Panel:
Regional political autonomy in decentralized states: Explaining policy shifts under constraints.

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Introduction

The comparative literature on federalism and decentralization has studied multi-level governance from central government perspectives, with an emphasis on the mechanisms structuring intergovernmental relations. The analysis of decision-making in decentralized states would gain insight if it focused on sub-central state units. This paper analyzes decision-making by sub-central governments, that is, how regional political autonomy is exercised under quasi- or federal constraints, specifically in welfare policies. The comparative literature on the impact of decentralization on the welfare state (Guillén and León 2011; McEwen and Moreno 2005; Rodríguez-Pose and Gill 2004), highlights Spain as an example of how political autonomy leads to the emergence of differentiated regional welfare regimes (Gallego, Gomà and Subirats 2003, 2005; Gallego and Subirats 2011a, 2011b, 2012). This paper asks why regions – namely, Autonomous Communities’ governments – in Spain have made such different policy options.

The paper analyzes a case study on a shift in public management policy in the Catalan health sector over the past decade, with a particular focus on a legislative decision that changed health management of public provision. Over almost three decades, the Catalan political and managerial elite in the health sector had explicitly considered such a change as not worth pursuing, because it was too difficult both from a political and from a juridical point of view. So, why was such a decision finally made in 2007 and through a relatively easy and quick process? We seek to understand the factors that influence decision-making by sub-central, politically autonomous governments, and how decision-makers perceive and process them within a quasi-federal state.

This type of analysis is more complex when sub-central units express a strong nationalist stand, such as the case of Catalonia. Both political discourse and scholarly analysis show competing arguments as to which factors influence regional political autonomy and, therefore, the choice of differentiated policy options by regional governments: either the economic resources available to each regional government (the territorial financing model), or the ideology of the party in office in the regional government. Thus, this paper will give a special attention to both ideological and economic factors, as well as to the particular quasi-federal institutional dynamics in Spain, and integrate them into the analysis of decision-making.

The analysis of policy making within an event causation approach provides an analytical framework useful for understanding how the static and dynamic context factors influence multilevel governance. Within this approach, Kingdon’s framework is seen as integrating both institutional and process factors into a dynamic explanation of policy cycles’ outcomes. This approach places Kingdon’s framework within a wider theoretical and methodological context to incorporate concepts from other models on policy and organizational change – such as social mechanisms (Elster 1989; McAdam, Tarrow and Tilly 2001), or the components of Baumgartner and Jones’ (1993) punctuated equilibrium model. This analytical integration is geared to interpreting policy cycles within an event causation framework (Abbott 2001, Abell 2004), which has been applied to a wide comparative research program on public management policy change under the formulation of ‘Institutional Processualism’ (Barzelay 2001, 2003; Barzelay and Fuechtner 2003; Barzelay and Jacobsen 2009; Barzelay and Gallego 2006; Barzelay and Gallego 2010a, b; Cejudo 2003; Corbett, A. 2010; Gaetani 2003; Gallego 2003a; Gallego and Barzelay 2010; Malee 2003; Mele 2010; Moynihan 2003).

This research effort has generated a pool of distinctive limited historical generalizations about public management policy making that have qualified and
enriched the existing knowledge about institutional and policy change (Barzelay 2003; Barzelay and Gallego 2010 a, b). However, this analytical approach has mainly been applied to decision-making processes involving one government level. The assessment of its explanatory potential would gain insight if it included the analysis of decision-making in decentralized states, thereby enabling an analytical connection with a wider political science literature.

The empirical data includes semi-structured interviews to over 20 key informants who either were directly involved in the process 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 these processes.

The paper first summarizes the analytical approach of this study. The following section presents analytical and empirical arguments to build the case of the reform of health public management in Catalonia between 2003 and 2007. The paper then proceeds to narrate the episode as the basis to build a further analytic explanation following event-causation and the role of social mechanisms. The paper concludes on how this approach allows us to generate research arguments on the sources and dynamics of public management reform by governments under quasi-federal constraints.

The analytical approach

The analytical approach used in this case analysis takes Kingdon as a principal reference because it provides an integrative framework of both processual and institutional factors. Summarizing Barzelay and Gallego’s (2006) interpretation, Kingdon’s framework defines the policy cycle in terms of a flow of events including three process components –agenda-setting, alternative-specification, and decision-making. Within this overall process, agenda-setting events influence alternative specification events, and both of them influence in turn decision-making events. That is, issue framing or problem definition as well as its assignment to particular actors and venues for elaboration (agenda-setting) may create expectations of policy change, which may encourage some actors to put effort to it (alternative-specification). The availability of policy alternatives in combination with a sustained or high issue status on the agenda may facilitate bringing the issue to a decision point.

In this flow of events, Kingdon sees decisions as the result of ideational effort and political interaction among numerous actors. Decision makers, media, and policy entrepreneurs interact to frame issues; experts, bureaucrats and policy entrepreneurs interact to elaborate policy alternatives; and decision makers interact to provide policy decisions. These policymaking actors inhabit distinct roles within a governmental-bureaucratic system and act across different institutional venues. They build different identities attached to them, which conditions how they perceive issues, how they interpret contextual factors, and how they respond to the flow of events (Barzelay and Gallego 2006).

