahl 1958; Lindblom 1959).[12]

In broad terms, power has been defined as having three dimensions (or faces). Its first face of power can be directly observed: power lies with the 'one who wins' (Dahl 1958). The second face is less visible, declaring that power lies with the 'one who sets the agenda' because s/he often decides what the issues are and who participates in decision-making (Bachrach and Baratz 1962). In line with this, Schattschneider (1960) described the exercise of power within policy communities, or close-knit policy networks, which determine which topics will receive attention. While these first two faces are overt uses of power, the third face is a covert process of manipulation. Posited by Lukes (1974), this third face of power highlights how those in power can manipulate others to act in agreement with a powerful group's preferences rather than their own interests. The first face of power is easier to identify than the other two, but these last two can be theorised from an examination of social, economic and political relations in the structured environment (institutional rules) that affect how actors exercise power (Dowding 1996).

Since the 1700s, societies have shifted from dominance by an elitist ruling class (an oligarchy) to greater pluralism (Dahl 1961). Initially, people with high social standing, education and wealth held leadership positions in government, but over time, people of lower social status have gradually gained political influence. Today, the latter group occupies a far greater portion of elected positions in government than in earlier times and, although some inequality persists, in most modern-day societies social status and money do not go along with control of government. In addition, according to Polsby (1960, 482), "the individuals who spend time, energy and money in an attempt to influence policies in one issue-area are rather different from those who do so in another" (See also Dahl (1961, 126,169,180,273-4) and Moran (2005, 15)). Today, most political systems are so large and fragmented that one actor cannot influence all areas of public policy; therefore, public policy is specialised by issue and area.

[12] Lindblom (1959, 85) characterizes "good" policy as that which is reached through consensus among many actors negotiating within the political system (e.g. pluralism).

Despite the more pluralist nature of modern society, this characterisation of directly observable decision-making does not take into account "non-decision-making" power (i.e., the second face of power, or excluding some people from participation; see Bachrach and Baratz (1970, 49–50)) or unobservable manipulation (the third face of power), both of which are very difficult to demonstrate empirically. When lacking all the facts, authors usually turn to ideological norms to fill in the gaps. As such, Hindess (1996) and others have suggested a normative perspective centred on the *right* to exercise power. Based on this perspective, elected governments are expected to act on behalf of the populations who elected them. Accordingly, Hindess (1996, 13) suggests, "At the heart of such relationships is the notion of a contract in which those vested with the right to exercise power are under certain obligations not to abuse that right, in part by upholding the values of those who consent." At the same time, he writes, "since one function of government is to regulate the attitudes and behavior of the citizens for the collective good, it produces a circular effect: consent for government action is based on government-influenced attitudes" (Hindess 1996, 43).

2.2.2. Rational Choice Institutionalism

Along with historical and sociological institutionalisms (see Appendix B), rational choice institutionalism falls under the umbrella of "new institutionalisms"; nonetheless, it is considered more of an interest-based—rather than an institution-based—policymaking approach. Rational choice institutionalism is the main interest-based approach in the public policy literature. Born in the late 1970s and early 1980s, it was pioneered by political scientists trying to understand American congressional behaviour (most notably Shepsle (1986; 1989)). Previously, majoritarian models to understand the effects of decision-making on legislative behaviour and policy outcomes. These models predicted that policy outcomes would be unstable; that is, they expected that secure stable majorities for legislation would be difficult to attain because a simple majority could always form a coalition to overturn existing legislation. When they looked at decision-making in the US Congress, where legislatures have to order multiple preferences on a multitude of complex issues, they found to their surprise that the empirical results for congressional outcomes actually showed considerable policy stability (Riker 1980). When rational choice theorists began to research possible explanatory factors for

this paradox of collective action, they found that institutions mattered (Shepsle 1979; Weingast and Marshall 1988; Riker 1982). For example, Shepsle (1979) argued that congressional committees could change legislative behaviour through the rules of procedure governing the agenda-setting process, for example by allowing or disallowing policy alternatives or by structuring the voting and veto powers of actors in the policymaking process.[13]

As an interest-based approach to policymaking, rational choice institutionalism places actors and their behaviour at the centre of policy analysis. In this regard, it generally employs a characteristic set of behavioural assumptions for individuals, conceiving human nature (in contrast to historical and sociological institutionalisms) as rational and self-interested, and contending that human decision-making is driven by this nature and guided by a logic of consequentialism. In this context, consequentialism means the presumption that behaviour is rational if and only if it is explicable by its consequences.

Although rational choice institutionalists believe that humans behave in a rational and self-interested way, they also view humans as intentionally strategic and calculating in their endeavours to obtain what they want. As noted above, they take a more calculating approach than do the devotees of the historical and sociological perspectives, postulating that actors are motivated by a strategic calculus to maximise their own objectives and utility. Moreover, they assume that actors adapt their strategies and utilise their resources to pursue their preferences (i.e., their fixed and ordered interests) to the fullest potential possible under the presumed consequences of their own actions and the actions of others in each decision-making situation (March and Olsen 1984; 1989; 2008).

Consistent with the calculus approach, rational choice institutionalists employ the methods of deduction and "methodological individualism" in their policy analysis. They derive their hypotheses from theory and then test them with empirical data, making assumptions regarding actor behaviour and modelling actor desires and preferences axiomatically and transitively (as discussed above). Finally, rational choice institutionalists aggregate the decision data of the individual actors in an attempt to explain socio-political outcomes (Cairney 2012). This is different

[13] As mentioned above, Ostrom (1986) further defined them to be "the rules of the game", showing *how* they mattered.

from, for example, the "cultural approach" of historical institutionalists, who inductively derive empirical generalisations and theories from the data.

Each behavioural approach and method has its advantages and disadvantages. For example, the deductions used in the calculus approach can result in competing explanations, while inductive analysis and the cultural approach more clearly differentiate between possible competing explanations. The calculus approach, however, allows rational choice institutionalists to demonstrate causality more precisely between institutions and actor behaviour, and between strategic interactions among actors and political outcomes. The resulting insights have greatly advanced traditional approaches to policymaking (see structure-based theories in Appendix B). Moreover, the behavioural assumptions in rational choice theory provide a micro-foundation for more systematic analysis and theory building than the other "new institutionalisms" or more traditional approaches to policymaking do. However, as we have seen, rational choice institutionalism is often criticised for its simplistic view of human behaviour and motivation (see also Cook and Levi (1990); Mansbridge (1990)). The trade-off, then, involves pursuing a more precise casual chain that lends itself to greater systematic theory building and analysis (including game-theoretic models of political processes) at the cost of a relatively crude theory vis-à-vis human nature and behaviour.

Since the early 1990s, though, rational choice institutionalists (e.g. Garrett and Weingast (1993)) have been adding the cultural approach onto the calculus approach in their analyses in order to distinguish between competing explanations. They have justified this extended analysis by arguing that a strategic and goal-oriented actor is likely to comb through competing policy choices or options and take action on the one that is more culturally agreeable (Hall and Taylor 1996).

Building on these ideas of rationality and rational choice theory, rational choice institutionalists emphasise the role of institutions in the policymaking process and outcomes. They broadly define institutions as the rules that structure or influence behaviour and that shape the strategic choices and interactions of policymakers and other actors (Steinmo 2008). They consider both formal and informal (or structured and unstructured) institutions in their definition. Rational choice institutionalists have usually favoured studying formal rules (Streeck and Thelen 2005, 10–11), but some scholars have treated institutions as both formal and informal or as solely informal rules (Shepsle 2006). According to Cairney (2012,

90), informal rules and norms of behaviour transcend formal rules. Moreover, rational choice institutionalists believe that institutional structures have a major influence on how actors perceive and calculate the costs and benefits of their actions; however, in most cases, they believe that actor interests and preferences are exogenously given.[14] As such, they believe that institutions provide the context within which actors operate, offering information to actors regarding the possible consequences of their actions (Hall and Taylor 1996). Such information limits the actions of individuals or groups and/or incentivises them to act in one way or another. As such, institutions play an important role in the policymaking process and outcomes.

Rational choice institutionalists believe that not only the structure or institutional arrangements of the political system (polity) but also political interests affect policy priorities and choices. For example, in the case of decentralization and other macro-organisational policies, the institutional rules define a specific amount and distribution of powers and resources between different levels of government, and the particular interests of the different levels and policy areas help to define further policy choices and priorities within the boundaries of the institutional rules. Compared to historical and sociological institutionalists, then, rational choice institutionalists place less significance on institutions in their policy analysis. Indeed, they tend to think of institutions as secondary intervening factors while actor interests serve as the primary independent factors for explaining political outcomes (Shepsle and Weingast 1987; Weingast 1996; Shepsle 2006). Consequently, they contend that while institutional structures determine the extent to which actor preferences may be translated into public policies (i.e., just how much a priority is a specific policy?), actor interests and preferences ultimately determine the policy choices.

2.2.2.1. Empirical Studies: Rational choice institutionalism has treated institutions as solutions to various public policy problems; for example, institutions may solve collective action problems, situations with high transaction costs, and problems of policy instability. First, collective action problems affect primarily interest groups and arise when there is a high potential for individual choices to have

[14] According to Shepsle (2006), there are two standard ways to interpret institutions: as exogenous constraints (e.g. North (1990)) and as equilibrium (e.g. Calvert (1995)).

adverse effects on society (cf. Olson (1965), Moe (1981), and Ostrom (1990)). Governments often justify their involvement in areas where groups are unable to cooperate on their own. Their intervention, however, can create other problems within government, such as principal-agent problems where discord arises between government mandates and their implementation by functionaries. Because the present thesis centres on already-organised actors in government, I will not delve further into the literature on collective action problems.

Second, stemming from the literature on the "new economics of organization", rational choice institutionalists have employed institutions as a solution for reducing high transaction costs as well as decision and information costs (Hall and Taylor 1996, 945). The premise of this approach is that institutions are a set of formal rules that can minimise certain costs when established (or amended) appropriately. Decision costs are those that result from an agreement, whereas information costs are acquired while one searches for the information needed to make a decision (B. D. Jones and Baumgartner 2005) and transaction costs occur after the agreement is reached (generally for monitoring and evaluation procedures). This understanding of transaction costs has been applied to the operation and development of institutions in public policy by Thompson (1998), Epstein and O'Halloran (1999), and Arias and Caballero (2003) and to the design of political institutions by Estache and Martimort (1999) and Huber and Shipan (2002).

Third, rational choice institutionalists have utilised institutions to explain problems of policy instability. As noted above, political scientists pioneered rational choice institutionalism in their efforts to explain why policymaking in the US Congress paradoxically appeared stable, and they found that institutions mattered (Shepsle 1979; Weingast and Marshall 1988; Riker 1982). Rational choice explanations for institutional change rest on the idea that, since people and policymakers will make choices or changes that are in their interest, the continued existence of an institution over time depends mostly upon the benefits it delivers. It is thus rare for an existing institution to fail so thoroughly to meet the preferences of the people or policymakers that they would be motivated to create a completely new institution or set of rules. As Cairney (2012, 80) explains, "Overall, institutions represent sets of rules that influence choices, often producing regular patterns of behavior. This regularity can be expressed in terms of equilibrium when we identify a stable point at which there is no incentive to divert from these patterns of

behavior." Indeed, policymakers most often face a Nash equilibrium situation when deciding whether to generate a new institution. Thus, this interest-based policymaking approach actually lends itself to explaining how existing institutions continue to exist. And, as observed by the punctuated equilibrium theory (Baumgartner and Jones 1993), a major turning point, event or window of opportunity is needed to motivate people to take on the cumbersome and sizeable task of creating a whole new institution. It is thus understandable why rational choice institutionalism is relatively successful in addressing the problem of change or instability.

Rational choice institutionalism has been widely applied to explain cases of policy instability (or stability). While some researchers (Shepsle and Weingast 1994; Weingast and Marshall 1988; Moe 1987) looked at the relationship between congress and congressional committees, Cox and McCubbins (2007) focused on the impact of political parties, McCubbins and Schwartz (1984) looked at congressional oversight, Ferejohn (1995) examined the relationship between Congress and the courts, Laver and Shepsle (1990) looked at coalitions and cabinets, and North and Weingast (1989) researched the influence of constitutions and other commitments. Still other authors expanded rational choice institutionalism research to cover democracy and the market (e.g. Przeworski (1991)), democratic transitions (e.g. Marks (1992)), and politicians' dilemmas (Geddes 1994; de Nardo 1985).

Moreover, rational choice institutionalism has been extended into the literature on multilevel governance, especially that concerning the European Union (Scharpf 1988; Tsebelis 1994; Martin 1994; Pollack 1996; 2005) and international organisations (e.g. Martin (1992)). Scharpf (1988), for example, argued that specific institutional rules like unanimous decision-making, along with the challenges of intergovernmental relations, caused inefficiencies and rigidities in EU policies. Subsequently, Tsebelis and others used rational choice institutionalism to examine the adoption, execution and adjudication of public policies in the EU. Tsebelis (2002) famously modelled the role of veto players in policymaking, using rational choice institutionalism and addressing the issue of policy instability (see Appendix Section A.4 on Tsebelis's veto players theory and others, e.g., Immergut's veto points).

2.2.3. The Principal-Agent Model

Still other authors have combined rational choice institutionalism with different structural models in an attempt to explain how relationships are structured and interconnected. Most commonly, rational choice institutionalism has been combined with the principal-agent model (or agency theory). This theory departs from the behavioural assumption that human beings are self-regarding and driven by self-interest. It represents a situation in which a principal contracts with an agent to act on its behalf. However, the principal is highly dependent on the agent to carry out the tasks and activities necessary for attaining the principal's interests and objectives. The principal monitors the agent's activities, but the agent has more information than the principal does on these actions. This asymmetry of information can lead the agent to act in his or her own interests[15] rather than the principal's interest. For this reason, the principal is likely to employ mechanisms that induce the agent to fulfil the agreements in the contract, such as incentives, sanctions and rules, and to obtain the desired outcome. Early empirical studies of this combination of rational choice institutionalism and the agency model in government looked at the relationship between politics and the administrative bureaucracy (North 1990), especially between the US Congress and the regulatory agencies it oversees (Pratt and Zeckhauser 1991; Milgrom and Roberts 1992; Moe 1984; Kiewiet and McCubbins 1991). In addition, Huber and Shipan (2002) explored more deeply the problem of agency with an emphasis on bureaucratic autonomy and discretion.

In the health literature, two uses of the principal-agent model stand out. Le Grand (2006) explored how the public sector may design policies with incentive structures that better align the interests of the principal and the agent toward achieving the desired outcomes. With respect to health care policy, he considered the general practitioner-patient relationship in various institutional settings of the British National Health Service and how policies may be designed to "go some way towards empowering patients, but … avoid the problems of unfettered patient choice" (Wetherley and Lipsky 1977, 105–6). Bossert (1998) also applied the principal-agent model to health policy, focusing on decentralized health systems,

[15] For example, bureaucrats might aim to increase their income and prestige by climbing up the career ladder and by seeking to realize their private interests when drafting legislation (Muller 2011). They may also be interested in maximizing their utility more through bureau-shaping than by budget maximization (Dunleavy 1991).

with the ministry of health as principal and the local health authorities as agents.[16] After defining decision space, he used this model to examine how the local health authorities used the decision space granted to them (e.g. do they innovate or continue doing what they had done before?) and how their actions affected health system performance. His decision-space map illustrates the range of choice that the agent is allowed within each functional area and how the agents' decisions in each functional area can influence performance (e.g. equity, efficiency, quality). He also examined the sanctions, incentives and other mechanisms that the ministry of health could use to keep the actions of local health authorities aligned with national health system objectives. Bossert (1998a, 1521) stated, though, that "the ministry's ability to change the decision space and even to provide incentives and punishments is limited by decisions made by the other institutions of the central government." This suggests that, while the principal-agent model as employed by Bossert may be sufficient for drawing conclusions on the performance of devolved health systems, looking also at what other institutions at either the central or local level participate in decision-making in a devolved health system and incorporating them into the model might tell a more complete story.

2.2.4. The Policy Network Approach

The policy network approach is a model used to explain how relationships are structured and interconnected. Policy network analysis initially developed in the political science literature in the 1970s (Heclo and Wildavsky 1974b)[17] in response to a growing dispersion of resources and powers, followed by increasing interdependence and coordination, among numerous public and private actors (Marin and Mayntz 1991; Héritier 2002). This development looked at a variety of political environments from community politics in cities to the EU's multi-level governance. It occurred simultaneously but independently on both sides of the Atlantic, in the US, Britain and continental Europe (Enroth 2011).[18] In the US, policy networks evolved naturally from the literature on sub-governments,

[16] The principal-agent model that Bossert uses can be applied to a centralized system and can accommodate more than one principal.
[17] The idea of policy networks is now common to many social science disciplines, including organisational theory, public administration and economic sociology in addition to political science (Rhodes 2006; Ansell 2006).
[18] See also Rhodes (1981; 1988; 1997), Borzel (1998), Kickert, Klijn, and Koppernjan (1997), O'Toole (1997), and Salamon (2002).

subsystems and 'iron triangles'. In Europe, this dispersion of resources accompanied strategies of regionalisation (also known as administrative decentralization or devolution to the regional-level government) and Europeanisation, which were ignited by a fiscal crisis and a major process of industrialisation (Ansell 2000). Through regionalisation, national governments increasingly transferred more responsibility and authority over various competencies to regional-level governments. It is well documented that many countries around the world have regionalised or decentralized since the 1970s. Consequently, centre-regional partnerships or stewardship relationships have evolved (Hooghe and Marks 2003; Rhodes 1981), partly due to the limited capacity of most regional governments in the late twentieth century (Le Galés and Lequesne 1998; Levy 1999) and also to ensure continued coherence in policymaking across governments (both vertically and horizontally). As a result, the concept of contemporary governance, also referred to as modern governance (Kooiman 1993) or network governance, was born (Ansell 2000). This model of networked polity has become progressively more important as it has been applied across different levels of government.

According to Rhodes (1997), contemporary governance is represented by a highly differentiated political structure and processes, comprising a diverse range of actors. It suggests an organised disaggregation of the traditional state into overlapping jurisdictions as well as the replacement of command-and-control governing strategies by vertical stewardship or both horizontal and vertical partnerships within and across territories and organisations (Ansell 2000). Bellini (1996, 66) explained contemporary or network governance based on partnerships as the "intertwining of decision-making between national and subnational actors according to patterns that can be defined as basically non-hierarchical, network-like, based on inter-institutional bargaining and political exchange." While the principal-agent model fits well with the analysis of a polity in general, it has limited ability to inform the analysis of a differentiated polity. In addition to better representing a differentiated polity, the idea of policy networks suggests that actors are linked by their mutual interests or interdependence in specific policy domains. Similarly, the literature on multi-level governance suggests that powerful actors gather around "centres" and exert informal influence on policy. With regard to our previous discussion of power and influence, the model of structure presented by policy networks encompasses the emphasis of pluralist theories on differentiation and elitist

theories on connectivity (Ansell 2006). Finally, policy network analysis adds value to rational choice institutionalism by conceptualizing the policymaking process as involving a range of diverse, mutually independent yet interlinked actors, permitting the combination of an overall institutional structural perspective with an actor-centred focus. This also provides a more accurate representation of the ever-increasing complexity of the political environment today. As Rhodes (1990, 313) notes, the concept of policy networks "directly confronts, even mirrors, the administrative and political complexity of advanced industrialized societies".

2.2.4.1. A Definition: Policy networks have several definitions in the social science literature. For the term's use in political science, Rhodes (2006, 425) captures the foundational aspects: "Policy networks are sets of formal institutional and informal linkages between governmental and other actors structured around shared if endlessly negotiated beliefs and interests in public policymaking and implementation. These actors are interdependent and policy emerges from the interactions between them." From the rational choice school of thought, Marin and Mayntz (1991, 16 emphasis in original) provide a more detailed definition:

> While policy networks *are* predominantly informal, decentralized and horizontal, they never operate completely outside power-dependence relations, i.e. outside asymmetric interdependencies and unequal mutual adjustments between autonomous actors, imbalanced transaction-chains, and vertically directed flows of influence…What distinguishes bureaucracies and complex organizations in general from policy networks is not so much hierarchical vs. horizontal relations, but single organizational vs. inter-organizational relations and the nature of power relations permeating *both,* but in *different* ways: the control over strategic rigidities in tight or loosely coupled systems, the conditions of entry/exit, inclusion/exclusion/expulsion, membership or other adherences, etc. …Policy networks are explicitly defined not only by their structure as *inter-organizational* arrangements, but also by their function – the *formulation* and *implementation* of policy.

With regard to the macro-structural organisation of the state, the definition of a policy network is nuanced. On one hand, the concept applies in a relatively straightforward manner to a decentralized unit in a unitary state, entailing vertically overlapping authority and shared governance, as well as high degrees of horizontal coordination and communication across functional boundaries. In theory, the central government of a unitary state has the ultimate power to modify or even abolish decentralized units or subnational governments. However, in reality, central

governments also depend on decentralized units and subnational governments for political support and resources, such as sectoral expertise, information from the field and policy implementation. As a result, these formal institutions are, to a certain extent, buttressed by the informal policy networks of intergovernmental (and private) actors in their efforts to formulate and implement policies (Heclo 1978). On the other hand, a federal state structure implies the jurisdictional autonomy of subnational (decentralized) units, because they have constitutional protection. In this case, federalism would have to be characterised further with either the concepts of vertically overlapping jurisdictions and shared governance (cooperative federalism) or horizontal coordination (competitive federalism) in order to construct a more complete definition of a policy network.

The policy network literature is divided into two broad schools of thought. First, the power-dependence approach characterises the relationships between actors in the policy network as resource-dependent; that is, the actors need resources that they do not have and employ strategies within the limits of the rules governing their actions in order to swap resources. This approach looks at all types of actors, both public and private, and views networks as having a large degree of autonomy (Rhodes 2006, 430).

The second school of thought, the rational choice approach, includes the concept of resource dependence but uses rational choice institutionalism to explain how policy networks work. This approach characterises networks as informally organised institutions in permanent, rule-governed relationships (Blom-Hansen 1999; Rhodes 2006). According to Ansell (2006), these types of relationships display "a stable or recurrent pattern of behavioral interaction or exchange between individuals and organizations". As such, the rational choice approach emphasises the structural relationship between political institutions and not the inter-personal relationships between individual actors within those institutions. For them, policy networks are specific structural arrangements of institutional actors (or organisations) in government that address policy problems in specific issue areas, and the connections between them are channels for communication and resource sharing (Kenis and Schneider 1991). Game theory, based on rational choice theory, can be used to analyse and explain the interactions between actors within a network and the outcomes. Mayntz, Scharpf and their colleagues at the Max Planck Institute developed the most prominent examples in the literature of this approach to policy

networks (Marin and Mayntz 1991; Scharpf 1997). Scharpf (1997, 195) calls his version of policy networks "actor-centred institutionalism", arguing that "policy is the outcome of the interactions of resourceful and boundedly-rational actors whose capabilities, preferences, and perceptions are largely, but not completely, shaped by the institutionalized norms within which they interact". In the following paragraphs, I focus on the literature regarding the rational choice approach to policy networks, which is the nexus between rational choice institutionalism and the policy network approach.

2.2.4.2. Conceptualizing Policy Networks: Policy networks across the public policy literature have some common features. First, they are characterised by a patterned distribution of decision-making powers, e.g. devolution. Second, the actors involved in the policy network are those who *de facto* make up the policymaking process; they are generally interdependent, yet formally autonomous. Third, the structure and mode of coordination within or between organisations is important (Powell 1990; Podolny and Page 1998). For a policy network, coordination is "both a driving force of governance and one of its goals" and it happens whenever "one or more policy actors pursue a common outcome and work together to produce it" (Bevir 2009, 56–57). Policy network actors are not arranged in a hierarchical, pyramid-type network with one-to-many relationships, but are rather in an enmeshed web of "many-to-many" relations (Kontopoulos 1993). Thus, networks operate horizontally as well as vertically or, to use Hedlund's (1994) term, they operate in a *heterarchy*[19] and thus achieve consensus through coordination and mutual agreement rather than by command-and-control methods (Lindblom 1965). Furthermore, the relationship between decentralization (with its "many-to-many" relations) and cross-functional linkage is important and depends on the degree of autonomy granted through decentralization (Ansell 2000). Fourth, markets cannot be policy networks because the discreteness and social content of their exchange relationships are different (MacNeil 1980; Granovetter 1985; Blau 1964; Marin 1990; C. Jones, Hesterly, and Borgati 1997). As opposed to the exchange relationships in markets, goods, actors and time frames are diffuse (rather than

[19] According to Hedlund (1994, 87), a heterarchy exhibits the features that "several strategic apexes emerge, that these shift over time, and that there are several ordering principles at work." As opposed to a hierarchy, in a heterarchy lower-level units can have relationships with multiple higher-level units as well as lateral links with units at the same organisational level. The network is multilateral rather than bilateral.

discrete), communication is thick (rather than thin), and the actors have extensive and usually long-term knowledge of one another in policy networks. Whereas the exchange relationships in a market are valued as a means to an end, those in a policy network are an end in themselves. Fifth, policy networks exhibit a mix of pluralist and corporatist ideas. As mentioned in the section on power and influence above, policy networks are portrayed by pluralism rather than elitism, as power is shared among many actors within the same area or overlapping areas of jurisdiction (Enroth 2011). Corporatism, however, emphasises the mode of governance more than the number of people wielding power in a society or government. It stresses a cooperative way of governing based on long-term exchange (Ansell 2000). In the corporatist mode of governance, people cooperate to achieve social agreement by stressing collective rather than individual interests. See more below on this perspective.

Policy networks can differ on several dimensions. Rhodes (1988) identifies five such dimensions: constellation of interests (e.g. variation by service, function, territory), membership (e.g. public vs. private sector, or elites vs. professionals), vertical interdependence (e.g. between central and sub-national actors), horizontal interdependence (e.g. relationships between networks and those that develop from a modified distribution of power), and the distribution of resources (e.g. actor control over different types and amounts of resources, which influences the previous two dimensions).

Authors adopting the policy network approach generally agree that policy networks can vary along a continuum depending on the closeness of the relationship between actors. The continuum ranges from tight policy communities to looser "issue networks"[20](Borzel 1998; Dowding 1995; Bevir 2009). Policy communities have a limited number of participants with similar values who interact frequently in high-quality activities and discussions on all matters related to a specific policy issue; the participants seek to make decisions on the specific policy issue by consensus and through negotiation, bargaining and exchanging resources. In a policy community, the members of the network tend to see themselves as in a

[20] Heclo (1978) coined the term "issue network" to describe more diffuse forms of linkage than were implied by the terms "sub-government" or "iron triangle". Rhodes (1985) distinguished Heclo's concept of "issue networks" from "policy communities" in terms of the stability and restrictiveness of networks.

positive-sum game. Contrastingly, an issue network is a communications network of people interested in a specific policy area. Here the participants include government legislators, academics, journalists and private interests (e.g. lobbyists), or a myriad of actors with relatively few resources, little access to decision makers, varying degrees of interactions with each other and an unequal balance of power between them. The literature on policy networks includes many more typologies and dimensions (e.g. van Waarden (1992a) and Marin and Mayntz (1991)); however, these are only useful for descriptive and not analytical purposes, and a description of all of them lies beyond the scope of the thesis.

Characteristically, networks are made up of actors in an inter-connected relationship, with the most basic unit being a relationship between two actors or a *dyad*. Policy network approaches are largely interested in "networks" or aggregates of inter-connected relationships, and the most modest form of these requires three inter-connected actors or a *triad* (Ansell 2006). Riply and Franklin's (1981) iron triangle is a famous example of a triad that has been used profusely in the literature. Freeman and Stevens' (1987) policy subsystems or "sub-governments", Richardson and Jordan's (1979) policy communities, Heclo's (1978) issue networks, and Haas' (1992) epistemic communities are other examples of prevalent descriptions of networks in the literature. Laumann et al. (1982) identified policy networks with as many as eighty participants. Most studies, however, analyse only a few actors (or actor groups) because it is not very realistic for more than this number to interact meaningfully and strategically with each other. In terms of membership, these actors are usually formal organisations or actor groups (not individuals) that interact on an informal basis. The actors in a policy network can come jointly from the public and private sectors, as in most cases, or exclusively from the public sector, as in intergovernmental relations (Marin 1990). The actors can also vary across different territorial levels: international, national, regional and local. Thus far, the policy network literature has focused mostly on policy networks at the national level. Although autonomous, policy network actors generally have divergent but mutually contingent interests. Furthermore, policy networks and their sets of actors change structurally over time with changing conditions and new policymaking demands.

In a policy network, the relationship between institutions and actors is unique and very different from that described by the traditional principal-agent model.

Indeed, according to Wasserman and Faust (1999, 6, emphasis in original), "The fundamental difference between a social network explanation and a non-network explanation of a process is the inclusion of concepts and information on *relationships* among units of study". Policy network actors see their relationships as conduits for information, ideas and resources and are thus interdependent on each other. This interdependence motivates them to engage in relationships of exchange, which naturally generate a mutual obligation and reciprocity between them (Ansell 2006). Some studies go further, taking more of a Durkheimian view of corporatism (or *corporate solidarism*) and emphasizing the element of social solidarity and harmony that can be found in many policy networks.

To the assumptions contained in rational choice institutionalism, the policy network approach adds five more. First, it assumes that relationships (precise patterns of connections) matter in explaining policy outcomes and, as such, it views social, political and economic action through a *relational* lens (Ansell 2006). Second, it supposes that relationships in a given policymaking situation are complex and non-hierarchical (or *heterarchical*), overlapping and crosscutting others (Elkin 1975). Third, in addition to the rational choice institutionalism view that institutions limit behaviour, networks are considered institutions as well as resources, channels of information and assistance that can be utilised to achieve particular objectives. Fourth, networks provide varied access to information, resources and other assistance in very different ways. Last, unlike the relationships in the principal-agent model, the policy network approach assumes that the actors involved in relationships are largely autonomous.

The process of collective decision-making between policy network actors is not always united, harmonious and collaborative. Indeed, the characteristic dimensions of collective decision-making can contain any of the following characteristics: consensus vs. opposition, symbiotic collusion vs. competition, and cooperation vs. antagonism vs. antagonistic cooperation[21]. According to Marin (1990), antagonistic cooperation is the most prevalent characteristic of inter-organisational arrangements. Adam and Kriesi (2007, 134) typify networks using two dimensions: the distribution of power (which can be concentrated or

[21] Although this seems an oxymoron, it is rather the two or more people or groups, who are able to work together to achieve common interest by suppressing their minor differences.

fragmented) and the predominant mode of interaction (conflict, bargaining or cooperation). They utilise these dimensions to create six types of policy networks (dominance, competition, asymmetric bargaining, symmetric bargaining, hierarchical cooperation and horizontal cooperation), which help to determine the potential for and type of policy change. In his investigation of the relationships between autonomous state actors and interest groups in Britain and the US, Smith (1993) shows that state actors' interests can shape policy development and that the type of policy network affects policy outcomes and changes.

Finally, policy networks can be identified by observing which actors participate in the bargaining, consultations and negotiations that take place before a particular policy decision is made. The amount of decentralization in society and in the state and the difference between the two are essential factors in the determination of policy networks (Katzenstein 1978). The *action focus* of policy networks is generally macro-political, sectoral or oriented to a single issue. However, most studies look at sectoral or issue-specific networks rather than macro-political ones (Lembruch 1984). Decision-making on a single issue within a sectoral policy network tends to mobilise the essential actors within that network (Laumann, Marsden, and Prensky 1982). Moreover, within the same sector, policy networks can also differ between nations. The use of general country characteristics to explain variations in policy network structures across policy sectors is limited (V. Schneider 1992; W. D. Coleman, Skogstad, and Atkinson 1997; M. M. Atkinson and Coleman 1985). Kriesi, Adam and Jochem's (2006) study of policy networks in seven Western European countries, for example, demonstrates the complex interplay of domestic and policy-specific contexts as well as the EU context in forming domestic power structures in the areas of agriculture, European integration and immigration.

2.2.4.3. Critiques: Despite its usefulness in policy analysis, the policy network approach has undergone some criticisms. Though an excellent framework for describing the characteristics of policymaking (e.g. its political and social complexities), some have said that it has very little explanatory power and few testable causal arguments. However, proponents of the policy network respond that it is particularly equipped to produce good descriptions and that, as Ansell (2006, 85) states, "a good description is the necessary foundation of a good explanation".

Although some earlier policy network studies fell short in the area of explanatory power, this has very rarely been the case since the late 1990s.

Next, there is little to no synthesis of the findings of policy network analysis in the literature (Rhodes 2006). This is because of the variance in the several dimensions that characterise policy networks, the conditions that surround them and the particular sectors and countries in which they are studied. For this reason and others, Dowding (1995) critiqued the policy network approach as a 'metaphor', questioning its analytical usefulness. Rhodes (2006, 434–35) responded:

> It is no more a metaphorical term than bureaucracy. The term's resonance and longevity stem from the simple fact that for many it represents an enduring characteristic of much policy making in advanced industrialized democracies. … Policy networks are but political science writ small." That is, these and most other recurring problems of policy networks reflect the major issues that bedevil all of political science.

Another common criticism is that policy networks do not explain policy change well. Richardson (2000) most famously argues this point. Rhodes (2006, 434–35) counter argues:

> There is no consensus in the political science community about how to explain, for example, political change, only competing epistemological positions and a multitude of theories. Students of policy networks can no more produce an accepted explanatory theory of change than (say) students of bureaucracy, democracy, or economic development. Debates in the policy network literature mirror the larger epistemological and ontological debates in social sciences.

Several authors have utilised policy networks to analyse policy change. In the US, Sabatier and Jenkins-Smith's (1993) *advocacy coalition framework* model represents that country's federal and decentralized government well.[22] Other examples, in addition to those presented below, include Marsh and Smith's (2000) *dialectical model* and Bevir and Rhodes' (2003 Chapter 3) *decentred* study of policy networks.

Overall, the policy network approach allows researchers to describe and analyse the power structure and interactions among all significant policy actors and to explain different policy outcomes (Knoke et al. 1996). Policy networks are a meso-level concept that links the micro- and macro-levels of analysis, dealing with the role of interests and government in policy decisions as well as broader questions

[22]However, it has not been successfully applied widely outside the US (W. Parsons 1995, 201).

about the distribution of power in modern society (at the macro-level of analysis). According to Atkinson and Coleman (1992; 1989), policy networks go beyond the bureaucratic-political models for understanding the policymaking process. They are most often used to solve problems in political science that involve complex bargaining and coordinating relationships between interest groups, public agencies and states – especially those regarding multi-level or intergovernmental governance (Hanf and Scharpf 1979). This is because, unlike in purely formal institutions, the decision-making rules of policy networks emphasise negotiation, bargaining, coordination and sounding out (Lindblom 1959). Furthermore, policy networks are particularly effective at managing complex problems in public sectors, such as health and education (Rhodes 2006).

2.2.4.4. Empirical Studies: Empirical research on policy networks, as in rational choice institutionalism, tends to test assumptions about policymaking; in particular, it can look at the structures that shape the policymaking process and outcomes (Marin and Mayntz 1991). In this way, policy networks emphasise the power of structured social relationships to explain policymaking and its outcomes (Wellman 1988, 31).

Empirical evidence, methodologies and techniques for policy network analysis have varied. Many studies combine quantitative network analysis with qualitative policy analysis, which is demanding in terms of research time and resources, but offers greater precision in identifying otherwise hidden details and patterns and, consequently, a more complete analysis as well as more accurate and reliable results. Most empirical studies compare policy networks across nations or sectors or over time. They look at sets of collective actor groups or institutions, using individuals as representatives of these formal organisations.

In the general public policy literature, a number of authors have discussed policy networks in Europe (Scharpf 1988; Marks, Hooghe, and Blank 1996; Rhodes, Bache, and George 1996). There are several policy network studies on the different types of decentralization. Sabel (1993; 1995; 1996) explores the state's role in creating trust and mutual learning among decentralized market actors. Dorf and Sabel (1998) observe similar patterns among decentralized public administrative units and in federalised states. Compston (2009) uses policy network theory to derive and test prepositions about major long-term technological, economic, environmental and social policy trends (or what he deems 'king trends') in 12 EU

member states from 1990 to 2005. Van Waarden (1992b) demonstrates that pluralist policy networks with greater participation by private actors developed in cases of weaker states and poorly organised civil society, such as in the US. Boase (1996) reaches a similar conclusion about the US in a comparative study of the US and Canada. On the other hand, more corporatist policy networks developed from stronger states and civil societies, such as the Netherlands. Kenis (1991) shows that informal domestic structures – such as the traditional political orientation of the economy, the management of industrial adaptation and the role of public agencies – have impacted the emergence of policy networks in the chemical fibre sector in Germany, Italy and the UK. Kriesi, Adam and Jochem (2006) emphasise the importance of informal practices and procedures in their study of policy networks in seven European countries. Knoke et al. (1996) underscore the role of both informal and formal institutional settings in explaining the nature of labour policy in Germany, Japan and the US. Based on several case studies in agriculture, business, health and consumer policy, Smith (1993) concludes that relationships vary between sectors. The Max-Planck Institute has also published widely on explaining policymaking through networks (which its scholars call *constellations*), using institutional theory and game theory (Mayntz 2003; Scharpf 1991; Scharpf 1997; Marin and Mayntz 1991). Rhodes (1997: 45) claims that policy networks in Britain changed in the 1990s due to a fragmentation of state institutions; his research led him to describe policy networks as a meso-level concept, representing the structural relationship between political institutions at different levels. John and Cole (2000), examining education finance policy networks in France and Britain, found that the type of policy sector actually mediates the impact of political institutions. On the other hand, Greenaway et al. (2007) found that the several layers of government involved in policy implementation networks compromised the accountability of locally elected officials responsible for building a new hospital in Britain. Using four different German labour policy networks, Konig and Brauninger (1998) examine why policy network actors pursue relationships with mutual contacts and test whether this is because of similar preferences or formal institutional settings. They indicate that actor preferences are more important than institutional settings in determining which relationships actors will choose for their network, although, institutional settings do limit the overall choice.

Most policy network research has been at the national level, but some studies have looked at the subnational level (Stohr 1992; Cole and John 1995; Conzelmann 1995; Deeg 1996; Thielemann 1998; John and Cole 2000; Le Galès 2001). The policy network approach has also been applied to intergovernmental relations within states, especially central-local or federal-state relations (Rhodes 1988; Rhodes 2006; Wright 1978; Galligan 1995). Cowell (2013) and Toke et al. (2013) examined policy networks and intergovernmental relations in the devolved renewable energy sectors of Scotland, Northern Ireland and Wales. Toke et al. also created a Westminster-level policy network to analyse the impact of devolution on renewable energy policy. They used primary data from 75 interviews with senior figures in government, industry and environmental groups as well as context analysis. They found that devolved arrangements and close-knit policy communities helped Scotland[23] by giving it greater freedom to promote its renewable energy efforts and expand these resources further with cross-party support. Devolution also facilitated cross-governmental integration and fostered a national economic agenda around energy development. Wales, Northern Ireland and England, all of which were less devolved at the time, displayed policy constellations more like issue networks than community network types. Perhaps this is why the successes of Scotland were not reproduced in these areas.

Because policy networks are generally studied across countries and sectors, there is very little research specifically on health policy in the empirical literature. Rather, most studies that include the health policy sector discuss it as one of multiple sectors examined in one or more countries. Dohler (1991) studied policy networks and neo-conservative reform strategies in the health sectors of Britain, the US and Germany, looking at the relationship between established institutional configurations in the health sector and past neo-conservative reforms. He (1991, 238) hypothesised that "policy networks, as a result of previous political decisions, produce certain interactive routines, modes of interest intermediation and decision making." She looked for a "goodness of fit" between structure and strategy over about ten years of reform efforts in order to understand the resulting policy change or continuity. He (1991, 241) defines health policy networks as containing the following characteristics:

[23] The results were less evident in Northern Ireland, Wales and England.

(i) *Structure,* or the organization of areas of the political system relevant to medical care administration and health policy. It is composed of *degree of centralization, sectoralization, homogeneity* and *system integration*.
(ii) A *constellation of actors*, which is the dynamic feature of all networks and for which the following need to be determined: *number of actors, who participates,* and *how they are linked to each other and the network (e.g. coalitions)*.
(iii) *Governance*, defined as the "mode of *economic coordination* in the health sector" (Dohler 1991, 247), including the *incentive structure, prevailing mode of resource allocation,* and the size and vitality *(mix) of the public and private sectors.*
(iv) *Patterns of interactions,* which have been referred to in the literature as "policy style" (or the standard operating procedure) and include the sectoral "rules" of *decision making, interest intermediation*, and *conflict regulation*.
(v) *Selectivity*, which is the summarizing category of the above-listed network dimensions and determines the "*range of available strategic options*" by analysing *strategic opportunities*, *cognitive maps* and *policy legacies*.

Dohler (1991) concludes that there is no apparent fit between a network structure and a market-oriented strategy, further stipulating that the predisposition of networks towards strategic changes depends highly on *network stability* (Aldrich and Whetten 1981, 391) and the strength or *structure of ties* between actors in the policy network.

Blom-Hansen (1999) presents an empirical example of the combination of rational choice institutionalism and policy network analysis for central-local policymaking in multiple public policy areas, including health, in three Scandinavian countries. His policy network framework is based on his previous research (e.g. Blom-Hansen (1997)) and is particular to intergovernmental relations within a decentralized policymaking environment. He uses an "iron triangle" model for actor behaviour, identifying three institutional actor groups and their likely self-interests: expenditure advocates, expenditure guardians and topocrats. The first two of these are prominently defined in the budget literature, and the third is defined previously in the policy network literature (Rhodes 1992). Using this policy network framework and actor behaviour model, Blom-Hansen empirically tests his framework with Scandinavian countries, showing that the organisation of decision-making process is an explanatory factor for both cross-country and cross-sectoral differences. He also demonstrates that categorizing actors into a few generic types and using basic but plausible behavioural assumptions is useful in the analysis of

policymaking and policy priorities in a decentralized setting. Furthermore, he emphasises the notion that relationships in central-local policymaking vary from sector to sector within the same country (Page and Goldsmith 1987).

2.3. A Combined Analytical Approach for the Thesis

For the analysis of the research questions of this thesis, the integration of the rational choice institutionalist and policy network approaches is intended to cover each other's weaknesses and maximise their strengths. In particular, on the one hand, rational choice institutionalism lends itself to illuminating the political impact of institutions as well as policy stability and change, whereas policy network analysis is weaker in these areas. On the other hand, policy networks paint a more realistic picture of the policymaking process, a function that rational choice institutionalism is often criticised for not doing well. Moreover, while rational choice institutionalism and the policy network approach overlap in their emphasis on actors and their behaviour and interests—in that both take a similar rational choice theory perspective—rational choice institutionalism also stresses the importance of institutions and the policy network approach highlights the additional value of a relationship-based perspective when studying the policymaking process and its outcomes. In addition, both approaches are adequate for studying collective action issues; however, rational choice institutionalism tends to focus on the individual, whereas the policy network approach concentrates mainly on actor groups. Where the policy network approach lacks explanatory power or any sense of consequentialism and strategic calculus, the rational choice institutionalist approach nicely supports it. In addition, while rational choice institutionalism and the policy network approach both may examine formal or informal institutions, the former tends to favour formal institutions while the latter favours more informal institutions (i.e., formal organisations operating under informal rules). Moreover, the latter is a better representation of a differentiated polity and intergovernmental relations, as it clearly has a "many-to-many" policymaking structure. Lastly, while rational choice institutionalism pays little attention to major community power theories, the policy network approach fills this gap with its pluralist interpretation of power and resource dependency.

In addition to harnessing the powerful synchronicities between these two approaches, the present thesis will help fill in the literature gaps on policy networks

in the health sector, at the regional level, and in Spain. Furthermore, it will present a policy network model for not only the national policymaking environment but also the subnational policymaking environment and which will be empirically evaluated with a comparative regional study in Spain. To complete my analytical framework for studying policymaking in a devolved health system, I combine this joint approach to policymaking with the comparative definition of health system decentralization by Bossert (1998). The following chapter gives a complete description of the analytical framework of the thesis.

3. The Analytical Framework

In the previous chapter, I reviewed and presented the literature on decentralization and devolution, and on interest-based approaches to policymaking, identifying some deficiencies in the current research as well as promising directions for it. In terms of deficiencies, the review found only a few relevant general and health system-specific typologies and analytical frameworks for decentralization, some of which included devolution; the most salient of these was Bossert's (1998a) decision-space approach for analysing health system decentralization. The typologies and frameworks reviewed centred on administrative matters (J. M. Cohen and Peterson 1997; A. Mills et al. 1990; Rondinelli 1981; Rondinelli, McCullough, and Johnson 1989) or examined the effect of decentralization on performance (Bossert 1998; J. M. Cohen and Peterson 1997; Gershberg 1998; A. Mills et al. 1990; S. Peckham et al. 2005) and on other outcomes such as accountability (Gershberg 1998) and innovation (Bossert 1998), but did not focus particularly on the health policymaking process and how it affects the policy priorities in a politically decentralized or devolved setting. In addition, the literature on interest-based policymaking approaches pointed to Blom-Hansen's (1999) intergovernmental policy network approach as offering much insight into policymaking and policy priorities in a devolved government arrangement by categorizing the bewildering number of actors into a few generic groups and applying relatively simple but plausible assumptions of the rational choice institutionalist kind.[24]

As a promising direction, then, the way forward for analysing health system devolution and its effects on health policymaking and policy priorities appears to involve a combination of two main analytical approaches derived from the literature: Bossert's approach for defining and measuring decision space in a decentralized health system and Blom-Hansen's policy network approach for analysing intergovernmental health policymaking and health policy priorities within the national policymaking environment. These approaches, however, tell us nothing about what happens to health policy priorities *after* devolution within subnational policymaking environments—a key question of the thesis. To fill this gap in the literature and with the goal of creating a coherent and tight analytical framework, as my own contribution to the literature, I build on Blom-Hansen's approach to design an approach for analysing the

[24] Which he has applied successfully to the health sector.

intergovernmental health policymaking and health policy priorities within the subnational policymaking environment.

Ideally, a comparative analytical framework for health system devolution should use concepts that can be defined, measured, and applied to all health systems or, at least, to the cases being compared. Most importantly, it should represent the policymaking process as structured by the institutional rules of devolution and should include an actor behaviour model that indicates the relative influence of the actors (taking into account such factors as balance of power and resource dependencies) and their strategic interactions in both national and subnational policymaking environments. In terms of structure, the framework should identify the main actor groups in the process and their relationships to each other. It should also include behavioural assumptions for the actors involved. Finally, the framework should be evaluated to determine whether it is robust enough to anticipate policy priorities in a devolved health system. I attempt to address all these issues in the analytical framework of the thesis as presented below.

This dissertation proposes a comparative analytical framework specific to the phenomenon being examined by drawing from mainstream policymaking models and theories in the literature and adapting them to the specific policymaking situation created by devolution in the health sector. More precisely, the framework modifies Bossert's approach to define and measure decentralization so that it is applicable to upper-middle- to high-income countries that have undergone devolution. It combines this approach with the analysis of the national policy network articulated by Blom-Hansen (1999), which incorporates concepts from rational choice institutionalism, and with my contribution to the literature that analyses the subnational intergovernmental policymaking network. Taken in conjunction, these three analytical tools offer a unique look at the institutional relationships that constitute the policymaking process in a devolved health system and their effects on policy priorities and choices, not only at the national but also at the, often overlooked, subnational level. Overall, the analytical framework (i) provides a thorough description of the policymaking process in a devolved health system; (ii) analyses this process more precisely and accurately in order to determine the effects of devolution on policymaking; and (iii) anticipates policy priorities in a devolved health system. The benefit of this framework is that, for a devolved health system, it should identify a relatively close correspondence between

the positions of actors in the national and subnational policy networks and the priority areas for future health policy.

I apply this three-part analytical framework for health system devolution to a case study to understand its ability to determine the effects of devolution on health policymaking and anticipate health policy priorities in a devolved system; and, then, I evaluate the anticipated results from the framework with a retrospective analysis of the actual policy choices at the subnational government level for the same case. The framework was designed for use in upper-middle- and high-income countries and looks only at domestic policy issues specific to the health sector at the national and subnational levels of government.[25] It is not applicable to lower-middle- and lower-income countries, because it does not account for two main factors that are prominent in those nations: (i) the strong policymaking influence of international actor groups (the United Nations, the World Bank, NGOs, etc.) and (ii) the significantly different impact of decentralization on lower-income countries, e.g. due to their lack of capacity (see Bossert and Mitchell (2011)). These considerations lie beyond the scope of the thesis.

The details of the analytical framework are presented in the following sections. The first section presents Bossert's decision-space approach and map, including its adaptation to upper-middle- and high-income countries. The second section describes Blom-Hansen's integration of the intergovernmental policy networks, with concepts of

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[25] Upper-middle-income countries, defined by the World Bank (2013) as having a GNI per capita between $4,126 and $12,735, include: Albania, Algeria, American Samoa, Angola, Azerbaijan, Belarus, Belize, Bosnia and Herzegovina, Botswana, Brazil, Bulgaria, China, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, Fiji, Gabon, Grenada, Iran, Iraq, Jamaica, Jordan, Kazakhstan, Lebanon, Libya, Macedonia, Malaysia, Maldives, Marshall Islands, Mauritius, Mexico, Mongolia, Montenegro, Namibia, Palau, Panama, Peru, Romania, Serbia, South Africa, St. Lucia, St. Vincent and the Grenadines, Suriname, Thailand, Tonga, Tunisia, Turkey, Turkmenistan, and Tuvalu. High-income countries, defined by the World Bank (2013) as having a GNI per capita greater than $12,736, include: Andorra, Antigua and Barbuda, Argentina, Aruba, ***Australia***, Austria, The Bahamas, Bahrain, Barbados, Belgium, Bermuda, Brunei Darussalam, ***Canada***, Cayman Islands, Chile, Croatia, Curacao, Cyrus, Czech Republic, ***Denmark***, Estonia, Equatorial Guinea, Faeroe Islands, ***Finland***, France, French Polynesia, Germany, Greece, Greenland, Guam, Hong Kong SAR, Hungary, **Iceland**, **Ireland**, Isle of Man, Israel, ***Italy***, Japan, Rep. Korea, Kuwait, Latvia, Liechtenstein, Lithuania, Luxembourg, Macao SAR, Malta, Monaco, Netherlands, New Caledonia, ***New Zealand***, Northern Mariana Islands, ***Norway***, Oman, Poland, **Portugal**, Puerto Rico, Qatar, Russian Federation, San Marino, Saudi Arabia, Seychelles, Singapore, Sint Maarten, Slovak Republic, Slovenia, ***Spain***, St. Kitts and Nevis, St. Martin, ***Sweden***, Switzerland, Taiwan, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, ***United Kingdom***, United States, Uruguay, Venezuela, and US Virgin Islands.
While a review of all of these countries is beyond the scope of the thesis, I reviewed 33 high-income (OECD-member) countries to understand which of them could potentially be a case study for the thesis. Of these 33 countries, I calculated that 13 have primarily tax-financed health systems—an important factor for distinguishing and comparing health systems—(see these in **bold** type) and, of those, 9 were politically-decentralized unitary states (see *italic* type). As such, the analytical framework of the thesis would be most applicable to these nine countries. This review would need to be expanded to include the remaining upper-middle- to high-income countries listed in order to understand how many more countries would also qualify.

rational choice institutionalism, for understanding the intergovernmental policymaking process within the national policymaking environment. Extending Blom-Hansen's approach, this section also describes the dissertation's original contribution to the literature of an analytical approach for understanding the intergovernmental policymaking process within the subnational policymaking environment. The third section brings together these three approaches for analysing health system devolution and constructs a methodology that can be used to understand and better anticipate health policy priorities. It also presents the methodology for empirically examining the framework with a case study. Finally, this chapter ends with a detailed account of the research design and methods employed in the elaboration of the thesis.

3.1. Defining Decision Space for Health System Devolution

As elaborated in the literature review, the study's definition of health system devolution is the transfer of power and authority over specific health system functions from the central government to subnational government units, with all the administrative, political and economic attributes and relationships that these entail, including the discretion to engage effectively in decision-making regarding health policies within their legally delimited geographic and functional domain. Although comprehensive, this definition (similar to other definitions found in the literature) does not provide a consistent means for measuring health system devolution or decentralization. Instead, Bossert proposes using the concept of *decision space*, or "the range of effective choice that is allowed by central authorities (the principal) to be utilized by local authorities (the agents)" (1998, p. 1518). With this definition, devolution and decentralization become measurable and operational, and we understand that the *degree of discretion* allowed to subnational authorities is more important than *who* gets more of it.[26] Decision space can be formally defined by the laws and regulations established by the relevant governing bodies (and national court decisions).[27] Bossert uses it to define the specific *rules of the game* for devolved or decentralized governments. He illustrates this concept with a "decision-space map", locating the amount of latitude granted to subnational decision makers over a series of key health system functions. This map

[26] As such, the form (i.e., administrative, political or fiscal) and type (delegation, de-concentration or devolution) of the decentralization is not useful at this point.
[27] Effective decision space can also be defined as what actually happens despite formal laws, allowing subnational governments more or less room for decision-making. This is similar to Kenneth Shepsle's (2006) conception of "institutions-as-equilibrium".

represents the amount of choice for each function at the subnational level of government as narrow, moderate or wide on the horizontal axis of the map; and lists a series of key health system functions on the vertical axis of the same map. See Bossert's original decision-space map in Table 3.1.

Table 3.1. Bossert's Original Health System Decision-Space Map

Functions	Range of choice		
	narrow	moderate	wide
Finance			
Sources of revenue	→	→	→
Allocation of expenditures	→	→	→
Income from fees and contracts	→	→	→
Service organization			
Hospital autonomy	→	→	→
Insurance plans	→	→	→
Payment mechanisms	→	→	→
Contracts with private providers	→	→	→
Required programs/norms	→	→	→
Human resources			
Salaries	→	→	→
Contracts	→	→	→
Civil service	→	→	→
Access rules			
Targeting	→	→	→
Governance rules			
Facility boards	→	→	→
Health offices	→	→	→
Community participation	→	→	→

Source: Bossert (1998, 1518).

The value of this approach is that it allows decentralization—or, in the case of the present thesis, devolution—to be conceptualised not as a single transfer of a defined amount of power, authority, and responsibility to a subnational government, but rather as varying degrees of discretion over a series of key functions that may be transferred differently to a subnational government. Following Bossert's original decision-space map with a few modifications, eliminating functional areas and key functions that are not germane to upper-middle- to high-income countries (e.g., "access rules"),[28] and using more recent literature (e.g. (2007)) to add new functions, the decision-space map for this thesis is illustrated in Table 3.2.

[28] Bossert's original approach analyses developing (i.e., low- to lower-middle-income) countries, where access is a bigger problem than, e.g., targeting service delivery.

Table 3.2. Health System Decision-Space Map for This Thesis

	Functional areas and Key functions	Range of Choice: Narrow	Moderate	Wide
	Service organization			
	Contracts with private providers			
	Hospital autonomy			
Δ M	Targeting service delivery			
+	**Regulation and planning**			
+	Policy formulation			
Δ M	Norms and standards			
+	Prescription drug planning			
+	Drugs and supply rationing			
+	Infrastructure planning			
+	Health information systems design			
	Financing			
Δ M	Insurance schemes			
M	Payment mechanisms			
	Sources of revenue			
Δ	Resource allocation			
Δ	Income from fees			
	Human resources			
	Salaries and benefits			
	Contracts (non-permanent staff)			
	Civil service			
+	Pre-service education and training			
+	Continuing education and training			
	Governance/Stewardship rules			
	Facility boards			
Δ	Territorial health offices			
Δ	Public participation			
+	Patient/user rights			
+	Complaint system			

Sources: Author's modification of Bossert (1998), also drawing from Bossert, Bowser and Amenyah (2007); WHO (2000); and Management Sciences for Health (2000).
NB: To show how I adapted Bossert's map, I use the following: M = Moved from another functional area; Δ = Changed key function title slightly; + = New functional area or key function.

In this table, the decision-space map of the thesis shows the key health system functions grouped in functional areas. For example, the category of financing contains five key functions: *insurance schemes, payment mechanisms, sources of revenue, resource allocation, and income from fees*. Following Bossert, I evaluate quantifiable indicators for each key function of the decision-space map to make this a tool for rigorous comparison, as shown in Table 3.3. The amount of choice is described as "moderate range" when the subnational government has some but not complete discretion over decisions regarding the function, e.g. when the national government prescribes a basic or common health care benefit package for all subnational health services but allows the subnational government to make decisions on additional benefits within its territory and finance them with its own resources. This part of the decision-space approach will be applied to the empirical case study before and after health system devolution to understand the degree of increased decision space for each health system function that is provided by the reform and its impact.

Decisions in each functional area are likely to have significant influence on a given health system's performance, particularly in the areas of efficiency, equity, financial soundness and quality. For example, key decisions on planning will influence the system's economic and political efficiency. Indeed, one of the oft-stated objectives of decentralization is to "bring government closer to the people" for greater responsiveness and accountability. Decisions made on the sources and allocation of revenue will affect the system's financial soundness and equity. Decisions concerning the service organisation may significantly influence the efficiency and quality of the services delivered. Permitting management of human resources at a more local level may also increase the efficiency and quality of services. Stewardship and governance rules outline the limits within which the different organisations can influence the health system. Finally, all of these will have an influence on the health policy priorities and decisions made after devolution.

Table 3.3. Key Health System Functions and Indicators for Comparative Mapping of Decision Space

Functional Areas Key functions	**Indicators**	**Range of Choice**		
		Narrow	**Moderate**	**Wide**
Service Organisation				
Contracts with private health care services providers	Choice of contracting with private health care service (institutional) providers	Defined by law or higher authority	Several models for local choice	No limits
Hospital autonomy	Choice of range of autonomy for hospitals	Defined by law or higher authority	Several models for local choice	No limits
Targeting service delivery	Choice in defining, monitoring and modifying equity of access to services by priority populations	Defined by law or higher authority	Several models for local choice	No limits
Regulation and Planning				
Policy formulation	Choice of range of health policies formulated	No choice or narrow range	Moderate range	No limits
Norms and standards	Choice of defining standards and norms (e.g. health care benefits)	Defined by law or higher authority	Several models for local choice	No limits
Prescription drugs planning	Choice of defining essential drug lists, generic substitution or a drug formulary	No choice or narrow range	Moderate range	No limits
Drugs and supplies (rationing)	Choice of developing protocols for prescriptions and utilisation of drugs and supplies	No choice or narrow range	Moderate range	No limits
Infrastructure planning	Choice of planning health infrastructure	No choice or narrow range	Moderate range	No limits
Health information systems design	Choice of health information systems structure and design	No choice or narrow range	Moderate range	No limits
Financing				
Insurance schemes	Choice of how to design and manage insurance schemes	Defined by law or higher authority	Several models for local choice	No limits
Payment mechanisms	Choice of how to pay public providers (incentives and non-salaried)	Defined by law or higher authority	Several models for local choice	No limits
Sources of revenue	Choice of sources of revenue, including role of intergovernmental transfers in local health expenditure	No choice or narrow range	Moderate range	No limits

Functional Areas	Indicators	Range of Choice		
Key functions		**Narrow**	**Moderate**	**Wide**
Financing (cont.)				
Revenue allocation (budgeting)	Choice of budgeting and allocating revenue	No choice or narrow range	Moderate range	No limits
Income from fees	Choice of range of prices allowed	No choice or narrow range	Moderate range	No limits
Human Resources				
Salaries and benefits (permanent staff)	Ability to modify salary and benefit levels	Defined by law or higher authority	Moderate range for salary and benefit levels defined	No limits
Contracts (non-permanent staff)	Choice of contracting non-permanent staff	None or defined by higher authority	Several models for local choice	No limits
Civil service	Choice of planning, hiring, evaluating and firing staff	National civil service	Local civil service	No civil service
Education and training (pre-service)	Choice of planning pre-service education and training of health professionals by each organisation	No choice or narrow range	Moderate range	No limits
Education and training (continuing)	Choice of planning continuing education of health professionals by each organisation	No choice or narrow range	Moderate range	No limits
Governance/Stewardship Rules				
Facility boards	Choice of the size and composition of boards	Defined by law or higher authority	Several models for local choice	No limits
Territorial health offices	Choice of the size and composition of local offices	Defined by law or higher authority	Several models for local choice	No limits
Public participation	Choice of the size, number, composition and role of community participation	Defined by law or higher authority	Several models for local choice	No limits
Patient/user rights	Choice of defining patient/user rights	Defined by law or higher authority	Several models for local choice	No limits
Complaint system	Choice of establishing a patient/user feedback system	Defined by law or higher authority	Several models for local choice	No limits

Sources: Author's modification of Bossert (1998) using Bossert, Bowser and Amenyah (2007); WHO (2000); and Management Sciences for Health (2000).

Bossert's (1998) decision-space framework does not finish here with the definition and measurement of decentralization; but, it continues on to explore how greater decision space is used, i.e., whether the subnational health authorities given this wider discretion choose innovations or no change, and how the changes (if any) affect the performance of the subnational government in achieving health reform objectives. He compares this with directed change from the central government in a situation of narrow decision space at the subnational government level.[29] Bossert's framework uses the principal-agent approach to consider how the principal (i.e., the national-level entity that maintains oversight) uses various mechanisms of control to assure that the agents work toward achieving the desired objectives. He focuses on analysing the ministry of health as principal and the local health authorities as agents; though, the principle-agent model does not preclude using multiple principles. My analysis takes a somewhat different route from Bossert's framework at this point. I am interested primarily in how the concept of decision space might be utilised to describe and illustrate the degree of discretion that is allowed to subnational governments for each health system function through devolution reform and, subsequently, how it affects the health policymaking process and the health policy priorities made after devolution (and whether the latter can be anticipated through an analysis of the policymaking process). This endeavour requires a more dynamic analysis, which I develop in the following section.

3.2. Intergovernmental Policy Networks for a Devolved Health System

For the second part of the analytical framework of the thesis, I build on Blom-Hansen's intergovernmental policy network approach with rational choice institutionalism to represent respectively the structure and agency of the policymaking process, and to examine policy priorities after devolution at both the national and subnational levels. This is an interest-based model offers a micro-level explanation of the policy processes and change, focusing on the role of actors, their relationships and interactions and their respective policy priorities and strategies. It focuses on the strategic actions of elite actors, including politicians and high-level bureaucrats, who play a significant role in intergovernmental relations for health policy at the national and regional levels of government. Thus, main groups of actors for this approach come from the health

[29] Bossert refers to "local" rather than "subnational" governments in his framework. I use the latter for consistency of the term throughout the thesis.

sector, the top positions of each government at each level of government and those responsible for budgetary issues. They interact with each other regularly in the policymaking process, forming policy networks.

This study defines policy networks as *institutions*, which according to Ostrom (1986) can be conceptualised as the *rules governing action*. However, as described more fully in the policy literature review, policy networks can vary along a cohesion continuum that ranges from tight-knit *policy communities* to more loosely coupled *issue networks.* Using Blom-Hansen's (1999, 239) modification of Ostrom's (1986) institutional rules, intergovernmental policy networks are categorised into these two major categories (see Table 3.4). This descriptive portion of the policy network approach identifies the structures, or main *institutional rules,* that enclose the intergovernmental policymaking process under devolution and limit the space for actors to manoeuvre.

Table 3.4. Intergovernmental Policy Networks as Institutions

	Intergovernmental Policy Networks	
Institutional rules	***Policy Communities***	***Issue Networks***
1. Position of actors	Negotiators	Rulers and pressure groups
2. Boundary of the institution	Includes only government and representatives of local governments	Government and various types of interest organisations
3. Decision-making procedure	Unanimity	Consultation
4. Scope of decisions	Policy formulation and implementation	Policy formulation
5. Pay-off rules	Influence and responsibility	Influence

Source: Blom-Hansen (1999, 239).

To enhance the explanatory effectiveness of this interest-based approach, the intergovernmental policy network depends on an actor behaviour model, including behavioural assumptions based on rationality. Blom-Hansen employs one such model designed for central-local relations based on the principles and assumptions of rational choice institutionalism. Additionally, actor behaviour models in intergovernmental relations shift in emphasis from agency towards partnership as a lower-level government gains greater autonomy and financial independence from its central government, e.g. through the devolution of powers (Rhodes 1981). The partnership principle of multilevel governance gives both formal and informal roles and powers to

a range of actors at each level of the policymaking process, creating an intergovernmental policy network. In the health system literature, this type of partnership is often referred to as "stewardship" (see e.g. WHO (2000) and Travis et al. (2003)). The following paragraphs elaborate the details of this model, starting with Blom-Hansen's (1999) analysis of *intergovernmental policy networks in the national policymaking environment* (or "national-level intergovernmental policy network") and then moving on to my own proposed model for analysing the policymaking process and priorities of the *intergovernmental policy network in the subnational policymaking environment* (or "subnational-level intergovernmental policy network").

Blom-Hansen identifies three essential types of actor groups involved in intergovernmental relations within the national policymaking environment and depicts the political process (or interactions between them) as a game. In a devolved political situation, he attributes sectoral policy preferences and priorities, and ultimately the determination of policy choice, to the interactions between these three groups. The political process, or 'game', is seen as an institutional conflict between the competing interests of the different actor groups to implement policies reflecting their own preferences.

The first two types of intergovernmental actor groups, or 'institutional actors', have been grounded in the government budgeting literature since the mid-20th century; they are called *expenditure advocates* and *expenditure guardians* (Wildavsky and Caiden 1997, chap. 1). Indeed, the interactions between budgetary spending and cutting groups make up the primary components of budgetary systems (Wildavsky 1975). These two types of actor groups have been widely used and accepted by governments, international organizations and the political science and economic literature. The main argument for their use in the literature is that budgetary politics, outcomes and performance can be analysed and even explained by focusing on the interplay of these two actor groups (Heclo and Wildavsky 1974a; Wildavsky 1975; 1986).

An expenditure advocate is interested in working on new or existing public programmes, which usually entails promoting increased funding and new types of policy regulation for such programmes. This specific, pre-determined motivation subjectively influences her judgements and decision-making. Thus, as a group and to the best of their abilities, expenditure advocates are expected to work towards sector-specific policy goals in the political system. They garner respect and admiration

especially for new spending initiatives. An expenditure guardian is a protector of the treasury, wishing to constrain public spending, most often, by limiting public sector activity. Savoie (1999, 162) wrote expenditure guardians "are in the business of saving public money". They are expected to work towards the goal of macroeconomic control of the political system to the best of their abilities. This goal influences their decision-making and judgements subjectively. Expenditure guardians often fear the political and other consequences of continually spending more money than the system can raise. Indeed, when advocates dominate guardians, two common issues arise: first, new policies rarely replace or eliminate existing programs; and, second, without the economic restraint of guardians, all of the line ministries (i.e., the expenditure advocates for each sector) would look to increase spending in their sectors and use all available resources to satisfy their constituents, leading to a 'tragedy of the commons' situation.

A variety of actors at the central level of government may take on these two roles; in general, however, sectoral (or line) ministries or secretaries and sectoral parliamentary committees (along with special-interest organisations) play the role of expenditure advocates, while finance ministries and parliamentary budget committees generally play the role of expenditure guardians. In contrast to the line ministries, finance ministries do not affiliate with any particular programme priority, making them more autonomous from social pressures for a specific programme and able to maintain oversight of the budget process (Hallerberg, Strauch, and von Hagen 2009).

The third type of intergovernmental actor group operating in the national-level policymaking environment consists of representatives from the subnational level of government. These representatives interact regularly with the other two types of actor groups, promoting subnational interests for national policymaking. Blom-Hansen calls this type *topocrats*—a term first coined by Beer (1978) in the federalism literature.[30] As a group, topocrats are increasingly important to the process of national policymaking in upper-middle- to high-income countries, which have potentially greater technical, human resource and financial capacity (Page 1991, 43–56). Rhodes (1886, p. 1), for example, documents the everyday existence of topocrats in the national policymaking environment in the United Kingdom due to their routine lobbying "in the village that is Westminster and Whitehall". As a group, it would seem

[30] This word comes from the Greek *topos*, meaning place or locality, and *kratos*, meaning authority. It is, however, newly invented and does not appear in the Modern Greek language.

logical that topocrats would act as the guardians and defenders of the territorial interests and associations of their constituents in the national political process (Cammisa 1995; Elazar 1991; V. A. Schmidt 1990). According to Haider (1974, 214–15), topocrats "are protective of the autonomy, fiscal viability, and integrity of the particular level of government they speak for." As a result, and according to Blom-Hansen (1999), a topocrat's ultimate goal is to defend their subnational autonomy.[31] Subnational government bureaucrats and politicians, especially those within the sector of analysis and the office of the presidency, generally play this role in intergovernmental relations with the other two main actor groups of the central government.

Together, these three actor groups and the structure of their relationships can be conceptualised as an "iron triangle" model of policy networks. Using rational choice institutionalism, their interactions and strategies can also be conceptualised as a game in which they rationally pursue their own self-interested goals. As noted, the three groups' top priorities, respectively, tend to be sectoral policy goals, macroeconomic control, and subnational autonomy. While they may agree that all three goals are important, each actor group has its own overriding priority. As all three goals can seldom be realised at the same time,[32] a policymaking situation of trade-offs emerges. In this way, the structure of the national policy network becomes paramount as it both constrains and facilitates the ability of the different actor groups to pursue their respective goals, which they do in a rational and self-interested (as opposed to altruistic) way. Hence, the "rules governing the action" of the three actor groups must be better understood. They can be determined by examining various measures regarding the relative power and influence (exerted power) of the three groups. This allows the analyst to determine where the actual balance of the three goals lies (i.e., how the trade-offs function) and the relative level of participation of each actor group in intergovernmental policymaking.

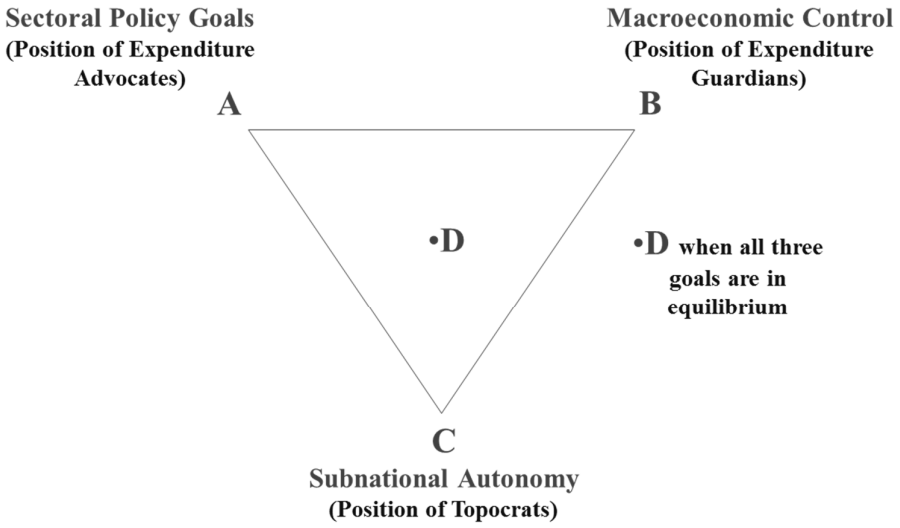
Figure 3.1 illustrates the national-level intergovernmental policy network in terms of the positions of the various actor groups and the trade-offs between their often-

[31] Blom-Hansen (1999) refers to "local" rather than "subnational" autonomy. I use the latter for consistency of the term throughout the thesis.

[32] Sectoral policy goals, especially those in social sectors such as health and education, can be expensive to pursue and often conflict with macroeconomic control goals. Meanwhile, macroeconomic control goals can conflict with local autonomy goals when local governments do not follow national economic policy guidelines. Finally, local autonomy goals conflict with sectoral policy goals when national and local policy positions on an issue differ (Blom-Hansen 1999, 241).

competing goals. For example, if one actor group is in a position to dictate intergovernmental policymaking, then the other two have little or no influence and policy will move towards the dictator's goal (which is located at one of the three corners of the triangle in the figure). However, if only one actor group is lacking political influence, then policy will be balanced between the goals of these remaining two actor groups (on one of the sides of the triangle). Finally, if all three actor groups participate effectively in intergovernmental policymaking with roughly equal power and influence, then the overall policy outcome will likely reflect a balance between the goals of all three groups (somewhere inside the triangle, with point D representing a rare but perfect balance between their goals).

Figure 3.1. Trade-offs in Intergovernmental Policymaking at the National Level



Source: Blom-Hansen (1999: 242), modified by author

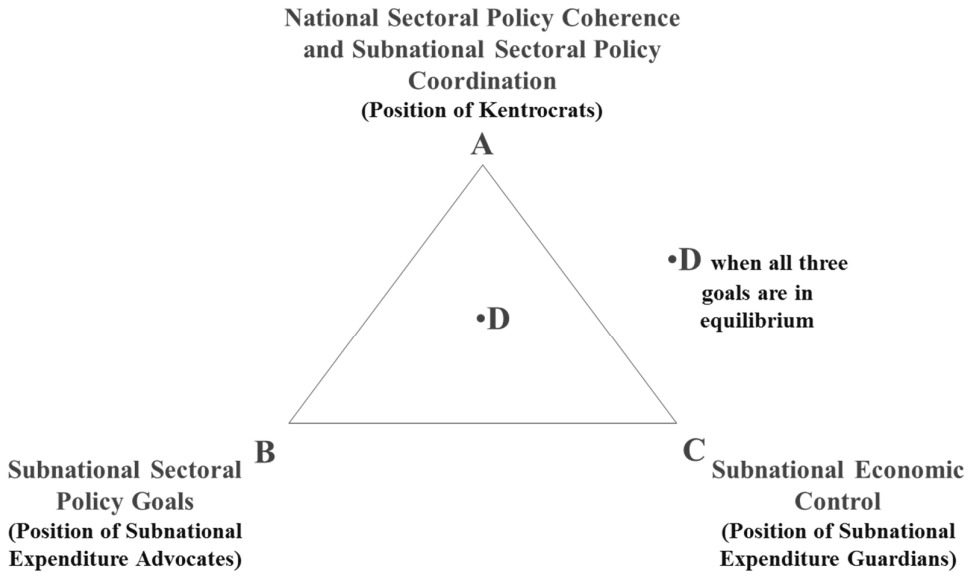
Building on this notion of national-level intergovernmental policy networks, I define, as an original contribution to the literature, an intergovernmental policy network that operates within the subnational policymaking environment. This subnational-level intergovernmental policy network is also modelled as an iron triangle, representing three actor groups and the structure of their relationships. The policymaking 'game' that is played out between the actor groups of the subnational-level intergovernmental policy network operates in much the same way as the national-level one does. The actor groups are also quite similar, considering that the subnational-level government structures and policymaking arrangements in Spain (and other countries) generally

correspond to those of their central government. Indeed, the first two types of actor groups in this network play analogous roles to the expenditure advocates and expenditure guardians of the national-level intergovernmental policy network: they are the expenditure advocates and guardians at the subnational level of government. I call them the *subnational expenditure advocates* and *subnational expenditure guardians*, respectively. Based on the same conceptual foundation, the entities taking on these roles are kindred to those at the national level; they are, e.g., subnational sectoral ministries or secretaries, and sectoral committees in the subnational parliament, and subnational finance ministries and parliamentary budget committees respectively for the expenditure advocates and guardians.

