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Explaining cross-regional policy variation in decentralized states: integrating public management policy-making in new institutionalist analysis.

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Introduction

Comparative public policy research has largely benefited from the use of new institutionalist approaches. A case in point is the study of public management reform. This literature shares a research interest about the politics of public management that has translated into different research issues, such as cross-national patterns in the content of reform policies and the role of particular factors in explaining policy variation (Campbell and Halligan 1992; Hood 2000; James 2003; Knill 1999; Pollitt and Bouckaert 2000; Sahlin-Andersson 2002; Zifcak 1994). This literature provides different, though often complementary, interpretations of the emergence, development and outcome of reforms, depending on the new institutionalist branch adopted –rational choice institutionalism, sociological institutionalism and historical institutionalism (Barzelay and Gallego 2006). Most of this complex analytical effort has focused on cases that score high on public management reform initiatives, and which tend to include anglo-saxon and centre and north of Europe countries. By contrast, the study of countries considered to score low on public management reforms is not only scarce, but also tends to converge on a single argument: cultural and institutional aspects, such as administrative traditions or institutional design, explain the fate of public administration reform initiatives and, therefore, of policy outcomes. Moreover, it is argued that a commonplace feature of reform processes in these countries is the incremental nature of institutional and policy change, which gives reform lower visibility and makes it difficult to analyze with the theoretical tools at hand (Capano 2003; Ongaro 2008, 2010).

These research developments suggest at least two challenges. First, as Radaelli et al. (2012) have recently put forward, there is an explanatory pitfall involved in assuming a causality link between institutional factors and policy outcomes just because they appear repeatedly associated. They argue that such a missing explanation link needs to rely on evidence from policy variables. Taking this lead, this paper analyzes how decision-making by sub-central governments in Spain, within a similar institutional setting, leads to different policy outcomes in the same policy sector –namely, public management in the health sector. The case studies include the analysis of the health management policy trajectory in Andalusia and in Catalonia. Both regions have consistently pursued different health management models since the early 80's, but the study focuses on the past decade, when important external shocks posed new challenges

and created a new scenarios for policymaking, but such different strategies still persisted.

Second, we need to improve our understanding of incremental institutional and policy change. The three strands of new institutionalism rely on assumptions that, although different, they all reinforce the idea of stability and are ill-suited for explaining change. Change is explained not as an incremental, endogenous process, but as an abrupt shock fostered by external factors. Recent contributions provide useful theoretical tools that could help advance on these lines. Hacker (2004) and Streeck and Thelen's (2005) elaborated typologies of institutional change that, despite some variations, were based on the identification of external and internal barriers to change. Despite being useful for analytical purposes, this sort of contribution only provides help for classification of empirical examples of institutional change. As Radaelli et al. (2012) highlight, there could be an explanatory pitfall if we attributed causal arguments in the use of typologies. Mahoney and Thelen (2010) develop a theoretical model that tries to build causality arguments by linking contextual and organizational properties to types of institutional change expected. They define a combination of variables –characteristics of the political context, characteristics of targeted institutions, and typology of actors and their strategies. They argue that particular context and institutional features facilitate the emergence of particular types of agents –with their associated type of strategies- in the pursuit of particular types of institutional change.

This paper pursues this explanatory interest for a causality link. It first applies Mahoney and Thelen's (2010) theoretical model to the analysis of the incremental institutional and policy change pursued in the public management of the Catalan and Andalusian health sectors. The next section argues that this model offers a static interpretation of change instead of a dynamic explanation of why and how actors relate with both the context and the organization. Although they acknowledge that the types of agents they define are not fixed identities but roles (Mahoney and Thelen 2010, footnote 7:23), an explanation is needed as to how and why actors may shift between roles. The paper suggests how their model may be complemented with an integrative approach elaborated by Barzelay and Gallego (2006) under the label of "Institutional Processualism". This approach has developed through analytical and empirical studies over the past decade that have provided complementary and alternative explanations to public management reform in non-benchmark cases (see the 2003 Special Issue of *International Public Management Journal* 6[3]; and the 2010 Symposium Issue of

Governance 23[2]). This approach explains institutional and policy change by integrating agency, structure and context factors into an event-causation approach, through the use of social mechanisms. The concluding section highlights the main contributions of this study. The empirical data includes official documents and semi-structured interviews to over 30 key informants who either were directly involved in the processes analyzed or have privileged knowledge about it, as well as hard data on the factors relevant for our hypotheses (financing model, electoral results, etc.). We will rely on the analytical dialogue between theory and empirical data to provide a resilient interpretation of the two selected processes of institutional and policy change.

The theoretical approach: context, institutions and change actors.

According to Radaelli et al. (2012), the explanations for variations in policy outcomes across countries and policy continuity and change within countries often rely on analytically questionable arguments. Specifically, they identify four explanatory pitfalls in the use of new institutionalist interpretations: considering institutional characteristics as determinants of policy outcomes; attributing explanatory power to typologies; not including policy-level variables in the explanatory argument of policy variation; and not identifying mechanisms through which particular institutional settings lead to observed policy outcomes. As a result, they claim, some comparative public policy research tends to gather evidence of institutional variation associated with policy variation, but does not provide hindsight on causal relationship between institutional level variables and policy-level variables.

However, including policy-sector variables into that causal link involves identifying them and justifying their selection in the framework of a theoretical model. This task is complex at least for two reasons. First, analytically relevant policy-sector characteristics may not be the same across all policy sectors: for example, the private-public mix in service provision or professionals' labor market regulations may be highly relevant for explaining policy outcomes in the health policy sector, but not in the transport policy sector; similarly, the degree of concentration of private financing entities may be relevant for policy outcome in the telecommunication policy sector but not in the education policy sector. Second, policy sector-level characteristics may vary

considerably across countries and within countries: for example, professionals' labor market regulations may differ substantially between Spain and the United Kingdom (UK), but not so the public-private provision mix; or there may be more variation in both such characteristics between two Spanish regions than between Spain and the UK as whole countries.