This interpretation of Kingdon’s framework allows us to explain issue trajectories and case outcomes of the selected episode of policy making through the use of analytic narratives (Abell 2004). In this sense, an institutional processualist analysis may proceed through the identification of conceptual schema, which Barzelay (2003)
defines as: sources of policy entrepreneurs efforts (such as logic of appropriateness); conceptual entities of the policymaking process (agenda-setting, alternative-specification, decision-making); dynamic relations among such components (changes in issue status, pace of alternative specification); stable context factors; dynamic context factors; and mechanisms providing a dynamic linkage between context factors and the trajectory of the policymaking process. Mechanisms, as theoretical constructs, suggest causal relationships between context and situation (interactions among participants in the policymaking process being analysed). 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.

Through those schema, Institutional Processualism combines institutional and processual elements (Barzelay and Gallego 2006). 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, this approach also asks how such situated interaction feedback upon context (Tendler 1997). The resulting explanation requires appreciating contingency and causal regularities (Skocpol 1984; McAdam, Tarrow, Tilly 2001). Thus, empirical observations about the episode are explained by causal processes, mechanisms, and context factors in the policy making process.

Placing Kingdon’s framework in this wider blend of theories helps overcoming some of its limitations. As Barzelay and Gallego (2006, 2010a, 2010b) point out, Kingdon’s framework is not geared to explaining either low-visibility adaptations (Levitt and March 1990) or ongoing processes of policy change (Baumgartner and Jones 1993), but politically visible authoritative decisions made by political officials. Moreover, Baumgartner and Jones’s causal model of disequilibrium situations is based on a mechanism of conflict expansion (Schattschneider 1960) through forms of contentious politics (McAdam, Tarrow, and Tilly 2001), while most public management policy making takes place under forms of non-contentious politics. Institutional Processualism suggests that Kingdon’s framework may integrate concepts from models that have those different types of changes as explanandum. Thus, in studies of policymaking, changes in structures affecting low-visibility policymaking may be treated as explananda; organizational factors may be treated in terms of policy subsystems; cultural-ideational factors may be treated in terms of domain structure and issue image; and changes in partial equilibrium situation, structured by these factors may be treated as explananda. Thus, Kingdon’s model may explain changes in issue images, domain structures, and policy subsystems through non-contentious forms of politics (Barzelay and Gallego 2010a, 2010b).

This Institutional Processualist approach has so far been applied to the analysis of public management policymaking where the case outcome is defined as change in the institutional rules and organizational routines of government-wide administrative practice. It has generated a pool of limited historical generalizations that are claimed to be relevant to the cases so defined. In this paper, the case analysed involves change in public management policy—the content of the ICS Law placed this initiative within the public management policy domain (Barzelay 2001), albeit circumscribed to the public health sector. Whether this domain’s specific features may have any influence in
explanatory arguments that will be eventually derived, is an empirical question this paper shall address if relevant for the research arguments.

Building the case of health public management reform in Catalonia.

The trajectory of the health policy in Catalonia over the last two decades of the XX Century has been widely analyzed (Gallego 2000, 2001, 2003b). 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. At the risk of oversimplifying, the Spanish and the regional health services are organized on the bases of a public, direct provision model (with hierarchal integration of purchaser and providers), while the Catalan health system is based on a 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. Such a difference is partly understood by the distinctive health provision network that had historically developed in Catalonia over the years: a high presence of private (both profit and non-profit) and public initiatives had long preceded and proliferated at the margin of the Spanish Social Security direct provision model. The latter had originated at the end of the 1950’s under the Francoist dictatorship, and was expanded and consolidated to reach universal and free access with the 1986 General Health Law under Spanish Workers’ Socialist Party (PSOE) government.

The Catalan health system’s design lied on the support of the 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). Those contracted providers where mostly hospitals of a variety of public and private (mostly non-profit) ownership formulae, amounted to 60% of hospital beds in Catalonia, and where consolidated by the 1985 Decree creating the Hospital Network of Public Utilization (XHUP). Meanwhile, the inherited Social Security providers transferred by the Spanish government (over 95 per cent of primary care providers and the equivalent to half of the XHUP’s hospital beds) remained unchanged, within the Catalan Health Institute (ICS), which had been transferred from the Spanish to the Catalan government at the outset of devolution in the early eighties. The 1990 Law of Organization of Health in Catalonia (LLOSC) reconfigured the structure of the health administration by establishing the separation of the purchasing and provision functions. The ICS had until then performed both functions and, with this law, it lost its authority to contract with other complementary providers and was left only with its provider functions (Gallego 2000, 2001, 2003b). To assume responsibility for such purchasing/contracting functions, the LLOSC created a new public health authority body—the Catalan Health Service (SCS).

The LLOSC formulated an ambiguous mandate that the ICS disappeared through getting integrated within the SCS’s contracting structure. However, while the

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1 As a result of the devolution process, the National Health System is formed by seventeen regional health systems, which share basic features defined by the central government legislation but which may differ in service catalogues and management models.
SCS was quickly set up, acting under the private management framework with which the LLOSC had endowed it, 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 at that time the LLOSC was passed.