The third type of intergovernmental actor group plays the inverse role of the topocrat; as central government representatives working in the subnational policymaking environment, they interact regularly with the subnational expenditure advocates and guardians. I call this type of actor group kentrocrats.[33] Acting on behalf of the central government and, essentially, the citizens of a whole country, kentrocrats' primary objective is to promote national interests. As the intergovernmental relations shift toward a greater amount of decision space at the subnational government level (especially in the case of political devolution), kentrocrats take on a role of stewardship, seeking to advance the goals of national policy coherence and subnational policy coordination, especially with regard to strategic national objectives. In general, kentrocrats are made up national-level bureaucrats, but in times of great need, national-level politicians can also become involved. Defined broadly like this, however, the kentrocrats, theoretically, could encompass many different central-level representatives and their goals could be just as different (and even sometimes competing). Therefore, for each study, it is important to specify the sector from which kentrocrats hail. Figure 3.2 illustrates the subnational policy network, with each actor group, and their respective positions and trade-offs in intergovernmental policymaking. Again, the same game situation assumptions specified for the national policy network also apply for the subnational policy network; the only difference that might be an additional factor in decision-making at the subnational level is some influence from the balance of priorities between the three actor groups of the national-level intergovernmental policy network.

[33] This word comes from the Greek *kentro*, meaning centre, and *kratos*, meaning authority. I have invented it. It does not appear in the Modern Greek language.

Figure 3.2. Trade-offs in Intergovernmental Policymaking at the Subnational Level



Source: Author's own elaboration

For the thesis, and complying with sector-specificity, I call this group *health-sector kentrocrats* and their specific goals are national health policy coherence and subnational health policy coordination. Moreover, when referring to the intergovernmental policy networks for an analysis of the health sector, I call them the "national health policy network" and "subnational health policy network", respectively.

3.2.1. Establishing the Position of Actor Groups in the National Health Policy Network

Blom-Hansen (1999) hypothesises that the organisation of central and local policymaking matters because it offers the three institutional actor groups different opportunities to achieve their interests and goals. He tests this hypothesis using a comparative analysis of three policy areas (economic, health and childcare policy) in the three Scandinavian countries (Sweden, Norway, and Denmark) before the year 2000. At the time, these three countries had similar political systems, as unitary states with parliamentary systems and proportional elections at all three levels of government (national, county and municipality) and similar political parties (Blom-Hansen 1999, 243). They also had similar, formally organised local governments, participating in the decentralization of core welfare state responsibilities and handling the majority of public expenditures. These similarities meant that many variables could be held

constant between countries. By analysing the power and influence of each actor group, Blom-Hansen found a point of equilibrium for central-local policymaking (i.e., the informally organised, intergovernmental institutions involved in the national policymaking process) for each policy area in the three countries. This point was the most likely compromise among the policy goals and priorities of the three actor groups for the specific sector and country (cf. Figure 3.1).

To find the relative position of each actor group of the national policy network, Blom-Hansen employs two main methods. For expenditure advocates and expenditure guardians, Blom-Hansen looks primarily at the national budget process to determine their relative influence and position. Examining the national budget is ideal because it encapsulates a process of continuous bargaining and negotiation between these two types of institutional actors and their opposing goals. The relative strength of each actor bloc can be measured first through the degree of openness of the national budget process. If the process is mostly closed (or "tight"), then expenditure guardians have a stronger bargaining position than advocates do; conversely, advocates benefit from a "loose" and open process. The national budget process has several phases: preparation, parliamentary enactment and (often) ad-hoc appropriations throughout the year. At each phase, expenditure guardians and advocates bargain for their respective goals. Blom-Hansen uses von Hagen's (1992) structural index of the national budget process in European Community countries to measure the tightness of all three phases of budgeting using a number of institutional indicators. The index is scored on a 60-point scale, where 1-30 seems to indicate a "weak" budgetary process and 31-60 indicates a "strong" budgetary process.[34] Because budget processes change over time and Blom-Hansen's study covers a relatively long period, he also verifies his results through content analysis of the major changes in each country's budget process.

For the topocrats, Blom-Hansen first verifies that local government associations exist in all three countries and that they routinely interact with the central government. To assess their level of influence in a particular sector and country, he looks primarily at their role in decision-making, asking: *How involved are they in policy formulation at the national level? To what extent are formal agreements or other mechanisms between local government associations and the national government used as alternatives to parliamentary decision-making?* These formal intergovernmental

[34] While Blom-Hansen (1999) does not explicit these details of the index, I gathered them through a careful comparison of his work and that of von Hagen (1992).

agreements hold political rather than legal value. They are corporatist decision-making tools, useful to the national government as an alternative to command-and-control methods (e.g. parliamentary regulation) that are inappropriate in a partnership model of governance. Local government participation in such intergovernmental agreements suggests a privileged position and considerable influence on the national policymaking process.

To determine the level of influence of the topocrats, Blom-Hansen does not use a quantitative scale but rather, he looks at the agreements negotiated between the central government and local government associations within the national policymaking environment. In cases where the central government consults local government associations as a matter of standard operating procedure only, he designates them as "weak". Where the local government associations have *exclusive* and *systematic* access to the central government and agreements between them are used as an alternative to parliamentary decision-making, Blom-Hansen designates them as "strong". Finally, he labels a country with intergovernmental relations that lie between these two examples as an intermediate case, labelling the topocrats as having "medium" strength and acknowledging that this determination may vary across sectors (e.g. in his study, Sweden represented an intermediate case and, thus, Blom-Hansen labelled Swedish topocrats as "medium" for all policy areas, but "strong" for health sector policy). For the analytical framework of this thesis, I apply slightly modified version of Blom-Hansen's method to the health sector and establish the position of the different actor groups in the national health policy network. For the national budget process analysis of the influence of expenditure advocates and guardians, I first look in the literature to see if von Hagen's empirical approach has been applied to the country case study of the thesis. If it has, but for a period that is distant from the dates of my analysis, then I will verify the budget tightness results by reviewing and assessing the major changes in the budget process since the period of the study and until the dates of my analysis, making any corresponding changes to values in the structural index. If von Hagen's approach has not been applied to the country case study of the thesis, then I will fully replicate it for the case. The results of each phase of the national budget process for the study will be reported in a table (see Table 3.5 as a template).

Table 3.5. The National Budget Process in Spain

	Spain	
	Von Hagen (1992)	**Other**
Government's preparation of the budget (maximum score: 16)		
Parliament's enactment of the budget (maximum score: 20)		
Observance of the budget during the budget year (maximum score: 25)		
Total score		

Explanatory note: The lower the score on the 60-point scale, the more open the budget process.

Finally, I modify Blom-Hansen's 60-point scale: instead of using a binary designation, I believe there is room in the analysis to add a third category to indicate a "moderate" budgetary process. Accordingly, for the thesis, a score between 1 and 20 points suggests a "weak" budgetary process, between 21 and 40 points suggests a "moderate" budgetary process, and between 41 and 60 points suggests a "strong" budgetary process. For the topocrats, I modify Blom-Hansen's method by creating an index for determining their strength in the national policymaking process, improving its objectivity and reproducibility. See Table 3.6 below. To understand the strength of the topocrats within the national policymaking process, I tally up the points for all index items and map the total on a 9-point scale, with '9' being the maximum overall value. Finally, I rank the topocrats as follows: "weak" for a score between 1 and 3, "moderate" for between 4 and 6, and "strong" for between 7 and 9.[35]

[35] NB: I prefer the term "moderate" as a substitute for what Blom-Hansen designates "medium" strength.

Table 3.6. Index for Topocrat Strength in the National Policymaking Environment

Items	Possible Values
1. Do the local government associations[36] exist in the country and sector of investigation? no [0]; yes, in the country only [1]; yes, in the country and sector [2].	2
2. Do local government associations routinely interact with, and have exclusive and systematic access to, the central government? no [0]; yes, for routine, exclusive access only [1]; yes, for routine, systematic access only [1]; yes, for routine, exclusive and systematic access [3].	3
3. How involved are local government associations in policy formulation at the national level? They are not involved at all [0]; they are consulted because of standard operating procedure only [1]; they provide some influence on policy formulation beyond standard operating procedures [3]; formal agreements and other mechanisms between them and the central government are used as an alternative to parliamentary decision-making [4].	4
Total Score	**9**

Explanatory note: The higher the score, the stronger the topocrat.

3.2.2. Establishing the Position of Actor Groups in the Subnational Health Policy Network

Parallel to Blom-Hansen's discussion of intergovernmental actor groups within the national policymaking environment, I contend that the organisation of intergovernmental policy network matters in a devolved health system because it structures the interactions between the three actor groups within the subnational policymaking environment, providing each with opportunities to pursue their interests and goals. In the following paragraphs, I present the methods used to analyse the power and influence of each actor group and position them on the trade-offs figure for intergovernmental policymaking at the subnational level (as shown above).

To identify the relative position and influence of the subnational expenditure advocates and guardians in their policymaking process, I apply a similar procedure to what I outlined for their national-level counterparts. First, I look for analyses of the tightness of the subnational budget process for the subnational government case studies. If I find one, but for a period that is distant from the dates of my analysis, then I will verify the budget tightness results by reviewing and assessing the major changes in the budget process since the period of the study until the dates of my analysis,

[36] The use of the term 'local government associations' is not strictly limited to the definition used in Scandinavian countries. It includes bodies existing in countries with different organizational structures to those studied by Blom-Hansen but that perform similar functions to the local government associations.

making any corresponding changes to values in the structural index. If an adequate analysis of this kind cannot be found for the subnational case studies, then I will adapt von Hagen's analysis to the subnational context and budget process and perform my own analysis of the subnational budget process. In any case, some adaptation of von Hagen's index and analysis to the subnational level is necessary and will inherently be influenced by the national context and budget process because the central government often establishes the rules for budget processes and procedures for all levels of government in a country. The results for the subnational expenditure advocates and guardians for each subnational case study will be presented in tabular form similar to Table 3.5 above. In addition, I designate each of these actor groups as having weak, moderate or strong power and influence for each subnational government case study, using the same methods as stated above for the national-level expenditure advocates and guardians.

To locate the relative position of the health-sector kentrocrats—that usually consist of national-level bureaucrats from the highest-level health ministry in a country—, I use two main methods. First, I look for evidence in the literature of these actors and their relatively routine interactions with their subnational governments, regarding the health sector (i.e., I look for any entities in the country case that perform similar roles and functions to Scandinavia's local government associations). Then, to assess their influence, I examine health-sector kentrocrats' as *stewards* over health policy within the subnational policymaking environment and, ultimately, their ability to accomplish their overarching goals of national health policy coherence and the coordination of subnational health policy.[37]

Drawing on Travis et al.'s (2003) framework on stewardship of the health system, I break down this assessment of the health-sector kentrocrats into four sub-functions of stewardship (or responsibilities): (i) ensuring tools for implementation: powers, incentives and sanctions; (ii) ensuring accountability; (iii) generating intelligence; and (iv) building partnerships. To assess these functions, I perform a content analysis of the literature and regulatory framework (including laws, decrees, standards, and procedures that exist to guide the health system) from the country studied to understand and assess the activities health-sector kentrocrats carry out for

[37] There is an abundance of scholarly literature on health system stewardship, especially for decentralized and multi-level governance systems. See e.g. WHO (2000), Boffin (2002), Travis et al. (2003), Gilson (2007), and Alvarez-Rosete et al. (2013).

each responsibility. For the first stewardship responsibility, I assess whether the health-sector kentrocrats are able to set and enforce fair rules, incentives and sanctions, taking a two-pronged approach: (a) I examine whether they have sufficient funding to use as a tool for setting incentives and ensuring the compliance of the subnational governments on nationally-established health policies; and (b) I look at whether they are able to identify, motivate and/or enforce subnational government to comply with nationally established laws and regulations. Then, for the second responsibility, I assess health-sector kentrocrat's efforts to ensure accountability within the health system, with a review of the mechanisms they have in place for accountability and public participation. Next, for the third stewardship responsibility, I examine their competence to ensure subnational governments have timely access to the information they need to make their contribution to the health system, including receiving the necessary data and intelligence from the central and other subnational governments (e.g. information appearing in sources that the kentrocrats produce, such as annual national health system reports). Finally, for the fourth responsibility, I examine whether they have built and been able to sustain partnerships with the subnational governments. For example, I consider to what extent they have created opportunities to interact with politicians and bureaucrats from individual or multiple subnational governments through special events, regular tasks or continuous activities.

Intending to standardize this analysis for replication and make it more objective, I construct an index to value these functions on an 18-point scale with '18' being the maximum overall value health-sector kentrocrats can achieve. See Table 3.7 below. The maximum possible value for each stewardship function is indicated in the table, along with their descriptions. Finally, to understand the strength of the health-sector kentrocrats as stewards of the national health system, I tally up the points for all of their functions and rank them as follows: "weak" for a score between 1 and 6, "moderate" for between 7 and 12, and "strong" for between 13 and 18.

Finally, I summarise the relative positions of power and influence of all the institutional actor groups in the two intergovernmental health policy networks. I illustrate these positions together in a table (see Table 3.8 for the format; in this

instance, I have provided a hypothetical set of results for Subnational Government 1 for use as an example later in the chapter).[38] .

Table 3.7. Index of Stewardship Functions for Health-Sector Kentrocrats

Stewardship Functions	**Possible Values**
1. Ensuring tools for implementation: financing and regulation	
a) Do health-sector kentrocrats have sufficient funding for setting incentives and ensuring the compliance of the subnational governments on nationally-established health policies? no [0]; yes, for setting incentives only [1]; yes, for ensuring compliance only [2]; yes, for setting incentives and ensuring compliance [3].	3
b) Do health-sector kentrocrats identify, motivate and enforce subnational governments to comply with nationally-established laws and regulations? no [0]; yes, for identifying and motivating only [1]; identifying and enforcing only [2]; identifying, motivating and enforcing [3].	3
2. Ensuring accountability	
a) Do health-sector kentrocrats have sufficient accountability and public participation mechanisms in place? no [0]; some [1]; yes [2].	2
b) Are health-sector kentrocrats able to ensure that subnational governments comply with the nationally-established mechanisms for accountability? no [0]; yes, in part [1]; yes, fully [2].	2
3. Generating intelligence	
a) Have health-sector kentrocrats been able to provide subnational governments with the data and intelligence necessary to carry out their responsibilities? No [0]; yes, some necessary data and intelligence [1]; yes, all necessary data and intelligence [2].	2
b) Have health-sector kentrocrats been able to do this in a timely manner? no [0]; yes, in part [1]; yes, for all necessary data and intelligence [2].	2
4. Building partnerships	
a) Have health-sector kentrocrats built active and effective partnerships with subnational governments? no [0]; yes, for activity only [1]; yes, for activity and effectiveness [2].	2
b) Have health-sector kentrocrats sustained their activities and effectiveness in these partnerships overtime? no [0]; yes, in part[1]; yes, fully [2].	2
Total	**18**

Explanatory note: The higher the score, the stronger the health-sector kentrocrat.

[38] I assume that all institutional actors will have at least a modicum of power and influence within their respective policymaking environments and, thus, none of them will dictate policy completely or be excluded entirely from the policymaking process.

Table 3.8. Intergovernmental Health Policy Networks for Subnational Governments

	Country Health Sector	
	Subnational Government 1	**Subnational Government 2**
National Health Policy Network		
Expenditure Advocates	Strong	
Expenditure Guardians	Weak	
Topocrats	Strong	
Subnational Health Policy Network		
Subnational Expenditure Advocates	Weak	
Subnational Expenditure Guardians	Strong	
Health-Sector Kentrocrats	Moderate	

3.3. Policy Directions in a Devolved Health System

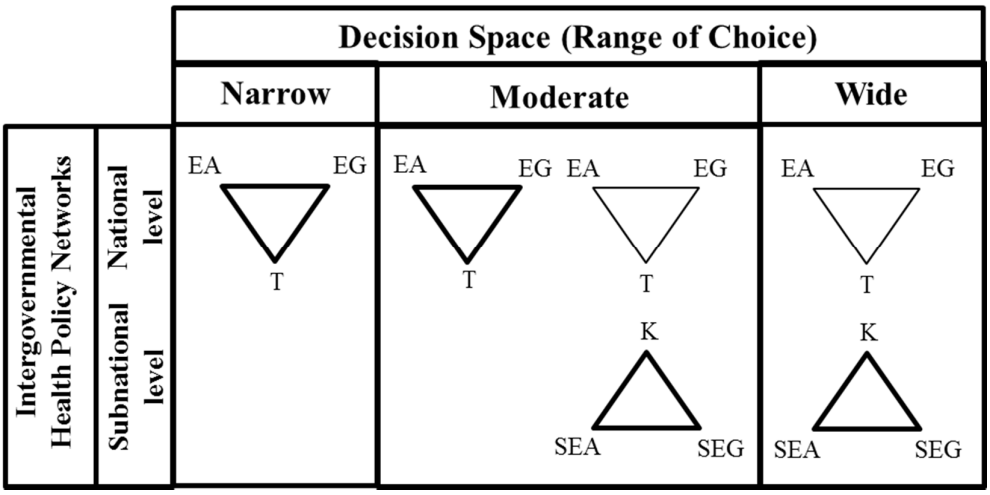
For the third and final part of the analytical framework of the thesis, I bring together the results of the analyses of decision space and intergovernmental policy networks for health system devolution to construct a methodology that can be used to understand and better anticipate health policy priorities.

3.3.1. Combining Decision Space with Intergovernmental Health Policy Networks

Combining the results of these two analyses for any given policy, I first examine the amount of decision space devolved to the health system function most implicated in the policy (e.g. if the policy involves changing the revenue source, then I look at the "sources of revenue" function). Depending on the range of choice for the implicated health system function, one of the two intergovernmental health policy networks will be dominant. If the amount of decision space for a given function is narrow, then the national health policy network is dominant and the top triangle of the scenario would be represented in bold type. If it is wide, then the subnational health policy network is dominant and the bottom triangle of the scenario would be bold. If it is moderate, then the two intergovernmental health policy networks share power and will need to be examined more closely with respect to the affected policy to understand whether one

supersedes the other or if the two should be described as fully interrelated (which I believe is rather rare empirically).[39] See Figure 3.3.

Figure 3.3. Decision Space and Intergovernmental Health Policy Network Possibilities



So, turning back to our example in Table 3.8 with our hypothetical Subnational Government 1 and assuming wide decision space, we would expect that most, if not all, policy decisions for the particular health system function would be mostly taken at the subnational government level. Thus, we would expect the subnational health policy network to be dominant, with policy priorities favouring its subnational expenditure guardians, with moderate influence from health-sector kentrocrats and little to no influence from the subnational expenditure advocates. Thus, the subnational expenditure guardians' goal of subnational economic control would be prioritised over the goals of the other two actor groups in most cases, and any given sectoral policy for the subnational government would tend toward the objectives of national sectoral policy coherence and coordination across subnational governments. In addition, any policymaking power for the health system function that remains at the national government level of our hypothetical example is expected to produce policies that reflect a compromise between the goals of the expenditure advocates and the topocrats,

[39] I believe that it is rare empirically to have a shared competency over policymaking between governments in upper-middle- and high-income countries because they tend to have already undergone a process to clearly define and divide competencies between governments so that they are not overlapping, and the governments tend to have already built sufficient capacity to implement their respective competencies properly.

with little influence in terms of macroeconomic control from the expenditure guardians. This means that policies should tend toward sectoral goals and favour local autonomy.

Furthermore, theoretically, in a politically devolved system, the power dynamics expressed in each of these intergovernmental policy networks may also have some influence on the other; though, it would be most likely for the national level policymaking process to influence the subnational level policymaking process than for the contrary to happen.[40] As such, for example, we could assume that the influence of national policymaking decisions may have a push or pull effect on the expected policy priority at the subnational level; this influence could be toward either the national expenditure advocates or guardians, whichever is stronger. As a result, turning again to our hypothetical Subnational Government 1 and considering the strong influence of expenditure advocates in the national health policy network, we would anticipate that health policy priorities and decisions for the health system functions with wide decision space may carry some additional influence from the national-level expenditure advocates. Consequently, although health policy priorities still rest mostly with the subnational expenditure guardians and their goal of subnational economic control, it may be dampened by a heightened level of priority for increasing expenditure on health policy. Therefore, considering the influence that the power and priorities of national health policymaking process have on the subnational health policy network may affect the originally-established balance between the priority goals of the three main actor groups at the subnational government level.

3.3.2. Examining Policy Priorities in a Devolved Health System

In this subsection, I present the method for examining the degree of correspondence between the results (i.e., health policy priorities) anticipated by the analytical framework of the thesis and the actual results of health policy decisions for a country case study. Following Blom-Hansen (1999), I retrospectively analyse the degree to

[40] Though, as abovementioned, at least some national-level influence is assumed to be built into the subnational adaptation of von Hagen's structural index, especially when the central government dictates budget rules, processes and procedures for all levels of government in the country case study (which, e.g., may happen in a highly politically-decentralized system or in a central government's attempt to contain expenditure levels for the whole system). The balance of power and, ultimately, the priority for future policies in the national policymaking environment can also be influenced by the power dynamics of the subnational health policy network. However, this is not likely to result from the actions of one or even a handful of subnational governments, but only from consensus among many of the country's subnational governments, which is already adequately represented in the framework by the topocrats. For this reason, this thesis does not consider the possibility of influence from a subnational health policy network of an individual subnational government on the balance of power of the national health policy network.

which actual health policy favours those actors who have a privileged position in the policymaking process, their respective intergovernmental policy networks and resulting prioritisation of policy goals by subjecting a selection of health policies[41] to three different measures of the effectiveness of intergovernmental policy. First, I assess the level of *policy efficiency* in the system; i.e., the degree of correspondence between policy objectives and actual outcomes. Often, however, policy efficiency is difficult to assess, as governments do not always explicitly stipulate their policy goals. For this reason, I apply two additional measures. As the second measure of intergovernmental policy, I examine the *policy strategies* employed by the diverse actors to attain their policy objectives. The third measure addresses *policy failures*, or the evidence that the efforts being made are insufficient to reach the policy objectives.

The results of my empirical analysis enable me to assess the degree to which the analytical framework successfully anticipates actual health policy priorities. Based on this assessment, I offer some conclusions regarding whether the policies formulated and implemented under devolution align with the specific objectives of the country's devolution policy and overall health system.[42] I also identify some general lessons and policy implications that emerge from the exercise undertaken in the thesis and present ideas for future research.

In summary, the analytical framework of the thesis allows for an improved understanding of the effects health system devolution has on the policy choices at the national and subnational level by using an established and original constellation of institutional actors to analyse the health policymaking process following devolution. The analytical framework is applied and evaluated with one country- and two subnational-case studies, the parameters of which are outlined below. Overall, the value of my analytical approach is threefold: (1) it analyses the level of decision space afforded by devolution and its corresponding effects on policymaking; (2) through an analysis of the structure and agency of the policymaking process, it estimates policy

[41] Criteria for selecting health policies: The selection should include (i) a balance of policies that fall within health system functions with wide and moderate range of choice; (ii) if possible, one policy from each of the five functional areas of the decision-space map. In addition, the selection will prioritize policies falling under the health system functions for which data is more readily available data for the case study. These criteria are not likely to introduce bias in terms of fitting with the model. The selection should also include the economic relevance of both the policy and key function, which triggers the trade-off among the goals of the three actor groups.

[42] Historically, devolution (along with decentralization in general) has been advocated as a desirable process for improving health systems, under the implicit assumption that the objectives for devolution in any given country are aligned with that country's overall health system objectives.

priorities in a devolved health system; and (3) it identifies the level of correspondence between the positions of the institutional actor groups in the intergovernmental health policy networks and the level of priority and content of future policies regarding the various functions of the health system.

3.4. Research Design and Methods

In this subsection, I describe the research design and methods of the thesis. First, I present the case study method, detailing the importance and selection procedure and parameters for the single-country case and the regional case studies of the thesis. Then, I describe the methods for selecting and collecting primary, secondary, and tertiary data, with particular attention to the research design details for collecting and performing interviews with key informants and stakeholders to obtain primary data. Finally, I present the way that I organised, handled and analysed the data for the thesis using the method of content analysis in both the traditional way and with computer-aided qualitative data analysis software.

3.4.1. The Case Study

The present thesis evaluates the effectiveness of its analytical framework for health system devolution by means of a single-country case study, with two regional case studies.[43] The case study method is the primary method of scholarly inquiry among researchers in the social sciences (Gerring 2004; Merriam 1992; Van Evera 1997; Exworthy, Peckham, and Powell 2012). It offers a means to assess specific contemporary phenomena in depth within a real-life context (Easton 1992; Yin 2009). In essence, "it tries to illuminate a decision or set of decisions: why they were taken, how they were implemented and with what result" (Schramm 1971, 6). It is preferred over other methods (experimentation and *large-n studies*) "when a 'how' and a 'why' question is being asked about a contemporary set of events over which the investigator has little or no control" (Exworthy, Peckham, and Powell 2012, 5). Eckstein (2009, 119) argues, "Case studies … are valuable at all stages of the theory-building process, but most valuable at that stage of theory building where the least value is generally attached to them: the stage at which candidate theories are 'tested'". Furthermore, in

[43] I hope that the analytical framework of this dissertation will be applicable to more than one country, but cross-country comparisons are beyond the scope of the present work. There is much debate on the viability of such an approach in the literature.

the field of health, case studies can be particularly useful in evaluating theories about policymaking and valuable in supporting theoretical generalisations (Ham 1981).

The selection of the case study is of fundamental importance. I selected Spain for my single-country case study because, as a high-income country, it clearly falls into the category of countries addressed by the framework and, most importantly, it has undergone health system devolution reform relatively recently and successfully. In addition, Spain's health system devolution reform (e.g. Urbanos-Garrido and Utrilla de la Hoz (2000), López-Casasnovas (2007), Simon-Cosano, Lago-Peñas and Vaquero (2012) and Costa-Font (2013)) and other aspects of its health system and services (e.g. Levaggi and Smith (2005), Borkan et al (2010), Carnicero and Rojas (2010) and McClellan et al. (2015)) have been used often as models for upper-middle- and high-income countries (e.g. Rodríguez et al. (1999) and Saltman et al. (2007)), especially in the Americas (e.g. see Montero (2001) for Latin American countries, and Walter (2012) for the US), to inform policy-makers and academics about their experiences and lessons learnt, which may be relevant to their own health system, service and policy situations.

The case study of this doctoral dissertation looks particularly at Spain's 2001 devolution of health service competencies from the central government to ten of its seventeen subnational governments. While it takes a countrywide perspective[44], it focuses on the ten subnational governments[45] that participated in this reform and examines two of them in depth: the Autonomous Communities of Extremadura and Madrid. For the thesis, I refer to these subnational governments or Autonomous Communities as 'regions' or by their simple names: Extremadura and Madrid. The uniform background and contextual conditions of a single-country case study create a semi-controlled environment for the regional case studies, thereby limiting the impact of potentially confounding variables by holding them constant. Extremadura and Madrid were selected from the ten regions that underwent the reform because they have the following features in common:

[44] I.e., data and information regarding the Spanish central government and the seven autonomous communities that did not participate in this reform will also be included in the analysis where relevant and available.

[45] See Table 3.9 for a list of all regions in Spain. The ten implicated in the 2001 health devolution reform were Aragon, Asturias, Balearic Islands, Cantabria, Castile Leon, Castile-La Mancha, Extremadura, La Rioja, Madrid, and Murcia.

(i) No potential path-dependence drivers: both are among the ten autonomous communities on the "slow track" to receive devolution powers, having experienced health system devolution in 2001 (enacted with Act 21 of 2001 on regulation of the fiscal and administrative measures of the new financing system of the regions and Royal Decrees 1471-1480 of 2001 on transferral of health care management competencies, and implemented from January 2002).

(ii) No drivers based on nationalism or regional identity: neither region had active nationalist or regionalist parties or separatist groups during the period of study, 1996–2006.

(iii) No potential drivers associated with changes in the political ruling party: one major political party consistently ruled each of these regions during the period of study. The *Partido Socialista Obrero Español* (Spanish Socialist Workers' Party, PSOE) governed Extremadura and the *Partido Popular* (People's Party, PP) governed Madrid continuously during this period.

At the same time, these regions have some differences between them that make them particularly useful and 'rich' case-selections, per purposeful sampling (Cresswell 1994; Patton 2002). Most notably, they represent opposite sides of the socio-economic spectrum in Spain (see Table 3.9). Madrid contains the country's capital and is one of the more industrial, urban and economically affluent regions of Spain. Extremadura is a more rural, agricultural region with a relatively low socio-economic status. In particular, in 2000, Madrid had a GDP per capita of 21,281 € and Extremadura had 9,965 €. In the same year, the average life expectancy at birth in Madrid (80.47 years) was higher than Extremadura's (78.90 years). Finally, in terms of educational level, a smaller proportion of Madrid's population (9.36 per cent) was illiterate than Extremadura's population (26.32 per cent), and a greater proportion had higher education (25.84 per cent in Madrid compared to 12.19 per cent in Extremadura).

3.4.2. Data Collection

I collected original primary data through in-depth interviews with institutional actors involved in the intergovernmental health policymaking process, in addition to secondary data from newspapers, peer-reviewed articles and public documents, including parliamentary debates, regulations and legislation related to my investigation, and tertiary data, e.g. from the INEbase (a database for Spanish statistics), von Hagen's (1992) Structural Index, and Blom-Hansen (1999).

3.4.2.1. Primary Data – In-depth Interviews: The use of in-depth interviews of institutional actors constitutes a major contribution of the dissertation, complementing both the literature review and the secondary data retrieved from other sources. In general, in-depth interviews provide first-hand information on events that took place during the period under examination. They also facilitate the compilation of large amounts of data rather quickly, with the potential for subsequent follow-up and clarification. Moreover, interviews are used frequently to examine the validity of assumptions made in theory development and in the specific context of a case study. Moreover, interviewing key stakeholders (or elite actors), in particular, can uncover unique and valuable information because of the privileged status of the interviewees, who usually hold high positions in society and/or the political system as well as an exclusive ability to report on past, present and future policies and agendas of their organisations.

For the design of the semi-structured interview guide, I based my questions on a stakeholder analysis (Schmeer 1999; Brugha and Varvasovszky 2000; Varvasovszky and Brugha 2000), which identified the needs and concerns of the various stakeholders in the health sector. Questions concerning Spain's 2001 health devolution reform and the roles of each primary actor group were developed to determine the interviewees' power, position, preferences, goals and interests, along with the alliances they made, the resources they had available and how they were used, and the stakeholders' willingness to lead action for or against certain policies. In addition, the interview guide included questions to validate the primary behavioural assumptions supporting the analytical framework of the thesis. I adapted the general interview guide to each actor group, considering each key stakeholder's experience (e.g. central or regional government) and expertise (e.g. health or economics) when and where possible. See Appendix C for an example interview guide that was used with regional key stakeholders.

I conducted 48 in-depth interviews for the Spanish case study. Twenty of these were with key informants and twenty-eight of these interviews were with key stakeholders of the Spanish NHS. Key informants included university professors and lecturers of health policy, public health and health economics, as well as a few representatives of non-governmental organisations and interest groups (e.g. one actor recounted his experience with Spain's physicians association and another worked for a private health policy foundation. Key stakeholders interviewed included a variety of

Table 3.9. Characteristics of Spain's Autonomous Communities

Autonomous Community	*Year of Health System Devolution*	*Nationalism/**Regionalism** Drivers*[a]	*Identity Driver*[b]	*Political Party 1995-2001*	*Political Party 2002-2006*	*Income (GDP per Capita)*[c]	*Health (Life Expect. at Birth)*[d]	*Illiteracy (% of Pop. ≥ age 16)*[e]	*Higher Ed. (% of Pop. ≥ age 16)*[f]
Andalusia	1984	NO	Nationality	PSOE	PSOE	11,538 €	78.20	24.45	14.91
Aragon	2001	YES, **Partido Aragonés (Centrism, Aragonese Regionalism, nationalism); Chunta Aragonesista (Democratic Socialism, Aragonese nationalism)**	Nationality	PP	PSOE	16,365 €	80.04	10.15	18.46
Asturias	2001	YES, Asturian Forum (Asturian regionalism)	Region[g]	PP-URAS	PSOE	13,081 €	78.79	14.76	16.42
Balearic Islands	2001	YES, **Més per Mallorca (Catalan nationalism); Eivissa pel Canvi (Catalan nationalism)**	Nationality	PP/ 1999 PSIB-PSOE	PSIB-PSOE/ 2003 PP	19,282 €	78.55	14.43	13.94
Basque Country	1988	YES, Partido Nacionalista Vasco (Basque nationalism); Geroa Bai (Basque nationalism); **EH Bildu (Socialism, Basque and left-wing nationalism)**	Nationality	PNV	PNV	19,182 €	79.64	7.86	26.18
Canary Islands	1994	YES, Coalición Canarian (Canarian nationalism)	Nationality	CC	CC	14,845 €	77.82	19.80	14.97
Cantabria	2001	YES, **Partido Regionalista de Cantabria (Regionalism)**	Region[g]	PP	PP/ 2003 PRC	14,634 €	79.32	7.37	18.08
Castile-Leon	2001	YES, **Unión del Pueblo Leonés (Regionalism)**	Region[h]	PP	PP	14,164 €	80.65	8.74	17.32
Castile-La Mancha	2001	NO	Region[i]	PSOE	PSOE	12,307 €	80.25	26.80	11.83

Autonomous Community	*Year of Health System Devolution*	*Nationalism/**Regionalism** Drivers*[a]	*Identity Driver*[b]	*Political Party 1995-2001*	*Political Party 2002-2006*	*Income (GDP per Capita)*[c]	*Health (Life Expect. at Birth)*[d]	*Illiteracy (% of Pop. ≥ age 16)*[e]	*Higher Ed. (% of Pop. ≥ age 16)*[f]
Catalonia	1981	YES, Convergéncia i Unió (Catalan nationalism); Esquerra Republicana de Cantalunya (Catalan separatism); Iniciativa per Catalunya Verds (Green Politics, Catalan nationalism); **Ciutadans (Social liberalism, European federalism, post-nationalism); Candidatura D'Unitat Popular (Catalan Independence)**	Nationality	CiU	PSC	19,072 €	79.67	14.33	18.90
Extremadura	2001	NO[j]	Region	PSOE	PSOE	9,965 €	78.90	26.32	12.19
Galicia	1991	YES, Bloque Nacionalista Galego (Galician nationalism)	Nationality	PPdeG	PPdeG/ 2005 PSdeG-PSOE	12,163 €	79.31	20.54	14.17
La Rioja	2001	YES, **Partido Riojano (Regionalist)**	Region	PP	PP	17,826 €	80.48	6.44	17.47
Madrid	2001	NO	Community[i]	PP	PP	21,281 €	80.47	9.36	25.84
Murcia	2001	NO	Region	PP	PP	13,132 €	78.38	22.77	16.26
Navarre	1991	YES, Unión del Pueblo Navarra (Conservatism, Navarese Regionalism); **Nafarroa Bai (Basque nationalism); Bildu (Socialism, Basque and left-wing nationalism)**	Chartered (Foral) Community[k]	UPN	UPN	19,927 €	80.50	8.28	24.34
Valencia	1988	YES, Coalició Compromís (Valencian nationalism)	Nationality	PP-UV	PP	15,102 €	78.74	17.19	16.24

[a] Nationalism/Regionalism Driver measure: political parties in Congress and additional political parties in regional parliaments (most information taken from 2011).
[b] Identity Driver: how each region defines itself in its Statutes of Autonomy. [c] Income: GDP per capita in euros, 2000. [d] Health: Life expectancy at birth, 2000.
[e] Education: proportion of the population 16 years or older that was illiterate in 2000. [f] Education: proportion of the population 16 years or older with higher education as of 2000. [g] Asturias and Cantabria are also identified as "historic communities" in their Statutes of Autonomy. [h] Castile-Leon is also identified as a "historic and cultural community" in its Statute of Autonomy. [i] Madrid was separated from Castile-La Mancha and made an autonomous community because it is Spain's capital and the seat of its national government institutions. [j] Extremadura Unida has represented Extremadura in a united Spain, but did not get a seat in Parliament until it formed a coalition with the Popular Party of Extremadura in 2007. [k] Navarra secured self-government through reintegration and improvement of its medieval charters. *Source:* INEbase *(Instituto Nacional de Estadística 2015)* online for income, health and education indicators. *Abbreviations:* CC = Coalición Canarian, CiU = Convergéncia i Unió, PNV = Partido Nacionalista Vasco, PP = Partido Popular, PPdeG = Partido Popular de Galicia, PRC = Partido Regionalista de Cantabria, PSC = Partit dels Socialistes de Catalunya, PSIB = Partit Socialista Illes Balears, PSOE = Partido Socialista Obrero Español, PSdeG = Partido Socialist de Galicia, URAS = Unión Renovadora Asturiana, and UV = Unión Valenciana.

Spanish national and regional politicians and bureaucrats, who held positions in the political system and NHS, and participated in the health policymaking process before and/or after the 2001 health devolution reform. See Appendix D for a list of key stakeholders interviewed. Most of them belonged to one of the main actor groups in the national and subnational policy networks, and more of a political, rather than a high-level technical, role. A few particularly informative and accessible participants granted follow-up interviews so that I could ask additional questions that emerged during the data collection and analysis processes.

Careful selection of the interviewees based on their professional background and experiences was essential to obtain a fair and accurate portrayal of the Spanish situation. In particular, key stakeholders from the Ministry of Health and Consumer Affairs and parliamentary groups concentrating on the health sector represented the expenditure advocates, and health-sector kentrocrats. Key stakeholders from the regions, especially persons who have held top positions in the regional parliament and/or the regional ministries of health, economy and finance as well as the regional presidents and regional ministers (*consejeros/as*) of health, represented the topocrats and subnational expenditure guardians and advocates.[46] Most of the key stakeholders interviewed for this group hailed from Extremadura and Madrid, though I also interviewed key regional stakeholders from Asturias, Baleares, the Basque Country, Castile-La Mancha, Catalonia, and Galicia.

I selected key stakeholders with the objective of being politically balanced. To this end, my pool of key stakeholders interviewed included similar numbers of participants from both the Socialist Party (*Partida Social de Obreros Españoles*) and the People's Party (*Partida Popular*) at each level of government. Eleven of the interviewees identified themselves as having views aligned with the Socialist Party, eleven with the People's Party, and one with the Catalan nationalist party, Convergence and Union (*Convergència I Unió*).[47]

Initial interviews were obtained using the procedures of key informant and snowball sampling techniques, following the recommendations of Patton (2002). I

[46] It is important to note that often there was overlap between the institutional actors in the two intergovernmental policy networks—e.g. an actor may have worked for more than one of the groups but at different times in the study or an actor's experience qualified him to answer questions as a (national) expenditure advocate as well as a health-sector kentrocrat. For this reason, I carefully designed and adapted each interview guide for each key stakeholder.

[47] The others did not explicitly define their political views or identify themselves as aligned with any one party.

actively pursued contact with key informants before beginning my fieldwork, mainly relying on sponsorship, recommendations and introductions for appointments gained through my association with LSE and its professors. Some key informants were also identified through the literature. I then sought to identify further interviewees through geographic and snowball sampling with help from the recommendations and contacts of the key informant pool. As this approach to recruiting interviewees could not by itself ensure a balanced representation, I consulted with academics to crosscheck the backgrounds of the interviewees and thereby avoid introducing any unintended bias. This led to the identification of a small but impressive network of experts on the topic. To complement this approach, I expanded my search by scanning State Manuals (*Manuales de Estado*) from the years 1994 to 1999 for more potential interviewees and their positions. In addition, I included some major actors who were still working in the field through 2007. I personally requested interviews via email and followed them up when necessary, scheduled them and sent out thank you letters.

I performed these interviews in three waves. The first wave took place during the period December 2005–March 2006. It consisted of preliminary interviews with mostly key informants but also some accessible key stakeholders. I explored their advice on my thesis's overall argument and its suitability for the Spanish case, the structure and questions of my interview guide, and my list of potential key stakeholders to interview.[48] I introduced my consolidated, semi-structured interview guide during the second wave of interviews, which took place during the period March–July 2007. The second wave entailed the first complete round of key stakeholder interviews. The third wave of interviews took place mostly during the month of October 2007, with an outlying interview in March 2008. It consisted of the second round of key stakeholder interviews, in which I employed the interview guide and dove deeper into details that were not clarified in the first round and after an initial interim analysis of the previously collected data.

[48] The first few key stakeholders were asked to sign a consent form signifying that they were consenting to participate in the interview, that I had informed them of their right to interrupt the interview at any time, and that I would preserve their anonymity (see Appendix E for the information sheet and consent form used). I later stopped using the consent form because it became an obstacle to conducting these interviews. Researchers with experience in qualitative interviewing in Spain advised me not to use it, as it is a culturally awkward concept for Spaniards in general and because elites in Spain are accustomed to giving consent for the release—not preservation—of their anonymity. Instead of using the consent form, I verbally advised each key stakeholder of his or her interviewing rights.

All interviews were performed one-on-one in a native language of the interviewees: Spanish. They were largely conducted in Extremadura and Madrid, with some taking place in Barcelona, La Coruña, Toledo, Seville, and Santiago de Compostela in Spain as well as Paris (at the Spanish Embassy) and Brussels (at the European Parliament). The average interview lasted 66 minutes, with a range from 17 to 100 minutes. I took handwritten notes during each interview and digitally recorded all but one of them (because one key stakeholder declined recording). The interview data were made anonymous by means of an alphanumeric coding system based on the actors' main organisation of expertise, political orientation and administrative position. I am the only person in possession of the list that matches the codes to the specific interviewees and their comments. I had all of the digital recordings of the interviews transcribed by a native Spanish-speaking professional.

Despite the many benefits of in-depth interviews, this method contains a few potential limitations, especially when interviewees are highly political, 'elite' actors. Data collection depends on participants' honesty, cooperation, and accessibility (Marshall and Rossman 1995). Moreover, an elite interviewee often has well-honed public speaking and interviewing skills, which may make the interviewer's attempts to obtain necessary information quite difficult. Additionally, an elite interviewee's own value judgements may present another limitation. After all, the raison d'être of coalitions or groups of political actors is to disseminate their ideas and values, and so they specialise in trying to bring others to share their viewpoints. Such endeavours by the interviewee can distract from or even overwhelm the intended focus of the interview. As human beings, interviewees tend to rewrite history, as "realities exist as mental constructs and are relative to those who hold them" (Becker 1963). For these reasons, juxtaposing interview data with more objective sources of information becomes an important safeguard. Furthermore, interviewing elite actors is also a particularly costly research method, both in time and money. Contacting them can be difficult; the researcher may have to go through a number of gatekeepers in order to make initial contact. In addition, the researcher must compete for a spot on the elite actor's busy professional schedule. When an interview is granted, it may often be cancelled or postponed at the last minute, especially during campaign season for government elections.

I experienced some of these limitations in my research for this study. For example, one of my key stakeholders declined to be digitally recorded during the

interview and was extremely (politically) guarded throughout it (e.g. refusing to answer certain questions without providing any good reason). The pool of female "key stakeholder" candidates qualified for the case study was extremely small and their response rate to my interview request was very low. Moreover, while I considered the timing of national elections when planning the different waves of interviews, I overlooked the timing of 2007 regional (parliamentary) elections, which were held on the 27th of May in thirteen of the seventeen autonomous communities: Aragon, Asturias, the Balearic Islands, the Canary Islands, Cantabria, Castile-La Mancha, Castile-Leon, **Extremadura, Madrid**, Murcia, Navarre, La Rioja and the Valencian Community. As a result, I had to postpone a number of interviews with key stakeholders from Madrid and Extremadura that were originally slotted for the second wave of interviews to the third wave of interviews. To minimise further potential obstacles to collecting primary data through 'elite' actor interviews, I was methodological with arranging my interviews and persistent in my contact methods. Moreover, in my correspondence, I emphasised the importance of my interviewing each potential key stakeholder. My affiliation with the London School of Economics and Political Science also seemed to be appreciated and (to my surprise) the fact that I was an American counted in my favour. To reduce travel costs, I resided in Madrid during my fieldwork, giving me convenient access to most key informants and stakeholders for my study. My interviews in Extremadura and other regions were more difficult to plan, less secure and more costly; though, they were rarely cancelled at the last minute.

3.4.2.2. Secondary and Tertiary Data: I conducted a review of the literature on public policy and decentralization, including literature specific to health policy. This review helped me the three parts of the analytical framework for this thesis in an informed and educated manner. The literature review and case study research was ongoing both prior to and during my fieldwork experience. This proved particularly useful because it allowed me greater access to information on new laws and regulations and information not widely disseminated outside Spain (due to the means of distribution or the language barrier). As a result, the focus of my thesis changed considerably over the years of study. In addition, being immersed in Spain and its culture permitted me to track daily developments in its political system and general news about the country more fully.

Key literature and secondary data resources for this study were collected from the following institutions and their libraries:

European Observatory of Health Systems and Policies, Spain
Harvard School of Public Health, United States
Harvard University, United States
Institute Juan March Centre for Advanced Studies in Social Science, Spain
Institute of Health Carlos III, Spain
Inter-American Development Bank, United States
London School of Economics, United Kingdom
London School of Hygiene and Tropical Medicine, United Kingdom
Ministry of Health, Italy
Ministry of Health, Spain
National Council for Research, Italy
National Institute of Health, Italy
Pan-American Health Organisation, United States
University of Barcelona, Spain
University Carlos III of Madrid, Spain
World Bank, United States

I performed a literature search using keywords and phrases in the LSE library and several online search catalogues, databases and journals, as well as BIDS IBSS, Dialnet, (dialnet.unirioja.es), Google Scholar, INGENTA, ISI Web of Knowledge, PubMed, and WorldCAT. I also consulted with experts and searched websites to collect additional bibliographic materials. The general search terms or keywords and phrases that I systematically employed included the following: decentralization, political decentralization, health system decentralization, health care decentralization, health sector decentralization, devolution, political devolution, health system devolution, health care devolution, health sector decentralisation, centralisation, intergovernmental relations, central-local relations, public policy, social policy, health policy, public administration, and the policymaking process. These data were collected in English, Spanish and, in a few cases, Italian.[49]

3.4.3. Data Handling and Analysis

3.4.3.1. Content Analysis: I used the scientific method of content analysis to analyse systematically the text from the primary, secondary and tertiary data that I collected. This method is commonly used in the social sciences, including political

[49] As such, language variants of the search terms in US and UK English, Spanish and Italian were also used, e.g. decentralization (US English) = decentralisation (UK English) = decentralización (Spanish) or las transferencias sanitarias = decentramento or decentralizzazione (Italian). Despite my decision to use UK English as the main language of the thesis, I chose to use the US English spelling of decentralization because, in my experience, it is most widely used in the literature and I believe that doing so will make my work more easily accessible in literature searches.

science and public policy (Abrahamson 1983). It is a reliable, discreet and context-sensitive technique that allows researchers to process and analyse relatively unstructured data in order to recognise meanings, patterns, systems, indices, institutions and expressive contents and make valid inferences from it to the contexts of their use (Krippendorff 2012). It is also constructive for answering policy questions regarding organisational phenomena, like decentralization. More generally, it is an effective method for objectively processing information that must be condensed and made systematically comparable (Berg 2007, chap. 11). Content analysis is better equipped to find inconsistencies and conflicts that are built into policies and policymaking processes than most quantitative methods (Patton 2002). It is also useful in finding more practical solutions to problems (Cantarero Prieto and Pascual Saez 2007). It can further cope with processing large volumes of data, especially but not necessarily when assisted by a computer (see Krippendorff (2012)).

I used the computer-assisted qualitative data analysis software, Nvivo 9, to help me analyse the transcriptions and digital recordings, simultaneously, as well as some secondary and tertiary data. I took a 10-week online qualitative analysis course to guide me in the use of Nvivo 9 with my research. Because I could work with my own data during this course, I was able to prepare and check my research design ideas and their application within the software with an expert in qualitative research and other students in the course. I followed di Gregorio and Davidson (2008) for designing and conducting my qualitative research in Nvivo 9 software environment and for implementing the research design. Data not analysed with Nvivo 9 were processed and analysed in the traditional way without computer assistance.

I examined the data keeping the research questions, analytical framework, and context of my research in mind. For the interview data, I was interested in examining the actors' accounts of the health devolution process and its effects on policymaking, especially at the subnational level. My units of analysis were the institutional actor groups that I identified in Section 3.2. The timeframe was longitudinal, spanning a decade (1996–2006) and retrospective. I inductively identified codes in the data and affixed them to sets of notes, documents, and interview transcripts, in the traditional way and with Nvivo 9. Next, I turned the codes into categorical labels and themes and sorted the materials by them in order to identify patterns, relationships, commonalities and/or differences among them. The result of the content analysis was that I could draw inferences from it and validate them. In particular, I juxtaposed and triangulated

inferences that stemmed from the primary interview data with the secondary data. Finally, I used these inferences to tell produce a narrative in the three empirical chapters of the thesis.

I followed di Gregorio and Davidson's (2008) guide for representing my research in Nvivo 9. Before actually getting to handle and analyse my data with the software, I prepared a design framework and outlined my research according to their core research design questions on the research topic/problem, research questions and data collection. For the handling and analysis of my data within the software, I first organised the different kinds of data into *document folders* and created a back-up folder for these on my hard drive. I then imported my interview transcripts and audio files as well as other secondary data into these folders. Next, I prepared the text files in word, structuring them when possible with automatic codes (e.g. headings). Since my interviews were only semi-structured, automatic coding of headings was not very useful. With my primary interview data, I linked the corresponding audio and transcript files, setting them up for simultaneous coding, and created *case nodes* for each interview. Then, I created *node classification sheets* for interviewee and place attributes and *node classification profiles* for the stakeholder interviews (people), key informants (people), and governments (places), mapping them to each interview case node. See Appendix F for an excerpt from the codebook. Because my research is longitudinal with two main timeframes, before and after the 2001, I created *document folders* for each period and mapped my primary interview data and other data to them. I created *thematic nodes* for broad topic areas that I expected to code. Finally, I began coding the data using Saldaña's (2012) coding manual as a guide. Throughout my analysis, I periodically reviewed my codes, nodes and their content, which led to changes, adaptations and an overall evolution of how they were represented and mapped to each other. While I coded and analysed the data, I took some traditional and electronic memos on key issues to record my research process (though, I was not rigorous in doing this, which may have hampered my process). As I analysed the data, I tried to connect ideas and capture questions that emerged from it and, working with Nvivo 9, I used its various tools for visualizing and modelling data as well as the *queries* to interrogate and filter the data and extract different sets of codes from it. Finally, I cross-referenced the inferences that emerged from the data analysis as well as my interpretation of the data for validity purposes. I present the results of the data

analysis in the three empirical chapters of the thesis, along with discussions and conclusions.

Looking back on my experience utilizing Nvivo, as I dove deeper into the analysis, the code-structure also evolved and, in the end, I found that some codes went unused while others were more heavily used than I had originally expected. I also found that, once I consolidated my research design within Nvivo, that data analysis was more efficient and productive—than the traditional coding and analysis methods I used. This made the time-intensive preparation and design phase worth it.

4. Defining the Decision Space for Health System Devolution in Spain

In the previous chapter, I introduced the comparative framework for analysing health system devolution. In this chapter and the following, I apply the three different parts of this framework to the case of Spain, comparing the regions of Extremadura and Madrid. Overall, the framework should point to the effects of health system devolution on the policymaking process and subsequent policy choices in Spain.

This chapter applies the first part of the framework: the definition and measurement of health system devolution in Spain, using the modified decision-space approach as designed and described in the analytical chapter. It examines the specific health system devolution reform enacted in 2001 (and implemented from 2002), which affected ten of the seventeen Autonomous Communities in Spain.[50] Of these ten regions, this study focuses on the Autonomous Communities (or "regions") of Extremadura and Madrid.

I first outline Spain's overarching health devolution reform, which stems from its 1978 Constitution, by presenting relevant background information to the 2001 reform and explaining legislation on the broader structure of the Spanish government, territorial organisation and health system. Then, I perform a decision-space analysis on the 2001 reform for the period 1996-2001, examining the five functional areas of the Spanish health system with a focus on the ten regions implicated in the reform and, in particular, Extremadura and Madrid (including relevant information regarding the other seven regions in Spain when it is contextually necessary). As a result of the analysis, I provide a health decision-space map for Extremadura and Madrid for this period. Next, I present the legislation on the 2001 health system devolution along with supporting regulations and financial agreements. Following this, I analyse the decision-space allowed by the 2001 reform to the same five functional areas of the health system, looking particularly at the period 2002-2006 and focusing on the ten Spanish regions, and in particular Extremadura and Madrid. As a result, I present a health decision-space map for Extremadura and Madrid for this period. Finally, in the discussion, I present a comparison of the two decision-space analyses, discussing their results and how they lead to a greater understanding of the 2001 reform and, finally, what they mean for the analytical framework of the thesis and the thesis as a whole.

[50] These ten regions accepted responsibility over health service policy and management for completing the overarching health system devolution reform that began with the 1978 Spanish Constitution more than for any desire to accentuate their cultural identity or economic independence.

In terms of expectations, I anticipate to find that the health system decision-space maps of Extremadura and Madrid will be the same for each period, mostly because I perform a *de jure* analysis of the regulations and legislation, which should be similar, if not the same, for all ten regions implicated in the 2001 devolution reform.[51] Moreover, I expect them to show that the regions had relatively narrow decision space for most functions of the health system for the period 1996-2001, with a widening decision space for most functions of the health system after devolution (2002-2006). It is difficult to state further expectations and *a priori* statements regarding the most desirable degree of decision space that should be devolved to subnational governments because research has yet to determine this and it is likely to be different for different countries. In is known, however, that a balance must be struck between the degrees of authority over the various health system functions afforded to the subnational government and the subnational government's level of resource capacity and available mechanisms for accountability.[52]

4.1. Background to the Health System Devolution in Spain

Spain is regarded by health decentralization scholars as a highly significant case because of its extensive devolution of health service responsibilities to relatively young subnational governments. The 2001 health devolution reform was the "second wave" and culmination of the devolution of health service competencies from the central government to subnational governments and part of a much larger state reform, devolving several different competencies to the subnational level of government, which began with the creation of the 1978 Spanish Constitution (Costa-Font and Greer, 2013).

The Constitution was modelled after that of post-World War II Germany in form, function, and governmental powers. It can be seen as an effort to democratise a previously totalitarian (centralised) state (Heywood, 1999).[53] Among other changes, this effort towards democracy established a new territorial organisation of the state into municipalities, provinces, and autonomous communities (or "regions"), all with the ability to administer autonomously the responsibilities ascribed to them in Article 137

[51] If they were analysed with *de facto* information, I would have expected these regions to have exercised their decision-making powers differently, due to variations in their political party systems and their socio-economic status.
[52] These other factors (improvement in population health, level of resource capacity and mechanisms of accountability) are not evaluated here, as they are beyond the scope of the thesis.
[53] From 1939 to 1978, Spain was a totalitarian regime for almost 40 years under General Francisco Franco. In 1978, it became a constitutional monarchy with a parliamentary democracy.

of the Constitution (Ministerio de la Presidencia 1978). While the provincial and municipal governments[54] were given authority over minor, mostly administrative matters, the seventeen newly created regions[55] were given extensive decision-making powers over several public functions in collaboration with the central government (Newton and Donaghy 1997).[56]

Part 1 of Article 147 of the Constitution established the fundamental terms under which each region should establish its legal framework, called the Statute of Autonomy (*El Estatuto de Autonomía*). This and other statutes hold the same legal status as the Constitution (that is, they are organic law) and form a part of the Constitutional Body (*Cuerpo Constitutional*).[57] Accordingly, these statutes have become the primary tool by which the regions can expand and modify their powers and authority over public functions, with the central government's definitive approval. Part 2d of the same article of the Constitution stipulates that the Statutes of Autonomy should be modified to identify explicitly each public function before it is transferred to the regions and state the basis for its transfer, including specification of the level of government from which it comes—municipal, provincial or central.[58] Article 148 presents all the public functions that the Constitution allows the regions to assume authority over, including the, then, Social Assistance programme (*Asistencia Social*) through social security (Part 20).[59] At the time of the Constitution's adoption, the Social Assistance programme performed the state's health service functions.[60]

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[54] As well as the cities of Ceuta and Melilla. Local governments in big cities are important in Spain, particularly in urban planning.

[55] A few of these were historical region-states.

[56] It should be noted, however, that municipal governments in large cities hold more power than the average municipal government and may be main stakeholders in policymaking.

[57] The hierarchy of Spanish laws contains (i) the constitution; (ii) international treaties; (iii) organic law (which requires an absolute majority of the General Court), ordinary law and regulatory laws; and (iv) executive laws, referred to as royal decrees, decrees, ministerial orders, etc. depending on the body enacting them.

[58] The 1986 General Health Care Law stipulated that most local municipal health care service areas (e.g. mental health) should be transferred (up) to the regions, even if they continued to own and finance their health care networks.

[59] The Social Assistance programme did not include public health and hygiene functions (e.g. activities for preventing disease, prolonging life, and promoting physical and mental health, sanitation, personal hygiene and infection control). The Regions were also allowed to assume public health and hygiene functions (Part 21), although these were devolved separately from the social assistance functions.

[60] The social assistance programme did not include public health and hygiene functions such as activities for preventing disease, prolonging life, and promoting physical and mental health, sanitation, personal hygiene and infection control. The 1986 General Health Law created a National Health System (NHS), bringing together the state-run health services and those of the autonomous communities with health care competencies, which were also to integrate the Social Security Health Centres into their regional health service. The National Institute of Health (INSALUD) managed the health services of the autonomous communities without health care competencies. After this law, the Royal Decrees regarding the transfer

The regions, however, were not slated to receive all public functions, including authority over health service functions, at the same time. After a heated debate on the issue of autonomy within the negotiations that preceded adoption of the 1978 Constitution, a compromise was reached between the desire for national unity from the centralist party, lobbying for minimal decentralization from the right-wing party and for federalism from the left-wing party, and a push for greater recognition through asymmetric (territorial) decentralization from the nationalist parties and territories (Newton and Donaghy 1997). Moreover, this compromise integrated concern for achieving an *effective* devolution of powers to the regional level, and not just the appearance of devolution in the form of administrative decentralization. Accordingly, the Constitution—while prohibiting the regions from ever forming a federation[61]—mandated a political decentralization of public functions to the regions. In doing so, it established an open process and laid out three tracks—"slow", "intermediate" and "fast" for regional accession of greater autonomy and power over the management and provision of the public function stipulated in Article 148. In doing so, it triggered a *de facto* period of asymmetric devolution, which eventually transformed Spain into the highly devolved, unitary state it is today.

The mechanics of this transformation are easy to reconstruct. Article 143 of the Constitution established the "normal" track, which later became known as the "slow track" to full regional autonomy. This route consisted of a five-year provisional period with limited powers, after which the regions could negotiate with the central government for additional authority until they assumed all the powers afforded by the Constitution. Additionally, the Second Transitional Provision of the Constitution established the "special track", later dubbed the "fast track," in which regions with a historic nationality—specifically, those that had previously initiated a constitutional process during the Second Spanish Republic[62]—did not have to adhere to the five-year

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of functions and services to the autonomous communities without competencies stated that they would be transferred from INSALUD (not from the social assistance programme of Social Security).

[61] "En ningún caso se admitirá la federación de Comunidades Autónomas" (Ministerio de la Presidencia 1978, pt. 1, Art. 145). However, all regions were permitted to work together with the approval of the General Courts (*Cortes Generales*) (Part 2 of Article 145) and the Basque Country and Navarra generally enjoyed fewer restrictions on their autonomy and self-governance than the other regions.

[62] The Second Spanish Republic (1931-1939) was a republican regime that stripped the Spanish Monarchy of its legal status and installed a republic government with the Spanish Constitution of 1931, which among other things granted the Spanish regions the right to autonomy. Catalonia gained autonomy in 1932 and the Basque Country and Galicia reached it in 1936, just before the Spanish Civil War started, eventually leading to the fall of the Republic in 1939 and General Franco's Totalitarian regime.

provisional period prior to attaining full autonomy. This was the case for the regions of the Basque Country, Catalonia, and Galicia in 1979, 1979 and 1981, respectively. Next, Article 151 of the Constitution established exceptional conditions for non-historic nationality regions also to pursue a "fast track" to full autonomy[63]. These conditions, however, were difficult to achieve; perhaps the most forbidding of them were the stipulations that the region would have to hold a referendum and win an absolute majority in every one of its provinces. Indeed, only one region, Andalusia, succeeded in complying with these conditions and moving onto the "fast track" toward full autonomy. Moreover, Article 144 gave Navarra special considerations and allowed it to skip the five-year provisional period because it was a Statutory Body (*Órgano Foral*) and consisted of only one province (Article 144). Although the Canary Islands and Valencia followed the "slow track" to full autonomy (Article 148), they each managed to pass their Statutes of Autonomy (Jefatura del Estado 1982a; 1982b) and corresponding transfer-of-power laws for assuming the competencies in 1982, effectively putting them on an "intermediate track" between the two tracks established in the 1978 Constitution (Jefatura del Estado 1982c; 1982d). The remaining regions proceeded on the "slow track" to full autonomy, completing it only decades later (in 2002).

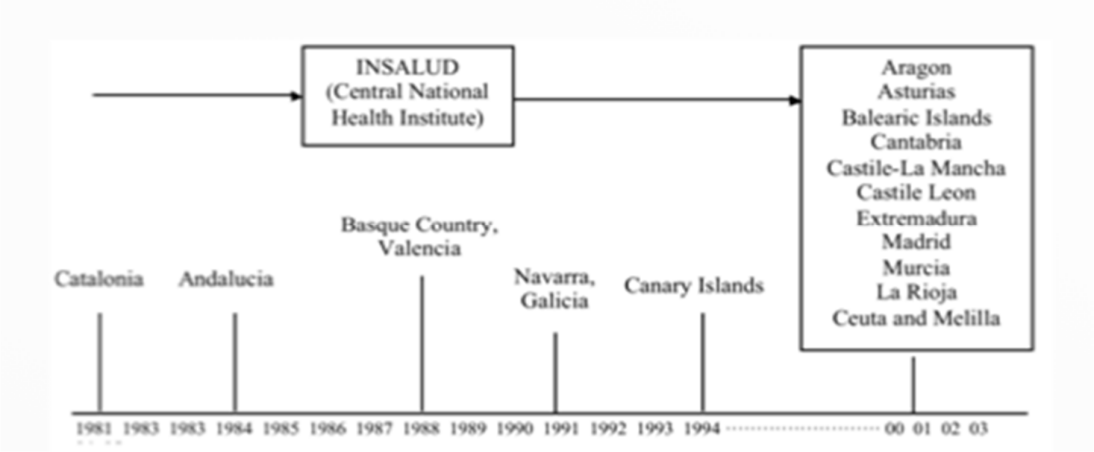
Following these processes, the public function of the health system and services (e.g. the Social Assistance programme) were devolved *de facto* in two waves.[64] The first wave of health system devolution began in 1981 with Catalonia. This first transfer, along with the six separate ones that followed it, illustrates the varying speed with which the first seven regions assumed authority over health services in their territories (see Figure 4.1). All seven "fast-track" and "intermediate-track" regions assumed health system responsibilities, ending with the Canary Islands possession of them in 1994. Then, there was a pause of seven years before the "second wave" of health system devolution at the end of 2001, when the Spanish government decided to devolve health service competencies to the remaining ten regions at once. Several objectives were stated for this move, most pointed to it being "a political decision, not a technical one" (Novinskey, Interview no. 16, 36 and 41). Some specified the benefits of bringing decision-making closer to the people (Novinskey, Interview no. 08, 09, 18,

[63] Sometimes referred to also as the "exceptional track".
[64] This is not to be confused with the public function of public health and hygiene, which was transferred to all regions in 1979.

23, 32, 33, 34, 37, and 39). Alternatively, one MOH stakeholder noted, "José María Aznar wanted to complete the model [of the Autonomous State] to end that debate: the permanent wound that inequality produced in the transfers, 'what I do not have and the other does'; the situation that created a social wound, a certain social unrest" (Novinskey, Interview no. 16). Another said, "The MOF was in favour of the transfers because they realized that health expenditures were growing at a faster rate than the GDP and, therefore, they could remove this burden…passing it to the Autonomous Communities" (Novinskey, Interview no. 15).

In the following section, I begin my analysis of the Spanish case before the "second wave" of health system devolution, with a focus on the ten "slow-track" regions and, particularly, Extremadura and Madrid. I employ Bossert's (1998) approach to define and measure the decision-space allocated to the subnational government level before the reform, for a baseline. In accordance with this approach, I break up the analysis into five subsections, one for each functional area of the health system, and finally I present the findings in these sections in the form of a decision-space map.

Figure 4.1. Chronology of Health System Devolution in Spain



Source: Duran, A. et al. (2006, 20), with modifications.

4.2. National Health System Functions for the "Slow-Track" Regions, 1996-2001

4.2.1. Service Organisation

With the enactment of the 1986 General Health Law (GHL)[65] (Jefatura del Estado 1986a), the Spanish health system moved from the Social Assistance programme through Social Security—a Bismarckian-style social health insurance system—to the Spanish National Health System (NHS)—a Beveridgean-style system based on Britain's National Health Service. This meant two major shifts: first, from a system funded through employment contributions to one funded through general taxation; and second, a shift from a system whose criterion for entitlement benefits was based on employment to one based on citizenship.[66]

During this period, the central government's Ministry of Health and Consumer Affairs (MOH) was the primary authority over the NHS, particularly over health services in the ten "slow-track" regions. It, however, shared responsibilities over health services with the seven "fast-track" and "intermediate-track" regions. In this arrangement, the MOH spearheaded the NHS, carrying out almost all decision-making functions for the central government and the ten "slow-track" regions. The power-sharing arrangement created by the asymmetric devolution of the Spanish NHS is illustrated in its organisation (see Figure 4.2). In particular, the MOH was responsible for strategic areas of the health system, including coordinating health services, formulating basic health legislation, health financing and defining the health care benefit package. In addition, the MOH was required to agree on financial and benefit policy issues with the Ministry of Economy and Finance (MOF)[67] and the Social Security system, and on human resource issues (e.g. recruitment and employment of health personnel, especially civil servants) with the Ministry of Public Administration

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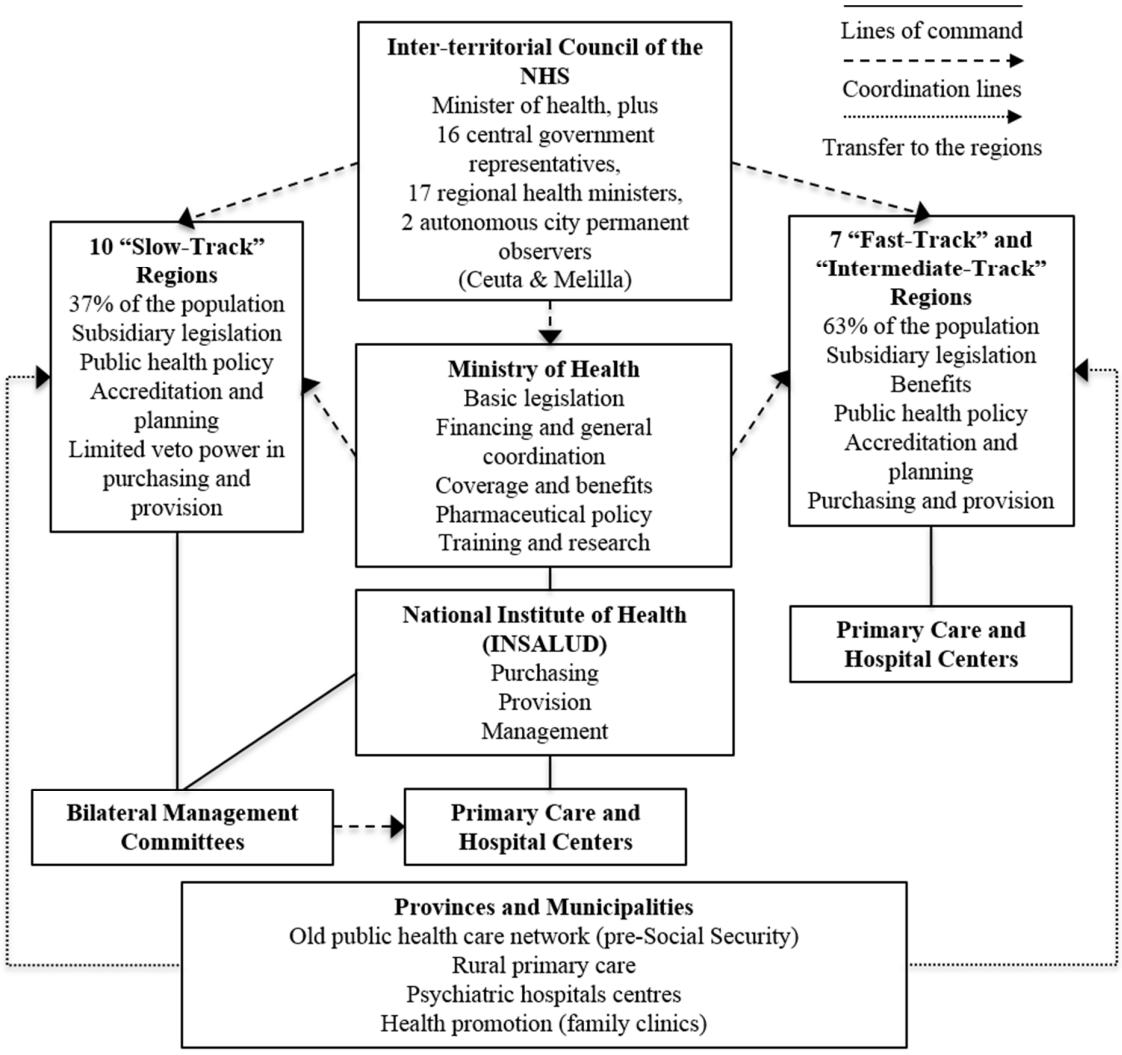
[65] The 1986 General Health Law created an NHS, integrating the state-run health services, the health services that had already been devolved to some regions, and the Social Security Health Centres into one health service for each region. The National Institute of Health (INSALUD) managed the health services of the regions without authority over health care competencies (yet). After this law, the royal decrees regarding the transfer of functions and services to the regions without authority over health care stated that they would be transferred from INSALUD not from the social assistance programme of Social Security.

[66] The Spanish NHS stipulated universal health care—health care for all free of access at the point of service—in Royal Decree 1088/1989 (Ministerio de Relaciones con las Cortes y de la Secretaría del Gobierno 1989). A small number of high-income, non-salaried individuals, however, elect not to be covered by the NHS (as per Royal Decree 1088/89). In 1997, this group was estimated as representing 0.6 per cent of the population (Rico, Sabes, and Wisbaum 2000, 37).

[67] In April 2002, the Ministry of Economy and Finance was split into two different ministries: the Ministry of Economy and the Ministry of Finance. When I refer to the MOF after this date, I am referring to the Ministry of Finance.

Figure 4.2. Organisation of the Spanish NHS, 1996–2001



Source: European Observatory for Health Systems (2000, 22), modified by the author.

(MOPA). The MOF played a particularly important role in the NHS, tasked with preparing a draft national budget and designing and planning of the regional and NHS-specific financial agreements (including resource allocation formulas). See the Financing subsection below for more information. The MOH also was required to coordinate with the Ministry of Labour and Social Affairs (MOL) in areas of joint responsibility, including social and community care-related issues and the authorisation of payments made within the NHS, and with the Ministry of Education[68] (MOEdu) on postgraduate training for medical professionals and human resources planning (see Table 4.1).

[68] In April 2000, the Ministry of Education and Culture changed its name to the Ministry of Education, Culture and Sports.

Table 4.1. Areas of the MOH's Joint Responsibility with other Government Entities, 1996–2006

	Ministry of Health
"Fast-track" and "Intermediate-track" Regions	Health service responsibilities
Ministry of Economy and Finance	Financial and benefit policy issues, especially the national health budget and the health resource allocation system for the regions
Social Security System	Financial and benefit policy issues
Ministry of Public Administration	Human resource issues
Ministry of Labour and Social Affairs	Areas of joint responsibility, such as NHS payment authorisation and social and community care
Ministry of Education	Postgraduate training for medical professionals and human resources planning

In terms of health services, the MOH had direct authority over the National Institute of Health (*Instituto Nacional de Salud*, INSALUD), which was the NHS's implementation body. INSALUD was charged with purchasing, providing and managing health services for the ten "slow-track" regions. It operated through territorially-based provincial delegations and the "slow-track" regions played only a limited role in the NHS, at this time. In terms of decision-making, however, the "slow-track" regions had some power over the formulation of a few types of health policies for which they were partially responsible, including primary and psychiatric care policies. In practice, all the decisions that INSALUD took were according to homogeneous criteria for all Autonomous Communities (Novinskey, Interview no. 31). A stakeholder from Extremadura recounts his experience, "but [this method] did not account for relevant aspects of the particular situations of each territory. Therefore, INSALUD made decisions…for both Madrid and Extremadura [but] their starting points were never the same…And at some point…there were inequalities that were accentuated" (Novinskey, Interview no. 07). Another regional stakeholder noted that party politics were also a part of INSALUD decision-making at times (Novinskey, Interview no. 09).

During this period, although they had not yet assumed full autonomy over health services in their territories, seven of the "slow-track" regions already had laid out the legal framework for receiving them (as according to the process outlined in the Constitution). Despite considerable latitude in drafting this legal framework, most of these regions designed their regional administration with a Regional Health Ministry

(*Consejería de Sanidad*, RHM) at its core, to which a regional health service (*Servicio Regional de Salud*, RHS) would be responsible. The RHM was designed to be the counterpart of the central MOH, carrying out decision-making and public administration functions for regional health policies and health services, and the RHS would manage health delivery functions for the region. In particular, the RHS was responsible for integrating the work of specialised hospitals and primary health centres and for ensuring the offer of planned health services within its territory.

As envisioned in the 1986 GHL, for all regions, services were to be administratively decentralized into Health Areas (*Áreas de Salud*) and then further into smaller Basic Health Zones (*Zonas Básicas de Salud*), neither of which were aligned with local government boundaries, but were rather based on catchment areas.[69] Each Health Area was to cover approximately 200,000 residents, and each Basic Health Zones between 5,000 and 25,000 residents; though, the latter also was strategically located according to population, epidemiology, and travel distance (maximum of 30 minutes by vehicle between any community and their services). The Health Areas were to be staffed with one area manager and its health professionals would provide primary care, specialised ambulatory care and hospital (outpatient and inpatient) care. Each Basic Health Zone operated as a single primary care team (*Equipo de Atención Primaria*).

Finally, all regions participated in two major intergovernmental bodies at the national level, namely, the Inter-territorial Council of the NHS (*Consejo Interterritorial del Sistema Nacional de Salud,* CISNS) and the Tax and Finance Policy Council (*Consejo de Política Fiscal y Financiera de las Comunidades Autónomas*, CPFF)[70]. The CISNS was the intergovernmental coordinating body between the central and regional governments on NHS-related policies and issues. It consisted of the regional health ministers (*consejeros de sanidad*) from each of the seventeen regions and an equal number of central government representatives including the national minister of health, who chaired its meetings. Its agreements held advisory, not executive, power. Like the CISNS, the CPFF functioned as an intergovernmental coordinating body between the central government and the regions but its focus was on fiscal and financial issues. In particular, it would negotiate and prepare the regional and NHS-specific

[69] Though, overtime and with their implementation, these administrative and organisational structures changed among the regions and between the RHS and their Health Areas, and Basic Health Zones within the regions.

[70] This Council was originally created in 1980 by Article 3 of the LOFCA (Jefatura del Estado 1980a).

financing agreements, which included the details of the resource allocation formulas.[71] It was composed of the national minister of finance and the regional finance ministers (*consejeros de hacienda*) from the seventeen regions. Although, formally, the CPFF held advisory and not executive power, its financing agreements were incorporated into the national budget, which was approved by Congress and generally implemented as planned.

4.2.2. Regulation and Planning

From 1996 to 2001, the central government and the seven regions with devolved health service powers mostly regulated the Spanish NHS together, with the ten "slow-track" regions having very limited regulatory powers. The 1978 Constitution charged the MOH with developing basic legislation (e.g. norms and standards for the whole system) and the regions were permitted to pass subsidiary legislation. In addition, the ten "slow-track" regions held some responsibilities over accreditation and planning, limited veto power over the purchase and provision of services and no authority over the determination of health care benefits. In the following, I describe the regulations and processes for establishing health plans and the health care benefit packages during this period.