Exploratory case studies may help identify the policy-sector characteristics that are relevant for explaining policy outcomes. On this line, this paper seeks to build explanatory arguments for variation in public management policy in the health sector in two Spanish regions –the Autonomous Communities (ACs) of Andalusia and Catalonia. While the formal design of their regional governmental institutions is similar, the health management policies they have pursued are strikingly different. Some policy-sector characteristics are similar at the regional level, such as the central state, health professionals' labor market regulation. Other policy-sector features are markedly different, such as the private-public provision mix, the number and nature of organized interest groups, and the patterns of relationship between them and the political elite.

However, when policy outcomes are experiences of institutional and/or policy change, we need to go beyond the identification of analytically relevant policy-sector features and understand why they are relevant. Policy-sector features are, by definition, structural variables with a considerable degree of stability. Thus, explaining change in such institutional/policy variables may require endogenizing the role of other, perhaps external, but more dynamic factors, such as developments in the political arena. For example, a government turnover (a dynamic context factor) may lead to redefine the political elite's interaction with professional groups (a relatively stable policy-sector factor). On this line, this paper compares the health public management policy trajectory in two contrasting cases. In Andalusia, the same political party (Spanish Workers' Socialist Party –PSOE-) has been in office since 1983, when the first Andalusian elections under democracy were held, to date. In this case, the health public management policy trajectory shows features of incremental institutional change. In Catalonia, the same Catalan nationalist party coalition (Convergence and Union –CiU-) ruled between 1981, when the first Catalan elections after the democratic transition were held, until the elections of 2003, when a governmental turnover brought to power a coalition of independentists and centre-left parties. After more than two decades of incremental institutional change, the new government fostered an institutional reform

that had been considered almost impossible to address until then, and which they finally passed as a law in 2007, under a second legislature.

Recent theoretical contributions define useful analytical tools for identifying relevant factors in the characterization of incremental institutional change. Hacker (2004) points to the nature of barriers that may impose constraints on change: barriers to internal policy conversion and barriers to authoritative policy change. The former are to be found within the organization itself, while the latter refer to external actors. As each type of barrier may be high or low, their combination results into four probable scenarios –namely, drift, conversion, revision, and replacement. Building on these insights, Streeck and Thelen (2005) conceptualize five types of gradual institutional change with transformative results: displacement, layering, drift, conversion and exhaustion, and provide a detailed characterization of the change involved in each type and the mechanisms underlying each process –defection, differential growth, deliberate neglect, redirection or reinterpretation, and depletion. These typologies will help classify empirical cases of incremental institutional or policy change, though not explain them.

To bring explanatory power to typology-based institutional change models, Mahoney and Thelen (2010) start by identifying two variable (rather than fix) components of institutions: distribution of power among actors and institutions, and degree of rule compliance. They argue that institutional change occurs when there are problems of rule interpretation and enforcement that provide actors with enough margin of *maneouvre* to apply existing rules in new ways. As Table 1 shows, they build a typology in which institutional change is influenced by the combination of two factors: the veto possibilities of those actors who support the status quo, and the level of compliance or discretion in the interpretation or enforcement of the status quo. Strong veto possibilities may lead to layering when the level of discretion is high and to drift when the level of discretion is low. Weak veto possibilities may lead to displacement when the level of discretion is high and to conversion when such a level is low. Thus, their theory of gradual institutional change relies on an interaction between features of the political context and properties of the institutions themselves. But they go a step beyond typology and argue that the causality link between both such variables is actors' behavior. These authors make the hypothesis that different types of change agents –namely, subversives, symbionts, insurrectionaries, and opportunists- and their strategies are likely to flourish in particular institutional environments. Thus, identifying change

agents has explanatory purposes: different institutional contexts facilitate or constrain the emergence of different types of change agents, who will have different interests in relation to institutional stability or change, and who will therefore develop different strategies that will lead to a particular type of institutional change (Mahoney and Thelen 2010).

Table 1. Contextual and institutional sources of change agents**.**

		Characteristics of the Targeted Institutions	
		Low Level of Discretion in Interpretation/Enforcement	High Level of Discretion in Interpretation/Enforcement
Characteristics of the Political Context	Strong Veto Possibilities	Subversives (Layering)	Parasitic Symbionts (Drift)
	Weak Veto Possibilities	Insurrectionaries (Displacement)	Opportunists (Conversion)

Source: Mahoney and Thelen 2010:28.

This model does not define types of actors as fixed identities but as roles (Mahoney and Thelen 2010:23, footnote 7), and foresees potential coalitional dynamics among actors that embody them. This prevision does not make all actors opportunists, but endogenizes actors' preferences, goals and strategies within the change processes. However, this model does not elaborate on how and why actors may change roles at a particular point in time and work for different types of institutional change. The model does consider veto possibilities and level of discretion to be variable –they may change over time for different actors-, but it does not provide insight on the mechanisms that explain actors' shifting roles as an answer to those changes.

We will argue that the causal argument for role shifting is to be found in the interaction between actors and contextual elements, that is, in the use of social mechanisms as explanatory tool (Elster 1989). Causal mechanism is defined as a "delimited class of events that alter relations between specified sets of elements in identical or closely similar way over a variety of situations" (McAdam, Tarrow, Tilly 2001:24) . Mechanisms, as theoretical constructs, suggest causal relationships between context and situation, that is, interactions among participants in the process being analysed, regardless of whether it involves a high or low-visibility institutional or policy change. Thus, we argue that empirical observations about particular empirical episodes on institutional and policy (incremental) change may identify actors' role/type as part of

the explanation for the type of change produced. However, the activation of actors' role and strategies' may be explained by causal processes, mechanisms, and context factors in the process analyzed.

Understanding change in public management policy in the Catalan health sector.