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, these studies 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 structural factors that, in principle, could be expected to remain stable over time, the question is: Why these factors were not an obstacle to the passage of the 2007 ICS Law that transformed the ICS into a Public Enterprise? As the actors analyzed in previous research foresaw, this 2007 law developed through one of the most complex processes among those promoted by the Health Ministry of the Catalan government over those years: it was one of the legislative initiatives that raised most controversy among different collectives as well as citizens’ responses of high resonance. To answer the question formulated, we shall organize the information collected into the theoretical model summarized in Figure 1. Understanding the mechanisms that connect contextual factors (both stable and dynamic) to the situation (actors’ interaction along the policy making process) will help us build an explanation for the outcome of the episode: a decision at a point in time that changes the public management model of the Catalan public health sector.

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 federation2 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. Ordered from highest to lowest number of seats, the coalition included the Party of the Socialists of Catalonia (PSC), the independentist Republican Left of Catalonia (ERC), and the eco-socialist coalition Initiative of Catalonia-Green (ICV-Verds), each of them representing different intensities of Catalan nationalist and leftist leanings. In accordance with the three-party government

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2 CiU had been a stable coalition from 1980 to 2001 and changed its statutes to become a federation at the end of 2001.
agreement they reached (*Pacte del Tinell Agreement*), both the Ministry of Health and the Ministry of Economy of the Catalan government went to PSC, while the Ministry of Interior (which includes the area of civil service and labor relations) went to ERC.

Figure 1. The Case of the ICS’s Law Policy Cycle (2003-07).

![Diagram of the ICS’s Law Policy Cycle](image)

**Source:** Adapted from Gallego 2003:288.

The policy cycle of the 2007 ICS Law unfolds throughout that legislative period and ends into the following one, under the edition of a second ‘tripartite’. As shown in Figure 1, the analysis of this process will have to integrate the influence of previous events (PE), which includes both the cumulative decisions that gradually built and consolidated the Catalan health provision system over the 1908s and 1990s, as well as the decisions that had been redefining the Spanish model of territorial (regional) financing since the democratic transition. The analysis will also look into how specific mechanisms channel the influence of contemporary events (CE), of later events (LE) –

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The agreement was named after the place where it was signed: a room of an emblematic XIV Century historical building in Barcelona.

PSC took office in 8 ministries, ERC in 6 (including the vice-prime ministry), and IC-V in 2.
namely, those anticipated or foreseen by the actors involved, and of related events (RE) –namely, those occurring in neighboring policy domains, on the events within the policy cycle process being studied (E). The analysis of social mechanisms (Elster 1989) connecting these events (E, PE, CE, RE, LE) will contribute to understand the factors that, from a process perspective, condition the outcomes of negotiations and decision making.

Reforming Public Management in the Catalan Health Sector

The post-electoral Pacte del Tinell agreement reached by the three parties that would form the Catalan government at the end of 2003 draw the framework for a self-defined as ‘Catalanist’ and leftist government. Overarching political priorities included the formulation of a new legal framework that would enhance political autonomy and would redefine the relation with the central state –namely, the Spanish government. Such an effort would require the elaboration and passage of a new Statute of Autonomy for Catalonia and the negotiation of a new financing model for Catalonia, whose bases would be prefigured in such a new Statute. Both projects were explicitly assumed by PSC Catalan Prime Minister, Pasqual Maragall, as governmental political priorities. The PSOE’s victory in the Spanish general elections of March 2004 generated positive expectations for the accomplishment of those projects. However, the first one opened up a three year-long controversial and complex negotiation process that led to the passage of a new Statute of Autonomy first by the Catalan Parliament, afterwards by the Spanish Parliament, and eventually by the Catalan citizenry by referendum. This process permeated all Catalan politics until the anticipated elections of November 2006.

The second project, the negotiation of a new financing model, involved an also controversial and complex negotiation process with the Spanish government that originated as embedded in the negotiation of the new Statute of Autonomy, and developed into the following legislative period, when a second tripartite was edited. The search for a better system of regional funding was expected to bring an increase in resources, particularly those allocated to health. At the end of 2001 a new model of regional financing had been approved, coinciding with the completion of the transfer of health competences to the Autonomous Communities that still had not received them (the ten regions, out of seventeen, with a lower powers ceiling). Since then, the amount of resources available to the Catalan government –and to the rest of Autonomous Communities- substantially increased, which was translated into a substantial increase in regional public spending. Academic research had repeatedly shown the fiscal deficit (difference between the taxes the region pays to the state and the budget resources it gets from it) afforded by Catalonia, together with Madrid and Balearic Islands, and kept providing evidence that such a deficit had not been reduced, but persisted despite de

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5 ‘Catalanist’ is not equivalent to ‘nationalist’: the former implies a weaker claim for a differentiated status as a political community. The use of the term ‘Catalanist’ point to the need to accomodate different preference intenities within the political parties signing the agreement.

6 The Statute of Autonomy is a quasi-constitutional text on which each Autonomous Community is built.

7 On request by the PP, 14 articles were declared unconstitutional by the Constitutional Court in a sentence that took until 2010 to come out.

