

COMMITMENT, CAPACITY, AND COMMUNITY: THE POLITICS OF
MULTILEVEL HEALTH REFORM IN SPAIN AND BRAZIL

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ABSTRACT

SANDRA CHAPMAN OSTERKATZ: Commitment, Capacity, and Community:
the Politics of Multilevel Health Reform in Spain and Brazil.
(Under the direction of Evelyne Huber)

Inequality is a primary concern for many social and political actors, yet often the distributive profile of society seems over-determined by structure and institutions. Federalism, ethnic heterogeneity, and greater numbers of veto actors are near universally associated with higher levels of inequality and less generous public support for the most vulnerable members of society. A key challenge for scholars has been unpacking multilevel governance and empirically assessing the way the territorial distribution of authority interacts with other forces that determine policies, inhibiting clear theorizing about why and how particular territorial arrangements matter for distributive outcomes. In this dissertation I choose two “hard” cases in which we would not expect equity-enhancing social policy reforms and assess a similar attempt at universal health reform in both cases. Spain and Brazil share long histories of authoritarian rule, ethno-linguistic or racial heterogeneity, lack of fiscal capacity, and asymmetry in the territorial distribution of authority. Spain has been more successful than Brazil at establishing a universal health system that is efficient, sustainable, and broadly supported in society. In both cases the role of structural factors has been significant, yet I argue that particular constellations of ideological commitment at multiple levels of government and at key moments in the reform process, combined with fiscal and administrative capacity, explain much of the difference in outcomes. I take a mixed-method approach, using statistical and comparative historical analysis and assessing variation both between and within the countries.

For my mom

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LIST OF ABBREVIATIONS

AC	Autonomous Community
ACS	Agentes Comunitários de Saúde
ACM	Antônio Carlos Magalhães
AI	Atos Institucionais
ANS	Agência Nacional de Saúde Suplementar
AP	Alianza Popular
ARENA	Aliança Renovadora Nacional
BNG	Bloque Nacionalista Galego
CC	Coalición Canarias
CCOO	Comisiones Obreras
CIB	Comissão Intergestores Bipartite
CISNS	Consejo Interterritorial del Sistema Nacional de Salud
CIT	Comissão Intergestores Tripartite
CiU	Convergència i Unió
CNS	Conselho Nacional de Saúde
CONASEMS	Conselho Nacional de Secretários Municipais de Saúde
CONASS	Conselho Nacional de Secretários de Saúde
CPFF	Consejo de Política Fiscal y Financiera
DAB	Departamento da Atenção Básica
EA	Eusko Alkartasuna
EAJPNV	Eusko Alderdi Jeltzalea-Partido Nacionalista Vasco
EE	Euskadiko Ezkerra
EH	Euskal Herritarrok
ELA	Euskal Langileen Alkartasuna

ETA	Euskadi Ta Askatasuna
EPF	Encuesta de Presupuestos Familiares
EU	European Union
FCI	Fondo de Compesación Interterritorial
FPE	Fondo de Participação dos Estados
FUNRURAL	Fundo de Assistência e Previdência do Trabalhador Rural
GDP	Gross Domestic Product
GP	General Practitioner
HB	Herri Batasuna
IAPI	Instituto de Aposentadoria e Pensões dos Industriários
IBGE	Instituto Brasileiro de Geografia e Estatística
IMERSO	Instituto de Mayores y Servicios Sociales
INAMPS	Instituto Nacional de Assistência Médica da Previdência
INE	Instituto Nacional de Estadística
INGESA	Instituto Nacional de Gestión Sanitaria
INP	Instituto Nacional de Previsión
INPS	Instituto Nacional de Previdência Social
INSALUD	Instituto Nacional de la Salud
IPEA	Instituto de Pesquisa Econômica Aplicada
IRPF	Impuesto sobre la Renta de las Personas Físicas
IRYDA	Instituto de Reforma y Desarrollo Agrario
ISFAS	Instituto Social de las Fuerzas Armadas
IU	Izquierda Unida
LISMI	Ley de Integración Social del Menusválido
LO	Ley Orgánica
LOAPA	Ley Orgánica de Armonización del Proceso Autonómico

LOFCA	Ley Orgánica de la Financiación de las Comunidades Autónomas
LOTG	Ley Orgánica del Tribunal Constitucional
MDB	Movimento Democrático Brasileiro
MPAS	Ministerio de Previdência e Assistência Social
MSC	Ministerio de Sanidad y Consumo
MUFACE	Mutualidad de Funcionarios del Estado
MUGEJU	Mutualidad General Judicial
NHS	National Health Service
NOAS	Norma Operacional de Assistência à Saúde
NOB	Norma Operacional Básica
OECD	Organization for Economic Cooperation and Development
PA	Partido Aragonés
PAB	Piso de Atención Básica
PACS	Programa de Agentes Comunitarios de Saúde
PADI	Programa de Asistencia Dental Infantil
PAS	Programa de Agentes de Saúde
PCE	Partido Comunista Español
PDS	Partido Democrático Social
PDT	Partido Democrático Trabalhista
PFL	Partido da Frente Liberal
PIASS	Programa de Interiorização de Ações de Saúde e Saneamento
PIE	Participación en los Ingresos del Estado
PMDB	Partido do Movimento Democrático Brasileiro
PP	Partido Popular
PPS	Partido Popular Socialista
PRN	Partido da Renovação Nacional

PSB	Partido Socialista Brasileiro
PSC	Partit dels Socialistes de Catalunya
PSDB	Partido da Social Democracia Brasileira
PSE	Partido Socialista de Euskadi
PSF	Programa Saúde da Família
PSN	Partido Socialista de Navarra
PSOE	Partido Socialista Obrero Español
PT	Partido dos Trabalhadores
PTB	Partido Trabalhista Brasileiro
RAI	Regional Authority Index
RMI	Renda Mínima de Inserción
SES	Servicio Extremeño de Salud
SIAP	Sistema de Información de Atención Primaria
SNS	Sistema Nacional de Salud
SUS	Sistema Única de Saúde
TCU	Tribunal de Contas da União
UBS	Unidades Básicas de Saúde
UCD	Unión del Centro Democrático
UFBa	Universidade Federal da Bahia
UGT	Unión General de Trabajadores
UNESCO	United Nations Educational, Scientific and Cultural Organization
UPN	Unión del Pueblo Navarro
VAT	Value Added Tax
WHO	World Health Organization

1 THE DEMOCRAT'S CONUNDRUM

Inequality is a primary concern for many social and political actors, for a variety of reasons including an ideological preference for social justice, desire to remove barriers to economic development, and concern about crime and public security. Yet often the distributive profile of society seems over-determined by fairly immobile institutional characteristics. Within the broad literature in comparative political economy and the welfare state, federalism, ethnic heterogeneity, and greater numbers of veto actors are near universally associated with higher levels of inequality and less generous public support for the most vulnerable members of society.

Not only are these structural features of society unlikely to go away, they have become increasingly salient. Immigration, globalization, and conflict have made many countries more diverse over time. Achieving governance structures that can channel the aspirations and identities of the inhabitants of a territory lies at the heart of the democratic endeavor, so the territorial distribution of authority is often front and center as countries transition away from authoritarianism. Forty per cent of the world's people live in federal polities, most of which are highly diverse. Even in non-federal societies, multilevel governance has become an increasingly important component of state reform. Given this reality, there is a pressing need for multilevel theories of politics.

Under what conditions, then, can policy makers in these countries hope to successfully implement "equity-enhancing"¹ reforms, despite what appear to be inauspicious

¹Widely used today to explore the distributional impact of social policies, one of the first to introduce the concept was Kurt Weyland in his work on social policy reform in Brazil (1996).

structural conditions? To answer this question one must shift away from “controlling for” diversity, federalism, or veto actors at the country level and articulate the mechanisms by which particular constellations of policies, actors, and institutions—at multiple territorial levels—generate outcomes in a given historical context.

As we shall see, multilevel territorial analyses are methodologically challenging. The territorial distribution of authority is usually policy-specific and the interests of territorial actors are highly contingent, depending a great deal on their relative position in the central and even international political economy and shifting over time as conditions change. I take up this challenging analytical problem by assessing the trajectory of multilevel health reform in Spain and Brazil—middle-income countries that represent “hard” cases for successful countrywide equity-enhancing reform. Policy makers in these countries faced high levels of decentralization, territorially concentrated inequality, and ethno-linguistic or racial heterogeneity, as well as asymmetry in the territorial distribution of authority, limited capacity, and several economic crises. Both countries had long years of centralizing military rule followed by “third wave” pacted transitions to democracy. In both cases the transition process included the creation of a new constitution—Spain in 1978 and Brazil in 1988. Both constitutions guaranteed health care as a universal citizenship right and coverage and access the responsibility of public authorities. In addition, both had achieved fairly high levels of coverage under authoritarianism, which might make reform less pressing (Falleti 2010b).

After the new constitutions, the reform processes diverge and variation exists both within and between the countries in the realization of the new mandate, as well as the overall process of decentralization and state reform. In both cases some structural characteristics made implementation more difficult while other factors helped propel reform forward. In neither case has the constitutional guarantee been fully realized,

but Spain was able to consolidate a high quality system early on, which included publicly provided primary care for all, as well as specialist, curative, and emergency services, which are all overwhelmingly used across the population.

Brazil, on the other hand, has struggled to extend various aspects of universal coverage, of which primary care was the weakest link early on. While nearly all Brazilians use the public system for complex and expensive hospital care, the primary network is still almost exclusively used by the poor. Access, quality, and coverage vary across regions in both countries, but far more so in Brazil.

I argue that the timing and content of decentralization, the presence (or lack) of actors ideologically committed to equity-enhancing reform at crucial moments in the reform process, and the fiscal and administrative capacity of those responsible for reform have been the driving forces behind variation in outcomes. Tables A.1 and A.2 summarize the levels of commitment, capacity, and health authority at different points in time in the two countries, relationships that are discussed in more detail in the chapters that follow.

Ideological commitment to equity could conceivably come either from left/right partisanship or from commitment to social solidarity within a salient and territorially defined identity group. While for some actors the two are difficult to disentangle, I expect ideological commitment on the left to generally trump nationalism in the successful implementation of equity-enhancing reforms. In addition, it is not heterogeneity, as such, that places constraints on equity-enhancing reform. Rather, it is the presence of high levels of conflict over actors' visions of the legitimate territorial scope for redistribution—what I call the “reference community” for policy making—which hampers reform.

As the only political actors capable of redistribution or policy implementation across the country, central government authority and action are necessary conditions

for countrywide equity-enhancing reform. If central authority, commitment, and capacity are lacking at important moments in the reform process, the results should be less equity-enhancing.

The international context was influential for the health reform process in both countries. Choosing cases in different world regions allows one to say something about the differing experiences of multilevel health reform in the European Union (EU) sphere of influence vs. the Latin American context. Policy legacies and starting points matter and were held constant along some important dimensions by the case selection, while varying on others. Finally, while democracy is not necessary or sufficient for equity-enhancing reform, it is a clear and powerful enabling force, particularly with regard to the ability of committed actors to gain access to power.

The consistent findings that federalism, ethnic heterogeneity, veto points, and even some forms of decentralization make redistribution more difficult capture dimensions of reality that have been under-theorized and empirically under-tested. Focusing on comparable attempts at equity-enhancing reform under conditions of asymmetric multilevel governance permit a nuanced assessment of the conditions for successful reform. I take a mixed-method approach to empirical analysis, utilizing time series data with the regions as the unit of analysis in Chapter 2 to explore the relationship of the hypothesized causal variables to a particular component of health reform (universal primary care coverage), as well as testing the impact of reform on health outcomes at the regional level. In addition to careful consultation of primary and secondary sources, the empirical evidence presented in this dissertation comes from 18 months of field research—Spain in 2012 and Brazil in 2009 and 2011.

In Chapter 3 I elaborate the theory for case study analysis. In Chapters 4 and 5 I use comparative historical analysis to trace the process of democratization, decentralization, and multilevel health reform in each country—in Spain at the level of

the center, the *Comunidades Autónomas* (ACs, Autonomous Communities), and—to a lesser degree—the provinces and in Brazil at the level of the center, the *Unidades Federativas* (Federative Units or states), and the municipalities. In the case studies I consider health reform in the broader context of social policy and service provision, as well as fiscal policy. This dissertation is therefore part of an expanding body of scholarship that assesses crucial questions in political science through a multilevel territorial lens while striving to increase the availability of regional-level data to allow for more sophisticated theory testing².

In Chapter 6 I step back and consider the potential to draw conclusions from comparison of the two country cases. I argue that differences in presidential vs. parliamentary system, as well as federal institutions have been less relevant for equity-enhancing policy reform in these cases than the timing and sequence of decentralization and the presence of ideological commitment at the center during key moments in the reform process. Higher levels of inequality and lower levels of development in Brazil have been potent historical constraints on equity-enhancing reform, particularly regarding the ability of the central government to implement a progressive tax system that would permit adequate funding of social policy commitments. The weakness of the health reform in Brazil has been due in large part to the fact that it took much longer for ideologically committed actors who prioritized redistribution to win control of the central government, as well as the particular constraints those actors faced in the Latin American context.

In Chapter 7 I offer a brief summary and conclusion, considering the policy implications of the results. Ultimately, the process of reform in both countries suggests that the equity-enhancing policies necessary to undergird a sustainable process of

²This literature is extensive and includes case studies as well as projects that combine theorizing with the creation of new cross country and cross regional data (Giraudy 2010; Gervasoni 2010; Daughters and Harper 2007; Falletti 2010a; Gibson 2004; Grindle 2007; Montero and Samuels 2004; Hooghe, et al 2010; Hooghe, et al 2014 forthcoming; Charron, et al 2012).

redistribution can be implemented even when the stars are far from aligned in their favor. Clear conditions can be laid out for creating the ideal (and next best) environments for successful reform, given a context of multilevel governance and diversity. That funding has never been sufficient and reform never complete in either country has made them particularly vulnerable to economic crisis. Fiscal pressures since 2008 have exposed the weakness in both reforms and in the Spanish case, threatens to bring the health system to its knees. Yet the gains made since the democratic transitions and the guarantees in the constitutions continue to be important rallying points for the defense of health reform in both countries.

1.1 Case Selection

For all the reasons discussed above, Spain and Brazil represent “hard” cases (Eckstein 1975) where we would expect equity-enhancing reform to be difficult to achieve. But why these particular countries and why not consider a broader group of cases in both regions? The focus of this dissertation—on regional variation within a country in the context of multilevel governance—requires that the unit of analysis be below the level of the country. In Spain there are 17 ACs and in Brazil 27 states, which for the statistical analysis offers over 400 unit years for Spain and over 600 for Brazil, depending on the model. While multilevel, cross-national comparisons may be on the horizon as data availability improves, the need to control for both cross country and regional level differences poses some challenges. Within country analysis of the regions allows me to hold political institutions and shared history constant.

For an inquiry with so many moving pieces, balancing variation and commonality with care is essential. It is fairly uncommon for decentralization to be substantively asymmetric across units with the same constitutional status (in the same “tier”). Yet in both of these countries the distribution of policy responsibilities has varied between regions at given time points. Counterfactuals in social science are rarely observable,

yet assessing decentralization in a particular policy area when regions shift from a shared starting point to asymmetry offers the closest approximation.

Still, cross-national comparison is central to comparative political studies and for generalizing beyond a particular world region or country experience. While not all theories must travel widely, the relationship between multilevel governance and successful equity-enhancing reform can be articulated in a way that permits the generation of expectations beyond these particular cases. I therefore choose two countries in different world regions where the institutional and historical conditions surrounding decentralization and policy reform are broadly comparable.

Spain and Brazil both share classic features of Latin American and Southern European development patterns and had similar high levels of income and land inequality, as well as welfare state effort, before the transition to democracy (Huber and Stephens 2012; Frankema 2009). Both countries had long periods of conservative authoritarian rule in which early welfare programs were implemented in efforts to incorporate the growing working class, with Social Europe as a powerful point of reference, even in Brazil (Weyland 1996). Democratic transitions in both cases were pacted, rather than revolutionary. The pro-democracy efforts in both countries were protagonized by actors on the left who also supported substantive decentralization.

In both cases, Bismarckian social insurance schemes covered large portions of formal sector workers in a hierarchical fashion, though the nature of the labor force meant that this provided higher levels of coverage in Spain than in Brazil. In addition, while in Spain this health provision had a large public component, in Brazil it was almost exclusively contracted with private providers, which generated different policy legacies for the extension of public coverage down the road.

Health reform took place in both countries in the 1980s—beginning in Spain in

1984 and in Brazil in 1988. The reform process involved efforts to guarantee universality and bring together the disparate pre-existing schemes for access to care. In neither case was a National Health Service (NHS) created in the pure sense, as public agencies were permitted to contract for services with private providers rather than provide them directly and the systems were never fully integrated. Private medical providers and interests have been the strongest opponents to reform in both countries and have made reform significantly more difficult. Yet direct public provision of the majority of services in the public system, free at the point of delivery, and with universal access has been the goal and the standard, despite differences and difficulties in consolidation.

The territorial distribution of authority over health has differed, as has the nature of regional finance, but in both cases the central government retains control of the basic structure and definition of the system, while regions (and in the case of Brazil, municipalities) provide the infrastructure and services. While in Spain both policy scope and fiscal autonomy have varied regionally over time, in Brazil only the level of authority in health policy has varied asymmetrically. These broadly shared characteristics of structure, politics, and reform make it possible to explore the impact of differences in decentralization, timing and sequence, commitment, and capacity in the two cases.

Several differences between the two country cases should be mentioned. First, while both have high levels of ethno-linguistic or racial heterogeneity, the characteristics of these differences vary. In Spain, minority national groups are clearly tied to particular territories and have been politically salient for centuries. Spain has no history of forced labor, even though the cultural rights of minority groups have been a salient and contested issue. In Brazil, indigenous groups have tended to be either small and isolated or dispersed due to geography and the nature of colonial

administration. Racial domination of indigenous peoples and African slaves and their descendants has been a defining element of power relations. Ethnic mixing and the radical changes in urbanization and land use over time have diminished the ties between particular territories and ethnic groups in Brazil. While land rights are a salient political issue with an important ethnic dimension, they are not primarily focused on the political rights of self-determination for groups in certain territories. Minority nationalism in Spain, however, has a territorial base and has defined the organization of and conflicts over the state since its inception.

For Spain, Europe has been the dominant frame of reference for policy making. Economic performance, democracy, and policy are always considered in comparison with the rest of Europe. EU preferences and norms were salient in both progressive tax reform and the design of health care in the early 1980s and have continued to matter since Spain joined the EU in 1986. Brazil is a big country with a big internal market and has historically been less interested in looking to its neighbors or international organizations for direction. Yet the strength of the Washington Consensus in the region, combined with the timing of health reform implementation, meant that neoliberalism was more influential for the orientation of technocrats and policy makers there. As we shall see, Spain experienced similar pressures at the same time, but its geo-political context was different and it had progressed much further in consolidating its health system by the time neoliberal influence peaked. These trends generated strong pressures for cost-containment in both health systems, even though in comparative terms both systems were frugal and efficient and neither had yet achieved full extension across their populations or territories.

There are also significant differences in the organization of political institutions. Brazil is a presidential system with open list proportional representation for the legislature and first-past-the-post elections to the Senate, which is a body of representation

for the states. Spain is a parliamentary system with closed list proportional representation and an upper chamber that is partly elected from the provinces and partly by AC governments, which has never served as a functional body of territorial representation. Parties in Spain are highly disciplined and programmatic, while in Brazil programmaticness, discipline, and party loyalty vary significantly among parties, with only the *Partido dos Trabalhadores* (PT, Worker's Party) historically possessing all three. These features represent constraints, making reform less likely. Yet as I discuss in Chapter 6, these have not been the dominant roadblocks to reform in either case.

Within each country I include regional case studies chosen on the basis of variation in commitment and capacity. In Spain the regions are Extremadura, the Basque Country, and Castilla y León. Extremadura is a case of high commitment throughout and low capacity at the outset while Castilla y León is a case of intermediate capacity and low commitment and the Basque Country of high commitment and high capacity. In Brazil the cases are Bahia and São Paulo. Bahia is a case of low capacity throughout and low commitment at the outset, while São Paulo is a case of high capacity and intermediate commitment. In both cases I include shadow cases of contrasting regions. For Brazil I also include assessment of municipal variation, assessing the capital cities of the states in contrast to other municipalities. In the statistical analysis all ACs and states are included and the time periods are dictated by data availability, generally beginning in the early 1980s for both countries. In the case studies I consider the historical preconditions to reform in some detail, but focus primarily on the democratic period. In Spain the ACs did not exist before the democratic transition.

1.2 Understanding Health Outcome Indicators

In Chapters 2 and 3 I discuss the indicators of health outcomes used in the statistical and comparative historical analyses. Because different indicators tell quite

different stories, a brief summary of the possible measures and how they respond to policies and changes in society can be helpful. Infant mortality rates, which I use in regression analysis, are a good choice for testing the impact of public policies concerned with equity but present some challenges, as well. Precisely because infant mortality responds fairly quickly to modest investments in improved access to basic health and sanitation, and is concentrated among the poor, it is usually the first indicator of health outcomes to improve as levels of economic development rise. Yet this means that infant mortality often declines even when structural factors do not seem to support improvements in health.

In Spain and Brazil, infant mortality has been declining since the middle of the 20th century and made rapid improvements under authoritarian rule as economic development increased in the seventies. It is therefore relevant that subnational analysis shows regional infant mortality to be significantly impacted by variation in the extent of primary care reforms in both countries, particularly in Spain where convergence to quite low levels had already taken place.

Life expectancy is a measure of health outcomes at the other end of the cycle and is much more difficult to tackle with public policies and can mask substantive differences between groups and across age cohorts. Life expectancy is impacted by every input over the course of someone's life and is therefore affected by culture, behavior, the slow accumulation of environmental stressors, and sometimes even biology. Women tend to live longer than men by five or six years, even when domestic violence is common, formal equality is low, and rates of depression and anxiety are higher among women.

Life expectancy in good health is increasingly being utilized by the international health community, and is much more clearly affected by public policies related to occupational and housing safety, quality of the environment, social class and community structure, and access to quality health care.

While asking patients about their health is the most direct and reliable way to obtain accurate information about an individual, health surveys are still plagued with the typical problems of survey data. In addition, health perceptions change frequently and may be biased not randomly, but by cultural or structural differences in attitudes of respondents. Because health surveys and nuanced measures such as life expectancy in good health are generally not available below the country level, we are left with indicators such as infant mortality and life expectancy for cross-sectional comparison. These are meaningful measures that provide empirical information about the reality in a particular community, yet it is still helpful to understand the limitations of the data.

2 THEORY

What are inequalities in health and health care? The question is not as straightforward as it might appear. The most commonly accepted definition was produced by Margaret Whitehead in 1992 as part of an initiative by the Programme on Health Policies and Planning of the World Health Organization (WHO) Regional Office for Europe:

Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided...Equity is therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible...Equity in health care is defined as: equal access to available care for equal need, equal utilization for equal need, [and] equal quality of care for all. (1992: 8)

We can see from this definition why health inequality is not determined exclusively by health policies, yet how equity-enhancing public policies are necessary as part of an overall realization of health. The definition also suggests that some crucial causal variables for equity-enhancing reform are also important for equity in health outcomes.

2.1 Equity-Enhancing Health Reform

Health outcomes are determined by a wide array of factors, some of which are behavioral or environmental, and many of which are difficult to impact with public policy in the short term. Yet health policies are quite directly the result of political action. Equity in health care should be increased by improvements in universality, quality, access, sustainability, and progressiveness of financing. Policies that improve

these characteristics of health care are “equity-enhancing.” Because both countries have constitutional guarantees of public responsibility for health care as a universal citizenship right, accompanied by National Health Systems designed to fulfill this guarantee, measures of equity in health policy are broadly comparable. The concepts of universality, quality, access, sustainability, and progressiveness of financing are incorporated into the case study assessments of policy legacies in both countries.

The type of care prioritized by public policy matters for sustainability and equity, as well as for outcomes. Curative hospital care and specialist care are inherently more costly than preventive and primary care (Donaldson 1996; McGuire 2010). Specialist care is also less effective in producing improved health outcomes compared to primary care (Starfield, et al 2005) and in most countries is more intensively used by wealthier individuals¹. Consuming curative health services carries with it the inherent risk associated with the treatment itself, which is often significant. Universal access to primary care is one of the most important determinants of health for the poor in developing countries (McGuire 2010). The empirical support for high quality primary care as the foundation for universal public health systems is strong, so this is the dimension I explore in the statistical analysis.

Primary care is also an important policy from a hypothesis testing perspective. In countries where markets for private health services exist (true in both Spain and Brazil), primary care is the one part of a public health system whose only utterly dependent stakeholders are the poor. Middle and upper class users can afford to access primary care privately because it is relatively inexpensive, while very few people in any society can afford to privately purchase specialist and complex hospital care

¹See Hanratty, et al 2007; Victora, et al 2000; Palencia, et al 2011; Vikum, et al 2011. Generally, what this research finds is that the poor, with poorer health, make use of primary care and prevention when it is affordable and are higher users of in-patient and emergency room care related to higher levels of need. High income users tend to “over” utilize specialist and out-patient hospital services—the most expensive, particularly in the absence of an emergency.

without assistance. Defense of public primary care is therefore fundamentally about concern for those at the bottom. Because it is the most effective form of health care in terms of the ratio of inputs (money) to outputs (good health outcomes), it should be a natural choice for public investment, particularly when resources are tight. Therefore, when an established health system faces resource constraints, primary care should be the first place to invest and the last place to cut for actors committed to equity.

That international organizations have discovered these features of primary care and begun to support them in poor countries as part of an overall emphasis on means-testing makes them no less equity-enhancing. The evidence from the literature on basic universalism² suggests that certain forms of targeting may not be regressive or unsustainable when populations are overwhelmingly poor. Improving the life chances of those at the bottom is a first step in enabling democratic participation as well as improving levels of education and human capital development. Regardless, the primary care reforms assessed in this chapter are both universal—not means-tested.

Despite the importance of primary care, the most urgent procedures cannot be managed through prevention and basic care, so a constitutional guarantee of universal coverage must include far more. Universality is achieved when all inhabitants of the territory have an equal right to receive the health services that enable good health. The government must guarantee this right through capable oversight and regulation, as well as systems to ensure access and coverage, or it will not be realized. Limitations to universality are less equity-enhancing³. Formally excluding from the public system those who could pay for services privately is regressive because it diminishes pressure for the public system to be “good enough” for those who have alternatives. It also

²Filgueira, et al 2005; Huber 2010; Martínez Franzoni 2012; Huber, Pribble, and Stephens 2009.

³The literature on why universality is better for equity than targeting and means-testing is large. A useful selection includes Stephens 1979; Korpi 1980; Castles and Mitchell 1992; Esping-Andersen 1990; Weale 1990; Huber and Stephens 2001.

decreases the number of political stakeholders who would defend the system against retrenchment or demand its expansion (Korpi 1980; Huber and Stephens 2001). Public systems will do the best job for the most needy when they must pass muster with those who could go elsewhere for care. Services just for the poor tend to be poor services.

Universal direct access also reduces administrative costs by eliminating the need to determine eligibility and enforce exclusion from coverage. The equity-enhancing capabilities of services that are directed to the poor are somewhat greater in places where the poor are a majority of the population and services therefore reach a broad electoral base. Yet this “basic universalism” is still more vulnerable than truly universal services, as we shall see in the case of Brazil. It may be impossible to achieve perfectly, but universality is the key to political sustainability.

Universality of access also includes whether people are capable of using the services that are provided. If transportation is inadequate or expensive, clinics and hospitals are not accessible to particular population groups, or are understaffed, access is limited. Linguistic and cultural competency is also important for access, particularly in multi-ethnic societies.

Equity-enhancing health coverage should include those services for health education, prevention, and treatment, which have been empirically proven to improve health outcomes. More is not always better if the public system is spending scarce resources on expensive new technology with no proven track record, or that works no better than less expensive conventional treatments (Ellwood 1988; Evans 2001). In most advanced industrial countries, public health systems struggle with the pressures of citizens and private medical interests to cover an array of services that may have little relationship to health outcomes. Cuts in covered services are easy to politicize,

even when they may be equity-enhancing by eliminating wasteful spending and redirecting it to services that do a better job of improving the quality of life and health of the population. Yet major areas of health coverage that decrease future costs and play a crucial role in individual health are often still under-covered, including dental care (particularly for the young), mental health services, women's health, health education, and prevention. These challenges are present for political actors of all stripes, in most countries.

Universal access does not require direct public provision, yet particular forms of organization tend to be more or less equity-enhancing. If private medical practitioners operate alongside the public system, permitting dual practices by individual providers is problematic because it creates incentives to channel low cost patients to private practices and high cost patients to the public system (González 2004). When a framework for public provision of care exists, choosing to contract services with private providers rather than hire through the public system may limit the collective bargaining and workplace protections of health workers, which are often stronger in the public sector. Choosing to support private provision rather than strengthen investment in an existing public system can lead to the loss of popular support for the public system, as users develop a set of assumptions about where care will be best. In addition, evidence suggests contracting services privately with public money is more expensive than directly hiring service providers (Barros 2010).

It is sometimes argued that the use of private services by those with means could remove some of the burden of use from the public health system, yet there is no evidence of a descent in the use of public services connected to the use of private alternatives—particularly because for emergencies and hospitalization, the most expensive services, the vast majority of the Spanish and Brazilian populations use public facilities. Analyzing more directly the question of subcontracting, a 2004 study of 180

Catalan health centers (where experiments with “contracting out” in Spain have gone the furthest) finds no evidence of efficiency gains in the purchase of health services where there exist public-private contracts (Puig-Junoy and Ortún 2004).

Yet as we shall see in the case studies, some regions have developed innovative systems of public contracting with public employees to introduce incentives for performance and cost control that have helped to keep the systems solvent without compromising their equity-enhancing nature. In addition, if regulation and oversight of private services is identical to that used for the public sector, there may be minimal differences in the equity-enhancing nature of funding and provision of services, or the rights of health workers.

Quality of care can be measured in a number of ways but they are almost all contested⁴. Both process (how care is provided, in what settings, with what resources available and applied) and outcome measures are part of the story of quality (Zeisler and Pettiti 2006: 236). Yet causal links between process and outcomes are hard to prove. Whether users believe their services are high quality (a patient-focused outcome indicator) depends entirely on what they believe they should be getting, which is conditioned by how good the system has been historically and cultural expectations about public care. Where expectations are low, satisfaction may be higher. Indicators of avoidable hospital illnesses and deaths, or deaths from infections contracted in the hospital are indicators of malpractice but do not touch on other aspects of quality.

Higher levels of household private health spending indicate poor coverage by the public sector (leaving important services out that must then be paid for privately), poor quality (inducing the purchase of private health insurance by those who can afford it), or both. Such data have been used cross-nationally to assess the equity-enhancing nature of health policy (van Doorslaer, et al 1999; Huber and Stephens

⁴For an accessible discussion of the challenges of measuring the quality of care from the perspective of purchasers, providers, and patients, see McGlynn 1997.

2012). Unfortunately, reliable regional data on private health spending are limited⁵.

The more progressive the financing of social policy, the more progressive a given policy will be, *ceteris paribus*. The most redistributive way to fund social policy in a country is through progressive taxes raised over the entire population and spent with a criterion of need. Health care is usually financed in four ways: taxes, social insurance, private insurance, and out of pocket payments (Wagstaff and van Doorslaer 2000). In the comparative historical analysis I discuss changes in the composition of financing over time. If regions are lucky enough to be in a lower-income country that is a member of the EU, they may even be able to finance social policy with revenue raised progressively over people in wealthier countries. Where transfers for the center are used for health financing, per capita formulas are less equity-enhancing than formulas with a need-based criterion, but more than when criteria are politically subjective or based on formulas not related to either need or population.

Quantifying the progressivity of tax systems is complex. Direct taxation of income and wealth tend to be more equity-enhancing sources of financing than consumption and payroll taxes⁶. Within any particular type of tax, the burden can vary significantly depending on the structure of the tax. If services are included in consumption taxes or finished and luxury goods are taxed at higher rates than basic necessities, consumption taxes can be made less regressive. Changes to income tax rates and

⁵In Spain, I compiled regional data on private household spending from the Household Budget Survey (*Encuesta de Presupuestos Familiares*), which are only available for 1998-2010. There is a major break in comparability in 2006 when the survey was fundamentally restructured and it does not include several sources of private spending captured by the OECD for its cross-national dataset. The most significant issue for the Spanish case, however, is that variation is minimal. In all ACs for this time period, public spending as a portion of total health spending is between 80 and 90 per cent using public and private household health spending data. This makes it almost impossible to gain traction in the statistical model.

⁶For in-depth discussion of the progressivity of financing for health policy see Wagstaff and van Doorslaer 1997; Wagstaff, et al 1999 and of income tax progressivity Aronson, et al 1994. Efforts to rank and categorize the progressiveness of tax systems are discussed in Kakwani 1977, which has remained the dominant indicator for measuring the progressiveness of systems of health care financing and focuses on how far the tax system departs from a principle of proportionality.

brackets significantly modify the burden on different income groups. Whether caps are placed on payroll taxes impacts how progressive they are. The system of deductions and credits modifies the overall distributive character of the tax system, as does the capacity of the government to collect taxes and prevent fraud. While a case study of fiscal policy in Spain and Brazil is beyond the scope of this project, the theoretical expectations are clear and I discuss significant shifts that impact the financing of health and social policy in the case studies.

2.2 Determinants of Health Inequality

A commission within the Spanish Health Ministry in 2010 spent two years working with regional health secretariats and academics to produce a report naming the following culprits in social inequalities in health, in order of importance: 1) The distribution of power, wealth, and resources, 2) Living and working conditions over the course of the life cycle, 3) Dignified housing and access to physical spaces that favored good health and health behaviors, 4) Equity-enhancing health services, and 5) Information, oversight, research, and education⁷. This is in line with the Acheson report in 1998 from the United Kingdom, which found that sufficient means, income inequality, access to health care, education levels, environment, and lifestyle all played a role in determining health inequalities (Acheson, et al 1998; Gordon 1999). While democracy is excluded from these studies, which took place within consolidated democratic regimes, citizen participation in governance and oversight were important in both.

In his groundbreaking book on public policy and health outcomes in developing countries, Jim McGuire (2010) argues that human welfare requires access to the basic inputs for quality of life—economic sufficiency, safe water and basic sanitation, education, access to basic health care, family planning—and that these are determined by both economic factors such as income and inequality, as well as public policy

⁷Comisión para Reducir las Desigualdades Sociales en Salud en España. Mayo 2010. Dirección General de Salud Pública y Sanidad Exterior, Ministerio de Sanidad y Política Social.

and service uptake. Democracy matters not only in its theorized role as guarantor of the expression of public preferences, but as an often transformative force in the way individuals interact with their communities and form expectations about their relationship with public institutions. This vision of how health “happens” finds strong empirical support in his case studies and statistical analysis.

2.3 The Territorial Distribution of Authority

In terms of its impact on equity, a series of case studies have been conducted in poor countries by international financial institutions (often in the role of policy advisors) to understand the impact of decentralization. While these institutions took a strong normative position in favor of decentralization in the early 1990s based on theoretical assumptions regarding efficiency and subsidiarity, subsequent investigation has found little evidence of improvement in policy or outcomes after reform⁸. This has caused a shift to more nuanced positions over time (Qian and Weingast 1995; Weingast 1995; Oates 1999; 2005).

A common finding in the comparative political economy literature is that federalism is related to higher inequality⁹. However, as Jonathan Rodden points out, federalism is not the cause of anything, but is simply an indicator that may or may not tell us something about the institutional processes at work within a country (2005). Yet levels of regional authority do tend to be higher in federal systems and the veto points literature clearly lays out the mechanisms by which increased numbers of actors capable of blocking policy inhibits redistributive reform¹⁰.

⁸Empirical studies finding increased inequality under decentralization include Kim, Hong and Ha 2003; Kanbur and Zhang 2002; Zhang 2006. For health policy decentralization, the empirical evidence has been overwhelmingly negative, finding that it generally worsens equity and efficiency, except in regions with high levels of administrative and fiscal capacity (Akin, et al 2001; Angeles, et al 1999; Bossert and Beauvais 2002; Fiedler and Suazo 2002; Blas and Limbambala 2001; Bossert, et al 2000; 2003; Saltman, et al 2011).

⁹Linz and Stepan 2000; Beramendi and Anderson 2008; Obinger, Liebfried, and Castles 2005; Weir, Orloff, and Skocpol 1988.

¹⁰Immergut 1992; Huber, Ragin, and Stephens 1993; Tsebelis 2002; 2011.

Studies of decentralization have become more prevalent in comparative politics in recent years, yet have tended to focus on determinants of decentralization, its relationship to democracy, or the intergovernmental balance of power, rather than on inequality and social outcomes¹¹. Comparative historical studies of advanced industrial countries have explored the nexus between welfare states, territory, and nationalism in the past decade¹². Obinger, Castles, and Liebfried argue that “the impacts of federalism on welfare state development are multiple, time-dependent, and contingent on a number of contextual parameters, including, most conspicuously, the design of federal institutions and the power resources of social and political actors” (2005: 2).

In research on ethnic diversity and impulses for redistribution, high levels of ethnic heterogeneity are consistently associated with less support for redistribution¹³. These findings offer support for assessing power constellations at multiple territorial levels, and for identifying the way conflicts over the reference community can produce shifts in the territorial rules of the game, but do not tell us much about precisely what to expect from decentralization.

This diverse literature has been unable to coalesce around a given set of expectations regarding the impact of shifts in the territorial distribution of authority on distributive outcomes in large part because of a lack of comparable data. Perceiving both the problems of widely differing operationalizations for decentralization and the paucity of data available to study its effects, Hooghe, Marks, and Schakel (2010) developed the Regional Authority Index (RAI) to measure eight dimensions of regional

¹¹On causes and relationship with democracy see Montero and Samuels 2004; Montero 2001b; Cornelius, Eisenstadt, and Hindley 1999; Diamond and Tsalik 1999; Eaton 2001; Gibson 2004 and Samuels and Mainwaring 2004 on federalism; Manor 1999. On the intergovernmental balance of power see Falletti 2005, 2010 and Montero 2001a.

¹²Béland and Lecours 2008; Obinger, Castles, and Liebfried 2005; McEwen and Moreno 2005.

¹³Grove 1979; Luttmer 2001; Soroka, et al 2004; Lee, et al 2006; Eisenberg 2007; Keely and Tan 2008.

authority in 42 OECD countries for 1950-2006. We have expanded the dataset to include 27 Latin American cases and several in Southeast Asia through 2010, the number of dimensions from eight to ten, and to cover periods of authoritarian rule (Hooghe, et al 2014 forthcoming). The dimensions are split between the concepts of self-rule and shared-rule. Increased shared rule should generally be associated with constraints on equity due to the effect of veto players, while the impact of self-rule within the region will depend on commitment and capacity.

The RAI is the best existing conceptual framework for parsing out the different types of regional authority. The extension of the dataset beyond the OECD is recent and there have been few efforts to theorize how different dimensions might impact equity-enhancing reform. In Spain and Brazil, the territorial distribution of authority shifts over time and across regions. There is not enough variation to capture most dimensions in the quantitative analysis. But in the case studies, the territorial distribution of authority is considered in more detail. Increased shared rule should be associated with constraints on equity due to the effect of veto players, while the impact of self-rule within the region will depend on commitment and capacity.

Territorial units can exert influence up, down, or across depending on the formal distribution of authority as well as their actual power (sometimes economic, sometimes cultural, technical, or historical). The focus of this dissertation is the central government of a country and the highest intermediate territorial level of government within it. In both Spain and Brazil there are also supranational and local actors that exert influence over the distributional impact of health policies and cannot be ignored. While there are important ways in which territorial units exert authority upward or laterally, the primary application of territorial authority is within the unit. A country government generally has more authority within the country than it has over other countries or over the supranational organizations of which it is a member,

and regional governments usually have more authority over their own territory than they have over the central government or other regions.

In Figures 2.1 and 2.2 one can see the operationalization of the RAI dimensions. Institutional depth is the extent to which regional government is autonomous rather than deconcentrated, while representation is the extent to which a region is endowed with an independent legislature and executive. Both are features of self-rule. Having elected, non-deconcentrated regional political institutions increases ideological variation among policy makers in a country, compared to having only a central government. Even if the responsibilities of the regional institutions are initially few and regional demands for self-rule did not drive the decision to decentralize, non-deconcentrated regional governments can be expected to try to expand their policy scope and resources, particularly if they are accountable to regional voters. They should also express regional positions and preferences, attempting to become veto players, even if they have little authority in shared rule or self rule in a given policy area. This increases the possibilities of conflict over the territorial scope of the reference community. Whether or not this constitutes a (new) source of intergovernmental conflict depends on what the relationship of the center was with the regions before increases in representation and/or institutional depth took place.

Regional institutions of self-rule represent the mechanisms by which the number of veto players begins to increase (deconcentrated regions can have no say in shared-rule, by definition) and the evidence about quality of regional governance compared to central governance is unclear. Yet regional governments can potentially be held accountable for regional performance more easily than central governments, and where minority nationalisms or historical regional identities are strong, institutions of regional self-rule are a crucial part of democratic government. Expectations for institutions of self-rule are therefore mixed and conditioned by other factors.