The trajectory of the health policy in Catalonia over the last two decades of the XX Century has been widely analyzed (Gallego 2000, 2001). A central aspect of this process is the configuration of a provision and management model of publicly financed health services, which differs both from the National Health System formulated by the Spanish government in the mid-eighties, and from the regional health systems defined by the rest of Autonomous Communities over the following years as a result of health policy devolution (Gallego 2003; Gallego and Subirats 2011, 2012; Gallego, Gomà, Subirats 2005). At the risk of oversimplifying, the Spanish and the regional health services are mainly organized on the bases of a public, direct provision model (with hierarchal integration of purchaser and providers). By constrast, the Catalan health system has developed an extensive, publicly funded indirect provision model (arm's length relationship between purchaser and provider), with a complex network of providers of different public and private ownership formulae.

The public providers transferred by the Spanish government to the Catalan government in 1981 amounted to over 90 per cent of primary care providers in Catalonia, but only to a third of the hospital beds at that time. Maintaining the inherited model, all those providers remained as units of a single organization, the Catalan Health Institute (ICS), which performed the roles of provider and purchaser –that is, contracting with a network of non-ICS providers. Since then, the contracted network was substantially expanded and strengthened as an explicit political option to develop the Catalan health model. By contrast, ICS did not experience formal changes in its legal nature, but external conditions (particularly relationships among contracted providers, but also the introduction of 'new public management' logic in the system) changed the ICS's situation in the health system, confining it outside the prevailing rules of the game. The evolution of the ICS fitted the Mahoney and Thelen's (2010)

category of *drift*, as small changes were mainly caused as a result of 'non-decisions' by policymakers.

The 1990 Law of Organization of Health in Catalonia (LLOSC) further weakened the ICS's role: the ICS lost its authority to contract with other complementary providers and was left only with its provider functions, while the purchasing/contracting functions were assigned to a new health authority body that would act under private management regulations –the Catalan Health Service (SCS). The LLOSC also formulated an ambiguous mandate that the ICS should disaggregate into its provider units and contract with the SCS. However, whereas the SCS was quickly set up, the ICS was not extinguished, but was left with its inherited legal nature of a Social Security management body, acting fully under an administrative law management framework. Thus, the ICS remained as an isolated exemplar of direct, public provision model in the Catalan health system: a large provider of health services, with a single legal personality, and which itself was the largest firm in Catalonia –over 35,000 workers, most of whom civil servants.

Overall, the strategy of strengthening a management model different and parallel to the ICS's, could be interpreted as *layering*, in Mahoney and Thelen's (2010) terms. The ICS lost its purchasing functions after de LLOSC, which mitigated the rest of providers' mistrust for it being both purchaser and provider. But the ICS still kept its differentiated public regulation in general and civil service and labor relations regulations in particular, with different financing mechanisms, and therefore was still seen as an opaque isle of obsolete privilege. Research has provided evidence that, over almost three decades, the Catalan political and managerial elite in the health sector had persistently criticized the ICS' management model as deeply inefficient. Some top officials interviewed argued that the administrative law tools, such as civil service and contracting regulations, constrained cost-effective and efficient management. For this reason, some of them would have preferred a radical change towards a private management framework –namely, a *displacement* in terms of Mahoney and Thelen's (2010) typology. According to numerous political and executive officials interviewed, several previous ICS's directors-managers had tried to address this issue with or without legal changes, but over two decades they had not found political support. A common interpretation of this lack of support is that CiU identified ICS as an example of Spanish centralist politics, on one hand, and of bureaucratic and obsolete management model, on the other. Those interviewees argue that CiU was not only convinced of the

impossibility to modernize or reform ICS into an efficient organization, but would have no interest in trying, just in case a public provision model could prove manageable effectively and efficiently –which would contradict the assumptions in CiU's discourse.

In this context, actors both internal and external to the ICS considered an overall reform as not worth pursuing, because it was too difficult both from a political and from a juridical point of view. They perceived high veto possibilities among external actors, such as the unions, the Treasury of the Catalan government, the contracted providers, and the local governments involved in the contracted network. Also, successive ICS's director-managers had perceived a high degree of discretion for improving management by low-visibility changes in tools and organizational practices, without a need to make formal authoritative changes. So, *why was such a change finally made through a law in 2007 that transformed the ICS from an administrative body into a Public Enterprise?*

Political context and institutional characteristics

The reformulation of the ICS's legal nature and the need to modernize its management tools had been permanent issues in the discourse of a large part of actors related to the Catalan health policy sector (politicians, managers and professionals), attracting varying degrees of attention throughout that time. However, published research also highlight that these same actors consider that such changes had not been addressed over those years because: a) from a legal point of view, it was very difficult to change regulations from a Social Security management body form to a Publicly-Owned Enterprise or to Autonomous Body forms; b) the Ministry of Economy and Finance of the Catalan government, and particularly its Intervention Unit, due to the institutional bias derived from its control role, opposed a management model that might involve ex post economic and financial control; and c) unions would probably mobilize a strong professional opposition if that proposal involved a change in labor relations. Some arguments also pointed out that a legal redefinition of the ICS required an injection of economic resources (to balance budgets) that could not be affordable by the budget of the Catalan government. *Taking into account that these arguments are based on factors that could be expected to remain stable over time, because they refer to institution-biased roles, the question is: Why these factors were not an obstacle to the passage of the 2007 ICS Law?*

The Catalan regional elections of November 2003 brought the first ideological turnover in the Catalan government since the Spanish democratic transition of the late

seventies. The nationalist, center-right party federation[1] *Convergència i Unió* (CiU) had ruled the Catalan government over 23 consecutive years, since the first regional election in 1980, and with an absolute majority between 1984 and 1995. As a result of the 2003 Catalan elections a post-electoral center-left coalition formed to add-up to an absolute majority in parliament and took office. The coalition included the Party of the Socialists of Catalonia (PSC), with 8 ministries; the independentist Republican Left of Catalonia (ERC), with 6 ministries (including the vice-prime ministry); and the eco-socialist coalition Initiative of Catalonia-Green (ICV-Verds), with two ministries.