8 However, the noticeable reduction of regional budgets and public spending from 2008 confirm scholars’ evidence that the increase in resources for regional budgets was more a consequence of the growing economic cycle than the effect of the 2001 new regional financing model.
2001 reform. A huge majority of Catalan politicians –CiU and the parties in the tripartite, which amounted to over 80 percent of seats-, profusely used this evidence to claim for the need to reduce this deficit, though with varying intensities.

On the leftist dimension of the Pacte del Tinell agreement, the text made an explicit political option for strengthening social policy in general, and health policy in particular, with a wide support for the modernization and sustainability of public services. The 2001 new regional financing system had established that the economic transfers for health would no longer be ear-marked, but would be merged with the rest of the regional budget. This change meant that regional governments’ decisions on health budget would more clearly reflect their own policy priorities. In fact, public spending on health by the Catalan government doubled in absolute terms between 2003 and 2010, the two legislative periods under this coalition government. Some political and top bureaucrats interviewed for this study argue that this increase shows a clear political stance in favor of publicly financed health policy. Others point that the general increase in the regional budget (not only for health) facilitated this policy option, including, as we will see below, the long-standing reform of the ICS.

Setting the agenda: Modernizing the Catalan Health Institute.

The PSC Minister for Health of the Catalan government, Marina Geli, made her first address to the Catalan Parliament one month after being appointed. She did not question the defining features of the Catalan health model build over the previous twenty-five years, and which had enjoyed a wide political support, but pointed to lines of what she termed as ‘modernization’. In particular, she mentioned her intention to strengthen public health, socio-health services, and the management improvement at the level of providers to provide better quality services to citizens, all within an overarching strategy for ‘territorialization’. 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’s participation. As for the ICS, she highlighted the need to modernize the management of all its services and increase what she saw as long standing needed investments. She expressed the need to truly understand the ICS and the non-ICS providers as pieces of the same system (a provision network under public responsibility), and address a redefinition of ICS’s organizational features and management practices in order to reinforce its provider role and ensure its sustainability. This management modernization strategy would also require, according to her, a decentralization of structures and provision processes. She called for “autonomy in management and decentralization in decision making”.

However, she pointed out that all these projects would require to strike a deal both with the Spanish government and the rest of Autonomous Communities to define a new territorial financing model, which would ensure the sustainability of both regional governments in general and of regional health systems in particular.

Only in answer to a question from a Popular Party (PP) member of parliament, did the possibility to legislate about the ICS come to the fore. The question explicitly asked whether her ministry had the intention to pass a law for the ICS. Without having apparently considered it, Geli answered: “We have to give it more autonomy and, obviously, probably, therefore, through a new, let’s say, legislative framework. There are 31,000 [sic.] workers that work at the Catalan Health Institute. It seems to me that it would be a mistake to revise the civil service [regulation] through the Health [sector].
By contrast, we do have to provide enough tools for [management] autonomy” (Parlament de Catalunya, Diari de Sessions 30/1/200, Série C, núm. 4:30). Geli also insisted that her ministry would respect the agreements signed by CiU and the majority of unions on the different regulations for ICS and non-ICS providers, but that she would search for complying with the obligation (mandated by the 1990 LLOSC) to reach a minimum common labor regulation for the whole health system (ICS and non-ICS).

Geli’s commitments were translated into effort priorities: the Decree of Health Territorial Governments was passed at the beginning of 2006 and the Law on Public Health in 2009, into the following legislature. However, the unplanned, ambiguous commitment to legislate on the ICS found an also unplanned, quick translation into specific efforts. At the outset of her mandate, Marina Geli appointed a new director-manager for the ICS –Raimon Belenes. As a doctor and previous top executive of the health services of the Autonomous Community of Andalusia, Belenes9 had a reputation for an experienced, pragmatic and strict manager, who was committed to the sustainability of the public sector through the development of quality, efficiency, and management modernization strategies. He received the mandate to draw a project for the modernization of ICS’s management –to pass a specific law on this was a political mandate to which he accommodated. 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 (the ICS was a francoist institution transferred to the Catalan government in 1981, after de democratic transition), on one hand, and of bureaucratic and obsolete management model, on the other. The ICS represented the opposite to the so called Catalan model, which was based on an indirect provision network, which was sustained and coordinated by the Catalan government, but which had mostly originated in civil society initiatives. According to several political and management officials interviewed, 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 fact, since the ICS was transferred to the Catalan government in 1981, it was seen as a huge unmanageable structure, on top of which a Director-manager was appointed by the Catalan government, but which had a fragmented and, therefore, weak political bosses: the ministries of Economy and Finance (budget allocation and control), Interior (labor relations and civil service), Health (activity and services portfolio), Universities and Research (medical research). The 1990 LLOSC mandated the extinction of the ICS –through fragmentation and its integration into the newly created SCS’s structure just as the providers of the concerted network. However, this mandated was not carried out and the ICS remained in a situation of lack of legal definition. 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.