Figure 2.1: Regional Authority Index: Self Rule Dimensions

Table 1: Self-Rule

Self-rule	The authority exercised by a regional government over those who live in the region
Institutional depth	<p>The extent to which a regional government is autonomous rather than deconcentrated.</p> <p>0-3</p> <p>0 no functioning general-purpose administration at regional level 1 deconcentrated, general-purpose, administration 2 non-deconcentrated, general-purpose, administration subject to central government veto 3 non-deconcentrated, general-purpose, administration not subject to central government veto</p>
Policy scope	<p>The range of policies for which a regional government is responsible.</p> <p>0-4</p> <p>0 very weak authoritative competencies in a), b), c), d) 1 authoritative competencies in a), b), c) or d) a) economic policy; b) cultural-educational policy; c) welfare policy; d) one of the following: residual powers, police, own institutional set-up, local government 2 authoritative competencies in at least two of a), b), c), or d). 3 authoritative competencies in c) and at least two of a), b), or c). 4 criteria for 3 plus authority over immigration or citizenship</p>
Fiscal autonomy	<p>The extent to which a regional government can independently tax its population.</p> <p>0-4</p> <p>0 central government sets base and rate of all regional taxes 1 regional government sets the rate of minor taxes 2 regional government sets base and rate of minor taxes 3 regional government sets the rate of at least one major tax: personal income, corporate, value added, or sales tax 4 regional government sets base and rate of at least one major tax</p>
Borrowing autonomy	<p>The extent to which a regional government can borrow</p> <p>0-3</p> <p>0 the region (or regional tier) does not borrow (e.g. centrally imposed rules prohibit borrowing) 1 the region (or regional tier) may borrow under prior authorization by the central government and with one or more of the following centrally imposed restrictions a. golden rule (e.g. no borrowing to cover current account deficits) b. no foreign borrowing or borrowing from the central bank c. no borrowing above a ceiling, absolute level of subnational indebtedness, maximum debt-service ratio for new borrowing d. borrowing is limited to specific purposes 2 the region (or regional tier) may borrow without prior authorization and under one or more of a), b), c), or d) 3 the region (or regional tier) may borrow without centrally imposed restrictions</p>
Representation	<p>The extent to which a region is endowed with an independent legislature and executive</p> <p>0-4</p> <p>Assembly: 0 no regional assembly 1 indirectly elected regional assembly 2 directly elected assembly Executive: 0 regional executive appointed by central government; 1 dual executives appointed by central government and regional assembly 2 regional executive is appointed by a regional assembly or directly elected</p>

Figure 2.2: Regional Authority Index: Shared Rule Dimensions

Table 2: Shared Rule^a

Shared rule	The authority exercised by a regional government or its representatives in the country as a whole
Law making	<p>The extent to which regional representatives co-determine national legislation. 0-2</p> <p>0.5 regions are the unit of representation in the legislature 0.5 regional governments designate representatives in the legislature 0.5 regions have majority representation in the legislature 0.5 the legislature with regional representation has extensive legislative authority</p>
Executive control	<p>The extent to which a regional government co-determines national policy in intergovernmental meetings. 0-2</p> <p>0 no routine meetings between central and regional governments to negotiate policy 1 routine meetings between central and regional governments without legally binding authority 2 routine meetings between central and regional governments with authority to reach legally binding decisions</p>
Borrowing control	<p>The extent to which a regional government co-determines subnational and national borrowing constraints. 0-2</p> <p>0 regional governments are not routinely consulted over borrowing constraints 1 regional governments negotiate routinely over borrowing constraints but do not have a veto 2 regional governments negotiate routinely over borrowing constraints and have a veto</p>
Fiscal control	<p>The extent to which regional representatives co-determine the distribution of national tax revenues. 0-2</p> <p>0 regional governments or their representatives in the legislature are not consulted over the distribution of tax revenues 1 regional governments or their representatives in the legislature negotiate over the distribution of tax revenues, but do not have a veto 2 regional governments or their representatives in the legislature have a veto over the distribution of tax revenues</p>
Constitutional reform	<p>The extent to which regional representatives co-determine constitutional change. 0-3</p> <p>0 the central government and/or national electorate can unilaterally change the constitution 1 a legislature based on the principle of regional representation can veto constitutional change; or constitutional change requires a referendum based on the principle of equal regional representation 2 regional governments or their representatives in a legislature can, alone or collectively, do one or more of the following: postpone constitutional reform, introduce amendments, raise the decision hurdle in the other chamber, require a second vote in the other chamber, require a popular referendum 3 regional governments or their representatives in a legislature can, alone or collectively, veto constitutional change.</p>

^a Shared rule criteria are adjusted for special autonomous regions.

Policy scope is the range of policies for which a regional government is responsible. Several authors have found that decentralized countries have poorer performance on public service delivery and pro-poor public spending (Ravallion 2002; West and Wong 1995), particularly in health care (Treisman 2000; Saltman, et al 2011). Yet Santos (1998) finds pro-poor outcomes under participatory budgeting reforms in Brazil. I argue this is because the impact of decentralization is indirect. The amount of authority different levels of government have in particular policy areas influences how important their levels of commitment and capacity are, which influence outcomes more directly.

Decentralized policy scope should still be expected to increase variation in policy provision relative to a hypothetically uniform centralized starting point, yet some policy areas are more likely than others to have been uniformly applied in the territory prior to decentralization. Centralized policies that require investments in infrastructure or staffing of regional offices (health, education, culture, transportation, public works) are likely to show more variation than those that are applied from the center (taxation, social security, unemployment insurance). The mechanisms through which commitment and capacity influence outcomes are the same regardless of the territorial distribution of authority, so if commitment and capacity were lacking prior to decentralization, regional inequalities in the application of policies and in social outcomes likely existed even under centralization.

Fiscal autonomy is the extent to which regional governments can independently tax their own populations and borrowing autonomy is the extent to which they can borrow. This definition of fiscal autonomy is substantively different from that used in most previous literature¹⁴. As an indicator of self-rule, measures that include how much money a central government decides to transfer to a region are inappropriate,

¹⁴See for example Falleti (2005; 2010a).

even if they give us information about the resources available for regional policy provision (included in our capacity measure in Chapter 2). Fiscal autonomy is therefore fundamentally different from fiscal capacity. The Spanish case is illustrative, where the correlation between the RAI fiscal autonomy score for the ACs is almost perfectly correlated with own source regional tax revenue, but not total revenue, which is mostly made up of ceded taxes from the center and EU funds. Having the authority to independently tax the regional population is a substantively meaningful dimension of self-rule and fundamentally different from regional transfers, which can be high even in the absence of self-rule.

Fiscal autonomy is the feature of self-rule most likely to increase regional variation and the most clearly regressive from the perspective of country-wide progressive taxation. If decisions about how revenue is raised are made and applied regionally, territorial variation in the progressivity of revenue generation will be higher than it would be under central control. Decentralized borrowing power will also increase variation in the resources available for policy provision by regions. Fiscal autonomy places downward pressure on revenue generation if regions can engage in competition, particularly by granting tax concessions to attract investment (Oates 1999; Bucovet-sky 1991). Empirical evidence suggests that in practice, regional taxes may also tend to be more regressive than central taxes (Chernick 1992).

Yet even in this case, the effect of fiscal autonomy is likely contingent. For example, in Spain Catalonia has often been in a position to block redistributive changes in regional finance because it loses a great deal of money in these arrangements and has few independent sources of revenue. In Brazil, because the states control an important value added tax and have significant own source revenues, wealthy states have been less obstructionist when the center has implemented redistributive criteria for its revenue-sharing. It may be that permitting certain formally regressive arrangements

creates the political conditions for other redistributive policies that would otherwise produce excessive opposition from rich regions.

Tax policy rarely varies regionally under central authority, even if some taxes impact regions differently because of differences in the economic activity and employment structure. Therefore, decentralizing tax bases and/or rates should increase regional variation in revenue generation. The progressivity of revenue generation across the country will decline if regions keep revenues raised over their own populations because existing inequalities are almost always territorially concentrated. Poor regions will raise fewer revenues than rich ones, even if their tax structure is the same. To generate the same resources for social provision, poor regions would need higher taxes or borrowing, at the same time that their social provision needs are greater than in rich regions.

If commitment is higher in the region than it was at the center, increased fiscal autonomy and borrowing power may result in greater revenue for social policy in those regions compared to what was provided by the center. If the committed regions are wealthy—which was the case in Brazil until the mid-2000s—they will have greater resources to implement equity-enhancing social policy for a population with lower levels of need. If the committed regions are poorer—which has often been the case in Spain—they will be limited by their tax bases, while having greater need. Increases in fiscal autonomy and regional borrowing power are therefore the dimensions of regional authority with the greatest capacity to inhibit equity-enhancing policy across a country and in poor regions, effects that can only be ameliorated by redistribution from a higher level of government.

The dimensions of shared rule tell us how regions participate in country-wide policy-making. Regions can influence central policies that impact the entire territory through regional representation in central government institutions (law-making and

fiscal control). In addition to legislative representation, regions may have varying levels of authority over central policies that impact the distributional character of social policies through intergovernmental bargaining at the central level (executive and fiscal control), or in special input over constitutional reform (constitutional reform).

Shared rule carries the ideological variation present in regional governments into the central government, increasing veto opportunities and variation in ideology within central institutions. If federal institutions (such as a territorial upper chamber) have authority, they diminish the ideological weight of centrally elected officials. This impacts outcomes differently depending on the direction of the shifts (particularly in terms of level of commitment), but generally preferences the status quo, which we know tends to inhibit welfare state development and therefore tends to be less equity-enhancing.

Giving regions greater say in setting the constitutional rules of the game does not have a clear expected impact on distributive outcomes. While increases in shared rule may generally be expected to constrain maximum levels of equity-enhancing reform or even cause greater variation between regions, rules about how regions participate in constitutional reform are almost always the same across a country. While increased authority in constitutional matters may empower veto players and therefore have the same constraining effect, it may also constrain asymmetrically powerful regions and force them to play by the same rules that apply to weaker or poorer regions.

Starting points and sequence matter for the distributive consequences of shifts in regional authority because redistribution must always be “compared to what/when?” Decentralization of policy scope or fiscal autonomy, departing from a highly egalitarian starting point, will increase inequality because of regional policy variation—barring the unlikely scenario of identical policy implementation in a group of regions

that have no variation in any other important characteristics. Even when certain regions implement policies that are equity-enhancing within their own territory (which has been the case for several regions in both Spain and Brazil), how this impacts countrywide redistribution depends on the relative status of those regions and what is happening everywhere else.

If the starting point prior to decentralization is high inequality, as was the case for both Spain and Brazil, then the field of possible outcomes is much larger and under many scenarios inequality in outcomes can decrease under decentralization, particularly if economic development and democracy take place in all regions in conjunction with decentralization. Still, decentralization will cap the possible levels of equity that can be achieved within the country, even if social outcomes improve across the board. International research on the impact of health policy decentralization across the OECD supports this theory, finding that in general inequalities in health and access to services have increased with decentralization of health policy responsibilities (Saltman, et al 2011: 201). I argue that decentralization reforms tend to exhibit increasing returns—they are hard to reverse democratically, once new territorial actors are invested. Therefore, these long-term possibilities for limits to equity-enhancing reform should be taken seriously by committed actors.

Substantive asymmetries in regional authority when wealthy regions have greater autonomy should diminish the equity-enhancing capacity of social policy reforms across a country. Asymmetry in regional authority is, in essence, institutionalized inequality between regions. This does not necessarily translate into more unequal outcomes, yet once again tends to place upper limits on the reach of equity-enhancing reforms. Assessment of shared-rule in Spain must be considered carefully because the formal weakness of the upper chamber persists in part because the strongest ACs have found that they are highly successful negotiating bilaterally and do not wish to

be constrained by the formal role of the Senate (Montero 2005). The combination of fiscal and executive control, as well as informal mechanisms of bargaining, permit asymmetric influence of different ACs over policy-making at the center.

The central state is still the international standard for maximum sovereignty—it is the status minority nationalists aspire to and is recognized as the core unit for membership in international organizations. If authority over the relevant inputs for equity-enhancing reform resides at the center, the center will have greater capacity to impact the entire territory than if those same resources are controlled by the regions. Even if the regions have shared rule over central policy-making, the coordination costs and number of veto actors decrease the chances of uniform implementation. Central governments therefore have greater capacity to implement policy across the country than regional governments do, even where regional governments are the protagonists in a particular policy arena. This suggests an additional mechanism through which increased shared rule may diminish capacity for equity-enhancing policy output. As I discuss in the following sections, how central capacity is used is what determines distributive outcomes. Centralization in no way guarantees equity-enhancing reform.

2.4 Commitment

My argument is rooted in the expectation that the balance of domestic class and party political power is a major driver of distributive outcomes in society (Rueschemeyer, Stephens and Stephens 1992; Huber and Stephens 2001; 2012). The mechanism that translates ideology into action is commitment. An ideological commitment to equity is the cornerstone of redistributive policy production at any level of government. There are two potential sources of commitment—left partisanship or social solidarity within a salient and territorially defined reference community. This second potential source of commitment usually manifests itself as nationalism. Both leftist and

nationalist forces often claim to be committed to equity, so both are analyzed¹⁵.

From whatever source, commitment plays a dominant role in equity-enhancing policy output because it cannot be substituted for, while its presence can make up for initial shortcomings in other factors that also impact the distributive character of policies. For example, commitment should spur investments to increase fiscal and administrative capacity. The reverse is not true—existing capacity does not produce incentives for increased commitment. The connection between governance by actors committed to equity and equity-enhancing reform should be clear—such policies are at the heart of what these parties and actors stand for.

If actors are committed, their presence in government should impact health outcomes through policy priorities that feed into the social determinants of inequalities in health: basic education and health care, poverty and income inequality, collective bargaining rights, the regulation and oversight of working and living conditions, environmental protection and recovery, and investments in equity-enhancing public infrastructure such as public transportation and subsidized housing.

Cross-national literature on the welfare state, as well as work on Spain and Brazil, has clearly established the protagonism of left parties in achieving policies that decrease inequality and poverty¹⁶. In Latin America and Western Europe, the ability of

¹⁵Christian Democracy is clearly another potential source of welfare state development, but for these cases it does not represent a credible source of commitment to equity. Because I am not assessing social spending or overall welfare state effort, but policies that are explicitly equity-enhancing, the theoretical foundation for the role of Christian Democracy is weak. Huber, Ragin, and Stephens find the welfare state investments of Christian Democrats to have a significantly less redistributive profile than that of Social Democrats (1993). In addition, the Spanish case is the only one in this dissertation where such parties play an important role (Brazil has only one and it is minor) and most of these actors are openly antagonistic to the idea of redistribution and often to social spending in general. The primary exception is in the Basque Country, which I explore in Chapter 4. Given the weak theoretical argument for assuming Christian Democratic forces should be committed to equity-enhancing reform, as well as the lack of traction available in my cases, I exclude this dimension.

¹⁶Stephens 1979; Korpi 1980; Huber and Stephens 2001; 2012; Segura-Ubiergo 2007; Brady 2009; Moller, et al 2003; Huber, et al 2006; Sandbrook, et al 2007; Scruggs and Allan 2006; Navarro and Shi 2001; Borges-Sugiyama 2007; Weyland, Madrid, and Hunter 2010; Levitsky and Roberts 2011.

left parties to govern and influence policies has been tied to democracy (Huber and Stephens 2012), just as preventing left governments from taking root often caused its demise, where democratic regimes existed before the onset of authoritarianism. The orientation of nationalist parties to equity should depend on how their territorial reference community lines up with the actual territorial distribution of authority, which is discussed in the next section.

Commitment is most important at whatever territorial level has primary responsibility for policies. However, in all cases of multilevel governance, decisions are made at several levels that are relevant for social outcomes—often including international organizations. The third cluster in the power constellations theory (Huber and Stephens 2012)—the role of international forces—is considered in this context. In Spain and Brazil, the commitment of international forces (or its lack) has been relevant.

2.4.1 Commitment vs. Electoral Strategy

A tension exists between electoral strategy and commitment because one could reasonably argue that rational actors will support those policies that will be popular with voters and that—if motivated by electoral interests—these cases should not be defined as commitment. There are several situations in my cases where this tension must be addressed, though the most important would be if we find that actors who are ideologically opposed to equity-enhancing reform support such reforms anyway because of electoral strategy. In addition there are several cases in which one might wonder whether ideological moderation is actually an electoral strategy, rather than a change in beliefs.

This tension is not unique to my operationalization of the concept of commitment. The partisan codings from Coppedge (1997), based on expert surveys, and from Power and Zucco (2009; 2012) based on legislator surveys both clearly capture changes in ideological placement that correspond to behavior changes by party actors, many of

which are arguably tied to electoral strategy. In this broader sense, my dissertation does not attempt to resolve the difficulty.

Yet I address this tension in two ways. First, the coding scheme utilized for statistical analysis broadly captures actual changes in party platforms and overall ideology and is not directly based on party behavior on the specific health reforms that are the focus of this dissertation. Second, the reason I argue that commitment matters most at particular moments is precisely because of the assumption that opposition to social policies on ideological grounds will diminish if they prove popular, which they usually do. This means that I place the greatest importance on the very time periods (constitutional mandate, legislation, and implementation of reform) at which it is easiest to differentiate between electoral strategy and commitment.

But what about the particular cases in which this objection could be raised? Let me briefly take positions, which I flesh out in the case studies. In neither country have uncommitted actors pushed for constitutional mandates, protagonized the passage of equity-enhancing legislation, or made efforts to implement progressive reforms—even when there was broad popular demand for the reforms and these would arguably have been popular electorally. They have sometimes been willing to take them up or not dismantle them later, but have almost always been highly opposed at the outset.

In Spain opposition was stronger at first because the reform was more progressive and a more substantive break from the past, but this opposition also dissipated more quickly than in Brazil. The conservative *Partido Popular* (PP, Popular Party) chose not to dismantle the Spanish health reform in the early 2000s (when it had an absolute majority and could have). This should be seen primarily as an electoral strategy. The programs were consolidated and clearly popular and there was little need for reform with a strong economy, but the party has been thoroughly willing to dismantle the same programs when the political and economic logic shifted in 2011.

In addition, the PP did attempt to privatize the health system in the early 2000s and its decision to completely devolve authority to the ACs was rooted in the failure of its central government strategy. In Spain, multilevel intergovernmental conflict has caused parties to position themselves differently at times depending on which party was in power at various levels and in the case studies I articulate the instances where this has impacted health reform.

In Brazil, the PT moderated substantially toward the center after winning the presidency in 2002. In addition, the Brazilian parties on the right have often not played an obstructionist role in the development of the PT's social program, particularly in recent years. This is reflected in the most recent Power and Zucco partisan placement surveys of Brazilian legislators, who see the PT and the parties on the right converging toward the center (Power and Zucco 2012: 7).

The PT could afford to be as committed to equity-enhancing reform as it wanted to be when it was in the opposition, marking out its electoral space by taking highly principled stances. Is the party less committed to equity now that it is in office? The party has shifted from the left to the center left, but the core changes appear to have been in response to electoral and institutional realities that had to be accommodated (Hunter 2009). As we shall see in the case studies, Lula was less committed to health care than to education and social assistance, but even here the Health Ministry was reorganized to focus on primary care with a clear ideological view that this would be more equity-enhancing. Party militants continue to be committed to equity-enhancing reform and the implementation of federally incentivized programs has born clear signs of differential results depending on the orientation of bureaucrats and policy makers toward the ideological goals of the programs (Borges Sugiyama 2007).

I would therefore argue that the PT has moderated due to electoral strategy, but has ultimately not become less committed to equity-enhancing reform. Because of

Brazil's strong presidentialism and the role played by individual ministers, coupled with the PT's relatively weak legislative authority in the context of Brazilian alliance culture, health policy suffered relative to other social policy areas under Lula. Yet this is not because of lack of commitment to equity-enhancing reform. As we shall see, because all equity-enhancing social policies feed into health outcomes, the fact that Lula was highly committed and focused on other such policies still produced important improvements.

The *Partido da Social Democracia Brasileira* (PSDB, Brazilian Social Democratic Party) was never leftist in the way that the PT was, but while its early rightward shift was caused in large part by alliance politics, the party has drifted right ideologically over the past 15 years. The PSDB is considered a center left party until 1994 and then it shifts to the center and then the moderate center right. Because of the complexities of Cardoso's policies from an ideological perspective, as well as the differences in commitment among particular ministers, I consider the PSDB Health Ministries to be moderately committed during the Cardoso years.

For the parties of the right, it was clear both from interviews and field research that the overwhelming popularity of the PT's program combined with federal carrots to induce policy adoption have discouraged ideological opposition. However, as can also be seen from the Power and Zucco survey data on party placement, as well as from the Kitschelt and Kselman (2011) expert survey, the Brazilian parties on the right have never been as ideologically coherent as the parties on the left. They are more opportunistic and less programmatic, so attempts to differentiate between electoral strategy and ideological commitment are less meaningful for these cases.

In the case studies I take the issue up in greater detail because it has played out in different ways in the two countries. In both these cases commitment is far easier to discern from electoral strategy earlier on. Overall, this is a problem that arguably

plagues any study of partisan placement—what is ideology and what is electoral strategy? Yet ideology clearly influences a party’s decision about the portion of the electorate that it will try to win over. This is a broader problem for the study of partisanship that will not be resolved here. For my cases, I argue that while electoral strategy will always be part of how political parties determine their stances in democratic regimes, I have reliably identified the most problematic cases—those in which uncommitted actors support equity-enhancing policies for electoral reasons only—and have avoided mistaking this for an ideological commitment to equity.

2.5 Conflict Over the Reference Community

Communities are social constructs—they are “imagined” but certainly real (Anderson 1983). When policy makers act, they must answer the question: “for whom?” For questions of distributive politics, the question must be addressed overtly. The vision of community that is activated when a policy maker considers the target audience for their effort is what I call the “reference community.” Reference communities can be smaller or larger in territorial scope, more or less inclusive, more or less egalitarian, and more or less salient for actors. In this dissertation I focus only on the territorial dimension. Territorial scope refers to the physical boundaries of the reference community. The vision of a particular political actor is used for their policy-making efforts and the aggregate results (in the form of policy output and actual characteristics of society) will generally not conform to all actors’ individual visions.

When conflict exists between the visions of the reference community that are held by actors regarding the status of communities in the institutions of government, pressures emerge to change the rules of the game. When the dominant visions of the reference community are highly salient and difficult to reconcile, political conflict over the institutional organization of governance dominates politics. This impacts distributive outcomes in two related ways. First, it diminishes capacity by tying up

scarce political capital in existential battles over the rules of the game rather than substantive policy making. Second, it moderates left-right partisanship by forcing actors to prioritize policy efforts along multiple dimensions, which may place distributive politics lower on the list. Such conflict likely favors the status quo in terms of policy output, and how this impacts distributive outcomes depends on how unequal the status quo is. Conflicts may be unavoidable when the different visions of the reference community held by actors within an existing polity are salient, yet cannot be equally realized within the existing institutional arrangements.

Like beliefs and norms more generally, an actor's vision of the reference community can be fluid and will be impacted not only by individual identity, but also by institutional socialization¹⁷. Because this is a study about the distribution of territorial authority and its impact on inequality, I focus on the malleability of territorial scope. When social rights, resources, democracy, or other aspects of public and private life are given a new territorial definition, incentives are generated for shifts in the vision of the reference community. This is the institutional dimension of social construction of identity, applied to a political actor's reference community for the application of public policies.

In discussing commitment, I argued that nationalism could offer a potential alternative source of ideological commitment to equity, beyond traditional left/right partisanship, but that I expected the non-nationalist left to be more significant for reform. The reason is tied up in the way that conflict over the reference community can limit capacity. Whether because increased self-rule has created new visions of the territorial scope for policy making or because strong existing regional identities generated demands for increased self-rule, conflict over the reference community—the territory over which political actors believe policy should be applied—exists in many

¹⁷See Hooghe 2005.

countries. In such cases, committed policy makers will have to set priorities. Some actors who would ordinarily militate in favor of redistributive social policies will compromise elements of this program if they conflict with basic stances on group rights or identity that are considered sacrosanct.

Where powerful regional actors contest the notion of the existing country as a legitimate sphere for redistribution, support for country-wide progressive policies is weakened among potential ideological allies. If decentralization is asymmetric and the territorial contest seems to yield greater resources to regions with high levels of autonomy, a decentralizing race to the top can leave the center with limited authority to ensure social cohesion, even in those parts of its territory without a distinct identity.

While minority nationalist forces at the regional level may advocate social cohesion and a sense of internal group solidarity, political resources are limited and the need to fight for group rights takes time and political capital. Also, these groups may be more inclined toward intra-regional redistribution than their location on the traditional left-right spectrum would suggest, but they may not. Regardless, a price is paid both in their own region for expending resources on ongoing battles over sovereignty, and for the poor in the rest of the country if these battles take central energy away from redistributive efforts. This does not mean equity-enhancing policy reform cannot emerge under these circumstances, only that we should expect more modest results when conflict over the reference community is high.

When intergovernmental bargaining takes place between regions and the center, autonomy itself becomes a goal and often pushes issues of social welfare to a secondary plane. If minority nationalist regions are higher income than average, these conflicts are more intense because the higher regional autonomy is more costly for the rest and more beneficial for the region. Even when formal arrangements are uniform,

conflict over perceived differences in resources, location of investment and infrastructure projects, or partisan access to central officials causes conflict in federal systems. If increased political autonomy, more authority in shared rule, extra revenue, or other valuable resources are distributed asymmetrically, then institutional competition over the rules of the game will absorb political resources for all regions acting rationally, even if they are not part of the conflict over the definition of the reference community. This has been the case for many non-nationalist regions in Spain. This conflict should be negative for equity-enhancing policy provision.

Settling the rules of the game in a way that mostly satisfies veto players and eliminates conflict allows policy to return to the fore. This is more easily said than done, yet the point is that this is not a normative argument against changing the rules of the game. It is an observation that prolonged conflict without resolution (or with a resolution that is unacceptable to powerful sectors) has political costs for all actors, particularly those committed to equity. While ethnically heterogeneous societies perform worse across the board on various quality of government indicators (La Porta et al. 1999; Alesina et al. 2003), there appears to be a significant improvement when the rules of the game can be settled using the compromise of ethno-federalism, rather than a unitary structure (Charron 2009). In other words, if conflict is high, settling on arrangements that accommodate multiple alternative visions of the reference community improves capacity.

For understanding the territorial distribution of authority in society, incorporating an analysis of conflict over the territorial scope of the reference community is central. In Brazil there is little disagreement that the country is the legitimate sphere for political action over a range of issues that are competences of the central government. Yet in Spain, nearly a quarter of the population lives in ACs where the dominant elected representatives believe the existing central state is not the legitimate territorial

scope for the application of any public policies.

There is no silver bullet for managing complex questions of national identity and sovereignty, yet we can still generally expect such conflicts to reduce the weight of commitment (whether nationalist or leftist) in determining outcomes. The left in Spain has historically been committed to democratic minority national self-determination, or at the very least strong federalism, which has created high levels of internal conflict regarding the legitimate territory for progressive redistribution—a conflict that does not exist within the Brazilian left. Because the cost of political conflict is hard to measure, while the immediate financial implications of shifts in the territorial distribution of authority are more easily quantified, actors may underestimate the resources taken up in ongoing struggles over the rules of the game.

While such conflicts have been common in Europe and less central in Latin America historically, an ongoing shift toward special indigenous rights tied to particular territories in Bolivia, Colombia, Nicaragua, Panama, and Peru (Hooghe, et al 2014 forthcoming) may produce greater conflict moving forward. Employing the concept of the reference community helps us understand why capacity and commitment may not be enough to generate equity-enhancing policy in such cases. Where conflict over the reference community is sharp and salient, the space for ideological commitment to equity-enhancing policy is diminished, as is administrative capacity. This should lead to less redistributive social policy output at the central level and possibly at the regional level as well, depending on the constellation of resources and commitment available in each one.

2.6 Capacity

Holding government office cannot be translated into the power to change social outcomes without administrative and fiscal resources. Capacity—fiscal and administrative—is a crucial link between policies and outcomes in society. For actors committed to

equity, a residual state will not do and capacity can be increased with time. Actors who are not committed to equity need less social provision by the government—they and their constituents are more capable of meeting their needs through private channels. Therefore, committed actors have stronger incentives to increase fiscal and administrative capacity.

In the city of Porto Alegre, Brazil (in the state of Rio Grande do Sul), decentralization allowed a committed local governing party to mobilize community members for direct democratic decision making over a small range of local budget priorities (orçamento participativo, participatory budgeting). Though limited and difficult because of low capacity, this process improved social outcomes and the quality of governance, which in turn increased capacity over time. But Rio Grande do Sul is a fairly high capacity state where GDP per capita is 1.6 times the national average and the population is 84 per cent white (one of the whitest states in the country).

In Brazil's poor and highly unequal Northeast where slavery was deeply rooted and oligarchic family rule has only been challenged in the past decade, decentralization placed inhabitants more thoroughly under the control of the entrenched elite interests that dominated the region. In those communities, there was little incentive for increased capacity and the possibilities for equity-enhancing reform decreased even further. In the state of Bahia, only when committed actors were able to win election to state government in 2007 were improvements in capacity prioritized, a slow and frustrating process for those trying to implement the equity-enhancing policy reforms they had promised voters.

While the importance of administrative and fiscal capacity for effective policy implementation are rarely questioned, their distributive impact has not often been studied, particularly at the regional level. In fact, few characteristics of regional capacity have been systematically studied at all because of the enormity of the empirical

challenges. Most of the quantitative measures used in the cross-national literature are either rough proxies or are based on data that rarely exists at the regional level. Concepts such as human capital or the Human Development Index are generally operationalized using income, education, and health in ways that make them impossible to use to test a theory such as mine, since those individual measures are all meaningful indicators of other important parts of the model. The level of education in the population will certainly be associated with the administrative capacity of the bureaucratic corps, but is not available in many countries at the regional level and is generally too highly correlated with GDP per capita.

Corruption is commonly used as a proxy for capacity, but the relationship between corruption and bureaucratic capacity is not completely clear (Schilde and Tubin 2009). This is neatly summed up by the old Brazilian adage about politicians who “rouba mas faz” (steal but get things done). Further illustrating these idiosyncrasies, while regional respondents to an EU Quality of Governance survey in Spain believed their public services were among the fairest and most equitable in Europe, they think levels of corruption in the regional administration of those services is higher than in Europe (Charron, et al 2012: 18).

Likely, the type of corruption matters for its impact on capacity to produce equity-enhancing reforms: we should expect forms of corruption that siphon off public resources into private hands, compromise public agencies that provide important services, or require payment of bribes for receipt of services to be most problematic. However, as with high levels of conflict over the rules of the game, administrative capacity can also be diminished when corruption scandals take center stage and require major investments of time and energy by parties, or the resignation of agency managers and policy makers. The current state of the data requires that such indicators be assessed qualitatively in the case studies, as they are not available systematically

across regions.

Charron, et al (2012) regionally disaggregate the EU Quality of Governance data to produce indicators below the level of the country. These data are imperfect because they combine answers on questions about corruption, the quality of public services, and the fairness of access to those services, along with questions about process and the rule of law. The findings across the Spanish regions are mostly consistent with the case study evidence of administrative capacity I present in the chapters to come. Variation is high, with the Basque Country at the top and Catalonia at the bottom. Some high-income regions like Madrid or Valencia perform as poorly as low-income regions like Andalusia, and the poorest region of all—Extremadura—performs better than all three. The reliance on survey data with few time points and on a topic sensitive to framing, social values, and the salience of the topic hamper reliability. Yet this study and the data on which it relies are an important part of incremental progress in measuring important concepts such as these. Overall, capacity measures are highly contested and some scholars argue that good measures of quality of public administration simply do not exist (van de Walle 2005: 2) .

Finally, under conditions of high poverty and inequality we might expect a “U-curve” in the level of capacity necessary to implement public policy given the size of the community. The smallest villages and townships are likely to have very low capacity, which may make reform difficult. As the size of a city increases, administrative capacity will likely increase and this could yield substantive improvements in public service provision and generate economies of scale. Yet beyond a certain point, mega-cities may require much higher levels of commitment and capacity to produce the same level of reform because of the complexities of service provision in large urban

areas¹⁸. In poor countries with high inequality, these often include daunting problems of service provision in slums, high levels of violence, and large cities with only minimal levels of urban planning.

Capacity is necessary but not sufficient for equity-enhancing reform. While government capacity is not required for the health outcomes of any given individual, it is necessary for addressing inequality in health. Some types of corruption, persistent high levels of intergovernmental conflict, high turnover in leadership of important state agencies, and persistent low levels of economic development can limit capacity. Globalization, demographic transition, and the decline of industry and manufacturing in favor of services broadly constrain the fiscal capacity of governments of all ideological stripes by reducing the potential base for revenue generation and narrowing the set of macroeconomic policy making tools available to governments. The revenue-generating system and the economic reality in the country and regions directly influence the availability of resources.

2.7 Timing and Sequence

For social policy outcomes, timing and sequence matter. For equity enhancing reform to take place and be implemented, particular constellations of commitment, capacity, and territorial distribution of authority at particular moments in the reform process influence how redistributive the reform is likely to be. Starting points cannot be ignored. Most forms of decentralization should, by definition, increase regional variation if the starting place were a very high level of equity. When the starting point is a high level of inequity under centralization, the possibilities are more complex.

Many of the causal variables hypothesized here are more important for successful

¹⁸Paraphrasing Peter Spink, expert in municipal policy innovation at the Fundação Getulio Vargas, “In a small municipality, one committed and capable person can make a very large difference. In large cities, it takes much greater commitment and capacity to achieve the same results because the systems are exponentially more complex.”

equity-enhancing reform at certain moments and generally exhibit patterns of increasing returns—with decisions made early in the reform process carrying more weight than at later moments (Pierson 2000). The crucial moments for the health system are constitutional guarantee/organic law, enabling legislation, implementation, and consolidation. If a universal health system of sufficient quality and coverage can be established, commitment is somewhat less important later on. Popular social benefits become accepted and thought of as social rights, which makes certain types of fundamental reform unpalatable for any governing party. Actors opposed to equity-enhancing reform understand this process and often fight reforms the hardest at the beginning when they believe there will be little chance of overturning them once they are implemented. Lacking government committed to equity at these key points in the reform process tends to diminish the equity-enhancing nature of the policy.

The importance of sequence for capacity is more complex. Variation in capacity will have more impact over the life cycle of the policy and the minimum level needed for successful system consolidation at the outset is hard to define *ex ante*. While a certain level of capacity is required at the moment of implementation and for consolidation (to keep a reform from being marginalized as residual), if the policy gains a foothold socially and politically, demands for increased capacity can force actors to generate resources and invest in administrative capacity that can improve the system gradually over time. Low capacity can diminish the equity-enhancing character of a reform at any point, since budget shortfalls or inept management can quickly deteriorate social services. Financing can also be made more regressive even when the policy itself is untouched, which makes it less progressive immediately.

The sequence of particular types of decentralization matters for social policy provision primarily because of how it interacts with capacity. Because experience with managing budgets and governance institutions should increase overall administrative

capacity, for regions without a history of self-government a lag between the creation of decentralized political institutions and the assumption of major social policy responsibilities should improve the way administrative capacity can be leveraged in implementing equity-enhancing reforms. Gaining policy responsibilities without capacity when a major reform is first being implemented can lead to inequalities in the system that become entrenched and difficult to remedy later. This has been problematic in Spain, where the logic of health devolution had nothing to do with proof of capacity to manage service provision and several relatively low-capacity ACs took on health responsibilities early. Devolution without capacity was also the standard in Brazil in the early 1990s, as well as in several states that were uncommitted to equity-enhancing reform and devolved greater authority to municipalities regardless of their level of capacity. Losses in capacity later matter, but are less likely to shape the fundamental nature of the system. Tables A.1 and A.2 summarize the patterns of commitment, capacity, and decentralization at different stages of health reform in Spain and Brazil. The cut off points are not exactly the same for each variable

The public-private split in health provision is a particularly good example. If capacity is low in what should be a universal public system, the demand for alternative private services and insurance will be high from the beginning. The chances of the system being stigmatized as a poor resource for the poor then increase, just as qualified personnel will not see the public system as a viable place to make a dignified career. This has been a particularly daunting problem in Brazil.

Problems of corruption are generally worse where the rule of law is weakest, democratic institutions and accountability are weakly established, and problems of poverty and inequality are high. This suggests an additional boon to a lag between political decentralization (institutional depth and representation) and extension of policy scope. Especially in new democracies, allowing time for civil society to develop and

establish mechanisms of accountability and oversight with public institutions before granting broad policy making authority and resources to those entities should produce better outcomes across the board, and a more programmatic attention to policies for the poor in particular.

Finally, decentralization itself likely exhibits increasing returns. Once political actors come to think of particular spheres of responsibility as “theirs,” taking them away is challenging. When theory suggests that higher levels of decentralization will make equity-enhancing social policies harder to implement across a country, the best chances for redistributive social policies is to consolidate them prior to decentralization. In this sense, Brazil is a somewhat mixed case because states and municipalities had a high level of social policy authority coming out of the democratic transition, but so did the center, and the center controlled most of the money.

Spain, however, offers a telling illustration. When health reform was passed centrally from 1984-1986, health competences had already been devolved to several ACs and they were partially beyond the reach of central policy implementation, with several more following before consolidation of the health system had progressed much. Indeed, Catalonia battled the center in the courts to prevent its encroachment in this new area of responsibility and ended up being the latest AC (by two years) to implement the reform. The extension of the equity-enhancing primary care reform of 1984 was much more uneven in the early decentralizers than in those that took over health after the consolidation of the reforms, and the poor regions that were early decentralizers have not performed as well as those that took on responsibilities later.

2.8 Democracy

The relationship between democracy and equity-enhancing reform is more complex than it might seem, and difficult to assess in a multilevel statistical analysis constrained by data limitations. There are two potential ways that democracy might

influence equity-enhancing reform—by giving the representatives of those at the bottom a chance to compete and govern (Huber and Stephens 2001; 2012) and through transforming civil society and its relationship to the state (McGuire 2010). For health outcomes directly, significant evidence exists that democracy is associated with improvements in health¹⁹ and the arguments are similar to those for other elements of social welfare—that health care is a public good that tends to be demanded and defended when the majority of the population can express its preferences.

Yet democracy is neither necessary nor sufficient for equity-enhancing reform or health outcomes. Economic development is one of the primary drivers of improved health outcomes in developing countries and the biggest shifts in my two cases took place under authoritarian rule. In addition, high levels of health access and coverage were attained under authoritarian governments—certainly equity-enhancing compared to the previous status quo. Still, for equity-enhancing health policy the evidence is clear that democracy is an important enabler of progressive reform and I explore the links directly in the case studies.

The question of assessing multilevel democracy has received increasing attention in comparative politics²⁰. Yet for a number of reasons I do not incorporate such a measure here. First, the same problem that exists at the central level exists at the regional level for my cases—that the transition to and consolidation of democracy are highly correlated with left rule. In Brazil, where concern about variation in subnational quality of democracy are strongest, clean government and participatory democracy have been important parts of the program of left parties and when they have won office in the historic strongholds of oligarchic rule, the quality of democratic governance has improved. Certainly corruption is not limited by left/right partisanship, but this

¹⁹Franco, et al 2004; Besley and Kudamatsu 2006; Ruger 2005.

²⁰See for example Gervasoni 2010; Giraudy 2010, among others.

brings us to the second challenge for measures of subnational democracy: if formal democracy at the center exists, parties are legal, suffrage is universal, and formal civil liberties are in place, then the level of subjectivity involved in differentiating between corruption and subnational authoritarianism (which should not be collapsed into one category) is problematic. Finally, even the definitions and measures of national-level democracy are highly contested. Shared understandings, measures, and datasets of subnational democracy are still in the very earliest stages of development. The burgeoning scholarly effort taking place in this arena will hopefully permit the inclusion of such measures in the future.

2.9 Income Inequality

For equity-enhancing social policy reform, higher income inequality means a smaller middle class and therefore more limited social consensus in favor of universality. While being poor is bad for the health of an individual, the relationship with income inequality is somewhat more tenuous. Most studies of inequality and health have been carried out in the United States. International comparative research suggests there is a threshold at which income inequality appears to have an independent impact on health outcomes, one that most European countries do not reach (Subramanian and Kawachi 2004). In the United States, the effects appear to operate at the state level, rather than the central or local levels, and have been linked robustly to a large variety of negative health outcomes²¹. In studies that work with individual level data, income inequality is particularly bad for the health of the poor (Wagstaff and van Doorslaer 2001), yet is statistically significant across countries as well (Doorslaer, et al 1997). I therefore expect income inequality to be negatively associated with both equity-enhancing reform and health outcomes.

²¹Blakely, Lochner, and Kawachi 2002; Kennedy, et al 1998; Soobader and LeClere 1999; Subramanian, et al 2000.

2.10 Income and Growth

Empirically, the relationship between income and health, for individuals and countries, follows the “Preston Curve” in which we observe significant health gains associated with increased income at the low end, with decreasing returns at higher levels (Preston 1975; Bloom and Canning 2007). Yet Preston assessed health at different levels of income, not at change over time in particular places or among specific populations. Rapid fluctuations in growth, as well as recessions, have a negative impact on the ability of policy makers to sustain equity-enhancing social and economic policies, which in turn support equitable distributions of health. In addition, some bases of growth are more sustainable than others over the long term. McGuire (2010) finds levels of income to be an important predictor of health outcomes in developing countries, but finds ambiguous effects for economic growth.

I therefore do not expect economic growth to have a clear impact on either equity-enhancing policies or health outcomes. Because neither Spain nor Brazil have reached the height of the Preston curve, I expect levels of income to be positively associated with improved health outcomes. In terms of the impact on equity-enhancing policy, there is no guarantee that increased revenue from population wealth or economic growth will be applied to equity-enhancing policy production, as with capacity more broadly. Even when committed governments are in power, if the needy are a smaller portion of the population there may be little political will for reform.

3 EVIDENCE FROM THE SPANISH ACS AND BRAZILIAN STATES

In this Chapter I present statistical analysis testing the hypothesized relationships discussed in the previous chapter. I discuss the data and their measurement, which are summarized in Table 3.1, below. For health outcomes, the presence of equity-enhancing health policies should be central and socio-economic factors should continue to have an independent effect. Ideological commitment and the territorial distribution of authority have an indirect effect on outcomes through equity-enhancing policies, rather than a direct effect.

In political science, a number of theories about the institutional organization of the state have been found relevant for policy and social outcomes. These include the structure of federal institutions, the electoral system, and the party system, among others. In studies where long enough time periods are covered, or where regions are pooled across countries, such factors will need to be included, but in this case they are held constant by the time period and within-country analysis. In Chapter 6 where I discuss the patterns in Spain and Brazil at the country level, I bring these factors back in, but they are not included in the statistical analysis.

The measurement challenges for regional level statistical analysis are significant, as we shall see. While there is a clear trend toward collecting more and better data below the country level, we are still in the early stages of this process. The data for these two cases have been compiled from country and regional sources. Coding of several new variables is based on field research in Spain and Brazil in 2011 and 2012. In both countries, the highest intermediate tier is the unit of analysis, though

Table 3.1: Variables, Measures, and Sources for Spanish ACs and Brazilian States

<i>Variable</i>	<i>Measure</i>	<i>Source (Spain)</i>	<i>Source (Brazil)</i>	<i>H: Policy</i>	<i>H: IMR</i>
Infant Mortality	Deaths under one year per 1000 live births	INE	IBGE		Outcome
Equity-enhancing health reform	Population coverage under primary care reform	González, et al 2004; López Casasnovas, et al 2001	DAB SUS	Outcome	-
Health Decentralization	0-4 scale	Author	Author	+/-	
Fiscal Autonomy	Regional Authority Index	Hooghe, et al 2014	n/a	+/-	
Central Commitment	Partisan weight in central cabinet	(Full cabinet) Author; CHES	(Executive) Huber, et al 2012; Power & Zucco 2012	+	
Regional Commitment	Partisan weight in regional cabinet	(Full cabinet) Author	(Executive) Author	+/-	
Capacity	Revenue/GDP	BADESPE & INE	IPEA	+	-
<i>Controls</i>					
Legacy of Slavery	White per cent of population	n/a	IBGE	+/-	-
Democracy	Years of central democracy	From 1978	20-year lag from 1985	+	-
Inequality	Income Gini	Goerlich 2012	IPEA	-	+
Poverty	Poverty rate	only post-2004	IPEA (state specific)	+/-	+
GDP/Capita	Regional, CPI-adjusted	INE & Author	IPEA	+/-	-
GDP growth	Regional, CPI-adjusted	INE & Author	IPEA	+/-	+/-

several country-level variables that change over time are also included. In the case of Spain, data for 17 ACs cover the period 1980-2010. In Brazil, the data for 27 states cover the period 1983-2010. The Brazilian panel is slightly unbalanced, as the state of Tocantins was created in 1988.