The tripartite government promoted a different view of ICS. The PSC Minister for Health of the Catalan government, Marina Geli, made her intention explicit to address the ICS's modernization through a change in its legal nature and the improvement of its management tools and autonomy, with an aim to make it closer to the way of operating of the contracted providers, all with an aim to ensure its sustainability as a central piece of the health system. She was aware that in order to take this path, she had to gain credibility in the eyes of the Minister of Economy and its Intervention Unit. The ICS had a differentiated budget within the government's budget, a unitary structure and strict ex-ante control routines, which were considered to facilitate expenditure and deficit control by the Intervention Unit –that is, *ensuring low degree of discretion in the enforcement of spending and financial management rules*. Economy's top officials commonly thought that decentralization or ex-post controls would weaken their inspection capacity, and that this option should be avoided, as the health budget was, for structural reasons (technology costs, age structure of the population…), potentially unstoppable. Therefore, Geli had to pursue a strategy for *lowering their veto possibilities* by influencing their *perception* on the *level of compliance* of spending and financial management rules.

Geli also *weakened veto possibilities* coming from top officials within the ICS by appointing director-managers with a favourable profile. The first one was a doctor and previous top executive of the health services of the Autonomous Community of Andalusia[2]. He had a reputation for an experienced, pragmatic and strict manager, who was committed to the sustainability of the public sector through the development of

[1] CiU had been a stable coalition from 1980 to 2001 and changed its statutes to become a federation at the end of 2001.

[2] Belenes had been Director General of the Andalusian Health Service –health authority and main provider in Andalusia-, managing director of the Barcelona Municipal Institute for Health Care –main provider dependent on the City Council of Barcelona, and ICSef manager of several hospitals.

quality, efficiency, and management modernization strategies. The second one was a lawyer and the secretary of the Hospital Consortium of Catalonia, an association which had represented the interests of local governments in the health sector over the previous 20 years. His profile was associated with decentralized, public corporate health management and his explicit preference was for introducing significant changes in the ICS, such as its disaggregation into different units across the territory and the progressive incorporation of non-civil service staff.

Having been an active voice in the 'municipalist' discourse in Catalonia, Marina Geli explicitly clarified her option for getting local governments more involved in health policy making and management and for opening new channels for citizens' participation. This stance could help *weaken veto possibilities* coming both from local governments and from the contracted providers' network. The reason is that the Catalan health system's design lied on the support of major pressure groups: the Catalan Union of Hospitals (representing managerial interests from contracted providers) and the Hospital Consortium of Catalonia (representing the interests of those local governments that had management responsibilities in contracted health providers). Both had a preference for the ICS 'playing under the same rules as them', which involved disaggregating it and placing it under a private law framework. Also, both groups had strong and explicit connections with political parties in the Catalan Parliament, which made that venue a major veto point itself.

High veto possibilities came from the unions, which would fight for the preservation of professionals' acquired labor rights. Civil service and labor relations were under the jurisdiction of the Catalan Ministry of Interior, under government party ERC, which introduced a parallel venue for issue-specific negotiation within the executive.

Explaining institutional change: from layering to displacement… or conversion?

The 2007 ICS Law formally sought both an authoritative institutional change and a policy change: it transformed the ICS from an administrative body into a public enterprise with the corresponding change in the public management model. At first sight, it could be argued that this change amounted to *displacement*, and that it derived from the external shock or critical juncture created by the ideology shift in the Catalan government. Over the previous decades, the *strong veto possibilities* from a multiplicity of actors had converged on a lock-in situation combining *drift* and *layering*.

Policymakers and health policy sector actors, all external to ICS, fitted the role of *subversives*. They were interested in expanding and strengthening the contracted network and eventually forcing the ICS get revamped. Within ICS, executive levels were generally interested in institutional change, but shifted between roles in Table 1 depending on their *perception about the degree of discretion* in rule enforcement. Unions and professionals had tended to fit the *symbiont* role, defending the status quo because of mistrust that change would inevitably lead to loss of rights. However, the low-visibility adaptations that led to *drift* and *layering* had not been enough to provide the ICS with the tools necessary for its modernization. The government ideological shift boosted a new context of *low veto possibilities* where ICS internal actors, both executive and unions and professionals, could develop *opportunist* strategies. Also, this new context would have facilitated the emergence of actors playing *insurrectionary* roles which would have led to *displacement*.

However, deeper analysis of the content and enforcement of the ICS Law places this institutional and policy change closer to *conversion*. In principle, shifting from administrative body to public enterprise involves higher *degree of discretion* in rule interpretation and enforcement, which was in line with what challengers of the status quo defended. However, the existence of numerous *veto players* and the need of parliamentary consensus as a *veto point*, made it difficult for decision makers and executive officials to force *displacement*. Al the same time, defenders of the status quo, despite having the power to press for the preservation of existing rules, were unable to prevent the introduction of small modifications.

The negotiations centered on four issues: legal personality, degree of financial autonomy, (non-)civil service status of health professionals, degree of organizational unity or disaggregation. Each issue had its own veto players and veto points. First, the Ministry of Economy and Finance of the Catalan government –and its Intervention unit opposed to any loss of ex-ante financial control, so the result of the negotiation led to choose the alternative of quarterly permanent auditing, which meant an increase in the existing ICS's financial and accounting autonomy, but less than that which is usually enjoyed by public companies. Second, the negotiation with respect to the staff employment regimes and the degree of organizational unity or disaggregation of the future ICS were more complex. This process involved not only the Department of Economy and Finance and the trade unions, but also the Department of Interior (responsible for civil service regulation). An agreement was reached with the trade

unions in which the government would not change the employment civil service status of ICS's staff. There would be the possibility of contracting new staff with non-civil service status, but only in certain circumstances and as an exception. The issue of organizational unity or disaggregation of the future ICS confronted several alternatives: disaggregating the ICS into different public companies; creating a public holding company (organizations with different legal statuses); or maintaining the existing legal unity. The alternative chosen was transforming the ICS into a unitary public company, its provider units (hospitals and primary care centres) would not have independent legal personality, and the use of the ICS's premises and services for private health care would be prohibited.