4.2.2.1. Health Plans: The central government and the regions also shared responsibilities for health planning during this period. There were two mostly-parallel processes for planning health services: one for health financing, led by the MOF, and another for health services, led by the MOH. Beginning in the mid-1980s, together with the regions holding health care competencies, the MOF worked on designing and implementing a priority-setting strategy and plan for containing health expenditures. This priority-setting strategy and plan was generally implemented as intended and fed into the annual national health budget.

From 1986 and according to the GHL, the MOH was to produce multi-year health plans as the main planning instrument of the NHS and with the objective of allocating resources efficiently in order for the system to meet the population's demand for health care. The process for elaborating these health plans combined bottom-up and top-down actions. For the regions with health system competencies, each Health Area was to create a health plan for its locality, which it would subsequently submit to its RHM. Then, the RHM would aggregate all the health plans in its territory, creating a

[71] Prior to 1994, they used bilateral management committees to negotiate the terms on an on-going basis.

regional-level health plan. Because the ten "slow-track" regions had still not received health system competencies during this period, their regulatory and planning functions were performed by INSALUD, working in conjunction with the existing RHMs (as they gained authority and responsibility over health system and service functions in their territories). Parallel to this process, the MOH would create a national-level health plan containing stipulations from the general regulatory framework, the organisation of health system programs and a set of priority action areas, with the objective of promoting cohesive planning across all regions. Once approved by the Spanish Parliament, the national health plan would be sent to the regions so that they could integrate its objectives into their regional health plans. After this integration and prior to their implementation, the regional health plans would require the regional parliament's approval.

In practice, however, the implementation of this health-planning tool developed slowly. Despite the 1986 mandate, the central government approved its first health plan only in 1995.[72] As a result, the regional health planning process was slow going and it was not until 1999 that every region had at least one plan approved. For example, the regions of Madrid and Extremadura each published a plan during this period. Madrid's plan spanned ten years, starting in 1995, and Extremadura's plan covered four years, starting in 1997. In their infancy, these regional health plans were used mostly as instruments for gathering information and developing intelligence on health needs across the region; this was perhaps a prerequisite for planning but certainly not a complete process.

By 2000, the MOF and MOH had combined their planning strategies to formulate joint plans that linked health resource allocation and financing plans with health status priorities and health service plans.

4.2.2.2. Health Care Benefit Package: Consistent with its regulatory role, the national parliament approved a common benefit package of health services covered by the NHS and to be offered in all regions with Royal Decree 63/1995 (Ministerio de Sanidad y Consumo 1995b). While the MOH was the main central government actor defining the health benefit package, it shared this responsibility with the MOF (which has the responsibility for authorizing the financing of these benefits), the MOPA

[72] Prior to this, however, the central government did mandate the introduction of the World Health Organisation's "Targets for Health for All" into the NHS (WHO 1985). The Health for All initiative emphasized objectives of equity, clinical effectiveness and quality of care.

(responsible for issues related to health personnel), and the MOL (responsible for social and community care during this period). The CISNS and the Health Institute Carlos III—the main public biomedical research entity in Spain[73]—also played important roles in the determination of the health care benefit package. The CISNS was responsible for granting equity and access to services across all regions; the Health Institute Carlos III performed much of the research underlying the decision on what benefits to include in the package. As the regions assumed health service responsibilities, their regulatory capacity and purview over the specific health care benefit package offered to their populations increased (Puig-Junoy, Planas-Miret, and Tur-Prats 2005). Although obligated to cover all the health benefits in the common package, these regions could decide the amount of financing for each benefit in the package and what additional benefits to offer with their own financing to their population (Novinskey, Interview no. 22). The regions participating in the "second wave" of health system devolution were not given the same latitude because their services were financed primarily through the central government—though, some managed to add benefits that were not dependent on financing (see examples below).

In terms of entitlement, a few major laws and regulations together defined the rights and criteria for access to the health services contained in the core benefit package. While Article 43.1 of the 1978 Constitution guaranteed health protection for all citizens, the health system continued to be managed mostly through the Social Assistance programme of Social Security, with entitlement based on employment contributions, until the 1986 GHL explicitly mandated a shift from a social health insurance-based system to an NHS-style system. In addition, the GHL extended the government's health protection guarantee to foreigners with a residence permit.[74] Shortly afterwards, Royal Decree 1088/1989 extended eligibility to low-income populations. As a result, the remaining population without coverage from either NHS or Social Security health services consisted mainly of high-income individuals, who declined participation in the system (Novinskey, Interview no. 07 and 21). Finally, on December 18, 1997, the Spanish Congress of Deputies approved a Parliamentary

[73] Health Institute Carlos III supports the development of scientific knowledge in the health sciences and contributes to innovation in health care and disease prevention (Ministerio de Economía y Competitividad 2015).

[74] This last provision did not apply to health centres of the social security system and foreigners who received care at social security health centres were obliged to pay out-of-pocket for services.

Agreement for the Consolidation and Modernisation of the NHS, which definitively extended health care as a universal right to the entire Spanish population.

Also during this period, the regions each passed their own entitlement legislation, especially regarding the coverage of foreigners within their territories.[75] Andalusia,[76] Aragon, Asturias, the Canary Islands, Cantabria, Castile-La Mancha, Galicia[77] and La Rioja all passed legislation containing the same entitlement rules as those specified by the central government. Valencia extended the benefits of long-term care services (*atención socio-sanitaria*) in addition to health services for all residents in Decree 88/1989 (Consell de la Generalitat Valenciana 1989), and subsequently in a 1989 order, a 1999 resolution, and Decree 26/2000 (Comunidad Valenciana 2000). In their regional health plans, the remaining regions (including Extremadura and Madrid) legislated that all health services would be free for all residents, independent of their legal or administrative status. In addition, the Balearic Islands, the Basque Country,[78] Castile Leon, and Madrid provide all health services without fee to non-resident travellers (Ministerio de Sanidad y Consumo 2003a).

Royal Decree 63/1995 (Ministerio de Sanidad y Consumo 1995b) defined a list of health services to be offered by the NHS (also known as the common health benefit package) and a list of excluded services. The common health benefit package included primary health care, specialised health care, infant dental care, pharmaceutical benefits (including a list of included and excluded drugs), and complementary benefits such as prostheses, orthopaedic products, and transport to health care services. It excluded psychoanalysis, hypnosis, sex change surgery, spa treatments, cosmetic plastic surgery, and any adult dental care beyond tooth extractions.

As mentioned, the regions were permitted to expand the health benefits offered in the common package for their territory. During this period, most additions to the common package were made by the seven regions in the "first wave" of health system devolution. For example, despite its explicit exclusion by Royal Decree 63/1995, Andalusia covered sex change surgery beginning in February 1999 (Parlamento de Andalucía 1999). In 1990, 1991, and 2001, respectively, the Basque Country, Navarra and Andalusia decided to offer full child dental care coverage (Puig-Junoy, Planas-

[75] This legislation is located in a region's health law or plan (*Ordenación Sanitaria*), or documents related to the creation of its RHS.
[76] Andalusian Decree 66/1990 (Consejería de Salud y Servicios Sociales 1990).
[77] Only residents receive additional region-specific benefits according to Galician Decree 63/1996 (Consellería de Sanidad y Servicios Sociales 1996).
[78] Decree 26/1988 and Order 28.6.1982 (Comunidad Autónoma del País Vasco 1988).

Miret, and Tur-Prats 2005). Under Law 10/2001, Extremadura added passive euthanasia to its benefit package (Presidencia de la Junta de Extremadura 2001a). In its Health Planning Law 12/2001 (*Ley de Ordenación Sanitaria*), although it did not add any items to the common health benefit package, Madrid did approve some relevant provisions, such as recognizing the legally binding nature of "advance care directives" ("*Instrucciones Previas*") by the patient regarding the final moments of life (Article 28)[79] (Presidencia de la Comunidad de Madrid 2001a).

4.2.3. Financing

Before 2001, there were three principal movements of financial resources for the health system. The first financial flow consisted of regional and NHS-earmarked intergovernmental transfers, which flowed from the central government to INSALUD and the regions with health care competencies. The second flow then moved from these regions and INSALUD to hospitals. At this stage, the regions with devolved power over health services had significant authority in determining payment methods but INSALUD primarily decided the payment methods for, and paid the hospitals in, the ten "slow-track" regions. The third financial flow regarded human resources for the health sector. Health employees have a similar status to national civil servants in Spain, and salaries and payment methods are regulated by the central government. The regions with health service competencies had some responsibility in this area; they could set or adjust some additional payment methods to basic salaries (see the Human Resources section for further details).

In this section, I discuss the flow of funds from the central government to INSALUD and the regions with health service competencies, which comprised two main systems of financing: the regional financing system and the NHS financing system. The CPFF was responsible for reaching agreements on all matters regarding the allocation of financial resources to regions (whether or not they flowed through INSALUD), including those for the NHS. The regional financing system reflects the evolution of the regions' fiscal autonomy as well as some important overall contextual financing issues that indirectly affect the health system. Because the funds for the NHS

[79] The "advance care directive" is a person's wishes expressed in advance about the care and treatment of his health or the fate of his body so that they may be followed in the moment the person may reach certain clinical situations, which prevent him from expressing his will, at the end of his life. This article was repealed and replaced by Law 3/2005, which regulated exercising the right to formulate "advance care directives" regarding health care and created a corresponding registry (Presidencia de la Comunidad de Madrid 2005).

financing system were earmarked for health, they served as the most significant method of direct financing for the NHS.

4.2.3.1. Regional financing system: In 1980, as stipulated by the 1978 Constitution, the central government established a system of regional financing with the Autonomous Community Financing Law (LOFCA) (Jefatura del Estado, 1980). Under this law, the regions were effectively separated into two regimes: the "foral" financing regime, composed of the Basque Country and Navarra[80]; and the "ordinary" financing regime, consisting of the remaining fifteen regions. In the following, I focus on the details of the "ordinary" financing regime, and its meaning for the ten "slow-track" regions. I structure these details according to four periods, beginning with the LOFCA and ending before the "second wave" of health system devolution. The first period was, in effect, a ten-year transitory period (1978–1987). It was then followed by three financing agreements covering five years each from 1987 through 2001 (Consejo de Política Fiscal y Financiera 1986; 1992; 1996).

During the transitory period, the central and regional governments agreed on the amount of goods and services as well as personnel that would have to be transferred from the central government to the regions so that the regions could furnish an effective level of services for each competency they received. The agreements were negotiated through the bilateral commissions of the CPFF, called Mixed Parity Commissions (*Comisiones Mixtas Paritarias,* MPCs), which were regulated by the LOFCA and the regional Statutes of Autonomy. Essentially, these Commissions were responsible for defining the amount of revenue that the central government would need to transfer to the regional governments and INSALUD so they could carry out their different public service responsibilities, such as health care, social services and education (Ramallo Massanet and Zornoza Pérez 1995). According to a mandate from the 1986 GHL, these Commissions calculated the cost of service delivery using historic annual budgeting practices. As such, for the first year of the transfers, they were to base their calculations on the total amount expended on these services within the region during the previous year. From then on, the amount of the transfers would be calculated based on each region's prior-year share of the total national expenditure.

[80] This was stipulated respectively for these regions in the first and second Additional Provisions of the LOFCA. *Foral* is a Spanish legal term and concept, drawn from the Latin *forum* and used to describe an open space for tribunals, councils or meetings. Its approximate equivalent in English is a leasehold or charter. In Spain, it has come to mean a compilation of laws for a region, often dating back to the times before kings. Present-day Spain has two foral regions, the Basque Country and Navarra.

In practice, however, as a result of significant political pressure and other factors, many observers maintain that the transfers were not determined by formula through the proposed costing system, but rather continued to be based on negotiations (Corona, Alonso, and Puy 1998; García-Mila and McGuire 2002; García-Mila 2005). For example, in the MPCs, regional representatives would vie for as many resources as possible, usually raising the ante from the previous MPC negotiations (Corona, Alonso, and Puy 1998). Moreover, concessions would be influenced often by political affiliations; for example, regional governments of the same party as the central government tended to have a stronger bargaining position than regional governments ruled by an opposing party (León-Alfonso 2007). The multilateral function of the CPFF came into play only to formally ratify the regional financing agreement after MPC negotiations were finalised.

In November 1986, the regional financing agreement for the period of 1987–1991 was approved. It changed the procedure for carrying out and approving regional financing agreements: instead of being adjusted annually, they would be modified every five years.[81] Additionally, the financing agreement changed the resource allocation formula to reflect regional needs better. For the regions still under INSALUD's management, this meant that 59 per cent of regional financing would be calculated based on population, 24.3 per cent on the number of administrative units operating in the region, 16 per cent on area, and 0.7 per cent on insularity. In addition, equalisation measures across regions were instituted. According to an index of fiscal strength, approximately 5 per cent of funds would be reassigned, and according to an index of relative poverty, 4.2 per cent of funds would be redistributed. There was a different financial resource allocation formula for the regions with health service competencies.[82] The financing agreement also set a maximum increase each year equal to the nominal increase in GDP.

According to León-Alfonso's (2007, 161) analysis of "per capita unconditional financing"[83] across the regions, the financing agreements made during this period for

[81] To the best of my knowledge, this provision did not appear in the LOFCA (Ramallo and Zornoza 1995) or in any other piece of legislation except the Statue of Autonomy of Valencia.
[82] The regions in the "first wave" of health system devolution employed a similar formula to that used for the "ordinary" financing regime, except for the count of administrative units and an additional adjustment constant, and the weights for each measure were considerably different.
[83] Referring to "per capita unconditional financing", León-Alfonso includes the unconditional funds transferred from the central government, which are composed of ceded taxes, service fees and revenue sharing between the central government and the regional government, as well as regional own resources, consisting of regional taxes and surcharges on national taxes.

the ordinary financing regime suggested that the regions of Aragon, the Canary Islands, Castile Leon, and La Rioja benefited the most (receiving higher-than-average capitation rates). At the same time, Asturias, the Balearic Islands, Madrid, Murcia and "fast-tracked" Valencia received below-average capitation rates.

For the 1992–1996 period, a five-year financing agreement was approved in January 1992 and updated in 1993 (Consejo de Política Fiscal y Financiera 1993). Authority over higher education and social services was devolved in 1995 and 1996 to regions in the ordinary financing regime. The main change in these financing agreements was the adjustment of the resource allocation formula. For the regions still under INSALUD's management, now 64 per cent of funds would be allocated by population (an increase from the previous formula), 17 per cent on the number of administrative units in each autonomous community (decrease), 16.6 per cent on area (slight increase), 0.4 per cent for insularity (slight decrease), and 2 per cent on an additional measure of population dispersion. The equalisation funds were considerably reduced to 1.82 per cent based on the index of fiscal strength and 2.7 per cent from the index of relative poverty. Table 4.2 presents a comparative view of the changing financing agreements over time. Moreover, this agreement set a minimum funding guarantee for intergovernmental transfer to the regions, equal to the amount that each region received from the central government in 1990. It, however, excluded any possibility of increased regional fiscal autonomy. For this reason, a study group was formed and a new agreement was reached in 1993, which amplified regional tax powers, in addition to the earlier agreements on resource allocation for the system. The 1993 agreement gave the regions the right to 15 per cent of the individual income tax yield collected by the central government within their territory. At the same time, however, this extra fiscal autonomy was limited by the central government, e.g., who also set a fixed maximum for the extra funding any one region could receive.[84] In practise, this agreement was also limited because the regions lacked the necessary taxation tools for implementation, starting with the power to change income tax regulations.

[84] Extra funding could not be greater than the percentage calculated for intergovernmental transfers (revenue sharing) in the 1992 financing agreement.

Table 4.2. Resource Allocation Formulas for the Ordinary Financing Regime

Criteria	**1987–1991**	**1992–1996** (in effect until 2002)
Population	59%	64%
Number of central government administrative units	24.3%	17%
Area	16%	16.6%
Insularity	0.7%	0.4%
Funds reassigned, fiscal strength index	5%	1.82%
Funds redistributed, r elative poverty index	4.2%	2.7%

León-Alfonso's (2007) per capita unconditional financing analysis further indicated that, the regions benefitting the most for the period 1992–1996 were Cantabria, Castile-La Mancha, Castile-Leon, and La Rioja as well as the "fast-tracked" Canary Islands and Galicia. Madrid and Murcia again received below-average capitation rates. Overall, in comparison with the previous period, regional differences actually increased over time.

Approved in September 1996, the financial agreement for the period 1997–2001 was created with the objectives of balancing the increasing differences in regional expenditure responsibilities and giving them greater taxation powers. In particular, it increased regional control over individual income taxes, giving the regions, for example, the capacity to regulate tax brackets, tax rates, and some tax credits. Initially, they were given power to raise and retain up to 15 per cent of these taxes; but once they assumed public education competencies (in 2000), they were allowed to raise and retain up to 30 per cent of these income taxes.

The objectives of this financing agreement, however, were mostly unmet during implementation. First, three regions – Andalusia, Castile-La Mancha, and Extremadura – declined to ratify this new agreement and instead remained under the 1992 agreement. Then, most of the remaining regions did not exercise their new authority to increase taxes; rather, they tended to introduce tax exemptions. According to Monasterio (2002), this was an attempt by incumbent governments to gain electoral favour. Next, as León-Alfonso (2007, 171) observed, average regional variations in per capita unconditional financing actually increased over time. The study also demonstrated considerable variation in per capita unconditional financing among the regions under the ordinary financing regime, with Cantabria, Balearic Islands, and La Rioja continuing to benefit from the new agreement, along with "fast-tracked" Catalonia and Galicia. At the same time, Murcia continued to receive a below-average

capitation rate. However, Madrid moved up from its disadvantaged position to an almost average rate, and "fast-tracked" Valencia moved down to a below-average rate. Having rejected this new financing agreement, Castile-La Mancha, Extremadura and "fast-tracked" Andalusia all fell well below the average capitation rate. The remaining regions in the ordinary financing regime showed some increase in their rates over time.

4.2.3.2. NHS Financing: During the period 1994–2001, just over 70 per cent of total health expenditure (THE) came from public sources, including the central government, regional and municipal governments, and social security funds. The private sector provided the rest of total spending, mostly through private household out-of-pocket payments (23.5 per cent of the total) (OECD 2005).[85]

The budgeting process for the NHS financing system was elaborated in several steps. Once each of the "fast-track" regions had drafted its annual health budget, it would send the budget to the central government, which would determine the actual amount of financial resources to be allocated to health. Incorporating the information from the proposed regional budgets as well as from the INSALUD field offices, the MOH would create an annual national health budget and bring it to the MOF for consultation and its integration into the larger national general budget. The MOF would then draft a bill for the national general budget, which would subsequently undergo the legislative process within the national parliament.[86] Once it was approved, the resulting financial resources would flow from the MOH to the regions with health service powers and to INSALUD for the regions without these powers, and then from these recipients to the various health services (e.g. primary, specialised and hospital care). Resources transferred via INSALUD were earmarked for items such as investment, current expenditure and personnel costs, primary care, and specialised and hospital care.

Per the 1986 GHL, most of the public financing for the NHS was mandated to come from individual taxes on the whole population. This funding system was established on the principle of solidarity: contribution levels were based on personal income, and access to health care was based on need. The GHL stipulated that revenues would initially be injected into the health system using a combination of intergovernmental transfers from the central government, fees for specific services not

[85] Small percentages were spent on private insurance enterprises and other private funds as well.
[86] From 1994 to 1999, social security also budgeted a small amount of funds for health. This budget required approval from the Spanish parliament as well.

included in the common benefit package, and contributions from the regions and municipalities as well as from social security. After this initial period, social security contributions would be phased out over time as they were supplanted by tax revenues, which would feedback into the regions via the intergovernmental transfers.

Prior to the GHL, the health system was financed mainly through employment contributions to the social security system, which then funnelled some of the funds to Social Security's health insurance system, Social Assistance. A little health funding was allocated from the national general budget as well. Financing for the health system changed radically with the 1986 GHL and the National Budget Law (NBL) for 1989 (Jefatura del Estado 1988), which mandated a major shift from a social health insurance-based system to an NHS-style system based on tax revenues. The transition in financing aspects would take ten years, ending in 1999; therefore, overlapping with the study period of this thesis. Before 1989, 70 per cent of health system financing came from social security and 30 per cent from the national budget. One of the functions of the 1989 NBL was first to turn this financing nominally on its head,[87] then to reduce the rate of social security contributions to the system at the same gradual pace that funds from the national budget would increase and, by 1999 all financing would come from the national budget. Indeed, this result took place and virtually the entire NHS (excluding civil servant pension funds) was financed by the national budget with general taxes in 1999.

Moreover, the 1986 GHL envisioned four-year financing agreements for the health system starting in 1994. It introduced a system of financial resource allocation to the regional level for health services, according to criteria based on capitation. In the following paragraphs, I discuss this and other major elements of the NHS financing agreements for the periods 1994–1997 and 1998–2001 (Consejo de Política Fiscal y Financiera 1997).

Similar to the regional financing agreements, the 1994–1997 NHS financing agreement was negotiated bilaterally by the MPCs and approved by the CPFF in November 1994 (Consejo de Política Fiscal y Financiera 1995; 1997). This agreement stipulated an increase of 3.5 billion pesetas to the health system by the end of 1997. In part, this increase covered debt that the health system had accumulated in 1992 and 1993 (Cabasés 1997; Echániz Salgado 1999; Elola Somoza 2001).

[87] The law did not stipulate a mathematical formula, but it envisioned the replacement of social security contributions with an equivalent amount in general revenues from the national budget.

This agreement also made a firmer commitment to allocating financial resources to the "fast-tracked" regions according to a single criterion: the size of the benefit population (a simple capitation figure, as stipulated by the GHL). Prior to it, the financial resource allocation process for these regions was warped by the highly politicised, bilateral negotiations that took place on the MPCs during the negotiation process for health service devolution. For the "slow-tracked" regions, however, capitation rates were used consistently, before and after this agreement, to calculate financing for the health services managed by INSALUD. With the firmer commitment to this single criterion for all regions, the agreement mandated the use of a new base year for calculating the benefit population: the March 1991 census carried out by the National Statistics Institution (*Instituto Nacional de Estadística*, INE). The complete implementation of this single-criterion allocation formula resolved the prior discrepancies in the distribution of financial resources among the regions.

Moreover, this period's financing agreement introduced a norm that linked the budgetary increase for the regions with devolved health services to the regional growth in GDP. This effectively eliminated any financing overlaps between the "fast-tracked" regions and the direct management by INSALUD. Finally, this agreement fixed a ceiling for the regions to spend on health, which was linked to 1993 spending levels of INSALUD with adjustment measures.

In November 1997, the 1998–2001 financing agreement for the health system was negotiated and approved by the CPFF (Consejo de Política Fiscal y Financiera 1997). During the year prior to this agreement, a parliamentary sub-commission had been formed to develop an appropriate reform of NHS financing to be implemented in this new period. The sub-commission's final reform proposal attempted to address several issues. The primary issue concerned the level of financial resources dedicated to INSALUD and their sufficiency to meet the volume of health services it provided. The proposal also earmarked financial resources to the administrative units under INSALUD's management for specific programme expenditures. For the whole system, it put general cost-containment measures in place as well as mechanisms to achieve savings in the system and obtain an optimal level of service delivery. Finally, it established an accountability system for health expenditures. The sub-commission's

proposal was approved by a 32-2 vote (with Castile-La Mancha and Extremadura the lone dissenters) and became the official financing agreement for this period.[88]

While this financing agreement did not change the capitation criteria for formulating the amount of financial resources to be allocated to the regions, it did acknowledge a need to supplement the defined allocation to them. As such, its formula began using part of the budgeted expenditures from the 1998 NBL to set an initial amount of financing to be transferred to the regions. Then, it injected additional funds—some of which were obtained from health expenditure rationalisation measures (i.e., savings)—into the system for five purposes: (i) increasing the health coverage of the population, (ii) implementing control programs and disability benefits, (iii) compensating regions with decreased population size, (iv) teaching and research, and (v) assisting residents who move from one region to another (Cantarero Prieto 2000; Echániz Salgado 1999). As a result, in 2000, INSALUD received 1.66 million pesetas to manage and provide health services for the remaining ten "slow-tracked" regions.[89] In the same year, the seven regions with health care competencies received 2.69 million pesetas. Overall, this signified a massive increase in the funding for the NHS. Appendix G holds health expenditure and population coverage data for Spain, Extremadura and Madrid.

4.2.4. Human Resources

Arguably, human resources are the most important resource of any health system; without quality staff, any system is practically useless. Spain has a long history of regulating health professions and professionals, starting in 1848 with a government declaration that medical, pharmacy and veterinary professions would constitute the field of health (*Reglamento para las Subdelegaciones de Sanidad Interior del Reino*, 24 July). However, regulating human resources for health is complicated not least because one has to agree with the research and investigation, labour, and education sectors (Novinskey, Interview no. 02). Thus, despite history, recent action has been sparse. The most recent legislation regarding health professions took place in 1986. First, the

[88] These agreements needed a majority greater than two-thirds of the total votes. A stakeholder from Extremadura said, "they did not agree because they thought [the agreement] was prejudiced against Extremadura in its financing terms. Because of the economic parameters, the region is already at a disadvantage compared to others…in fact, Extremadura took this agreement to the Constitutional Court" (Novinskey, Interview no. 07).

[89] The cities of Ceuta and Melilla were also covered by this allocation. The population of the remaining regions totalled about 38 per cent of the total Spanish population.

GHL referred only to the free exercise of health professions and designated the homologation of postgraduate specialisation programs for health personnel as well as job posts in health services as a competency of the central government. It, however, did not regulate health professions directly; it only stated, in Article 84, that a specific framework statute, separate from but similar to the civil service, should be created to regulate them. In addition, Law 10/1986 regulated orthodontists and other professionals related to dental health (deferring regulation of other medical and health professions, as no legislation covering these other professions was passed at that time) (Jefatura del Estado 1986b).

As a result, the vast majority of health professionals worked as civil servants during this period, regulated under the public administration Law 30/1984 (Jefatura del Estado 1984, 30). This law maintained that statutory health personnel, including those within the civil service, would be the object of future special legislation. However, when no special legislation regarding health personnel was legislated, it became the regulation for health personnel *de facto*. Among other things, Law 30/1984 granted each region the authority to regulate its own civil service.[90] It was complemented by Royal Decree 364/1995, which approved the General Regulation of the State and of the Provision of Employment Positions and Professional Promotion of the Civil Services of the General Administration of the State and also contained provisions for working in the regions (Ministerio para Las Administraciones Públicas 1995). The basic information, entry requirements, terms of mobility and salaries for both the national and regional civil services were practically the same. In general, the civil service was a gateway for entering into public administration. A large portion of both the national and regional civil services (18 per cent and 6.7 per cent, respectively) was composed of personnel who worked for the administration of ministries and other autonomous government bodies (Ministerio para Las Administraciones Públicas 1996). During this period before health service devolution, however, the majority of health personnel (including medical doctors and nurses), managers and administrators working in the NHS were national-level civil servants. When the responsibility for most public services was to be devolved from the central government to the regional governments, administrative personnel working for these services would also be transferred but

[90] Royal Decree 28/1990 approved the Regulation of the Provision of Employment Positions and Professional Promotion. This law was modified by Law 22/1993, which changed the methods of planning for employment in the public service.

health personnel would not. In 1996, 132,234 out of almost 800,000 national civil servants were doctors and nurses (Parrado Díez 2000).

Comprehensive Human Resource Plans (*Planes Integrales de Recursos Humanos*) are the basic instrument for global planning of human resources, defining the objectives of personnel, the strength and structure of human resources needed to adequately meet these objectives, and the necessary measures and actions (e.g. mobility, training and promotion) for adapting the current structure to meet the human resource needs. If the needs are not met, then recruitment for the civil service occurs through a public call and selection process, which must be approved by MOAP and MOF. Once approved, the regional ministry of the corresponding Body and Scale (*Cuerpos y Escalas*) of public servants proceeds with the selection and hiring process (Article 9, Royal Decree 364/1995). Promotions for this period were carried out though a competitive system, subject to the principles of equality, merit, ability and publicity, and authorised by the government or the competent body of public administration (Articles 74 and 75, Royal Decree 364/1995). Dismissal of civil servants who failed to fulfil their duties required a long disciplinary process (Article 31, Law 20/1984).

In addition to passing the selection process for entering into public service, health workers were required to have completed any technical training compulsory for the particular position (e.g. specialist training for medical doctors[91]). In general, salaries for health personnel were set at the national level and differed by level of health care (primary vs. secondary and tertiary). All health professionals in the NHS were salaried. Public general practitioners on primary care teams were paid 85 per cent of their salary directly with the remaining 15 per cent depending on a capitation component, which considers the population characteristics, including density and percentage of persons over age 65. Private General Practitioners were paid a fee for services provided. Doctors and specialists in public hospitals are usually civil servants and completely salaried; those in private hospitals are paid according to market forces. With the devolution of health services,[92] the regions were empowered to provide additional financial and non-financial benefits to their health personnel for achieving quality, performance, training and individual development objectives (Hidalgo and

[91] Public and private specialized care doctors and public primary care doctors were required to pass the civil service entry exam beginning in 1980 and 1995, respectively.
[92] Salaries were somewhat negotiable during agreements with the regions that had health service responsibilities.

Matas 2004). For example, Catalonia adjusted salaries based on a socioeconomic index of the population served. Health centre managers, however, had very limited capacity to negotiate salaries or incentives for their direct employees. Furthermore, during this time, *de facto,* one's professional profile seemed less important than their ideological link to a political party: "it used to happen that when the government changed parties, so did [most human resources] all the way down to the nurse supervisor of the night shift at the hospital of Cáceres" (Novinskey, Interview no. 09).

All undergraduate education and training of health personnel was overseen by the central government's MOEdu. Basic undergraduate education for medical doctors lasted six years. Since 1978, the postgraduate specialisation of medical doctors has been planned through an Internal Medical Doctor Residency (*Medicos Internos Residentes, MIR*) programme ('MIR' 2015). Depending on the type of medical specialisation, doctors would practise their speciality in hospitals and primary care services for three to five years, with pay. Hospitals and primary care centres that received these medical residents had to be accredited for this level of training. Accreditation was dependent on compliance with strict standards set jointly by the MOH and MOEdu along with the National Specialisation Councils (*Comisiones Nacionales de Especialidad*) and was authorised for up to three years. A separate national commission oversaw each medical speciality. Members of these commissions consisted of university professors, health professionals, residents and representatives from physician associations and medical societies. They were in charge of defining the training programs for each specialisation, the number of annual vacancies and the programme's duration. In 1996, the number of new graduates from basic medical training was slightly lower than the number of vacancies for specialised medical training, with almost a third of those vacancies in family medicine.

For nurses, undergraduate-level education and training lasted between two and three years. Only two nursing postgraduate specialisations were in effect by the end of 2001, in mental health and midwifery (both beginning in 1996), with others in development. The planning and operation of the nursing specialisation programs mimicked those of the MIR.

Health care managers were not required to follow any type of management training. The National Public Health School (*Instituto de Salud Carlos III*) and other regional-level public health schools offered them management training.

4.2.5. Governance and Stewardship Rules

Stewardship and governance rules for the health system include six main dimensions according to the WHO (2000) and Travis et al.'s (2003) comprehensive stewardship framework for health systems. The six dimensions concern the steward's ability to (i) formulate a strategic policy framework; (ii) ensure a fit between policy objectives and organisational structure and culture; (iii) ensure tools for implementation, i.e., powers, incentives and sanctions; (iv) build coalitions and partnerships; (v) generate intelligence; and (vi) ensure accountability. Because these stewardship dimensions overlap considerably with the NHS functional areas of the decision-space approach, in this section I focus on the one stewardship dimension that has not received much attention thus far: ensuring accountability. For the period 1996–2001, I will examine government organisational structures for ensuring accountability, such as the size and composition of health facility boards and territorial health offices, and consider mechanisms to ensure public participation as a means of accountability, such as the size, number, composition and role of community participants, legislation for patient and user rights, and the establishment of a user complaint system (Bossert 1998b; Travis et al. 2003).

During this period, the 1986 GHL established integrated mechanisms to ensure accountability through several organisations at all levels of the NHS. At the central level, it mandated that a Consultative Committee provide relevant health care information to the CISNS. The Consultative Committee contained a range of representatives, including health experts, trade unions, employers and users. At the regional level, the GHL regulated the structure of Health Areas and Basic Health Zones (as discussed in the section on Service Organisation above); while the regions with health service competencies and INSALUD designed "health maps" that defined the territorial borders of these Health Areas and Zones. To ensure accountability and public participation in the NHS, the GHL stipulated creation of a Health Council for each Basic Health Zone. These Councils were given an advisory role for the management of primary and community health care. In addition, for secondary and tertiary specialised health care, Hospital Participation Committees were created at the Health Area-level. These Committees had representation from municipalities, local professional organisations and user associations, and they provided advice on hospital management and the coordination and integration of primary and specialised hospital care. However, in practice, ever since Franco's prohibition of civic networks, public

participation by local professional organisation and user groups has been relatively weak (Durán, Lara, and van Waveren 2006).

In terms of patient and user rights within the NHS, the GHL stipulated, among other things, respect for users' personality, human dignity and intimacy; caution against the improper use of prognostic, diagnostic and therapeutic procedures and tests; assignment of a particular general practitioner to each user; public participation in health activities; and the establishment and implementation of user complaint and suggestion systems. In particular, its Article 10.12 recognised the right of any citizen to communicate a complaint or suggestion regarding NHS processes, procedures or service delivery. This right was designed both to protect patients and to serve as an opportunity for quality improvement (Durán, Lara, and van Waveren 2006). Later, in the 1990s, patient rights were expanded with Royal Decrees 1575/1993 (Ministerio de Sanidad y Consumo 1993) and 8/1996 (Ministerio de Sanidad y Consumo 1996) on the free choice of primary care physicians and specialists, respectively, within INSALUD. Prior to these decrees, residents were allocated a primary care physician, who would serve as the gatekeeper for referrals to specialists.

Furthermore, the regions with health care powers were allowed to develop their own regulations on rights and duties. For example, in its 1998 Health Law (Presidencia de la Junta 1998), Andalusia explicitly referenced users' rights to file complaints and suggestions, and to receive answers within a specific time. The regions under INSALUD were not given these specific powers during this period; mechanisms for public participation and accountability for these regions were implemented to some degree by the central government through INSALUD. In preparation for assuming health service competencies, however, almost all the "slow-track" regions, with the exception of Murcia, passed laws regulating health care (*leyes de salud*) or health care planning (*leyes de ordenación sanitaria*), which included some level of mandate that users be permitted to file claims and complaints regarding the NHS, and would be implemented after devolution. In particular, Extremadura legislated the right to complaint and suggestion procedures in Article 11.1n of its 10/2001 Health Care Law (Presidencia de la Junta de Extremadura 2001b) and mandated the creation of an ombudsman for patients of its RHS in Article 16 of this same law. At the same time, Madrid (in Title IV of Law 12/2001) stipulated the rights and duties of citizens with regard to the NHS, expanding the rights in their region to include, for example, the right to receive health care within defined waiting times, the right to give "advance care

directives", the right to access information from their medical records, and the creation of an ombudsman for patients (Presidencia de la Comunidad de Madrid 2001b).

4.2.6. Health System Decision-Space Map as of 2001

Table 4.3 shows the health system decision-space map for Extremadura and Madrid as of 2001.

Table 4.3. Health System Decision-Space Map for Extremadura and Madrid, as of 2001

Functional Areas Key Functions	**Range of Choice**		
	Narrow	**Moderate**	**Wide**
Service Organisation			
Contracts with private providers	No contracting with other organisations, defined by central government		
Hospital autonomy	Hospitals managed by INSALUD, defined by central government		
Targeting service delivery	Free access to public health services based on need, 1986 GHL		
Regulation and Planning			
Policy formulation	Defined by MOH, along with other central government ministries depending on the issue		
Norms and standards	The common health benefit package is defined by the MOH, along with the MOF (Royal Decree 63/1995)[a]		
Prescription drugs planning	Defined by the central government[b]		
Drugs and supplies (rationing)	Defined by the central government		
Infrastructure planning	Defined by the central government		
Health information systems design	Defined by the central government		
Financing			
Insurance schemes	NHS-style public health system, 1986 GHL[c]		
Payment mechanisms	Public health care providers payment mechanisms managed by central government		
Sources of revenue		Defined by the CPFF, which includes regional finance ministers; earmarked health financing is defined in consultation with the MOH; intergovernmental transfers fund almost all regional health expenditures[d]	
Revenue allocation (budgeting)		Resource allocation defined by INSALUD/MOH, in collaboration with deconcentrated field offices	
Income from fees	No fees for health services, as defined by the central government		

Functional Areas	**Range of Choice**		
Key Functions	**Narrow**	**Moderate**	**Wide**
Human Resources			
Salaries and benefits (permanent staff)	Defined by the National Civil Service		
Contracts (non-permanent staff)	Defined by the MOH's INSALUD		
Civil Service	Defined by the central government		
Education and training (pre-service)	Defined by the MOH, along with the MOEdu		
Education and training (continuing)	None		
Education and training (continuing)	None		
Governance and Stewardship Rules			
Facility boards	Defined by GHL and implemented by INSALUD		
Territorial health offices	Defined by GHL and implemented by INSALUD		
Public participation	Defined by GHL and implemented by INSALUD		
Patient/user rights	Defined by central government and implemented by INSALUD		
Complaint system	Defined by central government and implemented by INSALUD		

[a] The Fifth Additional Provision states that this Royal Decree does not affect the health activities and services provided by the regions, thereby offering them more choice; however, this opportunity would not be utilised by the "slow-track" regions during this period. [b] From 1998, Madrid implements central government pharmaceutical product legislation (Article 28, section 1.10 of Law 3/1983 (Jefatura del Estado 1983); updated by Law 5/1998 (Presidencia de la Comunidad de Madrid 1998)). [c] Mutual funds schemes exist for public sector employees; they analysis is beyond the scope of the thesis. [d] The regions were allowed to use their own resources or to use fees, taxes or other income to provide health services and activities in their territory. This opportunity offered the regions more choice, but none of the "slow-track" regions used these options during this period.

Note: One main difference between Madrid and Extremadura had implications for their financing and tax powers: for most of this period, Madrid followed the 1997–2001 regional financing agreement but Extremadura refused to adopt it and, *de facto*, continued to follow the 1992–1996 regional financing agreement.

4.3. The 2001 Health System Devolution to the "Slow-Track" Regions

Between 1996 and 1999, the ten "slow-track" regions modified their Statutes of Autonomy, giving them the means to exercise the health service competencies permitted in Part 20 of Article 148 of the Spanish Constitution.[93] To do so, they incorporated the following text:

> The executive function over the following matters corresponds to the Autonomous Community of _____: … Management of the health services of the social security system, in accordance with provision 17 of Article 149 of the Constitution, reserving for the State the role of high inspectorate over the performance of the function referred to in this provision.

For the regions, assuming health service competencies enjoined the development of the following new capabilities: (i) services and functions corresponding to health, assistance, and administrative centres and establishments taken over from Social Security, managed by INSALUD; (ii) inspection of the health services and management under the Social Assistance programme; (iii) the elaboration and execution of investments; (iv) contracting and managing agreements with other entities; (v) the creation, transformation, amplification, classification and suppression of health centres run by the Social Assistance programme; and (vi) planning programs and means of health care (Múzquiz Vicente-Arche 2002).

On 27 December 2001, as stipulated in Royal Decrees 1471-1480,[94] the Spanish central government transferred the functions and services of INSALUD to the ten remaining "slow-track" regions. A year prior to these Royal Decrees, the MOPA and the administrations of these regions formed joint working groups that negotiated the details of the transfer agreements, including the identification of which functions and services would be transferred, which would be reserved for the central government and which would be shared by both entities (Novinskey, Interview no. 05, 17, and 41). These decrees effectively devolved approximately 132,000 civil servants, 79 hospitals,

[93] Aragon modified its Statute of Autonomy in 1996 (Jefatura del Estado 1996), Castile-La Mancha in 1997 (Jefatura del Estado 1997), Cantabria, Madrid and Murcia in 1998 (Jefatura del Estado 1998a; 1998b; 1998c), and Asturias, the Balearic Islands, Castile Leon, Extremadura and La Rioja in 1999 (Jefatura del Estado 1999a; 1999b; 1999c; 1999d; 1999e).

[94] Royal Decree 1471/2001 regarding Asturias, 1472 Cantabria, 1473 La Rioja, 1474 Murcia, 1475 Aragón, 1476 Castile-La Mancha, 1477 Extremadura, 1478 the Balearic Islands, 1479 Madrid, and 1480 Castile Leon (Ministerio para Las Administraciones Públicas 2001a; 2001b; 2001c; 2001d; 2001e; 2001f; 2001g; 2001h; 2001i; 2001j).

1,087 health centres, and 12 billion euros[95] to these regions within six months (Múzquiz Vicente-Arche 2001).[96]

Parallel to the transfer agreement working groups, the CPFF worked on a new financing agreement for the regions, which was approved for the period after 2001 (Law 21/2001) (Jefatura del Estado 2001b). The new agreement, originally established for an indefinite period, integrated the general regional financing system and the NHS financing system into one system that aimed at attaining long-term financial stability, especially with regard to the NHS. Overall, it meant that regional expenditures would compose 45 per cent of total public health expenditures.[97] It also increased fiscal autonomy by granting new taxation powers to the regions (see the Financing section for 2002-2006 below).

Together, all of this legislation represented the "second wave" of health system devolution in Spain, and one of the most profound macro-organisational reforms it had ever experienced (Costa-Font and Rico 2006a). Importantly, it signalled the end of the period of asymmetric decentralization that had continued since the beginning of the implementation of the Constitution.[98] With regard to the NHS, Urbanos (2001) underscored that this reform effectively removed the earmarking of funds; from then on, allocating financial resources to health sector priorities would be the sole responsibility of the regions.[99] Because of this, some with a stake in the NHS feared that the regions might divert funds previously earmarked for health to other policy areas (Novinskey, Interview no. 23 and 36). In January 2002, the ten remaining "slow-track" regions began assuming responsibility for the management of their own health services, marking the end of the twenty-year process to devolve health service and system competencies to the regional level governments.

In the following section, I offer more information on the results of this reform and subsequent relevant legislation, giving an overall picture of the five functional areas of the NHS for the period 2002–2006.

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[95] Before negotiations this figure was originally intended to be 10.217 million euros, but the final transfer agreements with the regions cost approximately 12.1 million euros altogether.
[96] Law 16/2001 established an extraordinary process for the consolidation and provision of places for statutory personnel in the health institutions of the Social Assistance programme (Jefatura del Estado 2001d).
[97] The central government and the municipalities made up 40 and 15 per cent, respectively.
[98] Some asymmetry still exists with regard to the financing of the Basque Country and Navarra; e.g. because of their historic privileges, these regions retain full autonomy over their fiscal policy.
[99] The only exception was the minimum mandatory amount of regional health expenditures (European Observatory on Health Care Systems 2002).

4.4. National Health System Functions for the "Slow-Track" Regions, 2002–2006

4.4.1. Service Organisation

In addition to the above-mentioned 2001 health system devolution legislation, in terms of service organisation, Royal Decree 840/2002 modified the organisational structure and roles of the central government's health sector entities (Ministerio para Las Administraciones Públicas 2002).[100] First, the MOH assumed the role of steering body and inspector of the NHS and the CISNS became the chief coordinating body of the whole system. Then, INSALUD's name was changed to the National Health Management Institute (*Instituto Nacional de Gestión Sanitaria*, INGESA) and it took on a reduced role as manager of health services for the autonomous cities of Ceuta and Melilla and of related administrative activities.

A year later, the roles and organisation of directorates within the MOH and of the CISNS were later refined by what was arguably the most important health regulation affecting the NHS during this period of study: the 16/2003 Law on the Cohesion and Quality of the NHS (LCQ) (Jefatura del Estado 2003b). Chapters IX through XI of the LCQ refined the mandates of three NHS bodies: the CISNS for coordination, the NHS High Inspectorate (*Alta Inspección*) role for quality, and the NHS Council for Social Participation (*Consejo de Participación Social*) for the public's participation in the NHS.

More specifically, with the LCQ, the CISNS assumed a new role as overseer of the NHS's coordination, cooperation, communication and information activities (Article 69). In its role as the principal organising instrument of the NHS, the CISNS was given the power to debate issues related to, and to adopt recommendations for, the organising, advising, planning, evaluating and coordinating functions of the NHS as well as facilitating cooperation between the central government and regions (Article 71). The CISNS's status as a non-executive, advisory body, whose agreements are approved by consensus, remained unchanged (Article 73). Its general aim was to address issues regarding the competencies of both the MOH and the regions. However, as noted by Repullo Labrador et al. (2004), its lack of executive power has created some efficiency problems. Finally, the CISNS was authorised to create commissions and working groups to study and develop recommendations on issues within its

[100] This Royal Decree was later modified by Royal Decree 1087/2003, which established the organisational structure of the MOH (Ministerio para Las Administraciones Públicas 2003).

purview (Article 74). To carry out these new roles and tasks, the composition of the CISNS underwent a significant change to reflect the post-devolution (non-hierarchical) distribution of health service powers, reducing the number of voting members from thirty-four to eighteen by removing all central government representation except the Minister of Health, who remained the Council's president.[101] Article 70 stipulated that the seventeen regional health ministers would now elect one of their number as vice president.

In practice, the character and functioning of the CISNS was mixed during this period. An MOH interviewee mentioned that he thought, "The [CISNS] has always worked well on certain topics. [For example,] it is working with the Basic Minimum Data Set [and] the hospital information system" (Novinskey, Interview no. 36). At the same time, a regional stakeholder mentioned that "in reality, [the CISNS is] an instrument more at the service of the MOH for central policies of the ministry that have to do with the [health care] services and need to reach a consensus with the Autonomous Communities…it has not served as a coordination or cooperation instrument among the decentralized Communities" (Novinskey, Interview no. 27). An academic interviewee in a similar statement agreed with this assessment (Novinskey, Interview no. 29). An interviewee from a health association outside the government suggested that, "the CISNS does not work because they only try to stick it to each other politically…so, health problems are not raised" (Novinskey, Interview no. 34). Another regional interviewee went further, calling CISNS meetings "very violent" at times when the central government tries to establish obligations for the Autonomous Communities without offering additional financing (Novinskey, Interview no. 38). At the same time, an MOH official explains, "conflicts arise either because the MOH believes that there are rules that are not adhered to, or because a Community believes that some MOH norm invades their competencies" (Novinskey, Interview no. 04).

In addition, the LCQ gave the MOH the role of High Inspectorate over NHS responsibilities at all levels of government as stipulated in the Constitution, Statutes of Autonomy and other laws (Article 76). This role encompassed the following functions: (i) monitoring the integration of regional health plans and programs with the general

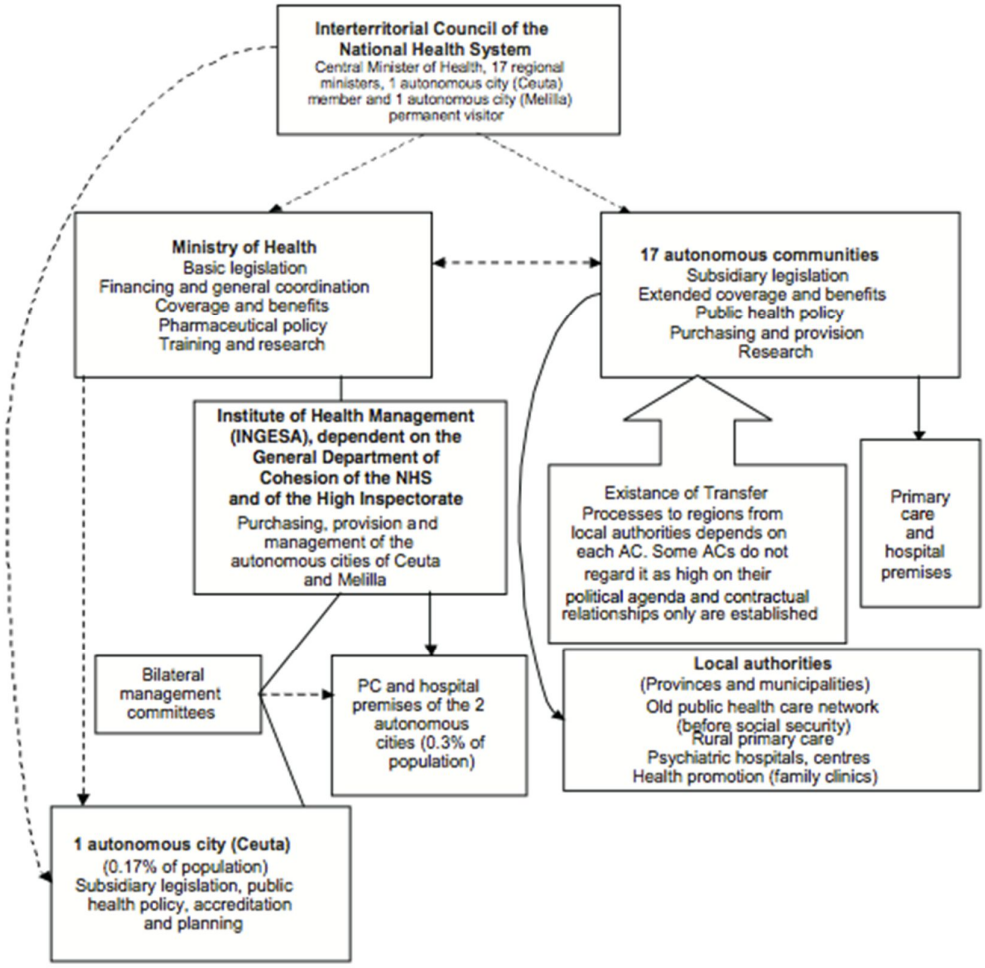
[101] As of February 1997, the representatives from the autonomous cities of Ceuta and Melilla were invited to attend. In April 1999, the representative from Ceuta became a member of the Council. As of the 2003 LCQ, the Under Secretary of Health and Consumer Affairs and the Director-General of Cohesion of the NHS and High Inspection are allowed to attend the Council meetings with voice but without vote.

objectives of the central government; (ii) evaluating compliance with the NHS's goals and objectives, including those defined in agreements made by the CISNS; (iii) monitoring the implementation and utilisation of central government funds and subsidies allocated to the regions; (iv) ensuring that funds for regional health services are utilised according to the general principles of this law, (v) ensuring proper operation of previously central government-owned health centres, services or establishments; (vi) verifying the absence of all types of discrimination in the NHS; and (vii) monitoring all health competencies and ensuring that their delivery incorporates the democratic participation of all stakeholders. In the event that the NHS Inspectorate were to find a regional health service to be non-compliant with any of its health functions, it would first give a warning; and, then, if the non-compliance continued, it would formally require the region to take the necessary measures to become compliant. Furthermore, the NHS Inspectorate seeks to prevent all forms of fraud, corruption and deviation in health benefits and services in the public sector (Article 79).

Finally, the LCQ stipulated that the MOH would create and regulate the NHS Council for Social Participation (*Consejo de Participación Social del Sistema Nacional de Salud*) to ensure the participation of citizens and professionals in the NHS. Accordingly, this Council's main role was to provide a permanent channel of communication between health sector authorities, professional and scientific societies, trade unions, businesses and users. The LCQ also established that this Council would ensure public participation in the NHS through an Advisory Committee (*Comité Consultivo*), an Open Health Forum (*Foro Abierto de Salud*) and a Virtual Forum (*Foro Virtual*). The Advisory Committee would be presided over by a representative of the General Administration of the State (*Administración General del Estado*), designated by the Minister of Health. Its members would be appointed, consisting of six representatives from the General Public Administration, six from the regions, four from local administrations, eight from business organisations and eight from the main national trade unions. The Open Health Forum would be an instrument that could be utilised by the Minister of Health to study, debate and formulate proposals on specific NHS issues. Accordingly, representatives from organisations corresponding to the issues under discussion would participate in this forum. The Virtual Forum would be a forum, accessible to the public through the MOH's website. Furthermore, Article 68 of the LCQ gave the MOH responsibility for creating networks for the exchange of experiences and knowledge in the areas of health information, promotion and

education, health technology evaluation, and public health and health care education and training, among other things. Figure 4.3 illustrates the organisation of the Spanish NHS for 2002–2006.

Figure 4.3. Organisation of the Spanish NHS, 2002-2006



Source: Durán et al. (2006, 20). AC = autonomous community or region.

The LCQ also altered the MOH's organisational structure by eliminating a number of its general sub-directorates and creating the Agency for NHS Quality (*Agencia de Calidad del Sistema Nacional de Salud*), the Health Information Institute (*Instituto de Información Sanitaria*) and the NHS Observatory (*Observatorio del Sistema Nacional de Salud*). The Agency for NHS Quality, created by Article 60, was established to elaborate and maintain the elements of the NHS's health care quality infrastructure. Its main activities include performing periodic external audits of health institutions and services and accrediting public and private health institutions. More information about the NHS Observatory (Article 63 of Law 16/2003) and Health

Information Institute (Article 58 of Law 16/2003) can be found in the Regulation and Planning section below.

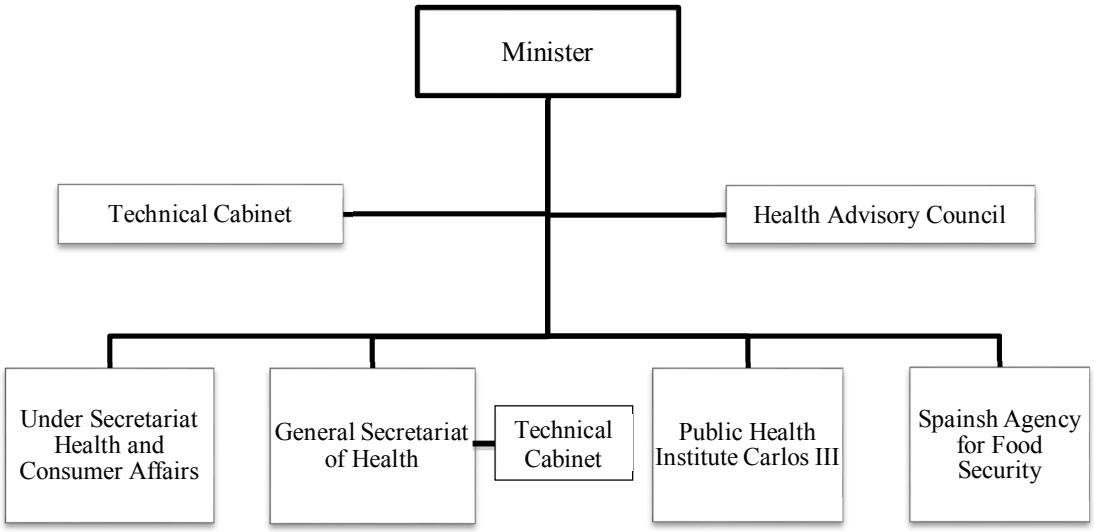
A year later, the MOH underwent another significant internal restructuring as mandated by three Royal Decrees (Ministerio para Las Administraciones Públicas 2004a; 2004b; Presidencia del Gobierno del Estado 2004). In particular, Article 15 of Royal Decree 553/2004 integrated the Government Delegation for the National Plan for Pharmaceuticals (*Delegación del Gobierno para el Plan Nacional de Drogas*) into the organisational structure of the MOH. Article 14 of Royal Decree 562/2004 restructured the MOH's Under Secretariat of Health and Consumer Affairs (into a General Technical Secretariat and General Directorates of Pharmacy and Health Products, of Human Resources and Economic-Budgetary Services, and of Consumer Affairs and Customer Care) as well as its General Secretariat of Health (into the General Directorates of Public Health, of NHS Cohesion and Inspection and—at the same level of organisation—the Agency for NHS Quality and the Government Delegation for the National Plan for Pharmaceuticals). See Figures 4.4, 4.5, and 4.6 for basic organograms. Finally, Royal Decree 1555/2004 further developed the basic organisational structure of the MOH into sub-directorates, incorporating an adequate and coherent structure consistent with the 2001 health system devolution and following the efficiency and efficacy requirements established by Royal Decree 1449/2000 of the Ministry of Interior (Ministerio para Las Administraciones Públicas 2000). Meanwhile, the MOH's joint management functions with the MOEdu, MOF and MOPA in defined areas of health remained the same. The organisational structure of MOH outlined in these Royal Decrees remained in effect through 2006 and beyond.

Once the "second wave" of health system devolution was completed, all regions enjoyed wide discretion over service organisation functions within their respective territories.[102] In anticipation of this new discretion over health services, Madrid passed

[102] The role of the municipalities was not affected by the 2001 health system devolution, nor was it changed at any point between 2002 and 2006. After the regional elections of 2003, twelve regions began to exercise their wide discretion by considerably modifying the organisational structure of their RHMs. All twelve added a planning office to the existing organisation of their RHM and RHS. Four of them added top-level offices to address pharmaceutical issues and one has a similar office subordinate to its human resources office. Moreover, in 2003, most regions transferred responsibilities for social and consumer affairs previously assigned to their RHMs to other regional ministries. The regions also converted the general manager positions of hospitals and primary care centres into political appointments. See the following laws: Andalusia, Law 2/1998 (Presidencia de la Junta 1998); Aragon, Law 2/1989, modified by Law 2/2004 (Departamento de Salud y Consumo 2005; Presidencia de la Diputación General de Aragón 1989) and Law 6/2002 (Presidencia del Gobierno de Aragón 2002); Asturias, Law 1/1992 (Junta General del Principado de Asturias 1992); the Balearic Islands, Law 5/2003 (Presidencia del Gobierno de Las Illes Balears 2003); the Basque Country, Law 8/1997 (Presidencia del

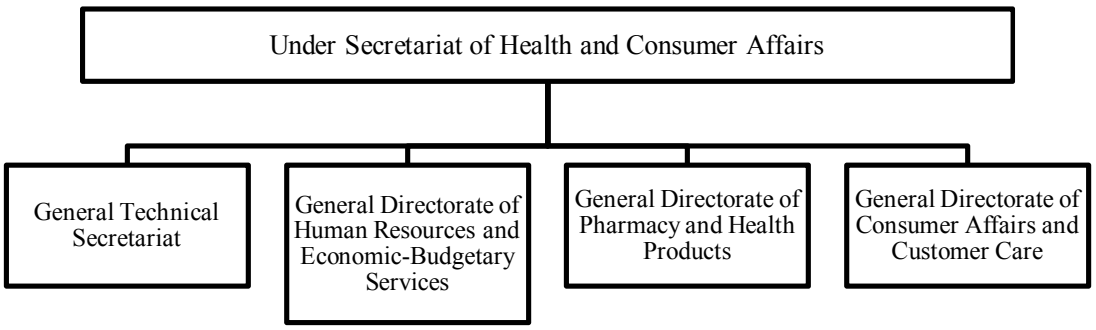
Law 12/2001 (Presidencia de la Comunidad de Madrid 2001b) on the establishment of its health system (*Sistema Sanitaria de la Comunidad de Madrid*). This law

Figure 4.4. Basic Organogram of the MOH, ca. 2006



Source: www.msc.es, accessed in 2006. This chart is not exhaustive and includes only those units, agencies and directorates mentioned in the text.

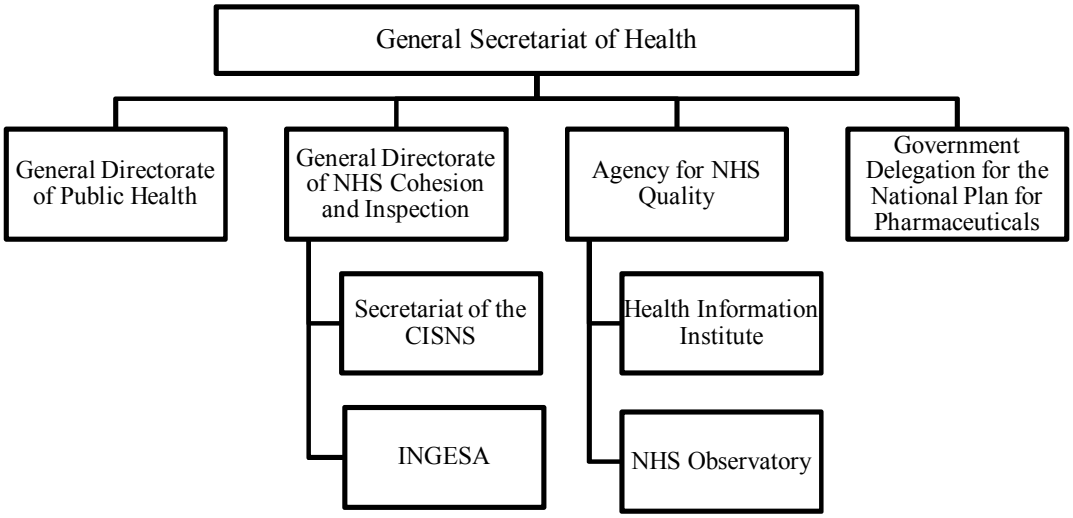
Figure 4.5. Organogram of the Under Secretariat of Health and Consumer Affairs, ca. 2006



Source: www.msc.es, accessed in 2006. This chart is not exhaustive and includes only those units, agencies and directorates mentioned in the text.

Gobierno Vasco 1997); Canary Islands, Law 11/1994 (Presidencia del Gobierno de Canarias 1994); Cantabria, Law 7/2002 (Parlamento de Cantabria 2002); Castile-La Mancha, Law 8/2000 (Presidencia de la Junta de Comunidades de Castilla-La Mancha 2000); Castile Leon, Law 1/1993 (Comunidad Autónoma de Castilla y León 1993); Catalonia, Law 15/1990 (Presidencia de la Generalidad de Cataluña 1990); Extremadura, Law 12/2001 (Presidencia de la Junta de Extremadura 2001b); Galicia, Law 7/2003 (Comunidad Autónoma de Galicia 2003); Madrid, Law 12/2001 (Presidencia de la Comunidad de Madrid 2001b); Murcia, Law 4/1994 (Asamblea Regional de Murcia 1994); La Rioja, Law 4/1991 (Diputación General de La Rioja 1991).

Figure 4.6. Organogram of the General Secretariat of Health, ca. 2006



Source: www.msc.es, accessed in 2006. This chart is not exhaustive and includes only those units, agencies and directorates mentioned in the text.

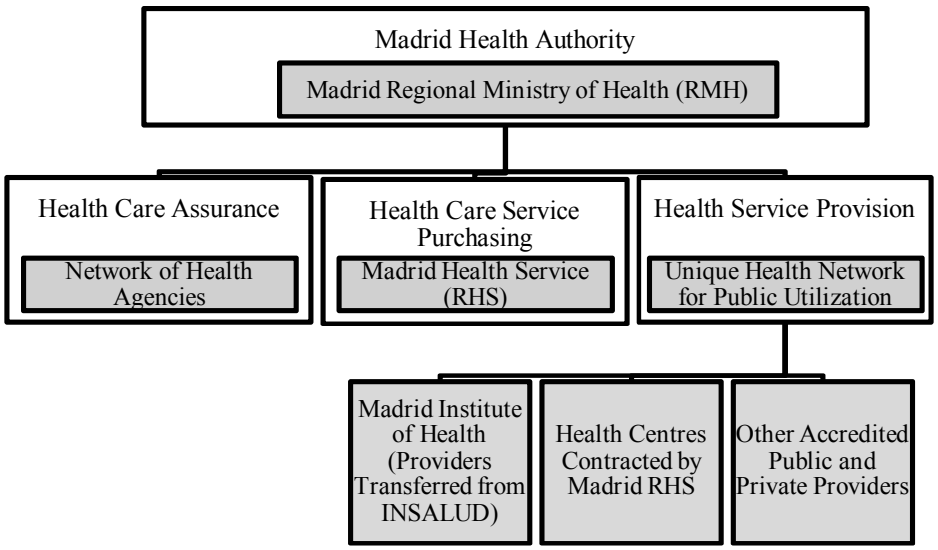
set up the administrative and bureaucratic functions of the health system as well as its health services. It envisioned an innovative separation of functions between health care assurance, purchasing and provision.[103] Accordingly, it instituted the Madrid Ministry of Health (*Consejería de Sanidad de la Comunidad de Madrid,* Madrid RMH) as the main health authority (*autoridad sanitaria*) for the area. Under this authority, it established the Network of Health Agencies of the Community of Madrid (*la Red de Agencias Sanitarias de la Comunidad de Madrid*) to carry out the function of health care assurance, with the tasks of guaranteeing the population's right to health care, regulating the health system, and monitoring, inspecting, evaluating and accrediting health services, providers and institutions. Also under the Regional Ministry of Health, the law created the Madrid Health Service (*Servicio Madrileño de Salud*, Madrid RHS) to carry out the purchasing functions of its health system and provide an adequate organisation and allocation of the budget to health services for the population. Finally, this law created the Unique Health Network for Public Utilisation (*Red Sanitaria Única de Utilización Pública*), composed of all of the publicly-funded health care providers, including (i) those whose management was transferred from INSALUD to the newly

[103] According to law 12/2001, this separation was an important innovation relative to the health model of other regions. It provided a much-needed connection between health care purchasing and planning based on health needs, as developed in the State of Population Health Report (*Informe del Estado de Salud de la Población*). It also adopted a model of patient-centred care.

created Madrid Institute of Health (*Instituto Madrileño de la Salud*), (ii) the health centres contracted by the Madrid RHS, and (iii) other accredited public and private providers that may provide services to the public system. It was envisioned that the Madrid RHS would purchase services from health care providers in this Unique Health Network. See Figure 4.7 for a summary of Madrid's health system organisational structure in 2002.

The Community of Madrid further applied its newly found discretion established by Law 12/2001[104], making several modifications to the organisational structure of its health system. For example, the organisational structure of the Madrid RHM was established by Decree 1/2002, which was successively repealed and replaced by Decrees 10/2004, 120/2004 (later modified by Decree 15/2005) and 100/2005 of the Governing Council of Madrid (Consejo de Gobierno 2004a; 2004c; 2005c).[105] At the same time, the organisational structure of the Madrid RHS was established by Decree 121/2004

Figure 4.7. Madrid's Health System Organisation, ca. 2002

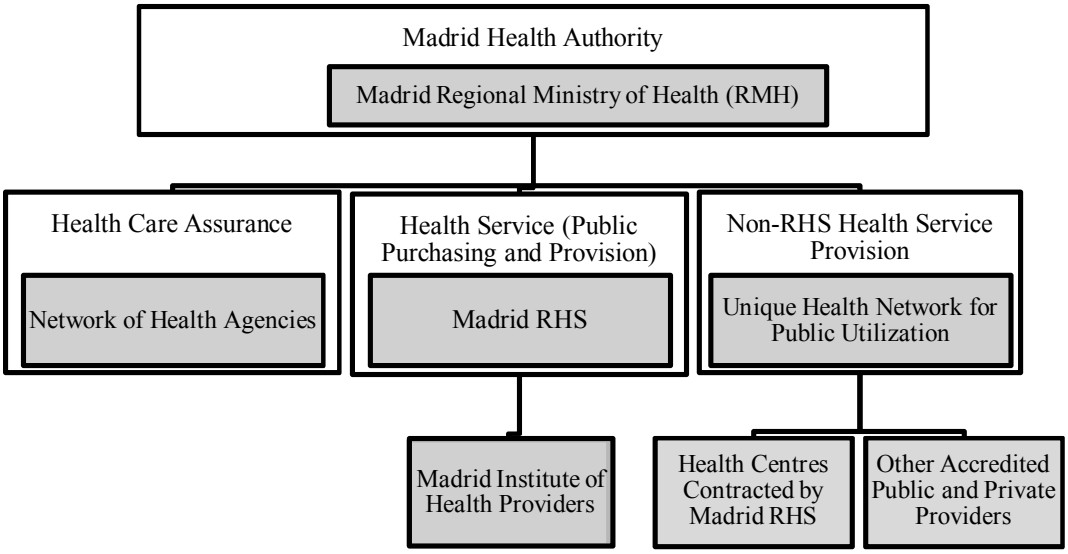


Source: www.madrid.org, accessed in 2006. This chart is not exhaustive and includes only those units, agencies and directorates mentioned in the text.

[104] Partially modified later by Law 7/2004 (Presidencia de la Comunidad de Madrid 2004).
[105] These provisions remained in effect until Decree 22/2008 (Consejo de Gobierno 2008a).

and later repealed and replaced by Decree 16/2005, following the integration of the Madrid Institute of Health into the Madrid RHS by Decree 14/2005 (Consejo de Gobierno 2004d; 2005a; 2005b).[106] Accordingly, the organisational structure of the previously established Madrid Institute of Health was repealed and replaced by Decree 197/2002 (which was modified by 48/2003) and later itself repealed and replaced by 123/2004, until its dissolution as a single public entity and its integration into the Madrid RHS via the above-mentioned Decree 14/2005 (Consejo de Gobierno 2002; 2003b; 2004e). See Figures 4.8 and 4.9 for an illustration of the Madrid's health system after these changes.

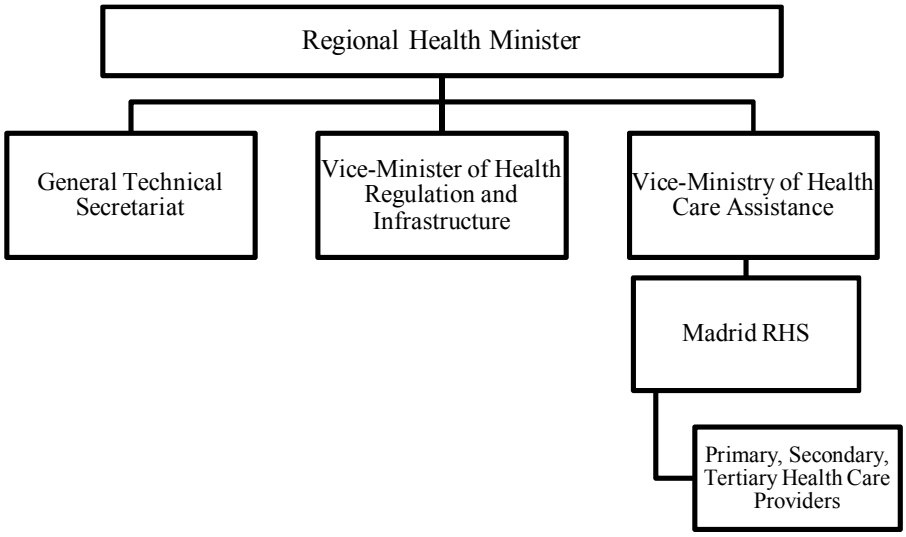
Figure 4.8. Madrid's Health System Organisation, ca. 2006



Source: www.madrid.org, accessed in 2006. This chart is not exhaustive and includes only those units, agencies and directorates mentioned in the text.

[106] These provisions remained in effect until Decree 23/2008 (Consejo de Gobierno 2008b).

Figure 4.9. Basic Organogram of the Madrid RHM, ca. 2006



Source: www.madrid.org, accessed in 2006. This chart is not exhaustive and includes only those units, agencies and directorates mentioned in the text.

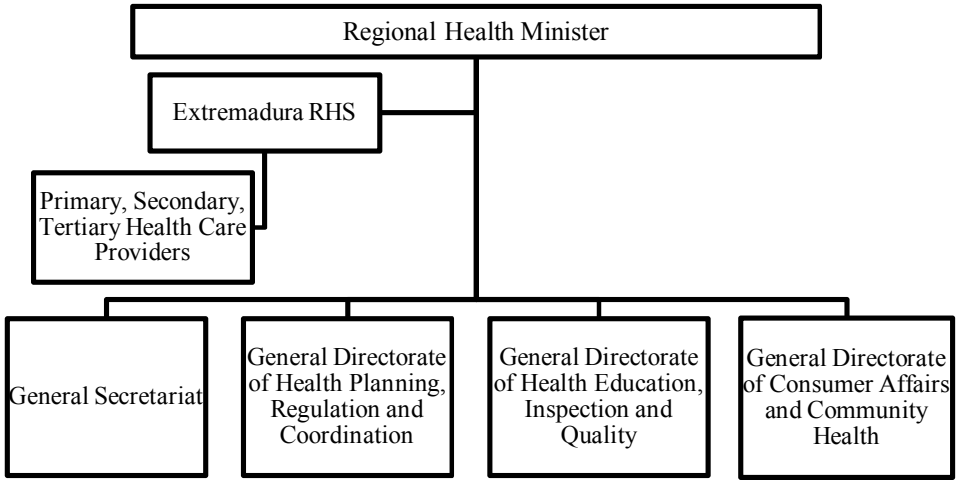
Turning to Extremadura, which in its Health Law 10/2001 established the constitution and foundation for the organisation of its public health system (*Sistema Sanitario Público de Extremadura*) prior to, and in preparation for, the actual transfer of health service competencies from INSALUD (Presidencia de la Junta de Extremadura 2001b). This Law adjusted the previous Decree 4/1999, through which the President of the Government of Extremadura (*Junta de Extremadura*) ordered the creation of the Extremadura Ministry of Health and Consumer Affairs (*Consejería de Sanidad y Consumo de Extremadura*, Extremadura RHM), to accommodate the new regulatory framework and competencies (Presidencia de la Junta 1999). It also newly created the Extremadura Health Service (*Servicio Extremeño de Salud,* Extremadura RHS) and regulated its organisational structure so that it could receive the health resource transfers from INSALUD. Importantly, Law 10/2001 mandated a separation of powers between the health authority's control over the health system (to be carried out by the RHM) and service provision (to be carried out by the RHS). The former is in charge of regulation and strategic planning of the regional health system, while the latter is in charge of operational planning, management of the services network and coordination of health care provisions across Extremadura. This Law also established the Extremadura Council for Health (*Consejo Extremeño de Salud*) as the highest consultative board in the system. Finally, it regulated the organisational structure of the

Extremadura RHS into Health Areas and Basic Health Zones, and stipulated the composition, powers and functions of the Health Area Councils (*Consejos de Salud de Área*).

Extremadura continued to apply its wide discretion in deciding the organisational structure of its regional health system and services through several modifications of Law 10/2001. For example, the organisational structure of the Extremadura RHM established by Law 10/2001 was repealed and replaced by Decree 210/2001, to more adequately reflect the assumption of health service competencies (Consejería de Presidencia 2001b). This decree was repealed and replaced by Decree 80/2003, which was then modified by Decree 152/2005, ultimately increasing the number of actual jobs available to match those necessary for eventual staff in the Government of Extremadura (Consejería de Presidencia 2003a; 2005g). These decrees remained in effect for the period under study. On the same day as it received health service competencies, Extremadura passed Decree 209/2001, approving the Statutes of Autonomous Organisation (*Estatutos del Organismo Autónomo*) of Extremadura's RHS and re-establishing it (from Law 10/2001) according to the statutes and as a public entity (Consejería de Presidencia 2001a). The Statutes of the Extremadura RHS were modified by Decree 81/2003 and remained in effect during the period of study (Consejería de Presidencia 2003b).[107] The organisational structure of the Extremadura RHS was modified with Decree 189/2004, with changes to the organisational structure of its Health Areas and to the composition, powers and functions of the Health Area Councils (Consejería de Sanidad y Consumo 2004b). The organisational structure of the Extremadura Council for Health was also repealed and replaced by Decree 88/2002 (Consejería de Sanidad y Consumo 2002).[108] See Figure 4.10 for the organogram of Extremadura's RHM as of 2006.

[107] The organisational structure of the Extremadura RHS was repealed and replaced by Decree 221/2008 so that it would be in accordance with the newly named RHM, Department of Health and Dependence, and its new functions and competencies (Consejería de Administración Pública y Hacienda 2008).
[108] This was later modified by Decree 216/2013 (Consejería de Sanidad y Consumo 2013).