9 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.
The tripartite government promoted a different view of ICS. Knowing she had the support of Catalan Prime Minister Maragall, 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. She was aware that in order to take this path, she had to gain the favor of the Minister of Economy. Most of the political and managerial officials interviewed for this study argued that one of the key reasons for the lack of political support for ICS reform attempts until then was the opposition by the Ministry of Economy and Finance of the Catalan government –and its Intervention unit, to any loss of ex-ante financial control. 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. Options of decentralization or ex-post controls would weaken this inspection capacity. Economy’s top officials commonly thought that this possibility should be avoided, as the health budget was, for structural reasons (technology costs, age structure of the population…), potentially unstoppable.

Geli was determined to have Economy as a collaborator instead of as an opponent and to do so she needed to gain credibility. Since the beginning of their mandates, and at Geli’s initiative, both Geli and the Minister of Economy and Finance, Antoni Castells, agreed that their highest political officials would meet monthly, so that Economy could monitor and closely follow how the ICS improved its management objectives. They also reached an agreement to clear the public debt in the area of health, meaning that a substantial part of the projected growth of the health budget would go for clearing the deferred spending –that is, spending incurred in the previous years, but on the bases of a deferred payment. Moreover, both Geli and Castells set up a Commission for the Reform of the Financing of Health in 2005, composed of experts with explicit different stances and gave them the mandate to come up with specific proposals for guaranteeing the sustainability of the health system10.

Specifying alternatives: Transforming the Catalan Health Institute into a public company.

On the ICS’s side, Belenes knew that most reports and studies carried out by previous ICS top directive teams had been elaborated without the participation of Economy. For this reason, Belenes met in two occasions with the Ministry of Economy and with the head of the Intervention Unit to explain them the project. Belenes specifically committed to provide evidence that ICS management could be efficient and would reduce deficit over the following years. He revised the studies elaborated over the previous years, which included several reports by the consulting firm McKinsey, as well as several initiatives of management improvement and modernization that had been developed by the previous director-manager team under the last CiU government. Those initiatives had included reports on strategy, communication, training, and the implementation of a new remuneration and career model, as well as two 2001 decrees

on debureaucratization. Apart from a legal report that Belenes commissioned to an administrative law professor, all works were elaborated within the advisory law units of both the ICS and the Health Ministry itself. He prepared a first draft of the project and got approval from Geli. Then, over two years, Belenes himself discussed the different options about legal forms available for framing the new ICS with other government departments, political parties and the trade unions.

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. The negotiations concerning the ICS legal personality progressed relatively quickly. Minister Geli aimed to maintain the ICS’s public ownership and suggested to transform it into a public company. Belenes and the ICS’s team studied the different alternatives for legal status and supported that option. Other alternatives were discarded for different reasons. For example, the idea of a state society was dismissed because it would require links to state legislation. The alternative of creating an anonymous society using public capital was rejected, in order to limit the debate on the issue of privatization. For most of the agents interviewed, it was a debate on a technical aspect on which there was consensus. However, from the beginning of the negotiation process top political officials had considered the possibility of creating a sui generis public company; in other words, limiting the degree of its financial autonomy and designing a unique employment regime.

The negotiation on that second issue, degree of the future ICS’s financial autonomy, was conditioned by the historical opposition of the Intervention Unit of the Catalan Ministry of Economy and Finance. The ICS operated with ex-ante financial intervention (lower level of autonomy), but had gradually incorporated (in certain aspects) permanent financial auditing (medium level of autonomy) with monthly or quarterly auditing. There was a third alternative: ex post control (highest degree of autonomy), usual in a public company. According to the officials involved, the collaboration set up between the ministries of Health and Economy on the basis of their monthly monitoring meetings had built some degree of trust on the ICS’s capacity for efficient management. The position of the heads of Economy and of its Intervention Unit was to favor greater autonomy while demanding direct responsibility: permanent auditing was preferred to ex-post auditing, even though the latter was more agile. Trade unions preferred the ICS remained within the previous administrative framework of control: “It’s a question of ideology” (interview with a former trade union representative). According to some management team members of ICS, some within ICS itself also preferred the existing model, as it placed responsibility on the controller (Inspection Unit within the Ministry of Economy). 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.

While the negotiation process was relatively fast for the two issues described, the negotiation with respect to the staff employment regimes and the degree of organizational unity or disaggregation of the future ICS was slower and 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 public employees regulation), which was in the hands of another of the governing coalition parties: ERC. Top political officials interviewed agreed that this negotiation was marked by ideological positioning and a turbulent context among the medical profession. In fact, nine days before the bill was sent to parliament, the Union of Doctors of Catalonia, the largest Catalan union of the medical profession, announced a five-day strike they held at
the end of March 2006, and two months later they called for a new strike that was eventually cancelled. They protested against what they considered to be unsustainable working conditions for medical professionals and against the differences between such conditions in the contracted providers and in the ICS.

With this background, the bill went to parliament at the beginning of April 2006. Even though the initial agreements progressed well, such as the conservation of the workers civil service statute, the bill decayed in July 2006, as a result of the anticipated call for the elections. The reason came from the macro political scenario: after the new Statute of Autonomy was passed in September 2005 by the Catalan Parliament, it went into the Spanish Parliament, which considerably reduced its nationalist and financing claims and passed it in March 2006. ERC considered that revision as unacceptable and called for a ‘NO’ to the Statute in the coming referendum in Catalonia. Prime Minister Maragall expelled ERC from the coalition government and called for elections after the referendum. The elections held in November gave a victory to CiU, both in the percentage of votes and the number of seats[11]; but the three parties of the previous government (PSC, ERC and IC-V) agreed the re-edition of a central-left government (Govern de Entesa)[12].