For the great majority of agents interviewed, the law had a limited impact on the specific management of ICS's activity. It was seen more as a formalization of pressures for specific management improvement practices that came from the organization itself but which did not aimed to revamp it. For defenders of the status quo, the law would demonstrate that it is possible to halt some of the inertia opposed to reform through gradual improvements and, at the same time, legitimize the place of the ICS in the Catalan health system. In other words, the ICS Law introduced amendments to existing rules just to ensure that the main structures remained stable. For challengers of the status quo, this law was the first step to deeper reforms in a near future.

Understanding public management policy change in the Andalusian health sector.

This analysis begins in the year 2000, more than 15 years after the transfer of health policy competencies to the Autonomous Community of Andalusia. At that time, the Andalusian government's healthcare system was based on a model of provision that was public, direct and centralized almost exclusively to one organization: the Andalusian Health Service (SAS) (MSPSI 2010). This autonomous, administrative organization performed planning, contracting, and health service provision roles in the areas of both primary and hospital care. The SAS was under the jurisdiction of the Ministry of Health of the Andalusian government, but the role of the ministry was limited and its functions were not clearly differentiated from those of a number of SAS departments.

However, the consolidation of this model did not prevent the government from exploring the introduction of organizational innovations in their incipient form towards the end of the decade (Martín, 2003; Palomo et al. 2012). On the one hand, these innovations included individual legal personification through the creation of certain state-owned companies outside SAS, and on the other hand, punctual agreements with private entities – both for-profit and non-profit – for the provision of hospital care. In this sense, the Law on the Health of Andalusia (1998) laid the foundations for a possible – and future – separation of functions between the Department of Health and SAS. In 1999 SAS published its Strategic Plan, entitled "A differentiated proposal of public management" (Torrubia and Higuera 2011), which recommended the introduction of clinical and administrative management strategies.

Ultimately, none of these processes at the time involved structural changes in the management of the healthcare system, although they did form the basis for institutional changes put in place at the beginning of the 2000s. However, before analysing these processes, it is useful to review the characteristics of the political context and the institutional rules of the healthcare model in Andalusia towards the end of the first decade of the 2000s.

The political context and institutional characteristics

In terms of political context, the Andalusian case is characterized by the presence of only a *few veto points* and a limited number of *veto players*, although some of these are particularly powerful. On the one hand, the early transfer of healthcare competencies from the central government (in 1984) meant that the Andalusian government could start undertaking significant actions in this policy sector. Thus, the Spanish Parliament did not become a particularly relevant veto point. However, as we will discuss, this does not mean that inter-territorial dynamics should not be considered as factors explaining institutional change. On the other hand, in an Andalusian political system characterised by bipartisanship[3], the Andalusian Parliament did not become a significant veto point for the development of healthcare policies either. The continuation of the Spanish Workers' Socialist Party's (PSOE) position in government since the first autonomous elections of 1982 – occasionally with an absolute majority – resulted in healthcare

[3] The main forces are the left-wing Spanish Workers Socialist Party (PSOE) and the right-wing Popular Party (PP). The communist United Left (IU) has tended to consolidate as a third force, playing a veto role under minority government legislatures.

policy decisions that were supported by government majorities – and less by parliamentary consensus – as well as by ideological preferences.

In the Andalusian context, veto players are also limited in number, although some accumulate significant power. The structure of the health policy sector reflects, in part, historical antecedents of the transfer of competencies in 1984. During the Franco era, as well as in the first few democratic years, the development of the state healthcare structure was limited in Andalusia, and was based on an integrated, direct provision model. At that time, private actors did not exist and only religious entities offered healthcare services in the form of welfare. As a former senior politician put it "All of this conditioned the decision to establish and maintain a public system".

This development of the public healthcare sector also brought about the establishment of some particularly powerful veto players, such as unions and a governing elite linked to the regional rather than local governments. In its turn, the Ministry of Finance and Public Administration of the Andalusian government exercises a certain veto power rooted in its institutionally-biased control roles.

Finally, regarding the extent to which institutions are open to contending interpretations and variation in their enforcement (Mahoney and Thelen, 2010), health policy makers in Andalusia consider to have a high *level of discretion*, particularly – although not exclusively – in terms of public healthcare spending. However, there are contending interpretations on the degree of discretion at the level of internal management processes within health care services, since, it is argued, healthcare professionals are the ones to prescribe medication, tests or treatments.

What happened to the healthcare management model in Andalusia in the first decade of the 2000s? It is accurate to talk about institutional change? Of what kind? What were the explanatory factors and what effects did they have?

Institutional change: between conversion and layering

The Andalusian case illustrates a process of institutional change in which organizational innovations were simultaneously conceived as ways of improving and strengthening the SAS public management model. The changes in the public healthcare administration during the first decade of the 2000s were numerous and diverse[4]. Here, we will focus on changes in the structure of service provision.

[4] Such as the development of a quality strategy, a clinical management model, and a change in labour policy at SAS.

From 2000-2010, the Andalusian government maintained the model of service provision that was public, direct, and centralized to SAS, but gradually – and throughout the entire decade – a network of new hospitals with unique characteristics emerged. This was a decentralized network of High Resolution Hospitals (CHAREs), that took on the legal status of state-owned companies. The aim of these hospitals, which are smaller than SAS hospitals, was to improve access to and efficiency of the healthcare system.

Which type of institutional change did this process involve? The answer is multifaceted. On the one hand, this was a process of *conversion*, in Mahoney and Thelen's (2010) terms. The legal status of state-owned company (and the resultant regulations) had been introduced originally during the 1990s. Formally, these regulations remained unchanged, although they were interpreted and enacted in new ways (Thelen, 2003). It was decided that the CHAREs would organically depend on the Department of Health – just like the existing state-owned companies – and not on the SAS, a decision that reinforced the government's general aim of separating, at least in part, the functions of these two organizations.