Figure 4.10. Basic Organogram of the Extremadura RHM, ca. 2006



Source: www.saludextremadura.com, accessed in 2006. This chart is not exhaustive and includes only those units, agencies and directorates mentioned in the text.

4.4.2. Regulation and Planning

In this section, I review some additional regulatory aspects of the NHS as well as key aspects of health planning and the health care benefit package that have changed since devolution. The 2001 health system devolution transferred regulatory and planning authority over health services from the central government to the "slow-tracked" regions. The MOH remained the nation's supreme health authority, but with a greater focus on guaranteeing the cohesion and quality of health services across the country. As one stakeholder stated, "the State establishes the requirements and the Autonomous Communities are to develop their respective norms latter" (Novinskey, Interview no. 26). In this capacity, the MOH and other central government authorities in charge of regulating the sector passed several regulations during this period (see Table 4.4). Although it no longer had exclusive control over regulation and planning of health services, through its National Constitutional Court the central government still accepted appeals regarding the unconstitutionality of regulations promulgated by either the central government or the regions.

Table 4.4. Principal Health Regulation of the Spanish Central Government, 2002–2006

Law 41/2002	Patient autonomy, rights and duties regarding medical information and records
Law 16/2003	Cohesion and quality of the NHS
Law 55/2003	Framework statute covering statutory professionals in the health services
Law 44/2003	Regulation of health professionals
Law 28/2005	Measures against tobacco consumption and regulating the sale, distribution, consumption and publicity of tobacco products
Law 29/2006	Guarantees and rational use of pharmaceuticals and health products

Sources: Jefatura del Estado (2002; 2003b; 2003a; 2003c; 2005; 2006c)

While all of the laws passed by the central government during this period warrant attention, Law 16/2003 on the Cohesion and Quality of the NHS is probably the most important national-level regulation regarding the regulatory and planning functions of the NHS. The main purpose of the LCQ was to update and complement the 1986 GHL framework and refine the NHS's operations now that health system devolution had been completed. The LCQ had three main objectives. The first was to promote coordination and cooperation, and ultimately to guarantee cohesion, among the RHSs as well as between them and the central government. The second was to facilitate the overall improvement of NHS's quality. The third was to integrate public participation in the NHS officially, respecting the autonomous decision-making of individuals over their own health, considering the overall population's expectations of the NHS and facilitating the exchange of knowledge and experiences from the population. To do this, the LCQ described the NHS within the context of the 2001 devolution, refining, redefining and clarifying those NHS elements that were common across all regions. For example, it redefined the health care benefit package that each region was obligated to offer its populations (further discussed later in this section). The LCQ also regulated the mobility of health professionals across regions. In addition, it updated issues pertaining to research and development in the health sector and it addressed the development of health management information systems. Finally, the LCQ introduced two main innovations for coordinating and facilitating cooperation between the MOH and the regions. The first of these established Comprehensive Health Plans for the NHS to be carried out jointly by the central government and the

regions, as a function of the CISNS (further explained below). The second innovation outlined different strategies for cooperation among public health authorities.

Since 2001, the regions have approved several health care regulations, mainly addressing organisational structure, human resources and financing issues. The most common policy issues included the role and accreditation of private health services, the working conditions of health personnel and mental health issues.[109] Importantly, all regions have had the ability to regulate third-party payers (primarily their own RHSs, but also contracted private health care providers). Madrid, for example, impressively exercised its new authority by enacting more than 50 pieces of legislation regarding the health sector.

In the following, I present details on how health plans and the health care benefit package regulation and planning has changed from the "second wave" of health system devolution until 2006, focusing on legislation produced by Extremadura and Madrid.

4.4.2.1. Health Plans: As stipulated in previous laws (the 1986 GHL, Royal Decree 63/1995 and the 2003 LCQ), the MOH and the regions were mandated to develop Comprehensive Health Plans jointly as a principal instrument for priority setting according to the needs of the region's population. In addition, the 2003 LCQ established a framework for monitoring and improving the quality of health care nationwide, called the NHS Quality Plan (*Plan Calidad Sistema Nacional de Salud*). Since its publication in March 2006, this Plan has been the MOH's main instrument for establishing and communicating norms and standards for the practice of quality health care in the regions. The 2006 NHS Quality Plan, in particular, set six action areas with a total of twelve strategies for achieving the goals of those areas (see Table 4.5) as well as 41 objectives and 189 projects (Ministerio de Sanidad y Consumo 2006e). It provided funding of 50 million euros for 2006. The plan was updated in April 2007.[110]

[109] Mental health competencies lie in the hands of provincial and municipal authorities, but their integration into the organisational structures of the RHMs has often been discussed.
[110] The 2007 plan did not change the action areas or strategies, although the number of objectives and projects changed to 40 and 197, respectively, and the fiscal allocation rose to 50.5 million euros for 2007. This plan remained in effect until 2010, when the next version was released (Ministerio de Sanidad, Política Social e Igualdad 2010).

Table 4.5. The 2006 NHS Quality Plan, Areas and Strategies for Action

Areas for Action	**Strategies for Action**
Protection, health promotion, and prevention	1. Protect health
	2. Health and life habits
Foster equity	3. Boost health policies based on good practice
	4. Analyse health policies and propose actions for reducing health inequities with an emphasis on gender inequalities
Support the planning and development of human resources for health	5. Better match human resources to health service needs
Foster clinical excellence	6. Evaluate clinical technologies and procedures as a pillar of clinical decisions and management
	7. Accredit and audit health centres and services
	8. Improve patient security in the NHS's health centres
	9. Improve patient health care with a determined pathology
	10. Improve clinical practice
Utilise information technology to improve health care	11. On-line Health
Greater transparency	12. Design a reliable, timely and accessible NHS information system

Source: Ministerio de Sanidad y Consumo (2006e), author's translation.

As of 2006, all regions had published at least one multi-year Comprehensive Health Plan, integrating items from epidemiological and demographic needs-based planning, infrastructure and capital investment planning, and human resource planning. In their second generation of plans, the regions refined the objectives in number and composition as well as the scope, indicators and evaluation systems, making them more realistic and attainable over time (SESPAS 2002).

Extremadura published two plans during this period, lasting four years each: 2001–2004 and 2005–2008 (Consejería de Sanidad y Consumo 2001; 2005b; Europa Press 2009). The 2005–2008 Extremadura Health Plan – the region's third health plan, but the first one created after the 2001 devolution – was impacted particularly by Decree 96/2004, which established the basic norms for elaborating, monitoring and evaluating the plan to develop it in an efficient and effective way (Consejería de Sanidad y Consumo 2004j). Accordingly, the Extremadura RHM began implementing

the plan by creating an information system to monitor the objectives and their achievement. Overall, the 2005–2008 plan focuses on the most prevalent health needs and problems of Extremadura's population, proposing 22 priority intervention areas, 66 specific objectives and 365 strategic lines of action as well as their corresponding evaluation criteria and the bodies or units responsible for their development (Junta de Extremadura 2004). For implementation of continuous improvement of health care quality, this plan outlined a strategic axis, including the incorporation of new technologies. *De facto*, an Extremadura stakeholder highlights, "the most striking leap we have taken has everything to do with technology…diagnostic and therapeutic technology...hemodynamic units…in vetro fertilization units…lithotripsy…technology is suddenly here" (Novinskey, Interview no. 01).

Complementary to the Extremadura Health Plan, Extremadura took several other planning actions. For example, the Extremadura RHS created its own strategic plan for 2005–2008 (Servicio Extremeño de Salud 2006a). In addition, the Extremadura RHM created the Framework Plan for Social-Health Services 2005-2010 (Consejería de Sanidad y Consumo and Consejería de Bienestar Social 2005). As actions towards the creation of a Comprehensive Plan on Cardiovascular Diseases in Extremadura (2007–2011), Extremadura also passed Decree 157/2005, establishing the Advisory Council on Cardiovascular Diseases in Extremadura (*Consejo Asesor sobre Enfermedades Cardiovasculares de Extremadura*), and appointed twenty-three members to this Council on 29 May 2006 (Consejería de Sanidad y Consumo 2005k; 2006i). It also passed Order 18 July 2006, establishing quality standards for health centres, services and establishments and a standard model of health care quality accreditation for them (Consejería de Sanidad y Consumo 2006l). Furthermore, during 2006, the Extremadura RHM began elaborating a Comprehensive Plan Against Cancer, an Education Framework Plan for Health, a Comprehensive Plan for Mental Health 2007–2011 and a Plan for the Humanisation of Health Services in the Extremadura Public Health System, as well as developing several other plans on specific health care and disease prevention areas in 2006 (Consejería de Sanidad y Consumo 2006b; Consejería de Sanidad y Dependencia 2007a; 2007b; 2007c). See Table 4.6.

At the same time, Madrid published only one plan spanning 10 years (1995–2004) and then proceeded to make several specific plans for specific illnesses and diseases or areas of health and disease prevention. Table 4.7 lists Madrid's active plans for 2005–2006.

Table 4.6. Development of Plans for Specific Health and Disease Prevention Areas in Extremadura, 2006

Education plan for health sciences
Comprehensive plan on drugs (e.g. detoxification programs)
Programs for health promotion and disease prevention (e.g. school health programs, HIV/AIDS programs)
Food security (e.g. health inspection and control of food retail establishments)
Zoonosis' (e.g. programme against brucellosis)
Environmental health and sanitation (e.g. sanitation of the public water supply)
Health inspection and control in camping grounds and hotels

Source: Consejería de Sanidad y Consumo (2006 Anexo Junta de Extremadura).

Table 4.7. Active Health Plans for Madrid, 2001–2006

Health Plan	**Year(s)**
Regional programme for the prevention and control of tuberculosis	2000–2003[a]
Comprehensive programme for detection of and advice on familiar breast cancer	2001–
Plan against social exclusion	2002–2006
Plan of continued education for health professionals	2002–2006
Plan for the elimination of measles	2002–2012
Breast cancer screening programme	2003–
Mental health plan	2003–2008
Action programme for the prevention and improvement of Diabetes Mellitus	2005–
Comprehensive plan for cancer control	2005–
II plan of action against HIV/AIDS	2005–2007
Action plan for the disabled	2005–2008
Support plan for families	2005–2008
Comprehensive action plan against gender violence	2005–2008
Plan for infant and adolescent health care	2005–2008
Integration plan (of immigration)	2006–2008
System of monitoring and control for nosocomial (hospital-acquired) infection	RHM Order 1.087/2006
Plan for the surveillance and control of Hepatitis C	n/a

[a] Since then, Madrid continues to maintain the activities established in the programme.

Sources: Informes, Estudios e Investigación (2007 Anexo Comunidad de Madrid; 2008 Anexo Comunidad de Madrid); Observatorio SNS (2005 Anexo Comunidad de Madrid; 2006 Anexo Comunidad de Madrid), author's translation.

4.4.2.2. Health Care Benefit Package: The common health benefit package for this period was based on the list of services defined by Law 16/2003 and Royal Decree 1030/2006 in addition to the previously mentioned Royal Decree 63/1995 (Ministerio de Sanidad y Consumo 1995a; 2006d; Jefatura del Estado 2003b). Law 16/2003 established that the common health benefit package would be guaranteed to all Spanish

residents, independent of where they reside. It newly added the areas (and corresponding interventions) of public health and geriatric care within the common package as well as pharmacy, orthoprosthesis, dietary products and medical transport. Within the area of specialised care, it included a new explicit reference to home health care services. Law 16/2003 also established a general procedure for updating the list of services, involving the Agency for the Evaluation of Health Technologies (*Agencia de Evaluación de Tecnologias Sanitarias*) of the Health Institute Carlos III to evaluate new health care techniques, technologies and procedures, and the Health Cohesion Fund (*Fondo de Cohesión Sanitaria*) to finance research on health techniques, technologies and procedures before they are added to the health care benefit package. It stipulated that new benefits would be included in the package through a Royal Decree and, it stated in its Single Transitional Provision that until this Royal Decree was approved, Royal Decree 63/1995 would remain in effect. In September of 2006, Royal Decree 1030/2006 established this new common health benefit package as well as the procedure for updating it. Article 6 of this Royal Decree stipulates that, with previous approval from the CISNS, the MOH can draft in detail the content of the common package. Articles 7 and 8 of the decree describe the procedure for updating the common package: the update is proposed by Ministerial Order of the NHS with previous approval from the CISNS, and then submitted to the Commission for Health Services, Assurance and Financing of the MOH. The MOH gives final approval of the package, with previous approval from the CISNS. Royal Decree 1030/2006 was updated by Order SCO/3422/2007 (Ministerio de Sanidad y Consumo 2007). In addition, Law 29/2006 regulated the guarantee and rational use of pharmaceutical medicines and health products (Jefatura del Estado 2006c).

Regarding entitlement to the common health benefit package, during this period, there were few additional changes to the criteria previously defined by either the central government or the regions. A ruling by the European Court of Justice expanded the realm of application of the common benefit package. On April 12, 2005, that court mandated that the National Institute of Social Security and INGESA to reimburse all medical expenses of a Spanish resident incurred in another country (outside the European Union) as long as the person was employed or self-employed in Spain and otherwise entitled to such benefits (European Court of Justice 2005). At the regional level, Extremadura regulated its offer of health service provisions to foreigners

residing in its territory through Decree 31/2004 (Consejería de Sanidad y Consumo 2004h).[111]

After the 2001 devolution, all regions had the power to make certain decisions regarding the common health benefit package provided to their populations. Although obligated to provide coverage for all benefits in the common package, they could decide how much financing to allocate for each benefit. The regions could also incorporate additional health activities and benefits into the benefit package offered to their populations, including some that were explicitly excluded from the common package by Royal Decrees 63/1995 and 1030/2006, and by Law 16/2003. However, the regions would have to use their own resources to fund these extra benefits.

During the period 2002–2006, Extremadura added a number of health benefits to its package. In an Order of 17 March 2004, it defined the organisation, procedures and criteria for developing, updating and evaluating the health care benefit package of the Extremadura Public Health System (Consejería de Sanidad y Consumo 2004g). Moreover, in Decree 80/2004,[112] Extremadura legislated the establishment of a programme that would permit low-income senior citizens (over age 65) who are prescribed specific orthoprosthesis products to pay the amount set out in the decree's Annex I[113] in periodic payments without interest over a period of up to two years in duration, with Extremadura paying the interest on their behalf to the financial institutions administering the grants (Consejería de Sanidad y Consumo 2004i). It later repealed and replaced this decree with Decree 55/2006, which expanded this benefit to all senior citizens (independent of their income level) and to persons entitled to a disability pension (Consejería de Sanidad y Consumo 2006g). In addition, in Decree 16/2004, Extremadura legislated the right to a second medical opinion within the Extremadura Public Health System (Consejería de Sanidad y Consumo 2004e). Also, in Decree 195/2004, Extremadura legislated free dental health care for children age 6 to 14 (Consejería de Sanidad y Consumo 2004c), emulating the legislation in this health area passed previously by Andalusia, the Basque Country, and Navarra (Departamento de Sanidad y Consumo del Gobierno Vasco 1990; Departamento de Sanidad de la Comunidad Foral de Navarra 1991; Consejería de Salud 2001). Following the mandate

[111] This decree regulates what Articles 2, 3 and 10 of Law 10/2001 stipulated. It also created the health care card for the Extremadura Public Health System.
[112] A correction of errors in this decree was submitted on June 19, 2004.
[113] Among the products covered were digital or analogue hearing aids, dental extractions, and multifocal glasses.

in Article 25 of the 2003 LCQ, Extremadura passed Law 1/2005, regulating waiting times for specialised health care from the Extremadura Public Health System (Presidencia de la Junta de Extremadura 2005a). In accordance with its previous legislation on euthanasia, Extremadura passed Law 3/2005, which in Articles 17-22 legislates recognition of advance care directives (*expression anticipada de voluntades*) regarding health care decisions when a person does not have the capacity to express them otherwise (Presidencia de la Junta de Extremadura 2005b).[114] Furthermore, in Decree 6/2006, Extremadura regulated the reimbursement of expenses related to pharmaceutical products, orthoprosthesis and health services from outside its public health system, including financial support for travel and subsistence (Consejería de Sanidad y Consumo 2006g).

During this period, while it did not expand the common health benefit package, Madrid legislated several regulations facilitating access to the health services contained in the package. For example, Instruction 1/2004 regulated the reimbursement of out-of-pocket, health care-related travel expenses (Comunidad de Madrid, 2004). Following the mandate in Article 25 of the 2003 LCQ, Madrid also passed Decree 62/2004, establishing and regulating a unified registry of patients on the waiting list for surgery in its public health system (Consejo de Gobierno 2004b).

4.4.3. Financing

The period following the devolution of health service competencies saw one major primary financing agreement regarding the NHS. As noted above in the section on the 2001 Health System Devolution, the CPFF approved the regional financing agreement, which became Law 21/2001 and would take effect from January 1, 2002 for an indefinite period (Consejo de Política Fiscal y Financiera 2001; Jefatura del Estado 2001b).[115] The 2001 financing agreement integrated the regional financing system and the NHS financing system—both of which would expire that same year—into a single system aimed at attaining long-term financial sustainability, especially regarding NHS expenditures. Overall, this agreement meant that regional expenditures, including those

[114] Extremadura Decree 311/2007 regulates the content, organisation and functioning of the Registry for Early Expression of Wills (Consejería de Sanidad y Dependencia 2007d).
[115] This new regional financial agreement was applied only to the ordinary financing regime. The CPFF also made agreements on 6 March 2003 regarding borrowing and indebtedness of the regions after the budgetary stability legislation of 1 January 2003 (Consejo de Política Fiscal y Financiera 2003a), and subsequently on 10 April 2003 regarding the request and submission of information to the MOF and the CPFF for the development of the functions concerning budgetary stability (Consejo de Política Fiscal y Financiera 2003b).

for health care, would represent 45 per cent of total public expenditures. It also meant the consolidation of financial flows for the NHS, where regional health financing was obtained through a combination of regional and national taxes and an intergovernmental block grant from the central government.

Prior to this period, the regions experienced incremental annual budgeting for health services and there was no specified ceiling on expenditures. Regions could, and often did, incur deficits, shifting them to later budget periods (historical debt) until they were assumed after tough negotiations by the central government.[116] Now, with Law 21/2001, the regions would be completely responsible for funding its health budget; health funding lost its previous earmarking by becoming integrated within the general intergovernmental grant allocated to the regional government, which had the final decision-making power over the allocation of funds to the health sector and other sectors. Each region had its own budgeting process. The only condition established in the new agreement was a minimum allocation for expenditures on health services for each region, based on 1999 expenditures adjusted for health needs.[117]

Additionally, the 2001 financing agreement also established a new resource allocation formula for calculating the intergovernmental block grant for the regions in the "ordinary" financing regime (called the Sufficiency Fund): 75 per cent based on the size of the population, 24.5 per cent on the size of the population over 65 years old, and 0.5 per cent for insularity. Notably, by considering the higher cost for the elderly, the allocation formula for regional financing began to be based on the population's health needs.

Moreover, the 2001 financing agreement increased fiscal autonomy by granting new taxing powers to the regions. It substantially redesigned the taxation system, giving the regions authority over the following taxes originating in their territories: (i) 100 per cent of gifts and inheritance tax, estates and estate transfer tax,[118] gaming tax, electricity tax and special taxes on specific means of transport as well as alcoholic beverages; (ii) 35 per cent of personal income tax;[119] (iii) 35 per cent of Value-Added Tax (VAT);[120] and (iv) 40 per cent of beer tax, intermediate product tax, alcohol and

[116] The regions usually relied on the argument that the financial resource allocation mechanism was flawed.
[117] The regions easily met this amount because the minimum was so low and because levels of health spending were increasing each year.
[118] These taxes are based on the location of the particular property.
[119] This tax is based on the residence of the taxpayer.
[120] This tax is based on the place of consumption.

alcoholic beverage tax, hydrocarbon taxes and tobacco tax. In some cases, the regions were also given the authority to modify the taxes. Madrid, for example, was the first region in Spain to implement the "Penny for Health" (*Céntimo Sanitario*) policy, which established a 1.7 euro cent per litre tax on petrol and diesel from August 2002 (Cosme 2014).[121]

In practice, as shown by Blanco (2008) for the period 2003–2005, this new financing agreement meant either a loss or an increase in the proportion of financing budgeted for health as a share of the general regional budget. On one hand, for example, Extremadura experienced a moderate and steady increase in its health budget as a percentage of its general budget, growing from 27.92 per cent in 2003 to 28.70 per cent in 2004 and 29.82 per cent in 2005. On the other hand, Madrid experienced a sharp decrease in this percentage, falling from 36.51 per cent in 2003 to 33.13 per cent in 2004 and then again to 31.62 per cent in 2005. Still, by the end of 2005, Madrid was allocating a higher proportion of its general budget to health than Extremadura was. Appendix G holds health expenditure and population coverage data for Spain, Extremadura and Madrid.

4.4.4. Human Resources

Adequate planning for human resources is fundamental to ensure quality health care, but there was virtually a regulatory vacuum regarding specific legislation on health professions in Spain until this period. Finally, starting in 2003, the central government passed three major laws concerning health professions and personnel. The first, Law 44/2003 on the Regulation of Health Professions (*Ordenación de las Profesiones Sanitarias*), covered training in both undergraduate and graduate education programs with regard to health care knowledge, skills and attitudes, as well as professional associations (Jefatura del Estado 2003c). This law aimed to equip the health system with a legal framework that would enable the greater integration of professionals into the health service, guarantee that all health professionals meet the skill and knowledge levels required to perform their health care functions, and facilitate their collaboration to improve the quality of care. To achieve this, it sought to refine the general norms, rights and duties of health professionals as well as the principles of education and training systems and the linkages between training and employment in the public NHS.

[121] By 2014, thirteen regions eventually exercised their power to establish this same policy in their regions, but at varying rates (which eventually were capped at 4.8 euro-cents/liter by the central government). Extremadura did not implement this tax until January 2011 (Soriano 2015).

In particular, Law 44/2003 regulated the registration and licensing of health professionals in Spain, accrediting university degree programs through a corporate professional organisation recognised by the Spanish General Public Administration (*Administración General del Estado*). This law also created two levels of university degrees: a high-level degree, called *licenciado*, for medical doctors, and a mid-level degree, or *diplomado*, for technical graduates such as nurses. Not only did health professionals have to graduate from an accredited, health care-related university degree programme, but per Law 44/2003 they also had to pursue continuing education and training to maintain their professional competencies and remain up to date with constantly advancing medical research. This type of professional re-accreditation would be overseen by the health centre and hospital managers[122] in each region. To ensure public accountability, Law 44/2003 also stipulated that public registries of accredited health professionals would be maintained continuously. Furthermore, in its Second Transitory Provision, it gave the regions four years to implement a system of professional development.

Building on this measure, Law 55/2003 established the long-awaited Framework Statute for Statutory Health Personnel (*Estatuto marco del personal estatutario de los servicios de salud*) and the rights of these workers (Jefatura del Estado 2003a). It identified three categories of staff: physicians, non-physician health care personnel, and non-health care personnel in the centres and institutions of the NHS. Moreover, it established special regulations for these three personnel categories and sought to enhance employee motivation through an incentive system, to decentralize the employment selection process and career development responsibilities, and to link other employment issues such as salaries, and staffing needs to the development of statutory health personnel education and training programs (Jefatura del Estado 2003a). Law 55/2003 created the Commission of Human Resources (*Comisión de Recursos Humanos*) of the NHS, charged with carrying out planning activities, designing training programs and modernizing human resources (Article 10). It stipulated that the selection of permanent (fixed) statutory personnel will take place periodically within each health service, and defined a process for public competition and procedures that would ensure fair selection based on merit and ability (Article 30). It also established similar principles for internal promotion to be implemented by the

[122] Hospital managers were in a political position in the sense that they were often changed with non-incumbent, incoming governments (Novinskey, Interview no. 9).

corresponding public administration (Art. 34). Furthermore, Law 55/2003 stipulates disciplinary measures (Chapter XII) for statutory personnel, distinguishing very serious, serious, and minor offenses, on which the regions could elaborate further (Article 72.5), and their corresponding sanctions, as well as disciplinary procedures and provisional measures (Articles 74 and 75).

The third piece of important national legislation during this period was Royal Decree 450/2005, which regulated the development of nursing specialties (Ministerio de la Presidencia 2005). This decree added five new specialties to the previously defined specialties of mental health and midwifery: geriatrics, occupational health, medical-surgical care, paediatrics, and family and community care (Article 2, c-g). It also established a residency programme for nursing specialties modelled on the MIR, including the formation of national councils for each speciality. This decree and related legislation received an abundance of support from stakeholders, including the Nursing Specialties Board, the Board for Official Nursing Associations, the NHS's Commission for Human Resources, and trade unions (including *Sindicato de Enfermería*, *Sindicato Unión General de Trabajadores* and *Comisiones Obreras*).

In addition, in June 2004, the Council for NHS Human Resources (*Comisión de Recursos Humanos del Sistema Nacional de Salud*) was established under the leadership of the Minister of Health and Consumer Affairs. This is an advisory body composed of representatives from the RHMs as well as from different ministries of the Spanish General Public Administration. In 2006, the central government also promulgated the 2006 Quality Health Plan, within which one of twelve strategies was to take measures to match human resources to health service needs. Finally, the Council for NHS Human Resources established on general guidelines for the professional career systems of the regional RHSs through an agreement on 19 April 2006 (Dirección General de Recursos Humanos y Servicios Económico-Presupuestarios 2007; Ministerio de Sanidad y Consumo 2006a).

The regions greatly exercised their new decision-making authority over human resources in the health sector during this period. While, payment mechanisms for human resource professionals in Spain did not change much at the national level after the "second wave" of health system devolution during the period of study, the regions began experimenting with different methods of remuneration and financial incentives. This included pay-for-performance mechanisms to motivate doctors and other health professionals to improve their quality of care (Eirea Eiras and Ortún Rubio 2012);

however, it appears that these mechanisms were not particularly effective (García-Armesto et al. 2010).

One of the most important uses of new regional powers over human resources for health involved compliance with the Second Transitory Provision of Law 44/2003, which required the regions to implement a career and professional development system for their health personnel. Extremadura negotiated an agreement between its RHS and trade unions in October 2005 regarding professional career and development (Dirección General de Trabajo 2005). This agreement, among other things, established an incentive framework of four consecutive levels of professional development, based on a minimum number of years of experience for each level (5, 14, 22, and 28, respectively) and an evaluation. Madrid also complied with the Second Transitory Provision of Law 44/2003, passing several agreements on the career development of health personnel. Moreover, in October 2004, Madrid negotiated an incentives programme to reduce its surgery waiting list (Consejería de Sanidad y Consumo and Organizaciones Sindicales 2004) and partially fulfil its April 2004 agreement to reduce waiting times to no more than 30 days (Consejo de Gobierno 2004b).

Since the 2001 health system devolution, Extremadura has made great efforts to improve staff quality and quantity at its health care institutions. By 2005, it managed to employ an additional 1,700 health and non-health professionals in these institutions (Informes, Estudios e Investigación 2007, 30). For primary care services, this staffing increase and the introduction of new technologies (such as electronic prescriptions) have enabled doctors to reduce their patient quotas and dedicate more time to each patient. For speciality care, the Extremadura RHM managed an increase in medical specialists by opening up more places in the Faculty of Medicine and increasing the number of hospitals and health centres with accreditation for training medical specialists via the MIR. It also began enlisting specialists from other EU countries and Latin America into its organisation. Furthermore, Extremadura made great advances in continuous education for health professionals. With survey input from its employees as well as from scientific societies, professional associations and trade unions, Extremadura's School for the Study of Health Sciences (*Escuela de Estudios de Ciencias de la Salud*) developed and implemented 178 continuous education activities in 2005 (Informes, Estudios e Investigación 2007).[123] These included review programs

[123] These activities served 4,315 students and delivered 4,414 lecture hours.

for specific skills in primary care as well as scholarships for training visits to other health centres.

Madrid legislated several pieces of minor regulation regarding human resources for health care. Continuing education and training for health personnel in Madrid were carried out by the Laín Entralgo Agency (*Agencia Laín Entralgo*), according to the guidelines set out in Law 44/2003 and following Madrid's 2005 Education Plan for Health Professionals. Among other things, this plan determined education and training needs based on the strategic objectives of each general directorate and management unit, developed criteria on the distribution of funding between health centres and achieved synergies through collaborative agreements between stakeholders. One innovative aspect of the plan was the coverage of gender violence in its training programs. Appendix H details Extremadura and Madrid's human resource regulations during this period.

4.4.5. Governance and Stewardship Rules

After the 2001 health system devolution, in the areas of governance and stewardship rules, the central government continued to set broad accountability mechanisms for the entire NHS, which the regions could then enhance if they wished.[124] After devolution, the central government passed two major laws that improved accountability mechanisms in the NHS: Law 41/2002 on Patient Freedom, Rights and Duties on Medical Information and Records (*la autonomía del paciente y de derechos y obligaciones en materia de información y documentación clínica*), and 2003 LCQ (Jefatura del Estado 2002; 2003b). Building on the GHL, Law 41/2002 refined regulation on the rights and duties of patients, users and professionals, as well as public and private health centres and services in the area of patient autonomy and clinical information and documentation. In particular, it regulated the right to health information, privacy, respect for patient freedom (including the right to deny treatment), the integration of, use of and access to information from clinical history documents, the patient's right to be discharged and the procedure for reporting discharges. In terms of accountability, this new law laid out more precisely the rights

[124] Bankauskaite and Novinskey (2010) evaluated the MOH's role as a steward of the Spanish NHS, following the framework of Travis et al. (2003). They found that, overall, the MOH fulfils its role as a steward of the health system in the areas of generating intelligence and formulating a strategic policy framework; however, it lacks appropriate authority to efficiently coordinate the health system and ensure the regions implement policies that are aligned with national NHS objectives (Novinskey, Interview no. 20).

of patients and users of the NHS and the criteria to which the system would be required to conform. As for coherence of medical records across the NHS, the law established the basic and minimum content of all medical records in the country and a method of coordinating them across all regions (Observatorio del SNS 2005 Anexo II: Normativa; Durán, Lara, and van Waveren 2006). In addition, the 2003 LCQ fostered user and citizen participation in the NHS, especially by creating the NHS Council for Social Participation (*Consejo de Participación Social del Sistema Nacional de Salud*), regulated by the MOH. This Council's main role was to provide a permanent channel of communication between health sector authorities, professional and scientific societies, trade unions, businesses and users. As explained in more detail above in the section on Service Organisation, the LCQ established three new means of public participation in the NHS: an Advisory Committee, an Open Health Forum and a Virtual Forum. Furthermore, since 2004, the MOH has used a Barometer of Users' Satisfaction (*Barómetro Sanitario*) to gauge patients' satisfaction with various aspects of the health system (Ministerio de Sanidad, Servicios Sociales e Igualdad 2012).

The 2001 devolution gave the regions the right to expand the central government's legislation on accountability within the NHS. The regions took such action at different times and in different ways. For example, all regions, except Murcia, mandate patient rights to make claims and complaints in their regional health planning laws (*Ordinación Sanitaria*). Moreover, Article 12.3 of Law 41/2002 obliged all RHSs to display guides on complaints in health centres and services as well as establish an adequate system for exercising patient freedom and rights. Some RHSs have created specific units for protecting and providing information on patient rights, called Patient Support Services (*Servicios de Atención al Paciente*) or User Complaint Units (*Unidades de Atención al Usuario*). At the same time, some regions have also created an ombudsman position.

In particular, Extremadura legislated the right to use complaint and suggestion procedures in Article 11.1n of its 10/2001 Health Care Law and created a patient ombudsman position in Article 16 of the same law (Presidencia de la Junta de Extremadura 2001b).[125] Subsequently, Extremadura passed Decree 4/2003, which developed the ombudsman's legal status, structure and (independent and autonomous)

[125] For more information about the Ombudsman for Patients in Asturias, the Balearic Islands, Castile-La Mancha, Galicia and La Rioja, see Table 4 of Annex II of the Annual NHS Report (Observatorio del SNS 2005). Section 2.5 of this same report includes information on the effective guarantee of citizen rights regarding the NHS for the remaining regions.

functions, including publishing an annual record of the office's activities (Consejería de Sanidad y Consumo 2003a).[126]

In Title IV of its Health Planning Law 12/2001, Madrid stipulated the rights and duties of citizens with regard to the NHS, expanding those regulated by the GHL to include, for example, the right to receive health care benefits within certain known waiting times, the right for patients to give "advance care directives" regarding their treatment, the right to access information from their medical records, and the creation of a patient ombudsman (Presidencia de la Comunidad de Madrid 2001b). In addition, Madrid's Decree 10/2004 guaranteed the ombudsman's independence and autonomy (Consejo de Gobierno 2004a). Following Decree 21/2002, which regulated all customer services for its citizens, Madrid legislated Order 605/2003, which developed the customer service platform for the health sector. This order contained regulations for the System for Handling Suggestions, Complaints and Claims for the Unique Health Network for Public Utilisation and created the Commission for the Monitoring and Evaluation of Suggestions, Complaints and Claims under the RHM (Consejería de Presidencia 2002; Consejería de Presidencia and Consejería de Sanidad 2003). Regulations on accountability and public participation in Extremadura and Madrid are presented in Appendix I.

4.4.6. Health System Decision-Space Map, as of 2006

Table 4.8 below presents the health system decision-space map for Madrid and Extremadura as of 2006.

[126] The Order of 26 November 2003 also regulates the handling of complaints and suggestions regarding health care activities (Consejería de Sanidad y Consumo 2003c).

Table 4.8. Health System Decision-Space Map for Madrid and Extremadura, as of 2006

Functional Areas Key Functions	**Range of Choice**		
	Narrow	**Moderate**	**Wide**
Service Organisation			
Contracts with private health care services			Regions may decide to contract with private services to provide care for public system
Hospital autonomy			Defined by regions
Targeting service delivery	Free access to public health services based on need, 1986 GHL		
Regulation and Planning			
Policy formulation		Defined by the MOH; regions can expand the definition of policies defined by the MOH and can make new policies in areas not covered by it	
Norms and standards		Defined by the MOH; regions can expand health care benefits with their own financing	
Prescription drug planning	Defined by the central government[a]		
Drugs and supplies (rationing)			No limits by the central government
Infrastructure planning			No limits by the central government
Health information systems design		Defined by the MOH in collaboration with the CISNS, which includes regional health ministers (Law 14/1986 GHL and Law 16/2003 LCQ)	
Financing			
Insurance schemes	NHS-style public health system, 1986 GHL[b]		
Payment mechanisms		Public health care provider payment mechanisms managed by central government; regions can add financial and non-financial incentives	
Sources of revenue		Negotiated by each region and the CPFF; no earmarking for health; intergovernmental transfers fund majority of regional health expenditures, but regions have ability to use own resources.	

Functional Areas	**Range of Choice**		
Key Functions	**Narrow**	**Moderate**	**Wide**
Financing (cont.)			
Revenue allocation (budgeting)			Regions have autonomy on allocating resources to and within health (central government set a minimum expenditure on health)
Income from fees	No fees for health services, as defined by the central government		
Human Resources			
Salaries and benefits (permanent staff)	Defined by the National Civil Service		
Contracts (non-permanent staff)			Regions have the liberty to contract non-permanent staff
Civil Service		General guidelines defined by central government with Law 55/2003, with more specific legislation allowed in limited areas by the regions	
Education and training (pre-service)	Defined by the MOH, along with the MOEdu		
Education and training (continuing)	Defined by the MOH, along with the MOEdu		
Governance and Stewardship Rules			
Facility boards			Appointed by regional governments
Territorial health offices			Regions have autonomy over their Health Areas and Basic Health Zones
Patient and user rights		Defined broadly by the central government (Laws 41/2002 and 16/2003); regions can expand and refine (but not limit) its definition	
Complaint system		Defined broadly by the central government (Law 16/2003); regions can expand and refine (but not limit) its definition	
Public participation		Defined broadly by the central government (Law 16/2003); regions can expand and refine (but not limit) its definition	

[a] From 2003, Extremadura implements central government pharmaceutical product legislation (Royal Decree 430/2003 (Ministerio de Administraciones Públicas, 2003)). [b] Mutual funds schemes exist for public sector employees; they analysis is beyond the scope of the thesis.

Note: The fifteen "ordinary" financing regime (or "non-foral") regions have the same amount of *de jure* decision space for each health system function; thus, the common health system decision-space map for Extremadura and Madrid.

4.5. Discussion

Determining the degree of discretion allowed at the regional level of government is the first step towards understanding the effects of health system devolution on the health policymaking process and subsequent health policy actions in Spain. Following the modified decision-space approach and corresponding methods described in the first part of the analytical framework of the thesis, in this chapter, I analysed the decision space allowed to the regions before and after the 2001 health devolution reform. In doing so, I paid attention to the ten "slow-track" regions and, in particular, Extremadura and Madrid. Using mostly *de jure* government and documentary information along with secondary and tertiary data, I constructed two health system decision-space maps for the Extremadura and Madrid.[127]

In terms of the research findings, Sections 4.2.6 and 4.4.6 present the resulting health system decision-space maps for Extremadura and Madrid, respectively for the periods before and after the 2001 health devolution reform. The first major finding is that the decision-space allowed to the regions for the periods before and after the devolution reform varied by health system function. Indeed, even before the 2001 health system reform, the regions had a moderate degree of decision space for some health system functions; to wit, in the determination of the revenue sources and allocation of funds for the NHS, through their participation on the CPFF and, in particular, the negotiations of the multi-annual, regional and NHS financing agreements. This is further evident from the health system decision-space map after the devolution reform, which showed that the regions had a varying amount of choice—from narrow to wide—depending on the health system function. In effect, they had a narrow degree of discretion over seven functions (including education and training of human resources), a moderate degree of discretion over nine functions (including formulating policy, and norms and standards) and a wide degree over eight functions (including revenue allocation). See Table 4.9 for a health system decision-space map that, using arrows, shows the shift in decision space at the regional level of government

[127] Here I present the results of the systematic, *de jure* analysis of health system devolution with the case study. However, I discuss the *de facto* results below for a more robust analysis. A systematic analysis and decision-space mapping of the *de facto* results is not within the scope of this thesis. Chapter 5 reveals additional *de facto* information, primarily with information from in-depth stakeholder interviews and other sources.

from before to after the "second wave" of health system devolution for Extremadura and Madrid.

Table 4.9. Decision-Space Map Illustrating the Effects of the 2001 Health System Devolution Reform for Extremadura and Madrid

Functional Areas Key Functions	**Range of Choice**		
	Narrow	**Moderate**	**Wide**
Service Organisation			
Contracts with private health care service organizations	* →	→	→
Hospital autonomy	* →	→	→
Targeting service delivery	*		
Regulation and Planning			
Policy formulation	* →	→	
Norms and standards	* →	→	
Prescription drug planning	*		
Drugs and supplies (rationing)	* →	→	→
Infrastructure planning	* →	→	→
Health information systems design	* →	→	
Financing			
Insurance schemes	*		
Payment mechanisms	* →	→	
Sources of revenue		*	
Revenue allocation (budgeting)		* →	→
Income from fees	*		
Human Resources			
Salaries and benefits (permanent staff)	*		
Contracts (with individual, non-permanent staff)	* →	→	→
Civil service	* →	→	
Education and training (pre-service)	*		
Education and training (continuing)	*		
Governance and Stewardship Rules			
Facility boards	* →	→	→
Territorial health offices	* →	→	→
Public participation	* →	→	
Patient and user rights	* →	→	
Complaint system	* →	→	

In particular, after the reform, the central government maintained power over policymaking for the health system functions of (i) targeting service delivery, (ii) prescription drug planning, (iii) insurance schemes, (iv) income from fees and (v) most human resource functions (with the exceptions of contracting with non-permanent staff and civil service). On the other hand, the regions gained the most discretion over policymaking for the functions of (i) contracting with private health service providers, (ii) hospital autonomy, (iii) rationing drugs and supplies, (iv) infrastructure planning, (v) revenue allocation, (vi) contracting with non-permanent staff, (vii) governing

facility boards and (viii) governing territorial health offices. For the remaining health system functions, the regions gained or maintained a moderate amount of discretion.

Comparing these results for regional decision space after the 2001 devolution reform in Spain with the "decision-space options" for optimal local discretion in Bossert and Mitchell (2010) demonstrates that the Spanish devolution reform emanated the optimal level of local decision space for most of the health system functions reviewed. For example, for regulating and planning, they recommend that norms (and standards) have a moderate level of local discretion[128], which is the case for Spain. Under financing, they suggest that both sources of revenue and revenue allocation should have moderate to wide local discretion, which is also true for the Spanish regions. Under this same area, they recommend insurance plans be allocated low to moderate local discretion[129], which is again the case of Spain. Additionally, under human resources, they suggest that optimal discretion over civil service terms of employment and performance are moderate or wide at the local level. This is the case for the Spanish regions, which were given moderate decision space after devolution. Under service organization, for hospital autonomy, they suggest an optimal level would be between low and moderate decision space, with greater levels of autonomy requiring mechanisms to balance responsiveness to local preferences with national-level goals. Finally, while the Spanish regions do not reflect this recommended level of local discretion after devolution (i.e., theirs is wide), they do have mechanisms to balance local and national goals (e.g. CISNS).

Using the degree of discretion allowed for different health system functions to analyse devolution reform revealed several otherwise hidden and important differences in it; therefore, validating the analytical framework's use of the decision-space approach for a more adequate and precise definition and measurement of devolution than an approach that analyses devolution as a single block-transfer of decision-making power from the central government to the regions. Thus, this analysis provides a relatively strong foundation for the rest of the framework and its examination of the health policymaking process in Spain and determination of policy priorities at the regional government level.

[128] They recommend avoiding extremes, too much or too little local discretion, because they lead to central-level mismanagement and a lack of effective national stewardship, respectively.
[129] They suggest that most aspects of insurance plans (except maybe enrollment of beneficiaries) will benefit from economies of scale.

Moreover, my findings confirm my two expectations for the Spanish and regional case studies. First, the regions had overall narrow decision space for the majority of health system functions before the "second wave" of health devolution reform, which widened considerably for most functions during the period after the reform. Second, my analysis identified only one health system decision-space map for both Extremadura and Madrid for each period because the analysis was mostly based on *de jure* legislation and regulations.

From these similar *de jure* changes in decision space, my research also revealed some real effects that differed *de facto* for Extremadura and Madrid. Most outstanding, I found that the two regions exercised their new health policymaking powers and responsibilities to different extents. Overall, Extremadura produced more legislation on health issues and policies than Madrid did. For example, Extremadura tended to expand the health care benefit package using its own financial resources and to develop definitions of health care rights more than Madrid did. Additionally, when it seemed not to have the necessary own-source financial resources available to support its policy on orthoprosthesis products for senior citizens, Extremadura innovatively created a public-private partnership for a supplemental fund. Alternatively, Madrid was conservative in its health policymaking, using its new power mostly to make organisational and structural reforms, perhaps, in the interest of improving the administrative efficiency. Moreover, it did not expand the common health care benefit package or pass any health policies using its own funds. At the same time, Madrid more innovatively used its tax raising abilities, for example, with the "Penny for Health" policy. The *de facto* impact of the accountability mechanisms in place or of each region's level of health care capacity on the effectiveness of the health system, however, could not be determined.

These real effects are particularly interesting given Extremadura's and Madrid's social, economic and geographic differences (cf. Table 3.9). Socially, Extremadura has always served less than a quarter of the population than Madrid has served (both in total population and population covered by the NHS); a percentage that decreased during the period of study, due in part to an influx of immigrants to Madrid. For example, in 2001, Extremadura's NHS covered 1,004,837 individuals and Madrid's NHS covered 4,709,391 individuals, and, in 2003, they covered 1,002,666 individuals and 5,295,677 individuals, respectively (Ministerio de Economía y Hacienda and Ministerio de Sanidad y Consumo 2005, 155). Consequentially, Extremadura's smaller

population means that its individuals have a greater potential of political weight than Madrid's population does; which could be a motivating factor for Extremadura's government to move more quickly on policy.[130] Additionally, correcting for the age structure of their populations, in 2003, Extremadura's dependent population (aged 65 years and older, and under 4 years) was 5 percentage points higher than that of Madrid (23.9 and 18.68 per cent of their total respective populations); which usually results in higher expenditures on health care (ibid. 179-180). Moreover, Extremadura's population has always had a lower average socio-economic status and higher unemployment rate than Madrid's population. Correspondingly, Madrid's income, productivity and tax revenues were higher than Extremadura's were during the study period. In 2003, Madrid's public health expenditure as a percentage of its regional GDP, for example, was 3.56 percent, while Extremadura's was 7.91 per cent (ibid. 49). At the same time, Madrid's per capita cost for health care (870€ in 2003) was lower than Extremadura's was (1,026€ in 2003)(ibid., 158); perhaps, due to its greater ability for economies of scale (Alesina 2003). In terms of geography, the Community of Madrid is mostly a highly dense urban area, whereas Extremadura's population is more rural and dispersed in comparison; the latter, which usually results greater spending on health services to either bring the person to the services (e.g. transport) or the services to the people (e.g. infrastructure). Lastly, I would like to highlight the fact that Madrid is the capital of Spain, which meant that the headquarters for the activities of INSALUD, which managed the health care services pre-devolution, was also located in Madrid, giving the Madrid a proximity advantage in the design and functioning of their health system prior to devolution that Extremadura did not have. As such, it would be hard for INSALUD decision makers not to see the conditions of, and plan for the needs of, heath care in Madrid when they were faced with them every day.

These characteristic differences between Extremadura and Madrid—besides being a major factor for advocating devolution in the first place—might also help to explain the overall differences in Extremadura and Madrid's exercise of their newly granted decision space *de facto*. One could hypothesise that Madrid's health service needs were more attended to by INSALUD prior to devolution than Extremadura's were; thereby, upon receiving responsibility over these competencies, Extremadura needed to adapt its health service more than Madrid did to fit its local reality. On the

[130] By bringing health care closer to the people in the territory, there is a certain political dependence at the regional level (Novinskey, Interview no. 01).

one hand, one Extremadura stakeholder suggested that health care devolution meant that they could use local businesses and vendors to support improvements in their health services (instead of those coming from Madrid), which also had the indirect benefits of increasing the region's public economy and social capital (and pride) (Novinskey, Interview no. 01). Madrid, on the other hand, assumingly still had the same pool of local business and vendors to pull from. Additionally, it is well-known that many former-INSALUD and MOH employees working on health services before devolution found jobs with Madrid's new administration after it (Novinskey, Interview no. 02, 05, 18, 24 and 39). One could suggest, then, that Madrid had less potential need for improving its situation and, in particular, for looking for innovative, new solutions (i.e., the solutions they had were already satisfactorily addressing their health care problems). This could have also been a contributing factor to Madrid's *de facto* lack of exercising its discretion as well as for the few innovative policies they produced during the study period (e.g. fewer fresh faces and ideas).

Political values may also play a part with Extremadura focusing their efforts on social programs, including health care, and Madrid acting more conservatively with expenditures, including those on health care. Indeed, during the study period, Extremadura was governed by the PSOE, which values a free, egalitarian society, with solidarity and peace for the progress of people, especially those of the working class (Partido Socialista Obrero Español 2017). At the same time, Madrid was governed by the PP, which supports a platform of freedom for all and bringing Spain and the Spanish to ever higher heights of prosperity (Partido Popular 2017). These hypotheses, however, are for future research.

Looking forward, the *de jure* health system decision-space maps from this chapter will become even more useful in the following chapters as they provide a foundation for further analysis of our regional case studies. More specifically, together with the intergovernmental policy network approach for analysing health policymaking process in politically decentralized countries, the health system decision-space approach should help to anticipate health policy priorities after devolution at the regional level of government. Furthermore, just the application of the decision-space approach as a means of defining and measuring health system devolution (and, more generally, decentralization) will also be useful for future comparative analyses at the national and/or regional level in Spain, although such work lies well beyond the scope of this thesis.

5. Intergovernmental Policy Networks for a Devolved Health System

In the previous chapter, I applied the first part of the analytical framework of the thesis—the decision-space approach—to the "second wave" of health devolution reform in Spain, focusing on the regional cases of Extremadura and Madrid. In this chapter, I apply the second part of the framework—namely, the intergovernmental policy network approach (combined with rational choice institutionalism)—to the same case studies to examine the structure and agency of the health policymaking process before and after the reform. I first describe the structure of the intergovernmental policy networks, according to the theory of intergovernmental policy networks as *institutions*. Next, I pair this structural approach with the rational choice institutionalist model of actor behaviour, validating the appropriateness of my classification of the actor groups involved in health sector policymaking in Spain through a stakeholder analysis, using primary qualitative interview data. Then, I examine various measures to establish the positions of the main actor groups within each of the intergovernmental policy networks in Spain. To do this, I adapt and apply Blom-Hansen's (1999) methodology for establishing the positions of these institutional actors on the national and subnational levels, as discussed in the analytical framework. Finally, I discuss the resulting power-sharing situation on the trade-off triangles for intergovernmental health policymaking at both the national and subnational levels of government before and after devolution.

In terms of expectations, for the period before the health devolution reform and with respect to the regional case studies, I anticipate this analysis to find all the power for health services and policies concentrated in the hands of the national-level expenditure advocates and guardians, with little influence from the topocrats. However, for the period after the health devolution reform, I expect this power to have shifted considerably to the subnational health policymaking environment, producing a relationship of shared responsibility between the central and regional governments within their respective health policymaking environments. In this regard, I expect to find that the national-level expenditure advocates have lost much of their power to both the national-level expenditure guardians and the topocrats within the national health policymaking environment, and in equal amounts to the subnational expenditure advocates and guardians within the subnational health policymaking environments for both Extremadura and Madrid. Similarly, I expect that the health-sector kentrocrats will have difficulty exercising influence over the subnational health policymaking

environment and that they (and the national expenditure advocates) might find themselves nearly organised out of politics.

5.1. Intergovernmental Health Policy Networks in Spain

To understand intergovernmental policymaking, it is imperative to define its structure and agency. For this reason, in this section, I first describe the structure of policymaking in the Spanish case study. Next, I define the structure of intergovernmental policy networks as institutions, in order to determine the space within which the actors have to manoeuvre. Then, I look at actors and their behaviour as represented by the rational choice institutionalist model and its application to the case study, for which I validate the use of the particular actor groups. For additional information on the intergovernmental policy network approach and rational choice institutionalist model for actor behaviour, please see Chapter 3. Finally, I present a matrix of the institutional architecture of intergovernmental health policymaking in Spain, which delimits the measures for establishing the positions of the different actor groups in both the national and subnational health policy networks.

5.1.1. Structure: Intergovernmental Policy Networks as Institutions

The Spanish Constitution of 1978 describes its state model, called the Autonomous State (*Estado Autonómico* or *Estado de las Autonomías*), as having characteristics of both a federal and a unitary state. The Autonomous State resembles a federal state in that the autonomous communities have legislative capacity over the policy areas within their competencies; however, it is similar to a unitary state in that it is composed of only one sovereign people. Ultimately, the autonomous communities do not hold sovereignty over the people in their territories; in fact, all three levels of subnational government in Spain—autonomous communities, provinces and municipalities—can be created or abolished unilaterally by the central government without formal agreement by the affected bodies. In reality, however, such an event is highly unlikely because the central government depends on its subnational governments—particularly, the autonomous communities (or "regions")—for political support, information, expertise, and policy implementation. Indeed, when the financial viability of the regions came into question in 2004, to assure them that the central government would take care of them, the President of the Generalitat of the Catalan Parliament, Pasqual Maragall, said "it has become clear that the Autonomous Communities are a part of the State from a legal and political point of view" (El País 2004) More recently, the regions

in Spain have expanded their competencies considerably and some have tried to expand their sovereignty.[131] In any case, it is technically appropriate to categorise the Spanish case as being a politically decentralized or devolved unitary state.

As described above, the intergovernmental relations in the Spanish case demonstrate the need to look at the underpinnings of formal institutions, using the concept of informal policy networks to understand how central and regional government actors interact with each other in order to formulate and implement policies. This thesis defines policy networks as "institutions", conceptualises them as rules governing actions, and further describes them according to their level of cohesion (from tight-knit policy communities to more loosely-coupled issue networks). In this sense, rules are defined as "prescriptions commonly known and used by a set of participants to order repetitive, interdependent relationships"(Ostrom 1986, 5). Thus, the rules shed light on the boundaries that surround actors in an intergovernmental policy network and that place limits on their actions (though not necessarily on their behaviour[132]). These rules are not automatically formal laws, because they are not necessarily backed by enforcement power; rather, they are behaviours that are commonly accepted and practiced by all actors. Ostrom (1986, 17) presented a "set of necessary variables for the construction of formal decision models where outcomes are dependent on the acts of more than a single individual"[133], which were later refined by Blom-Hansen (1999, p. 239), as illustrated in Table 5.1.

[131] For example, in June 2008, the Basque Parliament called a consultative referendum on independence ("the right to decide about the Basque people"). It was blocked by the Spanish Constitutional Court in September 2008. The Basque Nationalist Party (PNV) filed an appeal on this ruling with the European Court of Human Rights, which ruled against the appeal in February 2010. In January 2013, the Catalan Parliament adopted a Declaration for Catalan Sovereignty (*Declaració de sobirania*), which was provisionally suspended in May 2013 and declared null and unconstitutional in March 2014 by the Spanish Constitutional Court. In April 2014, the Spanish Congress also dismissed the Catalan Parliament's request to hold a referendum for independence (self-determination). The Catalan Government re-branded the vote as a "process of citizen participation" in October 2014, which was also provisionally suspended by the Spanish Constitutional Court. However, the Catalan Government defied the suspension and held the referendum in November 2014, in which some 80 per cent of the nearly 2.3 million (only 40 per cent of eligible voters) who voted also backed secession. Nota Bene: These actions took place after the period of study of the thesis.

[132] "Viewing rules as directly affecting the structure of a situation, rather than as directly producing behavior, is a subtle but extremely important distinction" (Ostrom 1986, 7).

[133] Indeed, it is not possible to generate any prediction about actor behaviour in an interdependent situation without these rules and their relation together in a coherent structure; thus creating what Ostrom (1986) refers to as an *action situation*.

Table 5.1. Intergovernmental Policy Networks as Institutions

	Intergovernmental Policy Networks	
Institutional rules	***Policy Communities***	***Issue Networks***
1. Position of actors	Negotiators	Rulers and pressure groups
2. Boundary of the institution	Includes only government and representatives of local governments	Government and various types of interest organisations
3. Decision-making procedure	Unanimity	Consultation
4. Scope of decisions	Policy formulation and implementation	Policy formulation
5. Pay-off rules	Influence and responsibility	Influence

Source: Blom-Hansen (1999, 239)

Both before and after the 2001 health system devolution, the intergovernmental policy network in the national policymaking environment in Spain performed more like a *policy community* than an *issue network*. For example, one very distinguished, key stakeholder described the agreement to devolve health care competencies to the 10 slow-tracked regions as negotiations[134], which the MOF carried out with a political game strategy. Being of the Popular Party Administration, the MOF decided,

> First, to agree with the Socialist [Autonomous Communities], instead of with [its] own party… and [of those] first with the Communities who did not agree on the previous financing agreement, namely, Castile-La Mancha and Extremadura.[135] Then, the rest came one by one, little by little. [Finally, it] extended agreements to [the administration] party's Autonomous Communities…Madrid did not have a problem negotiating[136]…[but] some of the smaller Autonomous Communities[137], like Asturias, were not happy, and they made their declarations against the negotiations… but after two days, it was over because the new system really was convenient for them (Novinskey, Interview no. 41).[138]

In addition, this stakeholder also revealed that part of the MOF's strategy was to "complement budget differences with additional specific concessions for the first Socialist Autonomous Communities that agreed (e.g. a special plan for developing

[134] This negotiation was particularly complicated because it was two pronged, having to do with both negotiating a new regional financing agreement and negotiating the transfer of health care competencies to the 10 slow-tracked regions.
[135] See page 149 for more detail.
[136] Madrid understood that there had to be a redistribution of funds in the system (Novinskey, Interview no. 41).
[137] Those with little room to maneuver and small budgets.
[138] Asturias was the only region to hold strikes after the health system devolution in July 2002. It did so to obtain what they called their "White Book", which diagnosed the health service and identified its needs (Novinskey, Interview no. 36).

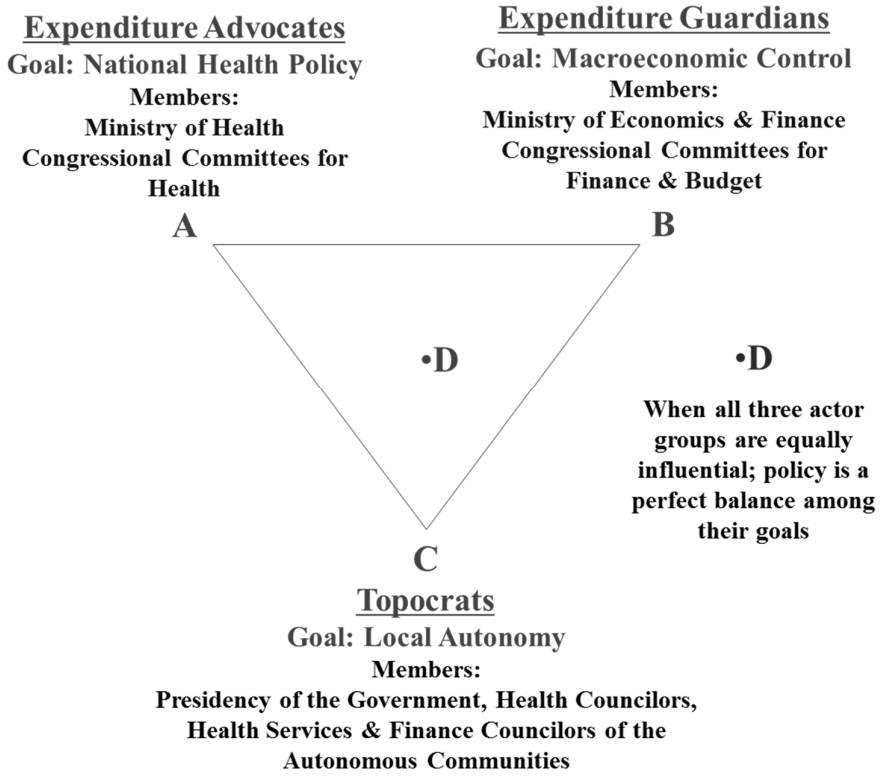
Castile-La Mancha's central hospital of Ciudad Real)[139]" (Novinskey, Interview no. 41). Once most of the agreements were negotiated, it was easy for the Senate to go ahead and pass this legislation with an absolute majority.

5.1.2. Actors and Their Behaviour: A Model of Rational Choice Institutionalism

Policy networks, however, have been largely considered a descriptive concept (see Chapter 2). To make the analysis more explanatory, as described in Chapter 3, I complement this policy network model with an actor behaviour model based on the principles and assumptions of rational choice institutionalism. For the intergovernmental health policy network within the national policymaking environment (or in the "national health policy network"), I apply a modified version of Blom-Hansen's (1999) actor behaviour model (which he applied in Sweden, Norway and Denmark) to Spanish case study, during the periods before and after 2001. This model conceptualises three actor groups—expenditure advocates, expenditure guardians and topocrats—and their relationships within a triangle-shaped policy network, wherein their interactions and strategies regarding health policy form a game situation in which each player rationally pursues its own self-interest. When making national health policies, expenditure advocates promote and defend national health system objectives, expenditure guardians promote and defend macroeconomic control and topocrats promote and defend subnational autonomy.[140] Figure 5.1 illustrates intergovernmental health policymaking at the national level, in terms of the positions and goals of the three actor groups, their example membership in Spain, and the trade-offs between their often-competing goals.

[139] Extremadura also received concessions regarding its Zafra Hospital (Novinskey, Interview no. 41).
[140] As a whole, one stakeholder said he thought that "the government, in spite of having little sector competencies, has to guarantee the principle of constitutional equality" (Novinskey, Interview no.37).

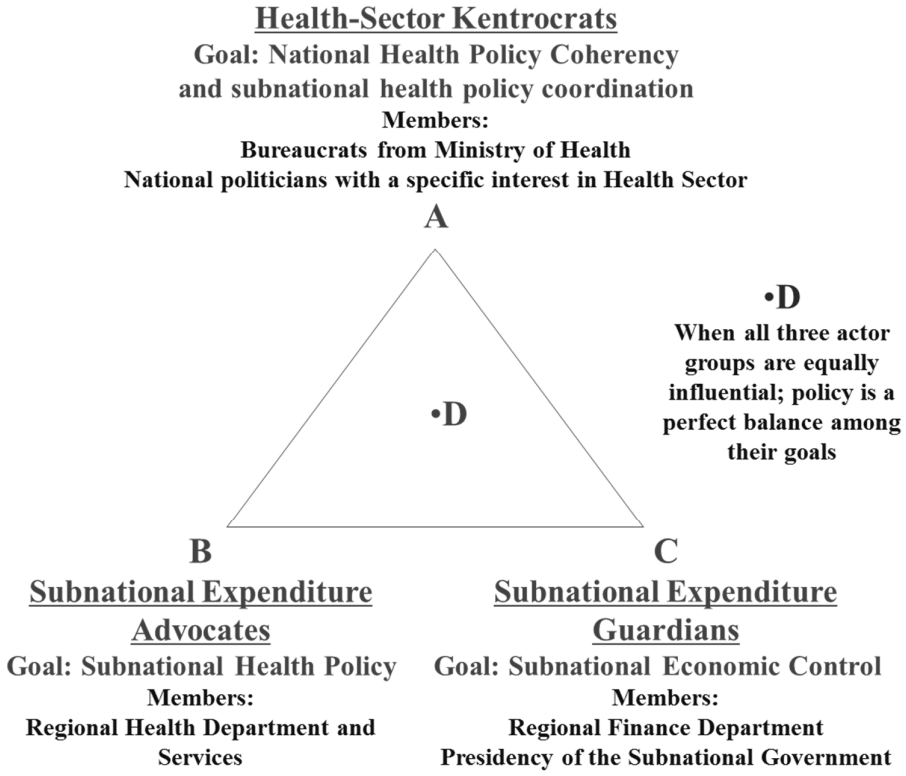
Figure 5.1. Trade-offs in Intergovernmental Health Policymaking at the National Level



Source: Author's elaboration based on Blom-Hansen (1999)

Building on Blom-Hansen's idea of intergovernmental policy networks at the national level, I apply my own model for analysing intergovernmental health policymaking at the subnational level (or in the "subnational health policy network") to the Spanish case study for the period following the "second wave" of health system devolution. Figure 5.2 illustrates intergovernmental health policymaking at the subnational level, with the respective actor positions and goals, example membership in Spain, and the trade-offs between their often-competing goals. The same rational choice institutionalism assumptions specified for the intergovernmental health policy network within the national policymaking environment also apply to the subnational health policy network.

Figure 5.2. Trade-offs in Intergovernmental Health Policymaking at the Subnational Level



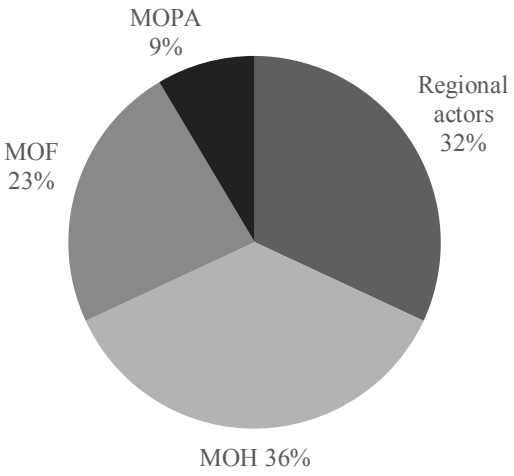
Source: Author's elaboration

5.1.2.1. Validation of Actors for the Case Study: To validate the appropriateness of the main actor groups in my analytical framework for the case of Spain, I asked key stakeholders to identify the main actors before and after the 2001 devolution of health services.[141] For the period before the 2001 devolution, 94 per cent of stakeholders identified the MOH and 22 per cent identified INSALUD as a main actor group. In addition, 72 per cent of those interviewed identified the regions and 44 per cent named the RMHs as a main actor group, while 61 per cent considered the MOF a main actor. No more than 22 per cent of respondents identified the MOPA, the regional ministries of finance, or the regional presidents as main actor groups; other actor groups identified by one or two respondents each were the President of Spain, the MOL, and citizens.

[141] For the period prior to the 2001 reform, I asked 18 of 27 key stakeholder interviewees (those qualified to answer for this period), "Who are the main actor groups involved in the decision-making process for health policy?" Four of the interviewees represented the views of Extremadura, three represented Madrid, four represented the Ministry of Economy and Treasury, and seven represented the Ministry of Health. For the post-reform period, I asked 11 interviewees, "Are these actor groups different from those involved in the decision-making process for health policy before decentralization? Two of these interviewees represented Extremadura, four represented Madrid, two represented the Ministry of Economy and Treasury, and three represented the Ministry of Health. Nota Bene: One (out of 28) key stakeholder declined to answer some of my interview questions.

Responses were generally comparable across all types of stakeholders interviewed. Figure 5.3 is a pie chart representing the total responses for the top actor groups within the national policymaking environment for the health sector before 2001 (e.g. the MOH—including responses for INSALUD—represents 36 per cent of the total responses). As a result, we can see that, overall, the top three institutional actors in health policy in Spain were the MOH, regional actors and the MOF (in that order).

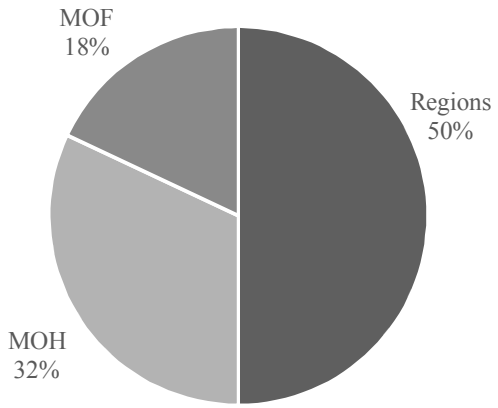
Figure 5.3. The Main Health Policy Actor Groups in the National Policymaking Environment in Spain, Before 2001



Source: Author's elaboration with data from stakeholders interviewed.

For the period after the 2001 devolution, 91 per cent of all stakeholders regarded the regions (in general) as a main actor group, with the RMHs were cited specifically by 36 per cent of respondents. In addition, the MOH was cited by 64 per cent and the MOF by 36 per cent of respondents. Other actor groups identified by one respondent each were the president of Spain, the MOL and citizens. Again, all types of stakeholders had comparable views. Figure 5.4 illustrates the percentages of total responses for the top actor groups within the national policymaking environment for the health sector after 2001 (e.g., the MOH represents 32 per cent of the total responses). As a result, the top three institutional actors in health policy in Spain are the same after the devolution reform as they were before it; though, their order has changed to regional actor first and then the MOH and MOF.

Figure 5.4. The Main Health Policy Actor Groups in the National Policymaking Environment in Spain, After 2001



Source: Author's elaboration with data from stakeholders interviewed.

Overall, the responses received from these stakeholders are consistent with the descriptions of the main actor groups for health policy proposed for the national policymaking environment in the analytical framework. Responding to a question regarding changes in main protagonists from before to after the 2001 health system devolution, a regional health minister (from a different region than Extremadura or Madrid) stated,

> The fundamental element of negotiation on the health system before devolution was in Madrid, it was INSALUD…and, after the 2000 elections, when they took the decision to transfer [health care competencies to the Autonomous Communities], it changed immediately and the different actors [of the system] began to look more toward the Autonomous Communities as the main interlocutor" (Novinskey, Interview no. 36).

Speaking specifically to the negotiations of the 2001 health system devolution, another key stakeholder responded, "The actors were the giants: the political leaders of the MOH, MOF, MOPA as well as those from the Autonomous Communities" (Novinskey, Interview no. 26). In addition, a regional stakeholder from Extremadura confirmed that at the regional level, those who negotiated the health transfers directly with the central government were not from the regional health ministry, stating, "the negotiators of the autonomous community were skilled enough to manage a deal with adequate funding for health within a global financing framework" (Novinskey, Interview no. 07). The MOH (and INSALUD) can be considered expenditure advocates, the regions fulfil the function of topocrats, and the MOF (along with, but to

a lesser extent, the MOPA and the president of Spain) are expenditure guardians. Interestingly, all of these actor groups were inherent in the following excerpt from a top MOF official involved negotiating the 2001 health system devolution reform, "because there was a big negotiation problem between the State and the Regions to receive the health care competencies [and] it was a political discussion with economic content. [The Minister of Finance] worked in parallel with the MOH to make this transfer happen" (Novinskey, Interview no. 41). In addition, he added,

> Because the regional and health-specific financing agreements were due to be merged to create one financing regime… with a system that was no longer unbalanced…without any ear-marked or conditional financing for the Autonomous Communities…This was the big step and this is the reason that MOF was such a key protagonist in this devolution. This would have been very difficult for the MOPA and the MOH to do (Novinskey, Interview no. 41).

Of his relationship with the regions, a top MOH official involved in the 2001 devolution negotiations noted,

> My relationship with the Regional Ministers of Health was terrible because they told me what they wanted to do in their Autonomous Communities and I had to say that I was responsible for the whole country and, therefore, when deciding on investments…the redistribution of resources is required…this generated a conflict of interests… [and] a tremendous pressure on the system, regardless of the political party (Novinskey, Interview no. 31).

Another top MOH stakeholder described the MOH's role with the other two actor groups as curious, "we are a part of the general administration of the State and we work in solidarity with what [the MOF] decides…but, at the same time, we are partners with the regional ministers of health…that is on spending we are with the regional ministers of health and with financing we are with the MOF" (Novinskey, Interview no. 02). After 2001, for the subnational policymaking environment, a few stakeholders identified the regional ministries of health and finance and the regional presidents as main actor groups. Additionally, eight of the eleven respondents (73 per cent) said that the regions had become more powerful while the MOH had become weaker due to the 2001 devolution reform. However, the stakeholder interviews produced limited information to validate the identification of main actors at this level. In support of these limited data, I further discussed my hypothesis that these actor groups play key roles in the subnational policymaking environment with seven key informants—mostly health policy and economics academics—, all of whom verified that it seemed

reasonable.[142] In general, these informants and the literature underscored the fact that the organisational structure and processes of Spain's regional governments were generally based on those of the central government. Thus, it is likely that the regional ministries of health and finance (subnational expenditure advocates and guardians) are main actor groups in the health sector at the regional level. Based on the prolific literature on health system stewardship, it also seems likely that the MOH—the primary member of the health-sector kentrocrats—plays a main role in the health policymaking process at the regional level, promoting the goals of national health policy coherence and coordination across regions.

Chapter 4 described the organisation of the Spanish NHS both before and after the 2001 health system devolution. In that chapter, the Spanish MOH, MOF, MOPA and regional health and finance ministries were salient institutional actors at the national level. This was mostly evident from their executive and administrative assignments on the two main high-level councils concerning the NHS: the CPFF and the CISNS. The interactions and roles of these main actor groups stood out during my stakeholder interviews. In particular, when asked about the relationships between them[143] , in addition to describing their formally organised interactions through the CISNS and the CPFF, interviewees described more-informal interactions. For example, an interviewee who worked for INSALUD before the 2001 health system devolution reform reported that securing financing for the all health services in the country was a fundamental task that the MOH performed each year. To do so, central INSALUD authorities would hold informal, "rather peripheral negotiations", with the regional INSALUD authorities to understand the needs of each "slow-track" region. At the same time, the regions already managing their own health services would participate and make informal requests for more financing. They knew that the more financing INSALUD received, the more they would receive, because they were given a certain per cent of what INSALUD secured each year. Then, formally, the MOH would meet with the MOF and the MOL to negotiate all health financing terms for the year (Novinskey, Interview no. 04).

Moreover, a stakeholder clarified that, after devolution the central government and the regions worked through two different channels depending on the topic. On

[142] One also suggested that I include a second type of kentrocrat of the finance variety, thus, having four main actor groups for the subnational policymaking environment (Novinskey, Interview no. 25).
[143] "How was your administration's relationship with these main actors since the 2001 health service devolution?" and "Was it different from before the 2001 health service devolution?"

health policies, the RHMs worked with the MOH; on health care financing, the regional finance ministries worked with the MOF and often through the CPFF, but there was little interaction between RHMs and the MOF (Novinskey, Interview no. 39). This interpretation does not necessarily contrast with the subnational health policy network model presented in the analytical framework, as it conceives the kentrocrat actor group as having both representatives from the MOF and MOH that interact with the regional health and finance ministries. Furthermore, another stakeholder emphasised his dual role since 2001 as a representative of his RHM as well as a representative of the NHS, interacting regularly with the other sixteen regional health ministers and the Minister of Health: "I form a part of the Inter-territorial Council for the National Health System, which is composed of the 17 regional ministers of health and the Minister [of Health]. I have always clearly thought that I was there representing not only my community but my community *and* a part of the whole [NHS]" (Novinskey, Interview no. 01).

In summary, the stakeholder interviewees confirmed that the main actor groups proposed in my analytical framework for the national policymaking environment were indeed active in health policy both before and after the 2001 health system devolution reform in Spain and are appropriate to use in analysing the Spanish case. As noted, they did not provide, however, enough information to validate the selection of main actors at the subnational level. In hindsight, the interview question was not sufficiently specific in asking for information about the subnational policymaking environment. As a result, only a few stakeholders mentioned subnational-level actors, such as the regional health and finance ministries and the presidents of the regions, as playing a role in health policymaking. In any case, no information was provided to suggest that my model overlooks any essential subnational government actors.

5.1.3. Matrix of Institutional Architecture of Intergovernmental Health Policymaking in Spain

In the next two sections, I use different measures to establish the positions of the actors within each of the intergovernmental health policy networks in Spain after 2003 and to establish the institutional architecture of the case study for the following chapter. The main laws that changed the institutional architecture and the power of the actor groups were introduced between 2001 and 2003. These are included in my analyses of national and subnational expenditure advocates and expenditure guardians, using von Hagen's structural index. For the analysis of the topocrats, after defining the main laws concerning changes in their institutional architecture during the period 2001-2003, I

examine their intergovernmental associations and activities to assess their relative power in the national health policy network (Nota bene: I look at *what* they do not *how* they do it, for the period after 2001 with a focus on 2004–2006). For the analysis of the health-sector kentrocrats, after defining the main laws concerning changes in their institutional architecture during the period 2001–2003, I examine their mandate as a steward of the NHS, assessing in particular their activities under four stewardship responsibilities in order to discern their relative power in the subnational health policy network for the period 2004–2006. Table 5.2 presents the institutional architecture of intergovernmental health policymaking in Spain and the measures used to determine the relative power of the topocrats and health-sector kentrocrats.

Table 5.2. Matrix of Institutional Architecture of Intergovernmental Health Policymaking in Spain for 2001–2003, and Measures to Assess the Power of the Topocrats and Kentrocrats for 2004–2006

Policy Network Actor Groups	**Institutional Architecture**			
	2001	**2002**	**2003**	**2004–2006**
National Expenditure Advocates and Guardians	Budget Stability Law		National Budget Law	
Topocrats	2001 devolution of health service competencies and Regional financing agreement		Law for Cohesion and Quality of the NHS	Assessment of intergovernmental activities to define their relative power in the national health policy network
Subnational Expenditure Advocates and Guardians	Budget Stability Law		National Budget Law[a]	
Health-Sector Kentrocrats	2001 devolution of health service competencies	Patient Autonomy	Law for Cohesion and Quality of the NHS and Statutory Framework for Health Professionals	Assessment of responsibilities and activities as a steward to define their relative power in the subnational health policy network

[a] Extremadura reformed the regulation of its parliament in 2003, 2004 and 2005, but these changes did not alter its institutional architecture in any way that would affect this study.