Decision making: passing the 2007 Catalan Health Institute Law.

The new PSC Prime Minister, José Montilla, supported the continuity of the ICS law negotiation process: “The Prime Minister wanted the [new] law but he wanted social peace and maximum political consensus” (interview with former senior politician of the Catalan government). For their part, Geli and Castells were reappointed as ministers of Health and Economy and Finance respectively. However, a significant change was the replacement of Raimon Belenes by Francesc José María as director-manager of the ICS. José María 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 (Gallego 2001). His profile was associated with decentralized, public corporate health management. His explicit desire was to introduce significant changes in the ICS, such as its disaggregation into different units across the territory and the progressive incorporation of non-civil service staff. So, with the consent of Geli, the bill was quickly sent to parliament again, and José María took on the task of negotiating with the political parties and trade unions and the process speeded up[13].

With the issues of legal personality and the degree of financial autonomy of the future ICS practically defined over the previous legislative period, negotiations centered on the degree of organizational unity or disaggregation of the future ICS, and on the (non-)civil service status of its staff. Concerning the latter issue, there were two alternatives. CiU and the PP wanted a progressive reduction in the number of civil service staff. The trade unions, together with the ERC and IC-V, supported the continuation of the civil service employment regime. Within the PSC there were mixed

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[11] CiU obtained 31.5% (with 48 members) and the PSC 26.8 % (37).
[12] This situation caused tension in the political arena among those who considered CiU to be the legitimate winners and those who considered the legitimate governors to be the three-party coalition. Moreover, CiU interpreted that term of office as being the last and prepared to return to power.
[13] “It was necessary to pass the law quickly because when you get into the second half of the term of office everyone starts to think about the elections and then you can’t get it through.” (Interview with a former senior politician of the Catalan government).
opinions. Finally, 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 agents interviewed highlight as key points in the negotiations of this issue the need for ‘social peace’, the initial position of Minister Geli, the difficulty of managing a public company with staff employed under two different systems (civil service and labor market contracts) and, finally, and the recall of the medical strike of 2006.

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. Within the government, and even within the PSC, there were different opinions. Some of the leaders (including the ICS’s director-manager José Maria) preferred disaggregation, whereas others (such as Minister Geli) favored decentralization (territorial and in terms of decision-making) and were less in favor of the creation of a holding company. The heads of the Department of Economy and Finance (and of its Intervention Unit) did not trust the disaggregation option since they saw the possibility of increased public spending without prior control as a danger. Also the Department of Interior (under ERC) opposed disaggregation, but in this case because of the party position (and its main advisors on health matters) in favor of maintaining legal unity and a clearly public, direct provision of health services.

Within the parliamentary opposition, CiU also expressed mixed opinions with respect to this issue. A significant sector defended the disaggregation option, a position that was shared with the College of Physicians of Barcelona, which encouraged the establishment of companies managed by the health service professionals themselves. The alternative of formally introducing public-private collaboration in order that the unused capacity of the ICS could be used by private companies was even contemplated. However, another significant sector of CiU opposed such proposals, interpreting them as a possible scenario for competition between the public and private sectors where it was not clear which would benefit. Paradoxically, and for different ideological reasons, IC-V and ERC were in agreement with this last sector of CiU in their opposition to the disaggregation and use of the unused capacity of the ICS. Thus, the alternative chosen was transforming the ICS into a unitary public company, its provider units (hospitals and primary care centers) would not have independent legal personality, and the use of the ICS’s premises and services for private health care would be prohibited.

The Law for the Creation of the Public Company Catalan Health Institute was passed by consensus in July 2007, with a vote in favor by the main opposition party (CiU), among others. The agents interviewed agreed that it would have been difficult for CiU to pass a similar law if they had been in power and in a context of economic recession. The characteristics of the law did not satisfy CiU, which wanted to see the introduction of non-civil service status for staff and organizational disaggregation. But the party heads (and also their health advisors) saw the law as an opportunity and a first step that would open the door to further reforming the ICS—a reform that could continue in what they saw as a near future, with CiU once again ruling the Catalan government, if opinion polls were to be right.

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14 For example, establishing agreements for the use of ICS’s health resources. This alternative was considered by the director of the ICS.

15 CiU was not only the party that received the greatest number of votes and MPs in the 2006 elections but the exit polls also showed a significant difference form the PSC (CEO, 2013).
The passing of the law by consensus was also interpreted from an opposite view – a lock in against deeper changes. 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 change pressures that came from the organization itself. The law would demonstrate that it is possible to halt some of the inertia opposed to reform through gradual improvements and, above all, it legitimized the place of the ICS in the Catalan health model.

From 2010 the political map of Catalonia and Spain changed significantly. First, CiU won the 2010 Catalan elections and returned to office though with a minority government. CiU also won the municipal elections in 2011, gaining municipal areas that had historically been governed by PSC (including the city of Barcelona). Finally, at the end of 2011, the Popular Party won the Spanish general elections with an absolute majority, after two legislatures (since 2004) under government by the PSOE. All of this happened in a context of economic recession and profound political discontent.