The Department of Health gained greater political visibility in the general governance of the healthcare system with its planning and contracting functions, while healthcare provision was centred at SAS, state-owned companies and certain state-subsidised centres. In turn, the decision to develop the CHAREs network under the legal status of state-owned companies reflected the need to improve the efficiency of the public system. Policy makers conceived and justified this choice as an alternative to cooperation with private centres. According to a former senior politician of the Andalusian government interviewed, "We have developed CHAREs; we have demonstrated that private management is not more efficient than public management".

However, the development of this network of unique hospitals can also be explained by the conditions of the policy sector itself, interpreted as problems to be resolved: the expansion and territorial dispersion of the population with consequent difficulties in access to specialised care, high hospitalisation costs and the need to speed up diagnoses and care. From this perspective, the establishment of the CHAREs reflected a *layering* process (Mahoney and Thelen, 2010): a new type of hospital complemented the existing healthcare system. New rules were linked to existing ones, bringing substantial change to the institution but without removing the old regulations.

In fact, the Andalusian government continued to construct different types of hospitals that organically depend on SAS.

Explaining institutional change: political context, institutions and agents

As we have pointed out, the Andalusian political context, where only a few veto points exist and where the institution offers a significant amount of discretion for actors to interpret and implement rules, conditioned the development of the CHAREs network. From this perspective, we observe a *conversion* process, where the interpretation of existing institutional rules – the status of the state-owned company – involved a change in the order of the healthcare system as a whole. In fact, it is important to highlight that the new hospitals did not take on their own, separate legal personality, but rather attached themselves to existing state-owned companies.

That said, who were the agents triggering the change? Mainly, they were senior actors in the Andalusian government, including the Prime Minister and those at the highest levels in the Department of Health. Mahoney and Thelen (2010) refer to these actors as *opportunists*, mainly because they have ambiguous preferences about institutional continuity. The CHAREs network was at the same time an opportunity to reinforce – and complete – the model of direct public service provision, as well as to drive changes in the global governance of the healthcare system. At the same time, it is important to bear in mind that the concept of the state-owned company has become increasingly ambiguous since its introduction in Andalusia in the 1990s: it implies greater administrative flexibility but also allows a certain level of political control.

Thus, institutional challengers did not need to pursue *insurrectionary strategies*. In this sense, the creation of these new hospitals was not faced with any great opposition. This was because, on the one hand, certain actors who could see their interests displaced – such as the private sector – did not have sufficient *veto power*. On the other hand, in a context of an expanding economy and public expenditure – "a period of implementation of new services", according to a former senior politician from the Andalusian government – it became difficult to openly oppose the creation of new hospitals[5]. One of the few groups of actors with significant *veto power* in the healthcare system, the unions, was a defender of the status quo and a potential *symbiont*, but did

[5] It is important to bear in mind that the population of Andalusia is significantly dispersed across a large territory. In this context, the objective of the CHAREs network was presented as "no person more than 30 minutes away from a hospital".

not oppose this project on the condition that it would not change institutional rules. The process did not lead to the unionisation of healthcare workers but rather to the creation of new jobs. In addition, it was a gradual, diluted change that foresaw the construction of the hospital network spanning over the whole decade. This construction is in fact still in progress, with some projects currently halted.

Finally, it is worth noting that this process of institutional change did not evolve in isolation from other modifications. Moreover, the senior levels of the Andalusian government were not the only agents involved in these changes. During the 1990s, and before the unions gained significant veto power, global changes in SAS were explored and ruled out, such as, for example, the conversion of the organisation into a state-owned company. In that context, agents with considerable professional scope in the health arena – for example, senior politicians, but above all, managers – disguised the extent of their preferences for change, instead working within the system and adopting the role of *subversives* (Mahoney and Thelen 2010). These actors accepted the development of the CHAREs network while also driving institutional change in the health system as a whole and, more specifically, in SAS. Among these changes, the introduction of a quality strategy, a model of clinical management and a new labour policy are particularly noteworthy[6].

In short, institutional change in Andalusia was perceived by the actors involved as a process of re-legitimization of the public healthcare system in the face of a particular context. Until the year 2001, economic resources for healthcare came from a specific state subsidy that was not part of the general model of regional financing. From that year onwards, and with the transfer of healthcare competencies to the ACs that still had not taken them on, hear-marked funding for health disappeared and the corresponding resources were integrated into the AC general funding. As a result, the parliaments of each AC became responsible for deciding the percentage of resources that would be allocated to policies such as those of health[7].

[6] "Working as if SAS was a state-owned company and taking advantage of the legal weaknesses that would allow us to keep going ahead" (from an interview with a former senior politician from the Andalusian government). Healthcare managers in the Andalusian government participated actively in the development of state laws that allowed greater flexibility in public administration: the Framework Statute. for Statutory Health Service Personnel (2003), the Law of Management of Health Professions and the Law of Cohesion and Quality of the National Health System (2003).

[7] "At the time, if you wanted to legitimise the system you had to satisfy the middle class, which sustained the system with its taxes." (From an interview with a former senior politician from the Andalusian government).

In this context, during the first decade of the 2000s, the issue image of institutional change in public healthcare management in Andalusia combined the promotion of a quality, public, direct provision system with the help of political autonomy – that is, organizational innovation, ideological positioning and separation of competencies from the central government. It is crucial to remember that health policy is perceived by Andalusian policymakers as one of the policies that most influences the electorate and as an element of acceptance of a territorial identity that is historically associated with a lack of innovation and economic development.

Explaining agents' strategies: insights from process, mechanisms and event-causation.

Mahoney and Thelen's (2010) theoretical model have helped us to interpret the roles played by change actors, their strategies, and the type of institutional change that came about in the two experiences analyzed. However, there are questions that cannot be answered within their conceptual framework, for example: How do actors' preferences influence the institutionally-biased role they would presumably embody? Will their profile –namely, past experience, formative background, ideology…- lead them to play different roles in a particular institutional position or in a particular situation? Why and how may actors' shift (or not shift) between roles? How do their beliefs and actions relate to contextual factors and vice-versa? Is the degree of discretion a stable, objective variable or may it be a function of actors' perception? In sum, there is little theoretical base in this model to analyze entrepreneurial strategies.