Source: Author's elaboration

5.2. Establishing the Position of the Actor Groups in the National Health Policy Network

In this section, I analyse the power and influence of each main actor group in Spain's national health policy network: topocrats, expenditure advocates and expenditure guardians. To determine their relative positions, I utilize von Hagen's index for expenditure advocates and guardians as well as the index I created for topocrat strength (see Section 3.2.1). After determining their relative positions, I discuss the general picture of the national health policy network in Spain and the corresponding trade-offs and priorities in policymaking at this level for the period before 2001 and then between 2004 and 2006.

5.2.1. Expenditure Advocates and Expenditure Guardians in Spain

The relative position of expenditure advocates and expenditure guardians of the national health policy network can be established by examining the national budget process. The idea is that the institutional structure, i.e., the arrangements that assign roles to participants and the scope and sequence of decisions, has important effects on the outcomes of the budgeting process and can tell us the relative strength of these two actor groups with respect to each other. The institutional structure is normally established by the general budget law of a country, parliamentary regulations and, sometimes, public sector administrative regulations.

The three main phases of the budget process where bargaining takes place—preparing, enacting and executing the budget—are generally managed by expenditure guardians, led by the MOF. In the preparation phase, the draft budget is usually prepared by the Minister of Finance, the Prime Minister, and/or the Cabinet and negotiated within the government. In particular, expenditure guardians negotiate the draft budget with the different spending ministries—in the present case, the MOH—who are key actors within the expenditure advocate group. During negotiations on health spending, the expenditure guardians try to limit health sector growth and the expenditure advocates aim to maximise health sector funding (Blom-Hansen 1999). The expenditure guardians depend less on particular interest groups for their support than expenditure advocates do and their decisions are more strongly guided by general economic considerations. The expenditure advocates are more exposed to political pressure from interest groups than expenditure guardians are and their decisions are biased in favour of larger expenditures and deficits. Thus, greater constraints in budget preparation and a stronger role for the Minister of Finance in constructing the draft

budget help the government to achieve greater fiscal discipline and stay committed to overall budget goals and strategies.

In the budget adoption (enacting) phase, the parliament's amendment and voting procedures are important factors affecting the institutional structure of the budget process. These factors differ across countries and may serve to limit or expand the parliament's role. Like the expenditure advocates, the parliament is more susceptible to political pressures from interest groups than is the Minister of Finance or the Prime Minister. Thus, the more limited the parliament's voting procedures and scope of action are, the more likely it is that the government will commit to fiscal strategies limiting expenditures and deficits, and successfully defend these strategies against political pressures.

In the final (execution) phase of the budget, the flexibility of the budget—i.e., whether the MOF can block expenditures, how changes are authorised and by whom, whether transfers and carry-overs are allowed—becomes important. These specific budget procedures limit the extent and depth to which the expenditure advocates (the spending ministries and their advocates in the parliament) can modify their budgetary allocations throughout the year and beyond (through carry-over authority). Thus, the strength of the role of the Minister of Finance and, more generally, expenditure guardians can be assessed, as well as the extent of the limitations placed on expenditure advocates during this phase of the budget process.

The organisation of the budget process and procedures tells us much about the relative strength of the expenditure guardians and advocates. It is assumed that the more inflexible the budget procedures are, the more likely the government is to commit to and pursue fiscal discipline and overall budget control strategies. As such, the budget process may be referred to as open (loose) or closed (tight). The looser it is, the greater the bargaining position of the expenditure advocates, whereas a tighter process benefits the expenditure guardians.

In one of the most comprehensive comparative analyses of national budget processes, von Hagen (1992) measured the tightness of the budget process in European Communities through a structural index that examined all three aforementioned phases of the budget process. This index described each phase in terms of four or more indicators (see Table J.1 for the index and complete description of its indicators). Von Hagen (1992) performed nonparametric tests and regression analyses on this structural

index, finding that the institutional framework in which budgeting takes place can have significant consequences for the level of fiscal discipline in a country. He commented:

> A budgeting process that gives the prime or finance (or treasury) minister a position of strategic dominance over the spending ministers, that limits the amendment power of parliament, and that leaves little room for changes in the budget during the execution process is strongly conducive to fiscal discipline (J. von Hagen 1992, 53).

By way of reminder, this paragraph summarizes the budget processes for health care in Spain prior to 2001. The central government sourced funds for its health system and services mostly from general tax revenues. Overall, it had the power to decide which policy sectors (e.g. health, energy, judicial)[144] to allocate (or budget) these and other revenues to. For the regions without health care competencies at this time, the central government's MOF would agree on health financing, including a resource allocation formula, with the regional governments on the CPFF, in consultation with the MOH (cf. Section 4.2.3). As a function of its overall responsibilities, in making this health-specific agreement, the MOF had also to consider and decide how much total financing it could give to the health care sector, as opposed to other sectors, within each regional territory. This 'macroeconomic' or 'inter-sectoral expenditure' flexibility that the MOF has in its preparation of the budget is captured well by the government constraint and negotiation parameters for the first phase of von Hagen's budget tightness index for Spain. See Appendix J. Their final agreement on health financing with the regions would then be passed to the Senate for approval (phase two of von Hagen's index). Once approved, these nationally earmarked funds were allocated to INSALUD for each region's health service, according to the agreed upon resource allocation formula. INSALUD, then, had the ability to decide, within the parameters of the allocation for each region's health services, where to budget, allocate and spend these health care funds (e.g., secondary vs. primary care vs. pharmacy and/or, within these categories, infrastructure vs. equipment vs. human resources). Finally, INSALUD would execute the budget under the limitations set by the MOF, for which are measured by indicators in phase three of von Hagen's index (i.e., how much space or flexibility the MOF allows INSALUD in executing; e.g., allowance of transfers between chapters or carry-overs to the next year, with or without approval by the MOF). See Figure 5.5.

[144] As long as they were not devolved to the regions.

Figure 5.5. Budget Flexibility for Health Expenditures, Pre-2001 in Spain

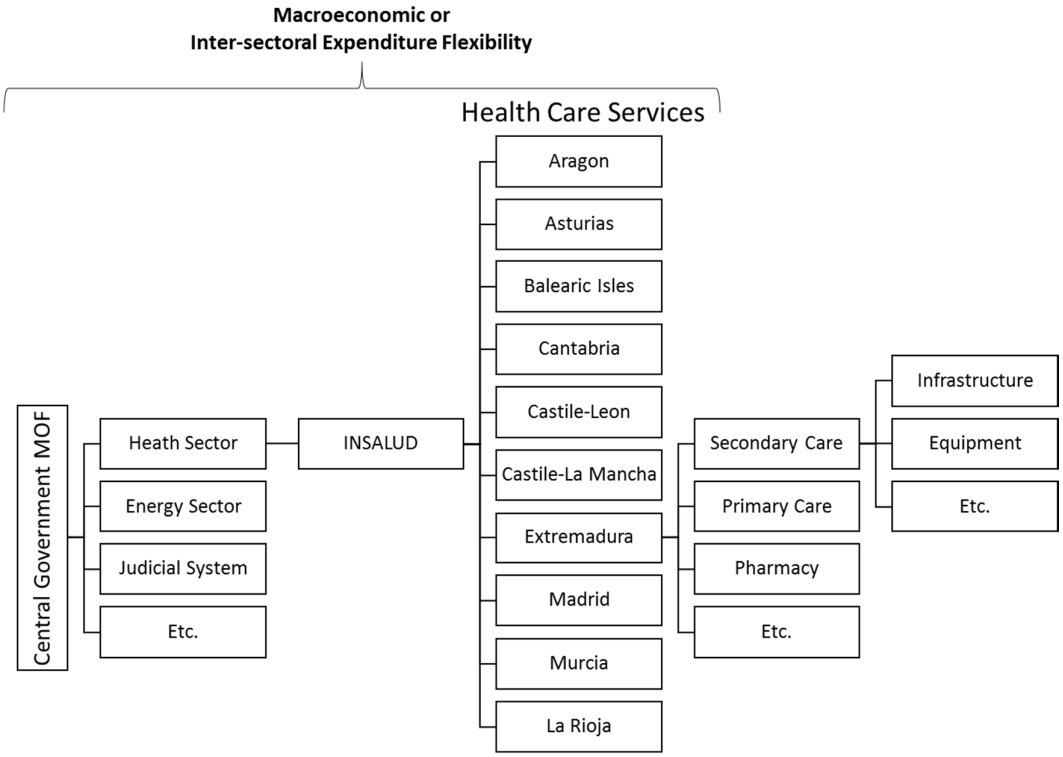


Table 5.3 reports von Hagen's (1992) results for Spain in the 1990s. For purposes of comparison, it also includes von Hagen's (1992) results for Denmark, as well as values for Sweden and Norway from similar analyses based on von Hagen (1992) and as reported by Blom-Hansen (1999 248).[145] Regarding their situation in the 1990s, Blom-Hansen described Denmark as an example country having a tight budget process, and Sweden and Norway as having relatively loose budget processes. Spain scores even lower than Sweden and Norway, indicating a looser budget process than those of all three Scandinavian countries. This implies that it was easier to be an expenditure advocate in Spain than in Sweden, Norway and especially Denmark during the 1990s.

[145] The Scandinavian countries' political systems, party politics and local governments differ from Spain's in many ways, so the comparisons must be regarded with some caution.

Table 5.3. The National Budget Process in Spain, with Comparisons to Scandinavia, during the 1990s

	Spain	**Denmark**	**Sweden**		**Norway**
	von Hagen (1992)	von Hagen (1992)	Molander (1992)	Borg (1997)	Helland and Rasch (1997)
Government's preparation of the budget (maximum score: 16)	6	12.33	4.0	8.33	8.0
Parliament's enactment of the budget (maximum score: 20)	8	12.0	6.0	8.0	8.66
Observance of the budget during the budget year (maximum score: 24)	5.8	10.4	6.7	6.73	8.53
Total score (max. score 60)	19.8	34.73	16.7	23.06	25.19

Explanatory note: The lower the score, the more open the budget process.

Sources: The scores for the studies on Denmark, Sweden and Norway were taken verbatim from Blom-Hansen (1999, 248). The scores for the study on Spain were taken from von Hagen (1992) with one modification from the author. See Appendix J.

Budget processes and procedures, however, change over time, and the thesis is interested in these for the period 2001–2006, starting ten years after von Hagen's snapshot situation (1991–1992). Therefore, I must consider whether any major changes to the budget process and procedures have taken place in Spain from the early 1990s through the mid-2000s.

From 1988 to 2001, the principal framework for national budget processes of the Spanish central government was generated by the Consolidated Text of the General Budgetary Law, approved by Royal Legislative Decree 1091/1988, which updated the 1977 General Budget Law (Jefatura del Estado 1977; Ministerio de Economía y Hacienda 1988). However, between 2001 and 2003, the central government passed a number of budget reform laws, which included major changes to the budget processes and procedures of the government. These reforms mostly resulted from Spain's integration into the European Economic and Monetary Union (EMU) (Iglesias Quintana and Morano Larragueta 2008), but they also arose from the high level of fiscal decentralization that transpired in Spain after the "second wave" of health system

devolution, with over 50 per cent of total public spending managed by the regional and local governments (Ballart and Zapico Goñi 2010a). Thus, in addition to Spain's central government budget policy itself, I cover the supranational EMU treaties and pacts that influenced budget policy in Spain in the following discussion.

In 1992, Spain signed the Maastricht Treaty, which outlined the path for creating a common currency for the EU, the euro. This Treaty created political pressure on the central government to undertake fiscal consolidation and restraint, known as the "Maastricht" effect (Ballart and Zapico Goñi 2010b; von Hagen, Hughes Hallett, and Strauch 2001). Immediately, Spain launched its first Convergence Programme, which among other things shifted the budget process from a fragmented to a contract-based approach in order to achieve a higher degree of centralization and to control spending (von Hagen, Hughes Hallett, and Strauch 2001).[146] This new approach gave additional political power to coalition agreements and boosted the finance minister's role in the budget preparation phase. The Convergence Programme also gave the finance minister responsibility for deriving annual budget deficit targets from macroeconomic forecasts[147] and proposing them to the Cabinet of Ministers for approval, and for inspecting "the consistency of the spending ministries' bids with their numerical spending targets" (von Hagen, Hughes Hallett, and Strauch 2001, 49). As a follow-up to the Maastricht Treaty, in 1997, Spain signed the Stability and Growth Pact (SGP), agreeing to strengthen the monitoring and coordination of its fiscal and economic policies in order to enforce deficit and debt limits and achieve non-inflationary growth and a high level of employment (as established by the Maastricht Treaty).

The SGP and the impending "second wave" of health system devolution, the latter which represents one of the largest public-sector expenditure areas, influenced the

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[146] Fragmentation is a problem for budgetary decision-making because the different actors may make decisions that do not consider overall spending levels. A centralized approach in general means shifting more power for budget preparation and execution to the executive and the Minister of Finance, while limiting the parliament's amendment powers (Hallerberg 2004; von Hagen 2006). A contracts-based approach, among other things, is more adequate for states with electoral systems of proportional representation (which are most likely to produce coalition governments) and multi-party coalition governments (Hallerberg and von Hagen 1998; 1999). "In a nutshell, it is difficult for a coalition government to work under a strong finance minister, since the latter necessarily comes from one of the coalition parties. Vesting him with special authorities raises concerns among the other parties about a fair treatment of their spending interests in the budgeting process. … [T]he threat to break up a coalition is a very effective one for enforcing negotiated budget targets in multi-party governments" (von Hagen, Hughes Hallett, and Strauch 2001, 46).

[147] The ministerial budgets are derived with the cooperation of the financial office within each ministry (*Oficina Presupuestaria*). The head of this office is appointed by, and hails from, the Ministry of Finance.

Spanish central government to pass the 2001 Budget Stability Laws,[148] which aimed among other things to formalise the culture of fiscal discipline in Spanish legislation (Jefatura del Estado 2001a; 2001c). These laws, which were meant not least to facilitate coordination between the regions and the central government (Novinskey, Interview no. 41), identified specific macroeconomic fiscal rules, including the definition of budget stability as a "surplus or balanced budget",[149] mid-term (triennial) budget stability objectives, a non-financial expenditure limit[150], and a contingency fund for budget execution (Iglesias Quintana and Morano Larragueta 2008). This last provision was intended to permit introduction into the budget of new non-discretionary expenditures due to unforeseen issues (e.g. natural disaster relief) by creating an exception to the procedure for approving modifications to the budget, which otherwise requires a new budget law (Zapico Goñi 2004). The 2001 budget laws also established budgetary procedure rules, including the production of cyclical situation reports, the processing of budget stability objectives in parliament, the determination of growth thresholds, and the establishment of consequences for budget deficit or surplus situations.

Moreover, with the 2003 National Budget Law (effective in 2005), the central government reformed the country's general budget legislation for the first time in more than 25 years. This law emphasised rules and principles for micro-management, performance management (output-outcome measures) and budgeting by objective (Jefatura del Estado 2003d). It also introduced an evaluation procedure for all public policies, with the Ministry of Finance initially coordinating the evaluation of spending programs until an independent supervisory agency took over. Spain passed further budget legislation, including a reform of the 2001 Budget Stability Laws, in 2006, but it was not implemented until 2007 and thus does not affect the present study (Jefatura del Estado 2006a; 2006b).[151]

In terms of the mechanics of the budget processes for health care after 2001, by way of reminder, this paragraph provides a summary. As they were prior to 2001,

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[148] Consisting of the 2001 Budget Stability Law (18/2001) and its Complement Law (5/2001), which both apply to all levels of public administration in Spain. These laws became effective in 2003 and were amended in 2006 (Jefatura del Estado 2006a; 2006b).

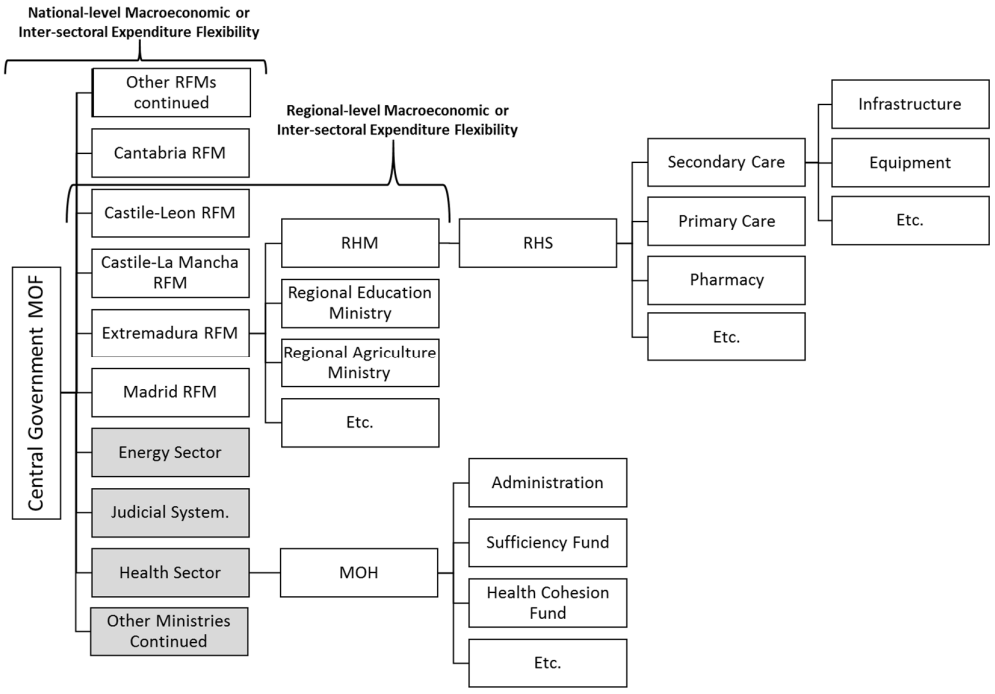
[149] A deficit is considered an exceptional situation requiring a correction plan to regain stability.

[150] The non-financial expenditure limit is based on accurate information related to the balance, budgetary deficit or surplus with the balance, and deficit or surplus calculated in accordance with the rules of the European System of National and Regional Accounts (Art. 13, Law 18/2001).

[151] In 2005, Spain also signed an amendment to the SGP that introduced additional economic considerations to the Pact and allowed greater flexibility considering individual national circumstances. The 2006 reform of the Budget Stability Laws included these aspects of the amendment.

general tax revenues were the main source of funding the health care system. These revenues were sourced from the central government, the Autonomous Communities and taxes, according to the tax revenue parameters in the 2001 financing agreement (see Section 4.4.3). Those from the central government were transferred directly from the coffers of the MOF to those of the RFMs, using the allocation formula of the 2001 regional financing agreement. It is important to remember that earmarked financing for health care was lost with this agreement. At this point, any changes to this financing agreement or the input of additional funds to the regional health services would represent informal intergovernmental policymaking within the national health policy network and among its main actors. As such, an assessment of the national-level macroeconomic or inter-sectoral expenditure flexibility can be measured here, using von Hagen's budget tightness index (using indicators from the first phase of the budgeting process). Each year the budget is then approved by the Senate (second phase of the budgeting process). Upon approval, the regional financing funds are transferred to the RFM, who is responsible for budgeting and allocating them, for example, to the different policy sectors like health; however, particular to Spain, the RFM's have to comply with a nationally set minimum allocation for health care. As another step of the budgeting process, the RFM confers and negotiates with the RHM on the specific budget line items and final total funds for health care in the region. In our subnational health policy network, this is a reflection of informal intergovernmental policymaking. It is also the point where a regional-level macroeconomic or inter-sectoral expenditure flexibility analysis has value, using my adapted version of von Hagen's budget tightness index (see Section 5.3.1 below). Once having negotiated with the RFM, the RHM is responsible for executing the budget within the limitations set by the RFM, which are measured by indicators in phase three of our adapted version of von Hagen's budget tightness index. See Figure 5.6.

Figure 5.6. Budget Flexibility for Health Expenditures, Post-2001 in Spain



Overall, for the period 2004–2006, the budget preparation and execution processes were affected mostly by the 1997 SGP and the 2001 Budget Stability Laws, and less so by the 2003 general budget law (because the latter only began implementation in 2005). The differences these changes made on Spanish national budget processes and procedures since the early 1990s can be seen in Table 5.4, which compares von Hagen's (1992) results for national budget tightness in Spain for 1990 with the results of my analysis of the national budget tightness in Spain for 2004 to 2006. In particular, the 2001 Budget Stability Laws affected the first phase of the budget by changing the general constraint of budget preparation: intending to become a European exemplar in fiscal policy, Spain introduced a "zero deficit" rule that goes beyond the "golden rule" of public finance (Ballart and Zapico Goñi 2010a; Domínguez Martínez and López Jiménez 2012). These laws also modified this phase through reshaping the negotiation procedure within government (i.e., the initial budget guidelines and agenda-setting procedure), as the Finance Minister now prepares the draft budget with spending recommendations according to general budget guidelines plus specific "budget stability objectives" before proposing it to the Council of Ministers.

These major changes increased Spain's score on the first phase of budgeting from 6 to 13.66 points. In addition, with the reforms during this period, budget

execution in Spain became less flexible: the Finance Minister was given the ability to block expenditures during this phase of the budget process and more power concerning transfers between chapters, albeit still with considerable limitation. These major changes also increased the score on observance of the budget during the budget year (i.e., the third phase) from 5.8 to 10.6 points. The score for the second phase of the national budget process did not change during the period of study. Therefore, the total score for all three phases of the budget increased from 19.8 to 32.26 points, showing a clear tightening of the national budget process in Spain across the two periods of study.

Table 5.4. The National Budget Process in Spain[a]

	1991-1992	**2004-2006**
	von Hagen (1992)	Author
Government's preparation of the budget (maximum score: 16)	6	13.66
Parliament's enactment of the budget (max. score: 20)	8	8
Observance of the budget during the budget year (max. score: 24)	5.8	10.6
Total score (max. score 60)	19.8	32.26

Explanatory note: The lower the score, the more open the budget process.

[a] The institutional architecture for this period was established at the end of 2003 and remained effective until 2007, when the 2006 budget stability reforms were implemented.

5.2.2. Topocrats in Spain

From the moment when it launched its Autonomous State model, the Government of Spain foresaw a practical need to underpin formal policymaking processes of its central and regional governments by creating an informal channel for their exchange and coordination of information as well as cooperation. This informal policymaking channel, first and foremost, manifested itself in the Sectoral Conferences (*Conferencias Sectoriales*) (Secretaría de Estado de Cooperación Territorial 2006). The Sectoral Conferences were first included in the 1981 Draft Bill for the Harmonisation of the Autonomic Process (*Ley Orgánica de Armonización del Proceso Autonómico*) (Article 9) and then appeared in Article 4 of the Law 12/1983 of Autonomic Process (*Ley de*

Proceso Autonómico) (Jefatura del Estado 1983).[152] They were ostensively sector-specific. Several interviewees mentioned the importance of the Sectoral Conferences in harmonising sector politics (Novinskey, Interview no. 37, 39, 41). The first Sectoral Conference developed was the Tax and Finance Policy Council (CPFF), established and regulated by Law 8/1980 on financing the autonomous communities (*Ley Orgánica de Financiación de las Comunidades Autónomas*) (Jefatura del Estado 1980b). Afterwards, they were established according to need, generally following the calendar of the devolution of public services from the central government to the regions; for example, the Agriculture and Rural Development Sectoral Conference was established in 1983, the Education Sectoral Conference in 1986 and the CISNS in 1987 (Secretaría de Estado de Administraciones Públicas 2012, 6, Table 1). By the end of 2006, there existed 30 Sectoral Conferences, most of which based their regulatory framework on that of the CPFF. Although some, like the CISNS, created their own specific regulatory framework.

Through their participation in Sectoral Conferences, the Spanish regional topocrats[153] play an important informal policymaking role within the national policymaking environment. Spain's Sectoral Conferences are the closest equivalent to Scandinavia's Local Government Associations, which Blom-Hansen (1999) described in his original analysis of this type of actor. The main function of these Conferences is to coordinate central-regional government relations and promote their cooperation. They serve as intergovernmental forums for making *formal agreements*, as a more agile alternative to parliamentary decision-making. The two Sectoral Conferences that influence the health sector are the CISNS and the CPFF.

By way of reminder, the CISNS is a permanent body of health system coordination, cooperation, communication and information between the regional and the central governments. Its main objective is to promote the cohesion of the NHS by guaranteeing citizen rights throughout the country. It is the only Sectoral Conference specific to the health sector, and all regions and the central government form its membership. Shortly after the 2001 health system devolution reform, in 2003, the LCQ

[152] The content of this Article was transferred eventually to Law 30/1992, and its current wording is given in Law 4/1999.

[153] I address all of the ten "slow-track" Spanish regional topocrats together here without distinguishing among them, although there is some evidence of differences in levels of *de facto* influence between them. Madrid seemed to be the most powerful of the group and was a major player in convincing the others to move forward at the same time with the 2001 health system devolution reform (Novinskey, Interview no. 39).

changed the composition of the CISNS to reflect the post-devolution (non-hierarchical) distribution of health service powers, reducing its number of voting members from thirty-four (a one-to-one ratio of central government to regional government representation) to eighteen, including the Minister of Health (as the only central government representative) and the seventeen regional health ministers. This effectively reduced the power of the central government (expenditure advocates) and increased the power and influence of the regions in the health sector. Agreements reached by the CISNS are non-binding recommendations and are normally adopted by consensus, but they carry considerable political influence (El Globalnet 2004).

Since 1996, the CISNS has held plenary sessions two to five times a year,[154] in addition to "second-level" working group and executive and technical committee meetings. The number of agreements made each year in plenary sessions varied (Ministerio de Sanidad y Consumo 2015). Before 2001, the CISNS held an average of 2.2 plenary sessions per year and made an average of 11.1 agreements per session (see Table 5.5). After health system devolution and during the period 2004–2006, the CISNS held an average of 3.7 plenary sessions per year and made an average of 37.7 agreements per session. . Its use of agreements in central-regional government relations indicates a privileged position for the topocrats in the decision-making process at the national policymaking level. However, it should be noted that prior to 2001, the topocrats from the Extremadura and Madrid were at a more disadvantaged position than the regions that had already received decision-making powers over health care competencies.

Table 5.5. Plenary Sessions and Agreements of the CISNS, 1996–2006

Year (1996-2006)	**96**	**97**	**98**	**99**	**00**	**01**	**02**	**03**	**04**	**05**	**06**
Plenary sessions	2	4	4	2	2	4	3	5	3	4	4
Agreements	18	56	34	30	18	21	19	37	29	41	43
Agreements per plenary session	9	14	8.5	15	9	5.3	6.3	7.4	9.7	10.3	10.8

[154] Despite a formal regulatory requirement that the CISNS meet four times a year (Consejo Interterritorial del Sistema Nacional de Salud 2003).

Regarding the scope of agreements, Table 5.6 shows CISNS agreements by thematic areas for the period 2002–2006.[155] It shows that the Council made 169 agreements, 43 of which were "interior system" topics (*Régimen Interior*) (e.g. adoption of minutes, appointments, modifications of its regulatory framework, and creation, modification or dissolution of technical and technical committees and working groups). The remaining 126 agreements were mostly in the areas of public health, health policy and evaluation, pharmaceuticals and planning. Some agreements covered the areas of professional organisation and human resources,[156] the European Union, health plans, service delivery organisation, specialised care, health care benefits and mental health. Since 2001, the Council has also been charged with assigning resources from the Health Cohesion Fund (*Fondo de Cohesión Sanitaria*).[157]

These thematic areas address competencies of the central government (e.g. pharmaceuticals and the EU) and some health issues devolved to the regions (e.g. health service management, health care benefits). Therefore, to an extent, the CISNS is a two-way channel that provides each level of government with exclusive access to each other's policymaking environment. On the one hand, it gives the central government a means of overseeing decision-making across the regions, to make it more coherent. Additionally, because the agreements are advisory and not executive, the central government can even encourage coordination with each region to achieve specific, mutually identified goals while not overstepping the boundaries of its own devolution mandate. On the other hand, the regions can take part in national-level policy decisions that have a potential impact on the activities of the central government as well as across all regions.

Overall, the increased proportional weight of the topocrats in the CISNS, its sustained activity over time, and the nature of the issues addressed (covering both national- and regional-level policies and coordination) show a greater and ongoing influence of the topocrats in the national policymaking processes over time.

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[155] Comparable data for before 2002 were not available.

[156] Since the 2003 LCQ, professional organisation and human resource topics are addressed in the Human Resource Commission of the NHS and not the CISNS

[157] The Health Cohesion Fund was created by Law 21/2001 (article 4.B.c), with the objective of guaranteeing equal access to public health care services throughout the country and for displaced citizens in the EU. At first, its management and distribution were competencies of the MOH, but with Law 16/2003 (LCQ), the CISNS was charged with allocating its resources. Royal Decree 1207/2006 regulates the management of the Health Cohesion Fund and, in particular, the eligible activities and distribution criteria for compensation.

Table 5.6. CISNS Agreements by Thematic Area, 2002-2006

Thematic Area	Total	Per Cent
Public health	36	21.3%
Pharmaceutical	17	10.1%
Professional organisation and HR	8	4.7%
Health policy and evaluation	21	12.4%
Planning	17	10.1%
European Union	7	4.1%
Health plans	3	1.8%
Health service management/organisation	5	3.0%
Specialised health care	2	1.2%
Health services/benefits	5	3.0%
Mental health	2	1.2%
Other	3	1.8%
Internal system	43	25.4%
Total	169	100.0%

The CPFF was created to coordinate tax and financing activities between the MOF, the MOPA and the regions. Its membership, throughout the period of study comprised the Minister of Finance, the Minister of Public Administration and the seventeen regional finance ministers (a two-to-seventeen ratio of central government to regional government representation).[158] The CPFF is required to hold meetings at least twice a year to establish agreements on various tax and finance matters, including "a) coordinating the budgetary policy of the regions with the central government. b) The production of reports and the adoption of agreements defined in Law 18/2001 [sic], Complementary to the General Budget Stability Law. c) The study and evaluation of criteria for the distribution of resources from the Compensation Fund" (Jefatura del Estado 1980, vol. 236, n. Article 3, section 2, a–c, own translation). CPFF agreements take the form of recommendations. As described in the financing sections of Chapter 4, most of the CPFF's agreements concerned the regional financing system and the NHS financing system, and they took place every five and four years, respectively, between 1987 and 2001. The 2001 regional financing agreement—the only one reached during 2001–2006—absorbed NHS-earmarked financing within the regional financing system. As such, the CPFF did not separately discuss health financing from that point on. Overall, the CPFF has proven an effective mechanism for negotiating central-regional

[158] Since the merger of these two ministries, just the (one) Minister of Finance and Public Administration participates on the CPFF.

finance and tax policy before presenting agreements to parliament for approval. The agreements reached involve major initiatives in finance and tax policy in which the regions participate.

Overall, the influence of the ten "slow-track" Spanish regional topocrats differed before and after the 2001 health system devolution, especially with regard to their level of exclusive access to the central government and the average number of plenary sessions and agreements made by the CISNS, as well as the membership ratios of both the CISNS and the CPFF. In summation, the regions had a slightly moderate position in the decision-making processes of their national health policy network before 2001; after it, they gained considerable influence and became relatively strong topocrats. See Table 5.7 on topocrat strength below.

Table 5.7. Topocrat Strength in Spain for before 2001 and 2004–2006

	Spain	
	Before 2001	**2004–2006**
1. Do the local government associations exist in the country and sector of investigation? (maximum score: 2)	2	2
2. Do local government associations routinely interact with, and have exclusive and systematic access to, the central government? (maximum score: 3)	1	3
3. How involved are local government associations in policy formulation at the national level? (maximum score: 4)	1	3
Total Score	**4**	**8**

Explanatory Note: The higher the score, the stronger the influence of the topocrat in the national health policy network. See Appendix K for index values.

5.2.3. The General Picture of the National Health Policy Network in Spain

In this section, I summarise the position of the three actor groups within the national health policy network in Spain during the period before the "second wave" of health system devolution (1991–2001), and after it, once the new institutional architecture for the health and finance sectors is re-established (2004–2006).

For the period 1991–1992, the national health policy network in Spain was close to the *policy community* end of the network continuum (cf. Table 5.1). This cross-sectoral network gave expenditure advocates a structurally favoured position in the formulation of national health policy. The institutional architecture of the health and finance (budget) sectors remained the same from this period until 2001, when it began to change, namely, with the "second wave" of health system devolution and the

2001 and 2003 budget reforms. With these reforms, the national health policy network loosened and shifted slightly towards the *issue network* end of the continuum (although still closer to the *policy community* end than to the *issue network* end). Moreover, as the budget process tightened and the topocrats gained strength, they also achieved a more structurally favoured position in the formulation of national health policy. The institutional architecture of the health and finance sectors stabilised after 2003 and stayed the same throughout 2006.

Table 5.8 presents the strength designations for the actor groups within the national health policy networks during each period in Spain, with a comparison to those in Scandinavian countries during the 1990s, which stem from Blom-Hansen's (1999) data. From the pre-2001 to the post-2003 period in Spain, the national budget process tightened considerably and the expenditure advocates and guardians exchanged positions, the former losing and the latter gaining power. At the same time, the topocrats become considerably stronger after the 2001 devolution of health system and services. Interview data from the study corroborate these results, with the exception that some expenditure guardians and topocrats have perceived expenditure advocates as always having been weak.

Table 5.8. National Health Policy Networks in Spain, with Comparison to Scandinavia

Actor Groups	Health Sector				
	Denmark 1991–1992	**Norway 1991–1992**	**Sweden 1991–1992**	**Spain 1991–1992**	**Spain 2004–2006**
Topocrats	Strong	Weak	Strong	Moderate	Strong
Expenditure Advocates	Moderate	Moderate	Strong	Strong	Moderate
Expenditure Guardians	Moderate	Moderate	Weak	Weak	Moderate

Explanatory Note: I use different thresholds from Blom-Hansen (1999) to determine the strength of power of expenditure advocates and guardians, and of topocrats (See Chapter 3). Therefore, for expenditure advocates and guardians, I have revised Blom-Hansen's designations according to my methods. For topocrats, I created an index and labelled the two periods in Spain accordingly. I was not able to revise Blom-Hansen's designations for this actor group as he used a more subjective (non-quantitative) method that was not clearly defined enough for assigning labels to topocrats. This should be taken into consideration when comparing topocrats across countries.

In terms of Figure 3.1 on the trade-offs in intergovernmental health policymaking at the national government level for the period 1991–2001, the Spanish health policy is somewhat close to the A–C line and further down that line more toward A. Thus, the balance of power favoured the expenditure advocates and their national health policy goals, with a slightly moderate influence by topocrats. For the period 2004–2006, the structural organization of the Spanish system has shifted from the realm of the expenditure advocates toward the expenditure guardians and topocrats, landing slightly to the right of and below point D (the point where all three goals are in equilibrium). Thus, the balance of power in the Spanish health sector after the 2001 health system is within the realm of the topocrats with moderate influence from the expenditure advocates and guardians. Interestingly, when comparing Spain's results with the national health policy networks in 1991–1992 Scandinavia, we find three variants out of the five studies: Sweden's structural set-up for intergovernmental health policymaking at the national level is similar to Spain's in 1991-2001, falling close to line A–C however in a more balanced position between A and C; and Denmark's is remarkably similar to Spain's in 2004–2006, lying slightly to the right of and below point D. Norway's structural set-up represents a third variant: the exact opposite of the Danish system, lying almost on the A–B line.

5.3. Establishing the Position of the Actor Groups in the Subnational Health Policy Network

I now analyse the power and influence of the three actor groups in the subnational health policy network—subnational expenditure advocates and subnational expenditure guardians, and health-sector kentrocrats—in Spain between 2004 and 2006. Then, I discuss their relative positions and trade-offs in intergovernmental health policymaking at the subnational government level to give an overall picture of the subnational health policy networks and where their priorities lie for the regions of Extremadura and Madrid.

5.3.1. Subnational Expenditure Advocates and Expenditure Guardians in Extremadura and Madrid

Similar to the analysis carried out for the expenditure advocates and guardians of the national health policy network, the relative position of subnational expenditure advocates and guardians can be established by examining the budget processes at the regional level of government. The institutional architecture of the regional budget

processes in Spain is established by regional public finance law, regulations of the regional parliament, national legislation and, sometimes, additional public administrative actions. Here, I examine this institutional architecture for Extremadura and Madrid during the period 2001–2003, after which this architecture remains stable for the period 2004–2006.[159] To do so, I implement the same methodology used in the prior analysis of national-level expenditure advocates and guardians in Spain; keeping in mind, though, that the regions are also subject to the financing constraints defined in the national budget laws and national constitution in addition to their own legislation (von Hagen, Hughes Hallett, and Strauch 2001). Since this empirical approach has not previously been applied to the regional level of Spain's health sector[160], I replicate von Hagen's (1992) structural index for measuring the tightness of the budget process for both Extremadura and Madrid (following the same procedure I used to update the index for Spain during 2004-2006).

The budget process in Extremadura is based on three main regional laws and their reforms. All legal and political processes in Extremadura are founded on the Statute of Autonomy, which was established in Organic Law 1/1983 and successively reformed in 1991, 1994 and 1999 (remaining in effect until 2011). It defines the character and functions of the main government institutions in Extremadura. The unicameral Parliament of Extremadura (*Asamblea de Extremadura*) is the legislative branch, while the Government of Extremadura (*Junta de Extremadura*) is the executive branch, containing a Governing Council composed of the president, vice presidents and the sectoral ministers. Following this statute, during the same year, specific regulations for the parliament's functioning were established and subsequently reformed in 2003, 2004 and 2005 (Asamblea de Extremadura 1983). These reforms, however, did not change the institutional architecture of the parliament for the purpose of this study.[161] In addition, Law 2/1985, on Public Finance of the Extremadura, constituted the legal reference document for regulating the financial functions of the regional public sector,

[159] From 2007, the 2006 updates to the Budget Stability Laws were implemented, modifying this institutional architecture. See discussion in Section 5.2.1.
[160] I performed a wide search of the budget literature and contacted Drs. von Hagen and Hallerberg as well as two public finance experts in Spain via email to understand if they knew of any such analyses. Unfortunately, neither turned up any regional application of von Hagen's structural index in Spain.
[161] The 2003 reform changed article 44.1, fixing the number, denomination and content of the permanent legislative commissions to the distinct competencies of the regional government ministries. The 2004 reform modified article 44.2 to create a parliamentary commission to control the newly created public enterprise "Extremadura Audio-Video Corporation" (stemming from Law 4/2000 and Law 4/2004). The 2005 reform modified article 44.1 according to the new designations of the ministries as well as the newly created Extremadura Housing Agency.

establishing all of its economic and financial bodies and procedures. From 1990 until 2003, several articles of this law were modified by annual budget laws until it was fully reformed in 2007 to better reflect Extremadura's extensive assumption of new functions and services from the central government (Presidencia de la Junta 2007), as well as aspects of the central government's 2001 Budget Stability Laws and the 2003 General Budget Law that had already begun to affect Extremadura.

Using information from the above legislation, I adapted von Hagen's (1992) structural index parameters to the regional context, and applied it to the cases of Extremadura and Madrid. See Section 5.2.1 for information on budget mechanisms, including regional macroeconomic or inter-sectoral expenditure flexibility. See also Table 5.9 for the general scores for each phase and total of the budget process, and Appendix J for the complete indices with indicators and their definition. For the first phase, on the government's preparation of the budget, Extremadura scored a total of 13.66 points. The Spanish national budget process received this score as well during this period; the similarity is mostly because of the influence of the EU Maastricht Treaty and the SGP, and of subsequent national budget legislation affecting the regional budget process. For example, the national budget law defined the general budgetary constraint—a 4-point indicator of the budget preparation phase of the index—for all levels of Spanish public administration. For the second phase of the budget process—the parliament's enactment of the budget—, while some indicators were affected by supranational budgetary agreements and national budget legislation, much of the information could be obtained from the regional parliament's regulation. For example, following the guidelines established by the national budget laws, Article 125.3 of the Extremadura Parliamentary Regulation set specific terms for offsetting additional expenditures with cuts in other areas of the budget; and Article 126 of the same regulation described the voting procedures for the assembly, which are original and specific to Extremadura. Extremadura scored a total of 14 points for this phase during the study period. Finally, for the third phase—observance of the budget during the budget year—, the indicators were mostly specific to the regulations regarding public finance in Extremadura. Extremadura received a score of 11.6 points. Extremadura's overall score for the budget process was 39.26 points; that is, seven points greater than the central government's total score of 32.26 on this index during the same period.

Table 5.9. The Regional Budget Process in Extremadura and Madrid, with Comparison to Spain, 2004-2006[a]

	Spain	**Extremadura**	**Madrid**
Government's preparation of the budget (maximum score: 16)	13.66	13.66	13.66
Parliament's enactment of the budget (max. score: 20)	8	14	10
Observance of the budget during the budget year (max. score: 24)	10.6	11.6	7.6
Total score (max. score 60)	32.26	39.26	31.26

Explanatory note: The lower the score, the more open the budget process. [a] The institutional architecture for this period was set by the end of 2003 and remained effective until January 2007, when the 2006 budget stability reforms were implemented at the national level, and the 2007 reform of Law 2/1985 on Public Finance of the Extremadura and the 2009 modification of the regulation regarding the Parliament of Madrid's functioning were implemented in Extremadura and Madrid, respectively.

Source: Author's analysis.

The regional budget process in Madrid is based on three main regional laws and their modifications, but also influenced by the EU Maastricht Treaty and the SGP as well as subsequent national budget legislation (e.g. 2001 Budget Stability Laws and 2003 General Budget Law). All legal and political processes in Madrid are founded on its Statute of Autonomy, which was established with Organic Law 3/1983 and successively reformed in 1994 and 1998 (remaining in effect until 2010). Madrid's Statute of Autonomy defines the character and functions of its main government institutions. The Parliament of Madrid (*Asamblea de Madrid*) is the legislative branch of the community, approving and controlling its budget (Comunidad Autónoma de Madrid 1997, vol. 36, n. Article 9). The Regional Government of Madrid is the executive and administrative branch and has a Governing Council composed of the president, vice presidents (if any) and the ministers (Presidencia de la Comunidad de Madrid 1983, vol. 161, n. Article 19). Law 9/1990, regulating the Treasury of the Community of Madrid, constituted the legal reference document for regulating the financial functioning of the regional public sector. This law was modified almost every year by either the annual regional budget laws or the (annual) tax and administrative measures laws (Presidencia de la Comunidad de Madrid 1990). Finally, in 1997, Madrid passed a specific regulation on the functioning of its parliament, which remained active without modification until 2009 (Comunidad Autónoma de Madrid 1997).

I applied von Hagen's (1992) structural index parameters to the case of Madrid. For the first phase of the budget process, the government's preparation of the budget, Madrid scored 13.66 points. It is not surprising that Madrid received the same scoring for this phase as Extremadura and the central government because it is under the same influences, namely the EU Maastricht Treaty, the SGP and subsequent national budget legislation. For the second phase of the budget process, the parliament's enactment of the budget, information was obtained from regional parliamentary regulations; for example, Article 162.2 sets specific terms for the offsetting of the budget (following national budget law guidelines) and Article 164 describes the voting procedures of the parliament (which are specific to Madrid). I awarded Madrid 10 points on this phase. For the third phase of the budget process, observance of the budget during the budget year, indicators were mostly specific to the budget regulations within the Treasury Law of Madrid. After careful analysis, Madrid scored 7.6 points, which was by far the lowest score across the board for any of the budget phases and case studies in this thesis. Overall, Madrid scored 31.26 points, which was one point lower than the central government's total score and eight points lower than Extremadura's total score.

Overall, from this analysis of subnational expenditure advocates and guardians, Extremadura almost ranked in the strong category, whereas Madrid was more moderate. Indeed, Extremadura can be said to have had stronger subnational expenditure guardians than subnational expenditure advocates; however, Madrid's expenditure advocates and guardians were both moderate. Moreover, in comparison with the central government, Madrid had a slightly looser budget process, while Extremadura's was considerably tighter.

5.3.2. Health-Sector Kentrocrats

By way of reminder, health-sector kentrocrats are representatives who promote central government interests in the health policymaking process at the subnational level of government. They can be thought of as the inverse of the topocrats, only sector specific. Health-sector kentrocrats are typically national-level bureaucrats from the health sector but can also include national-level politicians with an interest in the health sector. As the intergovernmental relations shift toward a greater amount of decision space at the subnational government level, especially in the case of health system devolution, health-sector kentrocrats "steward" subnational governments by guiding them in the policymaking and implementation of health policies and seeking to advance

their primary goals of national health policy coherence and coordination across the subnational governments.

In most governments, including Spain, health-sector kentrocrats consist primarily of representatives from the MOH, because the MOH is the ultimate governing entity responsible for the health system's performance and the welfare of the population (Roberts et al. 2004). In Spain in particular, the 1978 Spanish Constitution (Article 149.16) gave the central government exclusive responsibility over basic legislation and general coordination of health care, as well as health financing, health care coverage and benefits, pharmaceutical policy and training and research. The Spanish MOH is the public body responsible for proposing and implementing government policy on health planning and health care, and for guaranteeing the right to health care for all citizens. The 1986 GHL charged the MOH with ensuring the coordination and cooperation of the NHS and its various stakeholders, including health services at the regional level. With the completion of health system devolution in 2001, the government passed Royal Decree 840/2002, which modified and developed the MOH's organisational structure, giving it the role of steering body and high inspector of the NHS, and making the CISNS, the chief coordinating body of the NHS (Ministerio para Las Administraciones Públicas 2002, 840). The 2003 LCQ further regulated the MOH's oversight role vis-à-vis the NHS with a better systematisation of the MOH's functions, as follows (Jefatura del Estado 2003b):

i) to monitor the integration of the regional health plans and programs and the general objectives of the central government;
ii) to evaluate compliance with the common goals and objectives of the NHS, including those defined in agreements made by the CISNS;
iii) to monitor the implementation and utilisation of central government funds and subsidies allocated to the regions;
iv) to make sure that funds for health services at the regional level are utilised according to the general principles of this law;
v) to ensure that previously central government-owned health centres, services or establishments are being used appropriately,
vi) to verify the absence of all types of discrimination in the NHS, and
vii) to monitor all health competencies and ensure that they are carried out in agreement with criteria for the democratic participation of all stakeholders.

Furthermore, the 2003 LCQ gave the MOH joint responsibility (with the regions) over the development of quality assurance strategies for the NHS, which would be implemented through its Agency for NHS Quality (Article 60).[162]

To find the relative position of the health-sector kentrocrats in Spain from 2004 to 2006, I assess their influence on health policy priorities within the subnational health policymaking environment (see Chapter 3 for more details). To do this, using health system stewardship concepts from Travis et al.'s (2003), I analyse the MOH as a *steward* of the health system and its progress in advancing its primary goals as a health-sector kentrocrat (i.e., national health policy coherence and coordination across the regional governments). In particular, I examine the MOH and its ability to carry out the following four responsibilities: (i) to ensure tools for implementation: powers, incentives and sanctions; (ii) to ensure accountability; (iii) to generate intelligence; and (iv) to build partnerships.

To begin, for the MOH's first area of responsibility (Ensuring Tools for Implementation), I assess whether the MOH has sufficient funds to disperse to the regions in order to ensure regional compliance with national health priorities and policies. I also examine the most significant health legislation and regulations established by the central government and the MOH during the early 2000s. I take a close look at regional compliance with these provisions, especially in the cases of Extremadura and Madrid.[163] Next, for its second responsibility (Ensuring Accountability), I review the MOH's efforts to ensure accountability in the NHS (see more detail in Chapter 4). In addition, for its third responsibility (Generating Intelligence), I assess the MOH's ability to ensure access to health information throughout the NHS, for example, by looking at annual national health system reports and procedures. Finally, for the MOH's fourth responsibility (Building Partnerships), I examine its ability to build and sustain partnerships with the regions. The elements that I analyse under each one of these responsibilities are directly carried out by the health-sector kentrocrats within the subnational policymaking environment and/or provide them with a greater advantage to influence the subnational health policymaking process.

5.3.2.1. Ensuring Tools for Implementation: Financing: As described in detail in Chapter 4, after the 2001 health system devolution all earmarking of financial resources

[162] See the Sections 4.4.1 and 4.4.2 for more information.
[163] Reviewing the legislation of all Spanish regions is not within the scope of this thesis.

for health was removed. Instead, Law 21/2001 legislated the 2001 regional financing agreement, which for the first time integrated NHS financing into the regional financing system (Jefatura del Estado 2001b). The regional financing system consisted of intergovernmental block grants from the General Fund (*Fondo General*) channelled yearly from the central government to the regional government coffers. The regions would receive these funds and would conduct their own processes for budgeting and spending them, complying with the central government's stipulation of a minimum expenditure level (floor) for the financial resources that each region was obligated to spend on health.[164] Although this expenditure floor was a precautionary measure, it was relatively easy to reach. In general, the regions surpassed it and had difficulty, rather, containing the increasing costs of the health sector. For 2003, the expenditure floor was €27,814 million for the country, €840 million for Extremadura and €3,025 million for Madrid.[165] In comparison, for the same year, actual consolidated spending on health by all regions exceeded €38,648 million, with Extremadura spending just over €1,028 million and Madrid spending just over €4,606 million (Ministerio de Economía y Hacienda and Ministerio de Sanidad y Consumo 2005, 46).

Law 21/2001 also redesigned the taxation system, increasing the regions' direct control over taxes and their collection abilities. As a result, regional taxes could also be used as a source for health financing. In the regional financing agreement, a Sufficiency Fund (*Fondo de Suficiencia*) was established to supplement regional tax revenues and provide the funds that regional governments needed. In 2006, this fund received €364.7 million together from the Balearic Isles (€206.67 million) and Madrid (€158.03 million). At the same time, its budget for the same year totalled €29,248.61 million, of which Extremadura was allocated 5.83 per cent (€1,705.75 million) (Ministerio de Economía y Hacienda 2007a). Finally, the regional financing agreement included the Inter-territorial Compensation Fund (*Fondo de Compensación Interterritorial*), for which regions could submit proposals to finance investment projects intended to remedy any economic imbalances between them. In 2006, this fund totalled €1,159.89 million, of which it budgeted 7.7 percent (€87.79 million) for

[164] "This threshold is worked out by applying demographic and geographic indicators to calculate the expenditure in the reference year (1999) adjusted by health needs; this minimum amount has to be updated on an annual basis in line with the increase in the total state tax revenue" (García-Armesto et al. 2010, 97).

[165] These figures exclude funds from the Temporary Disability Savings Programme (described below).

Extremadura (Ministerio de Economía y Hacienda 2007a). In addition, it allocated funds to another nine regions, not including Madrid, and the two Autonomous Cities.

In addition to these forms of non-sector-specific regional financing, the central government also created two health-specific funds: the Temporary Disability Savings Programme Fund (*Fondo Programa de Ahorro en Incapacidad Temporal*) and the Health Cohesion Fund (*Fondo de Cohesión Sanitaria*). These funds were meant to cover particular expenses and foster the implementation of policies, ultimately increasing efficiency and reducing inequalities across the different regional health services. Initially, the Temporary Disability Savings Programme Fund was allocated €240.4 million for distribution to the regions in proportion to their number of people with temporary disabilities.

More interesting for this assessment, the Health Cohesion Fund, created under Article 4.B.c) of Law 21/2001, became the primary financing source managed directly by the MOH (Ministerio de Sanidad y Consumo 2002) and was "intended as a tool for the Ministry of Health to implement policies guaranteeing cohesion and equity in the [NHS]" (García-Armesto et al. 2010, 129). These monies were to be allocated to the regions based on two main objectives: (i) to compensate them for care provided to residents of other regions or countries, and (ii) to guarantee equal access to public health care services for all citizens (Consejo de Política Fiscal y Financiera 2001; Ministerio de Sanidad y Consumo 2002, 5th Additional Provision).[166] The Health Cohesion Fund's initial allocation was just €55 million annually for both the regions and other nations. In practice, however, the it was not an optimal instrument to reach these objectives because of its limited financial resources and scope (Urbanos 2004).[167] Thus, an annual increase of €45 million to this fund was recommended and approved by the Second Conference of the Presidents in 2005.

Also stemming from a recommendation by this Conference, the President announced the implementation of the 2006 NHS Quality Plan (*Plan de Calidad del*

[166] The eligible services for compensation and the level of compensation for each service are included in Annex I and II of Royal Decree 1247/2002.

[167] An MOH stakeholder went further to say, in general, "I think that [the MOH] should have a larger budget to perform our tasks of coordination and cohesion" (Novinskey, Interview no. 4). An MOF stakeholder disagreed with this, saying that "for a devolved country, the funds—including the Health Cohesion Fund—that the MOH had to carry out its main responsibilities, including "setting guidelines for the sector", were sufficient; it is not necessary to increase spending on the regions but rather [the MOH] can obligate them to reprioritise or reassign expenditures to comply with new guidelines" (Novinskey, Interview no. 41). He further stated that "any additional financial allocation to the regions in the name of 'health care' breaks with the logic of the financing system since 2001, which explicitly did away with conditional financing" (ibid.).

SNS) and a corresponding new allocation of €50 million to support it. This new allocation, also managed by the MOH, first appeared in the 2006 budget. It was intended primarily to strengthen the cohesion policy and strategy to improve the quality of NHS services (Urbanos-Garrido 2006).

Having reviewed all of these financing mechanisms for the NHS, during the period from 2004 to 2006, *did the MOH have sufficient funds to disperse to the regions to enable them to implement national health policy goals?* The short answer is no. The regions received close to 98 per cent of their funding for the health sector from the central government's General Fund, which was managed by the MOF. The additional 2 per cent managed by the MOH did not provide enough incentive for some regions even to process requests for compensation for the services they performed on residents of other regions or countries. An Interviewee from the MOH provided the best account of the nature of the Health Cohesion Fund and the bargaining power of the MOH in general after 2001 (Novinskey, Interview no. 15):

> The problem is that this fund is endowed with very little money. And with the little money that this fund had, they could not do anything. If it were well endowed, this fund would probably be conditional. … The only way to do health policy is to have a conditional cohesion fund for which you need to ask for money to do something. In the political game [around the consolidation of Law 21/2001], it was the Ministry of Finance that led negotiations because it was more important than the Ministry of Health. What the Ministry of Finance wanted was to achieve a unanimous agreement from the autonomous communities. I think they achieved that and to do so they had to put a lot of money on the table. All the money that they used [in this negotiation] was what we could not use, then, for cohesion policy. So [the central government] managed to make an agreement today but not in the future.

Moreover, it is questionable whether the additional funding that the MOH was set to manage in 2006 would be an effective incentive for the regions to carry out national health cohesion and quality policy goals. In reference to the new financial allocations to the regions resulting from the recommendations of the Second Conference of Presidents, an interviewee from the Ministry of Finance called them "Little gifts. Nothing. Peanuts" (Novinskey, Interview no. 38). Another interviewee said, "In 2005, the Conference of Presidents ended unfavourably, distributing insufficient funds" (Novinskey, Interview no. 39). In his analysis, Ferrandiz Manjavacas (2004, 700) calculated that in 2003 the financing for the Health Cohesion Fund would have needed to be at least €401 million—more than seven times the

original endowment and four times what it held in 2006—in order to satisfy the needs of the regions and fulfil the objectives of this Fund.

5.3.2.2. Ensuring Tools for Implementation: Regulation and Compliance: The foundation of the regulatory framework for the Spanish health sector is the 1986 GHL, from which a number of requirements were established for the regions. As one stakeholder stated, "the State establishes the requirements and the Autonomous Communities are to develop their respective norms latter" (Novinskey, Interview no. 26). Foremost among them was the requirement to elaborate health plans, which was discussed in the sections on Regulation and Planning both before and after 2001 in Chapter 4. Most importantly, the MOH published its first "global" plan in 1995 and, by 1999, all regions had at least one health plan approved (e.g. Madrid in 1995 and Extremadura in 1997). Nevertheless, the actual development of these plans at both the central government and regional levels was slow, taking up to 13 years in some cases.

From the completion of health system devolution in 2001 until 2006, the central government and the MOH enacted several regulations regarding health services. Of these, in this section, I examine the laws that have the greatest effect on the institutional architecture of the health sector and require specific actions from the regions. See Appendix L. They are Law 41/2002 on patient autonomy, rights and duties related to clinical information and documentation; Law 16/2003 LCQ; and Law 55/2003 on the framework statute of statutory health professionals.[168] To do so, I present the relevant portions of these laws and their requirements for the regions in the areas of medical records, individual health cards, waiting time guarantees, NHS quality plans and the professional career path. Furthermore, I assess Extremadura and Madrid's compliance with requirements in these areas, in order to evaluate the influence health-sector kentrocrats had on steering policymaking processes and priorities at regional level.

5.3.2.2.1. Medical Record Protection and Access. Law 41/2002 sought to regulate the rights and obligations of patients, users and professionals, as well as public and private health centres and services, related to patient autonomy and medical information records. This law stipulated two main actions from the regions; I review these required actions and Extremadura and Madrid's compliance with them. First, Article 14.4 requires the regions to ensure that health centres adopt adequate technical and organisational measures for archiving and protecting medical records and avoiding

[168] The Second Transitory Provision of Law 44/2003 allows the administrations four years from the time it takes effect to implement a professional development system, putting it outside our period of study.

their damage or loss; second, Article 16.7 requires them to regulate procedures for access to and use of medical records. Both Extremadura and Madrid comply with these articles.[169] Prior to this central government requirement, in its 2001 Health Care Planning Law, Madrid included general provisions for patient rights and access to medical records (Article 27.7); however, these provisions were rather broad and not defined as required by the central government (Presidencia de la Comunidad de Madrid 2001b). In 2004, Madrid's Agency for the Protection of Data (*La Agencia de Protección de Datos de la Comunidad de Madrid*) approved a resolution regulating patient autonomy and guaranteeing protection of personal health information (Dirección de la Agencia de Protección de Datos de la Comunidad de Madrid 2004). Meanwhile, with Law 3/2005, Extremadura passed legislation governing health information and patient autonomy (Presidencia de la Junta de Extremadura 2005b). In particular, Chapter 1 of this law defines the content of and outlines the treatment, utilisation and conservation of medical records as well as patient rights to access them. In its title VII,[170] the law also establishes the foundation for sanctioning administrative violations of rights and obligations related to medical records and patient autonomy.

5.3.2.2.2. Individual Health Care Card. Law 16/2003 regulates the cohesion and quality of the NHS. Its Article 57 stipulates one individual health care card (*Tarjeta Sanitaria Individual*) for the nation, which should be regulated and utilised by the regions in their respective territories. The primary means for collecting and holding the necessary data on this card is through a health information system. Thus, Chapter 5 of this law is dedicated to regulating the NHS's health information system.

Prior to Law 16/2003, beginning in the 1990s, there were seven different co-existing regional health information systems and corresponding health cards within the NHS: one for the ten "slow-track" regions managed by INSALUD plus the Canary Islands, and one for each of the remaining six regions that had devolved health service competencies before 2001 (García-Armesto et al. 2010, 131). "Each Autonomous Community has some embryo, some sketch of [data and information] but this is a task that we have to face collectively", said one stakeholder (Novinskey, Interview no. 04). These health information systems and cards, however, were not interoperable—a necessary condition for a coherent and cohesive NHS (Novinskey, Interview no. 12).

[169] See http://susananajera.com/index.php/historia-clinica-legislacion-autonomica-en-espana/ for information on other regions.
[170] This title was supported by Article 52 of Law 10/2001, on Extremadura Health and Article 44 of the Organic Law 15/1999, on the Protection of Personal Data and Information.

As one stakeholder, who worked previously in the MOH and a regional health ministry, affirmed, "prior to the transfers, we were not able to put a system of health information together because the Ministry of health had a very big fight with the Autonomous Communities to obtain information, so it would be viable and prevail over time" (Novinskey, Interview no. 36). Article 57 would remedy these problems through its mandate. It also created a National Health Information Institute under its Agency for NHS Quality, which became the secretariat for the CISNS's Sub-commission on Information Systems. This sub-commission was ground zero for consolidating the co-existing health information systems and health cards. In developing Article 57, and in accordance with Royal Decree 1479/2001[171] (Ministerio para Las Administraciones Públicas 2001i), the central government also passed Royal Decree 183/2004, which specifically regulated the emission and validity of the individual health care card with basic common data and a personal identification code for the entire NHS.

Importantly, the regions were to regulate the introduction and use of this card in their respective territories. Madrid complied with this measure through Order 1285/2006, the objective of which was to regulate the legal system and the procedure for obtaining and issuing the individual health care card within its territory (Consejería de Sanidad y Consumo 2006k). Extremadura established the requisite guarantees regarding the use of a health card as an instrument for accessing NHS benefits in the Second Additional Provision of the Extremadura Health Law (10/2001). It further developed this provision and complied with the central government's requirements through Order 29 September 2004, which regulated the procedure for its citizens to obtain this card (Consejería de Sanidad y Consumo 2004l). Moreover, Extremadura regulated the procedures for foreigners to obtain a card for receiving health assistance within the Extremadura public health system (*Tarjeta para Atención Sanitaria en el Sistema Sanitario Público de Extremadura*); this is a separate card pursuant to Extremadura's Decree 31/2004,[172] granting health care protection to foreigners and authorizing the creation of this card as an additional benefit to the common health benefit package (Consejería de Sanidad y Consumo 2004h).

[171] Royal Decree 1479/2001 required specific regulation of the health care card as well as the system of managing and processing it.
[172] This Decree was later modified with Order 25 April 2007, and the content and characteristics of the individual health care card and design of the corresponding new information system were later regulated with Decree 9/2008 (25 January).

5.3.2.2.3. Waiting Time Guarantees. Article 25 of Law 16/2003 also requires the regions to define the maximum waiting times for accessing health services in their benefit package. Following this, Article 2 of Royal Decree 605/2003 obliges the regions to establish an information system on waiting lists for external consultations, diagnostic and therapeutic tests and surgical interventions (Ministerio de Sanidad y Consumo 2003b).

Extremadura performed research on this topic, finding that, at times, its tertiary care[173] patients had to wait longer for care than was "socially or medically desirable" (Presidencia de la Junta de Extremadura 2005a). In accordance with this region-specific result and the above-mentioned central government laws, the Extremadura passed Law 1/2005, committing to guarantee all citizens an acceptable response time for specialised care (Presidencia de la Junta de Extremadura 2005a). As established in Article 11 of this law, Extremadura subsequently adopted Decree 228/2005, which regulates the content, organisation and functioning of the registry for the Extremadura Public Health System's patient waiting list and creates a file of personal characteristics for it (Consejería de Sanidad y Consumo 2005m).

Within the central government's framework for guaranteeing waiting times, the Community of Madrid prioritised a reduction in waiting times for surgical interventions and passed corresponding legislation in 2004. First, with Resolution 12 February 2004 of the Regional Parliament of Madrid, it charged the RHM with elaborating an integrated plan for the management and monitoring of waiting lists (Pleno de la Asamblea de Madrid 2004). Then, the Governing Council of Madrid approved the Integral Plan for Reducing Waiting Times for Surgical Interventions (*Plan Integral de Reducción de la Espera Quirúrgica*), and set its implementation for 2006. Finally, it legislated Decree 62/2004, creating a Central Unit for the Management of the Surgical Wait List and a Central Commission for Monitoring and Evaluating the Integral Plan. This decree also created and regulated the Unified Registry for Patients (*Registro Unificado de Pacientes*) on the surgical wait list of the Public Health Network for the Community of Madrid, in addition to establishing its content, management and procedures (Consejo de Gobierno 2004b). In agreement with the First Final Provision of this decree, Madrid legislated Order 602/2004, approving the Instructions for Managing the Unified Registry for Patients on the surgical wait list. It also legislated Order 676/2004, creating a file for the personal characteristics of the patients on the

[173] There were no waiting time issues for primary care services.

surgical waiting list. Note well that by the end of this period, Madrid had not complied with the national laws regarding information systems and waiting time definitions for diagnostic and therapeutic tests nor external consultations.

5.3.2.2.4. NHS Quality Plans. In Article 61, Law 16/2003 stipulates that the MOH and the RHMs will periodically elaborate plans for NHS quality, containing quality objectives for a determined period. As discussed in further detail in Chapter 4, the MOH published its first NHS Quality Plan in 2006 (*Plan Calidad Sistema Nacional de Salud*), including 41 quality objectives for the year (see Table 4.5).

Prior to this, in 2002, Madrid passed its Comprehensive Quality Plan for Health Services (*Plan de Calidad Integral de los Servicios Sanitarios*), a multi-year plan through 2007. This plan was generated with Madrid's own initiative, created before the 2003 LCQ with the objective of promoting the continued improvement of health care as perceived by citizens and the satisfaction of all health service professionals.

In compliance with Article 53 of Law 16/2003 and the Extremadura Health Plan for 2005-2008, the Extremadura created the 'I Framework Plan for Quality in 2006' as an instrument for the continued improvement of health care quality in the region. This Framework Plan contains eight Strategic Pillars regarding all aspects of health care quality improvement and user satisfaction, including (i) health care quality, (ii) relational quality, (iii) authorisation and accreditation of health centres, services and establishments, (iv) health care evaluation, (v) research and education, (vi) information systems, (vii) professional development, and (viii) management and financing. Because they were created prior to the NHS Quality Plan, Extremadura and Madrid's health care quality plans were not wholly consistent nor coordinated with it or each other.

5.3.2.2.5. General Criteria for a Professional Career and Remuneration in Health Care. Law 55/2003 creates the statutory framework for health care professionals, stipulating the general criteria for a professional career and remuneration in health care in Articles 40 and 41, respectively. The regions must establish career mechanisms for their health care professionals as well as the necessary mechanisms for ensuring payment for the activities they perform. In compliance with these articles, Madrid's Governing Council passed the Agreement of 24 January 2007, approving the agreement made by the Madrid RHM and trade unions on 5 December 2006 (Consejería de Sanidad y Consumo and Las Organizaciones Sindicales 2006), regarding the professional career paths of health care graduates and masters

(*diplomados y licenciados*). Furthermore, within its objectives, the 2002 Comprehensive Quality Plan for the Health Services of the Community of Madrid included the design of a new uniform compensation system for personnel providing services at its health centres and institutions.

Meanwhile, Extremadura passed Resolution 23 January 2006, which published the agreement reached on 24 October 2005 between the Extremadura RHS and five trade unions on the career paths and development of health professionals within the RHS. In addition, it passed Decree 37/2006 regulating the personnel management tools for the Extremadura RHS and the structure of the statutory workforce, followed by Resolution 24 May 2006 on optional procedures for health workers with a master's degree (*licenciados*) from the statutory regime.

5.3.2.2.6. Summary. According to my parameters, Extremadura and Madrid complied with these five areas of regional responsibility stipulated in the three laws under investigation by the end of 2006, with the exception of certain waiting time criteria for Madrid. However, interestingly, in all these areas (with the exception of waiting time guarantees), Extremadura and/or Madrid had adopted their own legislation before the central government did. For example, Extremadura regulated individual health care cards for its citizens in its 10/2001 Health Law and more specifically in its Order 29 September 2004; the central government did not mandate specific regulations for the cards until 2006. Therefore, the question of whether or not these regions were complying with central government law becomes moot due to the level of initiative from these two regions, showing that they are stronger actors within their own health sector than the MOH is (because the MOH is hardly leading the regions' regulatory efforts). Indeed, when talking about the MOH after the second wave of devolution, one stakeholder said that the MOH was lacking instruments to incentivise and sanction (Novinskey, Interview no. 36).

Compliance does occur, however, in cases where Extremadura or Madrid adjusted its legislation to make it consistent with subsequent regulations from the central government. For example, in its 2002 health care quality plan, Madrid included objectives and actions for addressing aspects of health care professional career paths and compensation, prior to the central government's Law 55/2003 that mandated further actions, with which Madrid complied in 2006 with a more specific agreement. Moreover, Madrid had already begun adopting regulation on medical records with its

2001 health care planning law before the central government passed Law 41/2002, following up with additional detailed regulation in 2004.

What I have described so far suggests good compliance by the regions with MOH regulations. However, whereas this pattern might normally be seen as evidence that the health-sector kentrocrats retain strong advantage or influence, in fact the regions are leading and partially pre-empting national regulations by enacting their own requirements autonomously, even before such national regulations are formulated or put into effect. This suggests that the role of health-sector kentrocrats is one of relatively little importance.

5.3.2.3. Accountability: As described in the section on Governance and Stewardship Rules after the 2001 health system devolution in Chapter 4, the central government and, more specifically, the MOH set broad accountability mechanisms for the whole NHS. Here we look in particular at actions that make the system accountable to the people, regarding patient and user rights, complaint systems and public participation. Laws 21/2002 and the 2003 LCQ were key legislation that updated accountability rules already established by the 1986 GHL.

The regions were able to expand on the central government's legislation in this aspect of the NHS. For example, all the regional laws regarding health planning, except that of Murcia, mandate claims and complaints as users' rights. Moreover, Article 12.3 of Law 41/2002 obliged all RHSs to display guides on how-to file complaints at health care facilities and to establish an adequate system for exercising patient freedom and rights. To this effect, some RHSs have created specific units for defending and guaranteeing, as well as providing information on patient rights, called Patient Support Services (*Servicios de Atención al Paciente*) or User Support Units (*Unidades de Atención al Usuario*). Moreover, some regions have appointed an ombudsman to assist patients with their concerns.[174]

In its 2001 Health Care Law, Extremadura legislated the right to use complaint and suggestion procedures (Article 11.1n) and mandated availability of an ombudsman for RHS patients[175] (Presidencia de la Junta de Extremadura 2001b). Subsequently, Decree 4/2003 further defined and developed the role of the ombudsman. In its 2001

[174] For more information on the Ombudsman for Patients in Asturias, the Balearic Islands, Castile-La Mancha, Galicia and La Rioja, see Table 4 of Annex II of the Annual NHS Report (Observatorio del SNS 2005). Section 2.5 of this same report includes information on the effective guarantee of citizen rights regarding the NHS for the remaining regions.

[175] Article 16 on the Defensor de los Usuarios del Sistema Sanitario Público de Extremadura.

Health Planning Law, Madrid also mandated the rights and duties of users, including the right to receive health care within certain waiting times, to advance care directives and to access medical record information. In this same law, it also created an ombudsman for patients (Chapter 3 of Title IV). Following this, it guaranteed the independent and autonomous status of the ombudsman (Decree 10/2004), regulated customer service (Decree 21/2002 and Order 605/2003) and established a system for handling suggestions, complaints and claims for the RHS (Order 605/2003).

Overall, Extremadura and Madrid have both fulfilled their obligations to define health care planning specifically for their respective RHSs and to establish a system for patient freedoms and rights. They initiated legislation in these areas prior to central government mandates and then added regulations as needed to conform to mandates imposed subsequently. As a result, the accountability mechanisms established by the central government and, more specifically, the MOH (through the 1986 GHL, Law 21/2002, the 2003 LCQ) were implemented and complied with by the regions, demonstrating the MOH's respectable ability to ensure accountability within the system.[176]

5.3.2.4. Generating Intelligence: As part of their stewardship of the NHS, health sector kentrocrats must be able to generate intelligence and coordinate an evidence base for decision-making. Intelligence is defined as reliable, up-to-date information on important health system performance trends and possible policy options, among other things (Travis et al. 2001; 2003). In Spain, according to the 2003 LCQ, the MOH is responsible for developing the NHS's Health Information System (*Sistema de Información Sanitaria del SNS*), creating the Institute for Health Information (*Instituto de Información Sanitaria*) under the auspices of the MOH (Alfarro Latorre 2006; Bankauskaite and Novinskey 2010)[177], and ensuring the availability and dissemination of health information. Along with this law, two others have created the legal framework for generating intelligence: the 1986 GHL mandates the fundamental exchange of information within the NHS and Law 41/2002 stipulates patients' freedom of information, provides for the rights and obligations of the medical

[176] A more robust analysis would analyse the MOH's ability to monitor and enforce dissenters of the central government mandates. Unfortunately, this information is very difficult to obtain and, thus, beyond the scope of the thesis.

[177] In November 2000, the CISNS Sub-commission for Information Systems was charged with constructing a comprehensive and integrated system. However, it was not until after the enactment of Law 16/2003 that the Sub-commission began to address this task (Subdirección General de Información Sanitaria e Innovación 2014).

records and information system, and sets the foundation of the national information technology strategy for the health sector. The Health Information System must respond to the needs of health authorities, professionals, citizens and health care organisations and associations. As such, respectively, it must include information for developing and making policy decisions, improving medical knowledge and aptitude, improving self-care and health service use and promoting civil society's participation in the NHS. Overall, the Health Information System is an essential element for meeting the current and future challenges facing the NHS.

While information and data generally flowed effectively between the different administrations after devolution (Esteban Gonzalo 2007), the Health Information System was a repertoire of mostly descriptive, somewhat independent statistical operations, with some remaining thematic gaps and without common criteria for its integration and analysis. Thus, the large amount of data reported had limited utility, and standardizing and harmonizing data and information systems presented a key challenge for the MOH. For example, during this period, the MOH published its annual report on the NHS (*Informe Anual del SNS*) with at least a two-year lag and the information it included from the regions was incomparable and presented in separate annexes because the regions often used different indicators and measures for the same objectives (Novinskey, Interview no. 12). The same problem characterised nearly all data reports coordinated by the MOH during this period (e.g. the National Health Survey and the Public Health Spending Statistics). This situation had developed largely because of the history of the regional health information systems, which were created at different times and developed at different rates, corresponding to some extent with each region's assumption of health service responsibilities.

Although the MOH improved its role in developing the Health Information System and generating the necessary intelligence for the NHS over this period, it was not until the promulgation of the 2006 NHS Quality Plan that it made great strides in this area (Ministerio de Sanidad y Consumo 2006b). At that point, through the CISNS's Sub-commission for the Information Systems, the MOH began to redefine and standardise data and data flows, the selection of indicators, and the technical requirements necessary for the nationwide integration of health information (Antón Beltrán 2006; Esteban Gonzalo 2007). This, however, is beyond of the period under investigation.

5.3.2.5. Building Partnerships: A steward should be able to build and sustain effective partnerships in order to promote changes within a decentralized health system (Travis et al. 2003). Here I assess the intergovernmental partnerships that the Spanish MOH has sustained from 2004 to 2006. I have already discussed the CPFF and the CISNS, which are undoubtedly the MOH's most important intergovernmental partnerships (Bankauskaite and Novinskey 2010). The CPFF has proved to be a successful partnership; together with the Minister of Finance and the regional ministers of finance, this Council established and enforced periodic agreements regarding the NHS and regional financing before the 2001 devolution, and implemented the 2001 regional financing agreement (set for an indefinite period) after the devolution reform and throughout the study period. Technically, however, the MOH did not build this partnership nor play a major role in its agreements.

The CISNS is the most sweeping partnership directed by the MOH, as a forum for the Minister of Health and its regional counterparts to discuss all matters of health policy. At a more technical level, some of its commissions, sub-commissions and working groups have proven successful. For example, its Sub-commission for the Information System was eventually effective in developing a coherent and interoperable system for the NHS, aided by the passage of legislation regarding the individual health care cards (García-Armesto et al. 2010). In addition, its Commission for NHS Human Resources was quite active. Moreover, the members of the Council participate on various professional bodies, including the Rector Council of the Institute of Health Carlos III, the Board of the National Foundation for Cancer Research, and the Board of the Foundation for the Institute of Cardiovascular Research (Ministerio de Sanidad y Consumo 2015).