In Spain there is no doubt that central and AC actors are primarily responsible for health policy, even though the 8,112 municipalities provide the land for building clinics and hospitals. While the *provincias* (between the local and regional level) are major actors in the provision of social services, they are generally even less involved in health policy than municipalities. Yet in Brazil, the 5,564 municipalities are all responsible for primary care provision and larger cities have also been empowered to take on medium and high complexity service provision. Brazilian states build hospitals, train municipal health officials, oversee quality control, and manage epidemiological data. They coordinate service provision in groups of smaller municipalities and directly provide specialist and hospital services for all but the larger cities. In addition, where municipal governments do not competently manage their responsibilities, there have been cases of central and state actors stepping in. The Brazilian states are crucial actors in health, though without the unique protagonism of the Spanish ACs, and are particularly important when municipal commitment and capacity are low.

Many variables for the statistical analysis were challenging to obtain and some have not-insignificant problems of reliability and quality—particularly those coming from survey data. These weaknesses are magnified exponentially for local level information, so lower tiers of regional authority are discussed and included in the case studies, but are excluded from the statistical analysis.

3.1 Health Outcomes

Health outcomes can be measured in different ways, yet few indicators are available over time at the regional level. Infant mortality rates are appropriate for my

hypotheses because they are more responsive to public policies, more quickly, than some outcomes (McGuire 2010). Infant mortality is more highly concentrated among the poor and therefore should be a target for equity-enhancing policies. It is also one of the few regional indicators collected over sufficient periods of time in both cases.

In Spain, infant mortality rates in the ACs are available for 1975-2010 from the *Instituto Nacional de Estadística* (INE, National Statistics Institute). For Brazil I utilize sources from the *Instituto Brasileiro de Geografia e Estatística* (IBGE, Brazilian Geographic and Statistics Institute) and *DATASUS-IDB*, the government database of health statistics (*Indicadores e Dados Básicos*). Municipal infant mortality rates are available for 1970, 1980, 1990, and 2000 and at the state level annually for 1997-2010. I aggregate and weight municipal data for a state-level indicator for 1980-1996 and then use the state level series for the later years. Missing data are interpolated, which is appropriate because in all cases the trend is steadily downward over time.

As McGuire discusses in detail, even from different government sources, Brazilian infant mortality data vary significantly and various authors have shown undercounting of infant deaths by as much as 25-30 per cent (2010: 150). In addition, this pattern should not be random, as infant births and deaths are much more likely to go uncounted in poorer areas. Yet this particular weakness in the data makes for a more conservative test of the theory, as variation between rich and poor areas is likely underestimated.

In the Spanish ACs and Brazilian states, estimates of infant mortality vary more from year to year than the actual reality likely does, indicating the need to see these more as ballpark figures than highly accurate measures. In Spain for recent years, infant mortality rates are so low in all ACs that some variation may result from actual changes in infant deaths from year to year, particularly in small ACs.

Figures A.1 and A.2 show average regional patterns of infant mortality over time

in both countries. In Spain infant mortality in 1975 ranged from a low of 14 in Madrid to a high of 24 in Castilla y León, while all ACs were below 4 by 2010. In Brazil, health outcomes, like other socio-economic and demographic characteristics, are concentrated regionally. In 1980 the highest infant mortality rates were over four times higher in the poor Northeast than in the Southern and Southeastern states, where rates were between 30 and 40. Yet the decline in infant mortality in Brazil has been no smaller as a per cent change than in Spain and has been even more radical in some areas, as the figures show.

Two shortcomings should be kept in mind for aggregated regional infant mortality rates and country averages. First, for regional aggregates, without the microdata, there is no way to know how infant mortality is distributed in the population. Because of the nature of infant mortality as a highly avoidable outcome when proper basic conditions are met, it is quite likely that in rich regions where infant mortality is low, what persists is still almost entirely concentrated among the poor. Higher inequality should exacerbate these trends. This is particularly important in Brazil, where it is quite likely that among the middle and upper classes, infant mortality rates look like they do in most advanced industrial countries, while the poor in those states suffer infant mortality rates more similar to the averages in very poor states. The favelas of São Paulo would be an example to consider—huge pockets of deep poverty in the middle of one of the highest average income states. Second, the central averages presented are not weighted by population—they are state and AC means. These figures are not used in the models, but for illustration only, yet likely inflate infant mortality rates because more populous areas tend to be higher income and have lower infant mortality rates.

3.2 Equity-Enhancing Health Policy

While health outcome indicators are fairly consistent across countries and the literature on determinants of health is large, there have been no unified efforts at measuring “equal access for equal need, equal utilization for equal need, or equal quality for all.” To tell us whether policies are equity-enhancing, we need indicators of actual policy implementation, rather than party platforms or legislation passed. To this end I have collected data on central primary care reform coverage rates.

While the Spanish government has never published formal statistics on coverage rates, the most prominent health policy experts in the country used the government health maps to construct population coverage rates for the reform for each AC (González and Urbanos 2004; López-Casasnovas, et al 2001). A government report on health care in 1991, the *Informe Abril* assesses primary reform coverage rates in that year, which match up precisely with scholarly estimates. Variation in coverage has been high and early decentralizers have had much higher variation and overall lower levels of implementation than those ACs that remained within direct central government health provision (INSALUD) until 2001. Figures A.5 and A.6 show the differing trends for the seven early decentralizing ACs and the 10 late decentralizing ACs. It was not until 2004, a full two decades later, that reform was considered complete in all ACs.

In Brazil, there is a Primary Care Division within the National Ministry of Health (DAB-MS, *Departamento da Atenção Básica*) that keeps tabs on coverage rates for the primary reform, called the *Programa Saúde da Família* (PSF, Family Health Program). The PSF is not a state level program, but is implemented with state support in the municipalities and the center publishes aggregate data on rates of population coverage in each state. The reform began in 1994 country-wide and shows similar variation to the Spanish case. Figure A.4 shows the average trajectory of

the PSF in Brazil. After 15 years, coverage has been nearly 100 per cent in many states for some time, while remaining very low in others. I interpolate the years 1994-1998, as central figures were not kept until this year but in all states it is much more accurate to assume a trend from 1994 to the level achieved in 1998, than to omit the first four years of the program.

There were quite a few state and municipal programs for primary care before the PSF began and the vast majority of these were folded into the PSF in order to take advantage of federal incentives for implementation. These processes are captured by high early levels of PSF in places like Brasília or Ceará, which had their own programs earlier. A handful of municipalities chose to forgo federal subsidies for primary care in order to maintain their own programs. Sometimes these were less generous, less efficient programs that were eventually scrapped (São Paulo city) and in some cases they are more generous programs (Porto Alegre). Regardless, even Porto Alegre has PSF operating alongside its municipal program. Determining the coverage levels of the handful of municipal programs that accompany the PSF is unfeasible, so these programs are not captured in the variable.

This indicator is not without problems, but its meaning is clear and the measure is comparable across regions and in both countries. The main drawback is that the composition of primary care teams has varied regionally and over time in both countries, though fairly consistently in the direction of more complete teams (incorporating dentists and pediatricians in addition to nurses and General Practitioners (GPs), for example), with better training and more resources. However, the current economic crisis has begun to erode the resources of the primary care network in Spain, while in Brazil it is still in an expansionary phase, having been implemented over a decade later. The Spanish data are somewhat less reliable because of higher regional

authority over program design, which means that there have not been uniform titles and terminology used for all ACs, making assessment of reform somewhat more difficult (Lamata 2012).

Assessing primary care also allows me to avoid using health spending as an indicator of equity-enhancing policy effort, which can be particularly problematic in health care. Uncommitted actors are often quite happy to spend public money on health when their electoral supporters include private medical and pharmaceutical interests and the construction industry. Because both countries still have under-funded health systems overall, I do consider health spending in the case studies.

The extent of equity-enhancing health policy should depend on the level of commitment to equity among governing actors at all relevant levels of government, the level of capacity in the region, and the territorial distribution of authority, while controlling for the legacy of democracy, income inequality, economic development levels, poverty, and growth. In Spain, conflict over the territorial scope of the reference community means that left and right parties that defend minority nationalisms should be considered independently. While in Brazil the territorial scope of the reference community is not politically contested, the legacy of slavery is territorially concentrated. One should control for the racial composition of the states—capturing the dominant dimension of ethnic heterogeneity in the country.

3.3 Territorial Distribution of Authority

There are no policy-specific measures of decentralization at the regional level established in the literature. Territorial authority over health policy is therefore coded along a 0-4 scale for each region in both countries. Like the RAI more broadly in policy scope, this measure aims to assess the formal reality—written or unwritten—of regional authority in health. However this measure combines depth and scope in an effort to minimize complexity.

A 0 indicates that the region has limited or no authority in health policy. This is the case either when no health legislation exists or when a region is formally granted a residual role. A score of 1 indicates a significant role in implementation, but a limited role in policy-making. A score of 2 indicates that regions play a role in implementation and also have the authority to expand and organize health services. A score of 3 indicates that regions have substantive policy making authority in health, but authority is shared with another level or levels of government. A score of 4 indicates that regions are the dominant health policy makers.

In Spain, the ACs score 0 until 1981 when public health and planning responsibilities are devolved to all at once and they score 1. Then, whenever they take on full health competences the score increases to 4. This took place in Catalonia in 1981, Andalusia 1984, the Basque Country and Valencia in 1987, Galicia and Navarre in 1990, Canarias in 1994, and the remaining 10 ACs in 2001. The process of health devolution was completely separate from the implementation of health legislation at the center—a part of the process of state reform rather than part of the implementation of the *Sistema Nacional de Salud* (SNS, National Health System).

In Brazil, the states score 0 until 1988 when the Constitution grants states and municipalities the right to supplement and complement central social policy and the score increases to 1. When the *Norma Operacional Básica 1996* (NOB 1996, Fundamental Operating Rule) is passed by the center, a process for territorial organization of responsibilities for the nascent *Sistema Único de Saúde* (SUS, Single Health System) is developed. Some states are *habilitados* (qualified) for an intermediate level of health service management after 1996 and others are qualified for *gestão plena* or full health service management. The first group is coded 2 in the year of qualification and the second group, 3. After the *Norma Operacional de Assistência à Saúde 2001* (NOAS 01/2001, Operating Rule for Health Care) is passed in 2001, states

begin to accede to full health responsibilities if they were not already qualified. By 2004 all states have attained a score of 3, but because the central government retains significant authority in health legislation and state health secretariats are vertically integrated into the central Ministry of Health (not the case in Spain), no Brazilian states score 4. A key difference, which we shall broach in the discussion, is that in Brazil increased authority was tied to increased resources controlled by the center.

For Spanish municipalities and Brazilian states and municipalities, the competence “roof” in health is somewhat unclear, and has been more or less concrete at different points in time. Before the creation of the SNS in 1986 and the SUS in 1988, there was no overarching central health legislation. In Brazil states had historically provided public clinics where the poor went for services and sometimes even free or subsidized medicines. In Spain provincial governments had owned and operated mental hospitals and homes for the elderly. Municipalities often had their own family doctors, paid for by the city council and available to residents. These have been important services and their presence or absence is tightly tied to local capacity, as they were not fulfilling central mandates accompanied by financing. Yet these were not citizenship, residency, or employment rights for users. If money was tight, clinics and hospitals were closed. If one region had resources and another did not, provision was vastly different. There is no way to accurately code what was done with no formal authority and no legislative guarantee, yet these practices should not go unmentioned.

While the dimensions of the RAI capture important variation across OECD and Latin American countries from 1950 to 2010, because of when most other data become available for regional analysis in Spain and Brazil, there is very limited variation across regions or over time. The exception is borrowing power in the Brazilian states, which decreases in 2000 because of the *Lei de Responsabilidade Fiscal* (Fiscal Responsibility Law). In Spain, fiscal autonomy increases in 1997 and was asymmetrical—with the

two special fiscal regimes having maximum scores from the start of the democratic period. But because the changes in fiscal autonomy modified the levels of revenue in the regions, there are serious problems of multicollinearity that prevent the inclusion of measures of fiscal autonomy with measures of capacity.

3.4 Power Constellations

The partisan placement of policy makers offers a good basic indicator of left/right sources of commitment, with policy makers on the left being more committed to equity than those on the right and significant variation existing within these broad categories—variation explored in the case studies. I use the model for ideological party scores developed by Coppedge (1997) and extended by Huber, et al (2012), using the Power and Zucco 2012 Brazilian legislative coding as a reliability check. Tables A.3 and A.4 list the political parties of the regional executive across the time period in each country, with their scoring and a brief description. Coppedge’s coding scheme—based on expert surveys—permits parties and coalitions to be coded as left (L), center left (CL), center (C), center right (CR), and right (R). Then, these parties can either be secular (S) or Christian (X). Parties may also be coded as personalist (P), independent (I), or unknown (U). Coppedge codes the Brazilian parties and coalitions and in the case of Spain I extend his coding model and verify its reliability based on the results of the Chapel Hill Expert Survey (Bakker, et al 2012).

In Spain I score left and center left parties 1 and all others 0 because no centrist parties have governed. While I do not argue that there are no differences between left and center left parties, the narrower the categories become, the more likely there will be significant discrepancies among experts regarding coding. If broad differences are robust in statistical analysis, this is a more conservative test than if particular parties are cherry-picked. While the regional affiliates of the major central parties differ in both countries, they do not differ across the 1/0 divide, which facilitates comparison

at the regional level.

In Spain, the *Partido Socialista Obrero Español* (PSOE, Spanish Socialist Workers' Party coded SCL) and the Euro-communist coalition *Izquierda Unida* (IU, United Left coded SL) are considered left parties, as well as a host of regional and minority nationalist parties. There are very few parties in Spain where left/right partisanship is not easy to discern reliably. There are no parties that have switched from left to right over the course of the democratic period.

In Brazil, weak programmaticness of parties may call into question the ability to reliably code parties as left or right. Yet left parties in Brazil have tended to be the most disciplined and programmatic (Kitschelt and Kselman 2011; Chapman Osterkatz 2012). In addition, the coding process for both Coppedge and Huber, et al takes into account actual policy effort rather than just party platform. Therefore, there are only five relevant parties coded as left or center left in post-1988 Brazil and we can be fairly confident of the use of the label. These parties are the *Partido dos Trabalhadores* (PT, Workers' Party coded SL), the *Partido Socialista Brasileiro* (PSB, Brazilian Socialist Party coded SL), the *Partido Comunista Brasileira* (PCB, Brazilian Communist Party, which became the PPS—*Partido Popular Socialista*—in 1992 and is coded SL), the *Partido Democrático Trabalhista* (PDT, Democratic Workers' Party coded SCL), and the *Partido da Social Democracia Brasileira* (PSDB, Brazilian Social Democratic Party coded SCL until 1994).

The one case where I modify the Coppedge coding is in the case of the PSDB, a case that is problematic for Huber and Stephens for the same reasons (2012: 125). The PSDB coalition that governed federally in 1994 included a hard right and a center right party (the PFL and the PTB) and the PSDB victory would have been impossible without their support. The coalition was highly criticized because of the PFL's affiliation with the dictatorship and cemented a shift to the right for the

PSDB, which could not compete with the increasingly popular PT on the left and has continued drifting to the right in opposition. In the Power and Zucco survey of legislators, the PSDB was to the left of the PMDB in 1990 and 1993, yet by the 1997 survey registered a significant rightward shift, now to the right of the PMDB, and has moved steadily rightward in each successive survey wave (2012: 9).

Yet as we shall see in the case studies, the PSDB at the center from 1995-2002 not only increased the capacity of the central state by stabilizing the economy, but began implementing modest social reforms and even redistributed a significant amount of land. At the subnational level, many of the states that pioneered equity-enhancing health reforms were governed by the PSDB¹. While the PSDB is commonly referred to as a neoliberal party, the fiscal responsibility and market-conforming macroeconomic policies put in place under Cardoso did not adhere to the orthodoxy of the IMF at the time. Equity-enhancing social policies must be sustainable to be consolidated and the macroeconomic position of the PSDB from 1994-2002 was not radically different from that of traditional nordic social democracy. Its lack of emphasis on social questions is primarily where the party loses its claim to the center left.

I therefore code the PSDB as center left until 1994, but then give the center and state affiliates a .5, after². This shift is defensible precisely because the PSDB position in 1994 was so unpopular among actors on the center left. In Maranhão and Bahia, where the PFL represented the old guard and the PSDB was a bitter opponent of oligarchic rule, state party affiliates refused to sign on to the central electoral coalition. The cost to unhappy PSDB politicians of joining other parties was fairly low, as only the PT presented barriers to party membership. Politicians

¹Though in nearly all cases this was prior to 1994, a period over which there is little disagreement about the coding.

²I test the models with various specifications for the PSDB and report the differences in the Results section.

uncomfortable with the shift could choose alternative affiliations, and many did.

Cumulative left variables can capture processes of increasing-returns. However, such measures are too highly correlated with democracy and economic development in these countries. I therefore use a ten-year moving average that bounds left control of the executive between 0 and 1, yet allows the effect to persist over time, as well as more realistically modeling the early years of new left governments—where inevitably previous policy legacies cannot be changed overnight. In Spain I code all members of the AC cabinet because the system is parliamentary, whereas in Brazil I code only the Governor because the running mate is chosen prior to the election and the cabinet is named independent of the state assembly. Figures A.7 and A.8 show the trajectory of partisanship over time in each country, by AC or state, and without the modification of the PSDB after 1994.

3.5 Conflict Over The Reference Community

In Brazil there is no substantive conflict over the territorial scope of the reference community. In Spain, I assess the strength of alternative territorial reference communities by weighting minority nationalist political representation in AC cabinets, distinguishing between left and right³. Minority nationalism is a more useful indicator than party system nationalization (Jones and Mainwaring 2003) because the operationalization of these concepts does not take into account the vision of community held by particular actors. In Spain there are many parties that only operate in the AC, contributing to a lower score on an index of nationalization, yet which see Spain as the territorial reference community for most public policies.

The same Table A.3 that includes Spanish left-right partisanship coding shows

³I tested alternative specifications in which there was only one category with left and right minority nationalists together, as well as one in which I allowed individual cabinet members to be double-counted—allowing left minority nationalists to appear as part of the proportion of the cabinet that is left as well as that which is nationalist. In part because there are very few left minority nationalist cabinet members in AC governments, the different specifications had no impact on the model.

coding on the reference community. The PSOE is distinguished as a federalist party because of its unique orientation toward minority nationalist right to self-rule. Yet the PSOE is only coded as a minority nationalist party in two cases. First, the Basque affiliate (the PSE-PSOE) in the pre-autonomic period when the Basque Statute of Autonomy was first being negotiated ran in a pre-electoral coalition with the Basque Nationalist Party (EAJ-PNV) and took a firm stance in favor of the right to Basque self-determination. This is the only period for which the PSE-PSOE is coded with the minority nationalist parties. Second, the Catalan affiliate (the PSC) is one of the primary pro-independence forces in Catalonia and has been for some time. In this regard, it is unique among PSOE regional affiliates in wholeheartedly distinguishing itself from the federalist project embraced within the PSOE more broadly.

In the regression analysis I use the same ten-year moving average as for the role of left parties in government. Minority nationalism is very common and in Andalusia, Aragón, Baleares, the Basque Country, Catalonia, Galicia, La Rioja, and Navarre minority nationalist parties have held cabinet portfolios, while in many others they win legislative seats but have never formed part of the government.

3.6 Capacity

In Chapter 2 I discussed the challenges of measuring capacity and the types of corruption and indicators of administrative capacity that can be drawn upon for case comparison. Given these constraints, capacity can be broadly captured for statistical analysis with revenue as a portion of GDP—the standard in the literature on state capacity⁴ and an indicator that is available regionally over time. In Spain, funding from the EU radically enhanced the fiscal capacity of poor ACs beginning in 1987. There has been no similar force to benefit the poor states of Brazil, which have much lower capacity than the worst off Spanish ACs. The distributive role of the center

⁴See Pribble 2008: 77 for a discussion.

is apparent in higher revenue/GDP ratios in poor areas in both countries. Still, in Spain the best off ACs have revenues over 20 per cent of GDP whereas in Brazil the best off states often are closer to 10 per cent.

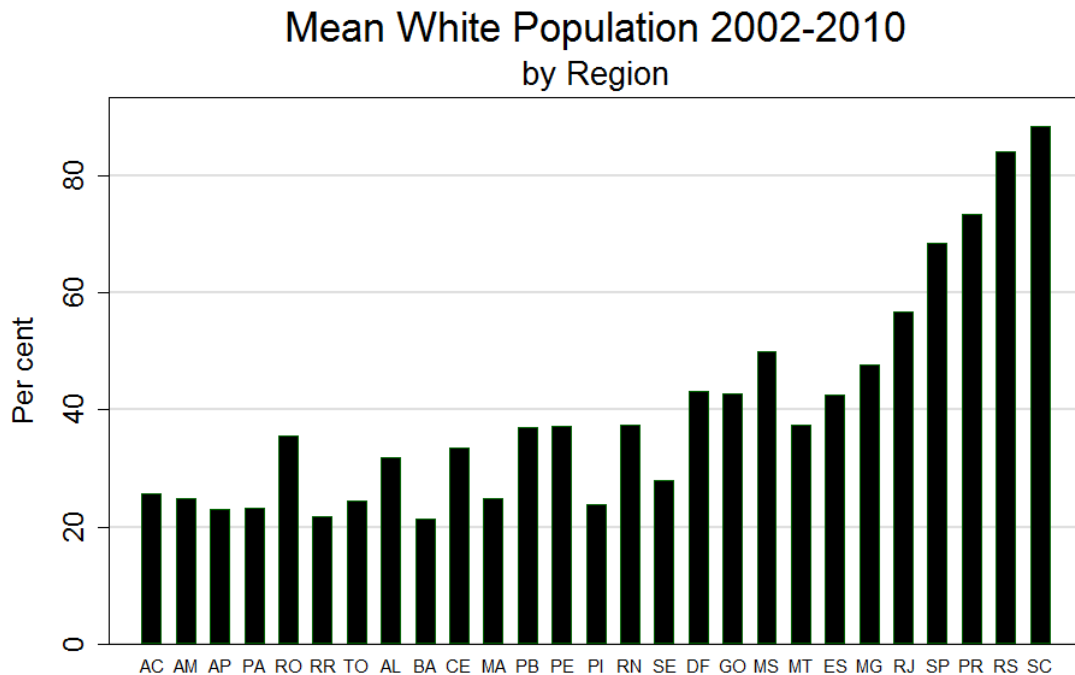
3.7 Race

Despite having no legal segregation or disenfranchisement based on race, Brazil's political economy is still deeply tied to the history of slavery. This is both because of the plantation economies that supported oligarchic white family rule in the Northeast for generations, and because there had never been substantive efforts to mitigate the accumulated effects of slavery until the rise of the PT in the 2000s. Because universal primary care began to expand in Brazil in the late 1990s, becoming a focus for the Lula government after 2002, and focused specifically on building centers first in the poorest neighborhoods before expanding, one would hope not to find an association between race and the implementation of the primary care reform. Yet health outcomes are another story and we should expect white populations to have better health outcomes for quite some time.

The IBGE has collected data on race in the Brazilian states only since 2002. In most states the breakdown does not shift much over this period, but there is a general trend toward greater numbers of inhabitants identifying as black or mixed, across most states. Yet it appears that this shift is not primarily because of changing demographics, but because of changes in the level of social stigma attached to blackness, with mixed race respondents who previously identified as white beginning to claim a mixed heritage. Because my purpose is primarily to control for the political legacies of racial oppression, small changes in racial composition over time are not especially meaningful. I therefore take the average white population of the past decade and apply it to the entire democratic period. Assessing whiteness as a residual category is more appropriate than developing an arbitrary theory about which particular racial

categories and subcategories matter the most for outcomes. Figure 3.1 presents the data, grouped alphabetically by the five regions in order to permit the reader a sense of the geographic shift.

Figure 3.1: Race in the Brazilian States



Source: IBGE

3.8 Democracy

Because most of my data are only available since the onset of the democratic transitions, a binary indicator for democracy provides little traction. Cumulative weights for democracy are the alternative, yet in the case of Spain are simply too highly correlated with other important variables that also increase steadily over time. Following the findings of Huber and Stephens (2012), I apply a 20-year democracy lag in Brazil. While governors were elected in 1982, not only was political competition still constrained, but the literacy requirements that had disenfranchised half the

population even before the onset of military rule were not eliminated until after 1985. Therefore, in addition to no variation across regions, there are very few years still in the post-20-year lag. Ultimately, comparative historical evidence can illuminate the role of democracy in social and policy outcomes for regions within a given country, but it is hard to gain traction statistically *after* the onset of democracy.

3.9 Income Inequality

State and AC income ginis are used, but a note of caution is in order because the figures come from household survey data. The sample sizes are almost certainly smaller than they should be for truly reliable estimates and so variation from year to year, as with infant mortality, is likely excessive. Still, differences between units and broad shifts over time capture an important empirical reality. In Brazil, several years are missing (1991, 1994, and 2000) and so are interpolated. In both cases gini are post-tax and transfer from household surveys—in Spain provided by a team of economists who have been working with the microdata data from the *Encuesta de Presupuestos Familiares* (EPF, Household Budget Survey) for many years (Goerlich 2012; Goerlich and Villar 2009) and in Brazil from the *Instituto de Pesquisa Econômica Aplicada* (IPEA, Institute for Applied Economic Research).

In the case of Brazil, where improvements in income inequality have been observed overall, it is important to understand the difference between a national gini and subnational gini. It is entirely possible for income inequality patterns within subnational units to vary considerably from the national gini because the unit for spacial comparison is completely different. In Brazil the subnational evidence suggests that we should not be overly optimistic about the national trend downward in income inequality. What we see at the state level is that income inequality increased in most states during the 1990s and then began to fall. Yet in the poorest and most unequal states, levels of inequality are still very similar to what they were in 1981

when the first indicators become available. In the South and Southeast, where income inequality was lower to begin with and incomes far higher, income inequality has improved the most. Figures A.9 and A.10 clearly show this pattern in the Northeast and in the South. What are the long term implications for equity if the worst-off places in the country are becoming pockets of persistent inequality, while the whitest, richest, and most egalitarian become more and more so?

3.10 Income and Growth

State and AC GDP per capita are used as a measure of income and, as with growth rates, control for local inflation. The Spanish data are constructed using GDP, census data, and the Consumer Price Index for each AC all published by the INE, and in Brazil are provided in constant reais directly by the IPEA.

Ideally we would test for the impact of poverty in both cases. In Spain, data are only available beginning in 2004 and for some ACs have sample size problems. Regardless, because primary care reform was mostly complete by 2004, the data are not useful for the Spanish model. In Brazil poverty data for the regions are provided by the IPEA and are calculated as double the rate of extreme poverty, based on a state-specific poverty line that quantifies the cost of a basic minimum basket of necessary purchases following WHO norms. The same years are missing as for the income inequality data (1991, 1994, and 2000). In 1986 the poverty data were unreliable for all states, nearly half the rates of the years on either side and dropping to zero in some cases, so I also interpolate 1986 for all states.

3.11 Analytic Technique

For this analysis I use Prais-Winsten regression—ordinary least squares regression with panel corrected standard errors and a correction for first order auto-correlation. Prais-Winsten estimation has been used for similar data in comparative political economy and sociology (Hicks 1999; Swank 2002; Huber and Stephens 2012). Arguments

have been made for the superiority of models with the incorporation of lagged dependent variables and fixed effects (Beck and Katz 1995; Garrett and Mitchell 2001) yet these concerns have been adequately addressed in the methodological literature (Achen 2000; Plümper, et al 2005; Beck and Katz 2011). For units within a country, fixed effects are arguably even less useful, as major sources of variation not incorporated in the model should be minimal and significant events and economic shocks should be felt almost simultaneously. In sensitivity analysis, I test all four models with lagged dependent variables and the results are consistent with my conclusions.

I first test the hypotheses for determinants of primary care coverage in each country and then include a lagged primary coverage variable in the model of health outcomes. While health decentralization, income inequality, race, and poverty can be applied for a given year, revenue/GDP and GDP growth should be lagged one year to give time for incorporation into the annual budget cycle. Because nearly every variable in this model could be theorized to have conditional effects⁵ (commitment, capacity, decentralization, growth, and income are the most obvious candidates, and all terms must be included), yet more than three-way interactions are virtually impossible to interpret, I reserve discussion of conditionalities for the comparative historical analysis.

3.12 Results

Tables 3.2⁶, 3.3, 3.4, and 3.5 present the regression results for the four models and Figures 3.2, 3.3, 3.4, and 3.5 permit comparison of the magnitude of the effects. In both countries, commitment at the center matters for equity-enhancing policy output. Central commitment has large significant effects on the extension of primary

⁵See Hall 2003 for a discussion of this issue in comparative historical political data.

⁶The structure of the Spanish data on primary care coverage causes the Prais Winsten model to omit an R^2 value. Alternative specifications with panel corrected standard errors, random effects, and robust cluster have R^2 values between .66 and .71.

care coverage. In both cases, the extension of primary coverage has a large and significant negative effect on infant mortality, which is particularly interesting for the Spanish case where infant mortality was already low prior to reform.

In Spain, left government in the ACs has been important for primary care extension, which one would expect given their greater authority over transferred health policy. Capacity has also been significant. Minority nationalist presence in regional governments has not been significant, nor has health decentralization. In Brazil the effect of left parties at the state level is actually negative⁷. These findings are discussed in the next section⁸.

In both countries, capacity matters directly for outcomes, as does income. Capacity is not significant in determining primary care extension in Brazil, where the policy's expansion was funded in large part by direct transfers from the central Ministry of Health. Because GDP per capita is measured in the thousands of euro or reais, a 100 unit increase in per capita GDP decreases infant mortality by about .09 in Brazil and .05 in Spain. In line with the impact of poverty, income is negatively associated with higher levels of coverage in Brazil—a stark contrast to the Spanish case, which I discuss in the next section.

As expected, economic growth is insignificant in all models except that of infant mortality in Brazil, where it is positive. In Spain, income inequality has a large effect in depressing primary care coverage and augmenting infant mortality. In Brazil, problems with multicollinearity due to inclusion of poverty measures preclude assessing inequality in the same model. Yet in preliminary analysis, inequality in Brazil was

⁷The negative association between left state governors and PSF coverage is driven by coding Cardoso's central government .5, rather than 0. Regardless of whether the state-level PSDB is given .5 or 0 after 1994, state governors become negatively associated with PSF coverage once Cardoso is included. The R^2 when Cardoso is included is much higher, yet otherwise the results are similar.

⁸The democracy control in Brazil is negative, but the indicator is highly correlated with the slowdown in coverage expansion caused by the economic downturn and the plateau experienced as the “easy” expansion associated with the initial implementation began to level off.

insignificant. This is not especially surprising once one views the patterns of inequality in the states. While inequality in Brazil has decreased since the 1990s and this pattern is true in many states, it is not universal. Income inequality has decreased the most in the highest income states, where it was the lowest to begin with, while in some states it has shifted little.

3.13 Discussion

The large effect of central commitment on primary coverage rates in the regions exists both in Spain, where the major equity-enhancing health reforms were initiated at the center, but also in Brazil, where state and municipal actors innovated and implemented policies first. For Spain the estimated effect of a two standard deviation change is 13.3 and for the ACs, 5.15, while in Brazil for the center it is a whopping 34.4 and for the states is actually negative⁹. Shifting from non-left to left government (from 0 to 1) at the center is therefore associated with significant increases in primary care extension (measured as a per cent of the total population).

⁹Widespread primary care coverage has been a federally driven project and the poorest states were mostly governed by the right during the period of greatest expansion of coverage during the late 1990s and early 2000s. In addition, while states can play a central role in expanding primary coverage—as in the case of Ceará—if large capital cities choose not to implement the reform, the average for the state is pulled down.

Table 3.2: Determinants of Primary Care Reform in the Spanish ACs

Prais-Winsten Regression: Primary Coverage Rates				
Variable	Estimate	PCSEs	Pr(> z)	
Health Decentralization	1.01	.746	0.177	
Revenue/GDP (1 lag)	1.04	.244	0.000	
Central Left	20.53	6.62	0.002	
AC Left	7.43	4.35	0.088	
AC Left Nationalist	-6.98	13.96	0.617	
AC Right Nationalist	3.58	5.39	0.506	
Gini	-1.97	.538	0.000	
GDP/capita	.017	.003	0.000	
GDP growth (1 lag)	-.119	.122	0.326	
			N=438	
			R ² =.	

Figure 3.2: Comparison of Effects on Spanish Primary Care Reform

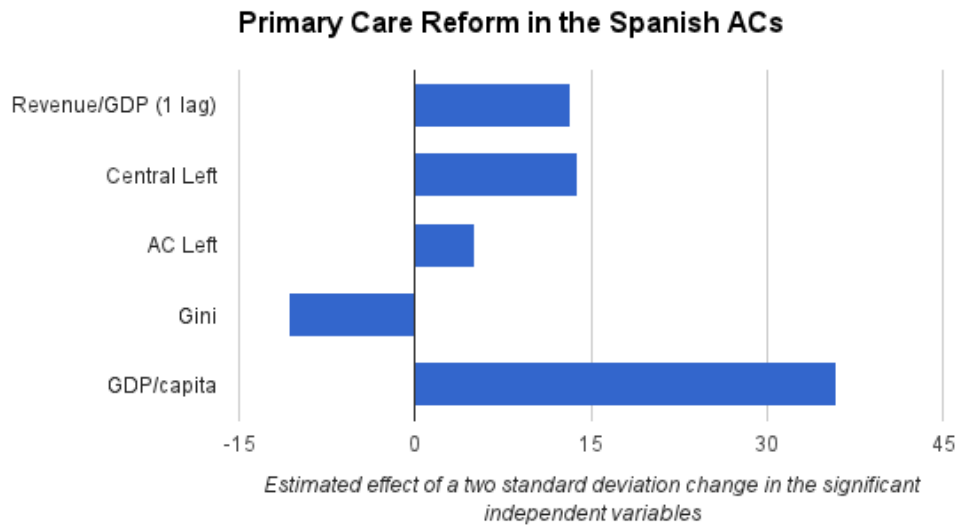


Table 3.3: Impact of Primary Coverage on Infant Mortality in the Spanish ACs

Prais-Winsten Regression: Infant Mortality in the Spanish ACs			
Variable	Estimate	PCSEs	Pr(> z)
Primary Care Reform (1 lag)	-.045	.004	0.000
Revenue/GDP (1 lag)	-.029	.018	0.109
Gini	.074	.044	0.092
GDP/capita	-.0005	1.40	0.000
GDP growth (1 lag)	.017	.015	0.293
			N=455
			R ² =.65

Figure 3.3: Comparison of Effects on Spanish Infant Mortality

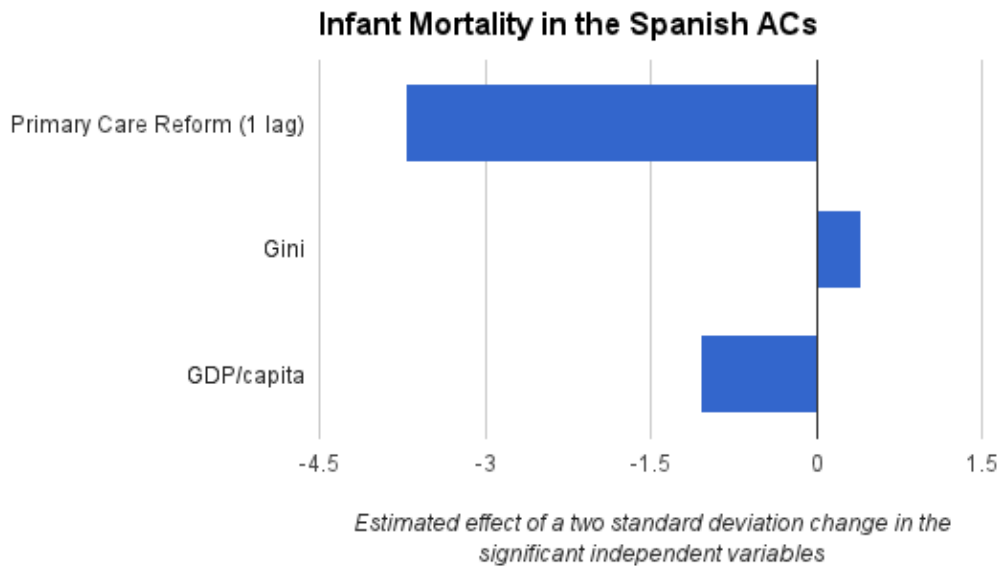


Table 3.4: Determinants of PSF Coverage in the Brazilian States

Prais-Winsten Regression: PSF in the Brazilian States				
Variable	Estimate	PCSEs	Pr(> z)	
Health Decentralization	.353	.828	0.670	
Revenue/GDP (1 lag)	.127	.095	0.182	
Central Left	99.29	9.16	0.000	
State Left	-8.40	3.62	0.020	
White Population	.019	.059	0.748	
Poverty	.095	.077	0.215	
GDP/capita	-.0009	.0005	0.087	
GDP growth (1 lag)	.013	.026	0.603	
Democracy (20 lag)	-8.71	2.85	0.002	
			N=642	
			R ² =.52	

Figure 3.4: Comparison of Effects on Brazilian PSF

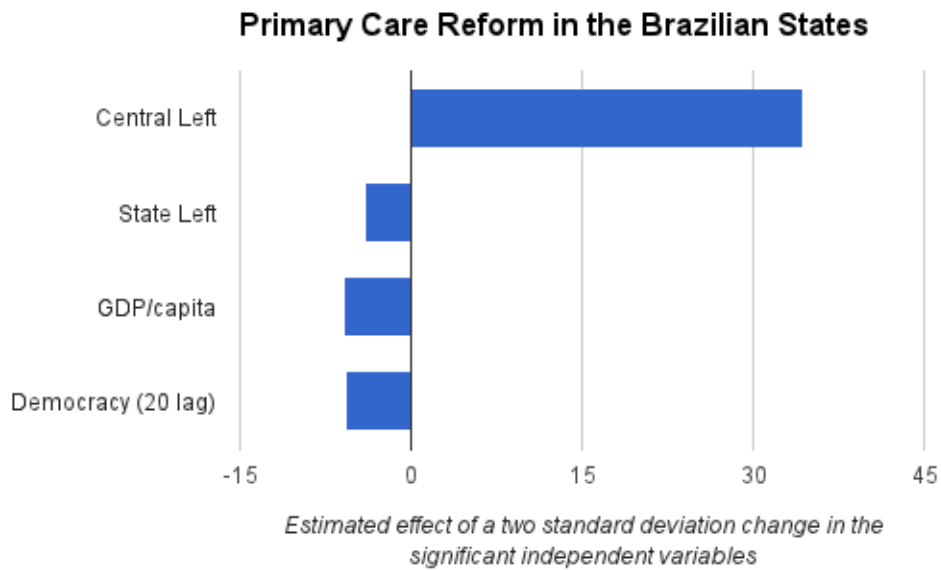
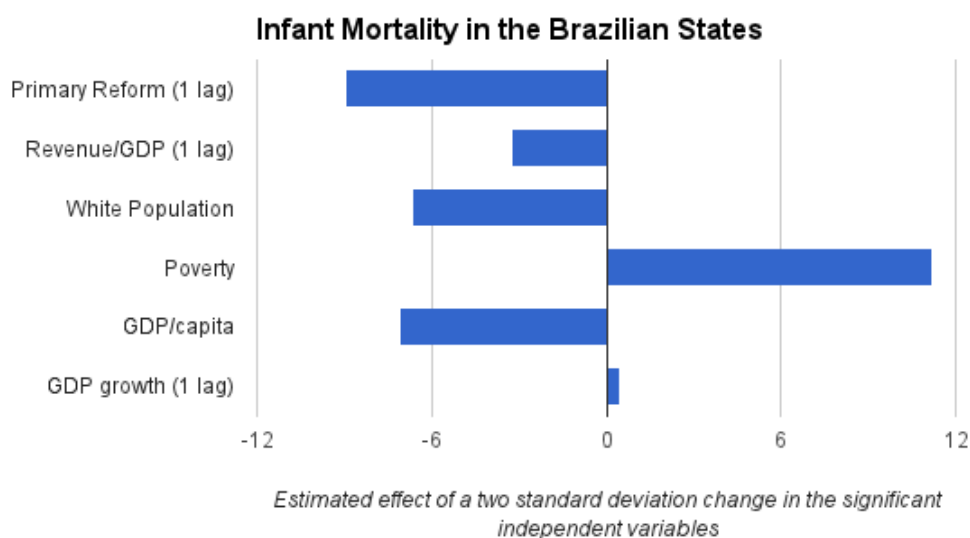


Table 3.5: The Impact of PSF Coverage on Infant Mortality in the Brazilian States

Prais-Winsten Regression: Infant Mortality in the Brazilian States			
Variable	Estimate	PCSEs	Pr(> z)
Primary Reform (1 lag)	-.179	.029	0.000
Revenue/GDP (1 lag)	-.167	.041	0.000
White Population	-.179	.039	0.000
Poverty	.304	.040	0.000
GDP/capita	-.001	.0002	0.000
GDP growth (1 lag)	.026	.015	0.091
Democracy (20 lag)	.871	1.33	0.512
			N=668
			R ² =.69

Figure 3.5: Comparison of Effects on Brazilian Infant Mortality



The large impact of committed central actors illustrates the importance of the center for taking up, funding, and extending regional innovations. In neither Spain nor Brazil have the most innovative regional reforms been initiated by poor regions with low capacity—arguably the ones who need them the most.

In Spain, minority nationalism ultimately has little to show for its time in government. At the AC level, it is the Spanish left that has delivered better coverage of

equity-enhancing social policy. This result could be surprising for two reasons. First, minority nationalist parties generally espouse a high level of commitment to social cohesion within their territory. Second, in Spain the ACs with the strongest minority nationalisms have tended to be higher income than average, so have greater resources to spend on expanding coverage. Why the lack of a relationship? First, the minority nationalist parties that have governed ACs in Spain have been overwhelmingly center-right parties. While leftist minority nationalist parties are active in Andalusia, Balears, the Basque Country, Catalonia, Galicia, Navarre, and Valencia, these parties have not been strongly represented in AC cabinets. Aragón, the Basque Country, Canarias, Cantabria, Catalonia, and La Rioja are the only ACs where minority nationalists have played an important role in cabinet formation, and these have all been right of center parties except for Catalonia for 2003-2010¹⁰.

Second, the ACs in Spain where minority nationalism tends to be strongest also had early devolution of health responsibilities, which meant they were often running the entire show themselves from an earlier date. This is partly a story about administrative capacity, because many nationalist ACs took on health not because they were better able to provide it but because their sense of national identity demanded that they control their own social policies. There were losses of scale and administrative capacity under early devolution in several ACs. But it has also been an issue of commitment, since the central socialist government was oriented toward ameliorating historic inequalities through social policy, while for minority nationalists gaining authority was an end in and of itself, not necessarily imbued with a strong commitment to equity within the territory.