Moreover, the empirical cases analyzed here are particulars of different institutional change types. The Catalan experience focuses on a highly visible process leading to a discrete decision, whereas the Andalusian experience focuses on a policy shift within a policy trajectory. Although both of them are instances of incremental institutional change, it is the process through which change comes about that makes them different. However, Mahoney and Thelen (2010) define conceptual categories that have allowed us to offer an analytically static picture of processes that are by definition dynamic. For this reason, there are questions we cannot answer. In the Catalan case, we

need to know: Why was the ICS reform issue included on the agenda, when over two and a half decades it had been considered not worth pursuing because of its inherent complexity? How can we explain that the alternative-specification process involved the consideration of options that had been until then disregarded as unviable? How can we explain that a decision was passed by consensus in parliament after a relatively rapid process? In the Andalusian case, we may still pose questions such as: Why did CHAREs not raise any opposition when the proposal (though limited) of introducing state-owned companies in healthcare had sparked a debate a decade before? With no apparent change in veto possibilities from actors or in the degree of discretion in rule enforcement, how can we explain the assumptions of new roles by change actors? How then was the policy problem constructed and how did the alternative specification process develop?

We argue that Mahoney and Thelen's (2010) model could be complemented and enriched by incorporating an institutional processualist approach. On this line, the questions above could be answered through the use of social mechanisms as analytical devices. Following Barzelay's (2003) classification, agency mechanisms may include attribution of opportunity, actor certification, policy entrepreneurship, or performance feedback; and mechanisms pointing to recurring causal processes among process and context may include focusing events, spillover effects, interference effects, or policy diffusion. Using mechanisms requires being attentive to the flow of events and, thus, helps integrate institutional and processual factors in the explanatory strategy (Barzelay and Gallego 2006, 2010a, 2010b). Emphasis on process means focusing on the flows of interactions among actors, the interrelation between their beliefs and actions, and their connection with the temporal context (Abbott 2001; Elster 1989). Emphasis on institutions involves being attentive to how situated interaction (human agency within particular circumstances) is influenced by stable context factors (Thelen and Steinmo 1992). By integrating both focuses, analysis may ask how situated interaction feedback upon context (Tendler 1997).

Answering research questions from an institutional processual approach would involve the definition of episodes as cases, analyzing empirical instances of policy cycle-related categories (Kingdon 1984; Baumgartner and Jones 1993), and pursuing an explanatory strategy based on analytic narratives rather than on the identification of variables (Abell 2004).

Conclusions

This analysis of the trajectory of public management policy in the health sector in two Spanish regions shows how, within similar institutional frameworks, governments may pursue divergent policy options. These case outcomes are partly explained by policy sector-specific variables that these exploratory case studies have shown to be analytically relevant: the relative weight of private and public provision, the number and characteristics of pressure groups, and their relationship with the political elite. Both Catalonia and Andalusia show opposite characteristics in all of these variables and have pursued different policy options, which would reinforce Radaelli et al.'s (2012) argument.

However, this datum by itself does not mean that policy sector characteristics are the causal link between institutional-level and policy-level variables. It is important to note that successive governments' and other actors' (in)actions have contributed to incrementally modify or intensify the characteristics of some of these variables. Thus, the main explanatory factor of the type of change that comes about is the type of strategies actors' pursue. This study confirms Mahoney and Thelen's (2010) point that the type of roles actors play and the strategies they follow are conditioned by contextual veto possibilities and by the degree of discretion in rule enforcement. However, this analysis shows that it is the perception change actors have of these two variables what influences most their entrepreneurial actions.

Therefore, institutionally-biased roles are not to be taken for granted. Instead, actors in the same institutional position may pursue different strategies depending on their perception of relevant factors. For example, an actor may try to weaken or strengthen other actors' veto possibilities depending on how they perceived them to be, or may pursue different change strategies depending on their perception of degree of discretion within the institution. This may be particularly relevant in decentralized states, such as Spain, where veto actors may be external to the immediate regional political system leading the change process. The central state government, for example, may not influence the regional change process directly, but regional change agents may build their own discourses and strategies on explicit references to the political contention about characteristics of the country's political and governmental systems.

Last, this study also shows that change actors may (un)intentionally weaken or strengthen veto possibilities of other actors, therefore paving the way for developing change strategies. Thus, Mahoney and Thelen's (2010) theoretical model would improve its causal argument by integrating a processual approach in the analysis and interpretation of cases of incremental institutional and policy change. This approach would help understand how and why actors interact with relevant situational factors in a dynamic model of entrepreneurial strategy for institutional continuity or change. At the same time, it would allow to endogenize the dynamic evolution of contextual and institutional features, instead of offering a static, non-realistic picture.

Bibliography

Abbot, A. 2001. *Times Matters. On Theory and Method*. Chicago, The University of Chicago Press.

Abell, P. 2004. "Narrative Explanation: An Alternative to Variable-Centered Explanation?" *Annual Review of Sociology* 30: 287-310.

Barzelay, M. 2003. "The process dynamics of public management policy change*", International public management journal*, 6 (3). pp. 251-402.

Barzelay, M. and Gallego, R. 2006. "From new institutionalism to institutional processualism: advancing knowledge about public management policy change", *Governance*, 19, 4, 531-557.

Barzelay, M. and Gallego, R. 2010a "The Comparative Historical Analysis of Public Management Policy Cycles in France, Italy and Spain: Symposium Introduction", *Governance* 23(2):209-224.

Barzelay, M. and Gallego, R. 2010b "The Comparative Historical Analysis of Public Management Policy Cycles in France, Italy and Spain: Symposium Conclusion", *Governance* 23(2):297-308.

Baumgartner, F. and Jones, B. 1993. *Agendas and instability in American politics*. Chicago, University of Chicago Press.