However, at a more political level, this body lacked real executive strength and was the source of great inefficiencies for the NHS (Elola 2004; Repullo Labrador, Ochoa, and et al. 2004). Importantly, during the period of study, it had difficulties coordinating and integrating the 17 RHSs (Bankauskaite and Novinskey 2010). Moreover, stakeholder interviewees from the regions referred to the lack of direction from the MOH and the CISNS. Indeed, because of this, Extremadura and Madrid, along with Castile-La Mancha and Castile-Leon (in total, two regions were governed by the PP and the other two by the PSOE), formed their own partnership (under the precepts of a Collaboration Agreement, which lasted approximately during 2002-2004) to navigate together the waters of their newfound health service responsibilities for the

first few years after devolution (Novinskey, Interview no. 01, 07 and 39). This partnership was small but effective, agreeing on many things (Novinskey, Interview no. 07). Overall, the MOH built one main intergovernmental partnership that had the potential to promote change in the NHS (CISNS) and participated tangentially in another (CPFF). By the end of the study period (2006), the CISNS still required strengthening to have a significant impact. Finally, these two partnership were sustained through the period of study.

In conclusion, this analysis on the influence of health-sector kentrocrats demonstrates that the MOH had insufficient funds to disperse to the regions to ensure their compliance with national health policies (part of its first responsibility). In addition, while the MOH and central government established important health laws and regulations during the period of study and the regions seemed to comply with them, most often the regions actually were leading the policy environment with their own legislation and anticipating national legislation. For its second responsibility, the MOH was successful in ensuring accountability in the NHS through its establishment of accountability mechanisms and the regions' compliance and implementation of them. For its third responsibility, the MOH was increasingly able to generate intelligence and ensure access to health information throughout the NHS; however, it was not truly successful in doing so until just after the period of study. Finally, for its fourth responsibility, the MOH's ability to build partnerships with the regions had little success when examining its activities, effectiveness, and role and potential to promote change in the NHS through the CISNS. Table 5.10 provides the index for health-sector kentrocrats in Spain and their scores for carrying out their stewardship functions of the system. Overall, considering the results for these four areas of responsibility, the MOH performed weakly as a health-sector kentrocrat because it was only able to carry out its stewardship role fully under one of these four areas (accountability) and somewhat but not fully improve its influence in another area (generating intelligence) during the period 2004–2006.

Table 5.10. Index for Stewardship Functions of Health-Sector Kentrocrats in Spain, 2004–2006

Stewardship Functions	2004–2006
1. Ensuring tools for implementation: financing and regulation	
a) Do health-sector kentrocrats have sufficient funding for setting incentives and ensuring the compliance of the subnational governments on nationally-established health policies?	0
b) Do health-sector kentrocrats identify, motivate and enforce subnational governments to comply with nationally-established laws and regulations?	0
2. Ensuring accountability	
a) Do health-sector kentrocrats have sufficient accountability and public participation mechanisms in place?	2
b) Are health-sector kentrocrats able to ensure that subnational governments comply with the nationally-established mechanisms for accountability?	2
3. Generating intelligence	
a) Have health-sector kentrocrats been able to provide subnational governments with the data and intelligence necessary to carry out their responsibilities?	0
b) Have health-sector kentrocrats been able to do this in a timely manner?	0
4. Building partnerships	
a) Have health-sector kentrocrats built active and effective partnerships with subnational governments?	1
b) Have health-sector kentrocrats sustained their activities and effectiveness in these partnerships overtime?	1
Total Score	**6**

Explanatory note: The higher the score, the stronger the health-sector kentrocrat.
See Appendix K for index values

5.3.3. The General Picture of the Subnational Health Policy Network in Extremadura and Madrid

In this section, I summarise the position of the three actor groups within the subnational health policy network in Extremadura and Madrid for the period 2004–2006, after health system devolution. In general, from 2004 throughout 2006, the subnational health policymaking networks in Extremadura and Madrid resembled *policy communities* on the policy network continuum (cf. Table 5.1). The health-sector kentrocrats held a weak position in both regions, to a point that some would say that they were "organised" out of politics. In addition, the subnational expenditure guardians held a structurally privileged position in the formulation of subnational health policy in both regions. However, this analysis demonstrates that the subnational expenditure guardians were much stronger, and the expenditure advocates much

weaker, in Extremadura than they were in Madrid. Table 5.11 outlines these positions. While the power designations appear to be the same for Extremadura and Madrid[178], Extremadura's actual scores for subnational expenditure advocates and guardians were only one point away from being labelled "weak" and "strong".[179]

Table 5.11. Subnational Health Policy Networks for Extremadura and Madrid, 2004–2006

	Extremadura	**Madrid**
Health-Sector Kentrocrats	Weak	Weak
Subnational Expenditure Advocates	Moderate (almost weak)[a]	Moderate
Subnational Expenditure Guardians	Moderate (almost strong)[a]	Moderate

[a] NB: The subnational expenditure advocates and guardians of Extremadura placed less than a point away from being categorized as "weak" and "strong" players, respectively. This is an important distinction from Madrid's average "moderate" score for the same actor groups.

In terms of Figure 3.2 on the trade-offs in intergovernmental health policymaking at the subnational government level for the period 2004–2006, the Extremadura policy network functions close to the B–C line and further down that line toward the subnational expenditure guardians. Thus, the balance of power in Extremadura intergovernmental health policymaking at this level favoured the subnational expenditure advocates and guardians, and a compromise of their respective policy priorities, more than the health-sector kentrocrats and their policy goals. Moreover, the subnational expenditure guardians appear in a considerably stronger position than the subnational expenditure advocates in Extremadura. The Madrid policy network also lies close to the B–C line, however, midline. Thus, the balance of power in Madrid intergovernmental health policymaking is likely a compromise between the policy priorities of subnational expenditure advocates and guardians, with little influence from the health-sector kentrocrats. Compared with the three previously identified variants of the national health policy networks, the health policy networks of both Extremadura and Madrid, resemble the structural organization of intergovernmental health policymaking in Norway (1991–1992) with their respective

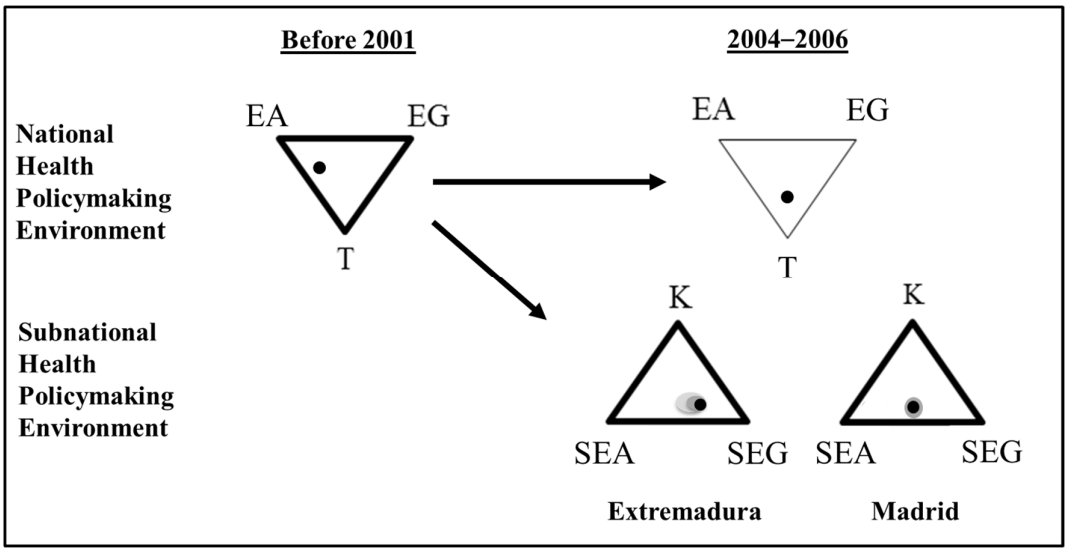
[178] This is the case for the health-sector kentrocrats' influence in both regions.
[179], Used to determine the power of subnational expenditure advocates and guardians, my adaptation of von Hagen's index builds in influence from the national policymaking environment by including some indicators that are determined by the national budget law and applied to all levels of government in the Spanish case.

expenditure advocates and guardians having moderate strength and the third actor being effectively organized out of politics and policymaking. Furthermore, if accounting for any possible influences from the power dynamics of the national policymaking environment on our model of the subnational intergovernmental health policymaking, then we may see a slight pull from of the balance of power in Extremadura back towards the subnational expenditure advocates but still within the realm of the subnational expenditure guardians; whereas, there is unlikely to be any such influence on the balance of power in Madrid intergovernmental health policymaking.

5.4. Discussion

Since none of our actor groups can be expected to be altruistic, it is important to understand who holds power in our intergovernmental policy networks at both levels of government in a devolved system. My structural analysis answers this question by paying particular attention to what constrains or facilitates the actors' pursuit of their interests (Blom-Hansen 1999). The overall results are presented in Figure 5.7, which illustrates the balancing act between main actor groups in both the national and subnational health policymaking networks for my case studies, during the two periods of study. The "iron triangles" in bold represent the dominant health policy network for each period of study. The dots estimate the location of the balance of power among the three actor groups within each policy network. The shaded areas around the dots in the subnational health policy networks represent the influence, if any, from the politics and policymaking of the national level. In both policymaking environments, there are clear trade-offs.

Figure 5.7. Overall Trade-offs in Intergovernmental Health Policymaking for the Regions of Extremadura and Madrid, before 2001 and 2004–2006



NB: These are illustrations to give the reader a visual idea of the estimated location of the power dynamics of intergovernmental health policymaking during the two study periods and how such dynamics shifted overtime with the health care devolution reform in Spain. They are not mathematically located, for example, using a ternary plot or any other graph or scale. EA = Expenditure Advocate; EG = Expenditure Guardian; T = Topocrat; K = Kentrocrat; SEA = Subnational Expenditure Advocate; SEG = Subnational Expenditure Guardian.

As expected, before the completion of health system devolution in 2001 and for the 10 slow-track regions (including Extremadura and Madrid), the main intergovernmental policy network involved in formulating health services and policy existed within the national health policymaking environment in Spain. Within this environment, I expected that the expenditure advocates and guardians would share power; however, the results of the analysis demonstrate dominance by the expenditure advocates, with some influence from the topocrats via intergovernmental councils (namely, the CISNS and CPFF).

After the 2001 health system devolution and the establishment of the health and financial institutional architecture by the end of 2003, I expected the power over the system to shift considerably toward the subnational health policymaking environment and it did. I also expected that, within the national health policymaking environment, the MOH—the main expenditure advocate—would lose almost all its power to the expenditure guardians and topocrats. This prediction was confirmed mostly by the analysis, as competencies for health care were devolved to the regional governments, policy influence still held by the MOH and other health expenditure advocates at the national level shifted to the topocrats and control over health financing moved to the MOF (the main expenditure guardian). The latter change was compounded by the

overall tightening of the national budget processes, initiated by supranational requirements for Spain's entrance into the EMU that also took place during this time as well.[180]

With more health system power in regional hands after 2001, an intergovernmental health policy network arose within the subnational policymaking environment in both regions. Within the subnational health policy networks of Extremadura and Madrid, I expected that the power transferred from the national expenditure advocates to this environment would be about equally balanced between the subnational expenditure advocates and guardians, and that the health-sector kentrocrats would be quite weak. For Madrid, the health policy network analysis did indeed result as predicted. For Extremadura, while the balance between subnational expenditure advocates and guardians lay closer to the latter, the health-sector kentrocrats in this network were also quite weak. Indeed, after 2001, despite having passed the 2003 Law for the Cohesion and Quality of the NHS, the MOH had few tools available to steward the health system and attain their goal of subnational health policy cohesion and coordination. The regions, rather, increased their level of influence over the CISNS, which directs NHS policy, and they often passed regional-level legislation for health care before the MOH did for the NHS as a whole. As it seems, then, the health-sector kentrocrats were effectively organised out of health politics and policymaking for the period of study. Furthermore, the influence of national-level health politics and policymaking demonstrate a pull on the original position of subnational health politics and policymaking in Extremadura toward the subnational expenditure advocates. The model analysis does not show any particular influence from the national level on the balance of power at the subnational level.

In terms of methodology, my main difficulty was the replication of von Hagen's structural index on the tightness of budget processes for Spain and the two regional cases for the period 2004–2006. In order to complete the index, I had to learn the terminology for public sector finance in English and Spanish, and to interpret the relevant legislation. To assist me in this, I consulted with von Hagen via email to understand better how to interpret some of the indicators in his index. I further consulted with a Spanish public finance specialist and former bureaucrat to confirm my interpretation of the budget and public-sector legislation as well as my results for each indicator in the index. For future study, it would be more efficient to have a team of

[180] Because of its being non-sectoral, this part of the analysis applies to other sectors too.

researchers—at least one specializing in health policy and the other in public finance—work together to replicate this index.

I modified Blom-Hansen's (1999) translation of the level of budget tightness in a country to the level of strength of expenditure advocates and guardians from "strong or weak" to "strong, moderate or weak", clearly defining a threshold for each *a priori*.[181] I also created indices for the assessing the level of strength of the topocrats and health-sector kentrocrats. While both of these changes helped to operationalize the analysis, making it more objective with stronger, more reliable results, further work is needed to improve the thresholds and designations for each actor group. Such work should be done in conjunction with a public finance specialist and look at several cases to, perhaps, understand better where thresholds for the different designations should be located. This should help make the designations matter more and represent differences between cases more appropriate (e.g., for the case of scoring the subnational expenditure advocates and guardians in Extremadura and Madrid).

[181] Blom-Hansen does not use the designation of "medium", with the exception of situations in which topocrats have different levels of strength across policy areas (e.g. when comparing economic policy, health policy and child care policy in Sweden). If he were to use this designation more generally, it is unclear as to where thresholds would be placed on the 60-point scale for budget tightness.

6. Examining Health Policy Priorities in a Devolved Health System

This chapter examines the results of the analytical framework of the thesis for the case of Spain, with regional cases of Extremadura and Madrid, during the period 2004–2006, as presented in the previous two empirical chapters. Its objective is to understand how effective the framework is in anticipating health policy priorities in a devolved system, focusing on the degree to which health policy in these two regions reflects the privileged position and priority goals of key actor groups in the decision-making process.

The results of the analytical framework of the thesis are presented separately in Chapters 4 and 5; I summarise them here. In Chapter 4, I defined the degree of discretion, or decision space, for the various functions of the Spanish NHS before and after the 2001 devolution reform. Results for Extremadura and Madrid showed that the same amount of *de jure* decision space was allocated to the two regions during both periods. Through health system devolution, the regions gained a moderate to wide range of choice with regard to many health system functions, while the central government retained control over a smaller set of functions, mostly in human resources.

In Chapter 5, I established the position of actors in the national and subnational health policy networks for the period before 2001 and for 2004–2006. The institutional architecture of the health and finance sectors changed considerably between 2001 and 2003, due to health system devolution and national health laws, as well as substantial national budget reforms. These changes greatly affected the power dynamics between actors and the balance between their primary goals. Before 2001, power was concentrated primarily in the hands of the expenditure advocates within the national health policymaking environment, with some pull towards the topocrats. After 2003, this power was rebalanced and distributed between the actors in two ways. First, within the national health policymaking environment it shifted away from the expenditure advocates and towards the expenditure guardians and topocrats; second, power moved downward to the subnational health policymaking environment, where it leaned away from the health-sector kentrocrats and more toward the subnational expenditure guardians for Extremadura and midline between expenditure advocates guardians for Madrid.

These results characterise an intergovernmental dilemma for national health policies in Spain: the central government has relatively clear policy goals but the

regional governments have a certain degree of autonomy; meaning that if central guidelines are to be implemented in Spain, then the regional governments must be persuaded to comply. A similar intergovernmental dilemma also appears with regard to subnational health policies in Spain: the regional governments have the discretion to make policies and to allocate expenditures to them as they like, but they rely on the central government for financing and some health-sector specific intelligence regarding these policies.

In this chapter, I integrate the results of the decision-space approach and intergovernmental health policy networks components of the analytical framework of the thesis. This is necessary to better understand, anticipate and examine health policy priorities for each health system function in a devolved health system. To do so, we use the amount of the decision-space at the subnational government level to tell us where decision-making for a particular health policy takes place, which is where we should focus the analysis. If the range of choice for a policy's health system function is narrow, then the national health policy network prevails; if it is wide, then the subnational health policy network is dominant. See, e.g., Figure 3.3. If it is moderate, then the two intergovernmental health policy networks share power over the health system function and the affected policy requires further examination to determine which level of government has decision-making power over it and, thus, supersedes the other, or if the two should be described as fully interrelated, which I believe is rather rare empirically.

I examine the case of Spain, with regional cases in Extremadura and Madrid, after the 2001 health care devolution reform for the period 2004–2006.[182] This timing ensures that the regions are fully in the implementation phase of their health service competencies and responsibilities. Through a stable institutional architecture for both the health and finance sectors, it also guarantees that the balances of power within the intergovernmental health policymaking environments in Spain are unchanging during the period of study. The focus of this analysis is on the degree to which health policy during this period reflects the privileged position and goals of key actor groups in the decision-making process. As described in Section 3.3, I do this by assessing three

[182] This period begins after the enactment of the second wave of health system devolution in Spain and after significant reforms to the institutional architecture of the public finance sector. It ends at the beginning of 2007, when the latter is modified most importantly with the implementation of the 2006 reforms of budget stability laws.

different measures for the effectiveness of intergovernmental policy: policy efficiency, policy strategies and policy failures.

From this analysis, I expect to demonstrate a relatively close correspondence between the *ex-ante* derived positions and priority goals of actors in the national and subnational health policy networks and the *ex*-post health policies at the national and subnational government level, respectively. I also expect that the degree of this correspondence will grow where greater discretion is granted to the subnational level.[183] Moreover, I expect to substantiate the proposition that to understand intergovernmental health policymaking in a devolved health system, we must focus on the interactions among three types of actor groups within each policymaking environment: expenditure advocates, expenditure guardians and topocrats in the national one and subnational expenditure advocates, subnational expenditure guardians, and health-sector kentrocrats in the subnational one. Finally, I expect to find that the ability of these actors to pursue their self-interests and goals is constrained and facilitated by the structure of the each of these intergovernmental policy networks, with the subnational one having some influence from the balance of power at the national level.

In summary, the following sections examine whether health policy priorities as anticipated by the framework of the thesis hold true in Spain and the regions of Extremadura and Madrid during 2004–2006. More specifically, at the subnational level, they analyse three health policies—waiting time guarantees, common health benefit package expansions, and paying medical specialists in hospital ambulatory settings—, each of which belong to a different functional area of the health system. The fourth section analyses increasing financing for regional health care within the national policymaking environment, under the functional area of financing. Although the analysis may be applied to health system functions with different amounts of decision space, this analysis is limited to some of the policies belonging to health system functions with a moderate amount of decision space after 2001. Moreover, for the first three health policies, only the regional government responsibilities for these functions and their corresponding subnational health policy network are examined. For the fourth health policy, the national government responsibilities for financing and its corresponding national health policy network is examined. Finally, I provide a discussion of these results.

[183] However, it is not within the scope of this thesis to examine and prove this expectation.

6.1. Governance and Stewardship Rules: Waiting Time Guarantees

Here, I examine health policies regarding waiting time guarantees in Extremadura and Madrid during the period 2004–2006 and using measures of policy efficiency, policy strategies and policy failures. Moreover, I evaluate whether the actual health policies for waiting time guarantees correspond with the policy priorities anticipated by the analytical framework of the thesis. The health policies of waiting time guarantees fall under the functional area of Governance and Stewardship Rules and, more specifically, the health system function of patient and user rights.

While health care is theoretically free at the point of service in Spain, the demand for health care exceeds supply, as in many health systems. When this happens, waiting lists for health services are common and they are difficult to reduce. One Extremadura stakeholder said,

> The hospital of Mérida was open and it had an index of urgent care frequency. Then, we opened another hospital in Almendralejo, fifteen minutes away by car […] and we thought that frequency would decrease in Mérida. [But,] it stayed the same and even increased because we offer a free service and, if you know that there is no or little waiting time for the doctor… [and] you have some discomfort, then that is enough to get you to go" (Novinskey, Interview no. 09).

Indeed, since the mid-1990s, waiting lists for health care have been endemic to the Spanish NHS (Durán, Lara and van Waveren 2006). Moreover, in 2000, they were the leading cause of complaints about the NHS (Centro de Investigaciones Sociológicas 2000). In such a situation, individuals suffer an additional health risk due to the time they must wait to receive their necessary treatment. Furthermore, when people have to wait for appointments, surgeries or diagnostic tests, their degree of dissatisfaction grows along with their health risk, together creating a considerable social and political problem for the system.

The Spanish Constitution ensures citizens the right to health protection and Royal Decree 63/1995 regulates the minimum services that the NHS should provide to them within this right. From 1996, INSALUD and the regions with health service responsibilities deployed various strategies to reduce them, including additional working hours, agreements with private providers, specific funding agreements and waiting time guarantees (Observatorio del SNS 2004). All of these were supply-side, not demand-side, mechanisms[184] and therefore required an increase in expenditures to

[184] Up until 2006, Spain had a history of using only supply-side mechanisms (Observatorio del SNS 2004).

fund them before the desired reduction in waiting times could be attempted and achieved. This funding, in turn, required negotiation between subnational expenditure guardians and advocates.

With Law 97/1996 (21 May), the region of Valencia was the first to introduce legislation on measures for reducing and eliminating waiting times (Cañizares Ruiz and Santos Gómez 2011). Then, in 2000, the CISNS created a working group to analyse the problems with waiting lists in the NHS and to elaborate proposals with methods to reduce them. As stipulated in Article 25 of the 2003 LCQ, it agreed on framework criteria guaranteeing a maximum waiting time to access NHS services, which would be approved by royal decree.[185] The LCQ also gave the regions decision-making power to define the specific maximum waiting times for the health services within their territories.[186] In addition, Royal Decree 605/2003 established methods for the homogeneous treatment of waiting list information for use in the NHS health information system, which defined and established the minimum, basic and common criteria, indicators, and requirements of waiting lists for surgical interventions, first outpatient visits, and diagnostic and therapeutic tests. Before 2004, in Spain, the waiting time guarantee policy had been legislated and implemented in eight regions[187] and was under consideration in three additional ones; however, it had not yet been adopted by Extremadura or Madrid (Observatorio del SNS 2004; Cañizares Ruiz and Santos Gómez 2011).

Extremadura regulated waiting times for specialised health care with Law 1/2005 in June 2005 (Presidencia de la Junta de Extremadura 2005a). Article 4 of this law stipulated the maximum waiting times as follows:

- 180 natural days for surgical interventions,
- 60 natural days for accessing first outpatient visits, and
- 30 natural days for performing diagnostic and therapeutic tests.

If it is anticipated that a patient may not receive care within these time limits at his or her original health centre, then the RHS will offer alternative assistance at another health centre within the Extremadura Public Health System. If the maximum wait time

[185] These criteria, however, were not approved until 2011 with Royal Decree 1039/2011.
[186] Waiting lists for organ or tissue transplant surgeries are excluded from the waiting time guarantee because they depend on the availability of the organs.
[187] Andalusia Decree 207/2001 (18 September), Aragon Decree 83/2003 (29 April), Canaria Islands Order 15 May 2003, Castile Leon Law 8/2003 (8 April), Castile-La Mancha Law 24/2002 (5 December), Decree 9/2003 (28 January) and Decree 1/2004 (13 January), Catalonia Decree 354/2002 and Order 203/2004, Galicia Law 7/2003, and Valencia Law 97/1996 (21 May).

is surpassed, then the patient may request care at a private health centre of her choice, through the ombudsman for health system users. This law took effect in October 2005, shortly after Extremadura passed Decree 228/2005, creating the patient registry for the waiting list (Consejería de Sanidad y Consumo 2005m). Finally, with its experience in implementing Law 1/2005 and considering the available technical and human resources, the Governing Council of Extremadura reduced waiting times for specific (prioritised) types of specialised care. Effective October 2006, Decree 132/2006 stipulated that patients who need:

- specific elective surgical interventions (non-urgent aneurisms, acute ischemic peripheral arterial disease, arteriovenous fistulas for dialysis, heart valve surgery and coronary surgery) would be attended within 90 natural days (Article 2.1);
- retinal detachment and vitrectomy within 60 natural days (Article 2.2); and
- surgical removal of malignant tumours within 30 natural days (Article 2.3).

In addition, it stipulated that patients suspected of having cancer would receive their first outpatient visit within 30 natural days, and any diagnostic and therapeutic tests within 15 natural days (Articles 3 and 4, respectively). See Appendix Table M.1 for Extremadura's legislation and regulations regarding waiting times during the period of study.

In Article 27 of its 2001 Health Planning Law, Madrid gave its citizens the right to receive health services within pre-defined and known waiting times (Presidencia de la Comunidad de Madrid 2001b). At the end of December 2003, the average waiting time for surgery was 57 days and 99 patients had been waiting more than six months for surgery (Consejería de Sanidad y Consumo 2004f). But it was not until 2004 that it firmly committed to reducing the maximum waiting time for elective surgical interventions to 30 business days by the end of 2005 (Consejería de Sanidad y Consumo 2004a; Salvador 2004). To carry out this commitment, through a Resolution of 12 February 2004, the Regional Parliament of Madrid charged the RHM with developing a comprehensive plan to address waiting times, including steps to increase surgical activities, improve the management of the waiting list, and facilitate reorganisation and improvement plans for both primary and specialised care. For this, the RHM agreed with trade unions on a programme of incentives for health professionals; e.g., to agree on increasing their surgical activities. It also determined the unmet need for surgeries (demand minus current supply) and, based on this calculation, established special agreements with public hospitals in the Unique Health

Network for Public Utilisation of the Madrid RHM to carry out additional surgical interventions. In cases where demand still exceeded supply, the RHM would offer the patient a choice of receiving care at a private hospital or a public one from another government administration. Madrid financed this comprehensive plan with a total of 113,089,558 euros through three two-year programs within Madrid's General Budget for 2004 and 2005. The plan was approved by Madrid's Governing Council in March 2004 and its implementation was regulated by with Decree 62/2004, which created a Central Management Unit, a Central Commission for Monitoring and Evaluation, a Unified Patient Registry (RULEQ), and ethics committees. Instructions for managing the RULEQ were further regulated by Order 602/2004, although this provision did not fully comply with national Decree 605/2003 on the homogenous treatment of the NHS waiting time data and information in two main ways. First, Madrid accounted for the results of waiting time guarantees in a different way from the central government and all other regional governments (*Elmundo.es* 2006) (Novinskey, Interview no. 12). Second, Madrid refused to share its waiting time data with the MOH or others from 2005.[188] According to one MOH stakeholder, despite legislation requiring the regions to inform the MOH of its waiting list data, it was common practice for the regions to hold back data in general (Novinskey, Interview no. 15).

In October 2005, speaking before the regional parliament, the President of Madrid, Esperanza Aguirre, promised to reduce waiting times for first outpatient visits and diagnostic tests as well. In particular, she committed to reducing the wait for mammograms to 40 business days by January 2, 2006 by investing another 16 million euros in the programme (Consejería de Sanidad y Consumo 2005a). At the same time, the RHM raised the maximum age at which women would be eligible for preventive mammograms from 64 to 69. Then, in May 2006, Madrid began to implement its plan to reduce waiting times for 31 outpatient medical specialties and 5 diagnostic tests to a maximum of 40 business days by the end of 2006 (Consejería de Sanidad y Consumo 2006a). Madrid took measures to increase the number of tests offered, partly by opening its health centres for business during afternoons. Patients who could not obtain care within the waiting time guarantees at their health centre of origin were offered the choice of going to a public health centre within the Unique Health Network for Public Utilisation, a private health centre or public hospital pertaining to another

[188] At least until the end of this study.

government administration. See Appendix Table M.2 for Madrid's legislation and regulation regarding waiting times.

In comparison, the waiting time guarantees in Extremadura granted patients legal rights, whereas in Madrid they were not legally binding and rested mainly on political statements and regulations for their implementation. In both regions, there was a certain level of political and financial commitment to the policy. However, in part due to the legal status of each policy, the processes of monitoring and accountability were more straightforward and transparent in Extremadura than in Madrid (despite the apparent efforts and financial investments in Madrid). The waiting time data for Extremadura and Madrid are presented in Tables 6.3 and 6.4, respectively. These data are not comparable between the two regions for several reasons, e.g. they calculate the number of days differently (natural days vs. business days) and define 'waiting time' differently. Extremadura counts days from referral for service to the date of service, including the date of scheduling the service. Madrid counts only the period between scheduling the date of service and the date of service. Additionally, in Extremadura, the data were presented clearly and consistently throughout the period of study, especially after Decree 228/2005. All data were published by the Public Defender of Extremadura Public Health System Users. Data for Madrid had a different trend: albeit largely lacking, they were clearest from the beginning of the period until 2005, when the Government stopped sharing its data with the MOH (Cañizares Ruiz and Santos Gómez 2011), effectively cutting off its relationship with the health-sector kentrocrats. For this reason, most of the relevant data after 2005 are unknown; making it impossible to evaluate objectively the efficiency of Madrid's waiting time policy. This is, despite regional government declarations that it had met and surpassed its waiting time targets during this period (Consejería de Sanidad y Consumo 2005a; 2006a; *Elmundo.es* 2005). Consequently, I am only able to examine data regarding the efficiency of Extremadura's policy on waiting times in the following.

The data in Table 6.1 demonstrate that the waiting time guarantees in the Extremadura were largely successful during 2003–2006 (taking 2003 as a baseline for the period 2004–2006). Over the whole period, Extremadura managed to reduce the number of patients on the waiting list for surgical interventions and diagnostic and therapeutic tests (despite a slight rise in this last category from 2005 to 2006). At the same time, its figures for the number of patients on its waiting list for first outpatient visits do not show a clear trend; first increasing between 2004–2005 and then

decreasing between 2005–2006. Extremadura made particularly great strides during 2005–2006, reducing the number of patients waiting more than a) 180 days for surgical interventions by 88 per cent, b) 60 days for their first outpatient visit by 84 per cent, and c) 30 days for their diagnostic and therapeutic tests by 34 per cent. This was concurred although by some stakeholders (Novinskey, Interview no. 07, 35 and 37).

Table 6.1. Extremadura Waiting Time Guarantees, 2003–2006

Measurement	**2003**	**2004**	**2005**	**2006**	**% change, 12/05 to 12/06**
Waiting Time Guarantee for Surgical Interventions (Goal: < 180 natural days)					
Number of patients on waiting list	16,021	15,971	14,155	12,757	-10
Number of patients waiting more than 180 natural days	899	2,720	1,517	179	-88
Average waiting time (natural days)	76	105	84	67	-20
Waiting Time Guarantee for First Outpatient Visits (Goal: < 60 natural days)					
Number of patients on waiting list	n/a	33,567	35,908	34,050	-5
Number of patients waiting more than 60 natural days	n/a	n/a	13,741	2,178	-84
Average waiting time (natural days)	n/a	30	34	28	-17
Waiting Time Guarantee for Diagnostic and Therapeutic Tests (Goal: < 30 natural days)					
Number of patients on waiting list	n/a	16,945	9,591	10,367	+8
Number of patients waiting more than 30 natural days	n/a	n/a	6,973	4,571	-34
Average waiting time (natural days)	n/a	197[a]	34[b]	29[c]	-15

[a] No global figure available; estimate is for mammograms, which had the longest average waiting time among all diagnostic and therapeutic tests in 2004. [b] This number masks the large variation of average wait times among the different tests; e.g. mammograms had an average of 47 days, still the longest of all tests, in 2005. [c] This number masks the variation of average wait times among the different tests; e.g. mammograms had an average of 33 days, still the longest of all tests, in 2006.
Sources: Extremadura Defensor de Usuarios (2004; 2005; 2006; 2007). Comparable data were not available for the additional waiting time guarantees for specific interventions in 2006.

Importantly, Extremadura appears to have met the guaranteed average waiting times for all three service-areas. With 2006 average waiting times of 67 natural days for surgical interventions and 28 natural days for first outpatient visits, Extremadura is well within its respective goals for these. However, it is less clear if Extremadura was meeting its goal of a 30-day average waiting time for diagnostic and therapeutic tests in

2006 because the global data may mask specific waiting times for each test (e.g. mammograms had an average waiting time of 33 days in 2006, which fails to fulfil the guarantee). Nevertheless, Extremadura increasingly made progress towards achieving its target guarantee for diagnostic and therapeutic tests (e.g. reducing the waiting times for mammograms from 197 days in 2004 to 47 days in 2005 and 33 days in 2006). Indeed, it was sufficiently confident in its progress that, with Decree 132/2006, Extremadura reduced the maximum waiting times even further for priority interventions, visits, and tests. Data related to the monitoring and evaluation of these waiting time guarantees, however, was not available for this analysis.

Table 6.2 demonstrates the data for waiting time guarantees in the Madrid during 2003–2006 (taking 2003 as a baseline). Because of a lack of availability, little can be said. Madrid managed to reduce the number of patients on its waiting list for surgical interventions from just over 54,000 patients in 2003 to 9,588 in 2005, which is impressive. It also managed to attain its average waiting time guarantee for these services of 30 business days by 2005. Comparative data for the number of patients on this waiting list for more than six months were not available. What this data does not show, however, are waiting times for diagnostic testing, which is intricately linked to surgical interventions. One key informant from Madrid explains,

> [Madrid] has done very well with the target for the surgical waiting list, an intermediate indicator…but it has done much worse with other indicators for the diagnostic test waiting list…so now what is much greater is the number of people who do not know if they are sick or not. So, over here [referring to people on the surgical waiting list], we know these people are sick, that some can wait but that the seriously sick ones are operated on. But over here [referring to the people on the diagnostic test waiting list], we do not know if these people have cancer or not… and there are many more of them (Novinskey, Interview no. 24).

In terms of user satisfaction, both regions achieved similar results, above the national average. According to the Health Barometer (Barómetro Sanitario) for 2006, 26.7 per cent of those surveyed from Extremadura and 28.4 per cent of those surveyed from Madrid believed that the waiting lists had improved in the last year (compared with 24.4 per cent of the national population) (Ministerio de Sanidad, Servicios Sociales e Igualdad 2012).[189]

[189] Figures are for resident populations, ages 18 and older.

Table 6.2. Madrid Waiting Time Guarantees, 2003–2006[a]

Measurement	2003	2004	2005[a]	2006	% change, 12/05 to 12/06
Waiting Time Guarantee for Surgical Interventions (Goal: < 30 business days)					
Number of patients on waiting list	54,032	40,433	9,588	n/a	n/a
Number of patients on waiting list more than 6 months	99	n/a	n/a	n/a	n/a
Average waiting time (business days)	57	55	30[b]	n/a	n/a

[a] Madrid stopped submitting data and information regarding waiting times to the NHS in 2005 (Cañizares Ruiz and Santos Gómez, 2011). [b] On June 30, 2005, Madrid reached its target waiting time guarantee. No data are available for first outpatient visits, mammograms or other diagnostic tests.

Sources: Consejería de Sanidad y Consumo (2004, 2005a, 2006); Instituto Madrileño de la Salud (2003).

In terms of their policy strategy for waiting time guarantees, Extremadura complies with central government mandates, thus implying a collaborative interaction with health-sector kentrocrats. My interview data from Extremadura generally corroborate this presumption of a cooperative attitude towards all health system stakeholders, including the MOH. This policy was also supported by the regional president and parliament, having been approved and legislated by them. Finally, although I did not delve into specific details of the implementation strategies used, the fact alone that Extremadura was able to meet and even surpass all of its waiting time guarantees by 2006 strongly suggests that it took sufficient actions in their regard.

Madrid's RHM (expenditure advocates) elaborated its policy strategy for reducing wait times thorough plans, created an organisational structure to implement those plans and took specific actions towards reaching this goal. Its president, parliament and ministry of finance (expenditure guardians) also seemed to back the plan, according to their political statements and the additional financial investments for it in annual budgets. Their plan, however, defined and elaborated its own criteria, indicators and requirements for waiting times and was hence largely non-compliant with the central government's Royal Decree 506/2003. This fact and Madrid's refusal to share its waiting time data after 2005 with the MOH demonstrate a strong push for regional autonomy.

In conclusion, with regard to the policy trade-offs in Extremadura and Madrid, from the evidence, subnational expenditure advocates and guardians seem to carry

greater weight than the health-sector kentrocrats in this area of policy. Given the privileged position of these two actor groups in both regions, this was to be expected. While Extremadura demonstrated respect for directives from health-sector kentrocrats, Madrid largely ignored them and was openly uncooperative after 2005, which—perhaps, coincidentally—occurred after the change in political party control over the national government from the People's Party to the Socialist Party in 2004. Indeed, one stakeholder suggested this phenomenon was mainly due to party politics,

> Because, in Spain, the Autonomous Communities are never all governed by the same party…they are divided. When the [central government] was governed by the PP, those from the PSOE gave opposition from the Autonomous Community level; now that the PSOE is governing, the PP makes their opposition from the Autonomous Community level. Therefore, when a PSOE government is arriving, a PP-governed Community has no interest in sharing information (Novinskey, Interview no. 15).

Another stakeholder commented, "Before [the 2001 devolution] health care was somewhat less political" (Novinskey, Interview no. 34). While Extremadura's outcome was unexpected from our framework, Madrid's was expected as it showed that the health-sector kentrocrats would be virtually shut out of politics within the subnational health policymaking environment (and their goals would not be a priority for the subnational policy network). What the framework did not capture here is policy changes based purely on party politics.

The power dynamics between the expenditure advocates and guardians are less easily ascertained. Given their degree of success in passing legislation on waiting time guarantees (twice in two years) that required additional funds, subnational expenditure advocates seem to have held a significant and persuasive position in Extremadura's subnational health policy network, and one greater than the subnational expenditure guardians did. From the framework analysis of the thesis, however, the opposite result was expected: the policy priorities in the subnational policy network in Extremadura were expected to have favoured more economic restraint. Yet, if we consider the influence of the national health policymaking environment[190] on the subnational health policymaking environment and incorporate it into the analysis, then the actual policy developments for waiting time guarantees in Extremadura would be slightly more —although not fully—aligned with the expectations of the framework. Turning to Madrid, given the intensity of the politics surrounding the waiting time guarantee

[190] Because the national-level expenditure advocates have a slightly more power within their policymaking environment than the subnational expenditure advocates do in theirs.

policy and its financial backing, from the limited data available, Madrid's expenditure guardians seemed slightly stronger than its expenditure advocates were, and that policymaking favoured regional economic control more than regional health policy. This actual development was anticipated from the framework's analysis of health policy priorities in Madrid.

6.2. Regulation and Planning: Common Health Benefit Package Expansions

In this subsection, I examine Extremadura and Madrid's efforts to expand the benefits of the common health care package during the period 2004–2006, using measures of policy efficiency, policy strategies and policy failures. Moreover, I evaluate whether the actual health policies correspond with the policy priorities anticipated by the analytical framework of the thesis. The policies for the health care benefit package fall under the functional area of Regulation and Planning and, more specifically, the health system function of norms and standard, for which the regions have been allocated a moderate amount of decision space during the period of study.

By way of reminder, the central government defines and guarantees a common health care benefit package for all Spanish residents (through Royal Decree 63/1995 and Law 16/2003).[191] In exchange for central government financing, the regions are responsible for providing this benefit package to their populations (as explained in detail in the sections of Regulation and Planning in Chapter 4). They were also given certain liberties in this area (hence, the moderate decision space). In addition to being able to decide how much financing to allocate for each health care benefit in the common package within their own territories, the regions are allowed to increase its breadth (e.g. broader coverage) and depth (e.g. number of benefits) for their respective populations, provided they finance those expansions themselves (Novinskey, Interview no. 20 and 22).

In the following analysis, I focus on the regions' share of responsibility for the norms and standards function of the NHS. In particular, in terms of policy efficiency, I look at how each region actually uses its newly obtained decision-making power for this key function of planning and regulation. I assume that an expansion of benefits—either by enlarging the population entitled to the package or particular benefits within it

[191] Royal Decree 63/1995 remained in effect until the new benefit package was passed with Royal Decree 1030/2006 in September 2006, which is at the end of our study period. Please note that these are general frameworks of benefits, not properly minimum benefit packages of health services (Puig-Junoy, Planas-Miret, and Tur-Prats 2005).

or by including new health services—would require an increase in expenditures to fund them and, ultimately, a negotiation between subnational expenditure guardians and advocates. The greater use a region makes of this decision-making power, the greater the influence of the subnational expenditure advocates. The lesser the use, the greater the influence of the subnational expenditure guardians.

Next, I look at the level of correspondence between the content of the policies produced by Extremadura and Madrid in this policy area and the national recommendations for them to show the level of influence of health-sector kentrocrats in these decisions (and their priority goal for national health policy coherence). For example, Annex III of Royal Decree 63/1995 explicitly excludes specific services from the common benefit package, e.g. sex-change surgery or cosmetic surgery. If a region were to include one of these as an additional benefit to the common package in their territory (e.g. Andalusia's addition of sex-change surgery as a benefit in 1999), this could be seen as an exhibit of great autonomy on behalf of the region but also a sign of disjointed national policy. This would demonstrate the weak influence of health-sector kentrocrats on subnational health policymaking.

While taking over responsibility for health services and competencies in 2001, both Extremadura and Madrid passed legislation that expanded the breadth and depth of the common health care benefit package to their respective populations. Under its Regional Health Law 10/2001, Extremadura added passive euthanasia to its benefit package (Presidencia de la Junta de Extremadura 2001a). In its Health Planning Law 12/2001, Madrid recognised the binding legal nature of advance care directives for patients in their final moments of life, and expanded access to its benefit package to non-resident travellers (Presidencia de la Comunidad de Madrid 2001a).

During the period study (2004–2006), Extremadura passed several more pieces of legislation and regulation that expanded the benefit package available to its population or segments thereof (see Appendix N). In particular, it regulated patient rights to a second medical opinion, waiting time guarantees, and advance care directives. It also granted foreign residents in their territory the right to health protection and access to health benefits through a special Health Care Card. Moreover, Extremadura passed legislation to assist seniors and persons with a disability pension to purchase relatively high-cost orthoprosthesis products with an interest-free, third-party loan (Extremadura paid the interest). With its own financing, it further reimbursed and provided financial aid for some expenses not included in the common benefit package,

including pharmaceutical products and necessary travel for health care services in institutions outside the region. Finally, also with its own funds, Extremadura legislated offering full child dental health care to its population aged 6 to 14 years old.

During the study period, Madrid did not expand the common health care benefit package at all, but it adopted several "Instructions" regarding aspects of the application of health services contained in the package. For example, Instruction 1/2004 regulated the reimbursement of out-of-pocket, health care-related travel expenses (Comunidad de Madrid, 2004). It also regulated systems and procedures for carrying out items on their political agenda; e.g. Decree 62/2004, which established the RULEQ as well as procedures for monitoring and evaluating it.

In summary, regarding policy efficiency, Extremadura clearly used its discretion to expand the common health care benefit package to its population more than Madrid did. This extensive activity demonstrates that Extremadura's subnational expenditure advocates in the health sector were quite accomplished and wielded considerable influence and power. This was the opposite result of what my framework anticipated. Again, if we consider the influence from the national health policymaking environment, then the actual policy developments for the expansion of the common benefit package in Extremadura would be slightly more in line (though, not fully) with the expected policy priorities gathered from the framework.

Turning to Madrid, it did not exercise its discretion to expand health benefits further.[192] Indeed, just looking at the study period, it would seem as if the policy permitting the regions to expand health benefits within their territory was a failure. However, in the period prior to this investigation, Madrid enacted two pieces of legislation that expanded on the common health benefit package: recognition of advance care directives[193] and free access to benefits for non-resident travelers (the latter of which could be a significant expense for the region, especially considering the Community of Madrid holds the country's capital city). As a result, this policy in Madrid cannot be deemed a failure. Indeed, compared to the actions taken by

[192] One stakeholder expressed the Community of Madrid's process objectives following its assumption of health care competences in 2002: "My fundamental objective from January to June was that no citizens would not notice any loss in quality [of health care]…Then, from June, we began to change some services and introduce new concepts and ways to do and see things that were more adapted to our reality. But important change happened after 2003, because between 2002 and 2003 basically we just received what [the central government] gave us. The structural changes that we have now began from 2003" (Novinskey, Interview no. 24).

[193] NB: advance care directives are 'cost neutral'.

Extremadura regarding only these two policies[194], Madrid could be considered more policy efficient because of its earlier adoption of them. Overall, it would seem that Madrid's subnational expenditure guardians and advocates held comparable influence over policy decisions on expanding health benefits within their territory. This result was anticipated by and corresponds with the resulting trade-offs for subnational health policymaking in Madrid from my framework.

Regarding the role and goals of health-sector kentrocrats with respect to this policy area, there was one additional health benefit regulation that seemed to create a stir: that on the post-coitus, emergency contraceptive pill.[195] Beginning in 2001, the MOH legalised and regulated the availability of this pill in pharmacies with a prescription and at the full cost (approximately 20 euros) to the user. In doing so, it also explained that the regions could do what they considered appropriate with this policy using their right to exercise their health care competencies in their territories but that the NHS would not finance it (*MedicinaTV* 2000). Indeed, in October 2004, backed by the MOH and broader Zapatero (PSOE) Administration, the Health Commission of the National Parliament approved and put forward to the whole parliament a proposition to offer this emergency contraceptive free-of-charge at health centres and hospitals nationwide with a prescription (Zanza 2004). The proposition failed; thus, showing the weak level of influence of the national-level expenditure advocates (which was expected from the results of the framework). To this day, the NHS does not finance the post-coitus pill. By 2004, considering its urgent character[196], Extremadura (and at least four other Spanish regions) upped the ante on this policy by making the pill accessible at its health and family planning centres, free of charge to users (Ministerio de Sanidad, Política Social e Igualdad 2011). The government of Madrid—along with the regional governments of Catalonia, Navarra, Murcia and Galicia—strongly opposed this practice, warning that "easy acquisition of the pill can spoil all the work done on sex prevention and education" (*El Imparcial* 2009, 1). At the same time, the Municipality of Madrid approved the use of this emergency contraceptive in its own health centres with the municipality covering the full cost. Considering that the Municipality of Madrid operates health centres within the confines

[194]Extremadura made similar health care benefit policy expansions regarding these two policies later than Madrid did.
[195] The World Health Organisation considers the morning after pill to be an "essential medicine" (*El Imparcial* 2009).
[196] To be effective, treatment with this pill needs to be administered within 72 hours of sexual relations.

of the Community of Madrid, this pair of contradictory positions begs the questions of what Madrid's population actually supported and with which government it was more aligned.

Overall, this is obviously a very controversial and politically motivating policy. However, to continue this aspect of the debate risks losing sight of its main points for the thesis: first, this is an instance in which one of our case-study regions passed legislation regarding a health benefit expansion that was not aligned completely with the national policy and, second, it demonstrates the incoherence and public confusion that happens when there is no common NHS protocol on a policy (e.g. there are differences in access, in the place of dispensing, and in the conditions for purchasing the post-coitus pill across regions in Spain). Considering this, it seems that the health-sector kentrocrats have little influence on regional health policies for this health system function and have not made sufficient efforts in this area to attain their policy priorities of national policy coherence and subnational policy coordination. This was an expected result from the analytical framework of the thesis for both regional cases.

6.3. Financing: Paying Medical Specialists in Hospital Ambulatory Settings

In this subsection, I examine Extremadura and Madrid's policy for paying medical specialists in hospital ambulatory settings during the period 2004–2006, using measures of policy efficiency, policy strategies and policy failures. Moreover, I evaluate whether the actual health policies corresponds with the policy priorities anticipated by the analytical framework of the thesis. The health policies for the health care benefit package fall under the functional area of financing and, more specifically, the health system function of payment mechanisms, for which the regions have been allocated a moderate amount of decision space during the period of study.

Since 2001 and throughout the period under investigation, the choice of how to pay public health providers in Spain has been shared between the central government and the regions. As we saw in Chapter 4, the central government regulates all statutory health personnel (a special civil servant status) through Law 55/2003. This law stipulates that health personnel be remunerated with a basic salary as well as supplementary (or "top-up") payments. The basic salary amount for each cadre is established for a three-year period and standardised by the central government for all statutory health personnel (Hidalgo and Matas 2004). Top-up payments for personnel within their territory are at the discretion of each region; thereby, constituting a moderate decision space for this policy at the subnational government level. The regions have varied considerably in their application of this decision space and in the amount of supplemental payments authorised (García-Armesto et al. 2010). In the following, I examine the situation of salary "top-ups" for medical specialists in hospital ambulatory settings. In doing so, I assume that any supplemental payment would require an increase in expenditures to fund it and, therefore, a negotiation between subnational expenditure guardians and advocates. In terms of policy efficiency, I establish the degree to which these regions use their discretion for supplementing medical professionals' salaries. The greater the amount of supplement payments allowed, the greater the influence of expenditure advocates within the subnational health policy network. With respect to the health-sector kentrocrats, I look at how the regions use their decision-making authority over these payment mechanisms and how this compares to the kentrocrats' priority for achieving national health policy cohesion and coordination. I also consider the possible influence of national health policymaking dynamics on the decisions made within the subnational health policy networks for each region, as I have done for the prior two policy analyses.

The various remuneration models across the Spanish regions display substantial complexity and variability. Each region can apply its own types of supplementary payments; e.g. Extremadura pays a supplement for "working conditions" and Madrid pays a supplement "linked to the specific position". Moreover, when they apply the same supplement, such as a fixed performance supplement, the amount allocated can vary. Additionally, the specific characteristics (e.g. civil servant status or not) and situation (e.g. number of years in service) of each medical specialist can differ. Moreover, the relevant contract terms can vary within and across regions (e.g. allowing compensation from private practice or defining the number of permissible hours on call). Consequently, comparing the "top-up" remuneration for medical specialists (or any health cadre) across regions is next to impossible. In their *Comparative Study of Physician Salaries in Spain*, Hidalgo and Matas (2004) reduced this complexity by defining three types of medical specialists working in hospital ambulatory settings, *ceteris paribus*, with identical conditions and only one variable: the remuneration model in each region. They presented data for December 2004.[197] Table 6.3 shows the gross monthly salaries for public medical specialists by level of dedication to the public service (measured in exclusivity and years of service)[198] and type of contract (measured as civil servant or stand-in medical specialist contract) for Extremadura, Madrid and the national average for 2004. It also presents the differences in gross monthly salaries for each region in comparison to the national average. Finally, we must remember that the cost of living in Extremadura and Madrid differs widely, and this variable is not controlled for in Hidalgo and Matas' study. So, for a more accurate comparison between the regions, I have included a column presenting a proxy for the cost of living in each region: the regional gross monthly salary for 2004 as an index, where the national average equals 100 (Instituto Nacional de Estadística 2005). From the gross monthly salary data (in euros), I calculate and introduce into the table the corresponding index for each physician type.

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[197] The process of standardizing remunerations across Europe (according to Directive 93/104/CE)was still being implemented and was anticipated to last until 2006, depending on the region.
[198] Medical specialists who do not exclusively work for the NHS can earn extra pay by working in the private sector, and this potential additional pay may be viewed as an incentive that the regional government offers the medical specialist without incurring any public costs. There are no data on the impact of this incentive, so it has not been factored into the analysis.

Table 6.3. Gross Monthly Salaries (in Euros) of Medical Specialists in Hospital Ambulatory Settings by Level of Dedication and Type of Contract, and Regional Gross Monthly Salary by Region for 2004

	Medical Specialist Type 1: "Civil servant" with no exclusive dedication and no on-call hours[a]			**Medical Specialist Type 2:** "Civil servant" with exclusive dedication and 50 on-call hours per month[b]			**Medical Specialist Type 3:** Stand-in medical specialists with exclusive dedication and 50 on-call hours per month[c]			**Regional Gross Monthly Salary Index, adjusted (100 is national average)**
	Gross Monthly Salary (Euros)	Difference from National Average	Gross Monthly Salary (index)	Gross Monthly Salary (Euros)	Difference from National Average	Gross Monthly Salary (index)	Gross Monthly Salary (Euros)	Difference from National Average	Gross Monthly Salary (index)	
Extremadura	2,539.03	-332.85	88.4	4,347.70	-51.37	98.8	4,065.67	48.54	101.2	84.1
Madrid	3,322.50	450.62	115.7	4,373.75	-25.32	99.4	4,091.72	74.59	101.9	115.0
National Average	2,871.88			4,399.07			4,017.13			
Minimum	2,481.17			3,907.62			3,238.58			
Maximum	3,680.94			5,408.21			4,813.88			

[a] Physician type 1: "Civil servant" with 21 years of service, without exclusive dedication to the RHS and with no on-call medical emergency service.

[b] Physician type 2: "Civil servant" with 21 years of service, exclusive dedication to the RHS plus 50 on-call hours per month, 12 of which are on weekends or holidays.

[c] Physician type 3: Stand-in medical specialists with exclusive dedication and 50 on-call hours per month, 12 of which are weekends or holidays.

Note: Specialists are not formally civil servants but most have an analogous status. Exclusive dedication means that the medical specialist's terms of reference do not allow compensation from private practice outside public sector working hours. Stand-in medical specialists have temporary contracts until a civil servant occupies that position. Yearly work hours are 1,533 hours in Madrid and 1,582 hours in Extremadura. On-call hours are usually at night or on weekends or holidays; both Extremadura and Madrid pay 12.27 euros per hour for nights and 17.38 euros per hour for weekends or holidays. The annual base salary established by the national government is 14,680.96 euros for all physician types. The national average, minimum and maximum include the 17 regions, and the autonomous cities of Ceuta and Melilla (whose supplementary payments are set by INGESA).

Sources: Medical specialist payment data: Hidalgo and Matas (2004), see also for further details. See Instituto Nacional de Estadísticas (2005) for data on general gross monthly salary by region.

As described in the table, the results for Extremadura demonstrate that medical specialist type 1 and type 2 are paid substantially and slightly below the national average, respectively, and type 3 is paid slightly above the national average. For Madrid, medical specialist type 2 is paid just below the national average, while types 1 and 3 are substantially and slightly above the national average, respectively. While the difference from the national average is relatively similar in the two regions for medical specialist types 2 and 3, there is a very large difference for type 1: –332.85 euros for Extremadura and 450.62 euros for Madrid relative to the national average.

Overall, from these figures, it would seem that Madrid has been more generous than Extremadura with its supplementary payments to medical specialists in (public) hospital ambulatory settings. However, when we consider the "cost of living" proxy, there is a shift in the results. The regional gross monthly salary for Extremadura (for all job types) is 16 points lower than the average gross monthly salary in Spain, whereas the gross monthly salary for medical specialist type 1 is 12 points lower, type 2 is only 1 point lower and type 3 is 1 point higher than the national average. Therefore, medical specialists in Extremadura are paid more on average than the cost of living for the region would require. This finding suggests that the subnational expenditure advocates for health have considerable influence in Extremadura, again the opposite of what was expected from the results of the analytical framework. Considering the influence of the balance of power from the national health policy network does not help us much to interpret this unexpected outcome either.

For Madrid, the regional gross monthly salary and the gross monthly salary for medical specialist type 1 are both 15 points higher than the average gross monthly salary in Spain. In contrast, the gross monthly salary for type 2 is a half a point less than the gross national average in Spain; for medical specialist type 3, this figure is only 2 points higher than the gross national average. Overall, when factoring in the cost of living, Madrid's medical specialists are paid equal to or less than the regional gross monthly salary for all jobs in the region. This result suggests that the subnational expenditure guardians have influence over health policy in Madrid that is equal to or slightly greater than that of expenditure advocates, as expected from the results of the analytical framework of the thesis. Compared with Extremadura and considering the cost of living, medical specialists of all three types are paid more in Extremadura than in Madrid

Turning to the health-sector kentrocrats, one might expect them to support standardisation of payments within Spain because it is consistent with their policy priorities for achieving national policy cohesion and coordination. Moreover, it is aligned with the European Community's Directive 93/104/CE to do this across its member countries, which includes Spain. As such, it would seem that a value close to 100 for the gross monthly salary of a medical specialist would represent an attempt by a region to standardise its payments with the national average. This is the case for supplementary payments of medical specialist types 2 and 3 in both regions. In contrast, payments for medical specialist type 1, "civil servants with no exclusive dedication and no on-call hours", are well below the gross national average monthly salary in Extremadura and well above it in Madrid. Overall, with two out of three types closely mirroring the national average, it seems that the health-sector kentrocrats may have at least a moderate amount of influence on both regions; this, however, is not aligned with the health policy priorities anticipated by the framework of the thesis.

6.4. Financing: Sources of Revenue

In this subsection, I examine the national health policy network and policies for increasing funds to the regional health services for the period 2004–2006, using measures of policy efficiency, strategies and failures. Moreover, I assess whether the *ex-post* policies adopted during this period correspond with the policy priorities laid out *ex-ante* from the analytical framework of the thesis. The policies for increasing funds to regional health care fall under the functional area of financing and the health system function 'sources of revenues', for which the central government and the regions share a moderate amount of decision space for 2004–2006. Additionally, informal intergovernmental policymaking within the national health policy network in Spain demonstrated moderate expenditure advocates and guardians, and strong topocrats for 2004–2006.

Throughout the study period, the discretion for determining revenue sources for the health system is held by the regions and central government, including actors from the MOF and RFMs, on the CPFF. The 2001 financing agreement determined the parameters for transferring general funds to the regions, including those for health care.[199] It also ceded tax-raising capabilities to the regions so that they could collect

[199] Funds for the health care sector lost their earmarking from the central government with this agreement.

and use their own resources (see Section 4.4.3). This agreement was established for an indefinite period. Thus, any attempts to introduce new funds to the system for health financing would be played on this field for informal intergovernmental policymaking.

As the regions began to exercise their new authority over health care, it became apparent that the 2001 financing agreement was not financially sustainable. Expenditures for health care were rising and the regions with newly devolved health care competencies began to take out loans in order to pay for them. Indeed, both Extremadura and Madrid began to borrow funds for health care at the end of 2002.[200] By the end of 2003, Extremadura had €40,311 thousand in accumulated pending debt for health care, and Madrid had €223,579 thousand, comprising 3.9 and 4.9 per cent of their total health expenditures, respectively. These were, however, rather low percentages, considering the average percentage of accumulated pending debt over total health expenditures for all regions was 15.6 per cent. In addition, by 2003, 13 of the 17 regions had taken out at least one loan to cover their health expenditures and most took loans out yearly from that year on.

Around this time, the regions began to make calls for a new regional financing agreement, in particular to help them cover the rising costs of health care. The central government responded to these calls by making this topic the focus of the newly organized Conference of Presidents (*Conferencias de Presidentes*), or the "Regional Summit". This conference was the highest political-level meeting between the presidents of the national and regional governments in Spain[201] and, therefore, also its highest political body of multilateral cooperation. It is presided over by the Prime Minister. Its purpose is to debate and adopt agreements on issues of special relevance for the autonomous system; however, decisions of the conference are not legally binding.

In 2004 and 2005, the first two Conferences of Presidents were devoted primarily to the inquiry of how health expenditures had evolved over recent years, their unsustainability under the current financing agreement and what the possible government solutions for it were (Ministerio de Economía y Hacienda and Ministerio de Sanidad y Consumo 2005; Ministerio de Economía y Hacienda 2007). In addition to institutionalizing the conference in 2004, the Conference identified the need for further investigation into health expenditures. To do this, it created a working group headed

[200] The regions that already had devolved health care competencies had long been taking out loans to cover their spending on health care.
[201] As well as the presidents of the autonomous cities of Ceuta and Melilla.

by the Comptroller of the State Administration (*Intervención General de la Administración del Estado*), with the objective of performing a study on the origin, composition, efficacy and efficiency of health spending during the period 1999–2003. The results of such research were supposed to inform a new model of health financing, which Zapatero, the President of Spain, announced would be agreed on in 2006. According to Zapatero, the new model would guarantee the sustainability of health care and improve "the quality and benefits" offered to all citizens" (El País 2004).

In June 2005, this working group reported on the analysis of health expenditures to the CPFF (Ministerio de Economía y Hacienda and Ministerio de Sanidad y Consumo 2005). Among its main findings, the report indicated that public health care spending in Spain had increased at an average rate of 9.01 per cent for the period studied (1.9 percentage points above the average annual increase in GDP). Public health spending on services beyond the common health care benefit package increased by 1.4 per cent annually. Importantly, included in these figures were the above-mentioned pending debts for health care that, at the end of 2003, totalled over €6 billion. Moreover, almost all regions showed an average annual increase in public health care spending above the average for all spending, but Extremadura's increase was aligned with, and Madrid's was below, this. The largest component of health care spending, according to economic classifications, was human resource salaries; by a functional classification, it was specialised and hospital care, followed by pharmacy and primary care. In addition, the total population of beneficiaries in Spain increased by an average of 1.62 per cent per year. The beneficiary population of Extremadura decreased annually from 1999 to 2003, while Madrid's beneficiary population increased at a higher annual rate than the national average. In 2003, health care spending per beneficiary was €954 nationally, €1,026 in Extremadura and €870 in Madrid (the lowest of the seventeen regions). For the same year, per equivalent person (*por persona equivalente*, calculated from a weighted scenario using seven age groups) it averaged €953 nationally, €988 in Extremadura and €920 in Madrid.

These results were further discussed at the Second Conference of Presidents, held in September 2005. Despite the Zapatero's announcement for a new financing agreement at the first Conference, no such mention was made at this one. Apparently, the President and the central government did not have the political conditions to negotiate a new financing agreement (Novinskey, Interview no. 38 and 41). However, the Presidents of the Second Conference did decide to increase funds and quality

measures to the health sector in other ways: (i) the central government agreed to make an additional financial contribution to the NHS (the total contribution was established at €3,042.4 million for 2006 and €3,142.4 million for 2007), (ii) the regions agreed to adopt measures for rationalizing health spending as proposed in the report, and (iii) the working group agreed to continue developing and specifying the measures for assessing health spending growth for a report in early 2007 (Ministerio de Economía y Hacienda 2007b).

In terms of financing, the Health Cohesion Fund was one MOH instrument that would receive some of these agreed upon funds. Prior to this, the endowment of this fund was just €54 million annually and it performed rather poorly (see Section 5.3.2.1). In an attempt to rectify this and make it more attractive to the regions and effective, the central government approved an increase of €45 million in its annual allocation, starting in 2006. In addition, another part of the agreed upon funds (€50 million) when to the implementation of the 2006 NHS Quality Plan (*Plan de Calidad del SNS*). This new allocation, also managed by the MOH, first appeared in the 2006 budget. It was intended primarily to strengthen the cohesion policy and strategy to improve the quality of NHS services (Urbanos-Garrido 2006).

In sum, this episode demonstrated the informal intergovernmental policymaking within the national environment in post-health system devolution in Spain. Importantly, when the trade-offs in informal policymaking for increasing central government financing of the regions in the name of health care became clear, efforts mostly a failed. While this issue certainly received a lot of pressure from the Presidents of the regions (topocrats), who unquestionably pushed their weight around on it and, even, political attention from the President of the central government, by the end of 2006, a new financing agreement was not in sight and a modicum of additional financing conceded to the health sector via the weak health sector expenditure advocates. The regions had made at least two high-level attempts at gaining financing through the Conference of the Presidents but their only concessions were that they could 'apply' for some of the additional funds from the Health Cohesion Fund or that they had to make specific, centrally-dictated improvements in the quality of health care in their region, under the NHS Quality Plan, to receive some of them. In addition, the amounts of these concessions were not close to fulfilling the needed financing for health care that the regions requested. Indeed, one regional stakeholder said, "in 2005, the Conference of Presidents ended unfavourably, distributing insufficient funds"

(Novinskey, Interview no. 39). Moreover, in comparison to what would have been the cost of a new financing agreement, an interviewee from the Ministry of Finance called this additional financing, "Little gifts. Nothing. Peanuts" (Novinskey, Interview no. 38). Clearly, from these interactions and despite concessions, the expenditure guardians were in a privileged position, with greater macroeconomic control on the health sector (and country) during this period.

These results were not completely predictable given our analysis. As expected from the results of our framework, while the health sector advocates were organized out of political discussions on health financing, especially those in the Conference of the Presidents, they did participate in the working group for the analysis of health expenditures. It was also expected that that the topocrats would come together as a strong group, supporting the health sector; and they indubitably did this by bringing the request of increased financing for their health sectors to the centre of the agenda of, not one, but two meetings of the highest political body in Spain. The topocrats efforts were not, however, strong enough to overcome the priorities of the national-level expenditure guardians for macroeconomic control. This was not expected from our model, which showed the topocrats having relatively greater strength in informal intergovernmental policymaking than the expenditure guardians.

6.5. Discussion

Overall, the results of the analyses of the above health policies in Spain and the regions of Extremadura and Madrid are mixed for the period 2004–2006. In the case of Madrid, the outcomes of the *ex-post* analysis for all three subnational policies were aligned with the *ex-ante* results from the framework of the thesis, with the exception of the position of the health-sector kentrocrats in the policy on paying medical specialists in hospital ambulatory settings. Conversely, in Extremadura, the *ex-post* results of these same policies did not reflect the *ex-ante* balance of power described by framework of the thesis for subnational expenditure guardians and advocates; although as anticipated, they did demonstrate the little influence that health-sector kentrocrats had for the policies concerning waiting time guarantees and health care benefit package expansions. Finally, for our last health policy examination, results from the *ex-post* analysis of increasing health financing were also mixed, with those concerning the health expenditure advocates matching but a bit questionable for the topocrats and mostly wrong for expenditure guardians.

The discrepancies between the *ex-ante* results from the analytical framework and the *ex-post* findings in Extremadura as well as for the national-level expenditure guardians are likely due to a confounding factor not controlled for in the study. The most probable factor for both is party politics. One regional-level interviewee stated, "health care is not a subject in which the temptation to take political party sides is minor" (Novinskey, Interview no. 37). Along these lines, another key informant said, "by bringing management closer to the territory, a certain political dependence is created" (Novinskey, Interview no. 34).

In his cross-country comparison, Blom-Hansen (1999) controlled for party politics by selecting countries with political environments dominated by a mix of the same three types of parties, roughly represented to the same degree at all levels of government. For my study, I took a different approach by intentionally selecting regions ruled by two different political parties (the Socialist Party in Extremadura and the People's Party in Madrid). My intent was to achieve a more realistic representation of regional-level political dynamics, since it is unlikely that all regions in a country will be dominated by the same political party, even in a two party system.[202]

While Extremadura and Madrid have been ruled by a single party over the period analysed, their opposite political orientation most likely contributed to the determination of health policy priorities in each region. The Spanish Socialist Workers' Party, which governed Extremadura during the study period, aimed to produce policies that protect and extend worker and citizen rights, especially in health and social sectors. This ideology is likely to be a confounding factor responsible for the discordance between the *ex-ante* balance of power and policy priorities among policymaking actors and the *ex-post* results of policies produced in Extremadura. It is also most likely a reason the government actually gave greater priority to health-sector kentrocrats and subnational expenditure advocates, as well as to health policy issues in general. Considering this factor in the framework analysis, potentially would have given these actor groups and their goals a higher level of priority in Extremadura and the *ex-post* results would have been more aligned with them.[203]

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[202] Indeed, it is even less likely that party politics would be the same across countries. A main objective of my analytical framework is for it to be used as widely as possible within upper-middle- and high-income countries.

[203] The People's Party ideology is founded on values of capitalism, defends private property, and promotes prosperity for Spain and its people, among other things.

Moreover, the difference between regional and national ruling political parties[204] and their resulting intergovernmental relations could have also been confounding factors. The change in ruling party of the Spanish government from the People's Party to the Spanish Socialist Worker's Party with the 2004 general election would have likely produced a change in policy due to ideology and/or intergovernmental relations. For national-level intergovernmental policymaking in the last policy addressed in this chapter, impending general economic problems[205] during this time may have provided more support to the PP and their conservative economic and financing agenda.

In addition to the potential importance of differences in political party alignment between the two Spanish regions, there also might be important differences in regional financing capacity and priorities, which have confounded the *ex-ante* results. Assessing the regional governments' ability to manage local resources efficiently and to make financial decisions to respond to citizen needs promptly could be a third determinant that helps to explain the discrepancy between the *ex-ante* and *ex-post* results for the policies in Extremadura.[206] There is evidence in the literature that points to the significance of decentralized governments' financing capacity (Brindusa Tudose 2013). Anecdotal data for Extremadura and Madrid also point to this potential influence. For example, according to the 2001 financing agreement, the total financing for Extremadura in 2003 was nearly €2.409 million, comprised of €2.208 million from the central government (91.66 per cent)[207], €179,476 thousand (7.45 per cent) from the region itself[208], and €21,543 thousand from taxes[209] (Ministerio de Sanidad y Consumo 2006c). For Madrid, during the same year, total financing was approximately €10.799 million, comprised of €7.717 million (71.46 per cent) from the central government, €2.956 million (27.38 per cent) from the region, and €744,646 thousand from taxes (ibid.). This suggests that Extremadura has a lower fiscal capacity than its needs and that Madrid's may be greater than its needs. The Sufficiency Fund enters into the

[204] Before the 2004 general election, the central government and the region of Madrid were both ruled by the People's Party. After it, the central government and the region of Extremadura were both ruled by the Spanish Socialist Worker's Party. This change could have potentially provoked differences in the intergovernmental relations of our policy networks.
[205] Indeed, this study (2004–2006) took place just before the 2007–2008 world financial crisis and the Great Recession in Spain in 2008. Thus, as time progressed, signs of economic decline would have increasingly revealed themselves to the policymaking world, especially the expenditure guardians but also to the President—both of which are privy to this type of intelligence.
[206] Financing may also be a factor at the national level.
[207] Resources from the financing system managed by the General Administration of the State in 2003.
[208] Actual collection of transferred traditional taxes.
[209] Collection of (normative criterion) taxes.

discussion here (See Section 4.4.3). It was managed by the MOH and created to redistribute funds and maintain the status quo in each region. Considering its lower fiscal capacity, Extremadura is likely to receive financial transfers from this fund, whereas Madrid is likely to be a contributor of financing to this fund. Moreover, by the end of 2003, Extremadura had €40,311 thousand in accumulated pending debt for health care, and Madrid had €223,579 thousand. These comprise 3.9 and 4.9 per cent of the total health expenditures in 2003, respectively; which was rather low considering the average for all regions was 15.6 per cent. However, one would need to explore the tendencies for health care debt over time to understand this relationship with debt better. Indeed, both Extremadura and Madrid began to borrow funds for health care in 2002, whereas the regions with health care responsibilities before 2001 started well before 1998 and represented the regions with the largest accumulated health care debt in 2003. It would be interesting to see how and to what extent our case-study regions use their borrowing capabilities for health care. Anecdotal evidence for later years, show that both regions accumulated much greater debt, Madrid in particular (El Confidencial 2016)

There are additional, perhaps more appropriate, financial and budget indicators for examining the financial capacity of regional governments, and determining their ability to manage regional health resources efficiently and make financial decisions that respond to citizen health needs promptly, within the context of budget constraints.[210] Tudose (2013), for example, puts forward an index of performance indicators on the general financial performance of local governments in decentralized systems. Her index includes revenue-based indicators (which, e.g., give an idea of the level of dependence of the regional budget on the national budget), expenditure indicators (which measure the flexibility of regional government spending), and results indicators (which measure the extent and quality of the regional government's involvement in boosting economic activity). Perhaps, aspects of this index or a similar one specific to the health sector could be integrated into the framework in future work. In that case, the set of indicators would have to be coherent and consistent, and data for them relevant and available for the Spanish case (as well as other middle-to-higher income countries). To have a full assessment of the financial capacity of the region here, however, is not within the scope of the thesis.

[210] (the latter is addressed by the modified version of von Hagen's budget tightness index in the thesis

The analytical framework of the thesis does not incorporate party politics and ideology nor financing capacity between the regions into the analysis; however, some of my results from the examination of health policies in Spain in this chapter do not point to these issues either. For example, when the health-sector kentrocrats exhibited strong and weak influence on a policy for paying medical specialists, and waiting time guarantees and benefit package expansions, respectively), they did so in both regions, irrespective of their political and ideological differences. Perhaps, then, it is necessary to consider the relationship between policy networks and processes, political party alignment and financing capacities at both the national and regional level and how they affect policy actions and outcomes. As one example from the Spanish case herein, the story of negotiating the 2001 financial agreement comes to mind. In this informal policymaking negotiation, it seemed that the regions (topocrats) of opposing political colours to the central administration (both expenditure advocates and guardians) and that also had seemingly less financial capacity were the toughest negotiators and obtained the greatest concessions for health care. The regions of the same political party as the central government but that had seemingly less financial capacity than others has a second place advantage in the negotiations. As such, these three factors may be causally related to policy actions and outcomes.

In summary, the results from this chapter confirm that the organisation of informal policymaking plays an important part but is not the only factor determining health policy priorities. They also suggest that the political orientation of the ruling party or coalition at the national and subnational government levels may also play a role in addition to regional financing capacity.

Regarding the methodology used, it is important to notice that the analytical framework permits analysing only those policies that have an effect on the level of expenditures, which limits the scope of the analysis considerably. This limitation is inherited from Blom-Hansen's decision to categorise actors into expenditure advocates and guardians, making the desire to increase or decrease expenditures the sole distinguishing factor between the two. Consequently, the framework is not applicable to health policies that may influence the sector in other ways, such as by increasing efficiencies without affecting the level of public expenditures.

7. Conclusion

The objective of this doctoral dissertation has been to understand how health system devolution changes the structure and agency of health policymaking process and, subsequently, its impact on health policy priorities. After reviewing the literature and determining that no one-piece adequately supported this objective, I created a comparative analytical framework for analysing health system devolution and the policymaking process and policy priorities that follow it. I hypothesised that, in a devolved health system, policy priorities are the result of the relative influence of key actor groups in intergovernmental health policymaking. Then, I applied the framework to the 2001 health system devolution reform in Spain with regional case studies of Extremadura and Madrid over the period 1996–2006. Finally, I examined and evaluated the framework's ability to achieve the dissertation's objective.

As suggested in the literature, the analytical framework used a comparable definition and measurement of devolution (and decentralization) that could be applied to upper-middle- and high-income countries, employing a modified version of Bossert's (1998) decision-space approach. It represented the policymaking process as structured by the institutional rules and intergovernmental aspects of devolution in Blom-Hansen's (1999) intergovernmental policy networks, fine-tuning and applying these to the national and subnational policymaking environments. In addition, it identified the main actor groups in the informal policymaking process within each environment, characterising the relationships between them and modelling their behaviour with assumptions, using a rational choice institutionalist approach. Finally, besides the framework as a whole, the thesis's primary original contribution to the literature was the elaboration of an intergovernmental policy network specific to the subnational health policymaking environment, using a newly termed actor group—health-sector kentrocrats—and method for indexing and analysing their relative power within it.

In terms of research design and methods, I chose Spain for the country case-study because it underwent a significant devolution reform of health service competencies to a regional government level and because it is a high-income country, whose health system and its devolution reform have been used as a model example for other countries—especially "newly industrialised" ones. I chose Extremadura and Madrid as regional case studies because of three common features: (i) both underwent the 2001 health devolution reform, (ii) neither had active nationalist or separatist

groups during the period of study, and (iii) one major political party controlled the regional government throughout the study period. I collected primary data though in-depth, semi-structured interviews with key stakeholders and key informants that were involved in the policymaking processes surrounding the 2001 health system devolution reform in Spain. These interviews were complemented and supported by secondary and tertiary data. All data were analysed using the scientific method of content analysis, which was carried out employing the assistance of the qualitative data analysis software program NVivo 9, in addition to traditional data processing methods. I collated, coded, categorised, interpreted and drew inferences from the data and validated them in order to tell a story in the three empirical chapters of the thesis.

In terms of improving the employment of the methods used in the thesis, one lesson I learnt concerns a better way to collect primary data by way of interviews. In future research, I would improve my methods by consulting with a handful of key informants throughout the development of the thesis and writing of the dissertation (rather than only to consult with them to inform the background of the analysis and to identify the elite actors for the stakeholder interviews). Moreover, once the stakeholders are validated for the case study, performing the stakeholder interviews with elite actors after running the *de jure* analysis of the entire framework could better inform the thesis. Furthermore, doing this could be used to explore the *de facto* side of the analysis, potentially deepening and enriching the study further.