¹⁰The Basque Country is an outlier because while the PNV that has dominated politics since the transition is a center-right party, it has governed most years in coalition with parties of the left and has a unique history of commitment to social cohesion. Since the weight of partisanship in the ACs is calculated based on the number of cabinet seats held, this complex reality is reflected clearly in the data, with left nationalists, center-right nationalists, and center-left federalists all holding portions of the Basque cabinets at different times.

As it turns out, the central health program for providing primary care in the non-devolved ACs was quite equity-enhancing and produced high levels of coverage quickly in almost all ACs. On the other hand, outcomes varied wildly among the early decentralizing ACs, encompassing some of the best and worst performers on primary coverage and other aspects of the SNS. Ultimately, performance on the extension of primary care coverage suggests that early decentralization did no favors for most ACs.

In Brazil, the rise of the PT has come with an ideological commitment to acknowledging racism and the legacy of slavery for the first time. While indigenous people have also suffered, they are a much smaller portion of the population. Because the measure is of the white portion of the population, these groups are included as well. The fact that regional racial distribution and poverty do not impact the expansion of the primary care network is significant. It offers support for the notion that the goals of the central government are being achieved in terms of prioritizing poor neighborhoods for the initial investments for new primary care teams and ensuring that uncommitted governors do not get in the way. Brazil has been far more capable (or heavy handed, depending on one's perspective) at tying strings to funding than has the central government in Spain.

The more pressing problems of poverty in Brazil and the more firmly leftist position of the PT help explain the party's willingness to incorporate redistributive and pro-poor criteria directly into the implementation of the primary care reform, which has not been the case in Spain. Unfortunately the Spanish data do not permit a comparison on the role of poverty. It is also important to note that while the immediate benefits to the poorest members of society are clear in the Brazilian strategy for PSF extension, the overarching challenge of the SUS is to solidify support within the middle and upper class, a process that may not be helped by this model.

In this same vein, one of the most striking differences between the two countries

lies in the impact of per capita GDP, which I argue is largely tied to the role of high inequality¹¹, as well as the timing and pace of reform. In Spain, higher regional levels of per capita GDP are associated with better primary care extension, independent of capacity. This is the relationship one would expect in a context where per capita GDP also likely captures elements of administrative capacity—the educational level of the population and those working in health and government administration, etcetera.

But these effects also illuminate one of the starkest differences between Spain and Brazil—the ghettoization of public primary care. In Spain, while this shift may happen if the crisis continues, public primary care is prized across the population. This was not true at the outset of the democratic transition, but the quality of the reform and the level of investment under the new SNS throughout the 1980s created a high quality network used by almost the entire population. Defense and support of the primary care reform has been widespread and outrage over cuts near universal. In Brazil, this has not been the case and we can see the result. In Spain, increases in per capita GDP are associated with significant increases in primary care coverage. In Brazil, the relationship is the opposite.

The Brazilian primary care program, the PSF, has always been perceived as a service for the poor. This is not because it has targeted poor neighborhoods first, because the goal has always been for the system to act as gatekeeper to public care across the population. The reason for the stigma is twofold. First, despite being in economic crisis in the early 1980s, Spain put significant resources into extending its primary care reform quickly across the country. While the transformation of the health teams and posts took time (what is measured here), the number of hours in which doctors were available to see patients extended from two morning hours

¹¹Given that the overall range of income inequality by region is fairly constricted within each country, a cross-country analysis would be required in order to condition the effects of a particular level of inequality on the role of per capita income.

to a full work day quite rapidly across the country (Bengoa 2012). In addition, the system that existed prior to reform was largely operated directly by the central government. In Brazil, the military regime had almost exclusively contracted with private providers and had no network of public providers that it could rapidly modify when reforms were ready to put in place. In addition, inefficient revenue generating systems and lack of commitment at the center meant no significant money was put toward the SUS for nearly a decade after its passage as law. These were the years for establishing a reputation, yet lacking major investments from the center, most states and municipalities could only provide the bare minimum of coverage.

Second, income inequality in Brazil is so extreme, the middle class historically so small, and private medical provision so entrenched, that no one with money has ever relied on the public system for primary care. Brazilian reformists were fighting a bigger uphill battle for user hearts and minds than were Spanish reformers, and their arsenal was more limited.

In both countries capacity is important. Revenue as a portion of GDP is associated with higher primary coverage rates in Spain and lower infant mortality in both countries. These findings support the argument in favor of redistributive transfers as the basis for financing important social policies, and the risk that insufficient funds can pose for health outcomes in society. For poor regions in Spain, EU transfers often make up nearly half of total transfers (all revenue not generated from taxes and fees levied independently by the region), and transfers, including ceded central tax revenues, are the dominant basis of regional finance for all but the two special fiscal regimes. In Brazil, the lack of external redistribution is partially made up for by the overtly redistributive criterion in the distribution of the block transfers from the *Fundo de Participação dos Estados* (FPE, state revenue sharing fund)—a criterion that has never played a major role in Spanish regional finance. Yet the FPE

is not the primary source for health financing, which generally comes in part from own-source state and municipal revenues and in part through a direct line from the National Health Ministry. Since a constitutional reform increased state and municipal health financing responsibilities in 2000, while holding central financing constant, health finances in Brazil have become increasingly regressive.

Economic growth has no relationship in three of the models, but is associated with higher infant mortality in Brazil. The general lack of relationship is consistent with concerns that international financial institutions and policy makers have focused excessively on economic growth as an enabler of expanded social provision. Volatility may decrease the possibilities of growth, and uncommitted actors may not use increased revenue from growth to expand social policy. In addition, if tax systems are dysfunctional, as is largely true in Brazil, increased economic growth may not be effectively harnessed for increased public revenue.

3.14 Conclusion

What to expect from decentralization is highly contingent and there is no silver bullet for the democrat's conundrum. For maximum equity-enhancing social reform, ideological commitment to redistributive goals, as well as capacity, are necessary at all territorial levels that influence policy making. While policy-making has become an increasingly multilevel process over the past century, political theories have remained focused at the country level and so an important part of the causal story—inherently present in observed outcomes—has not been theorized. In general regional data have been lacking, which has hampered attempts at multilevel analysis. Expanding power resources theory to account for multilevel governance requires developing a theory of how traditional economic attitudes toward redistribution interact with the territorial scope of an actor's reference community.

In the cases of Spain and Brazil, ideologically committed actors with a reference

community whose territorial scope spanned the entire country, acting at the central level, have protagonized the most equity-enhancing health reforms. Most importantly, this has been true for regional level outcomes—the greater the role of the committed center, the more equity-enhancing health policy was within the regions. Need is territorially concentrated and regions with high need tend to have low capacity. While committed actors in Brazil have faced more significant problems of limited revenue and high poverty and inequality, they have faced fewer internal conflicts over central government authority to redistribute through social policy reform. In both cases the extension of an efficient, frugal, universal primary care reform (even when incomplete) has had a clear and significant impact on health outcomes for the most vulnerable members of society.

4 SPAIN

The Spanish *Sistema Nacional de Salud* (SNS, National Health System) was created in 1986 during the first legislature controlled by the Spanish socialists after democratization.¹ The system is designed to be universal, financed through general taxation and free at the point of delivery—all features that took some time to establish. The SNS represented a shift from contribution-based Bismarckian social insurance, which had been consolidated for formal sector workers under Franco in the decade before his death in 1975 and offered some coverage to over 80 per cent of the population. Prior to the democratic transition, the intermediate level of government was the *provincia* (province). The *Comunidades Autónomas* (ACs, Autonomous Communities) were created over the period 1979-1983, above the level of the province, and became the dominant sphere for decentralized public policy, including health.

Devolution of health policy control has been asymmetric, with Catalonia (1981) and Andalusia (1984) taking over before the SNS was even created. Devolution to the Basque Country and Valencia (1987), Navarre and Galicia (1990), and Canarias (1994) came after the start of the health reform process. The other ten ACs were all under the control of the central health system, called the *Instituto Nacional de la Salud Gestión Directa* (INSALUD GD, National Institute for Health Direct Management), until 2001 when health responsibilities were devolved all at once to all ten. Unlike Brazil, increased health responsibilities in the ACs has been more of a zero sum process and significantly limited health authority at the center.

¹Portions of this chapter are adapted from my MA thesis (Chapman 2005).

Until 1993 the system was financed through negotiated transfers, special funds, and revenue sharing from the center for all ACs, even those with early devolution and the two with a special fiscal regime (discussed below). In 1993 the socialists decentralized revenues from a portion of direct taxes levied by the center in the ACs, but maintained the designated formulas that determined how much each AC would receive for the provision of health services in its territory. The system has vacillated since then, with an increasing portion of financing coming from these “ceded” or shared revenues generated in the ACs. Funding for all AC responsibilities was radically decentralized in 2001, but partially recentralized in 2009 due to the inability of the ACs to keep up with health care costs, which had produced massive debts. As the economic crisis continues, with cuts in health care at the heart of major public unrest, the model of regional finance may continue to change.

The central government still manages health services directly in the North African *Ciudades Autónomas* (Autonomous Cities) of Ceuta and Melilla through the *Instituto Nacional de Gestión Sanitaria* (INGESA, National Institute of Health Management). Local governments coordinate with ACs on the placement and financing of new facilities, but neither fund, provide, nor administer major components of health care. These units are mostly excluded from the case study.

The progressivity of the SNS has been shaped by the relative power of ideologically disparate political leaders at key historical moments at the central and AC level, the relationship of democratic consolidation with pressures for regional authority, the subsequent multidimensionality of partisanship along left-right and minority nationalist vs. Spanish nationalist lines, the health policy legacy of the past, and the scarcity of fiscal resources. Table A.1 offers a general overview of the main variables over time at the central level as well as in the three case study ACs. Overall, the system has made great strides with limited resources and has historically been an

equity-enhancing feature of social policy in the country. The strength of the private medical lobby, the neglect of primary care in favor of more expensive and less redistributive curative hospital services, and the lack of accountability and oversight in a now highly decentralized system contribute to lowering the equity-enhancing impact of the SNS across the country and within the ACs. Ongoing conflict over the territorial distribution of authority and the rules of the game inhibit substantive policy making at all levels.

The relatively high overall quality and equity-enhancing nature of the SNS are due to three primary factors: the ability of committed forces to make the government responsible for health care at the drafting of the 1978 constitution, the absolute majority of the *Partido Socialista Obrero Español* (PSOE, Spanish Socialist Workers' Party) in the central government at the moment when enabling legislation was passed (prior to decentralization for most ACs), and the decade of socialist government that followed and ensured full implementation. Ideological commitment to equity in this critical period meant that subsequent variation has taken place within a more constrained policy space. Yet within this more limited arena, commitment and capacity continue to determine differences between ACs.

In general, the SNS under central government control was more redistributive, favoring the poorest ACs and people, than it has been in the ACs with early regional control. The central Spanish socialists have done a better job of redistribution and improving outcomes in the ACs than minority nationalist parties have. Central PSOE policies had a greater equity-enhancing impact when they were implemented before decentralizing reforms, which then placed limits on the reach of central legislation and increased the strength of AC veto players. Poor ACs with low capacity but high commitment did a better job of implementing progressive health policies when decentralization took place later. ACs without high commitment, but with

late decentralization, have also been constrained in the possibilities for retrenchment. Central governments that were not committed to equity have attempted to roll back the more redistributive components of health policy and strengthen private interests within the system. Some of the most significant decentralizing reforms in health policy and finance have been undertaken by conservative forces after unsuccessful attempts to liberalize the system at the central level.

Figure A.7 illustrates patterns of partisan governance in the ACs from 1977-2010, with the Spanish right as the null category. Under decentralization of health, lower regional commitment has meant less egalitarian outcomes in those ACs and sometimes in the country, depending on how much authority an uncommitted AC has exercised in institutions of shared rule. Because there are cases of early and late decentralization across levels of capacity and commitment, AC case studies allow me to tease out these complex relationships. The Basque Country represents a case of high ideological commitment (in this case from Christian Democratic minority nationalism) and high capacity under early decentralization. In fact, the Basque case is the only one in either country where actors whose ideological commitment came from nationalist solidarity, rather than left of center partisanship, protagonized and innovated equity-enhancing health reform. Basque nationalist actors are fundamentally uninterested in redistribution across the Spanish territory, yet because the AC has been outside the standard fiscal system from the beginning, it has not fought for (centrally) regressive forms of fiscal autonomy, as the Catalans have.

Revenue scarcity has constrained the progressivity of health policy and health outcomes throughout the democratic period. Spain has faced three recessions during this time: 1981, 1991, and 2008 on. There has never been a time in which scholars of health policy and political leaders in the ACs have perceived resources for health care to be sufficient. The Basque Country and Navarre come the closest to having

historically been able to fund their health systems as they desired. Since the SNS is popular and highly valued, when fiscal capacity is high, uncommitted actors have little incentive to retrench the system.

Leftist ideological commitment to equity dominates explanations of the distributive nature of the SNS for three reasons. First, because the authoritarian rule of Franco was unabashedly conservative, yet leftist political forces had been strong prior to the Civil War, pressure for democratization and its consolidation were tightly tied to progressive politics and established left parties. Before the transition to democracy there had been an ideological vacuum for four decades in which the left exercised no role in policy making, but persisted in exile and underground. Democratic aspirations in Spain cannot be disentangled from a shift from conservative political domination to more progressive politics². The ideological legacy of the Second Republic, the Civil War, and Franco fundamentally shaped the role of parties of the left and right in the democratic era.

Second, the most significant decisions made about the health system from a distributive standpoint were ideologically contested and implemented in a partisan fashion: when the PSOE had absolute majorities it implemented the most progressive policies, when the *Partido Popular* (PP, Popular Party) had absolute majorities it implemented the most regressive policies. Third, the distributive nature of health financing and service organization has been determined in large part by the ideology of governing political parties at the center and in the ACs. These facets of health policy feed back into the distributive character of health care, even when the overarching structure of the system changes little.

For Spain, in the context of Social Europe, the baseline assumptions about what

²This stands in sharp contrast to the post-transition politics of countries of the former Eastern bloc that were governed by authoritarian regimes that enforced egalitarian resource distribution and in which democratic aspirations were not tied to support for the left.

the welfare state should look like and what citizens in a modern economy expect from their government means both left and right parties are less antagonistic to public health provision than they might be elsewhere. While ideologically uncommitted actors do not initiate and innovate equity-enhancing policies, retrenchment has been a low priority when the economy was booming.

Decentralization has been championed by different ideological actors at different moments depending on how far the country was from the centralized legacy of authoritarianism and how actors perceived their political fortunes to be tied to central vs. regional exercise of power. While left parties generally take into consideration the impact of decentralizing reforms on equity, conflicting visions of the reference community confound left/right positioning on even those forms of decentralization that can be expected to have a clear distributive impact. Historically, right parties considered the country to be the legitimate reference community, so in the early years of democracy these parties defended centralization in ways that, paradoxically, resulted in greater state capacity for equity enhancing reforms across the country, later on. During the transition in 1977, views on decentralization were tightly tied to left/right ideology³. This tendency has waned over time, as both major parties have come to accept regionalization and actors on the left have realized some of the equity-constraining features of the territorial model they once defended without question.

The Spanish left continues to struggle with an existential conflict between support for the right of nations to democratic self-rule and a desire for cohesion and solidarity across the country. When the Catalan left demands greater home rule, including the right to keep the taxes it raises over its population and use them at home, it is increasing its fiscal capacity for equity-enhancing reform. Yet satisfying those

³In order of preference for centralization ranging from 76 per cent at the high end to three per cent at the low end: Francoists, the Falange, Conservatives, those with no partisan identification, Christian democrats, Liberals, Carlists (only this far down the list because of their strength in the Basque Country), Social Democrats, Socialists, Communists, and Revolutionaries (Linz 1981: 25).

demands for the Catalans reduces the ability of the center both to increase equality across the country and to address the acute investment needs of poor regions, since taxes from Catalonia make up a large portion of central revenue. Because the reference community for Spanish parties on the right is one in which high levels of internal inequality are permissible, these conflicts have been less important and have been dealt with pragmatically.

Ultimately, in the presence of commitment and capacity, the center has the greatest ability to create equity-enhancing social policy by ensuring that social policies mediate territorial variation in outcomes and are applied across the country. Yet in Spain, a number of regions possess a national identity that cannot be squared with an overarching sense of responsibility for countrywide redistribution, regardless of ideological orientation. As independent units, these territories might be governed by capable and committed actors who would prioritize equity-enhancing policies. But they are not independent and persistent territorial struggle has sapped resources for equity-enhancing policy production both at the center and in the regions. As the social policy director for the CCOO⁴ in the Basque Country expressed,

*El Conflicto Vasco en este país ha tapado muchos problemas. Hay un Euskoproblema, ¿Y no hay otros problemas? Pero sí que los hay! Hay problemas de paro, de calidad en el empleo, de seguridad laboral, de discriminación, otros tipos de violencia que no sean la violencia de ETA y eso es lo que realmente me preocupa. No es que no me preocupa el conflicto vasco, pero a ver si resolvemos el conflicto y podemos hablar de otras cosas. Mientras sigamos con eso encima de la mesa, tapa todo para unos y para otros.*⁵ (Chapman 2006)

⁴*Comisiones Obreras* (CCOO) was historically affiliated with the Spanish Communist Party, but became independent in the 1990s. It is the largest union in Spain and second strongest in the Basque Country after ELA, which is affiliated with Basque nationalism.

⁵“In this country, the Basque Conflict has covered up many problems. There is a Basque Problem, but does that mean there are no other problems? Of course not! There are problems of unemployment, quality of work, employment security, discrimination, other kinds of violence besides ETA’s violence, and these are the ones that really worry me. It’s not that the Basque Conflict doesn’t concern me, but let’s see if we can resolve that conflict so we can talk about other things. As long as that continues to be on the table, it crowds out everything else, on all sides of the issue.”

The impact of minority nationalism on health policy across the Spanish territory has been mixed. From a simple arithmetic perspective, conflict with the center has consumed governing resources on all sides and encouraged policy and fiscal devolution that has not been equity-enhancing for the country or for poor regions. Minority nationalist parties have also been less effective, on average, at implementing equity-enhancing health policies within their own territories. Yet the best performers in equity-enhancing health reform and innovation have also been the (culturally Basque) foral regimes and there have been visible diffusion effects to other regions, which is equity-enhancing for Spain.

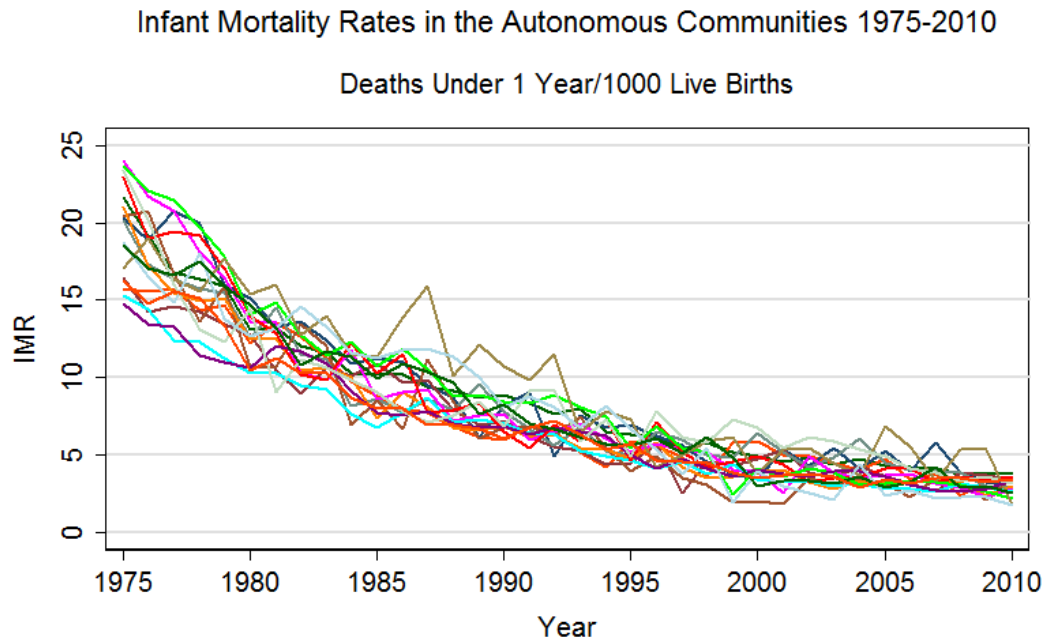
What follows this summary and introduction is a detailed case study of the SNS with a focus on the policies that have shaped the distributive profile of the health system. I begin with the central government, weaving together the story of commitment, capacity, and territorial organization of responsibilities. The case study proceeds chronologically, first at the center and then in three ACs: Extremadura, the Basque Country, and Castilla y León. “Shadow” cases are explored in the three ACs—other ACs that share most characteristics but differ along a dimension of particular interest. Table A.3 lists all parties that have been active in central and AC cabinets since the democratic transition, their left-right ideology, the territorial scope of their reference community, and brief notes. Tables A.5 and A.6 show a timeline of major policy and fiscal events and their equity-enhancing impact in Spain and the three case study ACs.

4.1 Health Inequality in Spain

What is the status of health inequality in Spain? Health outcomes have improved across the board and continuously since the mid-20th century, with large improvements in the 1970s linked to rapid increases in economic development and implementation of the first wave of Social Security reforms. As we saw in Chapter 2,

health outcomes are sensitive to income inequality, levels of economic development, and capacity, in addition to equity-enhancing reform. Life expectancy at birth and infant mortality rates have increased and decreased, respectively, across all ACs (See Figures 4.1 and 4.2). The differences in infant mortality in 1975 were much higher than at the end of the period, with Castilla y León the highest in the country at 24 and Madrid the lowest at 14. By 2010 the Spanish average had fallen to below three and variation was quite low across ACs. Life expectancy has increased steadily across the board, but retains larger variation⁶.

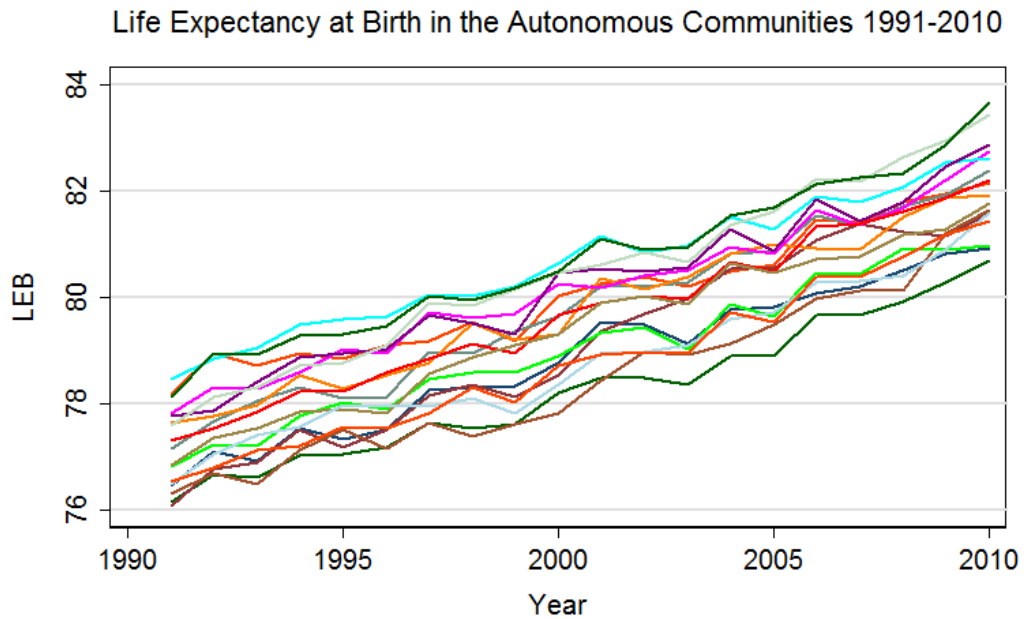
Figure 4.1: Spanish Infant Mortality



Source: INE

⁶It is worth noting, however, that regional variation in life expectancy with good health varies much more than life expectancy, yet the data are unavailable for comparison over time. While Castilla y León, the Basque Country, Cantabria, and La Rioja had high life expectancy with good health, Extremadura, Valencia, Murcia, and Galicia had the lowest, with an overall variation of 15 years between the highest and lowest (MSPS 2008: 41).

Figure 4.2: Spanish Life Expectancy



4.2 Foral Regimes: The Basque Country and Navarre

In this section I review the asymmetric fiscal regime in Spain, in which two ACs collect their own taxes and cede a small portion back to the center to cover the services the country provides in its regions, while keeping the rest. These amounts are referred to as the “cupo” or quota and are calculated, more or less, as the regional portions of what the center spends on non-transferred competencies. The amount was politically determined and amounts to approximately 6.24 per cent (Basque) and 1.62 per cent (Navarre) of the center’s budget for non-transferred responsibilities. The amounts and covered activities have shifted over time, as we shall see in the case of health care, and are hard to pin down because they represent the residual effort of the central government after specific tasks have been removed, rather than a comprehensive list of activities. In addition, some responsibilities such as social security pensions are

jointly managed but centrally financed.

The variation in fiscal autonomy among Spanish ACs is uncommon, even in other countries in the OECD⁷. In interviews, one of the most common reasons that Basque politicians and health experts gave for superior social policy provision was the fiscal system, which allows the Basque Country higher levels of revenue than other regions, as well as funding stability and the ability to plan budgets. Yet this system illustrates the kinds of differences that can emerge when regional fiscal authority (control of the base and rate of major taxes) is high and/or asymmetric. Therefore, understanding these cases is crucial.

In Spain, the term *fueros* is given to the local laws that were preserved in various kingdoms, sometimes unwritten until included in a pact when one kingdom was conquered or absorbed by another. The Basque territories were not the only ones to have *fueros*, but they were the only ones that retained special fiscal, civil, and judicial regimes into the 19th century. The Basques had long resisted feudalism and used their *fueros* to declare the general citizenry nobility (Strong 1893). From the 15th century, the *fueros* allowed the Basque provinces to operate as free trade zones without being subject to Castilian levies on exports and imports, avoid sending their young men to the crown's armed forces except under extreme circumstances, and pay no taxes to the crown (Castells 2003: 121). As a modern central state took shape during the 19th century, the Basque territories chose the losing side of the Carlist civil wars in which Liberals were pitted against the conservative monarchy. In part because the monarchy had mostly respected the *fueros* while the centralizing, secular tendencies of the liberal opposition promised to generate conflict, the Basque provinces fought for the monarchy, losing all but their special fiscal regime when the Liberals won.

While the Basque AC is composed of three historically defined territories, Navarre

⁷Belgium is the only other OECD country with variation in subnational fiscal autonomy among regions with no special status, in the same tier (Hooghe, et al 2010).

is a uni-provincial AC that is sometimes considered culturally Basque. Basque speakers are concentrated in the north of Navarre and the AC was historically differentiated from the other three Spanish Basque territories with the existence of the independent Kingdom of Pamplona at a time when the other Basque territories were part of the Castilian crown (Blinkhorn 1974: 587). The decision of whether Navarre should join with the other Basque provinces or go it alone (“¿Navarra, sólo o con leche?”)⁸ was made during the Second Republic, but was reopened during the democratic transition.

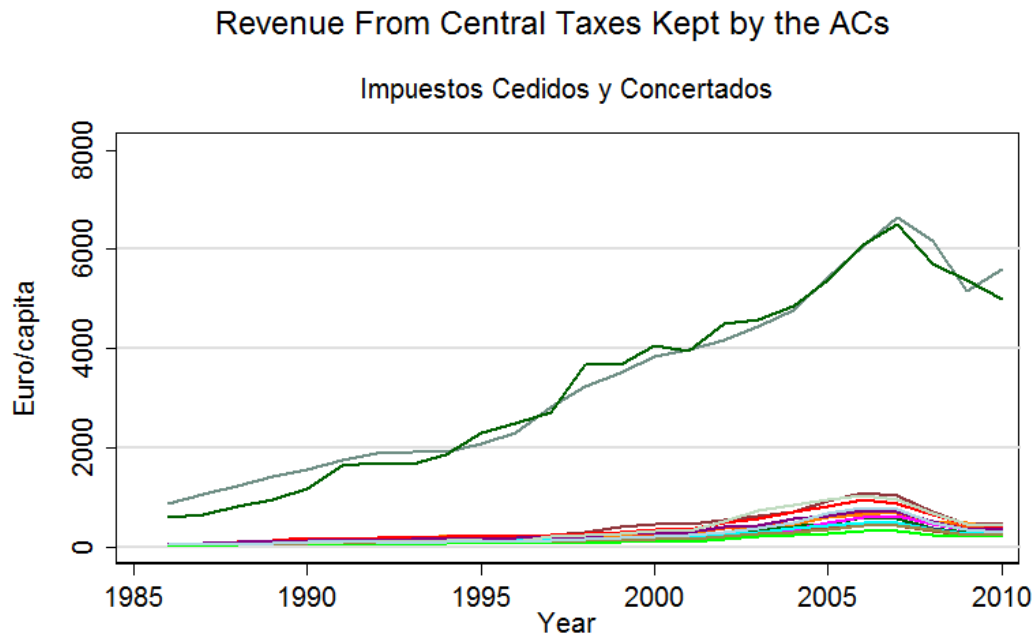
During the Spanish Civil War, the northern and most heavily Basque nationalist provinces of Vizcaya and Guipúzcoa sided with the Republican cause while Álava and Navarre sided with Franco. The result was that Navarre and Álava were permitted their fiscal regime under Franco, while Vizcaya and Guipúzcoa lost theirs when the Republic fell. While Franco made modifications to the amounts of the cupo, it was not abolished, whereas in the two coastal provinces the tax regime was forced into the common system of the national treasury.

How the two territories recovered their foral regimes during the democratic transition is discussed in the Basque case study. The special fiscal arrangements of Navarre and the Basque Country are not identical, but the outcome is the same from an intergovernmental perspective. These two ACs have political authority over their tributary system and collect their own taxes⁹. The same taxes generate far greater revenue for these two ACs than they do in the common regime ACs, but the center also redistributes resources to make up some of the difference. Figure 4.3 shows what the imbalance looks like before the redistributive efforts of the center, which even things out somewhat but still leave the foral regimes with higher overall revenues and far greater budget stability.

⁸“Navarre, black or with milk?”

⁹With minimal requirements that the overall tax burden not be exceptionally different for their citizens and for others, though this has never been defined juridically or contested.

Figure 4.3: Ceded Taxes in Spain



Source: BADESPE and author's calculation

It has not always been the case that the foral regimes were also better off—the Basque Country went through a powerful economic downturn at the height of de-industrialization in the 1980s. However, the situation does highlight precisely why Catalanian demands for independence are so much more powerful than in the Basque Country, despite a more intense history of conflict in the latter. The Basque Country already gets to keep most of its own money, whereas Catalonia, which has historically always been one of the highest income ACs, sends a great deal of money to the central coffers for redistribution to poorer ACs. Independence for the Basque Country can be considered on its own merits from an ideological standpoint, whereas for Catalonia it is tied tightly to the issue of fiscal capacity. The two foral regimes are also much smaller than Catalonia, so the fiscal pressure of losing the latter would be more extreme.

4.3 Health Politics Before Democracy

Prior to the transition to democracy that began after the death of Franco in 1975, health policy in Spain consisted of contribution-based social insurance for a subset of workers. The *Instituto Nacional de Previsión* (INP, National Welfare Institute) was founded in 1908 to administer social security and was expanded under socialist government during the Second Republic to include health care for low-income workers. It was implemented by Franco in 1942. From the beginning the system was fragmented because the administration of responsibilities could be delegated to private entities (Guillén and Cabiedes 1997: 152). Although the government of the Second Republic attempted an expansion and unification of social services in the early 1930s, the Spanish Civil War began before the new institutions could be set up. The risks covered by the INP only included maternity, work accidents, and retirement (Guillén and Cabiedes 1997: 153). Voluntary employer coverage, charity, and private provision were to meet the needs for the rest of the scope of social risks.

During the Franco regime from 1939-1975, health care fell under the *Ministerio de Gobernación* (Ministry of Governance) and the *Subsecretaría de Seguridad Social* (Social Security Subsecretariat). Various public health services were created in the 1940s but these were not integrated until after the transition to democracy. The various programs of social insurance that existed were brought together with the creation of the social security system in the 1960s, after the end of autarky in 1959, maintaining the distinction between the workers' *mutualidades laborales* (mutual funds)—to cover workplace illnesses and accidents—and government social insurance. In the 1960s and early 1970s, public hospitals were opened in all the provincial capitals and access to primary and specialized care expanded significantly. Industrialization was moving rapidly and by the mid-1970s Spain's GDP per capita was higher than Japan's.

The health system under Franco was in the Bismarckian social insurance tradition, but never provided full coverage and paid little attention to regional disparities in economic development or health needs. Addressing inequality was not an ideological priority for the regime—its commitment to redistributive health policy was low. In addition, the public sector was divided into three separate networks—the largest was social security, followed by public health and social assistance, which belonged to the Ministry of the Interior (Guillén and Cabiedes 1997: 322). Primary care was provided in a residual fashion in local *consultorios* or ambulatory care facilities for only two hours in the mornings (EUOHS 2000). Administrative capacity had increased markedly in the 1960s when a significant effort was put into improving the social security bureaucracy, but failure to unify the various systems created roadblocks.

In the early 1970s strikes and mobilization took place among health professionals advocating for the transition to an NHS, but forces within the regime were antagonistic. One progressive health reform proposal was put forth just before Franco's death by a parliamentary commission and another just after by the Ministry of the Interior, but neither made headway due to internal ideological opposition as well as the lack of a coherent plan among reformers (Guillén 1996). Guillén and Cabiedes argue that the reasons health reform did not take place between 1960 and 1980, despite various initiatives and pressures, as well as economic growth and development that would have permitted higher levels of spending and investment, were three-fold: the regressive tax system, Franco's personal opposition to progressive social policy reform, and a lack of information about existing health resources and deficiencies (1997: 324). These are very clearly limitations in ideological commitment and fiscal and administrative capacity.

During the democratic transition, health reform was being debated in all the major political parties and the socialists and the communists were pushing for an NHS. The

lack of central government commitment and administrative capacity clearly played a role in preventing redistributive health reform in this period, despite high growth and social pressure.

Authoritarian centralization in Spain swept regional inequalities under the rug in the context of Spanish nationalism that left no room for the expression of regional grievances. The social safety net that existed had been developed in the context of conservative economic and social ideology that did not place an emphasis on redistribution and was designed to meet the needs of formally employed male heads of household and their dependents. In 1975 Spain had the lowest number of hospital beds per 1000 people of any country in Western Europe (Pardell Alenta 1975) and infant mortality rates neared 19 per 1000 live births (INE 2012).

Spain, like Brazil, experienced a pacted transition to democracy in which no revolution took place and the former authoritarian rulers themselves molded the process of transition and—in exchange for leaving peacefully—were never tried for human rights or political crimes. Unlike Brazil where a bureaucratic authoritarian regime had been slowly liberalizing politically for many years prior to the creation of a democratic constitution, in Spain the shift was more abrupt. In addition, Spain had to territorially reorganize the state, which was not necessary in Brazil. Despite massive unrest and the quasi-revolutionary overthrow of authoritarianism in Portugal in 1974, Franco died in his bed of natural causes in 1975.

4.4 The Transition and the UCD: 1975-1982

By 1975, 80 per cent of the Spanish population had health coverage through social security either as workers or dependents, but the system remained fragmented at the administrative and organizational level (FOESSA 1983: 805). The starting point for democratic Spain is noteworthy: coverage rates were high under the military regime and most workers were in the formal sector.

Despite having sworn to uphold the ideals of the Franco's *Movimiento Nacional*, when Juan Carlos I was named King in 1975, he moved forward with a political reform law that was passed by the legislature and then put to referendum in 1976. This reform legalized political parties and paved the way for the writing of the new constitution. In 1977 the *Pactos de la Moncloa* (Moncloa Pacts) were signed by the parties with representation in congress, as well as business and unions, with the goal of pacting and smoothing the transition process. The pacts were also aimed at developing a quick plan of action regarding the economy, which was in inflationary free-fall. Though not what they are best known for, the pacts began the process of pulling social security policy making out of the hands of the small cadre of physicians and politicians who had controlled it under Franco (Guillén and Cabiedes 1997: 323).

Because the old guard was never ousted, the conservative parties that formed when the party system was legalized were the direct heirs of the ruling elite under Franco. Many of Franco's ministers and legislators continued in politics at the center or in the ACs. This was the case for Adolfo Suárez, who created the *Unión del Centro Democrático* (UCD, Central Democratic Union) to run as a center right, democratic and reformist coalition in the first elections. The UCD won in 1977 with 34.4 per cent and governed Spain from 1977 to 1982, after also winning the first elections in 1979 under the democratic constitution. In 1979 the UCD government was formed with the support of *Alianza Popular* (AP, Popular Alliance), a coalition of harder core right wing parties that included many unreformed members of the regime. Internal conflicts within the UCD caused Suárez to resign and with the economic crisis of 1981 and increasing unemployment and hardship, the coalition crumbled and disappeared. The modern right of center party, the PP was born from reform of the AP in 1989.

Spain uses a closed list proportional representation system for elected offices, except the Senate, which is elected partly in a plurality system from the provinces and

partly by AC legislatures. The Spanish President is chosen by the lower house of Parliament, the *Congreso de Diputados*, and formally named by the King¹⁰. The Cabinet is chosen and organized by the President and if the President falls, so do the Ministers. Unlike Brazil where ministerial portfolios are often distributed to powerful politicians and run with great autonomy, Spanish Ministers are more tightly tied to the ruling party and the President. One would not generally expect to see Spanish ministers acting with significant ideological autonomy or against the platform of the President, though cabinets still contain significant levels of ideological variation and conflict over policies, as we shall see.

The first *Ministerio de Sanidad* (Ministry of Health) was created in 1977 by the constituent legislature after Franco's death (Real Decreto 1558/1977), though was combined with the Social Security Administration at this time. Under the national leadership of the UCD, there were six health ministers in five years. During the democratic transition a temporary health financing formula was developed, which lasted only until the creation of a permanent system and did not address the entrenched inequalities between the ACs. At the outset, health care was financed slightly above 75 per cent from Social Security and 20 per cent from general taxation (López-Casasnovas 1998). In 1978, as a cost containment measure, a 40 per cent copay on pharmaceuticals was introduced, except for retirees, and has remained in place, since.

A number of major reforms took place during the UCD period that began the process of addressing the issues that were holding back the development of an equity-enhancing health system. One was the reform of the tax system in 1977-1978, which introduced direct taxation of personal income for the first time with the *Impuesto sobre la Renta de las Personas Físicas* (IRPF, Ley 44/1978). Spain was in dire need of increased revenue and in the process of negotiating entrance into the EU, which was

¹⁰Both the Spanish and most regional executives are called “presidente” or “presidenta”, though their method of election means they are what we call a Prime Minister in a parliamentary system.

pushing for the implementation of a progressive income tax. This reform was pacted with the PSOE and the UCD received harsh criticism internally for not supporting conservative positions, taking on “progressive” legislation that was considered the terrain of the socialists¹¹.

In 1978 the World Health Organization and UNICEF had called a conference on primary care, which was sponsored by the USSR and held in Alma-Ata, Kazakhstan. The Declaration of Alma-Ata was significant in the international health community and influenced thinking about the organization of care in both Spain and Brazil, pushing policy makers toward integrated public health systems founded on primary care. The UCD, with the cooperation of all the ACs and broad consensus among health professionals about the need for investments in primary care, passed Real Decreto 2221 of 1978 to begin the process of creating *mapas sanitarios* (health maps) so that policy makers could understand the actual state of health services in the country and organize the territory for the public provision of care.

Until 1979, the highest intermediate territorial level was the province. The ACs, which took on primary responsibilities in health provision, regulation, and financing, were created after democratization and after the 1978 Constitution. While historical territorial affinities existed across provinces, with varying levels of legality at different moments, these regions had never been simultaneously recognized and institutionalized in a centralized framework. As we shall see, in some of the ACs that eventually formed, the provincial composition of the territory was quite different from what had been expected by political elites at the central level.

The 1978 constitution paved the way for the creation of the ACs (Art. 147), which took place between 1979 and 1983 through bilateral negotiations and passage of *Estatutos de Autonomía* (Autonomy Statutes) that were unique for each newly

¹¹ *El País* 2/1/1978 “La reforma fiscal.”

created AC. The three “historic nationalities” that had acquired special statutes under the Second Republic—the Basque Country, Catalonia, and Galicia—were guaranteed a fast track to autonomy called the *vía rápida* (Art. 151). For these communities, the Statute was developed by gathering the central government deputies and senators elected from the provinces of those areas to write a proposed Statute, which then had to be passed by an absolute majority of that group, then passed by the Constitutional Commission of the lower house and within two months put to a referendum in the affected provinces (Art. 151.2).

While this avenue was designed for these three communities and was meant to be a more difficult but faster way to gain the maximum competences permitted (Art. 149), the provinces of Andalusia opted for this avenue as well. In fact, the UCD preferred only limited decentralization and had not planned for any other ACs to acquire autonomous political institutions. But when Andalusia pressed forward it forced the major political forces to regroup and negotiate a special exception, while trying to avoid having other ACs go down the same path. The *vía lenta* was to be the process of limited autonomy for the rest of the country and the process was initiated by provincial and local governments and then submitted to the full lower house for passage as organic law (Art. 143). This avenue was designed to yield lower levels of policy devolution, more slowly and in general has had this effect.

The different paths to autonomy were not predetermined. These were critical junctures in a highly volatile transition process. Once a path to was chosen, it defined the next few decades and ensured that an AC would either have a high level of policy autonomy in a wide variety of areas, quickly, or that the process would be slower and more limited. For the UCD, it was a story about attempting to contain regionalization as much as possible by forcing all but the most strident onto a slow path with Statutes that could only be renegotiated every five years. But because of this vision, the *vía*

lenta was immediately stigmatized as being for less capable, less “special” ACs. The UCD originally planned for only these three special ACs to have directly elected institutions of self-government, which deepened the perception that democracy was tied to decentralization.

The UCD’s reluctance to extend democratic institutions to all the new ACs solidified support for the *vía rápida* on the left in most provinces, which would have been the only way to guarantee elected autonomous institutions. This attempt to limit democratic political decentralization created high levels of partisan conflict and caused the provincial left to push much harder for substantive devolution than it might have if democracy and decentralization had not been so tightly intertwined. Herein lies one key to the association between democracy and decentralization in Spain. Because of the legacy of the dictatorship, the assumption that a strong Spain meant weak regions existed on both the left and right and propelled these forces toward often dogmatic stances in favor of particular territorial arrangements that have muddied their ideological policy preferences over time. At this defining moment in the democratic transition, the attempt of the UCD to limit democratic decentralization helped solidify support for broad devolution—beyond just the creation of democratic institutions—for actors on the left.