Campbell, C.; Halligan, J. 1992. *Political Leadership in an Age of Constraint: The Australian Experience.* Pittsburgh, PA: University of Pittsburgh Press.

Capano, G. 2003. "Administrative Traditions and Policy Change: When Policy Paradigms Matter. The Case of Italian Administrative Reform during the 1990s", *Public Administration* 81: 781-801.

Elster, J. 1989. *Nuts and Bolts for the Social Sciences*. Cambridge, Cambridge Univesity Press.

Gallego, R. 2000. "Introducing Purchaser/Provider Separation in the Catalan Health Administration: A budget analysis", *Public Administration*, 78(2):423-442.

Gallego, R. 2001. "La Política Sanitària Catalana: La Construcció d'un Sistema de Provisió Pluralista", Gomà, R. and Subirats, J. coord. *Govern i Polítiques Públiques a Catalunya (1980-2000),* Barcelona: Edicions Universitat de Barcelona-Servei de Publicacions Universitat Autònoma de Barcelona.

Gallego, R. 2003 "Las políticas sanitarias de las Comunidades Autónomas", in Gallego, R.; Gomà, R.; Subirats, J. eds. *Estado de Bienestar y Comunidades Autónomas*. Madrid, Tecnos-UPF.

Gallego, R. and Barzelay, M. 2010 "Public Management Policy Making in Spain: The Politics of Legislative Reform of Administrative Structures, 1991-1997", *Governance* 23(2):277-296.

Gallego, R.; Gomà, R.; Subirats, J. 2005. "Spain, from State Welfare to Regional Welfare", McEwen, N. and Moreno, L. eds. *The Territorial Politics of Welfare*. London: Routledge.

Gallego, R. and Subirats, J. 2011. "Regional welfare regimes and multilevel governance", in Guillén A.M. and M. León, eds. *The Spanish welfare state in the European context*. London: Routledge.

Gallego, R. and Subirats, J. 2012 "Spanish Regional and Welfare Systems: Policy Innovation and Multi-level Governance", *Regional and Federal Studies*, 22(3): 269-288.

Hacker, J.S. 2004 "Privatizing risk without privatizing the welfare state: The hidden politics of social policy retrenchment in the United States", *American Political Science Review*, 98(2):243-60.

Hood, C. 2000. "Paradoxes of Public-Sector Managerialism, Old Public Management, and Public Service Bargains", *International Public Management Journal* 3: 1-22.

James, O. 2003. *The Executive Agency Revolution in Whitehall: Public Interest versus Bureau-Shaping Perspectives.* Basingstoke: Palgrave.

Kingdon, J. 1984. *Agendas, Alternatives and Public Policies*. MiICSgan, Harper Collins.

Knill, C. 1999. "Explaining Cross-National Variance in Administrative Reform: Autonomous v. Instrumental Bureaucracies", *Journal of Public Policy* 19: 113-39.

Mahoney, J.; Thelen, K. ed. 2010. *Explaining institutional change. Ambiguity, Agency and Power*. New York: Cambridge University Press.

Martín, J. (2003), *Nuevas fórmulas de gestión en las organizaciones sanitarias*, Fundación Alternativas, Madrid.

MSPSI: Ministerio de Sanidad, Política Social e Igualdad, (2010), *Informe anual del Sistema Nacional de Salud 2009 - Andalucía*, available at: http://www.msc.es/organizacion/sns/planCalidadSNS/isns2009.htm

McAdam, D., Tarrow, S. and Tilly, C. 2001. *Dynamics of Contention,* Cambridge, Cambridge University Press.

Ongaro, E. 2008, "The Reform of Public Management in France, Greece, Italy, Portugal, and Spain", *International Journal of Public Sector Management*, 21:101-117.

Ongaro, E. 2010. *Public Management Reform and Modernization: Trajectories of Administrative Change in Italy, France, Greece, Portugal and Spain*. Cheltenham: Edward Elgar.

Palomo, L., Gené-Badia, J. and Rodríguez-Sendín, J. (2012), "La reforma de la atención primaria, entre el refugio del pasado y la aventura de la innovación." *Gaceta Sanitaria*. 2012;26(S):14–19.

Parlament de Catalunya. 2000. *Diari de Sessions* (30/1/2000, Sèrie C, núm. 4:30), Parlament de Catalunya, Barcelona.

Pollitt, C.; Bouckaert, G. 2000 *Public Management Reform: a Comparative Analysis.* Oxford: Oxford University Press.

Radaelli, C.; Dente, B.; Dossi, S. 2012 "Recasting Institutionalism: Institutional Analysis and Public Policy", *European Political Science*, 11:537-550.

Sahlin-Andersson 2002; Sahlin-Andersson, Kerstin. 2002. National, International, and Transnational Constructions of New Public Management. In Tom Christensen and Per Lægreid, eds., *New Public Management: The Transformation of Ideas and Practice.* Aldershot, Eng.: Ashgate.

Skocpol, T. 1984. *Vision and Method in Historical Sociology*. Cambridge, Cambridge University Press.

Streeck, W.; Thelen, K. ed. 2005. *Beyond continuity: Institutional Change in Advanced Political Economy*. Oxford: Oxford University Press.

Tendler, J. 1997. *Good Government in the Tropics*. Baltimore MD, John Hopkins University Press.

Thelen, K.; Steinmo, S. 1992. "Historical Institutionalism in Comparative Politics", Steinmo, S.; Thelen, K. and Longstreth, F. eds. *Structuring Politics: Historical Institutionalism in Comparative Analysis*. Cambridge, Cambridge University Press.

Torrubia Romero, F. and Higuera González, J. (2011), "Modelos de gestión sanitaria en Andalucía", In: Óscar David Marcenaro Gutiérrez, *Salud y Bienestar Social en Andalucía,* Fundación Pública Andaluza Centro de Estudios Andaluces, Sevilla, pp. 13-34.

Zifcak, S. 1994. *New Managerialism: Administrative Reform in Whitehall and Canberra*. Buckingham, UK: Open University Press.