In the first empirical chapter (Chapter 4), I analysed the first of three components of the framework of the thesis. To do so, I defined and measured health system devolution in Spain before and after the 2001 reform, using a modified version of Bossert's decision-space approach for upper-middle- and high-income countries. Bossert's approach defines devolution, and more generally decentralization, as the degree of discretion allowed by the central government to subnational authorities for a series of key health system functions. Viewing devolution as a transfer of varying levels of discretion that can differ among the different functions of the health system captured nuances in the level of devolution that more-traditional approaches would not otherwise have detected. The analysis produced health system decision-space maps for Extremadura and Madrid for both study periods. When compared, these maps showed a significant change in *de jure* discretion granted to Spain's regional governments from before to after the reform. The decision-space map for the period before the reform illustrated mostly narrow decision-space for health system functions at the regional

level, while the decision-space map for the period after the reform displayed a varying amount of choice for them, ranging from narrow to wide. *De facto,* the two regions both exercised their new health policymaking powers and responsibilities to different extents. Overall, Extremadura produced more legislation on health issues and policies than Madrid did, but Madrid used its tax raising capacities more innovatively. The results of this first part of the framework provided a rigorous foundation for the rest of the analysis by identifying the functions for which moderate and substantial discretion was allocated to the regions.

In the second empirical chapter (Chapter 5), I analysed the second and third components of the framework for the thesis. I employed the intergovernmental policy network approach in the national and subnational policymaking environments and applied it to the Spanish and regional cases for a period before 2001 and after it (2004-2006). Following the methods of the analytical framework, I identified and established the positions of the main actor groups within the national and subnational health policy networks and their trade-offs in intergovernmental health policymaking for both periods. Overall, there were clear trade-offs for health policymaking in both environments. Before 2001, *ex-ante* results show the national health policy network was the main network functioning in Spain. The main actor group implicated in this network was the expenditure advocate group, with the topocrats exhibiting some influence via their positions on intergovernmental councils; namely, the CISNS and CPFF. After the 2001 devolution, *ex-ante* results showed that the power and influence of the national-level expenditure advocates was redistributed to the expenditure guardians and topocrats within the national policymaking environment (forming a tightly knit policy network) and the subnational expenditure advocates and guardians within the policymaking environments of Extremadura and Madrid. In the subnational health policy network for both regions, *ex-ante* results demonstrated subnational expenditure advocates and guardians to be more influential than health-sector kentrocrats. Indeed, health-sector kentrocrats were expected to be virtually organised out of health politics and policy in both regions for this period. At the same time, Madrid's subnational expenditure advocates and guardians were expected to show proportional influence on health policy within their territory; while Extremadura's subnational expenditure guardians were expected to have more influence than subnational expenditure advocates did on health policy within their territories. The

latter expectation could have a slightly reduced effect when considering the impact from policy interests and priorities from the national health policy network

Overall, Blom-Hansen's method for analysing the intergovernmental health policymaking processes was straightforward, with the exception of clear indicators for assessing the relative power and position of the topocrats and health-sector kentrocrats which I ameliorated by creating indices for each of them. These indices were intended to make the definition of the relative amount of power for the topocrats and health-sector kentrocrats more objective (similar to the objectivity of von Hagen's index measuring the strengths of the expenditure advocates and guardians). Moreover, by further defining and expanding Blom-Hansen's categories (e.g. "moderate" strength) and their thresholds, the analysis for the expenditure advocates and guardians became more robust. In sum, this modified intergovernmental policy network approach provided important qualitative evidence and insight into the main actor groups involved in the health system, and how devolution affected their relative power positions and policymaking processes, and *ex-ante* health policy priorities.

In the third empirical chapter (Chapter 6), I integrated the results from Chapters 4 and 5 to examine whether the health policy priorities anticipated by the framework as a whole were aligned with the actual health policies produced in Spain and the Spanish regions of Extremadura and Madrid for the period 2004–2006. Within the subnational health policymaking environment, I analysed the health policies for guaranteeing waiting times, expanding the common health care benefit package and paying medical specialists in hospital ambulatory settings. These health policies all belonged to a different functional area of the health system and, for the period of study, were determined to have a moderate degree of discretion at the regional level. For the national health policymaking environment, I assessed the policy for increasing health financing, which belonged to the functional area of health system financing. For these analyses, I utilised three different measures of the effectiveness of intergovernmental policy—policy efficiency, policy strategies, and policy failures—to determine the actual output and priorities of these health policies.

The overall results of these analyses were more mixed than not. Madrid demonstrated a close correspondence between the expected positions and health policy priorities of their intergovernmental policy networks and the actual policy

developments within a devolved health system.[211] Alternatively, for Extremadura, the *ex-post* policy developments did not completely reflect the *ex-ante* balance of power and policy priorities resulting from its intergovernmental policy network. Rather, they favoured the subnational expenditure advocates' priority for regional health policy over the subnational expenditure guardians' priority for regional economic control. Moreover, the actual influence of the health-sector kentrocrats was underestimated by the framework analysis for the policy regarding payments for medical specialists in both regions. Finally, the *ex-post* results for increasing health financing in Spain showed weakly corresponded to the *ex-ante* balance of power and policy priorities from the study period's national health policy network.

The discrepancies between *ex-ante* health policy priorities and *ex-post* ones in our case studies are likely due to confounding factors not controlled for in the study; most likely party politics or, in the case of the regions, financing capacity. Party politics were held constant by Blom-Hansen (1999), a factor that I openly did not control in the thesis. I intentionally selected the regional case studies because they were ruled by two different political parties. My objective was to achieve a more realistic representation of regional-level political dynamics, since it is unlikely that all regions in a country will be dominated by the same party. Moreover, political ideology may have had an effect on regional government decision-making. From 1983 until the end of this study, Extremadura was led by the Spanish Socialist Worker's Party, which favours pro-labour social policies, including those governing the health sector. Meanwhile, from 1991 until the end of this study, Madrid was governed by the People's Party, which holds more conservative values and views, favouring greater constraints on spending in all sectors. In light of the prevailing party politics and ideologies in these two regions, I would have expected the subnational expenditure advocates to have had the greatest power among the three actor groups in Extremadura, and the subnational expenditure guardians to have had the greatest power in Madrid; and, thus, their health policy priorities to be followed. Incorporating the influence of party politics and ideology into the analysis would explain the empirical results for Extremadura without compromising the explanation of the results obtained for Madrid. For the policy examined within the national health policymaking environment, party ideology of the central government at the time may have played a lesser role. Rather,

[211] With the exception of the relative power and position of the health-sector kentrocrats for one policy as described above.

party politics between regional and national governments could have hand a hand in it. The overall economic climate at the time, which was essentially the period preceding the Great Economic Recession, may also have been a factor. Furthermore, in Chapter 6's discussion, I spoke to the potential importance of differences in regional financing capacity and priorities, which may have confounded the *ex-ante* subnational results. I also advanced the consideration that the relationship between policy networks and processes, political party alignment and financing capacities at both the national and regional level may affect policy actions and outcomes.

Three principle implications can be drawn from my analysis and the case of Spain and provide lessons for other countries to learn from. All three of these regard the *design* of decentralization and, particularly devolution, reform. First, when planning a decentralization of a specific sector's competencies, countries should consider details regarding the functional areas and key functions within the sector that would be affected by the decentralization and the consequences it may have on them. In Spain, for example, the health sector was decentralized along two dimensions: first, between different categories of health: health system, public health and pharmacy. Then, within these categories, the regions received different amounts of discretion for each functional area and key function. To identify these for their health system, low- to lower-middle-income developing countries could use Bossert's decision-space map and upper-middle to high-income countries could use my adaptation of Bossert's decision-space map.

Second, when contemplating the *design* for decentralizing and especially devolving health care competencies (or those of any sector, really), countries should consider the resulting power dynamics of the three main actor groups identified for the national-level intergovernmental policy network. Political party dynamics and their influence on the sector may change but these three actor groups are relatively stable and necessary overtime. As we saw in the case of Spain, if the sectoral ministry is left with too little power, then they will be effectively organized out of politics at this level and their policy priorities and goals will be over looked. On a related note, the third takeaway for other countries is that they should *design* devolution not only as a transfer of competencies to a subnational government, but they should prepare the subnational government for assuming such competencies as well as the sectoral ministry for their changing role after devolution, which usually requires them to become a steward of the system (kentrocrat within the subnational policy network). Countries should not be

mistaken; stewardship is not an easy way of governing and managing a system. It is completely different from the way they governed and managed before and requires a change of mind-set not only for the ministry as an institution but for individuals working within it. Additionally, it is important to think about all three of these areas *before* decentralization (or devolution) and to prepare and make corresponding legislation for them *before* or at the same time as the reform; it is not timely to do so afterward. In Spain, for example, not preparing for the MOH's stewardship role in its new devolved health system (e.g. producing the 2003 LCQ after devolution) was a lost opportunity, making it more difficult for the MOH to support and coordinate the regions' health service activities in a cohesive way and producing more inefficiencies and losses at both levels of government than it otherwise would have.

Several areas for further research on the topics of the thesis present themselves; I begin with the most promising. First, the adaptation of Bossert's definition and method of measuring devolution to upper-middle- and high-income countries produced decision-space maps for two different periods in Spain, which could easily be compared. As Bossert did with his decision-space approach for health system decentralization in developing countries, this adaptation could be scaled up and compared, for example, to later periods in Spain, to *foral* regions in Spain, and to other upper-middle- and high-income countries.

Additionally, it would be interesting also to expand this analysis to cover the areas of public health and pharmacy. Both policies often entail an increase in health expenditures. At least in theory, public health policies it should be applied as homogeneously as possible across regional borders (e.g. communicable diseases do not respect geographic borders). Pharmaceutical policy is an expensive and often contentious area of policymaking. Therefore, it would be important to see how informal policymaking would play out in practice for these policy areas.

Moreover, although the theory behind Blom-Hansen's intergovernmental policy network approach to the national policymaking environment and the parallel approach introduced in this thesis for the subnational policymaking environment were sound, the analysis has two common limitations, for which further research areas can be identified. The first stems from the method of analysing expenditure advocates and guardians using von Hagen's (1992) structural index for the national level and its adaptation at the regional level. Essentially, grouping policy actors into expenditure guardians and advocates only allows for a meaningful analysis of policies that have a direct impact on

the level of health expenditures. It is not conducive to analysing and anticipating policy priorities that are effectively cost-neutral or for which cost implications are indirect and difficult to quantify. For example, the policy of contracting with private health centres and hospitals does not necessarily increase the overall cost of the system, though it may lead indirectly to increased cost by virtue of increasing volume; often it is implemented with the objective of increasing competition between providers, increasing efficiencies and lowering the cost of health care provision. Further research could point to a more dynamic method for analysing these actor groups. The second limitation is that, although the approach distinguishes the power, position, and priority goals of the expenditure guardians with regard to expenditure advocates within the health sector, it does not account for other factors, such as party politics and financing capacity, which are known to influence the use of this power. For future research, as suggested in Section 6.5, regional financing capacity may also be a factor, which could be incorporated into the analytical framework of the thesis, using different indicators for revenue, expenditure and financial performance or even a separate index for it.

Also, the party politics hypothesis could be further validated and quantified in relative terms, compared to the influence of the structural aspects of the intergovernmental policy networks (i.e., it would be important to understand how much weight party politics carries in the overall analysis of expenditure guardians and advocates and to modify the current analysis accordingly). For such an analysis, one could consult party platforms, the political agenda of the government and/or examine a region's pattern of allocating funds to different sectors, and whether (and, if so, how) this pattern changes with the governing political party and its agenda.

As a further refinement of this hypothesis, researchers may consider how party politics influence intergovernmental relations and incorporate this feature into the analysis—for example, by assessing to what extent the political agenda of the central government influences the kentrocrats and their relationship with the subnational expenditure advocates and guardians in the subnational health policy network. It would also be interesting to consider how the policymaking architecture and the resulting health policy priorities are affected when the national and subnational governments are controlled by opposing vs. the same political parties (and what difference it makes). For example, when asked how intergovernmental relations were with Aznar's Administration in comparison to those with Zapatero's Administration, one Extremadura interviewee said,

> We had many problems with Aznar…and I do not believe this was a part of the Popular Party…it was because [he] considered the Autonomous Communities an additional barrier to governing and a bother to the system. So, he always treated us at arm's length. Zapatero is completely the opposite; he is open, permissive, [and] comprehensive of some autonomous tendencies. Relations are better with Zapatero, not only for ideological motives but because there is a concession in health care, in education, but also because of his sensitivity. For example, he gives us the opportunity to be in delegations with the European Union (Novinskey, Interview no. 37).

The extant research on intergovernmental relations and party politics could be incorporated into my analytical framework. Such a modified framework could be used to re-examine the cases of Extremadura and Madrid as well as to expand the scope of analysis to other regions in Spain. Finally, the analysis could be deepened by applying it to a broader set of health policies.

Overall, the thesis's analytical framework for policymaking within a devolved health system was only partially successful in anticipating the *actual* health policies. On the one hand, it was fully successful in defining and measuring health system devolution in Spain and describing the intergovernmental relations involved in a devolved health system. Moreover, it provided greater insight into the 'black box' of policymaking, which policymakers can utilise to develop and plan more adequate strategies for pursuing their primary goals and priorities within their respective health policymaking environments. Therefore, it could be particularly useful to national and subnational expenditure advocates as well as health-sector kentrocrats. For example, in the period after devolution in Spain, national expenditure advocates and health-sector kentrocrats—both of which were effectively organised outside of health policymaking—could have used information from the analysis to prioritise re-positioning themselves so that they would have more of a say and hand in the policymaking process (e.g. acting more to work with and through the regions, using 'softer' stewardship methods and tools for encouraging coordination and cooperation from and among the regions, redesigning its framework to ensure better tools for implementation—e.g. greater financial incentives—, advocating greater political backing from other central government actor groups). Moreover, with its application across all regions in a country, health-sector kentrocrats could also use the information resulting from the analysis to prioritise working with certain regions before others and ascertain the level of intensity with which they should work with each region, to achieve their overall priority goal of health policy cohesion and cooperation across all

regions in a more prioritised and systematic way. In addition, researchers could use the information produced from the analysis to understand better the differences in health policymaking processes (e.g. the variants in policy network organization), priorities and policies across regions within the same country, and potential causes thereof. However, to be completely successful, the analytical framework must be complemented by political and financial analyses, and, if possible, adapted to health policies that do not only influence the sector by changing the expenditure level.

In terms of the potential policy implications of future work, once the design is consolidated (e.g. accounting for and curbing its current limitations), the analytical framework could help to inform the 'right' design for analysing the health policymaking processes in a devolved health system. Then, it could be scaled up and applied to the many politically decentralized, unitary states in the world that have an upper-middle- or high-level of income (perhaps, using and expanding upon the variants identified for the structural organization of intergovernmental policymaking). The more case studies that are done, the more intelligence can be gathered and analysed on what the desired balance between the main actor groups of the intergovernmental policy networks is and how to achieve it (based on country experiences). Moreover, if the method of the analysis for the expenditure advocates and guardians (i.e., the use of von Hagen's structural index) is kept as is, then the framework could be pared down and focused explicitly on health policies that affect health expenditures. In doing so, as it is scaled up and applied to more country and regional cases, it could eventually come to identify which health system functions are generally more tied to expenditures. Furthermore, this intelligence could be utilised to inform countries that are looking to reform their health system through a devolution, decentralization and/or centralization and, at the same time, aim to ensure the political and financial sustainability of it.

Appendix A. The Potential Governance and Political Effects of Decentralization

When a government changes its organisational structure through a decentralization (or re-centralization) of decision-making power process, what difference does it make? Wolman (1990, 30) argues, "Presumably structure is important because there are a set (or sets) of important values that are enhanced or impeded by decentralized as opposed to centralized structures". So, what are these *important values* and how might they be affected through decentralization? The governance and political literature holds several accounts of the theoretical value for decentralization or a decentralized structure of government. Advocates often bolster its potential value for improving responsiveness and accountability (and, ultimately, liberty), diversity and innovation in public policies at a more local level, as well as political stability and policy stability. Antagonists often claim, however, that decentralization comes at the cost of inequalities and the nation's interest as a whole (assuming inequality is the same as uniformity), and is likely to lead to additional pressure on the state and a lack of coordination if the design of the state does not eliminate duplicities and if national government controls and constraints are perceived as being soft (Costa-Font 2013). In many cases, there exist raison d'être that both support the benefits of decentralization as well as purport its hindrances or support centralization (de Vries 2000). In this section, I assess the main theoretical effects of decentralization presented mainly in the governance and political literature.

A.1. Responsiveness, Accountability and Liberty

The political equivalent to the economic efficiency argument is that decentralizing brings government closer to the people, making it more responsive and accountable and increasing the liberty of the people. Based on proximity and size[212], local governments – which are closer to the people and smaller than central governments – are able to capture more and better information[213] on individual preferences and, thus, respond to these preferences with corresponding policies. According to Mill (1874), this is also because the local government has a greater interest in the results. Thus, there is a better match (less divergence) between individual preferences and public policy

[212] Reducing the size of government helps to guarantee democracy through the above-mentioned increase in citizen participation, accountability and liberty (Treisman 2007a).
[213] Local knowledge is a prerequisite for the determination of individual preferences in local communities and, thus, local government responsiveness (Smith 1985).

(Wolman 1990). In addition, individuals are more able to hold local governments directly accountable (than central government) because the smaller size is more comprehensible and easier to navigate. As such, individuals are more likely to participate in government mechanisms to collect their preferences (e.g. elections, petitions, etc.) and, even, to coordinate better in small groups on voting strategies (D. Treisman 2007a). Therefore, if they disapprove of local policies in their area, they can vote their local politicians out of office; thereby, changing the policies (Wolman 1990). It is assumed that voting out local politicians is easier for the individual to do than voting out central politicians because individuals in one locality are the main constituent of local politicians but only one of many constituents for central politicians. Moreover, voting out central government officials is more difficult because individuals have to weigh a multitude of policies and issues at both the central (e.g. foreign, defence, and macroeconomic policies) and local level (e.g. sewage, water supply, roads), and then can only cast a single vote. Thus, local issues are only one dimension of central government performance, which are probably low in priority compared to the whole of issues that an individual voter would use to evaluate central government performance. As a result, a decentralized system permits a closer match between individual user preferences and the policies implemented.

Ylvisaker (1959, 32)(1959: 32) further argues that a decentralized system keeps power "close to its origins, and governmental officials within reach of their masters". It provides more points of access, pressure and control than a centralized system. As such, minorities should be elected into office at the local government level more easily than at other levels.[214] Political decentralization also enables a *two-way flow* of information between local government and the citizens (which other forms do not necessarily allow). This *two-way flow* of information highly facilitates government responsiveness to local needs and helps to ensure democracy.

By increasing accountability at the local level, it is thought that decentralization also promotes the value of liberty because it allows local communities to self-govern on issues relevant only to them (Smith 1985).[215] This follows Mill's (2002, 86) argument that there is "liberty in any number of individuals to regulate by mutual agreement such

[214] Some even argue that political decentralization defuses ethnic conflicts. See Treisman (2007a Chapter 10) for more on this argument and its counter argument.
[215] The argument is that local government preserves the liberty of the local community against centralizing power. See Sharpe (1981) and Chapter 8 in Treisman (2007a) for more details on this argument and its counterarguments.

things that regard them jointly, and regard no persons but themselves." And after seeing the high degree of decentralization in the USA and how it helped the government to be close and accessible to citizens at the most local levels, Tocqueville argued (2003, 73), "Town [local] institutions are to freedom [liberty] what primary schools are to knowledge: they bring it within people's reach and give men the enjoyment and habit of using it for peaceful ends. Without town institutions a nation can establish a free government but has not the spirit of freedom itself."[216] Therefore, decentralization makes it easier for individuals in local communities to exercise their right to self-regulation; and, thereby, gives them more liberty (Smith 1985).

While decentralizing may in one way contribute to accountability between local government and individual citizens by giving them *more opportunities to participate* in political activities (e.g. elections, petitions, political pressures, public debates, etc.), it is in all other ways and ultimately an *a priori* argument that requires empirical scrutiny (Smith 1985). These same opportunities – although fewer in number – also could be offered in a centralised system with the same result: greater correlation between the individual preferences and public policies. In some cases, a centralised (single-level) system may even be easier to navigate and attribute blame or credit than a decentralized (multi-level) one, especially when competencies are shared between levels (Treisman 2007a).

This theory affirming that decentralization promotes government responsiveness and accountability and citizen liberty makes several assumptions on local-level politics as well. In general, it *romanticises* the political process at the local level by metamorphosing decentralization into *a value in its own right* (Felser 1965). Smith (1985, 29) argues, "It comes too close to presenting the identification of needs, and the right 'mix' of services to meet them, as a technical exercise in which a correct answer to the problem is found by tapping local knowledge and experience". In reality, the local political process may be more closed to the population, more susceptible to influence and domination by small, unrepresentative groups and, even, to corruption. Moreover, accountability may be abated if citizens do not see the importance in participating in political activities and voting (Wolman 1990). Some authors believe voter turn-out will be greater for elections of the more decentralized level of

[216] The USA has changed dramatically since Tocqueville toured it to study the strengths and weaknesses of its evolving politics. Some would argue that the schools of democracy, touted by Tocqueville and others, are broken: they claim that localities are too big and suburbanization weakens the educational potential of local politics.

government because an individual's vote is greater in smaller units (Borck 2002, 155).[217] Other authors find that empirical evidence supports the opposite, for example, the USA shows consistently low voter turnout for local elections (Treisman 2007a).[218]

The theory that decentralization supports democracy assumes that the individual will be more informed of local government actions and policies than those of the central government are and, thus, have a direct effect on accountability. If we assume that it is because voters are able to "absorb information about local government performance as a by-product of living in the local community" (Treisman 2007a, 165), then questions should be raised as to the reliability of this inadvertently acquired information. Moreover, any level of government would have to be monitored very effectively for individuals to gain such transparent information. More effective monitoring is done by third parties, which are often voluntary organisations (e.g. political non-governmental watchdogs, investigative journalists, interest groups, etc.). Wolman (1990, 37) writes, "In the American context political scientists have long observed the minority groups, the poor, urban interests and labour organisations are more influential at the federal level than in most states and are likely to have their interests less well served by decentralized policymaking."

Even considering a more-informed public on local issues, in general, it is thought that voting is a relatively poor mechanism for collecting information on grievances and bad administration, for measuring 'consumer satisfaction' with public policies and holding politicians accountable (Smith 1985; Treisman 2007a). Considering more-informed citizens formed small groups to consolidate voting strategies, these groups would have to be extremely small according to some authors (Yates 1973; Morlan 1984; Milner 2001). Treisman (2007a, 13) doubts this, writing: "incumbents at any level of government can undermine such voter coordination by playing groups of voters off against one another, using "divide and conquer" strategies".

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[217] This is based on the argument that an individual has a greater incentive to vote in smaller units of government and, thus, to hold incumbent officials accountable. It stems from the "paradox of voting" that states that "As the size of the electorate increases, the chance of any one voter's being pivotal – that is, determining the outcome – diminishes" (Treisman 2007a, 169).

[218] Voting turnout in local elections in the USA is notoriously low: approximately 30 per cent. At the same time, in less decentralized country systems, voter turn-out in local elections can be high: about 85 per cent in Italy and 70 per cent in France (Goldsmith and Newton 1986, 146).

A.2. Policy Diversity and Innovation

The policy diversity and innovation argument follows from the above argument on democracy. It maintains that decentralized systems promote greater diversity in public policies and opportunities for experimentation with policy innovations than centralised systems, which tend to impose uniform policies on local governments. Oates (1972, 12) adds that "the more monopolistic the government, the less the incentive to innovate." This argument is based on assumptions that local governments are better able to elicit and make use of local information than central governments (Treisman 2007a); overall, providing citizens a wide variety of tax and services packages to choose from (Wolman 1990). It also assumes that result of greater diversity and innovation in public policies leads to more successful policies that are eventually adopted by other local governments or even the central government. Indeed, decentralization can create a laboratory of sorts for policymaking. The idea is that decentralized governments have incentives to experiment at the local level, and that if cooperation mechanisms are in place for governments to emulate each other; then, innovations are extended to other areas (e.g. antismoking regulation in Scotland, Italy and Spain).

There are four major critiques to this policy diversity and innovation argument. First, as with other arguments above, this argument is not theoretical but empirical. That is, it is not theoretically understood why a decentralized system would have any advantage or not over a centralised system in promoting diversity and innovation. Second, the policy innovation benefits of the diversity argument depend not only on the local government's ability to elicit and use information but also on its ability to establish and implement the 'right' service package and successfully diffuse the effective policies to other local governments for adoption. What is more, Wolman (1987) evidences that, in any case, policy adoption is more likely to be encouraged by central government than local government. Therefore, while local governments may be more likely (inherently) to innovate, central governments will be more likely to promote adoption. Third, the diffusion of successful innovation has been shown in the literature to depend on a whole slew of other factors that are unrelated to organisational structure (Berry and Berry 2007). These factors include: (i) size of country, (ii) strength of professional networks among local government officials, (iii) strength of interaction among officials through local government associations and/or national party organisations (Wolman 1990). The question that we are left with is whether these

factors are in turn predictors of decentralization themselves. Fourth, policy diversity through decentralization implies that the levels of service and tax burdens for citizens in the same country will vary across jurisdictions. Thus, it necessarily results in inequalities, presumably based on (or limited by) need and financial resource capacity (tax base per capita) (Wolman 1990). That is, to provide the same quality (level and mix) of services, areas of greater need (e.g. more school-age children per capita, more handicapped individuals, more elderly per capita) will have to provide more services and, thus, charge higher tax rates than areas with lower needs. This is also true of poorer areas, as they tend to have greater needs than wealthier areas.[219] This is usually compensated for in decentralized polities with equalisation funds to level up poorer regions and guarantee equality of opportunities in the system of competition. Of course, equalisation mechanisms are not perfect, as it is difficult to take into account unobservable characteristics that explain why some regions not well resourced.

A.3. Political Stability

It is argued that decentralization performs a system maintenance function and leads to *national* political stability (Wolman 1990; Lederman, Loayza, and Soares 2005). It does so by contributing to increasing citizen interest and participation in local government, which helps to promote and establish a connection between citizens and the political system, increasing democratic values. One of the values that it is said to increase is citizen's trust in the leaders they choose, which is a necessary condition for political stability. There is one major counterargument for this argument: it is *a priori* argument, depending on empirical study.

Moreover, the political stability argument is related with what some authors (Wolman 1990) call the "countervailing power" argument and others (Smith 1985) the "political equality" argument. The *political equality* argument states that, by providing additional opportunities for citizens to participate in public policymaking (e.g. by voting and other forms of exercising freedom of speech), decentralization advances political equality and, at the same time, provides additional centres of power in the system (countervailing centres). The *countervailing power* argument sets out that, by increasing the number of power centres in the political system, decentralization counterbalances the pre-existing power and influence; thereby, protecting democracy

[219] One practical response to this territorial equality issue in a decentralized system is to implement a national equalization fund or system to compensate areas with high needs and/or low tax bases (Wolman and Page, E 1987).

and increasing political stability. This, however, has been dismissed as an argument more concerned with controlling central government behaviour than with decentralization. "Opportunism by the national government is best constrained by fragmenting power at the national level" (Bednar, Eskridge, Jr., and Ferejohn 2001, 9). One of the issues from decentralization is the emergence of regional political cycles in addition to the national political cycle, which might make political decision-making more complex (Costa-Font 2012).

With our example of voter turnout statistics earlier, we saw that greater decentralization does not necessarily lead to greater increased participation of citizens in government. Empirical studies also show a lack of political stability in several countries following times of active local government (Smith 1985). Ardanaz et al. (2012) illustrate the idea of countervailing centres in Argentina and the dire consequences it has had on the country due to the encroachment of political officials at the subnational government level on the authority and resources of other government officials above and below them. An extreme version of such consequences, Myerson (2014) notes this potential risk of 'federalism' to exacerbate the threats of regional success. He believes, however, that the solution is to limit the size of individual subnational governments (in particular, the provincial level governments in his study on the Government of Pakistan) so that they are not large enough to be viable independent states and, thus, their political officials are not tempted to lead a succession. Moreover, some authors (Smith 1985) even question the relationship between local democracy and national stability altogether, as well as the normative desirability of 'stability'. Because the impact of decentralization on national political stability is at its core an application of the democracy and accountability argument above, I do not address it separately in the empirical review below. Furthermore, there is an important measure of decentralization that determines political stability, which is the presence of countrywide parties at the subnational and national levels of government. If the same party runs the national and subnational governments, then there is a problem of double agency and generally, the extent of power of the national government is maximised; while a difference in parties between these two levels reduces the probability of cooperation (Costa-Font and Rico 2006b).

A.4. Policy Stability or Change

There are several arguments for the political and governance value of decentralization regarding its ability to promote or contribute to policy stability (or change). Most are rooted in the literature that considers the role of institutions (see the public policy literature review for more on 'new institutionalisms'). Institutions, especially political institutions, set the 'rules of the game' in policymaking. They include institutions of federalism, bicameralism, judicial review, and a powerful president (Hallerberg, Strauch, and von Hagen 2009). Most also use a variation of game theory to support their thesis. This is the most relevant argument of decentralization for the thesis.

The most prevalent of policy stability theories in the literature regarding decentralization are the veto power arguments, such as the *veto players* theory[220] and veto points approach. These arguments consider the *institutional conditions* (or constitutional configurations, including decentralization) as a potential driver of policy stability or change in different settings and periods. They do not have an a priori assumption being able to find a best-fit solution (S. Atkinson 2007). At their base, they theorise that the greater the number of veto points or veto players, the less likely current policy will change (i.e., policy stability). According to Treisman (2007a), of all the arguments supporting decentralization, the policy stability (or change) argument is the most convincing. However, he cautions, it is important to understand that *policy stability* does not have any normative value; rather, its value depends on the character of the policies established.

In her study on health politics in Europe, Immergut (1992) argues that different political patterns or specific policy choices (over time or in different countries) can be understood across countries by applying her *veto point* framework, which adopts a dynamic perspective of policymaking as a chain of political decisions (Jochem 2003). Her veto point framework in general is based on constitutional rules and electoral results and focuses on transaction costs in politics. The so-called veto points are not physical points but rather points in time of strategic political uncertainty over policy decisions, where particular actors have the potential to implement, transform, undermine or overturn policies. Immergut (1992, 27) states, "even a small shift in electoral results or constitutional provisions may change the location and strategic

[220] I will not discuss if the veto players theory is actually *theory* or would be more appropriately deemed an *approach*. Instead, I have chosen to follow the authors' own terminology in their papers – though, when referring to both at the same time, I will use the term *approaches* in an effort to be more concise.

importance of such veto points". When referring to 'institutions', Immergut means mostly the constitutionally fixed 'rules of the game' that indicate where a point of decision may be in the political system. These 'institutions' are taken to represent the political environment within which interest groups and potential interests manoeuvre. However, they do not determine the preferences and strategies of the political actors. Policy stability depends on the number of these veto points in a political system and the goal of legislators would be to close-off these veto points "to push their program unscathed through the political process" (Immergut 1992, 227). Therefore, fewer veto points means fewer possibilities for policy change and, thus, greater policy stability. Huber et al. (1993) 'multiple points of influence' theory and Shugart and Haggard's (2001) 'veto gate' theory approximates Immergut's veto points approach.

Despite its multidimensionality and *realistic* approach, the veto point theory does have drawbacks in particular for its application to the thesis. Immergut begins her research on *veto points* not thinking about any classification or *a priori* conceptualisation of political actors, rather she carries it out inductively, starting with the health politics and 'institutions' in Europe in mind. Her veto points approach necessitates an analysis of political systems as a whole, including their organisation and the overall logic within which they work to arrive at the number and location of the veto points in any given system (Immergut 1992). Only afterwards can the strategies employed by political actors be identified empirically. Additionally, the focus of the veto point approach is on the constitutional ('institutional') rules of the political game and their *interplay* with electoral results, not on the actors. As such, the key actors are taken mostly to be the political parties in the executive and legislative decision-making processes that are crucial at a particular veto point and, at the same time, open to pressure from interests groups. The focus of the thesis, however, is on institutional actors rather than partisan actors. Finally, although it was constructed with specific regard to health politics, it does not look at decentralization policy in particular (though, a few cases have applied the veto point approach to decentralized contexts; see the empirical evidence section).

Tsebelis' (1995; 1999; 2002) veto players theory argues that a certain number of individual and collective actors (a.k.a. v*eto players*) have to agree on a proposed policy change in order for it to be passed into legislation. It determines such veto players through the constitution or political system in a specific country, which are respectively referred to as *institutional* or *partisan* veto players. The theory provides its own rules

to both identify veto players and how they interact, which can affect the set of outcomes in the analysis. For example, a mainstay of the theory is the rule of absorption. That is, you cannot simply count the number of veto players; you also have to consider their policy preferences: If a veto player's preferences are similar to any of the other veto players, then they will be *absorbed* into the same group and only counted once. In the theory, the number of veto players, the ideological distance between them and the level of internal cohesion within each collective actor group are particularly important (Tsebelis 1995, 311). Tsebelis (2002) addresses the issues of cohesion within collective veto players most, where more cohesion leads to higher policy stability under simple majority voting and less stability under qualified majority voting rules. "If there is just one veto player, then that player gets his policy choice and there remains nothing more to explain. If there are multiple players, then one must determine where they stand on relevant policy issues and whether it is realistic to treat them as one actor" (Hallerberg 2010, 22). A change in policy is unlikely when the number of veto players is large, the ideological distances are great and their internal cohesion is strong.

Tsebelis's theory is quite elaborate – some suggest more so than the Immergut's veto point theory (Jochem 2003) – and it puts forth a general theory of institutions and a common framework for analysing and understanding policy change or stability in different constitutional settings and periods. Moreover, it provides researchers with an analytical tool for comparing institutional effects in seemingly distinctive countries and systems; e.g. those with presidential or parliamentary democracies, one- or multi-party political systems, single- or multi-level governments, industrialised or developing countries (though, admittedly, there is less supporting empirical evidence for the latter). Regarding multi-level governments, it can be used with regard to decentralization (see empirical section on this topic). According to this theory, decentralization would most likely increase the number of actors in the decision-making process, making significant policy change at the *national level* difficult or impossible; thereby, contributing to increased stability (no change in the status quo) of policies. In highly decentralized systems, such as the United States or Switzerland, one would expect that large-scale reforms would be less likely, due to the higher number of veto players (Tsebelis 2002). However, having more veto players may be an advantage for governments as they can more easily 'share the blame' or to 'pass the blame' for negative impacts or perceptions

of policies to other levels of government than governments with more concentrated power (Pierson 1994; Pal and Weaver 2003).

The veto player theory has a few shortcomings in general. In contrast to the *veto point* theory, the *veto player* theory assumes that there are no transaction costs in the politics between veto players (because it is so difficult to make these operational across countries and time) (Tsebelis 2002, 29). Crepaz's (2002) results differ from Tsebelis's, arguing that there is a difference between veto players in practice. They show that 'collective' veto players interact often and continuously and, thus, are more likely to pass legislation through logrolling; while 'competitive' veto players would be more likely block legislation. Strom (2000) argues that partisan and institutional veto players are sufficiently different due to their respective opportunities and motives. Similarly, Ganghof (2003) argues that veto players are close enough to one another to agree on policy changes through logrolling. He adds that veto players may also act to differentiate themselves from others in the eyes of their current and potential future constituents.

This theory also has some shortcomings that specifically regard the thesis. Like the veto point approach, the veto player theory does not examine intergovernmental actors in particular as needed by the thesis but rather focuses most generally on partisan actors. Indeed, largely, its centre of interest is political party competition and its impacts on public policymaking. Moreover, the veto player theory cannot be used to make any deductions about the *direction* of policy change, but rather the number of significant legislative changes (that is, a change in the status quo). The thesis of this dissertation is interested not only on the pure number of legislative changes but it is interested on the general *direction* of those changes. Furthermore, and most importantly, the number of veto players or veto points as overall indicators of the political system, which does not necessarily coincide with those of the health system. As Kotzian (2008, 243) puts succinctly, "Institutional or political veto players seldom have genuine interests at stake in health policy. Therefore, the number of veto players or veto points as such offers no information about the probability of a veto actually being cast or a veto point being used to block application of a certain control lever."

Appendix B. Structure-based and Classical and New Institutionalism Approaches to Policymaking

B.1. Structure-based Approaches to Policymaking

Structure-based approaches to policymaking look at the policy consequences of basic socioeconomic problems in society. That is, they look at how the structure of a society's socioeconomic development changes policy. Two primary models of these approaches are the 'socioeconomic school' and the 'cleavage' approach.

B.1.1. The Socioeconomic School Model

The socioeconomic school was pioneered Émile Durkheim and Karl Marx, arguably the fathers of sociology and main architects of all social science. Durkheim and Marx were the first to study *socioeconomic stratification*[221], among other topics, which is still mainstreaming the social science literature (Knill and Tosun 2012). Their work was developed, and strongly associated, within the context of the modernisation (or industrialisation) of societies, beginning perhaps in 18th century Great Britain. As such, the socioeconomic school is essentially a functionalist view of policymaking and argues that socioeconomic development produces positive and negative effects on societies and, thus, public policy's main purpose is to balance out (or correct for) the more negative consequences with new policies to support these societies. For example, as women began entering into the workforce, the 'old' concept of the family institution (i.e., traditional family structure) began to change, and the need for governments to provide 'new' public policies and services (mostly related to welfare) to support the 'new' concept of the family institution grew. Not all authors, however, think that there is a connection between socio-economic development and the need for government involvement/activity is positive; some have proposed that the relationship between the two is negative (e.g. Wagner's law of increasing state activity (Henrekson 1993; Lamartina and Zaghini 2011). With regard to health policy, the study of socio-economic status and health began in the 19th century, when "researchers investigated differences in health outcomes among royalty, the landed elite and the working class in Europe" (Cutler, Lleras-Muney, and Vogl 2008, 1). Today measures of socioeconomic status—including income, education, occupation, race and ethnicity—are prolific in the

[221] "The unequal distribution of valued goods or holdings in a society, including wealth, status and resources" (Knill and Tosun 2012, 71).

research on the determinants of health (and mortality) and widely utilised to inform those interested in designing policies.

This model—like any other—has its strengths and weaknesses. Its primary analytical strength is that it establishes a 'functional' understanding of public policy for systematically explaining policy variation across countries (M. G. Schmidt 2002). A weakness that this model has for the thesis is that it considers policymaking to be primarily motivated and explained by socio-economic development pertaining to industrialisation. By contrast, the thesis would like to examine a more micro-level understanding of policymaking, by looking at the specific policy of devolution of the health system.

B.1.2. The Social Cleavage Approach

A second prominent example of structure-based approaches is the social cleavage approach by Lipset and Rokkan (1967). It emphasises enduring socioeconomic conflicts in society as the main determinants of policymaking. Lipset and Rokkan (1967) propose four major social cleavages: (i) centre-periphery, (ii) state-church, (iii) rural-urban, and (iv) workers-employers. Regardless of the type of social cleavage, this approach explains how certain political parties have formed through deep divisions in societal groups and how such divisions still today influence their current preferences, thinking and actions in the policymaking process. The centre-periphery social cleavage relates directly to the topic of decentralization. It is the division of social groups based on their support or opposition of the centralization of political power and administrative structures in a nation-state. Generally, those opposing centralization do so by asserting their traditional autonomy. They are mainly associated with separatist-nationalist parties. While the centre-periphery social cleavage may partially characterise how some nation-states (including Spain) have arrived at a decentralization of power (i.e., through separatist-nationalist movements) as well as the general policy preferences of certain (separatist-nationalist) political parties, it says nothing about the effects of such decentralization on policymaking, institutions and agency. With regard to health policy, the social cleavage approach has been used mostly to describe how issues with health policies echo and even re-enforce the more general social cleavage patterns in a society (e.g. Huang (2013)).

B.2. Institutional-based Approaches to Policymaking

Institutional-based approaches emphasise the formal and informal institutional arrangements as the main determinants of policymaking. These approaches may be divided in two main groups depending on how they define the concept of 'institutions': (i) classical approaches to institutional analysis[222] (e.g. Castles' (1989) analysis of political-institutional variables and socioeconomic indicators) and (ii) new approaches to institutional analysis (e.g. sociological and historical institutionalisms).

B.2.1. Classical Institutionalisms

Classical institution-based approaches to policymaking define institutions as their formal-legal arrangement or "public laws that concern formal governmental organizations" (Eckstein 1979, 1–2).[223] These approaches dominated political science until the 1950s and, thus, are considered the "historic core of political science" today (Bevir and Rhodes 2010, 5; Lowndes 2010). They argue that, in addition to the socio-economic situation, key governmental organisations and the ideas embedded in them are the institutions that matter to the policymaking process (March and Olsen 1984; Chevalier 1996; Lijphart 1999; Bevir and Rhodes 2010). "Institutions also matter because they (or at least actors within them) typically wield power and mobilize institutional resources in political struggles and governance relationships" (Bell 2002). Some authors purport classical institutional analyses that combine both socioeconomic indicators and institutional variables. For example, Castles (1998) gives a systematic and comprehensive account of the transformation of policymaking in OECD countries post-World War II. With this approach, he makes an important contribution to the comparative public policy literature by arguing that public policy is the result of four family-specific policymaking processes among these countries: (i) an English-speaking policymaking family; (ii) a Continental European policymaking family; (iii) a Scandinavian policymaking family; and, (v) a Southern European policymaking family.[224] The classical institution-based approach has been applied to health policies. A more recent example of this is Kitchener's (1998) *Quasi-Market Transformation: An*

[222] Sometimes referred to as 'old' institutionalism or 'traditional' institutionalism in the literature.
[223] Rhodes (2008) contends that old institutionalisms can be categorized as 'traditions in the study of political institutions, including modernist-empiricist, formal-legal, idealist and socialist traditions.
[224] The English-speaking policymaking family includes Australia, Canada, Ireland, New Zealand, the UK and the USA. The Continental European family includes Austria, Belgium, France, Germany, Italy and the Netherlands. The Scandinavian policymaking family includes Denmark, Finland, Norway and Sweden; The Southern European policymaking family includes Greece, Portugal and Spain.

Institutionalist Approach to Change in UK Hospitals, which performs a comparative analysis on hospitals in the UK in the early 1990s and provides further understanding of the way in which changes in the institutional context influence the tracks of change within individual hospitals.

What classical institutionalism approaches fail to address, however, is the 'black box' of policymaking between the formal-legal arrangements of governmental organisations and the resulting policies. As such, it almost overlooks the broader social behaviour. Because of this, and returning to our previous example, Castles (1998) analysis cannot explain why policy choices may differ among countries within the same policymaking family. In addition, these approaches do not address policy change within countries over time when institutions have not changed. These two aspects are essential to the thesis in its examination of a newly decentralized structure in the health system affects the policymaking process and agency, before and after one reform within one country.

In the 1960s and 1970s, these gaps in the literature led researchers away from analysing the characteristics of formal institutions and towards the study of collective and individual actor behaviour as it relates to the political system, or behaviouralism in political science[225] (Hall and Taylor 1996). Moreover, behaviouralists prided themselves on studying the realistic, political side of how individuals behave in general rather than whether they abide by legal or formal rules of institutions (Grigsby 2011). In addition, behaviouralists prided themselves on their use rigorous methods and empirical research to validate their studies. Therefore, they restricted their studies to *measurable* behaviours (e.g. social and economic position, attitudes, votes) and not institutions (Steinmo 2008). While I do not review the behaviouralist approach, this brief is meant to provide a backdrop to the naissance of 'new' institution-based approaches to policymaking (or new institutionalisms[226]).

B.2.2. New Institutionalisms

Just as the behaviouralism movement in the 1960s and 70s was a response in part to the weaknesses of the classical institutionalisms, new institutionalism, emerging in the 1980s, was a response in part to weaknesses of behaviouralism (Thelen and Steinmo 1992). New institutionalism was developed in 1984 by March and Olsen in their

[225] Behaviouralism in political science was born and mostly studied in the United States.
[226] Also referred to as neo-institutionalisms in the scholarly literature.

seminal publication *The New Institutionalism: Organizational Factors in Political Life*. According to these authors, it seeks to emphasise "the relative autonomy of political institutions, possibilities for inefficiency in history, and the importance of symbolic action to an understanding of politics" (1984, 734).

New institutionalism is not just one stream of thought but it encompasses several.[227] These streams of thought are similar in that they define the concept of 'institution' with greater complexity than just the formal (physical) organisation of an institutional structure (Bell 2002). That is, their definition also includes the informal institutions of an organisation: the 'rules', norms, coordination activities, collective action and standard operating practices that are set by, and exist within the confines of, physical institutions. Thus, they contend that informal institutions also matter in the policymaking process. For some new institutionalisms, the informal (or unstructured) institutions of an organisation matter even more than the formal (or structured) institutions (Ostrom 2007; Shepsle 2008). "Institutions are also said to matter because they are seen as shaping and constraining political behaviour and decision making and even the perceptions and powers of political actors in a wide range of ways" (Bell 2002). In essence, they underscore that institutions are a main, if not primary, factor in shaping or structuring the actions and interactions and, sometimes, preferences of actors (i.e., the nature of politics and political debate) and how such actions, interactions and preferences influence the policy change process (March and Olsen 1984; 2005; Thelen and Steinmo 1992). "Institutions in this sense provide arenas for conflict, and efforts to alter them stimulate conflict inasmuch as they change the rules of the game in such a way as to alter the allocation of advantages and disadvantages" (Rhodes, Binder, and Rockman 2008, xiv).

Three streams of new institutionalism stand out for their potential utility in the thesis' analysis: historical, sociological and rational choice institutionalisms. These streams of thought within new institutionalism differ in how they view the political world (Hall and Taylor1 1996). Historical institutionalism developed primarily in the political science literature. It traces how the past shapes the future, arguing that policymaking is path dependent. Sociological institutionalism has emerged from

[227] Normative institutionalism, rational choice institutionalism, historical institutionalism, empirical institutionalism (sometimes referred to as modernist-empiricist institutionalism), international institutionalism, sociological institutionalism, network institutionalism, feminist institutionalism, and idealist institutionalism. Most of these are outlined in Lowndes, V. (2010), with the exception of modernist-empiricist and idealist institutionalisms, which are outlined in Rhodes (2008).

sociology and focuses on culture and norms, and an endeavour for legitimacy as the main determinants of policymaking. Rational choice institutionalism arose from the economics literature. It emphasises the (mostly) economic position of actors in a system of rules, interests and incentives (Goodin 1996; Hall and Taylor 1996; Sabatier 2007; Rhodes 2008). In this section, I discuss both historical and sociological institutionalism as they take a more institution-based approach to policymaking. I will discuss rational choice institutionalism under the section on interest-based approaches to policymaking as it emphasises actor interest more than institutional structure as the primary determinant of policymaking.

B.2.2.1. Historical Institutionalism: While historical institutionalism defines institutions in a similar way to the other new institutionalisms, it sets itself apart from them in many ways.[228] First coined in 1992 by Steinmo, Thelen and Longstreth[229], historical institutionalism is a distinct stream of new institutionalism because it centres on history and contends that it matters as a main determinant of policymaking. In particular, it argues that previous choices about institutions and policies affect subsequent ones, emphasizing the concept of path dependency in institutions and policies (Steinmo, Thelen, and Longstreth 1992; Hacker 1998). Weir and Skocpol (1985) stress this point in their comparative analysis of state structures and 'policy legacies' in Sweden, Britain and the US.[230] As such, historical institutionalism emphasises that institutions and certain ideas[231] about public policy become "locked in" to a point where deviations from the path they are on become increasing difficult and costly (North 1990). "In contexts of complex social interdependence, new institutions often entail high fixed or start-up costs and they involve considerable learning effects, coordination effects and adaptive expectation (North 1990, 95). Pierson (1996) describes the path dependency process in his empirical account of policymaking in the European Community. He, later, (2000) brings in lessons from the economics literature

[228] Though, as Hall and Taylor (1996) point out and Thelen (1999) elaborates, differences between these three 'new' institutionalisms fuzzy and often there are what they call "border crossers" who have muddled the lines between these three institutionalisms.
[229] The term grew out of a small workshop held in Boulder, Colorado in January 1989, including participants Steinmo, S., K. Thelen and F. Longstreth.
[230] Some authors (e.g. Immergut (2008)) consider Skocpol's (1985) 'state-centered' approach and Hall's (1986) model of state-society relations to be termed 'political institutionalism', which can be thought of as a type of historical institutionalism. These approaches are different in that they focus on the impact of autonomy of state institutions on policymaking. Of course, other authors explicitly disagree with the concept of state autonomy and the level of importance that Skocpol and other political institutionalists give it in policymaking (e.g. Sabatier and Jenkins-Smith (1993)).
[231] The literature on historical institutionalism pays a lot of attention to the relationship between institutions and ideas. A few references in this regard include Goldstein (1998) and Weir (1989).

and conceptualises it as a dynamic of 'increasing returns'.[232] Consequently, then, in a way, historical institutionalism portrays the general state of policymaking as one of policy stability (Steinmo, Thelen, and Longstreth 1992; Thelen and Steinmo 1992; Thelen 1999) or at least one of limited adaptive policy change (Capoccia and Kelemen 2007).[233] For more on policy stability with relation to decentralization see the theoretical sections in Appendix A.

According to Hall and Taylor, historical institutionalism is also different from other new institutionalisms, in that its authors generally perceive the relationship between institutions and individual behaviour in relatively broad terms (1996, 938-40). Indeed, historical institutionalists generally conceive of institutions as structures that not only provide an outline for moral and cognitive behaviour but also strategic and useful information; both of which "affect the very identities, self-images and preferences of the actors" (see March and Olsen (1989)). Amongst themselves, however, historical institutionalists differ in the behavioural approach that they assume actors take; most apply either a calculus or a cultural approach. While the calculus approach assumes that actors behave strategically to maximise their own objectives and utility, the cultural approach assumes that, while rational and purposeful, actor behaviour is 'bounded' by the information they have and, thus, their interpretation of the world. By applying one of these approaches, historical institutionalists are able to explain the endurance of 'regularised patterns of actor behaviour' over time. So, institutions either persist because actors understand that it would be more difficult or costly to change them (e.g. the Nash equilibrium in the calculus approach) or because actor behaviour in decision-making is so embedded in the institution that created them that they do not see any other way forward as fitting (the cultural approach).

Lastly, historical institutionalists set themselves apart from the other new institutionalists by applying a similar perspective to punctuated-equilibrium theory in their analysis (Thelen 1999; Pierson 2004; Kickert and van der Meer 2011). Continuing from the notion that institutions and policies are path dependent and, thus, the general status of policymaking is stable, they tend to look for major events or 'critical junctures' in periods of continuity to explain when and why a policy changes

[232] This is also referred to as policy feedback effects (Thelen 1999) as "path dependent patterns are characterized by self-reinforcing positive feedback" (Krasner 1988, 83). Ikenberry (1994) provides a thorough summary of the literature on policy feedback in historical institutionalism.
[233] Such path dependency and policy stability could actually generate inefficiencies and unintended consequences. See March and Olsen (1984) and North (1990) for further elaboration on these effects.

or branches off on to a new path (Krasner 1984; Gourevitch 1987; Collier and Collier 1991; Hall and Taylor 1996).[234] The challenge is to determine what constitutes policy stability and what creates change (Thelen 2003; 2004; Magnusson and Ottosson 2009). Streeck and Thelen (2005) examine institutional change theories, finding that they are not supported with analytical tools that allow them to identify change at the national government level in advanced political economies and proposing going beyond continuity and a new model of incremental but cumulatively transformative change processes. Mahoney and Thelen (2010) develop a theoretical model for causality arguments by connecting contextual and organisational properties to the type of institutional change expected.

B.2.2.1.1. Empirical Studies in the Health Policy. The literature provides a wealth of empirical examples using the historical institutional approach. Most of these are cross-country comparisons and are specific to a particular policy field (e.g. trade policy, health policy etc.)[235]. Here I will first discuss two recent empirical case studies that apply historical institutionalism to Spain public policy. Then, I will present a handful of empirical studies that apply it to mostly-OECD countries with a focus on health policies and reform.

Chari and Heywood (2009) apply the historical institutionalism approach to the public policy process in Spain. They argue that this approach advances previous literature on the policy process in Spain, which tends to use 'periodisation' in their explanations.[236] In using it, they are able to uncover continuities and policy changes in the policymaking process by examining institutionally driven structures of Spanish democracy and socio-economic model of capitalism as well as the political composition of the governing party. Important to the thesis, they demonstrate that the "increasing institutionalization of a very strong core executive in Spain … has been able to concentrate power in a systematic manner and dominate the policy process to the exclusion of parliament, interest group participation and even smaller, supporting

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[234] Wilsford (1994) examines the historical institutionalism concept of path dependency and how it can be used along with the concept of conjuncture to understand – not only incremental changes – but major changes systematically. He tests his hypothesis comparatively for health policy in Germany, France, Great Britain and the United States. His results show that radical reform is not the general decision rule across the four health systems.

[235] E.g. for Finance and Welfare policy, see Steinmo (1993) on Sweden, Britain and the US, and Parrado (2008) on Spain.

[236] Other authors that have paid attention to the policy process have concentrated mostly on specific policy domains or outcomes, including Subirats (1992), Subirats and Gomá (1997), Gomá and Subirats (1998), Gunther (1980; 1996a; 1996b), Gunther et al. (2004).

parties when policies are made by minority governments" (Chari and Heywood 2009, 49). They prove their hypothesis of path-dependency in the policymaking process in Spain with three case studies: (i) on privatisation, (ii) on Spain's response to the draft EU Constitution, and (iii) on education policy. Despite divergent policy outcomes, all three areas of policy followed the same policymaking process.

Ferreira do Vale (2012) also uses the historical institutionalism approach as an analytical base for his study of the public policy process in Spain, as well as in Brazil and South Africa.[237] Particularly interesting to the thesis, he looks at institutional change with regard to decentralization and federalisation after a democratic transition from an authoritarian regime in these three countries. He explains how the institutional change of decentralization and federalisation affected intergovernmental relations by tilting power and authority towards subnational governments. He does this by paying special attention to the causal mechanisms that drive federalisation and decentralization, and applying a framework that delineates the sequence of events leading to incremental changes in the intergovernmental balance of power. Similar to Chari and Heywood (2009), Ferriera do Vale finds that intergovernmental bargaining in Spain is path-dependent – with a self-reinforcing shift of power towards the political elites at the subnational government level – and exhibits a sequential pattern of decentralization. Overall, for all three cases, he concludes that internal factors—including the sequencing in which legislative measures are approved, and the bargaining between constellations of intergovernmental actors—have mainly driven intergovernmental institutional changes of decentralization and federalisation.

Turning to the health policy-specific literature, Immergut's (1992) study of health politics in France, Sweden and Switzerland was groundbreaking (see Appendix A.4. for further information). Through her institutional analysis, she was able to demonstrate that the structure of a country's political institutions determines the relative (veto) power of main actor groups and the (veto) points in which they are able to exercise such power (Hall and Taylor 1996). Following from this information, she was able to understand better the limits and types of political strategies and policy choices that different governments have (Immergut 1992; Steinmo 2008). More specifically, regarding her country-case studies, Immergut found that the structure of the Swiss federal system strengthens the political influence of Swiss physicians,

[237] He chose these specific country case studies partially because intergovernmental negotiations were a fundamental element in the transition to democracy for all three countries.

allowing them to oppose legislation more easily than their counterparts in France and Sweden.

Another notable empirical contribution to the historical institutionalism literature in health policy literature, Hacker (1998) studies the logic of National Health Insurance in Britain, Canada and the US. Not only does his research evidence the application of historical institutionalism in the health sector, but it also helps to expand the scope and explanatory power of historical institutionalism in general. Hacker's study dates back to the early 20th century. He investigates why countries with relatively similar cultural heritage, economies and battles over national health insurance could have such very different political institutions and end up on significantly different health policy paths. His findings illustrate how such differences can be attributed to the 'critical junctures' that each country took in policymaking. He also demonstrates how historical institutionalists can go farther in their analyses by emphasizing the role of historical sequence and timing in political decision-making, and examining the evolution and effects of private sector institutions on policymaking.

Extending his original historical institutional analysis, Hacker (2004) produces a comparative review of five countries, including Germany and the Netherlands.[238] The results of the review show structural reform does not cause policy change as much as analysts give it credit for; instead, it suggests that conversion (or the decentralized restructuring of policies by actors empowered under them) and drift (or the failure to update policies to reflect changing circumstances are much stronger catalysts (Hacker 2004, 722). In the same year, Hacker joins forces with Béland to explore the American welfare state 'exceptionalism' in health and old-age insurance, 1915–1965 (Béland and Hacker 2004). From this case study and building on previous works (e.g. Hacker (1998; 2002)), Béland and Hacker suggest that the institutional approach needs to broaden its analytical scope to cover private social policies and processes, and alternative policy paradigms and the agenda-setting processes that guide public officials and political leaders, including outside reformers, interest groups and social movements that influence policy. As it is, Béland (2005, 4) affirms that "mainstream historical institutionalism is excellent for explaining how institutions create obstacles and

[238] Also, stemming from Hacker (1998), Hacker (2002) compares two social sectors—health and pensions—within the US, exploring why these two on opposite sides of the public-private welfare spectrum.

opportunities for reform; however, it cannot shine a satisfactory light on the policy ideas that influence legislative decisions.

Yet another major work in the health policy literature, Tuohy (1999) uses the historical institutionalism approach to examine health system reform in Britain, Canada and the US. Her analysis, however, incorporates aspects of rational choice institutionalism (see below), producing an innovative conceptual framework for understanding change in the health policy arena.[239]

> It explores the distinctive logics of particular decision-making systems, within which actors respond, rationally, to the incentives facing them given the resources they can bring to bear. But it also recognizes that the dynamics of change in decision-making systems cannot be understood entirely in terms of the "rational choice" of the actors within them. Periodic episodes of policy change establish the parameters of the systems within which actors make their choices. (Tuohy 1999, 6).

Tuohy argues that health policy changes can be better understood by examining the 'accidents' of history that have shaped political systems at critical junctures and the 'logics' of both health and political systems. With her case studies, she illustrates "why particular windows of opportunity for change in health policy opened at certain times and not others—a pattern of timing that derived from factors in the broader political system not in the health care arena itself" (Touhy 1999, 6). She defines 'accidents' as by-products of ideas in wider circulation at the same time a window of opportunity opens, and 'logics' as parameters influenced by history, the sequencing of reforms, the 'institutional mix' (defined as the balance of power between the State, professional-colleges and the market) and 'structural balance (defined as the balance of power between the State, healthcare professionals and private financial interests) (Dixon 2006). Despite a slightly different methodology, Tuohy's research results do not differ significantly from those of Hacker (1998). For example, her results show that policy change occurs when choices become available (timing). In addition, she demonstrates that micro-economic characteristics and technological change are big factors for health system logic and change. Tuohy also contends that the relationship between the medical profession and the state is a key feature of the policymaking process in all three healthcare systems.

Looking particularly at Southern European health systems, Cabiedes and Guillén (2001) employ an historical institutionalism-based analysis[240] to the

[239] Dixon (2006) applies Tuohy's framework broadly for analysing change in the English NHS.
[240] They combine historical institutionalism with a social attitudes approach to policy change.

policymaking processes behind their reforms from social health insurance-based systems to universal, national health service systems. Their analysis concludes that, with the exception of Italy, the democratization of authoritarian regimes was one of four main factors influencing the formulation and legislation of these reforms. Additionally, Cabiedes and Guillén notes that, in all four countries, the European Community influenced the decision to reform and left-wing parties governed and passed them all. Lastly, in Spain and Italy, their research suggests that the subnational governments played a major role in pressuring the central governments to pass the reforms. They also provide evidence for the influence of different factors in the implementation stage of these reforms. For example, in Greece and Portugal, reform implementation met with difficulties due to economic constraints, and the low levels of coverage rates and public opinion of the social insurance systems at the initial point of implementation in these countries. Furthermore, and in accordance with Hacker's (1998) suggestion to incorporate private sector institutions into the historical institutionalism approach, Cabiedes and Guillén found that reform implementation in Greece and Portugal was also majorly hindered by their extensive private sector involvement in health, including powerful physician associations (similar to Touhy's (1999) results for Britain, Canada and the US) and pre-existing insurance funds.

Similar to Cabiedes and Guillén (2001), Rico and Costa-Font (2005) study the impact of devolution on the reform of the health system from one based on health insurance to a national health service. However, in contrast to both Chari and Heywood (2009), and Cabiedes and Guillén´s (2001) analyses regarding Spain, they dispute the idea that theories of path dependency were at play in Spain. They argue, rather, that consolidation of the NHS stemmed from regional diversity and policy innovation that was created through the egalitarian socio-political structure of Spain after democratisation.

B.2.2.1.2. Historical institutionalism for the thesis. Although a promising approach to analysing policymaking, historical institutionalism is a poor fit for the thesis because of a few main reasons. First, the focus of historical institutionalism differs from that of my research. As mentioned above, historical institutionalism focuses on history (path dependency) as the main factor in the policymaking process; whereas, the focus of my research is more on the relationships between main actor groups, how it affects their behaviour and, then, strategy and policy choice. In relation with this, the historical institutionalism approach gives a broad view of the relationship

between institutions and actor behaviour and it does not look at change as much as it does continuity (Streeck and Thelen 2005); whereas, my research examines closely the nexus of these aspects of the policymaking process, looking acutely at the causalities a change in institution may have on actor behaviour. Lastly, historical institutionalism views the policymaking process in a similar way to the punctuated equilibrium theory[241] in that it identifies major points in history that may change the path of policy. My research differs in that it does not look at critical moments in policymaking but rather at the influence of—perhaps, what could be considered a critical juncture in policymaking—devolution on subsequent policies. As such, I look at the smaller changes in health policies to discern what—if any—impact health system devolution may have had on them.

Despite theoretical differences, the empirical evidence reviewed above for the historical institutionalism approach provides some interesting insight into the policymaking process for Spain and, above all, health policy in Spain. Regarding the former, Chari and Heywood's (2009) analysis characterises the executive branch in Spain being very strong and having relatively more power in the policymaking process than the parliament, interest groups and, sometimes, smaller parties. In addition, Ferriera do Vale (2012) points to the importance of intergovernmental bargaining in Spain, and how decentralization changed power dynamics between governments, by shifting it towards political elites in the subnational governments. In the particular realm of health policy in Spain, Cabiedes and Guillén (2001) highlight that democratisation, the European Community, left-wing parties and the subnational governments all played significant roles in reforming the health system. In addition, Rico and Costa-Font (2005) emphasise the importance of the egalitarian socio-political structure in the policymaking process after democratisation. They also show that pre-existing regional diversity and striving for policy innovation at the regional level are also factors in the policymaking process.

B.2.2.2. Sociological Institutionalism: Sociological institutionalism (closely related to normative institutionalism in the literature) is another main institution-based approach to policymaking and policy change in the scholarly literature. It was first

[241] The punctuated equilibrium model by Baumgartner and Jones (1993) is a comprehensive model of agenda setting over time. They argue that, in any give policy area, dramatic policy changes occur with intermittent phases of instability that exist among long periods of stability. They also suggest that human beings process information in parallel rather than one at a time; that is, until they are forced to process them in serial during times instability.

born in the organisation theory literature of sociology (Selznick 1949). As a breed of the sociology literature, sociological institutionalism stems from the study of human social behaviour and focuses on social actions, structure and functions. It believes humans are fundamentally social and, thus, act within social norms and the confines of everyday practices and established routines. It is a separate branch within sociology because its perspective departs from the centre of organisations or institutions.

Sociological institutionalists define institutions slightly differently from other new institutionalists. They specify that institutions are not only formal but also informal structures. Much like historical and rational choice institutionalists, they believe institutions as the 'formal' rules and procedures and norms. However, they also believe these 'formal' structures more than often fail in their explanation of the less-rational dimensions of organisational behaviour (Selznick 1949, 25). Therefore, they emphasise the importance of 'informal' structures such as (a network of) symbol systems, cognitive scripts, moral templates and set routines (Swidler 1986; March and Olsen 1989).

In accordance with this definition, sociological institutionalists believe that institutions are largely autonomous, evolving mostly due to their internal dynamics and less so to factors in their environment (March and Olsen 1984).[242] This happens, for example, when institutions continue to exist despite not serving a useful purpose any longer. Consequently, sociological institutionalists believe that people act more on a collective basis than on an individual one. They do not analyse single organisations with their specific context and environment, but rather the population of organisational fields (DiMaggio 1982), including professional bodies (doctors, teachers, etc.) and civil servant bodies/bureaucracies of public organisations. The 'organisational field' is the "institutional context within which each single organization plots its courses of action" (Thoenig 2003, 130). For example, empirical investigations examined the following organisational fields: city administrations (Tolbert and Zucker 1983), nation-state features (see mention of empirical studies in Meyer et al. (1997)), institutional change in the EU (Stacey and Rittberger 2003), European regional policy (Baudner 2003), European environmental policy (Knill and Lenschow 1998), private and public elementary schools, or health care programs (Scott and Meyer 1994), rape prevention

[242] As opposed to a *functionalist* view of institutions, which believes that institutions evolve in an efficient way to better solve political or societal problems (Hall and Taylor 1996). Similarly, in political science, institutions are 'functions of political life' (John 1998, 39)).

programs (Townsend and Campbell 2007).[243] Thus, an understanding of the ethos within organisations (how people understand their world and how it should be) provides insight into how actors behave and institutions operate (Hall and Taylor 1996).

Following from this, sociological institutionalists believe that institutions provide a frame for guiding human action and decision-making. According to March and Olsen (1984; 1989), institutions generate a certain type of *order* and *predictability* as well as a *space* within which actors can manoeuvre and make decisions. This *space* delimits and directs their behaviour and actions. Thus, institutions affect actor behaviour. For sociological institutionalists, they do so by shaping and influencing their preferences, perceptions and identities over time (Rhodes, Binder, and Rockman 2008). Moreover, and differently from other new institutionalisms, sociological institutionalists believe that institutions imbue actors to behave *appropriately* and do the 'right' thing in accordance with the ethos of their organisation. They contextualise agency within the 'logics of appropriate' conduct in institutionalised settings. They believe that institutions "empower or constrain actors differently and make them more or less capable of acting according to prescriptive rules of appropriateness" (March and Olsen 2008, 3). These 'rules of appropriateness' are embedded within each institution, communicated through socialisation and adhered to because they are viewed as being socially legitimate (March and Olsen 1984; 2006). In essence, sociological institutionalists redefine 'culture' as 'institutions' (Zucker 1991; Meyer 1994). This blurs the traditional conceptual line that political scientists, for example, hold between culture and institutions (Hall and Taylor 1986).

Following from this, and referring back to the earlier discussion within the historical institutionalism review, there are two broad approaches to conceptualizing the relationship between institutions and individual behaviour: the calculus approach and the cultural approach. Sociological institutionalists largely take the cultural approach, looking at actor behaviour as if it were 'bound' by their worldview and to a point where they only see certain viable options for making decisions. As opposed to the calculus approach, they see individuals acting 'rationally' according to their social constitution[244] rather than in their own self-interest. Moreover, they view individuals

[243] I will not review the empirical evidence for sociological institutionalism because, as a theory, it does not fit my case (see weaknesses and complications below). See also empirical evidence in Nee and Brinton (1998).
[244] See the classic works by Berger and Luckmann (1966) and Wendt's (1987).

as bound by common values, working and making decisions with a sense of duty and obligation to their institutions and self-fulfilment (Selznick 1949). As such, they believe people are more 'satisficers' than 'utility maximisers' within organisations, valuing the broader cultural environment more than towards achieving the organisation's efficiency goals. They also emphasise that individuals are generally habit-forming and usually act on established routines and procedures, as well as practical reasoning in order to make decisions and devise a course of action. In accordance, they see an individual's decisions and choice actions as tightly bound within a given context and heavily dependent on interpretation.

With this perspective of institutions and their relationship with actors, sociological institutionalists seek to explain how institutional practices originate and change. They generally examine *why* organisations take on particular sets of institutional forms, procedures or symbols, and *how* these are disseminated through specific organisational fields and across countries. For example, there are theories as to why, despite the different local conditions and environment, education reform has converged across the world, showing similarities in organisational form and procedures. DiMaggio and Powell's (1983) lead research in this area with their theory regarding 'institutional isomorphism' and explanation of *why* there is so much homogeneity of organisational forms and practices. Their theory suggests three—not always empirically distinct—mechanisms of institutional isomorphic change for understanding politics the politics of organisational life better: "1) *coercive* isomorphism that stems from political influence and the problem of legitimacy; 2) *mimetic* isomorphism resulting from standard responses to uncertainty; and 3) *normative* isomorphism, associated with professionalization" (1983, 150).[245] Returning to the education-field example, they believe that the type of education reform was responding to primarily *coercive* pressures; that is, countries around the world have changed their education systems to emulate the 'successful' organisation model in the US in an attempt to also become successful in this field (See also Dobbins and Knill (2009) and Dobbins (2011)). Moreover, change happens not because of functional efficiency *per se* but rather because it enhances the social legitimacy of the organisations (sees also Meyer et al. (1977)). DiMaggio and Powell also explain that, "in the long run, organisational actors making rational decisions construct around

[245] Beckert (2010) shows how these mechanisms of isomorphic change can also support processes of divergent institutional development and change as well.

themselves an environment that constrains their ability to change further in later years" (1983, 148). The institutional sociological idea that actors within organisations are bound by common values, develop shared 'cognitive maps' and act according to a 'logic of *social* appropriateness' also helps to explain why organisation have such a capacity to 'unreflectively' reproduce themselves (Campbell 2010). Other more radical (forcibly exogenous) changes may be difficult to implement against, for example, the will and determination of actors, such as civil servants. As such, sociological institutionalism generally explains policy continuity (by comprehensible and routine processes) or stability rather than policy change (March and Olsen (1984; 1989); see also Goodin (1996, 34–35)).

B.2.2.2.1. A Garbage Can Model for Decision-Making. Within this literature, Cohen, March and Olsen (1972) put forward a Garbage Can Model for organisational decision-making. This model suggests that decision-making in organisations has a 'by-chance' or anarchical (as opposed to rational) nature. It views organisations as "collections of choices looking for problems, issues and feelings looking for decision situations in which they may be aired, solutions looking for issues to which they might be an answer, and decision-makers looking for work" (M. Cohen, March, and Olsen 1972, 1). When all of these things mix together with good timing, then a 'choice opportunity' becomes available. As they state, "the mix of garbage in a single can depends on the mix of cans available, on the labels attached to the alternative cans, on what garbage is currently being produced, and on the speed with which garbage is collected and removed from the scene" (Cohen, March and Olsen 1972, 2). In this model, solutions search for problems and the outcomes are a function of the mix of problems, decision-makers and resources.

This type of model is interesting to the thesis because it incorporates the 'role of ideas' into explanation of the policy process and can be used for explaining policy change over time. One of the most well-known public policy studies that use this model is John Kingdon's (1984) study of Agendas, Alternatives and Public Policies using qualitative interview data from elites inside and out of the US Federal Government. Kingdon adapted the 'garbage can model' of organisation choice to explain the policy change through the agenda-setting process. He conceives this process as one that emerges from a discordance of the three streams: the political stream sets the government agenda; the policy stream offers alternative policies or strategies that can be implemented to solve the problems or issues that the government

has to address; and, the problem stream carries information on current problems and various problem definitions, all of which are brought to the attention of policymakers by way of indicators, events and feedback. The policy stream—referred to as the *primeval soup*—Kingdon's alternative metaphor to the garbage can—where ideas float around, meet one another and combine—involves the advocates of solutions to policy problems and results in a list of alternative proposals to the governing agenda. In the *primeval soup*, Kingdon introduces the concept of policy entrepreneurs: "people who are willing to invest resources of various kinds in hopes of a future return in the form of policies they favor" (Kingdon 1984, 151). These policy entrepreneurs may be interpreted as lobbyist and advocacy or interest groups. They introduce the various policy alternatives to the government agenda. When one of these alternatives or solutions is attached to a problem, a 'window of opportunity' opens and the likelihood of it getting put on the government agenda increases.

While this 'by chance' way of explaining policy change over time has often been used in the study of health policies, it is however not fitting with the thesis for two main reasons. First, its generalisability to country case studies in Europe is questionable. Kingdon's study was focused on the structure and internal workings of the US political system. In particular, the US' presidential system with a separation of powers between different branches of government is different from most political systems in the EU[246], which are relatively centralised parliamentary systems (Cairney 2012). In more centralised, parliamentary political systems, the garbage can model with all of its ambiguity is less likely to occur because the policy environment tends to be less crowded, access to decision-makers is more guarded and politically appointed civil servants are fewer and less significant (Zahariadis 2007). Secondly, Kingdon's model does not weight the influence of the different streams and portrays policy advocacy and competition as indifferent to the distribution of power between actors. There is a whole literature on theories and approaches to power in society and its influence on the policy process (see Chapter 2 in Hill (2013)). Because these focus on the change in decision-making power between actors, the thesis requires a model that would examine the exercise of power in the making of policy as well as the sources and nature of that power. Further discussion regarding this view of the policy process is not within the scope of the thesis.

[246] That is not to mean 'EU policymaking'. Kingdon's multiple streams theory has been applied to EU policymaking by Zahariadis (2008) and other authors.

B.2.2.2.2. Sociological institutionalism for the thesis. Sociological institutionalism analysis does have its weaknesses and complications in general and for the thesis. First, the causal relationship between institutions and actors is complex and even unclear at times, portraying a causality similar to 'the chicken or the egg' dilemma. For example, does the institution affect how actor behaviour influences the structure of institutions? Moreover, some organisations are dependent on their environment and others are more independent in their decision-making (Perrow 1986). Additionally, the blurred line between the conception of institutions and culture challenges the distinctions between traditional 'institutional explanations' based on organisational structures and 'cultural explanations' based on shared attitudes and values. Regarding the thesis of this dissertation, these causal relationships in multilevel and multi-centred organisations (e.g. decentralized or federal systems) are also more difficult to disentangle (March and Olsen 2008).

Second, theoretically, the informal rules as understood by sociological institutionalists may not be clear, having different meanings to different people within the same organisation. Alternatively, people may choose not to follow the rules in making their different policy decisions. People may also 'wear many hats', having different roles and tasks to perform for one or more organisations, which can be contradictory. In general, according to Peters (2005, 26) "individuals must pick and choose among influences and interpret the meaning of their institutional commitments". In this case, the analyst also needs to understand *how* the rules are understood by people to understand their behaviour. Lastly, sociological institutionalism does not put power relations between actors at the forefront in explaining policymaking and change. Rather, it defines the institutional context as an organisational field and bureaucrats as the main actors in institutional organisation and decision-making. For March and Olsen (1984, 739), for example, political structures are "relatively invariant in the face of turnover of individuals and relatively resilient to the idiosyncratic preferences and expectations of individuals". As such, it pays little attention to the influence of actors—including policy elites—and other organisations outside the organisational field of the analysis. Elites clearly have an important role in policymaking and may even set the overall goals of organisations (Perrow 1986). This contrasts with the thesis of the dissertation, which emphasises the role of policy elites in policymaking and considers the interactions between different organisational fields and between levels of government, as well as their interactions and policymaking patterns.

Appendix C. An Example Interview Guide (Spanish Only)

C.1. Guía de la Entrevista para Actores Clave en las Regiones

Fecha: _____/_____/_____
ID#_____
Institución: _____

C.1.1. Introdución

Encantada de conocerle. Me llamo Christina Novinskey. Soy de la London School of Economics and Political Science (LSE) y estoy conduciendo un estudio sobre las relaciones entre las Comunidades Autónomas y el gobierno central en referencia al proceso de descentralización del Sistema Nacional de Salud (SNS).