The government of Adolfo Suárez had created a commission in 1979 to advise on “rationalizing” the process of autonomy. The central PSOE supported the idea of a unified strategy because it wanted to expand legislative institutions to all the ACs. It was also concerned about what would happen if ACs without a history of self-government opted for the *vía rápida* but could not meet the high thresholds of absolute majorities for the provincial referenda¹². This was a reasonable concern, given that it was precisely what ended up happening in Andalusia, which opted for

¹²*El País* 12/2/1979 “UCD y PSOE estudian una fórmula para ‘racionalizar’ reivindicaciones autonómicas.”

the *vía rápida* even though the provinces of Jaén and Almería did not reach the minimum threshold. But the PSOE's commitment to democratic decentralization extended into its own internal structure and its regional affiliates expressed territorial independence. Almost all demanded higher levels of autonomy, more quickly, than the central party supported. An unintended consequence of slowing the process and keeping non-nationalist ACs out of the *vía rápida* was that a larger number of ACs fell into the newly created centralized health service, INSALUD.

The 1978 Constitution for the first time guaranteed health protection (Art. 43 and 49) and foresaw that it would be developed from the outset as a responsibility of the ACs (Title XIII), even without knowing how many there would be. It took five years for all 17 ACs to be created. The constitution grants the center exclusive responsibilities in establishing the minimum services to be covered under the SNS, coordinating the systems of the ACs, and legislating pharmaceutical coverage and health policy that crosses regional borders (Art. 149.16). The document considers health care separately from social security, suggesting that the framers intended to put Spain on the path toward the creation of an NHS (Alonso Olea 1994; Guillén and Cabiedes 1996), which was also consistent with the impulses of Alma-Ata.

AC health secretariats are not hierarchically accountable to the central Ministry of Health, as they are (partially) in Brazil, but only to their AC parliament. Neither the Constitution nor later enabling legislation gave the central state authority to hold ACs accountable or for mandatory data collection that would permit independent monitoring. The courts have become the only source of arbitration over competences and are kept exceptionally busy with parties, ACs, and central actors suing each other over issues of the territorial distribution of authority. It is quite likely that the pacted transition to democracy would not have been successful if the constitution had been more explicit—its vagueness was quite intentional—yet the problems for the practice

of government later have been significant.

Social protection was reorganized into thematic institutions in 1978, with the creation of INSALUD for health assistance and a stronger social security administration for financing social expenditure. Social provision was to be handled by four new agencies that took the place of the old INP. Between 1979 and 1981 all communities gained authority over public health and health care planning. While Health Minister Sánchez de León began the process of modernizing the newly created INSALUD, health policy and the development of the welfare state remained low on the list of political priorities, far below the broader political reform project.

Despite the lack of focus on health policy at this time, state reform continued. It had been hard enough for the UCD to force the Basques and Catalans to wait for their Statutes until after the passage of the Constitution—not a minor point of contention, but rather a fundamental question of the source of sovereignty and the definition of the future limits to autonomy that would be defined for the historic ACs. These communities had their Statutes drawn up and approved, waiting for the constitutional process to be completed. The central government passed the Basque and Catalan Statutes in 1979. The pressure of demand from these two ACs had forced a fast pace and a higher level of devolution than the UCD had wanted. For much of the rest of Spain, awareness of conflict over the territorial distribution of authority had been relatively low (Linz 1981: 21). Blow by blow coverage of the tense negotiations for Basque and Catalan autonomy in the newly-freed press captivated the country and brought these questions to the fore in other ACs, as well. The pressure for a legal, judicial, and administrative framework for the autonomy process became intense.

In 1979 the *Ley Orgánica del Tribunal Constitucional* (LOTC, Organic Law of the Constitutional Tribunal LO 2/1979) became the supreme judicial law for the country, governing the ACs and their Statutes (Revorio 2009: 92). The *Ley Orgánica Sobre las*

Distintas Modalidades de Referéndum (Organic Law Regarding the Different Forms of Referenda 2/1980) enabled the popular consultations required for beginning the autonomy process through the *vía rápida* and for ratifying the Statutes in those cases. The *Ley Orgánica de la Financiación de las Comunidades Autónomas* (LOFCA, Organic Law for AC Finance 8/1980) set out the framework for regional finance. This included the *Fondo de Compensación Interterritorial* (FCI, Inter-territorial Compensation Fund, Art. 16) with the express purpose of ameliorating inequalities in level of economic development between the ACs through public investments. Also created by the LOFCA was the *Consejo de Política Fiscal y Financiera* (CPFF, Council on Fiscal and Finance Policy), which coordinated fiscal policy between the ACs and the center and has become the dominant organ for intergovernmental bargaining in this arena. Table A.6 places the creation of some of these institutions in the broader timeline of fiscal changes in health policy.

An attempted coup took place on February 23rd, 1981 in which the Guardia Civil took possession of the Congress, believing the monarchy to be on its side. While there is still great speculation about the event because the King waited many hours to appear publicly and renounce the events, the coup eventually failed. Democracy in Spain is therefore not seen as fully consolidated until 1981. The negotiations and policy-making that took place during these years were constrained by high levels of uncertainty, as well as political and physical risk for reformers.

The Health Ministry was separated from the Social Security Administration in 1991. This paved the way for political decisions to be made autonomously regarding the organization of an independent health service. Health maps were drawn up during this period that allowed for assessment of where coverage was weak, while access and coverage continued to expand. In 1982 the *Ley de Integración Social del Menusválido* (LISMI, Law for the Social Integration of the Disabled 13/1982) guaranteed the rights

of the disabled in the work place and granted access to health care—the first extension of health services not based on attachment to the labor market.

These pieces of legislation were primarily negotiated between the major political parties, which became the norm for major policies during the 1980s and 1990s (Encarnación 2008: 9). Under UCD leadership, the Health Ministry tried to tighten the relationship between the government and the private medical establishment¹³. In 1981 health competences were devolved to Catalonia (Real Decreto 1517/1981)—though because the state model was still in flux and the SNS was still five years out, its level of authority in health material was contested politically and in the courts.

Because decentralization was a priority for all the political forces that had been banned under Franco and substantive social policy decentralization was written into the Constitution, the devolution process was part of political reform and not treated as a secondary priority, as social policy reform generally was during this time. Therefore, while health reform did not take place countrywide, devolution of health responsibilities continued.

After the attempted coup, pressure within the PSOE for support of harmonization in the autonomy process was strengthened. The UCD feared centrifugal decentralization pressures that might create chaos and total asymmetry, or even independence for some ACs. The PSOE feared centrifugal decentralization both from a distributional perspective, with an intellectual base in the centrism of socialist doctrine, but also from a pragmatic concern about the level of autonomy the anti-democratic right in Spain would tolerate before attempting to retake the state. After the 1981 coup attempt, with the constitution still young, this was not a paranoid concern.

In 1982 the *Ley Orgánica de Armonización del Proceso Autonómico* (LOAPA, Organic Law to Harmonize the Autonomy Process) was passed with these ends in mind,

¹³ *El País* 2/14/1982 “La idea de estrechar relaciones entre el Estado y la medicina privada presidió el 27 aniversario de la Fundación Jiménez Díaz.”

but the Basques and Catalans sued in the Tribunal Constitucional, arguing that a central law could not limit the authority invested in the ACs within their Statutes, which had constitutional status and had been active for several years already. A third of the articles in the law were overturned, but the UCD and PSOE had nevertheless been able to impose their preferences about the tempo of reform because they dominated the central legislature, which had to approve each Statute.

As Spanish nationalists always claimed, and in what has turned out to be a prescient concern, there was no way to open the door just a hair for special rights in certain territories. The aspirations of the rest swung that door wide open. The issue of which areas were linguistically different, could claim their own nation, or had autonomy dating back to the Second Republic (the UCD's criterion for autonomy) was tricky. The combination of fuzzy distinctions between historic nationalities and others and the clear benefits of having this special status have driven what Luis Moreno calls "autonomic mimesis" in which all ACs claim special national traditions in order to maximize leverage in bargaining with the center (1997).

Most of the Spanish territory could claim origins in kingdoms with traditions that differentiated them from the rest of the country—one of the reasons Alfred Stepan considered Spain a quintessential example of "holding together" federalism (1999). In addition to Euskara (Basque) in the Basque Country, Gallego in Galicia, and Català in Catalonia, linguistic difference abounds throughout Spain. Basque is spoken in northern Navarre, while Valencia and Balears both speak dialects of Catalan (or Valencià, to valencianos). Within Catalonia the Aranés language is co-official and spoken in the Valle de Arán. Aragonés and Asturleonés are spoken by minorities in Aragón, Asturias, and Castilla y León, respectively. A wide variety of dialects of Castilian Spanish are recognized in the center and south of the country, as well.

The formation of the ACs could have turned out quite differently. In the Basque

Country, several counties of the southernmost Basque province of Álava sit like peninsulas in La Rioja (the Rioja Alavesa). In Castilla y León, as we shall see, great effort by central actors was put into ensuring that the nine provinces formed a single AC, when arguably the cultural and political differences warranted the creation of more than one. Aragón and Cantabria had initiated the process of autonomy during the Second Republic, but had not voted on their Statutes when the war began and so were not fast-tracked. The status of Navarre was up in the air in the early years and Madrid, La Rioja, and Cantabria were all originally conceived as pertaining to other communities, yet all four ended up as uniprovincial ACs. Therefore, which provincial groupings were considered “historic nationalities” was somewhat arbitrary, yet came to define the process of devolution.

Perhaps the entire process would have evolved differently if the Senate had ever been envisioned as a true territorial body of representation. But because possession of minority national identity is asymmetrically distributed across the country, the level of autonomy desired by these ACs was not the same as what was desired or reasonable for the rest, at least at the moment of the transition. The Senate is therefore a body composed of AC government appointed representatives, as well as provincially elected members (and originally, a large block appointed by the crown), which does not have the authority to initiate legislation and can be blocked by the lower chamber at every stage. The limited authority it does possess has rarely been used.

The asymmetric nature of the Statutes and central actors’ desire for a slow and orderly process played a significant role in determining how health responsibilities developed over time. It takes time for institutions to gain experienced and capable administration, so how long a community has run its own health system may influence administrative capacity. Yet ideological commitment is still the linchpin. For the Basque Country, with high commitment and high capacity, early decentralization

meant it could vastly improve health services, faster. For Extremadura, late decentralization meant that the government had time to establish a capable administrative institution before taking on health care, which seems to have prepared it well for executing policies after 2001. Yet Madrid, lacking commitment, has been able to run its health service into the ground quite quickly, even though it had late decentralization and a great deal of money. Catalonia has had surprisingly poor performance on health indicators and service coverage, despite early decentralization and high capacity. There is therefore significant variation in the quality of health service provision that cannot be explained by the timing of increased authority in self-rule.

4.5 Socialist Government in the New State of the Autonomies: 1982-1993

In the 1982 general election the PSOE won an absolute majority with comprehensive health reform a part of its platform. The UCD imploded and disappeared and the AP took its place as the primary opposition party—swapping a more moderate and reformist right for a harder right. While for the Spanish right the shift in support from the UCD to the AP and then the PP meant a shift from a centrist party to a harder core right party that did not moderate until a decade into democracy, the opposite was true on the left. The PSOE emerged as the dominant party of the left under the leadership of the charismatic Felipe González and over time the *Partido Comunista Español* (PCE, Spanish Communist Party) diminished. In 1986 the PCE fomented the creation of *Izquierda Unida* (IU, United Left) coalition, which remains the dominant party to the left of the PSOE at the center, garnering around ten per cent in general elections until 2000 and dropping to around five per cent since then (though with a notable increase in 2011 in mid-crisis). Both IU and the PSOE are federalist parties, meaning that they support autonomy for the ACs and in some cases, self-determination. It also means that the internal structure of the parties allows regional affiliates a high level of independence.

Ernest Lluch, an economist and historian, was appointed Health Minister in 1982. Lluch represented a radical shift from the past five years. He was an anti-Franco Catalan who had been a militant protestor against the regime and served as representative of the Catalan Socialists in the Congress before becoming Minister. Unlike his UCD predecessors, Lluch ran the ministry for the full term of the first PSOE government. During Lluch's tenure, restricted access to abortion was legalized for the first time (LO 9/1985) and both the primary care system and the SNS were created. In 1984 health competences were devolved to Andalusia (RD 400/1984). Health financing shifted during this period as well, primarily out of the social security budget and into general revenues. Transfers to the ACs with devolved health responsibilities were calculated on a mostly per capita basis.

In 1984, as the SNS was being developed within the government and Health Ministry, Lluch was protagonist in the creation of the first comprehensive health legislation in Spain—*Real Decreto 137/84 de Estructuras Básicas de Salud* (Basic Health Structures). This created Primary Care Teams and for the first time organized the Spanish territory to ensure universal access to the teams, which would later operate as gatekeepers for the new health system. The teams included a GP, nurses, pediatricians, and other specialists. The goal was to reorient primary care toward prevention, increasing the time dedicated to each visit, promoting teamwork and ending the practice of using ER specialists for routine visits (MSC 2004).

In practical terms, the hiring of primary care physicians as a distinct branch of specialist care and their incorporation into existing care teams was rapid under the reform, as well as their incorporation into the newly expanding health centers (Bengoa 2012). Some opposition came from the municipalities, many of which had full time GPs contracted by the city council who were on call 24 hours a day. The reform created health clinics that served outposts in several municipalities, meaning that

many smaller localities no longer had their own full time providers (Lamata 2012).

The *Ley General de Sanidad* (General Health Law 14/1986) created the SNS, defining it as the coordinated health services of the ACs¹⁴. Spain joined the EU in 1986 as Greece, Italy, and Portugal also began creating national health systems. The development and implementation of the SNS were Lluich's primary projects as Minister, including confronting the entrenched conservative interests in politics and private medicine that had dominated health policy making up that point¹⁵. Not only was there more health policy production under the PSOE, but the role of the Health Ministry was more significant than it had been under the UCD.

As part of the 1986 creation of the SNS, the *Consejo Interterritorial del Sistema Nacional de Salud* (CISNS, SNS Interterritorial Council) was created. The CISNS was composed of the Health Minister, with 17 weighted votes or representatives to equal the ACs, and regional health ministers for all ACs (both those that had taken on full competences in health care and those that had not). It was tasked with coordinating the SNS, including making consensus recommendations. In practice, the CISNS is where major decisions about the health system are negotiated.

The health reform that took shape from 1984-1986 was designed to place Spain firmly in line with the European norm among Spain's neighbors, but eventually achieved better coverage and services at a lower cost than several wealthier countries. Compared to the residual welfare regimes of the Anglo Saxon countries, even the 83 per cent coverage rates Franco had achieved were significant. The Spanish socialists were strongly committed to the propagation of what they hoped would be a progressive NHS: public provision, universal access, free at the point of delivery, and financed from general taxation.

¹⁴“El Sistema Nacional de Salud se concibe así como el conjunto de los servicios de salud de las Comunidades Autónomas convenientemente coordinados.”

¹⁵*Fundación Ernest Lluch* “Biografía” <http://fundacioernestlluch.org/es/biografia>.

The important role that a strong Ministry can play at key points in the reform process is illustrated by the internal challenges the Ministry of Health faced from other PSOE cabinet members, who felt the economic pressures of other state projects were a bigger priority and did not want health care funded from general taxation. The Health Ministry had to prevail against not only external ideological challenges, but internal challenges based on differing priorities for the spending of scarce resources.

The PSOE had tried to exclude private actors and the opposition from the development of the legislation, which produced high levels of conflict later on, but ensured that the starting point for negotiation was determined by the socialists. Physicians had been able to develop a system of dual practices, in which they maintained private practices while employed in the public sector, an arrangement that was threatened by the creation of the public system. But the dual practice norm was established in part by mediocre public coverage prior to reform, which could only provide employment for a few hours a day, leaving doctors no option but to also find other work. In the end, the compromise required not tinkering with the private contracting system known as *conciertos*, not demanding full coverage from the general budget, not providing full universal coverage, and allowing a weak structural definition of the system to appease the Basques and Catalans who wanted autonomy to define their own systems (Guillén and Cabiedes 1997: 325-326).

The highly redistributive and progressive system envisaged by the PSOE at the start of the reform process in Spain could not be achieved because of the strength of the private medical sector, the political opposition, and the ACs desiring higher levels of policy autonomy. These ACs were not all antagonistic to health reform, but wanted the authority to make decisions about redistribution within a distinct, highly salient reference community that was smaller than the Spanish state.

The promise of what the system was supposed to have been and the comparison

with Europe kept up the pressure for expansion to fulfill the constitutional mandate—the constitutional mandate was meaningful in and of itself as a reference point for committed actors. Creating a system that was clearly supposed to be universal and public, yet was not, fueled demand for reform moving forward. Under a nationalist-socialist coalition, the decentralized Basque health service opted to extend universal coverage first in 1988, which created increased pressure for the central government to move forward the next year. In Spain, an improving economy allowed for legislation to be passed in 1989 that brought full financing into the general budget and nearly full population coverage (Royal Decree 1088/89).

While many scholars and most Spaniards believe that the Spanish SNS became a universal system of public coverage, this has never actually been true. Access to the system has been primarily defined through social security status, even though benefits were not financed this way. As we shall see, patches were created for various groups at various moments, but if a person's unemployment insurance ran out and they were not a dependent of a retired or employed person, they would find themselves without health coverage for a period of time, sometimes quite long, while traversing the enrollment process to acquire status as someone too poor to pay for health care (the “universalizing” extension passed in 1989). Even then, only if a person were actually materially poor at the time would they qualify. Health officials have known of the loophole since 1990 and estimate that during the recession beginning in 2008, the number of people who lost their coverage from expiring unemployment reached over 1.3 million. While most were able to negotiate access by establishing dependency with a covered person, often they only discovered they did not have coverage when trying to access services and being denied¹⁶. The loophole appears to have been closed as part of the passage of the *Ley de Salud Pública* (Public Health Law) in 2011

¹⁶*El País* 12/4/2011 “¿Pero la sanidad no es universal?”

(Ley 33/2011). For the first quarter century, the constitutional guarantee did not materialize into legal reality (Areta Martínez 2011). These loopholes in the system expose the cost of not ensuring universality from the beginning, generating cracks that Spaniards fell through for decades.

The shift from a Bismarckian to a Beveridgean-esque model—in which (mostly) universal access was guaranteed, financed with general taxation instead of payroll contributions, and free at the point of delivery—represented a major coup in the role health care could play in addressing existing inequalities. The General Health Law of 1986 specifically mandates that health spending be oriented toward eliminating health inequalities and guaranteeing equal access to health services (Ley 14/1986). Civil servants covered by the mutual funds MUFACE, MUGEJU, and ISFAS are the only group eligible to opt out of the SNS and may choose fully private provision, taking up about three per cent of overall health spending.

Despite the shortcomings of the SNS, the achievement was monumental, particularly because Spain had been a developing country only a quarter century before and was still a newly consolidated democracy. Lluç's tenure was an important part of this success. Spending enough time in office to learn the ropes, develop a trusted and efficient team of administrators, and construct complex, large-scale policies is a key component of administrative capacity. Even holding ideological commitment constant, a project like the SNS could not have been completed with the ministerial turnover of the UCD governments. Taking account of the UCD Ministers' closeness with the private medical establishment and lack of commitment to equity-enhancing policies, the impossibility of reform between 1977 and 1982 was over-determined. In 2000, Lluç was assassinated by the Basque terrorist group, ETA.

In late 1987 the Basque Country (Real Decreto 1536/1987) and Valencia (Real Decreto 1612/1987) took on health competences, bringing the total to four. In 1989

general elections were held and while González did not quite win an absolute majority, the fact that the centrally elected representatives of the radical independentist left in the Basque Country (Herri Batasuna) abstained from participating in central government meant the PSOE was able to form a government. This same year AP reformed, becoming slightly more socially moderate and economically liberal as it shifted away from its fascist roots and was renamed the PP. In December of 1990 Navarre (Real Decreto 1679/1990) and Galicia (Real Decreto 1680/1990) took on health competences, bringing the total to six.

In 1987 Julián García Vargas took over the Health Ministry and carried the office for the full term of the second González government. García was a centrist who did not have Lluch's long and militant socialist history. This period also coincided with the upswing in international support for deregulation and neoliberal reform. Attempts at rationalization and cost cutting in the new system began in earnest under García Vargas' administration. In 1991, at his request, the Spanish Congress undertook a technocratic assessment of health reform since 1986, which included an analysis of shortcomings in the system and possibilities for cost containment. Because there was a widespread social and academic consensus that the system had never been adequately funded, yet the report suggested it had maximized some of its possibilities for expansion and was ready for rationalization, the report was skeptically received, to put it mildly. The so-called *Informe Abril* recommended an array of rationalization reforms that were not ultimately designed with a focus on ensuring equity and which were rejected at the time by left of center forces. Some of the measures would be adopted over the next few years, regardless.

González reshuffled his cabinet in 1991 and replaced the Health Minister, but in line with the broader problems the government began to experience with corruption and internal scandals, the new minister resigned ten months later when implicated in

a corruption scandal unrelated to the Health Ministry. Corruption has been present in both major central parties, often associated with party finance but also with use of public resources for personal enrichment or (in the PSOE just after democratization) extra-legal paramilitary action against ETA, and has been more prevalent in certain ACs. The next Minister, the first to arrive from the ACs with a background managing decentralized government health policy, stayed just six months before being shifted to another post. His second in command became the first woman to head the Ministry in 1993 and served out the last three years of the González government.

In addition to the internal difficulties of the PSOE, economic crisis in the early 1990s kept the focus on cost containment, even among socialists¹⁷. Yet there were no cuts and extension of primary care in centrally controlled AC health services continued. At the beginning of the 1990s the economy was souring, but the central government had successfully passed and begun to consolidate major reforms in health care. Yet AC pressure for decentralized policy control was mounting at the same time that fiscal resources were at their tightest since the early 1980s. Even though the Statutes of the *vía lenta* regions stated they could renegotiate their responsibilities after five years, in many cases the socialists held them off for far longer.

Center-right nationalists in Catalonia (*Convergència i Unió*, CiU, Convergence and Union) and the Basque Country (*Euzko Alderdi Jeltzalea-Partido Nacionalista Vasco*, EAJ-PNV, Basque Nationalist Party) were supporting the central government in parliament from 1993, on. The Catalans pushed hard for the decentralization of a portion of the IRPF. Catalonia has the unique status as one of the wealthiest regions, with stronger nationalist presence in AC government than any other AC, yet without the special foral regime of the Basque territories. It loses the most by being part of the central fiscal regime and faces constant powerful pressure by nationalists to

¹⁷ *El País* 7/18/1993 “Gastos sanitarios.”

remedy what they see as an unjust fiscal arrangement. Keeping part of the income tax collected in its territory would stem the outflow a bit and present a political victory for nationalists. The proposal was for 15 per cent of the income tax revenue generated in each AC to be sent directly on to the AC government.

Yet the central government was giving up no control over the base or rate of the IRPF—this was the key difference between the version of this policy put forth by the PSOE and that of the PP when it came to power in 1996. This was not a pro-poor, redistributive policy measure. The PSOE would unburden itself of the responsibility for negotiating and pacting part of the complicated AC finances. The compromise for equity was that the central PSOE stood behind the LOFCA of 1980, stating that the IRPF was not a tax that could be fundamentally decentralized (Art. 11).

Implemented by the UCD and PSOE during the transition, the IRPF had been consolidated under the PSOE, a major equity-enhancing reform that meant social policies were being funded from a much more redistributive base. Yet since 1986 the tax had become less progressive in its application and rates, while also becoming a less important part of the overall financing of public policies. These shifts were largely the result of international pressures as neoliberalism reached its peak and the EU pushed for a greater reliance on value added taxation. The ACs would gain resources but with no fiscal autonomy, and the progressive nature of the IRPF would be protected at one level, as it was compromised simultaneously by collection over a smaller and more unequal set of AC bases at another.

A group of poorer ACs initially refused to go along with the plan. These ACs were led by the popular, long-standing president of the Junta de Extremadura, Rodríguez Ibarra. Beginning with the first discussions of the 15 per cent IRPF revenue sharing scheme, the Extremaduran President was vocally opposed, primarily because the

amount generated in a poor AC would inevitably be less than in a wealthy AC¹⁸. The Catalan nationalists were demanding 100 per cent of the IRPF¹⁹, aiming for the equivalent of the Basque Concierto, as they had been since its inception. Basque Lehendakari (President) Arzalluz, whose AC contributed less to the central coffers than any other, told the Andalusians and Extremadurans: “Se le llama solidaridad cuando ayuda a desarrollarse, pero se llama egoísmo cuando lo que se quiere es vivir a costa de otros”²⁰. A study by supporters of the PP from the Xunta de Galicia estimated the cost of the reform and also found that Extremadura, Andalusia, and Galicia would lose the most, while Madrid and other wealthy ACs would benefit²¹.

Ultimately, the leaders of the losing regions were cajoled one by one and convinced to sign on. Yet Extremadura, Castilla y León, and Galicia opted out of the new system for 1994 and Extremadura, alone, opted out in 1995 as well. These regions continued operating under the old system, though because they all were still within INSALUD, the impact on health care was not direct. In this particular example we see the large number of veto players in the Spanish system braking a regressive reform, which was primarily on the table because of pressure from one politically powerful region. Just within the PSOE, the Catalan affiliate, the poor non-nationalist regions, and the central government all found themselves on different sides. The political calculus benefited the Catalans, who by this point were supporting a central PSOE without an absolute majority. Without them, there was no government. In the end, the PSOE

¹⁸Rodríguez Ibarra outlined his objections in an opinion editorial in *El País* 10/14/1992 “Mis Razones.”

¹⁹*El País* 10/20/1992 “Serra replica a Pujol que su propuesta boicotea el diálogo sobre la cesión del IRPF a las autonomías.”

²⁰“It’s called solidarity when the purpose is economic development, but it’s called egoism when what you want is to live at the expense of others” *El País* 9/7/1993 “González frena la ira de Rodríguez Ibarra.”

²¹*El País* 7/12/1993 “Un informe del PP prevé grandes desequilibrios entre comunidades si se cediera el 15% sin compensaciones.”

dealt with these contradictions by assuring poor regions that the center would make up the difference if they did not reach the amount of revenue the negotiated formulas guaranteed them to cover their policy responsibilities, while promising regions that generated a boon from the transfer that they would be allowed to keep the extra²². As we shall see, the cession of the IRPF has become a snowball quickly rolling down hill toward greater and greater decentralization.

In 1993 the CPFF tried to implement cost controls by tying the growth of per capita AC health finances for the early decentralizers to nominal GDP growth. Yet because the central government had little authority over health policy or spending in those regions, these efforts were largely unsuccessful. The impact on equity of such attempts is debatable. It is only in recent years that health reformers have begun to carefully unpack health spending and make a case for shifting away from expensive curative services and drugs with no proven track record in improving outcomes. In a system that has been chronically underfunded, blanket cost controls from the center, when ACs controlled health policy, would still have allowed outcomes to be dictated by the level of commitment and innovation in the ACs.

In March of 1994 Canarias (Real Decreto 446/1994) took on full health competences, the last bilateral devolution, bringing the total to seven regions with 63 per cent of the Spanish population.

4.6 The Rise and Fall of the PP: 1996-2004

In the 1996 general elections the PP won a simple majority as the PSOE struggled with corruption and the emerging scandal of the party leadership's use of paramilitaries in a dirty war against ETA. While the PP had run in coalition with the *Unión del Pueblo Navarro* (UPN, Navarrese People's Union) and the *Partido Aragonés* (PA, Aragonese Party)—both center-right regional parties—in the end it was forced to

²²*El País* 9/3/1993 "Hacienda garantiza una ventaja financiera a las autonomías que participen en el 15% del IRPF."

attain support from CiU, the PNV, and *Coalición Canaria* (CC, Canary Coalition).

The reliance on minority nationalist parties, despite campaign promises to avoid such a situation, fundamentally influenced and constrained the policies of the first PP government. While the ideological preferences of the PP, CiU, and the PNV were not as sharply divergent on economic issues as had been true in the previous legislature, strongly centralizing forces were present in the Spanish executive for the first time since the democratic transition and the differences in visions for the reference community were enormous. Yet as it turned out, the PP's vision of a centralized Spain was not as salient for its leaders as other dimensions of its policy preferences. As we shall see, the Catalans continued to exact preferential autonomous financing within the common regime, while the PNV used its leverage to negotiate greater authority over its foral regime.

The first Health Minister appointed by José María Aznar, the new Spanish president, was Romay Beccaría, who had been the head of health services for Franco. In addition to the PP's ideological opposition to public health expansion, Spain's project to join the euro required significant fiscal maneuvering and even stricter efforts at cost containment. The PP did not have enough legislative backing in 1996 to push through its plans to privatize the health system and by 2000, when it attained an absolute majority, the economy was booming and the SNS was thoroughly entrenched.

Still, in 1997 the PP led a successful campaign for fiscal reform. In September of 1996 the CPFF pacted a new AC finance scheme, as it had done every five years. The ACs would continue to receive 15 per cent of the IRPF collected in their territory, plus another 15 per cent over which they would have some normative authority—they could modify the rate of that 15 per cent by 20 per cent and they could control deductions. This second 15 per cent was related to the devolution of education competencies in the ten *via lenta* ACs and so was not applied at exactly the same time everywhere.

For the first time a portion of personal income taxes, property taxes, and a series of less important taxes were devolved to the ACs with normative authority over the base and rate (MSC Anexo III 2003: 219)²³. Poor ACs again objected, though those controlled by the PP were not quite as vocal this time. Previously, only Extremadura had been willing to go head to head with its own party at the central level and the other two had been controlled by the PP. This time, Andalusia and Castilla la Mancha, both socialist ACs, opted out of the new financing scheme, as well.

A section of these reforms, aimed at the decentralization and liberalization of the health sector, did not pass Congress, largely due to the pressure of national trade unions and healthcare workers. Still, the 1997 reforms included important changes in the administration of health and social service centers, which enabled them to bypass the rules of the public Social Security Administration (Puig-Junoy and Rovira 2003; Lopez-Casasnovas, et al. 2004). New public hospitals received the freedom of self-government outside the common administrative legal regime regulating state-run hospitals. These changes opened the doors to a greater heterogeneity in the administration, labor relations, and ordering of public services in the affected centers. The new financing model drifted even further from measures of health need, while appeasing regional elected officials by ensuring that each AC got an extra one-off injection of funding (Ruíz-Huerta and López 1997: 19). Since 1999, pre-existing public hospitals could negotiate a quasi-independent status as well.

These reforms were opposed by the PSOE and also by the trade unions in the medical field, due to concerns of the personnel about working conditions, wages and

²³The tinkering done by the ACs to date has mostly been limited to differing income tax deductions, which has marginally changed the effective rate paid by those living in different ACs (Durán Cabré 2006: 20).

the preservation of collective bargaining victories, and contracts negotiated and protected within the common administrative regime (Lopez-Casasnovas 1998; Lopez-Casasnovas, et al. 2004). The focus of health policy in the 1990s was clearly oriented toward cost containment (Puig-Junoy y Rovira 2003), yet under the PP it also took on an ideological component in favor of private provision. While the system was too established to be dismantled, an absolute majority was not necessary for substantial changes, as nationalist ACs were often in favor of loosening central regulations and decentralizing responsibilities.

In 2000 the PP won an absolute majority, allowing it to eliminate coalition agreements with minority nationalists. For the final phase of health devolution instituted in late 2001, the major regional players did not have a stake in the reform, regardless of their coalition status—they already had devolved health competences and did not stand to lose financially by having other ACs take on health care. The foral regimes have little riding on fiscal decisions made between the center and other ACs.

In late 2001 the PP's congress hurriedly passed legislation for the devolution of health competences in the ten remaining ACs. In July of 2001 the PP had passed a new system of financing for the ACs, which they proceeded to tie to acceptance of health decentralization²⁴. If the ACs wanted the new money that came with the new fiscal arrangements, they had to take health care. With several ACs successfully boycotting each of the past two financing accords, the PP was determined to have as many ACs as possible under the same fiscal roof. The PSOE sued over the manhandling, but was ultimately unable to prevent it. This did not save the PP from costly bargaining with each individual AC to get their consent—even those governed by the PP. Once again the poor ACs stood firmly against both the fiscal reform and the devolution of health policy responsibilities. Even some middle-income ACs felt

²⁴*El País* 12/27/2001 “El Gobierno añade 300.000 millones más para traspasar la sanidad.”

better served by the centralized system—Cantabria and La Rioja were the last to sign and for months had opposed the transfer, despite being governed by the party that initiated the reform.

The new financing system was a significant shift from what had existed for the seven early decentralizers, prior to 2001. The financing of health care was shifted from general taxation at the center to the general AC budgets. In order to finance this new expenditure, a series of taxes were ceded. The ACs were given 33 per cent of the IRPF (with some normative control as in the previous cycle), 40 per cent of some specific consumption taxes (alcohol, tobacco, and petrol were the most important), 35 per cent of the Value Added Tax (VAT), and 100 per cent of electricity and some transportation taxes. In the case of the indirect taxes, only the funds were ceded and full normative control remained with the center.

AC finances were therefore made up of taxes and fees levied directly by the ACs, fully “ceded” taxes that were normatively enabled at the center, but collected (or not²⁵) and spent by the ACs (the property tax, inheritance and donation taxes, taxes on gambling), and taxes collected by the center but whose revenues were destined to the ACs (part of the VAT, IRPF, and taxes on alcohol and electricity). In some cases of fully ceded taxes, ACs still had the center collect the taxes for them through special agreements. In the case of the centrally controlled taxes, for the portion normatively controlled by the ACs, for example the 20 per cent variation permitted in the portion of the IRPF going to the ACs, the center applied AC rates in collection and then turned over the revenue. In theory, the ACs may levy taxes if they do not violate central law or double tax the same base of a central tax. Yet the caveats to these taxes leave ample room for judicial challenge and ex-post changes in central legislation to nullify taxes it does not want the ACs levying, as we shall see. In addition, the

²⁵In 2013, Madrid opted out of levying the property tax.

central tax base is comprehensive so few areas are untaxed.

The decentralization of health took place without resolving any of the longstanding distortions in health expenditure and without an institutional program to assist those ACs with more limited capacity. The central PP placed high-ranking health personnel in permanent contract positions just before devolution, hamstringing ACs hoping to reverse the cutbacks in INSALUD under PP rule. Socialist ACs found that INSALUD had been operating in a manner not to their ideological liking, with reliance on overtime and short-term contract employment, as well as private contracting out, rather than the creation of stable full time positions within the public sector. After the transfer, the ACs across the board discovered that the waiting lists and infrastructure projects were in worse shape than they had expected²⁶. As we shall see, fiscal crisis in the health system, which had been covered up within INSALUD but marginally understood for years, came to light after devolution and produced a crisis of health debt among the ACs that has still not been resolved. The crisis of financing did not begin with the governance of the PP, by any means.

What drove the PP to push for devolution of health competencies? The core of conservative identity in Spain has been a commitment to centralization and devolving health required a nasty set of battles within the party, as well as with the opposition. The most important reason was ideology regarding social policy. In its first term the PP had attempted a substantive reform to health care with a plan to turn all hospitals into foundations with institutional decentralization and self-governance along market principles. The reform met with massive opposition from health care workers and unions and the decision to decentralize health care to the ACs was linked directly to the failure of this reform—with the Director of INSALUD stating that the reform would be tabled and instead the government would decentralize health and allow

²⁶ *El País* 2/17/2002 “Unas transferencias envenenadas.”

the ACs to make their own decisions²⁷. The PSOE centrally had agreed to the decentralization of health, conditional upon the set up of funds to compensate for the needs of poorer ACs and clear that its affiliates were not obliged to follow along. Regardless, the five ACs governed by the PSOE in 2001, as well as several governed by the PP, all tried to reject the transfer.

Active un-commitment to equity may have been a driving factor behind the 2001 reform, but it was not the only important reason. The PP as a party is ideologically opposed to asymmetry. It has always wanted as little regional variation as possible in order to dilute the special status of the nationalist ACs. While the party cannot do away with the foral regimes or undo the asymmetry that existed previously, it used its control of the central government to try to level the playing field—increasing the authority of *vía lenta* ACs while limiting access to new competences for the historic ACs²⁸. Paradoxically for the PP, eliminating asymmetry meant increasing devolution to the rest, whether they wanted it or not. After 2001, all Spanish ACs had the same overall policy scope (not just in health).

The PP did not prioritize distributive outcomes in its reforms, so ceded normative authority over the income tax and a higher portion of its revenues without compensatory funds. It did create a set of transfers to guarantee health financing in the first few years after the reform if own source revenues did not meet the formula laid out for minimum service provision, but this was not a significant transfer of resources and the disbursements did not have a redistributive criterion. The *Fondo de Suficiencia* (sufficiency fund) took the place of the *Participación en los Ingresos del Estado* (PIE, Participation in State Revenue) and continued its function as the catch-all fund for ensuring the financing of transferred responsibilities, but only beyond where own

²⁷ *The Lancet* 10/28/2000 “Spanish government reverses hospital independence ruling.”

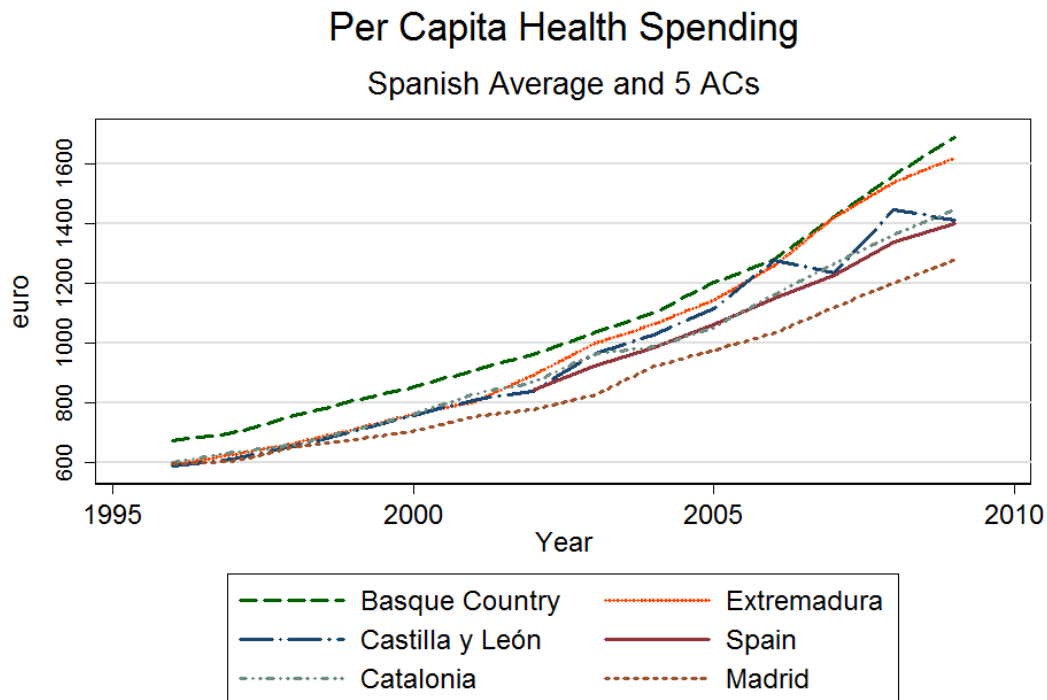
²⁸ *El País* 3/1/1998 “El Gobierno ve concluidos los grandes traspasos a las autonomías y abre la fase de cooperación.”

sources covered what the formulas said was “needed.” If the collection of ceded taxes covered the formula, transfers would not be forthcoming. If poor ACs had high revenues in a particular year, they would get no extra help despite the deeper health and wealth hole they were trying to climb out of. Two thirds of central transfers would come from ceded taxes and one third from the sufficiency fund.

These financing schemes were designed to ensure that no AC ended up with less money than in previous years—the so-called status quo guarantee that has dominated AC finance reform across governments of the left and the right. And for the Sufficiency Fund, this meant that when rich ACs with high growth collected more taxes than what their formula called for, they had to pay into the fund. This has generally been true for Madrid and Baleares. The AC finance formulas are progressive, overall—they combine per capita financing with some conditions for the aging of the population, insularity, and low population density, which are all things that make social provision more expensive, particularly health care. The less dense ACs also tend to be poorer and older, as young people move to urban centers with greater opportunity.

Yet there is nothing equity-enhancing about the original financing framework that set the foundation of the status quo, which has been untouchable. In addition, until 2009 there has never been any attempt to ensure that in practice the distribution of the various funds produced similar funding levels per capita and ACs can (and do) top off their central funds. The result has been highly unequal health spending per capita across ACs, though the differences were harder to measure within INSALUD. AC health spending data become available in 1995 and Figure 4.4 shows variation in per capita financing across the case study ACs, with Madrid and Catalonia for contrast. One can see clearly the increased divergence after 2002, as well as the poor performance of Madrid and Catalonia in relative terms. In December of 2001 the PP also approved the General Law of Budgetary Stability, imposing on all levels of

Figure 4.4: Health Spending in a Subset of ACs



public administration what has been called “the zero deficit rule.” Criticisms arose from the opposition and the health sector, arguing that the EU’s 1997 Stability Pact only required that public debt remain below three per cent of GDP. Critics also pointed out that health care in Spain had historically been under-funded at all levels, creating a situation in which increases in spending had been financed with a high level of borrowing for years (Garcia-Milá 2003). The new law meant that increased health spending could only come from cuts in other public services, from increases in those taxes controlled by the ACs and municipalities, or from an increase in regional GDP above and beyond the increase in Spain as a whole (Puig-Junoy and Rovira 2003).

While the Ministry of Health had not been the primary actor in these major political reforms around health, the conflicts took their toll and the Minister who had overseen the devolution process stepped down in 2002, halfway through her term.

Under the administration of Ana Pastor, a professional health administrator, the third major piece of health legislation after the primary care reform and creation of the SNS was passed. The *Ley de Cohesión y Calidad del SNS* (SNS Quality and Cohesion Law) marks the shift of the Ministry away from a policy-making role to one of coordination among 17 independent health services. Pastor opted not to make radical conservative reforms to the SNS, despite pressure from other members of the cabinet in that direction²⁹, which would only have been possible with the absolute majority the PP had at that particular moment in time. But after 16 years of development, the costs of radical retrenchment were high. In an EU context where national health systems were common and universal coverage was the norm, what was politically feasible or even desirable for many center-right actors had shifted.

While in some ways the new law made few substantive changes (Rey del Castillo 2003), at the time the primary opposition had to do with two issues related to territorial relations. One was that new services were to be included with no central guarantee of financing since the law included an update of the basic central *cartera de servicios* (list of covered services) and had added vaguely worded requirements for coverage of dental care and mental health (Ley 16/2003). Opposition was strongest from minority nationalists, while the non-nationalist left was most concerned with the financing proposals³⁰. A number of coordinated oversight institutions were created, including research and public health centers.