Among the first measures of the CiU government were the “omnibus” laws of 2011; that is, the simultaneous modification of a large number of previous laws, among them the ICS law. With only the support of the PP in the Catalan parliament, CiU modified significant aspects of it: the ICS provision units may opt out to have independent legal personality, opening the door to disaggregation; ICS’s premises might be used for private health care; and the possibility of contracting non-civil service status staff ceased to be restricted to exceptional circumstances.

These measures were taken in a context of social conflict, a reduction of the Catalan health budget of approximately 7% in 2011 and 5% in 2012 (MSSSI, 2012). This is a scenario that most of the agents interviewed saw as an ideological rupture in the social and political consensus (in particular between CiU and the PSC) on the health management model – a model valued for its apparent flexibility, but questioned for its “lack of oxygenation” (Interview with a former senior politician in the Catalan government).

Explaining public management policy reform in the Catalan health sector

How can we explain the inclusion on the agenda of the ICS’s reform? As we have seen, there was an apparent consensus on the structural reasons that had hindered inclusion on the agenda over the previous two and a half decades. The lack of CiU’s governments political support to successive ICS’s directive teams’ initiatives for modernizing management had been justified on the basis of stable contextual factors: juridical complexity, unions’ opposition to changes in workers’ civil service status, opposition from the Catalan Ministry of Economy and Finance to ex-post auditing, and lack of resources for clearing debt before re-launching it as a public company. However, in CiU’s political discourse, those factors were explicitly related to the issue image that the ICS was an obsolete, unmanageable organization, which represented the opposite provision model that had developed and consolidated over the previous two decades in Catalonia. CiU was convinced that efforts to reform or modernize the ICS were doomed to failure. Moreover, in their discourse, the ICS’s management and organization model

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16 See CEO (2013).
17 See, for example, Rico (2012).
were considered as a reminiscence of Francoist centralist politics across the territory. CiU’s preference was for disaggregating it into a contracted network of autonomous provider units with a diversity of juridical regimes. In sum, ICS’s reform *issue image* was defined within the public management policy domain and within a potential contentious politics arena because it was explicitly linked to controversy about the territorial organization of power in Spain.

The ideology shift of the 2003 government transition in Catalonia helped activate the mechanism of *attribution of opportunity* on several fronts, leading numerous actors to believe that efforts might eventuate in policy changes. The impact of that mechanism was strongly reinforced by several factors. First, a *focusing event* in the political stream –namely, the victory of the PSC ‘brother-party’ PSOE at the central government level- created positive expectations on Spain-Catalonia relationships. Second, a sensible increase in the regional budget had *spillover effects* on many policy domains, including health policy. That budget increase had resulted from a change in the macro-economic policy domain, with the passage of the 2001 new territorial financing system-, and the upward economic cycle. As a leftist leader of the ‘municipalist’ movement, and with a prospective generous budget, Catalan Health Minister Marina Gélí’s priorities may be interpreted under the *logic of appropriateness*: she should promote the modernization and sustainability of public healthcare, but she should do it through enhancing the political role of local governments in health policy-making and management. She explicitly defined non-contentious policy aims at the outset of her mandate: consolidating the structural features of the Catalan provision system, promoting public health better regulation, promoting service quality, and modernizing ICS’s management, all under the general umbrella of territorialization.

By appointing Belenes as director-manager of the ICS, Gélí *certified* him as an *actor*, on the basis of his managerial reputation. In contrast to previous ministers, Gélí’s political support for a legal-managerial reform was explicit when she commissioned the project to Belenes. The message was clear and involved a redefinition of the *issue image*: legal changes could be defined and promoted from within the ICS itself, and modernization was necessary –and viable- to ensure the ICS’s sustainability within the Catalan health system. Both Gélí and Belenes defined the ICS modernization as a public management *issue*, conceptually and processually distinct from other issues and initiatives promoted by the Catalan Health Ministry that fell under other policy domains. Thus, the elaboration and passage of the 2006 Decree on Health Territorial Governments in the territorial policy domain, and the elaboration and passage of the 2009 Public Health Law in the health policy domain, would have, if any, positive *spillover effects* on the public management policy cycle of the ICS’s Law. If the ICS’s Law was to be eventually passed, it would be conceived as a reinforcing piece of the government program, but its development should not interfere with the other two main pieces of regulation.

*How can we explain that the alternative-specification process involved the consideration of options that had been until then disregarded as unviable and too complex?* Both Health Minister Gélí and ICS’s director-manager Belenes were aware that the health public management *policy subsystem* was highly fragmented among the Departments of Health, Economy and Finance and its Intervention Unit, Interior, and the ICS itself. The *policy learning* mechanism made them interpret such a fragmentation as one of the main obstacles for negotiation over the previous years. Thus, both Gélí and Belenes consciously took actions to bridge distances and promote cooperation for building trust –for example, through regular control and report meetings between top officials of Health and Economy, including an agreement to gradually clear the health
budget debt. A positive interference effect to allow for this agreement came from the increase in the regional budget.