Con este estudio, quiero analizar los cambios que se dieron con la última transferencia de competencias sanitarias en la gestión del SNS en 2002. Por lo tanto, se concentra en las CCAA de 'vía lenta' y, en particular, en las de Extremadura y Madrid.

Para el estudio, planeo realizar aproximadamente 30 entrevistas para la producción de datos primarios basados en las opiniones de los actores clave del sistema sanitario. Habiendo usted cubierto un papel importante en este proceso, es muy importante para mí el hecho de poder escuchar directamente de usted cómo se dio el proceso y su opinión sobre ello.

La información obtenida a través de las entrevistas será solamente para mi uso, y estará presentado en mi tesis doctoral de LSE sin identificar las opiniones individuales a no ser que en un segundo momento yo le pida y usted me conceda el permiso de reportar literalmente una cita específica.

Tomaré notas para así tener información clara de lo que usted me habrá dicho. También grabaré la entrevista para mayor apoyo, claridad y exactitud a la hora de interpretar la información ya que el castellano no es mi lengua materna. Todo lo que me pueda contar será tratado de forma confidencial y su anonimato será respetado.

C.1.2. Características de los Actores

Para empezar, me gustaría recoger algunos datos preliminares sobre usted y su trabajo. (Esto es parte de los datos que necesito para el análisis / Quiero confirmar la información que tengo y por favor corrígeme si estoy equivocada)

1. Nombre_____
   (to be converted into a number to preserve anonymity - be sure to keep the key for this number to assign by type of official)

2. Grupo de Actores_____
   (to be converted into a letters to preserve anonymity - GDN, AVC, MAD, EXT, OTH)

3. Tipo de Oficial_____
   (to be converted into a letters to preserve anonymity - P, T, A, O)

4. Fecha_____
   (To be used in code only if necessary (i.e., more than one interview has been done with the same actor on the same questions)

5. Cargo actual_____

6. Cargos anteriores (desde 1994)

   Desde 1994, ¿Cuáles son los principales cargos/responsabilidades que ha tenido?

   _____
   _____
   _____
   _____

7. Orientación política_____

8. ¿A qué se dedicaba antes de entrar en la administración?
   _____

9. No estoy muy familiar con el sistema institucional de España todavía y le voy a preguntar algo que le puede parecer obvio. ¿El cargo que usted ocupa es un cargo que se obtiene por nombramiento, elección, progreso en la carrera profesional u otra forma?
   _____

C.2.3. La Entrevista

Ahora le voy a hacer algunas preguntas sobre la política sanitaria en general y el antes y después de la última transferencia sanitaria (en la gestión del SNS) en 2002.

	Preguntas	**Notas/Preguntas de Seguimiento**
1.0	¿Quiénes son los principales protagonistas (individuos o instituciones) implicados en el proceso de adopción de decisiones relativas a la política sanitaria?	A ambos niveles el central y el regional
a.	¿Son estos protagonistas diferentes a los que participaban en este proceso antes de las transferencias sanitarias de 2002?	¿De qué manera es diferente y por qué razones?
2.0	¿Cómo ha sido la relación de su CA con estos protagonistas desde las transferencias sanitarias?	¿Cómo trabajaron con ellos? (bien, poco bien, mal, etc.) ¿Hay diferencias significativas entre su CA y las otras instituciones?
a.	¿Estas relaciones eran diferentes antes de las transferencias sanitarias de 2002?	¿Por qué?
3.0	En su opinión, ¿Qué significaron para España y para su Comunidad en particular las transferencias sanitarias de la gestión del SNS?	
4.0	¿Qué objetivos perseguía la política de transferencias sanitarias de 2002?	
a.	En su opinión, a día de hoy, ¿cuáles de estos objetivos se han cumplido?	
5.0	¿Qué beneficios han traído a su CA las transferencias sanitarias?	
6.0	¿Qué desventajas o desafíos le han supuesto?	
7.0	¿Cuál de estas categorías describe mejor la posición de su CA en el proceso de aprobación de las transferencias sanitarias? 1. la apoyó mucho, 2. la apoyó algo, 3. no la apoyó ni se opuso, 4. se opuso algo, 5. se opuso mucho.	Si diga 1, 2 o 3, CONTINUO con "apoyo". Si diga 4 o 5, CONTINUO con "opuso" para las siguientes sub-cuestiones
a.	¿Por qué su CA la apoyó o se opuso a ella?	
b.	¿De qué manera la apoyó o se opuso?	¿Fue su CA la primera en apoyar (oponerse a ella) la transferencia?
d	¿Cuáles eran los factores que influyeron en la política de apoyo u oposición de su CA?	¿Fue está apoyo u oposición anunciado públicamente?
8.0	¿Qué otros instituciones apoyaron o se opusieron la transferencia?	p.ej. Ministerios, gobiernos de otras CCAA, otros niveles de gobierno u otros actores privados
a.	¿Estas instituciones según Usted ganaron o perdieron algo con la transferencia?	
b.	¿Cuál fue la primera institución en tomar la iniciativa para apoyar/oponerse la descentralización?	¿Cómo lo hicieron?
9.0	¿Según Usted, hubiese sido posible traspasar las competencias sanitarias antes de 2002?	Si, sí, por favor explíquemelo por qué.

10.0	¿Con la descentralización, los partidos han tenido contrastes en su interior sobre los objetivos y las políticas sanitarias entre el nivel autónomo y el nivel central?	En particular entre el estado y las CCAA
a.	¿Y cómo eran esas relaciones antes de la descentralización?	
11.0	¿Pensando en el desarrollo futuro del SNS, apoyaría una mayor descentralización?	
a.	¿Por qué?	
12.0	Ahora le voy a hacer 6 preguntas cortas sobre cómo ha afectado la descentralización al poder de su CA en la toma de decisiones en 6 áreas funcionales. 5 son las respuestas posibles: 1. significativamente más que antes, 2. algo más que antes, 3. el mismo, 4. algo menos qué antes, 5. mucho menos que antes	
a.	En el área funcional de financiación ¿qué diría usted?	Decisiones relativas a las fuentes de recursos/ingresos y asignación de gastos para el sistema sanitaria ¿Si, es algo menos o mucho menos, quién tiene el poder en la toma de decisiones de esta área funcionar?
b.	¿En la planificación sanitaria?	¿Si, es algo menos o mucho menos, quién tiene el poder en la toma de decisiones de esta área funcionar?
c.	¿En recursos humanos?	
d.	¿En la organización del servicio de salud?	Sobre salaries, contractos, el Servicio Civil y como asumir/despedir/trasferir. ¿Si, es algo menos o mucho menos, quién tiene el poder en la toma de decisiones de esta área funcionar?
e.	¿En las prácticas de supervisión y control?	Monitoring & evaluation, incentives, sanctions etc. ¿Si, es algo menos o mucho menos, quién tiene el poder en la toma de decisiones de esta área funcionar?
f.	¿En la gobernanza sanitaria? (cómo se gobierna)	(facility boards, health offices, community participation) ¿Si, es algo menos o mucho menos, quién tiene el poder en la toma de decisiones de esta área funcionar?
13.0	¿Existen publicaciones, documentos u otros materiales que usted cree puedan ayudarme en este estudio?	
14.0	¿Cree que existe alguna persona que debería entrevistar sin falta para proseguir con éxito con mi proyecto de investigación?	(¿Madrid? ¿los actores del gobierno central?) ¿Cuándo contacte con ellos les puedo decir que he entrevistado usted anteriormente?

15.0. En particular, tengo una seria de preguntas técnicas acerca de las áreas funcionales del sistema sanitario de su CA. Pero ya le he quitado demasiado tiempo y no le quiero molestar con este tipo de detalles. Es por eso, que me gustaría preguntarle si puedo contar con su ayuda directa o indirecta para entrevistar o encontrarme con los jefes técnicos de esas áreas funcionales.

Appendix D. List of Key Stakeholders Interviewed

Note: This is an alphabetical list of the key stakeholders interviewed for the thesis. The interview numbers in the text are the author's own reference, and are not a direct cross-reference, in order to protect the interviewees' anonymity. In addition to giving their consent for sourcing their interviews in person, all interviewees listed gave their consent (via email or other electronic source) to be included in this list; those who could not be reached for the latter are not listed.

Interviewee Name / Date of Interview(s)	**Relevant Position(s) During Period of Study**
Antonio Beteta Barreda 8 October 2007	Regional Member of Parliament (MP), Madrid (1983-2000, 2003-2011) Regional Minister of Finance, Madrid (1995-2000) Secretary General of Fiscal, Territorial and Community Policy, Regional Ministry of Finance, Madrid (2000-2003) Speaker of the PP Group, Parliament of Madrid (2003-2008)
Josep María Bonet Bertomeu 21 June 2007	Director-General, INSALUD (2000-2002)
Enrique Castellón Leal 16 April 2007	Vice Minister of Health and Social Services, Madrid (1995-1996) Secretary of the Ministry of Health (1996-2000)
José Luis Conde Olasagasti 16 April 2007	Director-General, INSALUD (1992-1999) Under Secretary of Health and Consumer Affairs, Ministry of Health (1993-1994)
José Ignacio Echániz Salgado 9 October 2007	Regional MP, Castile-La Mancha (1991-1999) Regional Minister of Health, Madrid (1999-2003) Advisor to the PP Parliamentarian Group in the Congress and the Senate (1999-2003) Regional MP, People's Party, Valladolid, Castile Leon (1996-2000, 2004-2008) Regional MP, Parliament of Madrid (2003-2007)
Francisco Javier Elola Somoza 20 April 2007	Director-General of Health Planning, Ministry of Health (1991-1994) Director-General of Health Coordination and Planning, Ministry of Health (1995-1996)

Interviewee Name / Date of Interview(s)	**Relevant Position(s) During Period of Study**
Luis Espadas Moncalvillo 4 May 2007	Director-General for Financial Economic Planning, Ministry of Health (1994-1996) Deputy Director-General of Budgetary Policy, Ministry of Finance (2003-2004) Director-General of Budgets (2004-2006) Secretary General of Budgets and Expenditures, Ministry of Economics and Finance (2006-2011)
Guillermo Fernández Vara 21 March 2007 and 10 November 2007	Regional Minister of Social Welfare (Health), Extremadura (1996-1999) Regional Minister of Health, Extremadura (1999-2006) President of the Government of Extremadura (2007-2011)
José Luis Ferrer Aguareles 19 April 2007	Director-General of Health Planning, Ordination and Coordination, Regional Ministry of Health, Extremadura (2003-2007)
Jesús Galván Romo 30 May 2007	Director-General of Health Planning, Regional Ministry of Health, Madrid (1999-2002) Director-General of Planning for Health, Innovation and Technology, Regional Ministry of Health, Madrid (2002-2004) Head of Regional Ministry of Evaluation and Quality, Institute of Public Health, Madrid (2005-2011)
Francisco Manuel García Peña 18 April 2007	Director-General of Extremadura Regional Health Service (2001-2007)
Victor Manuel García Vega 2 October 2007	Secretary General of the Regional Ministry of Health, Extremadura (2002-2007)
Enrique Gómez Campo 16 May 2007	Advisor, General Directorate of Autonomous Policy, Ministry of Public Administration (1996-2004) Director-General of Autonomous Cooperation, Ministry of Public Administration (2004-2005) Director-General of Autonomous Development, Ministry of Public Administration (2005-2009)
Fernando Lamata Cotanda 29 May 2007	Director-General of Health Planning, Regional Ministry of Health, Castile-La Mancha (1999-2000) Regional Minister of Health, Castile-La Mancha (2000-2004) Secretary of the Ministry of Health (2004-2005) First Vice President of the Government of Castile-La Mancha (2005-2008)

Interviewee Name / Date of Interview(s)	**Relevant Position(s) During Period of Study**
Cristobal Montoro Romero 17 March 2008	MP and Speaker on the Economy for the PP (1993-1996, 2000-2004, 2004) Secretary of State for the Economy (1996-2000) Minister of Economy and Finance (2000-2004) Member of European Parliament for Spain, European People's Party, Committee for Economic and Monetary Affairs (2004-2009)
Alberto Núñez Feijóo 4 July 2007	Secretary General of Health Assistance, Ministry of Health (1996-2000) Executive President, INSALUD (1996-2001) Secretary General of the Regional Ministry of Health, and Vice President and Secretary General of the Galician Health Service, Galicia (1992-1996) Vice President of the Government of Galicia (2004-2005) Regional President of the PP, Galicia (2006-Present)
Jorge Juan Relaño Toledano 25 April 2007	Deputy Director-General of Economic Analysis and the Cohesion Fund (2004-2012)
José Ignacio Sánchez Amor 4 October 2007	Director of the Cabinet of the President of the Government of Extremadura (1996-2004) Vice President of the Government of Extremadura (2004-2007) Speaker of the PSOE Parliamentary Group, Parliament of Extremadura (2007-2011)
Ana María Sánchez Fernández 14 May 2007	Director-General of High Inspection and Coordinator of the NHS, Ministry of Health (2002-2004) Director-General of the Hospital of Fuenlabrada, Madrid (2004-2007)
Francisco Sevilla Pérez 9 July 2007	Director-General of Public Health, Regional Ministry of Health, Castile-La Mancha (1998–1999) Regional Minister of Health and Health Care Services, Principality of Asturias (1999–2003) Social Affairs Attaché at the Embassy of Spain to France and the Embassy of Spain to the OECD (2004–2007)

Interviewee Name / Date of Interview(s)	**Relevant Position(s) During Period of Study**
Xavier Trias i Vidal de Llobatera 21 June 2007	Regional Minister of Health, Catalonia and Vice President of the CISNS (1988-1996) Regional Minister of the Presidency of the Government, Catalonia (1996-2000) MP, and President and Speaker of the Catalonian Parliamentary Group Convergence and Union, Parliament of Catalonia (2000-2003) Convergence and Union Councillor to the City of Barcelona and President of the Convergence and Union Municipal Group to the City of Barcelona (2004-2011)
Pablo Vázquez Vega 4 May 2007	Director of the Regional Ministry of Welfare and Education, the Presidency of the Government (2000-2002) Under Secretary of Health and Consumer Affairs, Ministry of Health (2002-2004)
José María Vergeles Blanca 23 March 2007	Director-General of Health Education, Inspection and Quality, Regional Ministry of Health, Extremadura (2003-2007)
Celia Villalobos Talero 8 May 2007	Minister of Health, President of the CISNS (2000-2002) MP for People's Party, Malaga, Andalusia (1986-1993, 1996-2008)

Appendix E. Interview Information Sheet and Written Consent Form

Making Health System Decentralization Work:
Policies & Politics in Modern Spain

London School of Economics and Political Science

Information Sheet

You are invited to take part in a research project of a PhD student in Health and Social Policy. This information sheet explains what the project is about and what will happen if you decide to participate in it. Whether or not you decide to participate is entirely your own choice. Please feel free to ask any questions you have about the research and I will try my best to answer them.

Decentralization of health systems is a widely used strategy for improving resource allocation, efficiency and efficacy of health services; however, little is known about the processes and politics behind the making and implementation of these policies. Spain, in particular, has been noted for its model of health system decentralization from the central to the regional level.

The purpose of this project is to investigate and report on the implementation process of health system devolution from the central government to the regional governments, and a cross-regional comparison of the policies put in place. This is done in search of further insight into the policy process and the reasons behind it in Spain.

If you agree to participate in this research, you will be asked about the politics and policies of health system decentralization in Spain since the transition to democracy (1978) to date. I expect the interview to last 45 minutes to an hour, but you may finish it at any time. I will take notes so that I will have clear records of what you have told me. After the discussion, you will decide whether they will be used in the research. I will also tape record the interview for backlogging, clearness and accuracy of interpretation as Spanish is not my native language. Everything that you will say will be treated as confidential and your anonymity will be preserved.

This research has been approved by the Ethics Committee of the London School of Economics and Political Science (University of London).

It is important that you know that you do not have to participate in this research. You are free to decide not to give any information on the topics discussed. If you decide not to participate, this decision will not have any consequences for you. If you are concerned about this research in any way, or would like more information, please contact Christina Novinskey at the address below:

Ms. Christina Novinskey

Permanent Address:
LSE Health and Social Care, J8
London School of Economics
Houghton Street
London WC2A 2AE
c.m.novinskey@lse.ac.uk
Tel. +44(0)7891714821

Current Address:
C/ Eloy Gonzalo, 7, 3º Izquierda I
28010 Madrid
Mobile: +34. 617906078

Written Consent Form

Title of research project: Making Health System Decentralization Work: Policies & Politics in Modern Spain

Name:
Address:
Telephone:
Email:

Please tick the boxes to indicate that you have read and agreed on the following statements:

- ☐ I have been invited to participate in this research through an interview.
- ☐ I have read the information sheet concerning this study [or have understood the verbal explanation] and I understand what will be required of me and what will happen to me if I take part in it. I have a copy of the information sheet to keep.
- ☐ Ms. Novinskey has answered my questions concerning this study.
- ☐ I understand that at any time I may withdraw from this study without giving a reason and without affecting my normal care and management.
- ☐ I agree to participate in this study.
- ☐ I decided that the content of our conversation could be used in the study.
- ☐ I decided that I could be directly quoted in the study.
- ☐ I know that if there are any problems, I can contact:

Ms. Christina Novinskey

LSE Health and Social Care, J8
London School of Economics
Houghton Street
London WC2A 2AE
c.m.novinskey@lse.ac.uk
Tel. +44(0)20.7955.6476

Signed …… Date: ……

La Política Sanitaria Española: Un Estudio Sobre la Descentralización de las Competencias del Estado a las Comunidades Autónomas (CC AA)

London School of Economics and Political Science

Documento Informativo

Está usted invitado a tomar parte en la investigación del proyecto de doctorado de un estudiante de política social y sanitaria. Este documento informativo explica sobre el proyecto en sí y lo que ocurrirá si usted decide participar en él. Que decida o no participar es una decisión que le pertenece exclusivamente. Por favor, siéntase libre de preguntar lo que desee y de consultar cualquier duda sobre la investigación e intentaré contestar lo mejor que pueda.

La descentralización de los sistemas sanitarios es una estrategia ampliamente usada para la mejora de la distribución de los recursos y la eficacia del sistema; sin embargo, poco es sabido sobre los procesos y las políticas detrás la creación, implantación y ejecución de estos sistemas. España, en particular, ha sido destacada por su descentralización del modelo de sistema de salud pública del nivel nacional al nivel regional.

El propósito de este proyecto es el de investigar e informar sobre la implantación y ejecución del proceso de devolución del sistema sanitario por parte del gobierno central a los gobiernos regionales, y también hacer una comparación entre las distintas políticas aplicadas en las distintas regiones. Esto se hace en busca de un mayor entendimiento de las políticas y las razones detrás éstas en España.

Si usted estás de acuerdo con participar en esta investigación, será entrevistado sobre las políticas de la descentralización política general y la del sistema sanitario en España desde la transición a la democracia (1978) hasta ahora. Espero una entrevista de entre 45 minutos a una hora, pero usted puede acabarla en cualquier momento que desee. Tomaré notas para así tener información clara de lo que usted me habrá dicho. Después de la entrevista, usted decidirá si esa información será usada o no en la investigación. También grabaré la entrevista para mayor apoyo, claridad y exactitud a la hora de interpretar la información ya que el castellano no es mi lengua materna. Todo lo que me pueda contar será tratado de forma confidencial y su anonimato será respetado.

Esta investigación ha sido aprobada por el comité de ética de la London School of Economics and Political Science (University of London).

Es importante que usted sepa que no tiene ninguna obligación de participar en esta investigación. Usted puede decidir lo que quiere hablar sobre los temas planteados en la entrevista. Si usted decide no participar, esta decisión no traerá consigo ninguna consecuencia para usted. Si usted está interesado de alguna manera por esta investigación o le gustaría obtener más información acerca de la misma, por favor contacte con Christina Novinskey en las direcciones siguientes:

D.ª Christina Novinskey

Dirección permanente:
LSE Health and Social Care, J8
London School of Economics
Houghton Street
London WC2A 2AE
c.m.novinskey@lse.ac.uk

Tel. +44(0)7891714821
Dirección actual:
C/ Espronceda, 28, 2º dcha.
28003 Madrid, España
Móvil: +34. 617906078
Global Tel.: +1.248.841.4925

Formulario de Consentimiento por Escrito

Título del proyecto de investigación: La Política Sanitaria Española: Un Estudio Sobre la Descentralización de las Competencias del Estado a las Comunidades Autónomas (CC AA)

Nombre:
Dirección:
Teléfono:
Email:

Por favor marque las casillas para indicar que ha leído y que está de acuerdo con los siguientes puntos:

- ☐ He sido invitado/a a participar en esta investigación a través de una entrevista.
- ☐ He leído el documento informativo sobre este estudio (o he entendido la explicación verbal) y comprendo lo que se me pide y lo que pasará si participo en ella. Tengo una copia de este documento para conservar.
- ☐ D.ª Novinskey ha contestado a mis preguntas acerca de este estudio.
- ☐ Entiendo que, en cualquier momento, puedo retirarme de este estudio sin tener que dar ninguna explicación y sin que esto me afecte de manera alguna.
- ☐ Accedo a participar en este estudio.
- ☐ He decidido que el contenido de nuestra conversación puede ser usado en este estudio.
- ☐ He decidido que doy permiso para ser citado textualmente en este estudio.
- ☐ Sé que si surge algún problema puedo contactar a :

D.ª Christina Novinskey

Dirección permanente:
LSE Health and Social Care, J8
London School of Economics
Houghton Street
London WC2A 2AE
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Móvil. +44(0)7891714821

Dirección actual:
C/ Espronceda, 28, 2º dcha.
28003 Madrid, España
Móvil: +34. 617906078
Tel. Global: +1.248.841.4925

Firma: …….Fecha: ……

Appendix F. Excerpt from the Codebook for the Thesis, in Nvivo 9

3/26/2015 1:43 PM

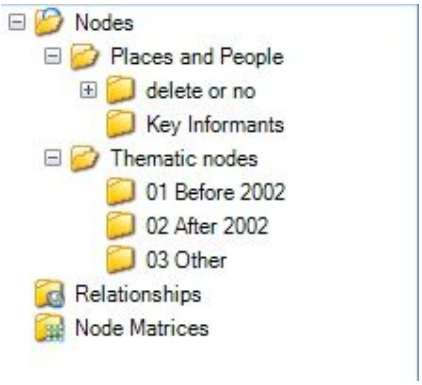
I am changing my coding today to fit better with my interview data and its use. First, I created note classification sheets for both Interviewee Attributes and Places Attributes. The places included each AACC and the Central Government, divided into National Expenditure Advocates and Guardians. Then, I made nodes for each one and mapped the interviewee nodes to the Places Nodes. I created three Node Classification Profiles: one for stakeholder interviewees (people), one for key informants (people) and one for Governments (places).

The key Informant Profile contains the following attributes:

The Actors Profile contains the following attributes:

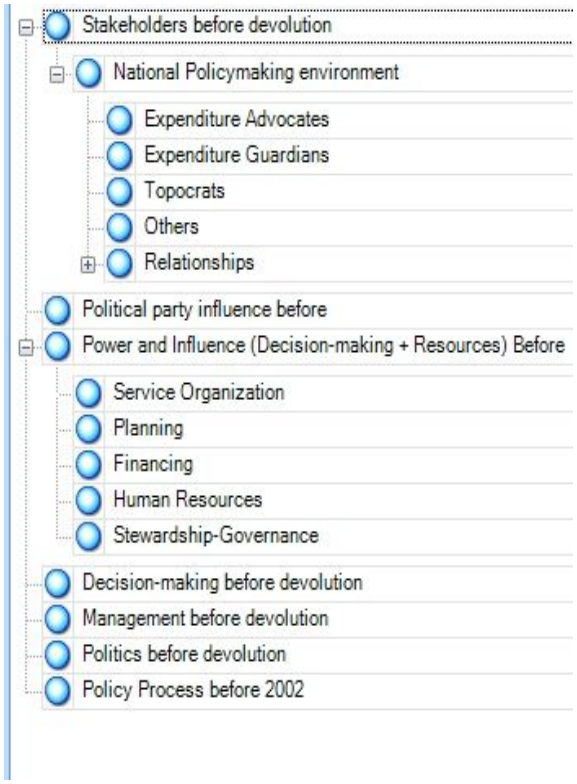
The Government Profile contains the following attributes:

Next, I sorted the Thematic Nodes into Before and After the 2001 Health Care Devolution Reform as well as Other nodes that did not depend on a timeframe. Here is a snapshot of the new node format (NB: all interviewees are under Places and People, 'delete or no' is an old categorisation that I have not decided to delete yet):



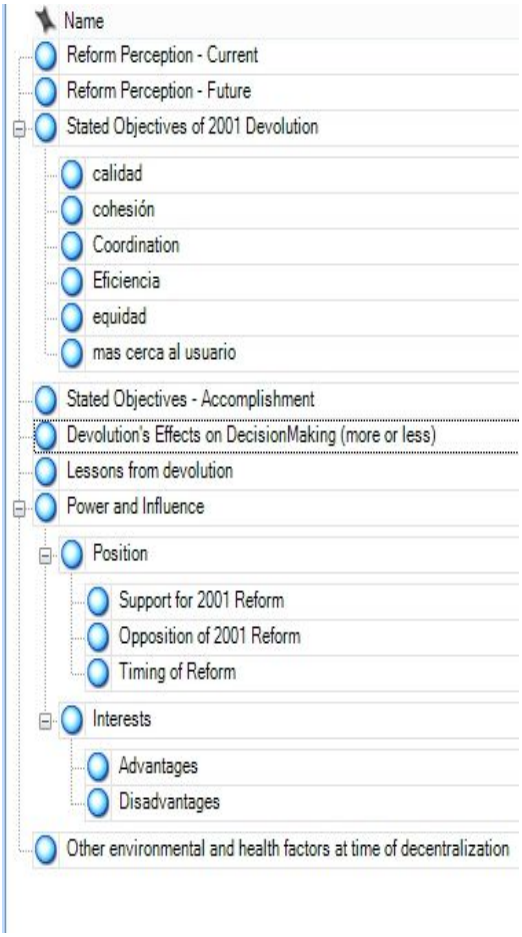
Within People and Places Folder:

In Thematic Node '01 Before 2002':



In Thematic Node '02 After 2002':

In Thematic Node '03 Other':



In nodes that became unnecessary for the analysis, I went through each already-coded reference and deleted and/or allocated the reference to a newly created node (according to the new sort).

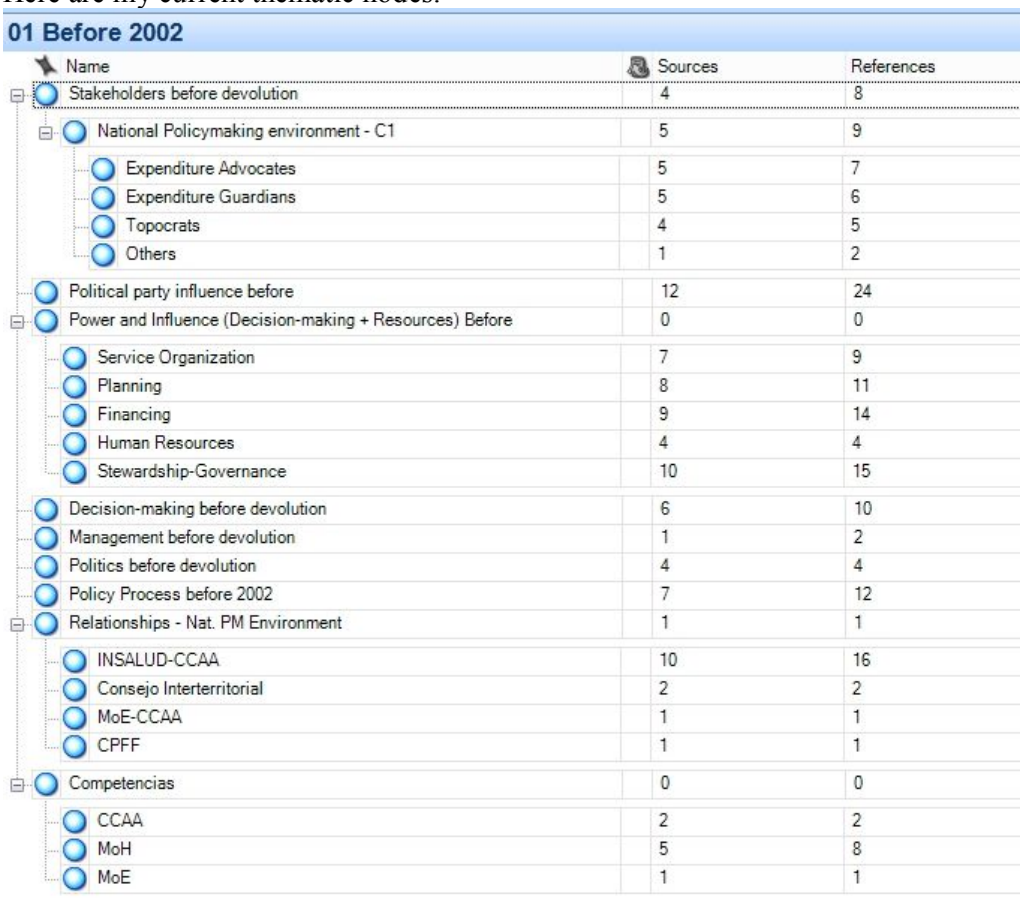
I have a feeling that some of these classifications might not work or may be superfluous. I will only see this during the next round of coding.

4/21/2015 12:20 PM

After a first round of primary coding, I am starting secondary coding and some write up of results. I am focusing on the section for validating main actors in the national and subnational policy networks. This at first has meant rearranging of old codes and adding some new ones.

I have decided that instead of having separate categories for the different actor groups that I have proposed, and an "other" category that answers to each of these questions should go to only one node. To do this, more easily with the software restraints, I will move categories that do not pertain to this question out from under the "policymaking environment" nodes and then aggregate at this level and eliminate any duplications of codes. I will use these aggregate nodes as the only node for responding to the questions about "who the main actors are before and after the reform". In addition, I have moved some previously coded items within these categories to new categories regarding the competencies of certain organisations, such as the MOH, MOE, and Autonomous Communities (AACC).

Here are my current thematic nodes:



01 Before 2002

Name	Sources	References
Stakeholders before devolution	4	8
National Policymaking environment - C1	5	9
Expenditure Advocates	5	7
Expenditure Guardians	5	6
Topocrats	4	5
Others	1	2
Political party influence before	12	24
Power and Influence (Decision-making + Resources) Before	0	0
Service Organization	7	9
Planning	8	11
Financing	9	14
Human Resources	4	4
Stewardship-Governance	10	15
Decision-making before devolution	6	10
Management before devolution	1	2
Politics before devolution	4	4
Policy Process before 2002	7	12
Relationships - Nat. PM Environment	1	1
INSALUD-CCAA	10	16
Consejo Interterritorial	2	2
MoE-CCAA	1	1
CPFF	1	1
Competencias	0	0
CCAA	2	2
MoH	5	8
MoE	1	1

02 After 2002

Name	Sources	References
Stakeholders after devolution	5	31
National Policymaking Environment - C2	8	32
Expenditure Advocates	4	5
Expenditure Guardians	3	4
Topocrats	3	8
Others	1	1
Subnational Policymaking Environment - C2	11	29
Subnat Exp Advocates	5	5
Subnat Exp Guardians	3	3
Kentrocrats	3	6
Others	1	1
Political Party Influence After	13	48
Power and Influence (Decision-making + Resources) After	2	2
Service Organization	18	67
Regulation and Planning	20	59
Financing	22	117
Human Resources	11	21
Goverance-Stewardship Rules	23	103
Decision-making after devolution	20	73
Management after devolution	7	16
Politics after devolution	11	33
Policy Process After devolution - Negotiation of health transfers	8	17
Relationships	2	2
National Policymaking Environment	0	0
Consejo Interterritorial	13	40
CPPF	4	14
MoH-MoE	2	3
Subnational Policymaking Environment	0	0
MoH-CCAA	3	5
CCAA-CCAA	6	12
Competencies	0	0
Competencias MOH	20	83
GDN - competencies	3	5
Competency CCAA	10	26
MAP	1	1

03 Other

Name	Sources	References
Reform Perception - Current	13	17
Reform Perception - Future	13	39
Stated Objectives of 2001 Devolution	30	257
calidad	9	24
cohesión	13	42
Coordination	18	75
Eficiencia	12	22
equidad - Igualdad	18	44
mas cerca al usuario	14	23
Experimentation-Innovation	6	11
Coresponsabilidad	4	8
Stated Objectives - Accomplishment	13	31
Devolution's Effects on DecisionMaking (more or less)	22	50
MoH	1	1
MoE	0	0
CCAA	1	1
Lessons from devolution	6	14
Power and Influence	0	0
Position	1	1
Interests	0	0
Other environmental and health factors at time of decentralization	4	6
Example policies	7	16
Negotiation for transfers	9	14

Appendix G. Health Expenditure and Population Coverage Data[247]

Table G.1. Public health expenditure in Spain, 1999–2003

Year	1999	2000	2001	2002	2003
Millions of euros	30.64	33.09	35.50	38.55	42.95
As a percentage of GDP	5.42	5.42	5.43	5.48	5.72
As a percentage of total public administration spending	13.48	13.57	13.72	13.72	14.45

Table G.2. Pending health debt in Spain, Extremadura and Madrid, 1999–2003

Year	1999	2000	2001	2002	2003
Pending health debts, Accumulated debt at the end of the year Thousands of euros					
Extremadura	0	0	0	14,400	40,311
Madrid	0	0	0	125,038	223,579
Total (All Regions)	2,817,304	3,271,637	3,757,946	4,355,286	6,036,233
Pending health debts, Debt contracted in each year Yearly variation					
Extremadura	-	-	-	14,400	25,911
Madrid	-	-	-	125,038	98,541
Total (All Regions)	67,633	462,974	439,450	597,340	1,680,947

Table G.3. Consolidated health expenditures in Spain, Extremadura and Madrid, 1999–2003

Year	1999	2000	2001	2002	2003
Consolidated health expenditures Thousands of current euros					
Extremadura	728,914	785,622	828,450	971,320	1,028,778
Madrid	3,411,976	3,589,472	3,899,619	4,155,492	4,606,433
Total (All Regions)	27,372,222	29,713,798	31,829,188	34,640,003	38,648,620
Consolidated health expenditures Percentage of inter-annual variation					
Extremadura		7.78	5.45	17.25	5.92
Madrid		5.20	8.64	6.56	10.85
Total (All Regions)		8.55	7.12	8.83	11.57

[247] With the 2001 health system devolution came a change in the way that health system data was reported. Because of this, it is hard to find data from before and after 2001 that are comparable. This data comes, however, from the Report for the Analysis of Health Expenditures (Ministerio de Economía y Hacienda and Ministerio de Sanidad y Consumo 2005), which worked to harmonize data from 1999-2001 with 2002 and 2003. For this reason, only these data are reported here and not data for the whole study period (1996-2006).

Table G.4. Health expenditures as a percentage of regional GDP in Spain, Extremadura and Madrid, 1999–2003

Year	**1999**	**2000**	**2001**	**2002**	**2003**
Extremadura	7.45	7.41	7.43	8.02	7.91
Madrid	3.51	3.41	3.41	3.42	3.56
Total (All Regions)	4.84	4.87	4.87	4.96	5.19

Table G.5. Population covered by the NHS in Spain, Extremadura and Madrid, 1999–2003

Year	**1999**	**2000**	**2001**	**2002**	**2003**
Population covered by the NHS					
Extremadura	1,004,837	999,343	1,002,907	1,002,061	1,002,666
Madrid	4,709,391	4,775,061	4,947,132	5,101,101	5,295,677
Total (All Regions)	37,980,437	38,281,497	38,905,395	39,618,276	40,497,751

Table G.6. Indicators for health expenditure per population in Spain, Extremadura and Madrid, 1999–2003

Health expenditure per population covered by the NHS Euros					
Extremadura	725	786	826	969	1,026
Madrid	725	752	788	815	870
Total (All Regions)	721	776	818	874	954
Average health expenditure per equivalent population covered by the NHS Seven age groups Euros					
Extremadura	712	768	801	936	988
Madrid	766	792	830	859	920
Total (All Regions)	727	781	818	874	953
Health expenditure per person / GDP per capita percentage					
Extremadura	7.96	7.93	7.95	8.59	8.47
Madrid	3.84	3.71	3.71	3.70	3.84
Total (All Regions)	5.13	5.15	5.15	5.24	5.48
Health expenditure per person / Gross disposable income per capita percentage					
Extremadura	10.58	9.89	10.62	11.63	
Madrid	6.52	5.84	6.55	6.48	
Total (All Regions)	7.84	7.51	8.06	8.20	
Health expenditure per person / Total public expenditure per person Percentage					
Extremadura	45.20	37.90	36.87	38.00	37.81
Madrid	47.55	41.04	38.62	36.72	39.87
Total (All Regions)	40.52	38.83	38.35	37.95	39.68

Appendix H. Relevant Human Resource Regulation

Table H.1. Relevant Human Resource Regulation in Extremadura, 2002–2006

Law 11/2002, 12 December, of the Presidency of the Extremadura	Completed the normative framework of the Associations and Professional Councils of Extremadura (*Colegios y de Consejos de Profesionales de Extremadura*)
Resolution, 13 September 2004, of the Minister of the Presidency	Agreed to publish the adaptation of the By-laws of the Physicians College of Cáceres to Law 11/2002 (12 December) of the Associations and Professional Councils of Extremadura
Decree 165/2004, 9 November, of the Regional Ministry of the Presidency	Constituted, by segregation, the Association of Psychologists of Extremadura
Resolution, 25 January 2005, of the Minister of the Presidency	Agreed to publish the adaptation of the By-laws of the Physicians Association of Badajoz to Law 11/2002 (12 December) of the Associations and Professional Councils of Extremadura
Resolution, 26 January 2005, of the General Directorate of Health Care Training, Inspection and Quality	Established that educational activities would be determined by the Training Programme in Health Sciences and made its first call for proposals of educational activities
Resolution, 25 February 2005, of the Management Directorate	Modified the relationship between health worker jobs and the RHS
Decree 26/2005, 9 February, of the Regional Ministry of the Presidency	Created the Council of the Extremadura Pharmacist Associations
Order, 4 March 2005	Created and regulated the composition and functioning of the Council for Specialised Training in Health Sciences
Resolution, 6 April 2005, of the General Directorate of Health Care Training, Inspection and Quality	Scheduled the 2005 activities and courses programmed for the Continuing Education Plan for the Extremadura RHS
Decree 76/2005, 12 April	Modified the ratio of workplaces to functionaries in the Extremadura RHM
Order, 27 May 2005	Requested the authorisation of financial assistance to fund 2005 training activities for health professionals
Order, 27 May 2005	Announced that financial assistance would be held for socio-health research projects for 2005
Resolution, 31 May 2005, of the General Directorate of Health Care Training, Inspection and Quality	Determined the 2005 training activities for the Extremadura Health Sciences Training Plan and made its second call for proposals of training activities

Resolution, 13 June 2005, of the Minister of the Presidency	Agreed to publish the adaptation of the By-laws of the Nurses Association of Cáceres to Law 11/2002 (12 December) of the Associations and Professional Councils of Extremadura
Resolution, 20 June 2005, of the Minister of the Presidency	Agreed to publish the adaptation of the By-laws of the Pharmacists Association of Cáceres to Law 11/2002 (12 December) of the Associations and Professional Councils of Extremadura
Resolution, 20 June 2005, of the Minister of the Presidency	Agreed to publish the adaptation of the Bylaws of the Official Pharmacists Association of Badajoz to Law 11/2002 (12 December) of the Associations and Professional Councils of Extremadura
Order, 20 June 2005	Created new categories of health professionals: Continued Care Medical Doctor (*Médico de Atención Continuada*) and Nurse (*Enfermero/a de Atención Continuada*)
Resolution, 14 July 2005, of the Minister of the Presidency	Agreed to publish the adaptation of the By-laws of the Psychologists Association of Extremadura to Law 11/2002 (12 December) of the Associations and Professional Councils of Extremadura
Resolution, 27 October 2005, of the Secretary General	Published the Resolution from the Minister of Health that entrusted the Foundation for the Training and Research of Extremadura Health Professionals (*Fundación para la Formación e Investigación de los Profesionales de Salud de Extremadura,* FUNDESALUD) with implementing the activities of the Extremadura RHM
Resolution, 27 October 2005, of the Regional Ministry of the Presidency	Approved the benefit plan called "Urgent and Emergency Health Care 1.1.2" and its public dissemination
Decree 237/2005, 9 November, of the Regional Ministry of the Presidency	Created the Council of Extremadura Physician Associations
Resolution, 28 December 2005, of the Management Directorate of the Extremadura RHS (errors corrected in Resolution, 10 January 2006)	Established the procedure for the election of posts announced with Resolution 12, May 2005, by the Management Directorate of the RHS, in the category of faculty specialist in the area of anaesthesiology and resuscitation for health centres of the Extremadura RHS
Resolution, 22 December 2005, of the Director-General of the Extremadura RHS	Modified the ratio of working posts to statutory personnel in the Extremadura RHS
Resolution, 12 December 2005, of the Minister of the Presidency	Agreed to publish the adaptation of the statutes of the Official Podiatrist Association for Extremadura to Law 11/2002, 12 December, of the Associations and Professional Councils of Extremadura

Decree 37/2006, 21 February	Regulated the personnel planning instruments of the Extremadura RHS and the structure of staffing statutory personnel
Resolution, 27 May 2006, of the General Directorate of Health Care Training, Inspection and Quality	Determined the 2006 training activities for the Extremadura Health Sciences Training Plan and made its second call for proposals of training activities
Decree 109/2006, 13 June, of the Regional Ministry of the Presidency	Approved the name change of the Association of Dentistry and Stomatology of the IX Region to the Official Association of Dentists of Extremadura
Order, 19 July 2006	Created the statutory categories of Pharmacist and Veterinary of the Primary Care Team
Resolution, 21 July 2006, of the Minister of Health	Agreed to publish the By-laws of the Council of Physician Associations of Extremadura and its legal status
Resolution, 24 July 2006, of the General Directorate of Health Care Training, Inspection and Quality	Scheduled the 2006 activities and courses programmed for the Continuing Education Plan for the Extremadura RHS
Law 4/2006, 10 October	Created the Extremadura Association of Occupational Therapists
Decree 203/2006, 28 November	Established the procedures for the integration of civil service and non–civil service personnel who provide health services in the Extremadura RHS within the regimen of statutory personnel of the health services

Sources: (Consejería de Presidencia 2004a; 2005e; 2005f; 2005h; Consejería de Presidencia 2006b; Consejería de Presidencia 2004b; 2005a; 2005b; 2005c; 2005d; 2005i; 2005j; 2006a; Consejería de Sanidad y Consumo 2005c; 2005d; 2005g; 2005h; 2005i; 2005j; 2005n; 2006e; 2006h; 2006n; Consejería de Sanidad y Consumo 2006p; Junta de Extremadura 2005; Presidencia de la Junta 2002; 2006; Servicio Extremeño de Salud 2006c; 2006b)

Table H.2. Relevant Human Resource Regulation in Madrid, 2002–2006

Decree 47/2003, 3 April, of the Governing Council	Laid out the procedure for integrating tenured medical personnel who were transferred into its health institutions[a] as part of the 2001 devolution
Resolution, 10 October 2003, of the General Technical Secretary of the Regional Ministry of Health	Delegated the competencies under Article 5, paragraph 1 of Decree 50/2001, on the proceedings before the Directorate General of Human Resources regarding the authorisation and other steps necessary for the interim coverage of job posts reserved for public officials, to the Director-Generals of the Instituto Madrileño de la Salud, Instituto de Salud Pública y de la Agencia "Pedro Laín Entralgo" for health care training, research and studies for the interim coverage of job posts in their respective institutions
Order 1380/2004, 3 November, of the Regional Ministry of Health	Convened the 2005 course of Health Care Diploma
Resolution, 22 November 2004, of the General Directorate of Human Resources	Regarding the retirement and extension of active stays of statutory staff of the Community of Madrid
Agreement, 18 February 2005, of the Council for the Monitoring of the Framework Agreement	Regulated the proposals of the reduced working hours laid out in Article 60.4 of Law 55/2003, Statutory Framework for Statutory Personnel
Agreement, 18 November 2005, of the Council for the Monitoring of the Framework Agreement	Regulated the general criteria for the professional career model of the Community of Madrid for licensed (*licenciado*) and graduate (*diplomado*) statutory (permanent) health personnel
Agreement, 21 November 2005, of the Council for the Monitoring of the Framework Agreement	Regulated the general criteria for professional promotion of statutory (permanent) personnel
Agreement of the Sectoral Round Table on Health, 24 January 2006	Regulated the selection of temporary personnel for health centres dependent on the Regional Ministry of Health
Decree 22/2006, 9 February, of the Governing Council	Regulated the process of voluntary integration of the statutory regimen of labour (non–civil service) and civil service personnel who provide health services at the Hospital Carlos III
Resolution, 14 February 2006, of the General Directorate of Human Resources	Approved the single package for the recruitment of temporary staff in the professional category of Family Doctor and SUMMA 112 Doctor in all health centres dependent on the Regional Ministry of Health
Resolution, 15 February 2006, of the General	Approved the single package for the recruitment of temporary staff in the professional category of

Directorate of Human Resources	Paediatric Primary Care Doctor in all health centres dependent on the Ministry of Health
Resolution, 9 March 2006, of the General Directorate of Human Resources	Approved the single package for the recruitment of temporary staff in the professional category of ATS/DUE of Primary Care, Specialised Care and SUMMA 112, in all health centres dependent on the Ministry of Health
Agreement, 11 May 2006, of the Governing Council	Approved the Agreement of 22 November 2005 of the Sectoral Round Table of the Staff in Health Care Institutions of the Community of Madrid regarding the various measures of the Agreement of 10 December 2004 of the Monitoring Committee of the Working-Day Agreement
Order 1436/2006, 21 July, of the Ministry of Health	Approved the Comprehensive Plan for the Sick Health Professional, for health care institutions of the Community of Madrid
Order 1806/2006, 2 October, of the Ministry of Health	Convened the 2007 course of Health Care Diploma
Agreement, 5 December 2006, reached at the Sectoral Round Table on Health, between the Regional Ministry of Health and the trade unions	Regulated the career of licensed and graduate health professionals

[a] The transfer of health care service management responsibilities also meant the transfer of approximately 132,000 civil servants from the central to the regional-level governments.
Sources: (Consejería de Sanidad y Consumo 2003b; 2004n; 2004o; 2005e; 2005o; 2005p; 2006c; 2006d; 2006f; 2006m; 2006o; Consejería de Sanidad y Consumo and Las Organizaciones Sindicales 2006; Consejo de Gobierno 2003a; 2006a; 2006b).

Appendix I. Accountability and Public Participation Regulation

Table I.1. Extremadura Health Regulation Related to Accountability and Public Participation, 2002–2006

Decree 4/2003, 14 January	Developed the legal status, structure and (independent and autonomous) functions of the Ombudsman for Patients
Order, 26 November 2003	Regulated the handling of complaints and suggestions regarding health care activities
Instruction 1/2004, 13 January	Regulated the procedure for handling claims and suggestions for the Extremadura RHS
Decree 16/2004, 26 February	Regulated the right to a second medical opinion within the Extremadura Public Health System
Decree 31/2004, 23 March	Regulated health care protection for foreigners in Extremadura and created the health care card for the Extremadura Public Health System
Decree 189/2004, 14 December; Correction of Errors, 15 January 2005	Regulated the organisational structure of the Health Areas of the Extremadura RHS as well as the composition, powers and functions of the Health Councils in the Health Areas
Order, 4 March 2005; Correction of Errors, 5 May 2005	Regulated the basic minimum set of data for speciality care
Law 1/2005, 24 June	Regulated waiting times for specialised health care in the Extremadura Public Health System
Decree 166/2005, 5 July	Approved the Health Map of Extremadura
Ley 3/2005, 8 July	Regulated health information and patient autonomy
Decree 228/2005, 27 September	Regulated the content, organisation and functions of the Registry for the Waiting List of Patients of the Extremadura Public Health System and created a personal data file for the registry

Sources: (Consejería de Sanidad y Consumo 2003a; 2003c; 2004b; 2004d; 2004e; 2004h; 2005f; 2005m; 2005l; Presidencia de la Junta de Extremadura 2005a)

Table I.2. Madrid Health Regulation Related to Accountability and Public Participation, 2002–2006

Order 605/2003, 21 April, of the Regional Ministries of the Presidency and of Health	Developed the customer service platform for the health sector; regulated the System for Handling Suggestions, Complaints and Claims for the Unique Health Network for Public Utilisation and created the Commission for the Monitoring and Evaluation of Suggestions, Complaints and Claims under the RHM
Decree 10/2004, 29 January, of the Governing Council	Guaranteed the independence and autonomy of the Ombudsman for Patients of its RHS
Decree 62/2004, 15 April, of the Governing Council	Created the Central Management Unit, Ethics Committees, the Central Commission for Monitoring and Evaluating, and the Unified Patient Registry of the Integrated Plan for the Reduction of Waiting Time for Surgery
Order 602/2004, 14 June, of the Community of Madrid	Regulated the management of the Patient Registry for the Surgery Waiting List
Order 676/2004, 24 June	Created the personal data file for the management of patients on the Surgery Waiting List, under the General Directorate of the Unique Health Network for Public Utilisation of the Madrid RHM
Order 1195/2004, 5 October	Created the personal data file for the Ombudsman for Patients of the Madrid RHM
Order 1285/2006, 22 June	Regulated the individual health card for the Community of Madrid

Sources: (Consejería de Presidencia and Consejería de Sanidad 2003; Comunidad Autónoma de Madrid 2004; Consejería de Sanidad y Consumo 2004k; 2004m; Consejo de Gobierno 2004a; 2004b)

Appendix J. Author's Implementation of von Hagen's Structural Index of the Budget Process

Table J.1. Author's Implementation of von Hagen's (1992) Structural Index (SI2) for Spain, 1991–1992 and 2004–2006

	Item 1. Structure of Negotiations within Government (Government's Preparation of the Budget)					**Item 2. Structure of Parliamentary Process** (Parliament's Enactment of the Budget)					
Indicators	**General Constraint**	**Negotiations within Government**			**Total score**	**Amendments**			**Joint vote on all GS**	**Global vote on budget**	**Total score**
		Agenda set by	**Type**	**Budget negotiations**		**Are ltd.**	**Are off-setting**	**Can cause fall of government**			
1991–1992 (von Hagen 1992)	None [0]	Cabinet [2]	General budget guidelines [4]	Cabinet [0]	**6**	Yes [4]	Yes, unless authorised otherwise by government [4][a]	No [0]	Yes [0]	After general debate [0]	**8**
2004–2006 (Author)	"Zero deficit" rule, goes beyond golden [4][b]	MOF proposes budget norms to be voted on by cabinet [3][c]	General budget guidelines plus specific "budget stability objectives" [2.66][c]	Bilateral between SMs and MOF [4]	**13.66**	Yes [4][d]	Yes [4][e]	No [0]	Yes [0]	After general debate [0]	**8**

Table J.1. Author's Implementation of von Hagen's (1992) Structural Index (SI2) for Spain, 1991–1992 and 2004–2006 (cont.)

	Item 4. Flexibility of Budget Execution (Observance of the budget during the budget year)							**Final Total Score[g]**
Indicators	**MOF can block expenditure**	**Cash limits on SMs**	**Disbursement approval[f]**	**Transfers between Chapters**	**Budget changes authorised by**	**Carry-over to next year**	**Total Score**	
1991–1992 (von Hagen 1992)	n/a [0]	n/a [0]	n/a [0]	Limited [0.8]	New law [4]	Limited [1]	**5.8**	**19.8**
2004–2006 (Author)	Yes [4][h]	No [0]	No [0]	Requires consent of MOF [1.6][i]	New law [4][j]	Limited [1][k]	**10.6**	**32.26**

[a] Von Hagen (1992, 41) reports that, for Spain during 1991–1992, amendments are off-setting; however, this is not consistent with the final table of his appendix, in which he writes that they are not off-setting. I use the figure in the text because it is also supported by Article 134 (7) of the 1978 Spanish Constitution. [b] Modification from 2001 Budget Stability Laws. [c] Modification from 2001 Budget Stability Laws and 2003 General Budget Law. [d] OECD and World Bank (2002); Verified by Spanish public finance specialist. [e] Spanish Constitution of 1978, Article 134 (7) mandates prior approval by government before passage of amendments that involve an increase in public expenditure or decrease in budget revenue. In general, amendments must be off-setting: "Standing orders of both houses [of parliament in Spain] require that all amendments that result in an increase in expenditure on one budgetary item must be presented in combination with a parallel decrease in another expenditure in the same section" (OECD 2004, 392). [f] By authority other than executive of resource ministries, e.g. minister of finance or financial comptroller. [g] Final total score is out of 60 points. [h] With extraordinary budget measures and parliament approval (von Hagen 2005a; 2005b). [i] 2003 General Budget Law: transfers between lines of appropriations (Chapters) are possible but with a series of limitations (Article 52).
[j] 2003 General Budget Law, Article 59. [k] Carry-over of appropriations are generally forbidden (Article 49 of the 2003 General Budget Law), with some exceptional circumstances (Article 58) (OECD 2004, 395). See also Hallerberg, Strauch, and von Hagen (2004, 17).

Source: von Hagen (1992), Tables A3, A6 and A8, for 1991-1992 data; author's modifications and own analysis for 2004-2006 (using legislation leading up to 2004).

Legend for Country Analyses[248]

B: Public Debt; D: Deficit; GS: Government Spending; ltd.: limited; MOF: Ministry of Finance: PM: Prime Minister; P: Parliament; SMs: Spending Ministries; Y: Nominal GDP; "Golden Rule" refers to the provision that the budget deficit must not exceed investment or capital expenditure.

Criteria used to assign values to each item indicator

Item 1:

a) General constraint: none [0], B/Y [1], B/Y and D/Y [2], G/Y or Golden Rule [3], G/Y and D/Y [4]
b) Agenda setting for budget negotiations: MOF or cabinet collects bids from SMs [0]; MOF or cabinet collects bids subject to pre-agreed guidelines [1]; cabinet decides on budget norms first [2]; MOF proposes budget norms to be voted on by cabinet [3]; MOF or PM determines budget parameters to be observed by SM [4].
c) Scope of budget norms in agenda setting: expenditure or deficit [0]; 'specific' [1.33]; 'broad' and 'specific' [2.66]; 'broad' [4].
d) Structure of negotiations: all cabinet members involved together [0]; multilateral [2]; bilateral between SMs and MOF [4].

Item 2:

a) Amendments unlimited [0]; limited [4].
b) Amendments required to be offsetting: no [0]; yes [4].
c) Amendments can cause fall of government: no [0], yes [4].
d) All expenditures passed in one vote: yes [0]; mixed [2]; votes are chapter by chapter [4].
e) Global votes on total budget size: final only [0]; initial [4].

Item 4:

a) MOF can block expenditures: no [0]; yes [4].
b) SMs subject to cash limits: no [0]; yes [4].
c) Disbursement approval required from MOF or controller: no [0]; yes [4].
d) Transfers of expenditures between chapters: unrestricted [0]; limited [0.8]; require consent of MOF [1.6]; require consent of P [2.4]; only within SMs possible [4]; only within SMs and with consent of MOF [5].
e) Changes in budget law during execution: at discretion of government [0]; by new law, which is regularly submitted during fiscal year [1]; at discretion of MOF [2]; require consent of MOF and P [3]; only by new budgetary law to be passed under the same regulations as the ordinary budget [4].
f) Carry-over of unused funds to next year: unrestricted [0]; limited [1]; limited and requires authorisation by MOF or parliament [2]; not possible [3].

[248] *Source*: von Hagen (1992) with author's modifications. In particular, there is a mismatch in von Hagen's (1992) values for indicator f) of Item 4 as explained in his criteria and as used to assess the countries. I am representing here and adopting the values that he actually used in his country assessments.

Table J.2. Author's Implementation of von Hagen's (1992) Structural Index (SI2) for Extremadura, 2004–2006

	Item 1. Structure of Negotiations within Government (Government's Preparation of the Budget)					**Item 2. Structure of Parliamentary Process** (Parliament's Enactment of the Budget)					
Indicators	**General Constraint**	**Negotiations within Government**			**Total score**	**Amendments**			**Joint vote on all GS**	**Global vote on budget**	**Total score**
		Agenda set by	**Type**	**Budget negotiations**		**Are ltd.**	**Are off-setting**	**Can cause fall of government**			
Extremadura 2004–2006	"Zero deficit" rule, goes beyond golden [4][a,d]	RFM proposes budget norms to be approved by Governing Council [3][a,e]	General Economic Policy guidelines plus specific "budget stability objectives" [2.66][a,f]	Bilateral between RSMs and RFM [4]	**13.66**	Limited [4][g]	Yes [4][a,h]	No [0][i]	Mixed [2][j]	Initial [4][k]	**14**

	Item 4. Flexibility of Budget Execution (Observance of the budget during the budget year)							**Final Total Score[c]**
Indicators	**RFM can block expenditure**	**Cash limits on RSMs**	**Disbursement approval[b]**	**Transfers between Chapters**	**Budget changes authorised by**	**Carry-over to next year**	**Total Score**	
Extremadura 2004–2006	No [0]	No [0][l]	Yes [4][m]	Require the consent of RFM [1.6][n]	New law [4][a,o]	Limited and requires authorisation by RFM [2][p]	**11.6**	**39.26**

[a] Indicators that do not change between the central government and the regions because they are set by a national budget law or the Spanish Constitution, with which the regions then comply through regional legislation. [b] By authority other than executive of resource ministries, e.g. regional minister of finance or financial comptroller. [c] Final total score is out of 60 points. [d] Modification of 2001 Budget Stability Laws, which affect all levels of administration in Spain. Compliance with this is noted in Fernandez Llera and Monasterio Escudero

(2010, 146; 2008): by 2007, all regions complied except Catalonia and Valencia. [e] Articles 9–11 of Law 3/1985 of Public Finance (Comunidad Autónoma de Extremadura 1985). Coherent with modifications of 2001 Budget Stability Laws and 2003 General Budget Law. [f] Article 41.3 of Law 3/1985 (and Article 35.1 of Law 5/2007, which states in the Exposition of Motives that this law updates in writing what has been happening in practice). Coherent with modifications of 2001 Budget Stability Laws and 2003 General Budget Law. [g] No reference to a limitation on the number of amendments in regulations of the parliament (or in Law 3/1985), but "off-setting" is considered a limitation and Article 110 states that there are limitations as to the number of days to submit an amendment, who can submit it (deputies and parliamentary groups) and the specific approval process (Asamblea de Extremadura 1983). [h] Article 125.3 of Regulations of the Parliament of Extremadura. [i] Assumption because not stated otherwise. [j] Article 126.3 of Regulations of the Parliament of Extremadura states that voting takes place according to the preference of the chairperson. [k] Article 126.1 of Regulations of the Parliament of Extremadura states that a global vote on total budget size is to occur at the beginning of the budget debate. [l] No mention in any documents of "cash limits". [m] Articles 45 and 57.1 of Law 3/1985 state that the heads of the line ministries or the Governing Council will approve disbursements. [n] Articles 54 of Law 3/1985 states that at the proposal of the various regional spending ministries (RSMs), the RFM can agree to transfer appropriations with the limitations. [o] Exposition of Motives and Article 49 of Law 3/1985 (effective until 2007). [p] The carry-over of appropriations is generally forbidden, with exceptions, over which the RFM has decision-making authority (Article 47.1 of Law 3/1985).

Source: Author's modification and analysis of the regional budget process in Spain for the situation in 2004–2006, using von Hagen's (1992) structural index 2 (Tables A3, A6 and A8) and Spanish national and regional legislation leading up to 2004.

Table J.3. Author's Implementation of von Hagen's (1992) Structural Index (SI2) for Madrid, 2004–2006

	Item 1. Structure of Negotiations within Government (Government's Preparation of the Budget)					**Item 2. Structure of Parliamentary Process** (Parliament's Enactment of the Budget)					
Indicators	**General Constraint**	**Negotiations within Government**			**Total score**	**Amendments**			**Joint vote on all GS**	**Global vote on budget**	**Total score**
		Agenda set by	**Type**	**Budget negotiations**		**Are ltd.**	**Are off-setting**	**Can cause fall of government**			
Madrid 2004–2006	"Zero deficit" rule, goes beyond golden [4][a,d]	RFM proposes budget norms to be approved by Governing Council [3][a,e]	'Broad' and plus specific "budget stability objectives" [2.66][a,f]	Bilateral between RSMs and RFM [4]	**13.66**	Limited [4][g]	Yes [4][a,h]	No [0][i]	Mixed [2][j]	After debate [0][k]	**10**

	Item 4. Flexibility of Budget Execution (Observance of the budget during the budget year)							**Final Total Score[c]**
Indicators	**RFM can block expenditure**	**Cash limits on RSMs**	**Disbursement approval[b]**	**Transfers between Chapters**	**Budget changes authorised by**	**Carry-over to next year**	**Total Score**	
Madrid 2004–2006	No [0]	No [0]	No [0]	Requires consent of RFM [1.6][l]	New law [4][a,m]	Limited with RFM approval [2][n]	**7.6**	**31.26**

[a] Indicators that do not change between the central government and the regions because they are set by a national budget law or the Spanish Constitution, with which the regions then comply through regional legislation. [b] By authority other than executive of resource ministries, e.g. Regional finance minister or financial comptroller. [c] Final total score is out of 60 points. [d] Modification of 2001 Budget Stability Laws, which affect all levels of administration in Spain. Compliance with this is noted in Fernandez Llera and Monasterio Escudero (2010, 146; 2008): by 2007, all regions complied except Catalonia and Valencia. [e] Article 48 of Law 9/1990 states that the RFM will develop the procedure for elaborating the general budgets of the community. [f] In order to be coherent with modifications of the 2001 Budget Stability Laws and 2003 General Budget Law, it would have to include these, although

Law 9/1990 does not explicitly state that it does include them. [g] Article 141 of the Regulations of the Parliament of Madrid states that there are limitations as to the number of days to submit an amendment, who can submit it (deputies and parliamentary groups) and the specific approval needed (although there is no limit on the number of amendments possible). Amendment "off-setting" is also considered a limitation. [h] Article 162.2 of the 1997 Regulations of the Parliament of Madrid. [i] This is an assumption because it is not otherwise stated in the relevant legislation. [j] Paragraph (c) of Article 164 of the 1997 Regulations of the Parliament of Madrid. [k] The law does not make any specific reference to a global vote on total budget size in the initial phase (as does the legislation for Extremadura). [l] Article 62.2 of Law 9/1990 states that the RFM may authorise transfers from the provisions contained in the global programme to any of the chapters of expenditure in the Budget, the regional ministry of finance should justify such transfers and they should be presented at a hearing of the Budget Committee. See Articles 54, 61.1, 61.2, 62.1, 62.3, 62.4 and 62.5 for more information on transfers. Article 64 states the general limitations of the above transfers. [m] Article 58 of Law 9/1990. [n] Article 56 of Law 9/1990 states that unspent appropriations will be cancelled if they do not comply with one of the exceptions to this rule established in Article 67. Article 67 states that, through the decision of the RFM, appropriations may be carried over to the next year if they are (a) extraordinary and supplementary appropriations and transfers, which were granted or authorised, respectively, in the last month of the budget year, and could not be used within that month for good reason; (b) appropriations that cover commitments made but that, for good reason, cannot be implemented during the budget year; (c) appropriations for capital operations.

Source: Author's modification and analysis of the regional budget process in Spain for the situation in 2004–2006, using von Hagen's (1992) structural index 2 (Tables A3, A6 and A8) and Spanish national and regional legislation leading up to 2004.

Legend for Regional Analyses of Extremadura and Madrid[249]

B: Public Debt; D: Deficit; GS: Government Spending; ltd.: limited; RFM: Regional Ministry (*Consejería*) of Finance; P: Parliament; RSMs: Regional Spending Ministries; Y: Nominal GDP; "Golden Rule" refers to the provision that the budget deficit must not exceed investment or capital expenditure.

Criteria used to assign values to each item indicator

Item 1:

a) General constraint: none [0], B/Y [1], B/Y and D/Y [2], G/Y or Golden Rule [3], G/Y and D/Y [4]
b) Agenda setting for budget negotiations: RFM or cabinet collects bids from RSMs [0]; RFM or cabinet collects bids subject to pre-agreed guidelines [1]; cabinet decides on budget norms first [2]; RFM proposes budget norms to be voted on by cabinet [3]; RFM or President of the Government determines budget parameters to be observed by RSM [4].
c) Scope of budget norms in agenda setting: expenditure or deficit [0]; 'specific' [1.33]; 'broad' and 'specific' [2.66]; 'broad' [4].
d) Structure of negotiations: all cabinet members involved together [0]; multilateral [2]; bilateral between RSMs and RFM [4].

Item 2:

a) Amendments: unlimited [0]; limited [4].
b) Amendments: required to be offsetting: no [0]; yes [4].
c) Amendments: can cause fall of government: no [0], yes [4].
d) All expenditures passed in one vote: yes [0]; mixed [2]; votes are chapter by chapter [4].
e) Global votes on total budget size: final only [0]; initial [4].

Item 4:

a) RFM can block expenditures: no [0]; yes [4].
b) RSMs subject to cash limits: no [0]; yes [4].
c) Disbursement approval required from RFM or controller: no [0]; yes [4].
d) Transfers of expenditures between chapters: unrestricted [0]; limited [0.8]; require consent of RFM [1.6]; require consent of P [2.4]; only within RSMs possible [4]; only within RSMs and with consent of RFM [5].
e) Changes in budget law during execution: at discretion of government [0]; by new law which is regularly submitted during fiscal year [1]; at discretion of RFM [2]; require consent of RFM and P [3]; only by new budgetary law to be passed under the same regulations as the ordinary budget [4].
f) Carry-over of unused funds to next year: unrestricted [0]; limited [1]; limited and requires authorisation by RFM or parliament [2]; not possible [3].

[249] *Source*: von Hagen (1992) with author's modifications. In particular, there is a mismatch in von Hagen's (1992) values for indicator f) of Item 4 as explained in his criteria and as used to assess the countries. I am representing here and adopting the values that he actually used in his country assessments.

Appendix K. Indices for Topocrat Strength and Health-Sector Kentrocrat Stewardship

Table K.1. Index for Topocrat Strength in the National Policymaking Environment in Spain, Before 2001 and 2004–2006

Item	Spain	
	Before 2001	**2004–2006**
1. Do the local government association exist in the country and sector of investigation? no [0]; yes, in the country only [1]; yes, in the country and sector [2].	**Yes, in the country and sector [2]** NB: Although it existed, the CISNS was weak, especially for regions without health care competencies.	**Yes, in country and sector [2]** NB: By this time, the CISNS had gained strength as a local government association in the health sector.
2. Do local government associations routinely interact with, and have exclusive and systematic access to, the central government? no [0]; yes, for routine, exclusive access only [1]; yes, for routine, systematic access only [1]; yes, for routine, exclusive and systematic access [3].	**Yes, for routine, exclusive access only [1]** NB: CISNS plenary sessions and agreements were sparse at this time and not systematic.	**Yes, for routine, exclusive and systematic access [3]**
3. How involved are local government associations in policy formulation at the national level? They are not involved at all [0]; they are consulted because of standard operating procedure only [1]; they provide some influence on policy formulation beyond standard operating procedures [3]; formal agreements and other mechanisms between them and the central government are used as an alternative to parliamentary decision-making [4].	**They are consulted because of standard operating procedures [1]** NB: This is especially true for regions without health care competencies at this time, like Extremadura and Madrid.	**They provide some influence on policy formulation beyond standard operating procedures [3]** NB: During this period, CISNS agreements were not executive but recommendations. While executive, CPFF agreements needed final approval from the parliament.
Total Score	**4**	**8**

Explanatory Note: The higher the score, the stronger the influence of the topocrat in the national health policy network.

Table K.2. Index for Stewardship Functions of Health-Sector Kentrocrats in Spain, 2004–2006

Stewardship Functions	**2004–2006**
1. Ensuring tools for implementation: powers, incentives and sanctions	
a) Do health-sector kentrocrats have sufficient funding for setting incentives and ensuring the compliance of the subnational governments on nationally-established health policies? no [0]; yes, for setting incentives only [1]; yes, for ensuring compliance only [2]; yes, for setting incentives and ensuring compliance [3].	0
b) Do health-sector kentrocrats identify, motivate and enforce subnational governments to comply with nationally-established laws and regulations? no [0]; yes, for identifying and motivating only [1]; identifying and enforcing only [2]; identifying, motivating and enforcing [3].	0
2. Ensuring accountability	
a) Do health-sector kentrocrats have sufficient accountability and public participation mechanisms in place? no [0]; some [1]; yes [2].	2
b) Are health-sector kentrocrats able to ensure that subnational governments comply with the nationally-established mechanisms for accountability? no [0]; yes, in part [1]; yes, fully [2].	2
3. Generating intelligence	
a) Have health-sector kentrocrats been able to provide subnational governments with the data and intelligence necessary to carry out their responsibilities? No [0]; yes, some necessary data and intelligence [1]; yes, all necessary data and intelligence [2].	0
b) Have health-sector kentrocrats been able to do this in a timely manner? no [0]; yes, in part [1]; yes, for all necessary data and intelligence [2].	0
4. Building partnerships	
a) Have health-sector kentrocrats built active and effective partnerships with subnational governments? no [0]; yes, for activity only [1]; yes, for activity and effectiveness [2].	1
b) Have health-sector kentrocrats sustained their activities and effectiveness in these partnerships overtime? no [0]; yes, in part [1]; yes, fully [2].	1
Total Score	**6**

Explanatory note: The higher the score, the stronger the health-sector kentrocrat.

Appendix L. Principle Health Regulations, 2001–2006

Table L.1. Principal Health Regulations of the Central Government and their Responsibilities for the Regions

Law/Article	**Regional Responsibilities**
Law 41/2002	**Patient autonomy, rights and duties on clinical information and documentation**
Article 14, Paragraph 4	*Medical Records Protection:* The regions will approve provisions ensuring that health centres will adopt adequate technical and organisational measures for archiving and protecting patient medical records and avoiding their accidental destruction or loss.
Article 16, Paragraph 7	*Access to Medical Records:* The regions will regulate procedures for access to and use of medical records.
Law 16/2003	**Cohesion and quality of the NHS**
Article 25	*Waiting time guarantees.* The regions will define the maximum waiting times for access to services in their health care benefit package.
Article 57, Paragraphs 1-5	*Individual health care card.* Citizen access to health care will be given by the NHS through an individual health care card (*tarjeta sanitaria individual*) … the MOH, in collaboration with the regions and the rest of the counterpart public administrations, will establish the requirements and necessary standards for this card. … [T]he individual health care card should be adapted, where necessary, to the standardisation established by all public administrations and within the European Union.
Article 61, Paragraph 1	*NHS quality plans.* The MOH and the competent bodies of the regions will periodically elaborate, within the CISNS, plans for NHS quality, without prejudice for regional health planning and service organisation. These plans will contain quality objectives for the relevant period.
Law 55/2003	**Framework statute of statutory professionals in the health services**
Article 40, Paragraph 1	*General criteria for the professional career.* The regions, following negotiations in the appropriate boards, will establish, for statutory staff of its health services, professional career mechanisms in accordance with what has been established in general in the norms applicable to the rest of the public services, so that the law allows the promotion of this staff together with the better management of health care institutions.
Article 41, Paragraph 4	*General criteria for remuneration.* The RHSs and their management bodies will establish the necessary mechanisms, such as management of job posts, management of fringe benefits and decoupling of teaching positions, to ensure payment for activity actually performed.

Appendix M. Waiting Time Legislation and Regulation

Table M.1. Extremadura Waiting Time Legislation and Regulation, 2004–2006

Law 1/2005, 24 June	Regulated waiting times for specialised health care in the Extremadura Public Health System
Decree 228/2005, 27 September	Regulated the content, organisation and functions of the patient registry for the waiting list of the Extremadura Public Health System and created a personal data file for the registry
Decree 132/2006, 11 July	Reduced waiting times for specific health care specialities

Sources: Presidencia de la Junta de Extremadura (2005a), Consejería de Sanidad y Consumo (2005b, 2006).

Table M.2. Madrid Waiting Time Legislation and Regulation, 2001–2006

Article 27 of Law 12/2001	Granted citizens the right to receive health services within pre-defined and known waiting periods
Resolution, 12 February 2004, of the Madrid Regional Parliament	Established that the RHM would elaborate a comprehensive plan for the management and monitoring of waiting lists
Comprehensive Plan for the Reduction of Waiting Times for Surgery, March 2004	Presented the Government of Madrid's strategy to gradually reduce the maximum waiting time for accessing elective surgical interventions to 30 business days by the end of 2005
Decree 62/2004, 15 April, of the Governing Council	Created the Central Management Unit, the Central Commission for Monitoring and Evaluation, the RULEQ, and ethics committees
Order 602/2004, 14 June, of the Community of Madrid	Regulated the management of the patient registry for the waiting list for surgery
Order 676/2004, 24 June, of the RHM	Created the personal data file for the management of patients on the surgery waiting list, under the General Directorate of the Unique Health Network for Public Utilisation of the Madrid RHM
Pact on the Programme for Motivating Professionals to Reduce the Waiting Times for Surgery, 14 October 2004	Created an incentive programme to reduce the surgery waiting list

Sources: Presidencia de la Comunidad de Madrid (2001b); Comunidad de Madrid (2004); Consejería de Sanidad y Consumo (2004a, 2004b); Consejería de Sanidad y Consumo and Organizaciones Sindicales (2004); Consejo de Gobierno (2004b); Pleno de la Asamblea de Madrid (2004).

Appendix N. Legislation on Health Benefit Package Expansions

Table N.1. Legislation on Health Benefit Package Expansions in Extremadura, 2004–2006

Legislation	Description of Content	Effect on Expenditures
Decree 16/2004, 26 February	Guaranteed its citizens the right to receive a second medical opinion within the Extremadura Public Health System on information initially received regarding diagnostic and therapeutic procedures (not to be confused with medical referrals)	Increased cost
Decree 31/2004, 23 March	Regulated health protection for foreign residents in Extremadura and created the Health Care Card in the Extremadura Public Health System. Foreign residents are offered the same level and number of rights and services as offered to its citizens	Increased cost
Decree 80/2004, with correction 19 June 2004	Established a grant programme that would permit low-income senior citizens (over age 65) who received prescriptions for specific orthoprosthesis products (including digital or analogue hearing aids, dental extractions and multifocal glasses) to pay the amount set out in the Decree's Annex I in periodic payments without interest to the financial institutions administering the grants	Increased cost (from interest payments and programme administration)
RHM Internal Circular, October 2004	Regulated the availability of the post-coitus (abortion) pill free of cost if administered in a health care or family planning centre in Extremadura. It should be noted, however, that the cost of the pill was not financed by public health care but rather a third party[a]	Cost neutral
Decree 195/2004, 19 December	Regulated free full-coverage child dental care through the Dental Health Programme for resident children age 6-14 years old and indicated how the programme would be managed (effective January 2005)	Increased cost
Law 1/2005, 24 June	Regulated patients' right to waiting time guarantees for specialised health care within the Extremadura Health System	Increased cost
Law 3/2005, 5 August	Recognised patients' right to advance care directives (Articles 17-22)	Cost neutral
Decree 6/2006	Regulated the reimbursement of expenses related to pharmaceutical products, orthoprosthesis and health services from outside the Extremadura Public Health System, including financial support for travel and subsistence expenses	Increased cost

Decree 55/2006, repealed and replaced Decree 80/2004	Expanded the benefits from Decree 80/2004 to all senior citizens and persons with a disability pension.	Increased cost (from interest and programme administration)

[a] As per central government regulation, the pill is available in all of Spain, including Extremadura, with a prescription in pharmacies and paid 100 per cent by the patient.

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