In contrast to concerns in nationalist ACs about the center overstepping its bounds, one change may have weakened the role of the center in health policy making. Before the reform, the CISNS had equal representation of central and AC representatives. Because a strong planning and oversight role was never given to the center

²⁹ *El País* 11/21/2002 “Ana Pastor reivindica que el Gobierno ‘lleve las riendas’ de la Sanidad.”

³⁰ *El País* 2/14/2003 “Pastor estudia aportar nuevos fondos para consensuar la ley de sanidad.”

even under the 1986 health law³¹, this reform further inhibited the already minimal capacity of the center to either plan or enforce the important areas of basic legislation and standards that were within its purview. Under the 2003 reform, the CISNS only has one representative of the center—the Minister of Health. Prominent health economists and health system managers argued that the reform left the central government with no role at all³². In its favor, the law created mechanisms for centralized data collection and health information systems that have been sorely lacking. Overall, the reform was supported by political actors and did not make radical changes to the structure of the SNS.

4.7 The Third Way in Spain: 2004-2011

Amidst the scandal surrounding its handling of the Madrid train bombings, the PP lost the 2004 general elections. The PSOE did not win an absolute majority, but was still able to form a government. The health debt of the ACs—what they must spend to cover their systems above and beyond what the central state guarantees—hit all 10 of the newly empowered ACs in 2002. Most political actors recognized the need for assistance for the ACs. When the central PSOE took power in 2004 its path was once again determined by promises made to Catalonia. When the PP modified the system of AC finance and devolved health and education to the *vía lenta* ACs, it expressly denied the desire of the Catalans to modify their *Estatut*, which had remained unchanged since 1979 (still true for the Gallegos and Basques). The PP

³¹“La Ley general de Sanidad olvidó darle un papel relevante al Ministerio de Sanidad en la planificación. El ministerio no se ha quedado en su mano ninguna medida sólida que garantice la equidad en el acceso, porque lo importante es saber a qué se tiene acceso”, “The 1986 General Health Law forgot to give a relevant role to the Health Ministry in terms of planning. The Ministry has been left with no solid measures to guarantee equal access because the crucial issue is to know what one has equal access too,” says Juan Cabasés, professor of Applied Economics at the Public University of Navarre and spokesman for the Spanish Society for Public Health and Epidemiology (SESPAS). *El País* 1/29/1996 “La asistencia sanitaria mantiene notables desigualdades regionales en España.”

³²*El País* 4/29/2003 “Lejos de la realidad.”

saw the State of the Autonomies as consolidated with this final set of devolutions. During the campaign the PSOE had promised to pass a revised Catalan *Estatut*, taking a stance of transcendental importance for Catalan nationalists. The Catalan socialists, after 25 years out of power in the AC, won the autonomous elections prior to the general elections, binding central socialist fortunes even more tightly to the nationalist sentiments in that AC. The PSOE had promises to keep.

Under José Rodríguez Zapatero, the program of the socialist party had shifted somewhat³³. In relative terms it was still a left of center party, and certainly the previous PSOE governments had instigated a variety of less-than-egalitarian fiscal policies in the early 1990s. But Zapatero was part of a younger cohort of socialist politicians for whom high levels of decentralization were the norm and for whom “third way” politics had pulled the party further toward the center—with less antagonism toward business and greater acceptance of the liberal rules of a globalized economy³⁴. Part of this derived from the fact that Spain had experienced strong growth for nearly a decade, despite the downturn after September 11th, 2001. Many people had made small fortunes in real estate and had risen out of a precarious lower middle class into a solidly middle class situation. Revenue was relatively abundant, which minimized the trade offs the PSOE felt it had to make between potential constituent groups. The first Minister of the Economy, Pedro Solbes, implemented a regressive reform to the IRPF and tried to block some of the social policy expansions described below out of a desire to avoid raising taxes to cover new social expenditures.

The PSOE central government spent two years developing an AC finance reform that could appease its dual demands of democratic self-rule and equality. In the interim, it began subsidizing the health spending of the ACs with additional transfers

³³See Interview with Zapatero in Gabilondo 2006: 419.

³⁴*El País* 10/1/2006 “ ‘El problema es que Zapatero no ha explicitado su modelo de Estado’. ”

in 2006. While the new financing system was being drafted and negotiated, the socialists implemented major additions to public service provision and social welfare guarantees. In 2006 the PSOE at the central level, with the support of the ACs, passed the *Ley de Dependencia*³⁵ (Dependency Law 39/2006)—adding a fourth pillar to the welfare state by providing cash benefits for those in situations of dependency either because of old age or disability. Financing was supposed to be split in thirds between users, ACs, and the central government, but has fallen mostly on the shoulders of the ACs, who are directly responsible for implementation and face the primary burden of public accountability—similar to what has happened with the chronic underfunding of health services in Brazilian municipalities.

In 2007 the socialists pacted the expansion of youth dental coverage with all of the ACs through the CISNS and began with coverage of 7 and 8 year olds, gradually expanding upward each year, and providing a portion of the resources to fund the expansion. As we shall see in the case studies, this was a catch up measure to pull up ACs that were not implementing important services, as the committed and capable ACs had long since implemented youth dental coverage more generous than what the center was now requiring. When an AC takes on decentralized health competences it may produce its own *cartera de servicios*, which can go above and beyond what is guaranteed by the center. The Basques and Navarrese had implemented full youth dental coverage within the public system in 1990 and 1991, respectively, and many other ACs had followed as soon as they took over health responsibilities. Yet the central reform was still important because when the center guarantees services, it generally must also provide resources. ACs that had been tapping their own coffers to provide youth dental care would now get some compensation for their efforts. This was particularly important in places like Extremadura, which had implemented the

³⁵Actually called the *Ley de Promoción de la Autonomía Personal y Atención a las personas en situación de dependencia y a las familias*.

policies on their own but were tapping a poorer tax base to do it.

Here we see how committed central actors can find ways to enhance equity in the health system, even when their authority has waned. The PP had placed dental coverage on the list of covered services in 2003, but taken no action to implement, fund, or ensure AC expansion, so coverage had remained highly disparate. Uncommitted ACs had not responded to the new mandate. The PSOE plan had to be agreed with the ACs, but as both parties in theory supported the expansion, conservative ACs were hard pressed to turn it down, particularly since it came with some additional funds. However, the reform was difficult to negotiate and could not be implemented all at once. It illustrates the real loss of authority, on the part of a committed center, to ensure equitable access to guaranteed services across the territory under high levels of decentralization, particularly when fiscal resources are scant.

The SNS was a PSOE project and from its position in the opposition for eight years from 1996-2004 had campaigned on a platform to provide major injections of funding to the ACs, all of whom were running health deficits (regardless of when devolution took place). The central government, under Zapatero and Public Administration Minister Jordi Sevilla, committed to paying half of the health care debt while asking the ACs to cover the rest, though legally the responsibility for health care financing had been completely devolved. The government argued that ACs such as Madrid and Baleares, run by the PP, were those that had cut taxes most on the wealthy and were most unwilling to increase them to fund health care and cover their debts.

The 2009 revision of AC financing, passed after three years of negotiating, represented another dramatic shift. This time, all ACs were on board. For the first time, the reform introduced mechanisms for updating guaranteed resources to the ACs based on actual changes in the cost of service provision in order to, hopefully, adjust spending on an annual basis without having to overhaul the entire system. It

forced 80 per cent of ceded taxes back into a central fund that would be re-disbursed to cover basic social services on a per capita and need-based formula (the *Fondo de Garantía de Servicios Públicos Fundamentales*, Fund to Guarantee Fundamental Public Services). This reform ameliorated some of the distributive damage done by ceding tax revenues generated over AC populations, from an equity perspective.

In 2009, for the first time, specific portions were allotted to help account for the extra health spending needs associated with elderly and highly dispersed populations. The Sufficiency Fund continued to operate and two new funds were also created, one (the *Fondo de Cooperación*, Cooperation Fund) with redistributive aims and the other (the *Fondo de competitividad*, Competitiveness Fund) to compensate the largest economies. The reform also implemented the precise proportions of new ceded taxes that the Catalans had demanded in their new Estatut—50 per cent of the IRPF, 50 per cent of the VAT, and 58 per cent of alcohol, tobacco, and hydrocarbon taxes (Law 22/2009). *En balance*, the reform was an improvement from the previous system from an equity perspective, though deepened some forms of revenue sharing that had previously been problematic.

Yet the PSOE misdiagnosed the seriousness of the recession that began in its second term and made several fiscal decisions that have proven problematic. In 2008 it eliminated the property tax, a fully ceded tax to the ACs, arguing that it had become a tax on the middle class. Not only did it have to compensate the ACs for the lost revenue, but in 2011 it had to reinstate the tax because it could not afford the loss. The government also overpaid the ACs in the first few rounds of the new 2009 AC financing scheme. While the center has always paid up when it underpaid the ACs, the ACs are now in poor conditions to repay the center. The PSOE held early elections in full economic crisis and the PP won an absolute majority in 2011.

4.8 Entrenched Economic Crisis: the PP after 2011

Despite the declining role of the Health Ministry as protagonist of health policy making in Spain, the central government still has important latitude for action, as the economic crisis has revealed. In 2012 the PP cut the health budget by more than 14 per cent, passed copays for seniors on medicines for the first time, and made the SNS inaccessible for those who could not document their residency status. Nearly half the ACs have attempted to defy both the centrally mandated copay and the restrictions on access to the SNS. Yet if ACs did not want to cut their health budgets to reflect lost resources from ceded central taxes and guarantees, they would have to come up with the extra themselves, which at the moment is nearly impossible for many.

Centralizing efforts have also emerged in other areas. In 2001 Extremadura passed a regional tax on bank deposits and credit operations, and was followed by Andalusia and Canarias. Implementation was held up by the PP in the courts, and when the rulings favored the ACs in 2011, the PP changed central laws to prohibit the taxes—a touchy process given that Extremadura was now in the hands of the PP and had made public plans for spending the new revenue³⁶. When several AC governments tried to pay their public employees the traditional extra holiday paycheck, which had been rescinded by the center, the PP took them to court to block the payments.

Some policies undertaken to ameliorate the crisis and quell public discontent have had an equity-enhancing impact. Income tax rates were increased on the wealthy in 2011 by the PP. Some of the cost savings proposals, such as centralizing drug purchasing and unifying the menu of available services, pose difficult questions for a system where those who provide more than average are unwilling to cut back to appease the center, but might be more efficient and equitable for lower capacity ACs. In ACs with high capacity, these central efforts are perceived as incursions into the

³⁶ *El País* 11/20/2012 “Hacienda elimina la tasa a la banca y compensa a las autonomías que la tenían”

terrain, while those with low capacity and without strong minority nationalisms are more inclined to see the silver lining of some level of recentralization.

4.9 Case Study: Extremadura

Extremadura is a poor AC whose political forces mostly share a Spanish territorial definition of the reference community and that experienced one of the longest unbroken stretches of left rule. In addition to the impact of democratic consolidation, central commitment at key moments, and economic development that have been shared by all ACs, abundant resources from the EU and redistributive domestic transfers have helped Extremadura converge toward the countrywide average on health outcomes and quality of service provision. Political leaders in Extremadura have fought hard against increases in fiscal autonomy and policy scope that they did not have the capacity to manage. In contrast to the traditional view of decentralization as the achievement of regional demands for self-rule, Extremadura is one of several ACs upon which high levels of decentralization have been imposed in efforts by central governments of the left and right to accommodate the self-rule strivings of minority nationalists, without increasing asymmetry.

This case allows for an in depth assessment of the impact of Spanish central commitment and capacity with a constant level of commitment at the AC level. Extremadura highlights the way that the EU's commitment and capacity has impacted health provision in the AC, primarily by supporting economic development and growth with large structural fund transfers and allowing quasi-fungible fiscal resources to be spent elsewhere³⁷. Because Extremadura and Andalusia have similar profiles in many respects, one can also explore the different outcomes under early and late decentralization of policy responsibility for health between the two.

³⁷Structural funds are designed for economic development purposes and are technically prohibited from replacing other spending.

4.9.1 Overview

Extremadura—situated geographically between Portugal, the two Castillas, and Andalusia—has long been the poorest AC in Spain. Still, while GDP per capita was 57 per cent of the Spanish average in 1980, it was 82 per cent in 2010. Figure A.11 captures these shifts over time along with the other two case study ACs.

Extremadura is, per capita, the largest Spanish regional beneficiary of EU transfers at around three times the AC average from 1987-2009 (BADESPE 2012). EU funds managed directly by the AC represented 10 per cent of transfers to Extremadura in 1987, increasing to 35 per cent from 1995-2001. By nature, EU funds are more redistributive than Spanish central transfers so these resources have played a major role in supporting equity-enhancing policy in the AC.

The AC is made up of the two most expansive provinces (by surface area)—Cáceres and Badajoz—and was a Roman capital in the dying days of the empire. Social policies must cope with the existence of a highly dispersed population, with only three cities with more than 50,000 inhabitants and 383 municipalities (2.36 per cent of the Spanish population) spread across 8.25 per cent of the country's territory.

Extremadura was repeatedly devastated in wars of nation building between Spain and Portugal, and later in the Napoleonic wars. Like the rest of southern Spain it was also characterized by the presence of large *terratenientes*, the social and economic actors who pushed back the hardest against democracy and redistribution (Moore 1966; Rueschemeyer, Stephens and Stephens 1992). The economic development strategy of the Franco regime during the 1960s and early 1970s focused on the industrial and financial centers of Bilbao, Barcelona, and Madrid, producing unequal development and an internal periphery in ACs like Extremadura (Curbelo 1994: 24). In the absence of ideological commitment to redistribution, centralized authority was used to foment economic development that exacerbated existing territorial inequalities.

The region has been bleeding population for centuries. From Pizarro and Cortés on, Extremadurans have been searching for places of greater opportunity—emigrating in modern times to the wealthier ACs of Spain. Population plummeted from 1960-1980 and then stabilized for the next thirty years, increasing for the first time in half a century to just over 1.1 million inhabitants in 2011 (INE 2012).

Extremadura is also the AC that vies with Andalusia for the staunchest history of left rule in the country (see Figure A.7), with the PSOE in control of AC government from 1983-2011, with the PP forming a minority government in 2011. In Extremadura, unions mobilized with an artisan and campesino base (Ayala 2002: 172). There is no conflict over the territorial scope of the reference community—the traditional left and right dominate politics and the legitimacy of the central government as a source of authority and redistribution is not broadly questioned.

While in 1973 regional income inequality was the third highest in Spain at .36 on the Gini index (Goerlich 2012; Goerlich and Villar 2009)—topped only by Galicia and Castilla y León—by 2011 Extremadura had a distributive profile similar to that of the other ACs (see Figure A.12), despite little change in its relative level of economic development. The decrease in inequality is particularly notable given that unemployment rates have risen steadily from around five per cent in 1976 (INE 2012). Income inequality increased in the AC, as it did in most of Spain, beginning in the mid-2000s, well before the onset of the 2008 housing crisis.

In 1975 the infant mortality rate in Extremadura was 22.9, lower only than Galicia, Murcia, and Castilla y León, and a full eight points higher than in Madrid. By 1991 not only had infant mortality dropped to about 6, lower than the central average, but life expectancy was 76.8 years, only four months below the Spanish average and substantially higher than other poor ACs. In 2010 infant mortality rates had stabilized around 3.5, *en par* with the most advanced industrialized countries. Life

expectancy reached 80 years in 2005 and was almost 81 by 2010—an impressive improvement in one generation, but still a full three years less than those living in Madrid or Navarre and one of the lowest in Spain (but within a much diminished range of variation). As in the rest of Spain, the most drastic improvements in health came quickly in the years after the death of Franco, but have steadily continued to improve over time. Figures A.13 and A.14 show infant mortality rate and life expectancy patterns in the three case study ACs.

The socialist government of Extremadura for a quarter century has focused on increasing the quality and accessibility of social services, viewing these as key to economic development and growth in the AC, as well as part of the social democratic commitment. Average health ministerial tenure in Extremadura is the highest in Spain, with two competent ministers in office for over a decade (see Figure A.15), one of whom went on to become the President of the AC. Extremadura has benefited from a high level of political commitment to equity-enhancing policy among AC, central, and supranational actors, which has increased its capacity over time.

While none of the Spanish ACs suffered the levels of utter debilitating lack of capacity experienced in the poorest Brazilian states after its democratic transition, Extremadura came the closest in the early years. At the democratic transition, many in the AC were living in deep rural poverty with no access to social services, often without electricity or running water, in the service of the large-landowning nobility.

4.9.2 Multilevel Health Reform in Extremadura

Despite the lack of nationalist identity there was little doubt in 1977 that Extremadura's two provinces would become an AC—however limited its purview was expected to be. There was no expectation, for example, that Cáceres and Badajoz could have joined other ACs. Though there was an upsurge of debate in the years after Franco's death regarding whether or not Extremadura “existed” (García 1991:

307), the questions its nascent regional leadership grappled with were how to manage autonomy, not what territories should be included. This experience stands in stark contrast to that of Castilla y León and, to a lesser extent, the Basque Country.

The UCD governed in most regions during the early years of the transition from 1977-1979. Precisely because the pre-autonomic governments that functioned in the regions from 1978-1983 had the awkward status of being indirectly elected executives (mostly chosen from among the provincial representatives in the central legislature) during a pacted democratic transition, their composition was more balanced in terms of partisanship than later cabinets would be, when directly elected leaders could form governments with clear mandates. Once again, we see a stark contrast with Brazil where the democratic transition began with the states having the only competitively elected leaders. Within a month after the first central democratic elections in 1977, a *Junta de Parlamentarios de Extremadura* (Council of Extremaduran Parliamentarians) had formed, made up of all the central government deputies and senators elected from the region that year.

In 1978 Real Decreto 19/1978 created the pre-autonomy framework for autonomous governing institutions in Extremadura, a sign of the strength of desire for autonomy that had arisen, despite its lack of regionalist history. In contrast, several ACs never had pre-autonomy statutes because they had not been expected to form ACs of their own. In August of 1978 the Junta Regional took shape and in mid-September the it formed a cabinet with policy portfolios, in anticipation of the policy transfers that were expected to take place soon after. As we shall see, the ruling party at the time the AC was first formed mattered a great deal for the path to autonomy, which determined the scope of health policy making and fiscal autonomy.

As in the other ACs, a *Comisión Mixta* was formed, in this case with 15 central administration representatives and 15 members of the Junta—eight from the UCD,

five from the PSOE, one from AP, and one from the PCE—to organize the passage of transfers (Chavez Palacios 2002: 535). While the central government recognized the new regional government and passed legislation to begin transferring competences, no responsibilities shifted for over a year. The central government was undergoing total transformation itself and, despite attempting a process of “café para todos” with the passage of the Spanish Constitution before any of the Statutes, had not been able to avoid bilaterally negotiating unique processes of decentralization, with unique sets of transfers in each newly formed AC. The UCD won the 1979 general elections in Extremadura by just a few points.

The Extremaduran socialists and communists stood firmly behind the *vía rápida* outlined in Article 151, already taken by the historic nationalities, because they believed that the slower route would lead to simple deconcentration, rather than substantive political autonomy, and leave them at a disadvantage compared to other ACs (Chavez Palacios 2002: 540). This position placed the regional parties in conflict with the central PSOE, which was advocating the *vía lenta*.

But it was the UCD that controlled the Junta Regional from 1978-1983 and the UCD did not have an expansive view of the prospects for autonomous institutions in the new ACs. The UCD leadership in Extremadura took the process forward slowly in an effort to avoid having what was arguably the least nationalist region in the country opt for the autonomy path created with only the most fiercely independent regions in mind. Instead of making a decision about what path to take, President Ramallo created a commission to study the issue and then another.

In December 1979 the “actividades molestas, insalubres, nocivas y peligrosas”³⁸ were transferred: urbanization, regional festivals, tourism, transportation, local administration, culture, public health, and some elements of agricultural policy—and

³⁸“The bothersome, unhealthy, damaging, and dangerous activities” Chavez Palacios 2002: 536.

while these did not go into effect until the spring of 1980, it is still notable that transfers were made a full two years before the Statute was passed. The process of bilaterally negotiating new responsibilities in advance of formal changes in the Statutes has been common across ACs. In the end the socialists and communists were outnumbered and the slower, more limited path to autonomy was chosen by the UCD majority. Extremadura was one of the last ACs to form, despite its quick start out the gate. Like the other *vía lenta* regions, its Statute gave it the competences outlined in Article 148.1 of the Constitution—the only transfers allowed in the first round of policy devolution for those accessing autonomy through the *vía lenta*.

Article seven of the original statute enshrined exclusive competences in own institutional set up, urban planning and housing, internal transportation and public works, agriculture, natural resources, economic development, culture and tourism, social assistance³⁹, and local police (though with regulation through Organic Law in this last case). The Statute also covered a more extensive list of responsibilities over which the region would have shared and implementation authority. Extremadura was to have an Assembly elected by proportional representation (Art. 20-32) that would elect a President from within its ranks (Art. 33), who would choose the cabinet (Art. 37). This set up is shared by all the regions, though the names of the governing bodies differ. While the organization of the judiciary was not controlled by the region, the regionally organized judicial branch gained the final word on a broad range of civil and penal matters within the territory (Title III). Laws passed by the Assembly could only be challenged in the Tribunal Constitucional (Art. 49).

Crucially—and something that has never happened in Brazil—the central government stated that if the economy of Extremadura did not allow the public administration to provide its new service responsibilities at the level of the national average, the

³⁹Social assistance is the only major facet of the Spanish welfare state that was immediately decentralized everywhere and had a legacy of provincial provision even under Franco.

center guaranteed financing to eliminate the disparity (DA 2). This language complied with the 1980 LOFCA on regional financing that made the center responsible for ensuring that fundamental social services like education and health were financed equitably on a per capita basis and achieving service provision that adhered to the national average (though in practice this has not been the norm). Still, Extremadura and other regions have successfully demanded additional one-off resources at various times, citing this clause.

Until 2001 when health was decentralized, the *Consejero de Sanidad* (Health Secretary) in Extremadura was responsible for representing the region in the CISNS, coordinating with INSALUD, and managing the devolved responsibilities in sanitation and public health. Levels of commitment and capacity in the secretariat were less important during this period because of the diminished responsibilities of the office, yet many ACs did not even create Health Secretariats until responsibilities were devolved. While it is common to see control of sanitation and public health as residual competences, in reality these are some of the most important for the poor. Low levels of capacity would have made even these difficult to ensure for the population—particularly with widespread rural and urban poverty—as we shall see in the poor regions of Brazil. Alfredo Jimeno Ortíz was named *Consejero de Sanidad y Consumo* under Ibarra and remained in his post from 1983 to 1995 during the first three PSOE governments in Extremadura. During this period, health policy was still an almost fully centralized responsibility and the AC government coordinated the expansion of primary care and the SNS with INSALUD.

In regional economic shifts more broadly, land reform was one of the outstanding questions that would have shifted the level of inequality in southern Spain and that had been a major focus of reformers in the Second Republic. Ultimately, pacted reform by moderate parties took radical land reform off the table at the central level.

Most of the expropriations that did take place, however, took place in Extremadura and Andalusia and these were the two regions whose socialist leadership fought hard (and successfully) to acquire regional authority over land use. Extremadura and Andalusia were the territories with the highest rates of land ownership concentration in a country with one of the highest concentrations in the world. Southern Spanish society was defined by the large agricultural working class, tied to the land, without ownership rights.

In 1984 Andalusia and in 1986 Extremadura passed laws that would allow the new regional governments to expropriate land and redistribute it (Law 8/1984 and Law 1/1986 Sobre las Dehesas en Extremadura, respectively). These laws were high profile political battles that pitted the new governments against the most powerful landholders in the country, a mix of nobility and large corporations. The reforms required going head to head with the PSOE in Madrid, which had decided not to implement redistributive land reform through the central government. After several years of intergovernmental challenges, Andalusia convinced Madrid to devolve control of the *Instituto de Reforma y Desarrollo Agrario* (IRYDA, Institute for Agrarian Reform and Development) and passed its law. Extremadura's law was more limited, applying only to the dehesas⁴⁰ and not to all land, and in the end was more successful. While the right of the region to expropriate property for the public good was upheld in the Tribunal Constitucional, lengthy court cases ensued over particular parcels of land, with Franco-era judges ruling that the peasants' goat herds decreased the profitability of the Duchesses' hunting grounds⁴¹.

In 1986, the first year for which data are available, 90 per cent of transfers to Extremadura from the central government were from central revenue sources and no

⁴⁰The dehesa is a particular type of semi-forested agricultural land often used for pasture in the southern Iberian Peninsula.

⁴¹*El País* 4/8/1990 "La vieja batalla por la tierra."

taxes were legislated by the region. In 1991 the first regional taxes were collected, representing about .3 per cent of total revenue. For a poor region, having most costs paid for out of central government general revenues is generally the most redistributive way to finance services. Some other common fiscal regime regions without historic status did choose to impose regional taxes as early as 1986 and collected relatively larger amounts. In this regard, the regional government took advantage of a redistributive central revenue stream.

But from the perspective of central government distributive policy, Extremadura still lost out in relative terms. The unavoidable asymmetry in regional intergovernmental power and bilateral nature of transfer negotiations did not benefit the poorest regions. Until the end of the 1990s, real central transfers per capita in Extremadura were about 70 per cent of the Spanish average⁴². In addition, if the central government were successfully implementing pro-poor regional financing schemes, we should have seen an inverse relationship between relative GDP per capita and relative transfers per capita—which was the case for transfers from the EU. Instead, Extremadura’s relative receipt of transfers was precisely proportional to its level of economic development—the most regressive arrangement in the country at the time. No region as poor as Extremadura had such a low relative level of transfers per capita, and this was with the PSOE at the center and in the AC.

On the policy scope front, while in theory new competences could be devolved five years after the passage of the Statute, this reform did not take place for nearly a decade. While the ACs clamored for more authority, the center—controlled by

⁴²Relative real transfers per capita to the ACs includes all resources except AC borrowing, own source taxes, and contracting between levels of government. I also exclude health transfers because those ACs that were receiving health transfers had much higher levels of per capita transfers, but were also paying for health provision themselves. I therefore compare only the parts of the budget that cover the same activities by the ACs. The Basque and Navarrese cases are excluded entirely because their fiscal regime is not comparable. “Real” transfers means that I have controlled for regional inflation using the regional CPI. All data on transfers and revenue from own sources comes from BADESPE.

the PSOE—held these demands at bay. In 1992 the major parties at the central level pacted an expansion of competencies to the 10 *vía lenta* ACs (the *Acuerdo Autonómico*, Autonomic Accord) and on December 23rd passed LO 9/1992 enabling the reform of the Statutes to accommodate 32 new responsibilities. In March of 1994 the new Extremaduran Statute was passed (LO 8/1994). Slowly, the *vía lenta* ACs were converging with the early decentralizers in policy scope.

While these reforms and financing debates were taking place, INSALUD was steadily expanding and implementing the primary care reform of 1984—the most progressive component of the SNS and the most ideological. Extremadura outperformed even the INSALUD average. In 1992 the primary care teams covered 68 per cent of the population of the region, while the INSALUD average was 58 per cent and the SNS as a whole just 50 per cent. In 1996, Extremadura tied Castilla y León and was behind only Navarre and Castilla la Mancha for extension of primary coverage at 88 per cent. The rate was 93 per cent by the year 2000 (González, et al 2004: 83). Central reforms such as the incorporation of rural health providers into the *Equipos de Atención Primaria* (Primary Care Teams) resolved long-standing differences in rural ACs like Extremadura and helped eliminate disincentives to public health employment by equalizing salaries.

In Extremadura the PSOE and Rodríguez Ibarra continued to dominate AC politics. From 1993-1996 Extremadura vocally rejected the new autonomous financing scheme that had been implemented by the center after hard bargaining by the Catalans, therefore remaining within the old scheme that had been in effect from 1986-1991. In 1996 Guillermo Fernández Vara took over the Social Welfare Secretariat and in 1999 shifted with the renewed creation of a separate Health Secretariat, where he served until 2007 when he became President of the Junta de Extremadura.

When the PP deepened the devolution of tax revenue generated in the regions and

incorporated a real element of fiscal autonomy in 1997, Rodríguez Ibarra completely opposed the measure, as he had before. The regions governed by the PP, which had opposed the measure when it was proposed by the PSOE central government, accepted it from the PP⁴³, though they did not go along as quietly for health devolution in 2001. In 1997 Extremadura and the other socialist regions sued the central government over the transfer in the *Tribunal Constitucional*, but were unable to prevent the agreement. Still, they could abstain from participating and Extremadura did just that, along with Andalusia and Castilla la Mancha. Somewhat paradoxically, Extremadura leveraged its full authority in shared rule in an attempt to prevent greater authority in self-rule over resources and policies it felt would increase regional disparities and negatively impact the population.

In 1999 under the PP minority government at the center, the second reform of the Extremaduran Statute took place, raising its maximum level of policy scope near that of the historic nationalities (Ley Orgánica 12/1999). This reform paved the way for the decentralization of health and education policy to the remaining regions and permitted substantive devolution from the ACs to the municipalities and provinces within their borders. The reform was similar to that being negotiated in most of the *vía lenta* ACs at the time, as the PP prepared for more substantive decentralization.

Rodríguez Ibarra was a firm believer that decentralization should be tied to a redistributive program and that committed actors should theorize what distribution of responsibilities would best meet the demands of social justice⁴⁴. He continued to oppose devolution of health and the simultaneous fiscal reform proposed by the PP in

⁴³*El País* 10/4/1995 “Las autonomías socialistas dan la espalda al Gobierno y CiU en la concesión del 15% del IRPF.”

⁴⁴“Yo quiero un Estado fuerte porque mi región, que es Extremadura, necesita un Estado fuerte. Y, sí, soy un patriota. Porque a mí, si me quitan la patria, me dejan sin nada.” “I want a strong central state because my region, Extremadura, needs a strong central state. And yes, I am a patriot. Because for me, if they take away my country, they leave me with nothing.” *El País* 10/1/2006 “‘El problema es que Zapatero no ha explicitado su modelo de Estado’.”

2001. The primary concern of all the ACs that opposed the transfer from INSALUD was whether the resources transferred were fair and sufficient. The PSOE tried to present legal challenges to the PP's decision to tie access to the new fiscal system to health care devolution so that ACs could reject health decentralization without having to accept lower levels of revenue by staying in the old system, but was unsuccessful.

With nearly two decades of administrative capacity development in regional self-governance, Extremadura was in good standing to take on health competences, aside from the question of sufficient fiscal resources. Committed leadership took over the newly empowered Health Secretariat and the *Servicio Extremeño de Salud* (SES, Extremaduran Health Service). In the years since taking charge of health provision in 2002, the government has pumped resources into the system and improved upon the user/GP ratios achieved under socialist central government when the system was at its strongest, decreasing the number of people per GP from 1441 in 2000 to 1190 in 2004 (SIAP MSCIS 2012; González, et al 2004: 84). The number of clinics has increased steadily since devolution, as well. While coverage of dental health has generally been residual in the SNS, in 2005 Extremadura implemented the *Programa de Asistencia Dental Infantil* (PADI, Program for Juvenile Dental Care), initiated by the Basque Country and Navarre in 1990 and 1991.

This expansion in the regional health system took place under the direction of Secretary of Health Fernández Vara, a popular and capable protégé of Rodríguez Ibarra. Like Ibarra, Fernández Vara has repeatedly argued that certain responsibilities should be transferred back to the center, particularly in basic social services and environmental management (Palomo 2006: 3). In 2007 Fernández Vara was elected president of Extremadura. Public health spending relative to private household spending increased after devolution and health outcomes continued their trend of improvement. Despite the pressures of economic crisis, until 2011 no public clinics in Extremadura

had closed their doors, which has not been the case everywhere (SIAP 2012).

Yet the fiscal burden this has required cannot be ignored and lies at the heart of the redistributive problem of decentralized financing. Under the top-down process of fiscal devolution in 2001, Extremadura's finances have become much more highly concentrated in revenues generated over its own still poor population. The shift in 2001 was particularly important because it ended central government accountability for AC health financing. From receiving almost all revenue from Spanish general budgets, Extremadura shifted to receiving 33 per cent of the IRPF, over which the AC could exercise some normative authority, 35 per cent of the VAT, and a series of consumption taxes generated in the AC. From 1995-2001, the central government through INSALUD spent approximately 7.5 per cent of regional GDP on Extremaduran health care, compared to just over 5 per cent spent in the country as a whole. But the spending in the poorest ACs was financed by taxes raised over the entire country. In 2002 Extremadura increased health spending to almost 8 per cent of GDP, from money raised in significant part over its own population. In 2009 it was spending over 9 per cent of GDP on health, a full three points above the country average, and this time with half the VAT and IRPF collected over a local base .

In terms of regional commitment and administrative capacity, the first year of PP governance in Extremadura has seen a visible shift away from the expansion of services and managerial continuity seen under the PSOE. The first PP Consejera de Sanidad served for six months before shifting to another position in the government. She was followed by a surgeon and hospital administrator, who served for three months before resigning when it was discovered that he was operating a private office in Portugal, which violated Extremaduran law prohibiting cabinet members from any private business activity while in office. As part of cost-containment efforts, in May the new government took the drastic step of closing all primary care clinics—the

gateway to public health services—in the afternoons⁴⁵. Extremadura is now one of several PP governed ACs taking rapid steps toward privatization of health service provision. The Monago government plans to implement direct private administration of some services within two new hospitals (Cáceres and Don Benito-Villanueva) in the coming years⁴⁶.

4.9.3 Extremadura and Andalusia in Comparative Perspective

The clearest way to assess decentralization is to compare cases in which most other explanatory factors are held constant, yet level of decentralization varies. In politics, creating the conditions for such a comparison is always a challenge. Yet Extremadura and Andalusia are the closest approximation in the Spanish case. They are both southern ACs that were peripheral during the dictatorship, have been run by the PSOE for the entire democratic period, lack strong minority nationalisms, are among the poorest ACs, and have faced similar economic conditions over the past few decades. The two major differences are greater ethnic heterogeneity in Andalusia (because of the Roma population and larger numbers of African and Latin American immigrants) and the larger size of its economy and population⁴⁷. However, this latter should make it a conservative comparison, as one would expect it to have greater capacity and intergovernmental leverage due to the size of its economy.

Unlike Extremadura, Andalusia formed through the *vía rápida* and took on health responsibilities in 1984 (Real Decreto 400/1984). I argue this is largely due to the fact that the PSOE held the majority in Andalusia from 1978, which meant its pro-decentralization zeal in the early years was unfettered by a minority position in the

⁴⁵ *El País* 5/8/2012 “Extremadura suspende las consultas de atención primaria por la tarde.”

⁴⁶ *El País* 11/3/2012 “La gestión privada de la sanidad se extiende en las autonomías del PP.”

⁴⁷ There also appear to be institutional differences in the cleanliness of socialist governance between the two regional affiliates. While scandal and corruption has been fairly low within the PSOE de Extremadura, despite the longevity of party rule, the Andalusian affiliate appears to have been much more prone to cronyism and patronage politics.

cabinet, as it was in Extremadura. While it is certainly true that Andalusia has a more substantial history of self-government and autonomist leanings than Extremadura, if the socialists had governed Extremadura from 1978-1983 it would almost certainly have opted for the *vía rápida*.

In terms of health outcomes like infant mortality and life expectancy, despite starting out in a worse position in 1975, Extremadura improved more and more rapidly than Andalusia. The total share of health spending done by the public sector has also been higher in Extremadura both under INSALUD and after decentralization. While in Andalusia the user/GP ratio has steadily increased since 2004, in Extremadura the number has remained stable. In 1995 Andalusia was spending about 6.5 per cent of GDP on health care and decreased slowly until the onset of the recession in 2008⁴⁸. In 1995 INSALUD was spending 7.5 per cent of Extremadura's GDP on health care, which increased steadily to 9 per cent by the time the crisis hit, with Extremadura determining its own spending levels from 2002. Health systems have been traditionally underfunded in all the common regime ACs, so higher levels of spending should generally be associated with supplying needed resources to the system.

What does this brief comparison tell us? Here are two ACs that faced similar challenges as poor, agricultural peripheries with a history of high inequality and poverty. They have both been run exclusively by the PSOE since 1983 and are both recipients of large transfers both from the EU and the Spanish central government. Andalusia took over health policy in 1984, while Extremadura did not take it on until 2002 after nearly two decades of democratic decentralization in which to develop administrative capacity and experience with self-rule.

While actors committed to redistribution in both ACs felt the *vía rápida* was the best avenue to achieve their goals in 1978, the evidence from policy and health

⁴⁸Because GDP has fallen faster than spending during the economic crisis, social spending as a portion of GDP has risen in all Spanish regions since 2009.

outcomes suggests there may have been substantive trade offs to early devolution. Taking the *vía lenta* meant that Extremadura was guaranteed to remain within the INSALUD system for a longer period of time, and it turned out INSALUD under social democratic governance at the center did a better job of promoting egalitarian access and outcomes than the health systems developed in some of the early devolution ACs. Extremadura arguably had the lowest levels of administrative and fiscal capacity out of the gate, with no history of self-government, and is the strongest case in favor of a managed devolution process that allowed the AC to develop capacity over time before taking on health responsibilities. The differences in outcomes are not stark, but Extremadura outperforms Andalusia on health outcome indicators and measures of the progressiveness of the health policies of the government, despite starting out in a substantially worse position in both health and capacity.

4.9.4 Extremadura: Conclusion

Despite Extremadura's peripheral status under the Franco regime, the population of the AC still benefited from economic growth, modernization, and major investments in social services undertaken by the military regime after the abandonment of autarky in 1959. We see this in the improvements in population health indicators that were clearly underway before the democratic transition. Yet internal regional income inequality was still very high in 1973, infant mortality was over 50 per cent higher than in the wealthiest and most urban ACs, and life expectancy even today is almost three years below the ACs with the greatest longevity.

In the initial moments after the onset of the democratic transition, the left in Extremadura pushed hard for the highest possible level of autonomy, associating this with "true" democracy. The quicker path would have permitted fast-paced decentralization. The unintended consequences of center-right governance during the decision-making period in 1979 ensured that Extremadura would be one of the ten

ACs that remained under centrally provided health services until 2002. The performance of INSALUD from 1978-2001 and the universalizing central health policies passed and consolidated under the periods of absolute socialist majority at the central level (1982-1992) have been the most equity-enhancing for health policy and outcomes. The UCD, with the PSOE in parliament, also made crucial reforms under democracy in the early years—primarily in the establishment of a progressive taxation system and beginning to reform social security and taking early steps in expanding health coverage.

Revenues, on the other hand, have been more complex in their distributive impact because the equity-enhancing nature of revenue generation at the outset is then influenced by the way that money is distributed between ACs. Because Extremadura is a poor AC with many poor people, the continuous expansion of decentralized tax bases has had a negative distributive impact on social policy financing. At the same time, Extremadura was disadvantaged in the status quo per capita territorial distribution of resources for the first two decades after democracy and only began to receive more than the central average in 2000. Yet because variation between the ACs diminished greatly after 2000 and most ACs were centered closer around the mean, this represents a larger relative shift than it would in absolute terms.

When comparing Extremadura to poor states in Brazil, its higher levels of capacity, the fact that the PSOE and PCE had persisted in exile and did not require a long period of societal consolidation to begin influencing politics, and the role of the EU are clear contributors to better outcomes for equity. And unlike northeastern Brazil with its legacy of slavery, the poorest ACs in Spain are not primarily populated by an historically oppressed and disenfranchised ethnic group.

In comparing Extremadura to other Spanish ACs, the regional PSOE's high level of commitment to equity-enhancing health policy, capacity improvement, and strong

leadership in intergovernmental bargaining have been key. In the Spanish context, the fact that the dominant left forces in Extremadura were not minority nationalists also played a role. It is one thing to advocate for redistribution when it will cost your AC money, and quite another when redistribution will benefit your constituents directly. Independent of issues of nationalism, Extremadura's place in the socio-economic hierarchy meant its committed leaders did not have to choose between resources for redistribution in Spain and resources for redistribution in the AC. Yet because committed actors at the center were constantly pulled toward regressive arrangements that would benefit wealthier ACs, intergovernmental conflict has persisted.

4.10 Case Study: The Basque Country

The Basque Country is unique on a number of fronts. It has a special fiscal status, unique ethno-linguistic heritage, and is the only AC in which violent conflict over the definition of the state has persisted into the democratic period. It is an important case because it is one of only two ACs with asymmetric fiscal autonomy and I contrast it with this other special case—Navarre. The dominant Christian Democratic nationalist party also has a unique position on social policy that even competitors on the left characterize as progressive. Among the 17 Spanish ACs, the Basque Country most closely approximates a case with high capacity, high commitment, and early devolution of health responsibilities⁴⁹. Health outcomes in the Basque Country are not as good as in Navarre, but are still among the best in the country. The health service, Osakidetza, is credited across the country as the best regional health service in terms of coverage, innovation, quality, and efficiency.

While the special fiscal regime in the Basque Country represents a regressive outflow of resources for the rest of the country, the fact that it consolidated fiscal independence early in the democratic transition has removed a major area of conflict

⁴⁹Catalonia was nationalist and high capacity, but low commitment. Galicia and Andalusia were low capacity, while Navarre, Valencia, and Canarias were low commitment.

from the arena of intergovernmental relations. As we have seen in the Catalan case, persistent territorial conflict is detrimental to equity enhancing outcomes, in and of itself. Resolving these disputes definitively, even if regressive in name, can allow all parties to get back to the business of policy-making. Because Basques know that regardless of which party is governing them, they will have their *Concierto Económico*, parties must compete on substantive policy issues more so than in Catalonia where the rules of the game are deeply problematic for voters. Still, while this resolution has taken place for fiscal matters, it has been less settled in matters of policy scope and the cost of intergovernmental conflict there has been significant.

Until 2010 when ETA declared a permanent and unilateral end to the use of violence, the “Basque Problem” dominated intergovernmental relations along another dimension that certainly did take attention away from other areas of policy-making.

4.10.1 Overview

The Basque AC is composed of three of the four historic Basque territories in Spain—Álava, Guipúzcoa, and Vizcaya. Provincial identities and institutions are more politically important here than in most ACs. The Basque Country lies on the northern coast of the Iberian Peninsula and because of early sea trade with the United Kingdom and continental Europe, became an industrial ship-building and financial center in the 19th century. Geographically the population is disbursed in a tight network of small municipalities, as well as a handful of dense, mid-sized cities. Overall, while many Basques live in very small communities, they are concentrated over a much smaller territory than those in Castilla y León or Extremadura. It is the most densely populated AC in the country, outside Madrid.

In terms of real GDP per capita, the Basque Country has been one of the wealthiest ACs in the country, but with more variation over time than some. While it had the highest GDP per capita in 1980 and 1981, the first years for which we have

regional data, de-industrialization and the loss of the ship-building industry required massive restructuring and the AC spent the 1980s and 1990s behind Aragón, Navarre, Catalonia, Madrid, and Baleares—but still above the mean. The Basque economy has been second only to Madrid since 2007 and has felt the effects of the recession less than many other ACs. Figure A.11 shows the inflation-adjusted relative regional GDP per capita of the Basque Country in contrast to the other case study ACs.