The effort to provide evidence of management improvement was initially decoupled from the law drafting efforts by the ICS’s directive team, in order to show political will to pursue real change—rather than just the symbolic act of passing a law. Such efforts allowed for regular performance feedback on the ICS’s financial management improvement, which helped the Ministry of Economy and Finance accept the alternative of an increase in the degree of financial autonomy. At this point, the logic of appropriateness did not lead to the persistent institutional bias of previous years that had led Economy to oppose any increase in ex-post control.

The pace of specifying alternatives was fast, partly because of the professional commitment of the actor certified for specifying alternatives—namely, the ICS’ director-manager—and by the frequent contact between the minister of health and the ICS’s director-manager, which provided a sense of political support to the actors certified for specifying alternatives. This helps understand why even though legislating on the ICS was not a priority for the Minister of Health, the issue status of that initiative scaled positions in her agenda and the policy subsystem built momentum for a decision.

How can we explain that a decision was passed by consensus in parliament after a relatively rapid process, when over two and a half decades it had been considered not worth pursuing because of its inherent complexity? The bill had decayed as a result of the advanced end of the legislature in 2006, therefore, the mechanism of actor certification by which the ministers of Economy and Health were ratified in their posts involved approval of their previous initiatives and helped speeding up the process. The appointment by Geli of a new ICS’s director-manager, with a more pro-municipalist profile and pro-public corporation profile, activated the mechanism of actor certification: the change signaled a clearer political commitment for reform.

However the new Prime Minister overarching mandate to preserve social peace called for concessions and negotiation. The alternative chosen of a sui generis public company legal personality and a single unitary structure gathered consensus on the bases of providing legal exceptions: avoiding links to central government legislation, avoiding a potentially controversial debate on privatization, and protecting workers’ civil-service status. The mechanism activated here was attribution of opportunity by all actors involved: some interpreted this design as the protection and consolidation of the ICS’s strength within the Catalan health system, and others considered this effort as a first step to further changes.

Conclusions

The nature and scope of regional political autonomy in Spain is a permanent issue in the political discourse and academic analysis about decision-making, with an emphasis on the factors that condition regional governments’ policymaking—particularly in policy sectors, such as healthcare, which were transferred as exclusive competencies to the Autonomous Communities. The exploratory case presented in this paper shows how decision-makers in regional governments refer to such factors when justifying their preferences, (in-)actions, and policy choices. However, it also shows that such factors—namely, the territorial financing system, inherited structures in the policy sector, institutional bias-based roles, or political party coincidence on regional and central governments—do not always exert the same sort of influence on their decision-making.
capacity. Instead, the influence of stable and dynamic contextual factors changes over time, depending on how actors interpret them and take action accordingly.

This case study reinforces some research arguments already formulated by comparative research on the politics of public management policy making, particularly within the institutional processualist framework (Barzelay 2003; Barzelay and Gallego 2010b). First, in a decentralized state such as Spain, public management reform may be intertwined with political controversy about public governance—that is, about the territorial organization of political authority and the consequent relation between central and regional governments. Thus, while the multiple streams framework would suggest that the political stream factors influencing the politics of public management reform are public mood, bases of partisan competition, and turnover, this approach includes political contention about characteristics of the country’s political and governmental systems. Second, such an influence may be channeled into the framing of public management issues and into the alternatives they consider for negotiation and eventual choice. As the case analyzed here shows, actors’ perceptions of multilevel governance dynamics led them make explicit arguments for or against reform in general, or of specific alternatives, on the bases of potential links to Spanish politics and authority structures.

Third, agenda-setters tend to be within the executive and their political will and actions are of pivotal influence for issue inclusion on the agenda. However, this study shows that when public management reform is circumscribed to a particular policy sector, such as health, the agenda-setter is most probably within the top political level of the corresponding ministry. The successful inclusion of the issue on the general government agenda depends on how the issue framing reflects governmental discourse on multilevel governance. Fourth, as in cases of government-wide public management policy, the agenda setting and alternative specification processes in sector-specific public management reform appear to be closely coupled, which shortens the length of predecisional phases of the policy cycle.

Fifth, as shown in other researches, alternative specification is influenced by the prerogatives of institutional actors in the policy subsystem, their background profile, and inherited conditions in the policy stream. Sixth, the politics of public management policy making in a specific sector, such as health, is influenced by how actors in the policy subsystem interpret past and future events in their relations with actors affected by the policy alternatives under consideration.

Last, the politics of sector-specific public management is highly sensitive to spillover and interference effects coming from conditions and occurrences in neighboring policy domains. However, while comparative research has widely provided evidence that economic crisis has tended to prompt public management reform, this study shows how upward economic cycles may also pave the way for reform. This is particularly relevant for expanding research knowledge on the analysis of the politics of public management reform. The caveat persistently posed by the comparative literature has been why, in answer to an economic crisis, many countries dived into public management reform over the 1980s, the 1990s, and beyond, while others did not. Among the latter, there are those of a Napoleonic administrative tradition, and research has already shown how to better identify and understand such the politics of public management in those countries (Ongaro, 2008, 2010; Barzelay and Gallego 2010b). However, there are still unexplored issues such as how upward economic cycles influence public management policy making and how, in decentralized states, such influence differs between central and regional governments.
Bibliography