Income distribution has historically been more egalitarian in the Basque Country than most ACs, hitting its most equitable point in the early 2000s (see Figure A.12). Yet over the past decade income inequality has increased in the Basque Country at the same time that its relative position has moved closer and closer to the mean—no longer a substantially more egalitarian community. Population in the AC has increased from 1.9 million in 1973 to almost 2.2 million in 2010. As in the rest of Spain, in the mid-2000s population increased as the second wave of the democratic transition baby boomers were born. The urban centers of Bilbao, San Sebastián, and Vitoria have also seen significant increases in immigration from Latin America, sub-saharan Africa, and the Maghreb over the course of the democratic period.

Franco's economic development policies, which poured investment into infrastructure and industry in Bilbao, also had a cultural component—he intentionally moved large numbers of southern Spanish workers to Barcelona and Bilbao and settled them in public housing projects and neighborhoods built to supply cheap labor to his projects, but also to dilute minority nationalism. In addition, the uniqueness of Euskara as a non-Romance language, the particular efforts of the regime to eradicate it, and its historically more limited use in Navarre meant the Basque language was much more thoroughly wiped out than other minority languages during the dictatorship. After the death of Franco, 90 per cent of Catalans and Gallegos still spoke those languages, but in the four Basque provinces only 41 per cent of native-born Basques

(let alone immigrants) spoke Euskara (Linz 1981: 23).

The special fiscal autonomy of the AC has allowed for greater levels of social investments over the years, enabling the Basque Country and Navarre to become pioneers in a variety of areas of social provision and policy innovation. At the same time, politics has been dominated by conflict over the institutional relationship between Spain and the Basque Country. The intergovernmental conflict has been unique on two fronts—the lack of major conflict over fiscal arrangements because of the consolidated nature of the foral regime and the history of violence and its effect on institutional relations.

In 1973 infant mortality hovered around 18, much lower than in the poorest ACs but still reflecting Spain's incomplete process of development (see Figure A.13). As in the rest of the country, infant mortality dropped rapidly over the course of the 1970s and has continued to fall, just as life expectancy has continued to increase. Throughout the 1980s Basque cities showed the health costs of rapid industrialization with high levels of pollution, work place injuries, and related health problems. Major efforts at environmental and urban clean up, the decline of industry, and the expansion of health services have all ameliorated these special challenges.

The Basque Country had special constitutional status as one of three “historic nationalities” that had approved Statutes during the Second Republic. It took on health in 1987—with Valencia and after Catalonia and Andalusia. Given its high capacity and strong desire for self-rule, 1987 was a very late date for the transfer of health and was felt as an intentional effort at central domination by actors in the AC.

The regional health service has been at the forefront of equity-enhancing policy innovation for many years, while at the same time private care has been strong and expanding. The extension of the 1984 primary care reform was slower than one might expect given the reputation of *Osakidetza*, yet in the early years this was fundamentally the responsibility of INSALUD and not the Basque government and

at the same time, high levels of conflict between the nationalists and the central PSOE presented coordination challenges. In addition, the extension of this reform has not hampered access as much as it has elsewhere because of the uniquely integrated nature of the Basque health system, which its founders designed to be an actual NHS and implemented as such, even before the formal transfer of authority in health.

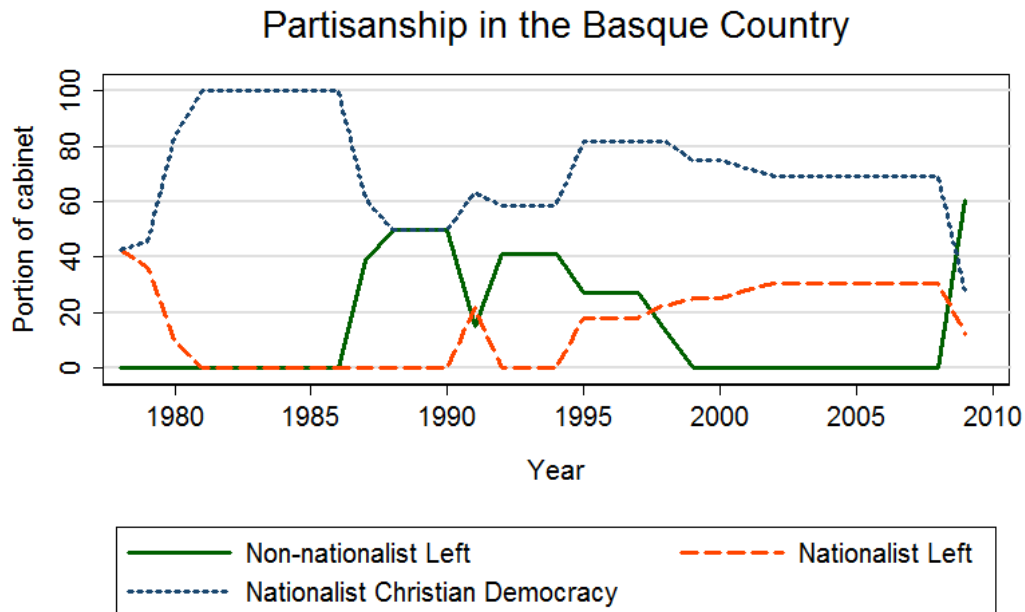
As we shall see, the PNV has governed for most of the democratic period and while technically a center-right party, has had a unique commitment to social service provision that is fundamentally different from other center-right minority nationalist parties in Spain. The party supports gay marriage and adoption and has fought to maintain health access for illegal immigrants in the most recent round of reforms. The PNV has governed in coalition with the Basque socialists several times and from 2000 to 2009 formed a stable electoral coalition with a leftist Basque nationalist party to run in elections. Among both socialist and *abertzale*- (leftist independentist) officials, the idea that the PNV is a center-right party in matters of social policy was consistently rejected (Ezenarro 2011; Fantova 2011).

Figure 4.5 shows the partisan trajectory of Basque government. The *Partido Socialista de Euskadi* (PSE-EE-PSOE, Basque Socialist Party) is a federalist party that formally supports the Basque right of self-determination, but is not a Basque nationalist party, as the PSOE affiliate in Catalonia (PSC) has become. Because of the foral regime, the Basque government has had only a peripheral role in conflict over the way revenue is generated and distributed in the rest of the country. But outside of fiscal matters, the Basque AC is no different from any other and must operate within the constitutional limits of its authority.

4.10.2 Multilevel Health Reform in the Basque Country

In the Basque Country, as in Castilla y León, there was great conflict and debate

Figure 4.5: Basque Government Partisanship



about what territories would be included in the new AC. Yet while there was significant uncertainty about what the form the central state would take and how this would relate to Basque aspirations for self-rule, there was no doubt that whatever the highest levels of autonomy were to be, the Basque territories would be at the top of the list. Basque forces, both pacific and insurrectionist, had been at the forefront of the movement for democratic transition.

The history of self-rule in the Basque territories contributed to high levels of administrative capacity at the outset of democracy, with little learning curve required. Prior to the 19th century, the territories had been collecting their own taxes and running their own affairs for centuries. While this self-rule was forcibly diminished after fighting on the losing side of the Carlist civil wars in the 19th century, the Basque Country still retained a higher level of administrative self-government than other territories. Nationalism and the loss of self-rule through war contributed to the

sense of these autonomous responsibilities as valuable in and of themselves, which has not been the case for most ACs.

In more proximate terms, the first contemporary autonomous Basque government formed in 1936, a coalition between members of the *Frente Popular* (Popular Front)⁵⁰ and the PNV under nationalist Jos'e Antonio Aguirre in the three provinces (already excluding Navarre, which in a contentious set of votes had decided to form its own government). In fact, the Health Secretary at that time was an anti-monarchical doctor and republican political activist, Alfredo Espinosa, who took charge of the Basque operations of the Red Cross, social assistance for victims of war, and basic rural hygiene programs until he was assassinated by Franco's forces in 1937.

The PNV formed in 1905 and was actively involved in oppositional politics from exile under Franco. Only Vizcaya and parts of Álava and Guipúzcoa were under Republican control during the Civil War, yet the government functioned in these territories and mobilized its own army while cut off both from France and the rest of the Republican territory. The government provided social services and took control of the Spanish armed forces within its reach, reorganizing them for land and maritime defense. Ultimately the Basque government forces held Bilbao for a year before succumbing after the bombings of Durango and Guernica in the spring of 1937.

We have seen that in contrast to Brazil, established left parties in Spain hit the ground running after the transition. Previous experience with political opening and competition during the Second Republic also became the point of reference for democratic actors during the transition that began in 1975, particularly because the territorial organization of the state had already been taken up in the Second Republic, so the nationalist regions had a sense of where the starting point for negotiations

⁵⁰The *Frente Popular* was an electoral coalition that formed in 1936 to run in what would be the last democratic elections in Spain for more than a generation. It was composed of all the major Spanish left parties, as well as leftist nationalist parties in the Basque Country, Galicia, and Valencia.

should be. But the levels of autonomy achieved from 1931-1936 were much higher than conservative forces and the military were willing to consider in 1978.

While earlier roots of territorial conflict can surely be sought, the way the pacted transition and new democratic constitution emerged played a significant role in the alignment of political forces moving forward in the Basque AC. The dynamics at the center were different than they had been when the first Statute was negotiated. The dictatorship had weakened central forces of the left⁵¹ and reminded democratic actors of the price of antagonizing the military. The UCD was mostly made up of reformers from the old regime, which meant they had no experience with strong minority nationalists as legitimate democratic veto players and were not accustomed to accepting that Spain was not the legitimate definition of the political reference community for large portions of the population. They had never had to anticipate the role of a free press nor the potential costs of not treating minority nationalist negotiation partners seriously. These shortcomings derailed the UCD's attempts to bring democratic Basque nationalism into the broader constitutional project and generated ripples that have influenced politics throughout the democratic period.

In the general elections of 1977 the PNV formed a coalition with the PSE to compete in all four provinces. The formation was called the *Frente Autonómico* (Autonomic Front) and the simple fact that it existed is of note. The coalition showed both the support of the PSOE for a Statute for the four Basque provinces, as well as the shared interests the PNV perceived with the Basque socialists. While the nationalists and socialists have formed ex-poste coalition governments several times since, this is the only time they ran together—and was the most loaded political

⁵¹While forty years of exclusion from politics certainly took its toll, it is important not to ignore the physical eradication of the left that took place. Many Republican forces died on the battlefields of the Civil War or in the persecution that followed defeat. Half a million Republicans fled to occupied France after the fall of Catalonia and overall 10,000 were sent to Hitler's death camps, in particular to Mauthausen in Austria. In Spain, unmarked common graves are still being uncovered. Many of those who would have led the democratic left were, quite literally, gone.

moment to do so, for both sides.

Historically, conflict over the nature of the state had been more intense in the Basque Country than in Catalonia, and it showed in the way the constitutional negotiations played out during the transition. The Basque problem was thorny and the UCD, in power centrally after the 1977 general elections, faced intense pressure from the far right and the military leadership to ensure the unquestionable unity of the Spanish state and limit special rights for the historic nationalities. The government attempted to sideline the Basque problem by constructing a model of autonomy based on the reality of the Catalans. Among the authors of the first draft of the Constitution, only a Catalan representative was involved to speak for the minority nationalist parties (Miquel Roca i Junyent). While the Basque and Catalan nationalists shared the desire for a constitution that would prevent the central government unilaterally making decisions about their level of autonomy, as well as concerns over linguistic and cultural rights, only the Basque territories were concerned with the return of the *fueros*, which was an absolutely transcendental issue for most Basque politicians.

In reality, the UCD was not prepared to take on resolution of the Basque conflict as part of the process of democratic constitutional reform and likely hoped to set forth the basic rules of the game and take these issues on later, in line with its general approach to regional autonomy. Ironically, the Basques are likely to be content with their arrangement for much longer than the Catalans, despite their marginalization in the negotiation process during the transition. But as a result of not dealing with the Basque question from the outset, the issue was forced later in the game and resulted in several feverish months of difficult negotiations among the major parties and a high level of tension and sense of limited time. When all else had been decided, the negotiations with the PNV dominated newspaper headlines and held up finalization of the document. While the issues would have been difficult no matter what, shutting

the Basques out at the beginning encouraged the PNV to take a firmer stance, with less good faith, once talks finally began.

The UCD, facing intransigent Spanish nationalism to its right, was not able to make credible commitments to the agreements it reached with the PNV and other political forces behind closed doors. In the end, after several agreements made by the UCD and later broken when those not at the table declared the arrangements unacceptable, the PNV determined that it would not be possible to negotiate a binding consensus with the government. The nationalists walked away from the negotiating table and the constitutional process unfolded in the Spanish Congress without the consensus the major central actors had hoped for.

While it was not at all clear early on that the UCD would permit the special fiscal regimes to persist in Navarre and Álava, let alone reinstate them in the other two territories, in the end the PSOE supported an amendment in favor of the reinstatement of the *fueros* (Euzko-Alderdi Jeltzalia 1978). The indissolubility of the Spanish state—negating the right to self-determination (Art. 2)—and the constitutional basis of the Statutes—which ensured that the center controlled the rules of the game by which Basque autonomy could be modified moving forward (DA 1)—were eventually included in the final document. The combination of a fundamentally different concept of the legitimate scope of the central state, the inability to guarantee its own autonomy in crucial areas, and the lack of faith engendered by the way the decision making process unfolded lead the PNV to formally call for abstention in the constitutional referenda carried out in the four territories.

Radical Basque independentists had rejected the entire constitutional project from the beginning and ETA violence continued throughout the process. The political grouping *Herri Batasuna* (HB, Popular Unity) would eventually run in elections only to refuse to occupy its seats in the central governing bodies. Yet the *izquierda abertzale*

(leftist independentists) had split in 1978, with HB only representing a part. Many of those who chose to abandon armed conflict, accepted the Constitution as a framework for working toward independence, and participated in politics formed the party Euskadiko Ezkerra (EE). The PNV had participated intensively in the process in an attempt to attain the highest possible levels of autonomy and to promote a model of the Spanish state that would be viewed as legitimate for Basques (Euzko-Alderdi Jeltzalia 1978: 24).

HB and the far right Spanish nationalists (AP) both called for no-votes on the 1978 Constitution. Between the forces calling for abstention or no-votes, majorities of eligible voters in favor of the Constitution were not attained in any of the three provinces that later formed the Basque AC. Because the PNV had not called for no-votes, but only for abstention, the constitution still passed in these provinces among those who went to the polls. This is notable, as Álava has never been strongly nationalist and like Navarre maintained its *fueros* during the dictatorship because of its support for Franco. Yet even there 41 per cent of the voting population abstained and another 11.38 per cent voted no. In Guip'uzcoa and Vizcaya, abstention was 56 per cent and no votes similar to the other territories (though from the far left, rather than the Spanish nationalist right, as in Álava and Navarre). Even in Navarre, 33.5 per cent of the population abstained (Congreso de Diputados 2012).

The democratic period therefore began in the Basque Country with no resolution for several crucial issues and with the vast majority of the political class feeling it had not been democratically included in the decision making process. In contrast, the Catalan provinces passed the Constitution by a significant margin of eligible voters and the only Spanish provinces where it was not supported by a majority of eligible voters were the four Galician provinces. A weak starting point indeed, and one that has shaped the sense of commitment to the broader Spanish community ever since.

Yet despite its sense of failure in other arenas, the PNV had won the inclusion of a special disposition guaranteeing the foral regime and proceeded to negotiate back historic Basque fiscal autonomy. In practice, this has meant that the Basque AC could effectively plan and implement budgets for its own social priorities (Ezenarro 2011), and that it—like Navarre—has had higher revenues than other ACs.

The main Basque political forces that supported autonomy had agreed in advance of the 1977 elections that the elected Senators and Deputies from the territory would write the Statute. As soon as they were elected, all the representatives except those of the UCD created the *Asamblea de Parlamentarios Vascos*. The UCD did not want to negotiate permanent Statutes for Navarre and the Basque Country before the passage of the Constitution, and it was due to this reservation that the pre-autonomy system was created, though it was eventually used countrywide. The pre-autonomic entity that governed with limited authority during this period was called the *Consejo General Vasco* (CGV, Basque General Council) and in 1978 included Navarre. The first president, Ramón Rubial, was a Basque socialist. Rubial was elected with the support of the UCD representatives of the CGV, who preferred the Spanish left over the Basque nationalist center-right.

While in Extremadura competences were transferred to the pre-autonomic government two years before the Statute was signed, the CGV was a purely executive organ charged with drawing up the Statute and a plan for the restoration of the special fiscal regime, as well for the status of Navarre. As we shall see, the striving of minority nationalists has not always been the driving force behind asymmetry. Spanish nationalist forces have regularly applied different standards for the different ACs in an effort to stymie the self-rule aspirations of minority nationalist ACs, granting authority to “españolista” ACs that it refuses to minority nationalists.

The provincial and municipal elections of 1979 produced a major increase in support for the PNV, as well as an evening out in its support across the territories. While Basque political leaders had begun drafting a model for self-rule in early 1977, they were not able to negotiate the project with the central government until the UCD and AP were satisfied that this could be contained within the Constitution. The Statute of Guernica was sent to the central government as soon as the 1978 Constitution was passed, but was not submitted to referendum until October of 1979 and then not signed by the King until the end of the year. While for Basque leaders the process felt unfair and unbearably slow, it was still the first Statute passed in Spain.

Once again we see the contrast with Brazil, where the distribution of responsibilities laid out in the constitution did not require organic enabling legislation before municipal and regional governments could begin to act because there were no new territorial political institutions to be created. Yet in Spain, nothing could be done until the territorial framework was settled and the very earliest institution took a full two years to approve. The vote on the Statute in the Basque territories was very similar to that on the Spanish Constitution, with 40 per cent abstaining and 10 per cent voting against. Yet this time, the no votes came almost exclusively from the AP, which felt the Statute threatened the territorial integrity of Spain. This is the Statute that was still functioning in 2013, and aside from Galicia is the only AC never to have renegotiated its basic law (though not for lack of trying).

Within just a few years, the existence of the special fiscal rights in the Basque Country and Navarre had become completely unquestioned and off the table for negotiation. So much so, in fact, that concerns about equity almost always focus on Catalonia and its push back against participating in the common fiscal regime. Certainly, Catalonia is much larger than the Basque and Navarrese economies and its loss would be more harshly felt. Still, one can easily understand why the Catalans

strive to rewrite the rules of the game. The future of the fiscal arrangements was not at all certain at the outset of political negotiations in 1978, yet almost as soon as the agreements were made, the Basque and Navarrese arrangements became their status quo. The starting place for negotiations in the future shifted with the acceptance of a basic foundation of asymmetry in devolution that is perceived as unchangeable. It is for this reason that Spanish nationalist forces fought bitterly to prevent the extension of special rights in the Constitution and why Catalan demands for independence cause the military to start rumbling. For Spain, the path of decentralization since democratization has been that of a boulder rolling downhill, for all that it has not felt that way to most Basque political actors.

The Basque Country and Catalonia were the only two ACs to form in 1979 and immediately had the highest level of transferrable responsibilities. However, health competencies still had to be negotiated bilaterally and while Catalonia was able to negotiate the transfer of INSALUD and take over health provision in 1981, the Basques were unable to wrest health control from the center until the end of 1987, nearly a decade after being legally empowered to manage health provision. While a variety of competences were devolved immediately after passage of the Statute, the PSOE government of Felipe González struggled to square legal recognition of the “hecho diferencial” with its ideological commitment to regional solidarity and cohesion. The Basque government saw it as a “permanent boycott” of transfers⁵². Competences listed in the Statute still had to be negotiated one by one and took place at what seemed a snail’s pace for Basque leaders. Once again, this perception persisted alongside the comparative reality that what the Basque AC had was still a much higher level of autonomy than other ACs had (and in some cases, wanted).

Prior to the Civil War, the *Foru Iurralde* (Historic Territories, coinciding with

⁵²*El País* 10/7/1994 “Euskadi afronta el bloqueo de siete años sin transferencias.”

the boundaries of the provinces) had been the locus of Basque self-government. The special status of the four Basque Historic Territories was recognized by the Constitution and in 1983 the Basque *Ley de Territorios Históricos* (Ley 27/1983, Historic Territories Law) set out the institutional relationship between the Historic Territories and the AC. Of special importance, the Territories have full fiscal autonomy and coordinate AC finances with the AC government. They set taxes and decide how much revenue the AC will generate, for example, even though the Basque government sets the budget. They keep a portion of their revenue (around 30 per cent) and send the majority on to the Basque government.

The coordination challenges of these arrangements are intense. The difficulties emerged immediately and produced a significant division within the ruling PNV during the early 1980s, with the Lehendakari, the Basque President, supporting centralization in the AC and the party leadership supporting decentralization to the Territories. The Lehendakari, Carlos Garaikoetxea, resigned and early elections were called in 1986. The conflict caused the PNV to split, with a new party forming around Garaikoetxea, Eusko Alkartasuna (EA), as a secular, social democratic Basque independentist party. EA has been stronger in Guipúzcoa and Navarre than the PNV and identifies with the *izquierda abertzale*, yet has governed frequently in coalition with the PNV and/or PSE since 1990.

The elections of 1986 and the Basque government it produced, from 1987-1991, were the most important for social policy production in the democratic period. A number of important equity-enhancing programs were innovated by the Basques in this period, sparking uptake by other AC governments and placing pressure on the central government to keep up—lest the central PSOE with an absolute majority be out-done by an AC it governed in coalition with a center-right party.

Unlike other ACs where provincial representation in the AC assembly is at least

somewhat tied to population, each Territory receives the same number of representatives in the Basque parliament. The elections of 1986 created a situation in which the popular vote went to the PNV, but the PSE won a larger number of seats. The result was the first socialist/nationalist coalition government for the Basque AC. Up to this point, not a single transfer of substance had taken place since 1982 and frustration over the inability to gain control of health care was running high. Under the first Basque government with socialist participation, the transfer of health competences from the central PSOE finally took place, just before the provincial and municipal elections. After these, there were no more for another seven years when a few minor transfers were made, once again just before election time⁵³.

Social services were also transferred at the end of 1987, from the central administrative counterpart to INSALUD, called IMSERSO. The Basque government passed the responsibilities immediately to the *Diputaciones Forales* (provincial governments) that had historically managed these services. The example of social service provision allows an illustration of the role the special fiscal regime has played. While Álava has always been more socially conservative, governance by an economically liberal party—the PP—has been a recent phenomenon. In the democratic period, Álava was governed by the PNV or the PSE except for the 1999-2007 and post-2011 period.

That Álava had kept its special fiscal arrangements under Franco meant it had greater resources than the other two territories coming out of the dictatorship. The legacy of this difference is notable in the high quality of public social services adopted and financed autonomously in Álava, a tradition that began under Franco when in the other two territories such services were residual (Mondragón 2006). These publicly provided social services have become entrenched, as public employees mobilize in their support and the PP has been unable to implement liberalizing reforms (Fantova

⁵³*El País* 10/7/1994 “Euskadi afronta el bloqueo de siete años sin transferencias.”

2011). In addition to spending significantly more per capita on social services, in Álava 80 per cent of social service spending is public, while it is between 60 and 70 per cent in the other two territories (Mondragón 2006: 77).

On September 30, 1988 Lehendakari Ardanza (PNV) announced the Basque War on Poverty (*Plan de Lucha Contra la Pobreza*). The plan involved an integrated set of programs, including the *Renta Mínima de Inserción* (RMI, Minimum Income Guarantee). The Basque RMI was the first such program in all of Spain, where social assistance and social services have never been protagonized by the central government. Within three years every other AC had adopted some version of the Basque RMI, but it has remained the only true minimum income program and the most generous—spending more money on higher benefits with fewer limitations, a truly universal program. The Basque RMI in 1995 reached 2.5 per cent of Basque households, almost twice as many as the next most significant program in Navarre, and paid 75 per cent of the minimum wage (increased to 80 per cent in 2003), also a higher benefit than in any other AC (Arriba 1999). Between social assistance, social services, and health care, the safety net for Basque citizens had rapidly become the strongest in the country.

The Health Secretary under the coalition government when health was transferred was the socialist Freire Campos. Freire was a pioneer in health policy, defining *Osakidetza*, which in only a few short years had the highest user ratings, the shortest wait times, and had begun to win a variety of awards from provider and user associations. *Osakidetza* was created under the PNV in 1983 and was designed as an NHS (*Osakidetza* 2012). This step has not been taken in most ACs and represents a greater level of public commitment to provision of services than the model of the SNS. The provincial governments had owned and managed a small network of public hospitals even through the dictatorship and public health responsibilities had been

transferred early on, as it had been in other ACs. Osakidetza took over management of these services with an early orientation toward a fully integrated system with high quality basic care at the foundation. There was significant opposition on the part of professional medical associations to the creation of a unified system that was free and universal in coverage⁵⁴. It was the first AC health service to integrate mental health and then took on the property, personnel, and clinics of INSALUD when it was transferred at the end of 1987.

That the PNV was ready to take on private sector interests, in addition to its efforts in universal, public, social welfare provision, illustrates the theory that ideological commitment to equity-enhancing reform could potentially also come from social solidarity within a salient national community. Yet there are no other such cases in either country. Certainly, the fact that its fiercest competition comes from the socialist and abertzale left plays a role. Still, in the Basque Country, humanist and egalitarian trends within Christian democracy have been strong and have deeply influenced political culture and society (Espiau 2011). This commitment to social cohesion is unique among center-right nationalist parties in Spain and is rooted in the particular heritage of the Basque Country, where feudalism was rejected early on and civil society has always been strong. Even the Basque PP does not challenge social policy in this AC to the extent that it does in some.

Two major equity-enhancing reforms were undertaken immediately under Freire and the newly empowered Osakidetza: universalization of health coverage and the inclusion of youth dental care within the public system. In February of 1988, bare months after taking on health competencies, the Basque Country mostly eliminated the gaps in coverage by passing legislation to ensure that those without sufficient economic resources could access health care (Decreto 26/1988). The central government

⁵⁴*El País* 10/26/2003 Interview with Azkuna “Hubo mucha resistencia al principio entre los profesionales’.”

in Madrid was put in an awkward position, having been shown up by its Basque affiliate, which was initiating more progressive reforms than it was instituting centrally (Esnaola 2011). On September 8, 1989 the central government, following the Basque AC, passed health coverage for those without resources who were not tied to the Social Security System (Real Decreto 1088/1989).

At the end of April 1990, the PADI was passed (Decreto 118/1990). The law was immediately followed by implementation guidelines from the Health Secretariat for basic coverage guarantees and the hiring of providers (Orden 2 de Mayo and 3 de Mayo, respectively). In both the Basque Country and Navarre (which also implemented the program as soon as it received health competences) the PADI has reduced social class based differences in dental health significantly, in addition to overall decreasing cavities, extractions, and other dental problems requiring treatment among the young (Freire 2003).

The first Spanish National Health survey in 2003 showed staggering regional differences in dental health outcomes and the PSOE placed the issue of extension of the PADI into its electoral program. The major parties that together negotiated the 2003 health reform under the PP's leadership also included dental health as a covered area of the SNS. Yet no enforcement or implementation action had been taken at the center, so regional differences remained large.

Universalization, the PADI, and the RMI are examples of best practice sharing where other ACs or the central government have improved services in order to keep up with the highest performing ACs—in this case the Basque Country. The possibility of regional innovation and diffusion, in Spain and Brazil, is the most significant equity-enhancing attribute of decentralization, even though its impact is structurally limited. Innovation in the Basque Country should be credited with a portion of the equity-enhancing improvements in health policy in the Spanish territory as a whole.

While in general corruption has not been as significant an issue in Basque politics as in some other ACs, one quite spectacular case directly impacted health care. In 1990, actors associated with the PSE changed 581 civil service exams for high level technical and management positions in Osakidetza, ensuring that supporters of the PSE and UGT⁵⁵ received the jobs. The 50,000 people who had taken the exam had to take it again. The event was glossed over at the time and only four years later, when electoral relationships had shifted, did the PNV bring forth documents allowing the stalled court case to move forward⁵⁶. The Director General of Osakidetza, his second in command, and two others were found guilty and sentenced to jail time at the end of the 1990s. In 2007 the central PSOE pardoned them before they had begun to serve their sentences⁵⁷.

The governing pact with the socialists continued in the fourth and fifth legislatures, from 1991 to 1999, yet was not a static process, which can be seen in Figure 4.5, above. A nationalist coalition between the PNV, *Euskadiko Ezkerra* (EE, Basque Left) and EA in 1991 broke down after just six months, causing the renewal of a coalition with the PSE. Yet in 1993 a fundamental shift took place, with the Basque socialists forming a permanent coalition with EE. The decision tied the PSE to an historic political formation of the *izquierda abertzale* that had been born from the political wing of ETA and split, reformed, and moderated over time to accept democracy, the Statute of Guernica, and more moderate social democratic positions. This pattern of alliances and coalitions illustrates the way that parties with shared moderate left of center views on social cohesion and support for Basque autonomy have blurred the distinctions between traditional left and right, nationalist and non-nationalist

⁵⁵The UGT—*Unión General de Trabajadores* (General Workers' Union)—was founded in 1888 and was originally affiliated with the PSOE. It is the second strongest union at the central level in Spain.

⁵⁶*El País* 5/30/1994 “El otro ‘fraude Osakidetza’.”

⁵⁷*Gara* 10/7/2007 “Indultan a los implicados en el ‘caso Osakidetza’.”

partisanship in the operation of pragmatic Basque politics.

Under the leadership of the nationalist Iñaki Azkuna, Osakidetza improved patient care despite high pressures for cost containment. During the 1990s, costs were controlled primarily by avoiding excessive hospitalization. Mobile care teams for dialysis and other specialized areas of provision were used to permit patient care at home. Whereas in Spain overall the trend has been toward concentrating health spending in the most expensive and least equity-enhancing areas, Osakidetza bucked this trend and improved wait lists, the time GPs spent in clinic visits, and perceptions of the system, while still controlling costs⁵⁸. The reforms were not perfect and particularly nurses' unions articulated concerns that cost savings were being attained by forcing their members to work more, without more pay. Osakidetza has not been impervious to liberal market reforms and private sector pressures.

During this period Osakidetza restructured the health system, incorporating some market principles of management and administrative decentralization, as well as some rationalization (the *Plan Osasuna Zainduz*, approved by the Basque Parliament June 23rd 1993). Reforms that rationalize access to services or provision of care are not automatically regressive, since health care has the perverse status of being a service area in which higher levels of consumption are not necessarily better for outcomes. However, as was true for the early reforms by the central PP during this same period, granting hospitals and providers greater autonomy has often been used as a way of sidestepping collective bargaining by health workers. The largest Basque unions and parties to the left of the PSE have criticized the measures.

In the Basque context, where cooperatives and public/private ventures have a long history and have often been imbued with a commitment to equity, the results of

⁵⁸*El País* 10/13/1998 "Curar mejor sin gastar más."

central rationalization efforts after the *Informe Abril* appear to have been less detrimental than has been the case in Catalonia, for example. One of the most significant differences is that the Basque mechanisms have generally been to incorporate standards for performance and accountability, as well as cost containment, into public contracts with public employees, rather than outsourcing to private providers. For all ACs, the cost pressures have always been real and neither Health Secretaries nor their administrators set budgets. After the central reform of under the PP, the PNV and Azkuna introduced legislation in 1997 to change the juridical status of health centers and hospitals, after which they became foundations that operated under clearer market principles, though still owned by Osakidetza (Ley 8/1997). The new Basque health law also took citizen rights and participation in the system to a new level, incorporating a patient bill of rights, deepened options for provider choice, and institutional paths for public accountability.

In 1996 the PNV supported the candidacy of the PP in the Spanish Congress and was rewarded in the next round of negotiation over the *Concierto Económico* in 1997 with an increase in authority over direct taxes, which amounted to almost complete autonomy (Ruíz-Huerta and López 1997). In October of 1998 the PP was in power in the center for the first time when autonomous Basque elections were taking place and ETA had signed an indefinite ceasefire. In Vizcaya the PNV won the elections, in Álava the PP, and in Guipúzcoa, *Euskal Herriarrok* (the unreformed izquierda abertzale formation, EH). With the support of EA and EH, the PNV candidate Juan José Ibarretxe took office in coalition with EA. Territorial government in the AC could not have been more ideologically disparate. Gabriel María Inclán took over Osakidetza in 1999 and remained in the post until 2009, making the Basque Country another AC with exceptionally high ministerial tenure in Health (see Figure A.15).

Coalitions of convenience and the politics of concessions illustrate the ideological complications of multilevel governance. The PNV supported the PP centrally in Madrid, despite deep antagonism on both sides, because it knew it could extract valuable benefits for the AC. The PP had vowed not to bargain with minority nationalists during the campaign, but in the end had no alternative if it wanted to govern.

But by 2001 the central PP was governing alone with an absolute majority and when ETA broke its ceasefire, regional politics in the Basque Country shifted radically and quickly. The Basque PP and PSE joined together in an attempt to unseat the PNV, forcing early elections. The PP and PSE partnered across perhaps the most acrimonious political divide in the country in order to keep the *izquierda abertzale* out of the Basque government, and in defense of a (somewhat) similar vision for the future of the Spanish state. Yet their attempt backfired. The PNV, in coalition with EA, won all three territories in the early elections forced by the “constitucionalistas.” Of note, the unreformed *izquierda abertzale*—still unprepared to break with ETA—was the biggest electoral loser. Violence and insecurity were at the forefront of voters’ minds and they overwhelmingly supported Ibarretxe and the democratic, moderate nationalists to deal with ETA at that historical juncture.

In 2001 Ibarretxe began the process of reforming the Statute of Guernica, which in 1979 had not been able to overcome a number of crucial issues Basque nationalists had with the Spanish Constitution. Non-nationalist forces declined to participate in the project and the *izquierda abertzale* rejected it, so the proposal was elaborated only by the moderate nationalist forces. The reform was presented to the Basque parliament in 2003, narrowly passed in 2004, and presented to the Spanish Congress in 2005. It would have enshrined the right to self-determination, representation for the Basque territories in the EU akin to that enjoyed by the regions of Belgium, Holland, and Germany, an autonomous judiciary, and reform of the Constitutional

Tribunal that would ensure the Spanish central government could not unilaterally change the character of Basque autonomy through constitutional reform.

It was defeated in the Spanish Congress overwhelmingly, with only the central deputies from the PNV, the Catalan nationalist parties (left and right), EA, Nafarroa Bai (the Basque nationalists in Navarre), and the BNG (*Bloque Nacionalista Galego*, leftist nationalist party in Galicia) in support. Therefore, along with Galicia, the Basque Country remains one of only two ACs that has never been able to reform its Statute, in this case because of a central veto when the project was attempted.

At the turn of the millennium the Basque Country was flush with resources and at its strongest economic point relative to the rest of Spain, with income inequality at its lowest level ever. Investments were made in completing extension of the primary care network. Osakidetza has continued to win awards for the quality of its services and more Basques use and support the system than in other ACs. Rates of double coverage through the purchase of private health insurance are lower in the Basque Country than elsewhere (Esnaola 2011). The Basque Country has steadily expanded public coverage and access to reproductive and women's health, as well as mental health—both areas historically neglected in basic coverage requirements at the center.

In the autonomous elections of 2009 the PSE-EE won election outright, for the first time able to form its own Basque government. The unreformed *izquierda abertzale* had been illegalized as a terrorist organization by the Spanish courts and could not participate, while EA and the PNV were running separately for the first time in years. The Basque Country now had a government in which the AC was governed by the PSE-EE while all three Territories were governed by the PNV.

Rafael Bengoa, Director of Planning and Evaluation from 1991-1995 under Azkuna and author of the *Plan Osasuna Zainduz*, became Health Secretary in 2009. The most significant reforms during this time have been the elaboration of the *Estrategia de*

Cronicidad—a measure to reorient the entire health system toward the management of chronic illness, which with an aging population has become increasingly important. The reform has already begun to save money for the department by allowing for home care and electronic management of chronic illnesses. In 2011 Osakidetza was the first regional health service to institute unified electronic patient histories, which appear to have reduced errors in medication significantly⁵⁹.

In 2011 the foral elections created an historic and challenging scenario for fiscal management in which four different parties governed in the Territories and the AC. The newly legalized *Bildu* (reformed izquierda abertzale) governed Guipúzcoa for the first time, the PNV in Vizcaya, the PP in Álava, and the PSE in the Basque Government. When the new PP central government with a large absolute majority introduced co-pays on drugs for seniors and banned those who could not document residency from using the SNS for free, the Basque Country was one of several ACs that challenged the decisions, in this case by simply saying it would not comply.

The distribution of responsibilities has never been as fast or as deep as the Basque Country wanted. While the authority of the center continues to be regularly questioned, the courts appear to be the only source for clarification, which themselves are politicized and ultimately controlled by the central government. The autonomous elections of 2012, the first since the permanent and unconditional ceasefire of ETA, yielded almost equal numbers of seats for the izquierda abertzale and the PNV, and this latter will govern as the economic crisis continues. The Basque independentists have steadily improved their electoral performance since rejecting violence, so as the Catalans draw closer and closer to a referendum on independence, the Basque Country may not be as far behind as they seem. Other forms of “civil disobedience” may be more likely in the near term if the izquierda abertzale were to govern—refusal to

⁵⁹ *Sanitaria 2000: Directivos de la Salud* 10/18/2011 “La historia clínica de Osakidetza reduce el 67% los errores asociados a la medicación.”

pay the cupo or meet other agreements made with the Spanish state (Fantova 2011).

The segment of the *izquierda abertzale* that has long rejected violence⁶⁰ has played a role in bridging the left and nationalist political tendencies in the AC. Yet the threat of ETA violence has also had an impact on the functioning of government. Violence places democratic policy-makers in the situation of having to take difficult positions, which can easily be encased in absolutist language. When ETA attacks, Basque nationalists become defensive about the Spanish government using the violence as an excuse to ignore democratic calls for increased home rule, while Spanish politicians face intense pressure to appear “tough on terror.”

Arguably, like corruption, violence has limited administrative capacity in the AC and the central government. Perhaps one of the starkest examples is that politicians have historically risked their lives and the lives of their families by participating in politics, particularly in the Basque Country, but also in Spain. The threat has been real and persistent and has placed high stakes on interactions that might otherwise be mundane, as well as dissuading capable socialist or popular officials from participating if they felt their views would draw the threat of violence.

The outlook of health officials has been bleak, with an assumption that in the coming years inequality in the system will likely increase as the crisis shows no signs of abating. But it is clear that the Basque Country will still suffer less than many other ACs because of its high capacity and high commitment. Early investments in quality facilities, personnel, and coverage—not only in health care but also social

⁶⁰In 1978 a group of forces of the independentist left met at the Mesa de Alsasua. Most of these forces formed HB. For many years HB and its successors did not denounce violence and maintained a relationship with ETA. This is usually the reference when the term *izquierda abertzale* is used. Yet EE (before joining the PSE), EA, Aralar, the coalition Nafarroa Bai in Navarre, and the coalition Amaiur that presented in the general elections of 2011 after the definitive ceasefire of ETA are all leftist independentist groupings that should not be considered part of the insurrectionist and violent opposition to the Spanish state. These forces have participated in democratic government and eschewed violence, unlike HB and its posterior formations before 2011. The issue of what is required to have substantively rejected violence is a difficult one, but lumping all independentist forces together without making this distinction misses important variation in Basque politics.

services and welfare—meant that when the crisis hit, as one official put it, there was “more fat, and room to cut deeper before hitting the bone.” The Basque Country has not been as hard hit economically as many other ACs and the extra padding of a healthy, highly educated population impacts other areas of the economy, feeding back into lower health service demand, as well.

4.10.3 Commitment or Capacity?: Comparison with Navarre

Navarre and the Basque Country differ on a number of dimensions, but are the only ACs with special fiscal autonomy. The cases are worth understanding in historical context because Navarre arguably has the most equity-enhancing health system of all and the best outcome indicators in terms of life expectancy and infant mortality. These are the only ACs in which a majority of the population feels that management of health is better under decentralized government management and in which longer experience with decentralized management has increased the percent of people who feel decentralization is better. In all other ACs, the positive valuation of the system under decentralization has decreased over time (Barómetro Sanitario 2012).

While the perception of the PNV as a “special” center right party that really does prioritize social cohesion within its territory is widespread, this factor is weaker in Navarre. Despite having lower levels of *vasquitud* (basqueness), health outcomes have been even more egalitarian than in the Basque Country. As we shall see, the history of Navarre militates against such progressive health policy, as it has always been more conservative than the northern Basque territories. Certainly, there are no other ACs where center right parties have governed as long as in the Basque Country where health policies and outcomes have been as equity-enhancing.

Navarre was within INSALUD three years longer than the Basque Country and is much smaller, but has performed better on primary care reform implementation and has been nearly as pioneering as the Basque Country in health policy—introducing

universal coverage and youth dental coverage at the same time. Its health outcome indicators are also superior. Comparing these cases highlights the importance of fiscal capacity, as well as high levels of ideological commitment at key moments.

In the 19th century, *carlismo* (support for the conservative traditional monarchy) was a strong political force in both regions, but while it ceded to strong communitarian Christian democratic tendencies among Basque nationalists in the north, in Navarre *carlismo* encompassed a staunchly conservative “españolista” and anti-Basque nationalist political wing. The anti-feudalism of the Basques in the north was less pronounced in the Navarrese foral institutions and the more egalitarian thrusts within *carlismo* were weak in Navarre. These differences favored the creation of a large political sector in Navarre that supported autonomy from the Basque project. The Navarrese party that came to power after Franco was much more conservative than the PNV in the Basque Country—the UPN in 1979—and defined its regional-nationalism in the context of avoiding absorption into the Basque nationalist project, rather than over tension with Spain.

In fact, part of the reason the PNV is less staunchly aligned with the conservative ideology of other right of center parties emerging from *carlismo* is that its leaders felt betrayed by the Carlists, who did not fully back Navarrese membership in the Basque autonomy Statute in 1932 (de Pablo 2007: 2; Blinkhorn 1974: 596). Because foral rights in the Basque areas would have allowed religious government to persist, resistance to autonomy within the Spanish left and on the part of the Republic was even stronger than on the right, at first (de Pablo 2007). Basque nationalists warily welcomed the Republic in 1931 because for the first time limited democratic self-determination and autonomy were actually on the table, but at the same time the anarcho-sindicalist and communist left at the heart of the Republican project were deeply antagonistic to the religious government enshrined in the Basque *fueros*.

Different proposals were put forth for a four-territory statute of autonomy in Navarre in 1931 and 1932 and the one that was eventually determinant in 1932 would have diminished provincial authority significantly vis-à-vis the new four-territory autonomous government. Navarrese provincial elites feared domination from Bilbao and support for integration into the Basque autonomy project diminished. Because the municipalities voted not to join the Basque region in 1932, Navarre entered the post-Franco democratic period in the unique position of having a specially recognized foral fiscal regime protected by the Constitution, without a clear road map for whether it would join the Basque AC or form its own. Álava had backed out of the Statute in 1933 (Blinkhorn 1974: 595), but was still considered part of the Basque project after 1978 because it had approved the original Statute almost unanimously, unlike Navarre, which had rejected it.

The fiscal arrangements in the regions are different, but in terms of their revenue generation produce similar results. The legacy of experience with self-government, high levels of own-source revenues, and commitment to social cohesion within the region helps explain why the quality of decentralized health services in these two ACs has been so far superior to that in the rest of Spain.

Yet there are differences between the two ACs in terms of health reform. For the 1984 primary care reform, the divergence was large by 1992, eight years after implementation⁶¹. At this point, Navarre had 80 per cent coverage and the Basque Country 47 per cent. The gap was the same in 2000, with Navarre at 100 per cent coverage and the Basque country at 67 per cent (González, et al 2004: 83). Both were within INSALUD until the late 1980s and in both ACs the Territories had maintained and continued to operate their own hospitals and health centers.

⁶¹One must keep in mind that some elements of the primary care reform were implemented uniformly across the country—namely the extension of schedules and incorporation of GPs and support staff for primary care into the *consultorios*—so these numbers should not be interpreted as total lack of change in primary care (Bengoia 2012; Lamata 2012).

The patient load on each GP has decreased steadily in the Basque Country while stagnating in Navarre since at least 2004, if not earlier (SIAP 2012). The same pattern has held true for the number of inhabitants served by each health center. While the number of centers has not changed in Navarre since 2004 and population has grown, increasing the number of people assigned to each center by nearly 1000, in the Basque Country since 2004 the number of centers has increased to keep pace with the population and the burden on each center has not increased (SIAP 2012)⁶².

So what trends might explain the early superior performance of Navarre with the Basque Country slow to catch up in the early years of the system, then stagnation in the Navarrese health service later? Two important differences stand out. First, in Navarre fiscal resources have existed longer and the network of foral hospitals and health centers had been established before the return of democracy. Second, in Navarre, the *Partido Socialista de Navarra* (PSN-PSOE, Navarrese Socialist Party) governed from 1983 to 1991—during the most important period of primary care expansion and in concurrence with socialist government in the center (yet before the devolution of health care). In the Basque Country those years were dominated by the PNV and high levels of conflict with Madrid. The PADI was instituted at the end of the PSN government in Navarre, immediately after the transfer of health competencies and before the end of socialist government in the AC. Clearly, the smaller size of Navarre also made reform simpler in some respects.

Yet in other ways reformers in Navarre faced significant obstacles that required ideological commitment to be overcome. The Opus Dei has played a strong role in the Navarrese medical establishment, with the PSN early on generating high levels of conflict in an attempt to disengage the public sector from its long history of reliance on

⁶²Population density is five times higher in the Basque Country than in Navarre, which explains the higher numbers of inhabitants served by each clinic there. This is why it is best to avoid direct comparison of the number of people served by each clinic.

religious medical institutions for contracting service provision through social security. These elements of reform were never complete and private medicine still plays a more significant role in Navarre than in some other ACs. Despite the fact that medical doctors in Navarre have virtually refused to provide legal abortions and the health service must pay to send women to neighboring ACs for care, in other ways the Navarrese health service has continued to be exemplary even under conservative control by the UPN.

The primary care reform is the most notable difference between the two ACs. In 1992, only Cantabria, Baleares, Murcia, Catalonia, and Galicia had lower primary care reform coverage than the Basque Country—all but one governed exclusively by right of center parties up to that point. Certainly this relationship is not deterministic, as many other ACs were governed by the socialist party during that period, under INSALUD, without coverage rates as high as those in Navarre. Yet the Basque government in the early 1980s was not a coalition government that included the left and after being forced to wait so long for the health transfer, the Basques prioritized their own integrated reform model. Yet the difference in primary reform, which has clearly played a role in improving health outcomes in Spain, casts doubt both on the notion that the PNV has been universally supportive of equity-enhancing social policies, despite being a right of center party, as well as on the notion that Navarre has achieved what it has simply because of higher levels of financing than other ACs. The Basque Country had the same special resources, took over health care earlier, and chose not to invest as heavily in primary care.

4.10.4 The Basque Country: Conclusion

When comparing the Basque Country and Navarre to the rest of Spain, a traditional left-right assessment of policy preferences is clearly insufficient to explain

vastly higher quality health services, with far superior user ratings and excellent outcomes. Left parties have been important at key moments in fighting tough battles with entrenched private sector interests opposed to redistributive public social service implementation, and their impact is observable. Yet center-right parties have dominated in both ACs and have not behaved in the way that the PP has or that even the Catalan CiU has, despite also being a minority nationalist party (in the case of the PNV). The dominant features, then, that make these two ACs different are their superior level of fiscal capacity, their historical experience with self-rule (administrative capacity), and the salience and inclusiveness of a territorially defined reference community. The characteristics of the Basque reference community are unique in Spain in generating a commitment to social cohesion across social class, for the historical reasons outlined above.

The Basque language is completely unique, the only minority nationalist language in Spain that is not a romance language. The ability to distinguish insiders from outsiders is much easier in the Basque territories than elsewhere because the ethno-linguistic differences are larger. The intensity of repression and persistence of independentist violence have both contributed to increasing the salience of the reference community. For the PNV, in particular, showing that it could do better by its community than the Spanish, left or right, has been important. This is also true of other parties, which in the Basque territories have to respond to the strong sense of identity and the alternative options available to Basque voters under democracy.

The significantly higher level of fiscal resources combined with the long legacy of self-governing institutions and provision of social services before (and in some cases during) Franco is the other obvious difference between the Basque territories and the rest of Spain. These are ACs that were collecting their own taxes and running their own hospitals for decades when only centralized authority existed elsewhere.

They have been innovators in health care, finding more equitable ways to cope with cost containment pressures than other ACs and more willing to experiment with alternatives to traditional medical organization and practice.

Despite high levels of intergovernmental conflict over policy scope and the vision of the Basque Country's role in the Spanish state, sufficient political capital has remained to invest major resources in producing a high quality and highly egalitarian health service. As with high commitment states in Brazil, the Basque Country is the prime example of what decentralization would do under best case scenarios—promote innovation that pushes the center to improve its own policies and provide an excellent service for its citizens. Yet there is no way around the fact that this project has been made possible primarily by a fiscal model that would functionally end the Spanish state if it were applied to all ACs. That the Basque Country is wealthier than average also means the health challenges it must confront are less acute than those for poor ACs with higher income inequality and unemployment, as well as a higher concentration of poor health.

Finally, it is worth noting that if the Basque AC were a country, its process of health reform would have been highly centralizing in an effort to ensure equality of access and universal coverage, bringing provincial and municipal health resources into the centralized system under the authority of the Basque AC. In this case, the territorial scope of the reference community has been the key difference. Within the Basque Country, a majority of citizens view the authority of the AC as legitimate.

4.11 Case Study: Castilla y León

Castilla y León is one of the clearest cases of a AC that might have functioned better if it had been several ACs, instead of one. Yet major support from the EU, lack of high poverty and inequality, and rule by a more pragmatic regional PP affiliate have made this AC the best performer among those with low levels of commitment.

Problems with corruption and inter-provincial territorial conflict have hindered administrative capacity.

4.11.1 Overview

The AC of Castilla y León is composed of nine provinces, the most of any AC in Spain by a significant margin. It is the most expansive geographically and one of the largest regions in Europe, yet with a small and highly dispersed population that had been declining for decades and only reversed course slightly in 2002. Of the three ACs considered here, Castilla y León was the least coherent when it formed. It still has no official capital and no unified regional newspaper, as well as completely lacking a strong, shared identity. Still, it is the birthplace of Castilian Spanish and encompasses the majority of the UNESCO recognized historical patrimony of the country.

Castilla y León is a middle-income AC that has hovered near the Spanish average for most of the democratic period and has had almost exclusively conservative leadership, with no minority nationalism (see Figure A.7). Using this particular AC to assess the role of political forces with low levels of commitment to equity is a conservative choice meant to press the theory. The PP is not a monolithic party and while Madrid, Valencia, and Galicia have been the centers of the harder right of the party (and bear clear signs of ideologically rooted social policy retrenchment), the leadership of Castilla y León has tended to be somewhat more pragmatic.

While in 1973 the infant mortality rate in Castilla y León was the highest in Spain at 24, by 1982 it had been cut in half and was below the country average. Life expectancy was a year and a half higher than the Spanish average in 1991 but had diminished to a few months difference by 2010 (see Figures A.13 and A.14). As in Extremadura, the benefit of being within INSALUD until 2001 was that during the most important years for the implementation and consolidation of the system, it was in the hands of a committed center. By the time the last phase of devolution took

place, the SNS was unquestionable as a social right for Spanish citizens.

Still, while Castilla y León has basically maintained a steady effort in health policy, Madrid (another AC run by the PP that took on health in 2001) has instituted a variety of reforms that have drastically damaged access to and quality of public health services. EU investment in the AC has been notable, around twice the country average throughout the period, beginning in 1987, as in other ACs.

4.11.2 Multilevel Health Reform in Castilla y León

Castilla was the region in which the rural *campesinado* overwhelmingly supported Franco, quite possibly determining his victory in the Civil War (Blanco Rodríguez 1998). These were for the most part small independent farmers, without the high concentration of land ownership found in the south (384). Yet far from investing economic and political energy in the glorified rural roots of Spain, after the war the countryside languished for a decade and could never compete for the regime's interest with the more lucrative investment centers of Madrid, Bilbao, and Barcelona. Franco also bypassed the region in choosing his cabinets (Almeida, et al 2003: 90).

The AC was originally imagined as an eleven-province region, including Santander and Logroño in the 19th century. Geographically, the provinces surround the basin of the Duero river and bring together the historic regions of Castilla la Vieja and León. A pre-autonomy project was even elaborated to this end, just before the Civil War.

The politics of the creation of this AC expose the complexity of the political maneuvering that was taking place among the newly empowered democratic actors. From the beginning, the PSOE and PCE were juggling a complicated ideological balance. They had set themselves up as defenders of regional democracy and the right of the historic communities to determine their political organization, yet had powerful pragmatic political interests as well. Democracy was not consolidated or guaranteed at this stage and the forces of the right had been ambivalent toward the

democratic project, at best. For the new democratic left, the future of democracy was intertwined with successfully unseating the right from power. In Castilla y León, where the right had more popular support than almost anywhere else in the country, parties on the left tried to minimize the number of ACs that would be created there.

For the UCD, warring pressures and visions for Spain generated territorial disagreements over how the ACs should be constructed. The Basques and Catalans had pushed their Statutes to be as decentralizing as possible, taking centrist reformers aback. The problem of centrifugal minority nationalism overlay an UCD vision of Spain that militated against creating large numbers of small ACs with a great deal of authority. It disliked the idea of uniprovincial ACs and so ended up in the same camp as the PSOE in the case of Castilla y León—pushing with heavy handed authority to enforce an encompassing geographic territory for the new AC. If the ACs had to exist, let there be as few as possible. The UCD feared a free-for-all with every province trying to win maximum power and resources for itself in the heartland of the Spanish nation. This pitted the central UCD against the parochial interests of the political leaders in the provinces, who saw resources, jobs, and central legislative seats slipping away from them, the larger the projected new AC became.

While the PSOE in Castilla y León, as in Extremadura, originally advocated for the *vía rápida* (Reol Tejada 2005: 395), it became clear there was no way the provinces and municipalities would pass the Statute under those conditions. The issue of where the capital would lie was an enormous problem, as well as what the relative status of each province would be. While Santander (which became the AC of Cantabria) and Logroño (which became the AC of La Rioja) had legitimate enough claims to historic nationhood to go it alone, Segovia did not, despite its attempt to form its own AC. Rodolfo Martín Villa, Minister of Territorial Affairs, central legislator elected from León, and authoritarian enforcer from the “sector azul” of the

franquistas, legislated the inclusion of León in the project, against the wishes of the elected provincial leadership.

These provinces had all been strongholds of the right and socialist and communist forces feared that calls for uniprovincial autonomy masked attempts to create personalistic fiefdoms of conservative economic and political power with ties to the UCD at the center. Segovia voted not to join the new AC due to the provincial representation formula being considered for election to the AC assembly⁶³, yet the UCD central government approved it as part of Castilla y León, regardless. In the case of León, 53 senators from the AP in 1984 sued in the Tribunal Constitucional to try to separate León from Castilla y León, but to no avail⁶⁴. The formation of Castilla y León is yet another example of a decentralization process driven by central forces with little substantive commitment to the preferences of the regions themselves.

In much of the region during the democratic transition, the ideological space on the far right was occupied by the UCD, rather than the AP. Many of the most important central leaders in the UCD had come from the region and forces on the right had historically supported them, so the AP was weaker. Martín Villa was utterly invested in the nine-province Castilla y León, while provincial UCD members wanted their own ACs, so the majority of the conflict played out within the UCD itself⁶⁵. In León, the provincial AP wanted provincial autonomy while the provincial PSOE and PCE advocated for joining the autonomy project of Castilla y León⁶⁶. These conflicts persisted well into the 1980s, with a portion of the regional UCD

⁶³ *El País* 12/7/1980 “El cantonalismo de Segovia, otro problema interno de UCD.” and 6/4/1983 “AP-PDP-UL recurre contra la inclusión de Segovia y León en la comunidad castellana.”

⁶⁴ *El País* 9/29/1984 “El Tribunal Constitucional no permite que León se separe de la comunidad castellano-leonesa.”

⁶⁵ *El País* 10/9/1981 “La opción uniprovincial de Segovia, sin posibilidades de éxito en el Congreso.”

⁶⁶ *El País* 3/19/1980 “La posible ruptura de Castilla y León inquieta a las fuerzas políticas de la región.”

abandoning the party and joining AP—one of many nails in the UCD coffin.

The 1983 Statute did not fix the capital, but left it for a later date, a decision that remains impossible to make formally even today, though the government seat is in Valladolid. Election to the Cortes (the assembly) is based on a provincial circumscription, with a minimum of three representatives in each province and another for each 45,000 inhabitants (Art. 11).

Politics in Castilla y León has been less stable than in many ACs, across all parties, and largely due to the same lack of regional identity and high levels of provincial competition that characterized the initial creation of the AC. The UCD governed the pre-autonomic territory until 1983. After the fundamental issues of territorial organization were mostly resolved, the first autonomous elections took place in 1983. The PSOE won these elections in the heartland of conservative Spain, yet in a deeply conflicted AC affiliate headed by Demetrio Madrid, a politician who had been at odds with the central party leadership on and off throughout the transition⁶⁷.

Health was caught up within the social welfare department until 2002, which was common among ACs without decentralized health competences. While the Basque Country planned for an autonomous NHS, creating the institutional structure to be ready for the responsibilities five years in advance, and even Extremadura had a Health Secretariat throughout most of the period of INSALUD control, Castilla y León did not. Still, for the early years of the primary care reform, Castilla y León was also under center-left governance at the AC level. Coverage in primary care was similar to that in Extremadura and better than in the Basque Country after the initial phase of implementation. As in other ACs such as Madrid, which later became conservative strongholds but started out socialist, having committed government at the time of reform improved implementation.

⁶⁷ *El País* 3/4/1985 “La dirección del PSOE teme fuertes tensiones en el próximo congreso regional de Castilla y León.”

The problems culminated with Madrid's loss in internal elections for Secretary General in 1985 (a race with four candidates, each provincially affiliated), which was followed by his resignation in 1986, when charges were brought against him for the alleged mismanagement of the sale of a company he owned. He was eventually cleared of all charges, but the PSOE in Castilla y León never recovered. The socialists have never won another election in the AC, after losing to José María Aznar and the AP in 1987. Aznar was an economic liberal and a pragmatic politician who led the reform and rebranding of the Spanish AP to become the PP in 1989. He governed in the AC for two years before stepping down to run the central party as candidate for president in every general election until his victory in 1996. The AC passed a reform to take on new competences in 1988, but as in the case of the other ACs, the central government held the proposal at bay for years before renegotiating all the *vía lenta* regimes at the same time through the *Acuerdos Autonómicos* 1992 (LO 11/1994).

Beginning in the late 1990s, charges began to emerge around issues of preferential dispensation of public jobs to friends and family of the governing PP, so called "enchufismo."⁶⁸ The Health Secretary in 1999, Carlos Fernández Carriedo, was also implicated in the irregularities⁶⁹. The Statute was reformed in 1999 to expand elements of AC executive authority and made administrative adjustments in preparation for the transfer of health and education (Ley Orgánica 4/1999). When Castilla y León took on health competences at the start of 2002, Carriedo was Secretary, an economist and president of the PP in Palencia. He took over the Consejería de Medioambiente (Environment) after leaving health, as had his predecessor.

After the transfer from INSALUD, most ACs found that wait lists were longer than

⁶⁸*El País* 4/2/1998 "El PSOE denuncia 3.500 'enchufados' en la Junta de Castilla y León" and 5/24/1999 "Una comunidad amenazada por la despoblación."

⁶⁹*El País* 10/2/1999 "Condenado por malversación el ex presidente del Consejo Económico de Castilla y León."

they had been told and that public infrastructure projects were not as far advanced as they had been led to believe. In addition, INSALUD appointed a significant number of permanent staff, including high-level political appointments, just before making the transfer. In Castilla y León these “contratos blindados” were not a major concern, since they been made from within the existing ranks of PP leadership in the ACs.

After devolution, the norm in Castilla y León was to contract with private providers to deal with wait lists rather than expanding the capacity of the public system—in contrast to the Basque decision 15 years earlier to confront private medical interests head on in the process of consolidating an integrated NHS, or the socialist path in Extremadura of greatly expanding the scope of public service provision. This policy came to a head after the first few years of autonomous health management, when a series of scandals revealed that the public system had been paying private providers high prices for services that were performed at lower cost in the public system. The scandals involved many resignations within the ranks of the AC health service.

Unlike the Basque Country where provincial health responsibilities were centralized under *Osakidetza*, in Castilla y León provincial directors managed significant responsibilities in contracting and service provision. The first Director of SaCyL in Valladolid was Pedro Luis Antona. When he was first appointed he proceeded to grant public contracts with private providers for large sums, when it turned out that the private middle company—owned by a friend—was paying much less to provide the service than it was being reimbursed for, making a hefty profit at the expense of the government. Yet it had been the Health Secretariat itself that had told provincial directors and hospitals to pay bills directly through the hospitals, rather than going through the legal approval process for paying out contracts, which required defending

and explaining the payments⁷⁰. The so-called “Caso Antona” unfolded in the mid-2000s when the AC government had passed into the hands of a new executive, Juan Vicente Herrera. The government itself pushed prosecution of the case and tried to recover the money, as well as reorienting the administration of health resources after the scandals, generating immediate savings for the AC by eliminating many of the high cost private contracts.

What occurred in Castilla y León in 2001 was the turnover of health services to an AC government that was not ideologically committed to equity-enhancing health reform and had significant problems with cronyism and conflicting private interests in the public administration. The AC also faced significant administrative coordination challenges because of the large number of provinces. In addition, the costs of serving a highly dispersed population are significantly higher, yet only recently under the PSOE was territorial dispersion incorporated into the financing formula for health.

While the SNS was consolidated after 15 years of implementation and was not, itself, at risk, public resources were directed toward private business interests in a way that prevented investments in public capacity and ate into the fiscal capacity of the AC. It is therefore not surprising that in 2002 only 20 per cent of citizens thought the health system was doing better under decentralized governance than under INSALUD, the third lowest evaluation in Spain (Barómetro Sanitario 2002). Citizen evaluation of the relative quality of decentralized care has decreased even further, as it has in every AC except the Basque Country and Navarre, and Castilla y León remains at the very bottom.

Yet Castilla y León is an interesting case in which to study low commitment because it is not as starkly ideological in its antagonism to equity-enhancing reform as several wealthier ACs also governed by the PP, such as Madrid or Valencia. The

⁷⁰*El Norte de Castilla* 5/7/2006 “Exigen a Antona que explique la dimisión del gerente de SaCyL en Valladolid.”

economic elite in the AC was smaller, without the base of large landholdings or finance capital present in some other ACs. The population has been more ethnically homogenous, despite the challenges of distinct provincial autonomy projects. And the majority of voters are not as high income as they are in the wealthier ACs. Among political actors of all stripes there is a shared view that the AC has been neglected in public investments by the center, under Franco, the PSOE, and the PP.

Although in 2001 the two serving vice presidents competed publicly for the executive post, outgoing President Lucas (headed to run the Senate in Madrid) chose Herrera, someone who had not been in line for the job⁷¹, yet who was seen as a conciliator, capable of managing the complex relationships within the party. He had been an AC legislator for several years and had experience working with the opposition. Like Ibarra in Extremadura, he has had a reputation for putting what he believed to be the interests of his region before obeisance to the central party, even though the PP is not as decentralized internally as the PSOE. In 2005 he refused to vote against the PSOE's AC financing plan, which he believed would be an improvement for Castilla y León. During the debates about an ideal financing system, while in Madrid and Valencia PP leaders stated that they felt the PP's 2001 system did not need reform, Herrera clearly articulated the problems of equity in the existing system, defending the need to pay more attention to inter-regional solidarity⁷². The previous system implemented under the PP only took into account population and not aging or dispersion (both significant issues in Castilla y León).

Herrera has a strong support base and since the crisis has once again illustrated differences with Madrid—giving a speech defending the State of the Autonomies at a

⁷¹*El País* 2/28/1995 “Juan Vicente Herrera, portavoz parlamentario del PP, será el nuevo presidente de Castilla y León.”

⁷²*El País* 5/23/1995 “Los presidentes autonómicos piden más dinero.”

time when central actors and AC leaders in Madrid were calling for recentralization⁷³. Still, Herrera's view of how autonomy should be used is in line with his party's ideology: the model for public provision should be "austere and rational"⁷⁴.

In 2003 after Herrera was elected, he replaced Health Secretary Carriedo with César Antón Beltrán, an economist who had previously coordinated the Health Department's services, as well as managed the Social Services division of the AC executive branch. A number of new services were added to the *cartera de servicios* during these years⁷⁵. While the *Caso Antona* came to light during this time, there appears to have been a general improvement in management of health services, partly in response to public outrage over the scandals and awareness in the government of how costly the previous patterns had been from a fiscal capacity perspective.

Since 1987 EU funds had been of nearly as important for Castilla y León as for Extremadura—ranging from five per cent of transfers at the beginning to over 50 per cent in the mid-1990s. EU transfers declined incrementally after 2004 when the AC began to phase out of Objective 1 for EU cohesion policy. In 2010, EU funds of various kinds represented 14 per cent of transfers to the AC (BADESPE 2012).

In 2006 the PSOE at the central level, with the support of the ACs, passed the *Ley de Dependencia*. While in Madrid and Valencia dependency benefits have been slow and irregular in approval and dispersal, Castilla y León has been one of the most competent among the ACs governed by the PP. In an AC with an aging and highly dispersed population, implementation of the law has provided important sources of employment in small towns and "quietly" improved the quality of life of dependents

⁷³*El Mundo* 10/2/2012 "Herrera defenderá el modelo de las autonomías en la Conferencia de Presidentes."

⁷⁴*El Mundo* 10/2/2012 "Herrera defiende el modelo autonómico, pero cree que 'algunos lo han usado mal'."

⁷⁵*El País* 3/7/2005 "Una comisión de las Cortes de Castilla y León aprueba la financiación del cambio de sexo."

and their caregivers (Diego 2012).

In 2007 Herrera was reelected, Antón moved on to the Social Welfare Secretariat and Francisco Javier Álvarez Guisasola took over in Health. Guisasola had previously served as Secretary of Education and had been implicated in the 1990s as the responsible party under whose supervision the grades for university access exams had been changed for the children of his fellow rectors⁷⁶. In 2007 Castilla y León was one of five ACs whose health funds for fighting smoking were rescinded because they had not implemented the law⁷⁷—one of the few areas in Spanish health policy where the center has successfully tied resource transfers to policy implementation.

As in several other ACs, the Statute was substantively reformed in 2007. In line with a general movement in public policy during this period, participatory instruments were built into the institutions of governance, guaranteeing social dialogue as a responsibility of the government and considering the social rights laid out in the Constitution and the Statute to be legally defensible for the first time (Art. 7-18). Title II expands the policy authority of municipalities, which with a highly dispersed population has been defended by all major political actors. In particular, Article 45.3 gives municipalities residual powers to implement policy in any area of local interest that is not expressly forbidden to them. In Title V new competences were laid out, authorizing the AC to create an autonomous police force and to exercise authority over the Duero river basin (authority which was unanimously rescinded by the *Tribunal Constitucional* later). Article 77.3 specifically demands that the competences of Castilla y León be updated in accord with those held by other ACs .

The central PSOE 2009 regional finance reform established measures to take dispersion and old age explicitly into account in the health financing formula (Manzano

⁷⁶*El País* 9/14/1999 “Condenado un catedrático por falsificar notas de selectividad”

⁷⁷*El País* 10/31/2007 “Cinco comunidades perderán los fondos de Sanidad para prevenir el tabaquismo.”

Mozo 2010). This is an equity-enhancing reform for Castilla y León, yet inequality has not been a focus of health planning by AC officials at either a symbolic or operational level (Borrell, et al 2005).

After 2001, while most of the conservative ACs chose not to use their new health authority to expand youth dental coverage, the stance of Castilla y León was in line with its overall approach to health services. It did not institute the PADI system that most of the socialist ACs initiated, which was more comprehensive and anchored in the public health system, following the Basque and Navarrese model. Instead, it contracted with private dentists for some services beyond what was included under primary care (Bravo-Pérez, et al 2006), therefore offering more than the bare minimum of coverage, but not through the public system. Castilla y León is not one of the best performers nor one of the worst in public health provision.

4.11.3 The PP Context

Why has Castilla y León taken a more nuanced approach to territorial policy at a time when the PP was calling for greater central authority, yet also been more supportive of a pro-poor model of AC financing than other conservative ACs? The bulk of the answer is simple—Castilla y León has been a net beneficiary of central government redistribution. It has always been near or just below the average in GDP per capita and remained within the network of redistributive transfers from the center and the EU. Common fiscal regime ACs that are higher income than average with traditionally conservative government (Valencia, Madrid, and La Rioja) have a double incentive (practical and ideological) to shun redistributive central transfers. Yet when responsibility and accountability for provision of health care lies with the AC, it is lower income than average, and financing formulas have a component of territorial redistribution, rational actors do not turn down resources. The position of Castilla y León is only unique because few conservative ACs are below average income and

among those, the ideology of Herrera's PP has been more moderate on issues of the territorial organization of the state.

Castilla y León performs better than higher income conservative ACs in terms of equity-enhancing health policy. The ruling PP organization in Castilla y León has been more moderate ideologically on the economic left-right spectrum than in Valencia and Madrid. The latter two ACs have large and densely populated communities with a sizeable upper middle class that is entrenched in politics and has clear interests in residual public service provision. The scandals of illicit party financing and funneling of public money to private interests have been the most acute in Madrid and Valencia. These influences have existed, as we have seen, in Castilla y León as well, and have certainly compromised the equity-enhancing nature of health provision.

Where Madrid and Valencia have unabashedly cut public spending on social services and begun to dismantle the public system during the crisis, Castilla y León has not. When former Health Secretary César Antón was named the new head of IMSERSO under the central PP to manage the Ley de Dependencia country-wide, this was seen as a political statement in favor of a more moderate conservatism that favored competent service provision in the public sector.

Yet executives in Castilla y León have had lower administrative capacity because of the need to balance the competing demands of nine unique provincial party identities. As we have seen, executive portfolios have revolved through provincial PP leaders who often use the AC government as a platform for becoming executives in their province of origin. Castilla y León has had less continuity in the secretariats than Extremadura or the Basque Country, where these provincial demands for representation have been less powerful. The Health Secretariats in Castilla y León have been held by economists or professional party leaders who have also managed education, economy, or environment portfolios. These problems are partially the result

of creating a territorial administration that does not overlay the primary reference communities of its members, and where lower level territorial loyalties are dominant.

Castilla y León has shown visible lack of commitment to equity-enhancing reform with resulting deficiencies that stand in contrast to the way health policy has been prioritized in the Basque Country or Extremadura. Yet results have been better than in other conservative ACs where fiscal capacity is lower (Galicia and Murcia), or where commitment has been noticeably lower still (Madrid and Valencia). Services “existen, pero no van más allá” (Diego 2012)⁷⁸. The case illustrates the way that the impact of decentralization depends on the relative position of the AC and the resulting availability of resources, as well as ideological commitment.

4.11.4 Castilla y León: Conclusion

The case of Castilla y León is a hard case for exploring the absence of commitment—it is arguably the least neoliberal of the PP governed ACs. Yet this is in large part because it has historically been poorer, with a smaller elite and many small-holders. Because of its relative lack of wealth, the AC has been a net beneficiary of central government redistribution, as well as a recipient of EU funding, which has made it hard for AC government to snub resources and programs funded by the center.

The large number of provinces in Castilla y León has created dynamics not present in any other AC. Capacity has been limited by provincial politics because the AC does not line up with the primary reference community for any of the parties or leaders in the region. Just as Extremadura benefited from late decentralization from a capacity building perspective, Castilla y León benefited as well.

In addition, due to lack of commitment in the AC, having health reform implemented primarily by the center under the PSOE meant the system was consolidated before it was devolved. Once it was decentralized, conflicts of interest emerged as

⁷⁸“Services exist, but they don’t go the extra mile”

political actors connected to private medical industry channeled public resources to friends and business partners. In the past decade, AC government has been more stable and capacity has increased, yet the difference from the more highly committed ACs has been palpable.

4.12 Spain: Conclusion

In Spain we have seen that while economic development created crucial impulses for the expansion of the welfare state, ideological commitment to redistribution and pro-poor social policies by centrist and leftist parties under democracy have driven equity-enhancing health reform. Fiscal and administrative capacity have constrained or enabled equity-enhancing reform, depending on their relative abundance. Minority nationalism has rarely been positive for redistributive policy production at the AC level—the Basque Country is the only case that shows such benefits and even there these results cannot be fully disentangled from high levels of fiscal capacity and a long history of coalition government with the left. Decentralization has activated local sources of commitment and capacity, bringing variation to the fore.

At the central level, minority nationalism has clearly constrained equity-enhancing policies by dividing the left, inhibiting institutional reforms that would benefit poorer ACs, and pushing hard for fiscal decentralization that was regressive at the country level and for poor ACs. If the minority nationalist forces in Spain were poorer than average, or leftist, their role would likely have been less regressive. But the conflicts of overlaying territorially divergent reference communities on traditional left-right policy cleavages should generate competing pressures that moderate ideological commitments to redistribution, regardless. The challenges of defining the state are particularly difficult when two visions of the reference community are incompatible, yet highly salient for actors. Spanish nationalists see Catalonia as part of Spain and Catalan nationalists do not. It cannot be both, yet significant actors on both sides

are willing to go to great lengths to realize their vision of the reference community.

The most enduring characteristic of AC finance in Spain has been its constant reform. The ACs are powerful and not equally content with the organization of the state and their role in revenue, so conflict is a constant and significant drain on political resources for policy making. The dominance of territorial conflict has diminished energy on the left for redistributive policy advances both at the central and AC levels.

The scarcity of revenue at various levels of government gnaws at the foundation of the SNS and poses the greatest risk to its future. In the face of the economic crisis of the past five years, this has been the dominant ideological struggle over health policy. Committed ACs are trying to keep their systems adequately funded, but the central government is now cutting back on the coverage and services it guarantees, placing a greater burden on individual ACs that wish to maintain high levels of coverage. As the sources of revenue for health have been mostly decentralized, the possibilities for greater inequality now increase regardless of commitment.

In the case studies we have seen committed poor ACs pouring resources into historically underfunded health services while wealthier committed ACs achieve even better results with far less effort and fewer trade offs. The consolidation of the system during its formative years under socialist tutelage at the center prevented major retrenchment until the current crisis, but disparities creep in at the margins under constant pressure to contain cost in a system that has been underfunded since its inception.

The role of timing cannot be overstated. In 2010, the seven early decentralizing ACs were split in terms of health spending per capita in a telling manner. The Basque Country and Navarre were the two highest spenders, Catalonia precisely in the middle, and Galicia, Andalusia, Valencia, and Canarias dead last, with only one

AC spending less. Madrid, the AC with the highest level of GDP per capita in Spain, spends less per capita than any other AC on health care. As the broad-based 2012 protests and mass resignations of clinic directors in Madrid illustrates⁷⁹, it is not that madrileños desire less public health provision than others. These decisions are directly tied to regional variation in ideological commitment. These figures illustrate the way that decentralization opens the possibilities for dispersion, which are realized (or not) depending on combinations of central and AC capacity and commitment, as well as the starting point for equity prior to shifts in territorial authority.

Timing is also important because equity-enhancing social policies often display patterns of increasing returns. A number of ACs appear to be anomalies in health policy, with long legacies of conservative government or low capacity, yet high coverage rates for equity-enhancing reforms. But the impact of commitment, as we have seen, is particularly important at particular points—especially when policies are passed, implemented, and consolidated. Once they become viewed as social rights, they are harder to rescind. In 1984 and 1986 the PSOE, with an absolute majority in the central government, passed health reforms that were highly contentious and ideologically contested by private medical associations and parties on the right. Where the PSOE governed regionally during the crucial early years of implementation, coverage rates started out higher and then increased over time regardless of which party governed. Early decentralizers had the greatest variation in policy implementation and include the worst performers, as well as the best. Table A.7 illustrates this process in the context of the primary care reform, with the most recent data on per capita spending and GDP per capita relative to the Spanish average. In addition, Table A.8 presents overall primary reform coverage in the ACs given the levels of commitment and capacity at particular moments.

⁷⁹*El País* 1/8/2013 “Directivos de más de la mitad de los centros de salud presentan su dimisión.”

Where Brazil began the democratic period with little authority to hold subnational units accountable for guaranteeing health care rights but has steadily strengthened mechanisms for central oversight, Spain has had the opposite experience. Over time, the Spanish central government has found itself with less and less authority to oversee or ensure even the basic minimum social policy guarantees it has the authority to legislate. While ACs with committed and capable government can fend for themselves without the center, ACs without committed and/or capable governments need commitment and capacity at the center to avoid leaving the poor and vulnerable without protection. The socialists in Spain, as the only centrally committed political agents, have continued to defend social and fiscal policies that will protect these members of society. Over the course of the past thirty years we have seen Spain reach a high level of social cohesion, given the reality of democratic decentralization. A zero-sum shift in health responsibilities from the center to the ACs has weakened possibilities for equity-enhancing health reform at the center, while prolonged economic crisis has eroded the capacity of all territorial actors.

5 BRAZIL

In this chapter I assess the development of equity-enhancing health reform in Brazil over the past few decades¹. I trace the development of Brazilian health policy in terms of capacity, commitment, and the territorial distribution of authority from the policy legacies generated under Vargas, through the initial political opening after 1946, and the military regime through the 1988 democratic constitution to the current day. Compared to Spain, health reform in Brazil has been slower and more halting, with significant shortages of capacity and commitment at key moments in the reform process, but has still continued to improve access and coverage for the neediest members of society over time. Key for reform expansion has been improvements in capacity and commitment at multiple territorial levels.

Progress has been slowed by inconsistency in the level of commitment at the center, great variation in commitment and capacity in the states and municipalities, the stigma attached to crucial parts of the *Sistema Única de Saúde* (SUS, Single Health System) because of failure to achieve high coverage and quality provision early on, its complex relationship with private providers, and the regressive nature of public finance in the country. The one crucial arena that has not become more equitable since democratization is that of health financing, where the burden has shifted significantly toward local governments, private spending has continued to outpace public spending, and the overall tax system continues to be dominated by indirect taxes, many of which are collected subnationally.

¹Parts of this chapter were presented at APSA 2011 and I am grateful to Barry Ames for his thoughtful comments on that early draft.

In addition, whereas in Spain the commitment of the central government to equity-enhancing social reform has been fairly uniform across policy areas, the nature of Brazilian presidentialism means this has not been the case in Brazil. As Ed Amenta describes in his work on the United States, in presidential systems the attention of the executive is crucial for successful social policy reform (2000). Combined with the high levels of authority exerted by individual ministers over their portfolios in the Brazilian system, the opportunities for variance in level of commitment and capacity across policy areas under the same government are far greater than in Spain.

The territorial distribution of health authority in Brazil is far more nuanced than in Spain and therefore displays tendencies that can seem contradictory. The combination of little conflict over the role of the center in policy making and strong presidentialism has allowed central executives since the mid-1990s to improve accountability and uniformity in coverage using primarily fiscal conditionalities. Yet because the 1988 constitution granted concurrent competences in social policy to all three levels of government (center, state, and municipal), responsibilities are only as explicit as particular legislative initiatives make them. All three levels retain authority to innovate in health policy, though over time the territorial distribution of the SUS has become more transparent and accepted by all actors. Yet as long as the basic framework of the SUS operates, subnational units are not bound to participate in many programs and quite a few have opted out in order to operate their own versions—some more equity-enhancing and some less.

Variation has remained high in access to services, quality of care, and health outcomes in large part because of this policy autonomy, combined with the increasingly decentralized nature of health service provision and management. The timing and sequencing of decentralization and health reform have played an important role in the development of the SUS, which makes a comparative historical approach particularly

useful. In contrast to Spain, the primary legislative framework for the SUS began under conservative government at the center and when subnational units already had substantive authority in health. This has made equity-enhancing implementation across the country more difficult. I explore these processes with case studies of two states and their capital cities—Bahia and São Paulo—as well as shadow cases of comparable states and municipalities.

In the first decade after the transition to democracy, Brazil shifted from a highly centralized contributory health system that served only formal sector workers to the SUS—a decentralized universal system in which state and municipal governments bore nearly full responsibility for the provision of health services, as well as some of the financing. Two decades of authoritarian rule had convinced reformers that decentralizing health care would be more democratic and would improve outcomes for Brazil's millions of poor people. As in Spain, democratic forces had high hopes for decentralization.

The 1988 Constitution guaranteed health as a social right and implicated the government in ensuring equity and access to public services, as well as embedding health care in the broader network of public services necessary for realizing good health. All three major territorial levels of government were given authority to act in social policy material, which has made coordinating institutions an absolute necessity. Municipalities play a crucial role in providing and managing health services. Enabling legislation was passed in 1990 and 1991 and major health reforms aimed at ensuring the institutional foundation of the system, improving its financing, and guaranteeing equity and quality under decentralization have been passed over the past two decades.

Brazilian states have taken on differing levels of responsibilities in health over time, with all having full competences in coordination and oversight of the SUS in their territory, but negotiating an increased role in direct provision of medium and

high complexity care over time. A similar model has been used for municipalities and states have been responsible for making the decision about when and how to devolve expanded responsibilities to the municipalities. The early rounds of SUS legislation gave the municipalities full responsibility for provision of primary care.

The states play a central role in training and assisting municipalities in managing their health responsibilities, as well as directly providing services—especially hospital and medium and high complexity infrastructure. All three levels have decision-making authority, provision responsibilities, and oversight tasks in the SUS. This has allowed for significant variation in the organization and implementation of health policies.

In Brazil, state and municipal health secretariats are financed directly through the central Health Ministry, in addition to having own source revenues. Both the level of transfers and the strings attached have increased substantially over time. Unlike Spain, Brazil keeps no national system of health accounts, so while we know how much is being spent on health at different levels and what portion of central government health spending comes from social security vs. general taxation, we do not know how much money is being sent to each subnational government from the Health Ministry.

Municipalities tend to be the face of the SUS and an increasing burden for supplemental financing has developed over time as municipalities top up insufficient central transfers. This situation was worsened by Constitutional Amendment 29 in 2000, which fixed set per cents of state and municipal revenues for health and education, but froze federal spending by tying it to real GDP growth. Not only are tax revenues insufficient, they are quite regressive. Public health spending in Brazil is just over three per cent of GDP and private spending is over 60 per cent of total health spending, as it has been since the mid-1990s (World Bank Database 2013).

Poverty and inequality in Brazil are so intense that there has been little ideological opposition to pro-poor social policies in health, education, and social assistance when

these have remained fairly inexpensive and targeted. Yet as committed central actors have attempted to expand the primary care programs originally designed for very poor regions, transforming public primary care providers into the gatekeepers envisioned by early health reformers, opposition has increased.

There has never been enough money for universal access with dignified levels of quality for three main reasons: pension spending has never been fully reformed and consumes significant resources, the tax system is regressive and the wealthy do not pay their share of direct taxes (even though the overall burden is large), and the elitist nature of national politics combined with many veto actors means reforms are introduced and then slowly wither away with no resolution. The early institutionalization of private markets for health insurance and service provision has been one of the dominant barriers to fulfilling the constitutional mandate of the SUS. Yet until the public primary care system becomes valued by the middle class, the most equity-enhancing and efficient components of the SUS will continue to be vulnerable.

The central government has never been interested in hands-on management of health care provision. For example, the center never directly provided care in the states and municipalities, as it did in Spain until 2002. While in Spain there is significant conflict over what territories represent the legitimate terrain for redistributive social policy reform, even among actors committed to equity, in Brazil this dimension of conflict does not exist. Actors at different levels of government have their preferences and constituencies, but there is no debate about whether Brazil is a single nation. Levels of opposition to territorial redistribution are muted by comparison and the federal rules of the game are fairly settled.

Commitment has been no less defining in Brazil than in Spain, it simply arrived late. Leftist parties and social actors were wiped out during the dictatorship and had not been particularly independent or institutionalized beforehand. The *Partido dos*

Trabalhadores (PT, Workers' Party) is by far the most disciplined and programmatic of the parties on the left, which in turn are generally more programmatic and disciplined than most other parties, with some exceptions. Table A.4 lists the Brazilian parties with a brief description and partisan coding.

Yet the PT began modestly in 1980 accumulating municipal electoral victories and awards for good governance and innovative social programs, not winning its first governorship until the end of 1994 and the presidency until the end of 2002. Because the PSDB governed in coalition with right wing parties and, itself, shifted right over time, its eight years in central government from 1994-2002 are complex to assess. While issues of redistribution were not as central as they are for the PT, the state reforms of the PSDB that stabilized the economy and its decision to federally back a large number of equity-enhancing local initiatives mean its governance of Brazil was positive for equity.

Brazil has long had a strong intellectual tradition that permeates the federal bureaucracy. Major public and non-profit think tanks and universities, with prestigious records of research and publication, have forcefully backed the movement for equity-enhancing health reform, and politicians have paid attention. Since the mid-1990s, evidence-based policy making in the social arena has been the norm. Because there has been broad academic and bureaucratic consensus that Brazil's elevated poverty and inequality levels are bad on multiple fronts, successful health pilot programs from the states and municipalities have been taken up at the center over time and sent back, countrywide, with resources and technical support.

The phenomenon of the *direita envergonhada* (the ashamed right) has made politicians shy away from being labeled as right wing because of the images it conjures of the military regime (Power and Zucco 2009). While this can complicate assessments of party placement, it also bends political elites toward support for equity-enhancing

policies when the benefits appear clear and the costs are low. The social programs expanded or created once the PT came to power at the center in 2003 have generated strong public support for the policies, including health reforms that had stagnated since the late 1980s.

Yet the obstacles facing committed actors at the center have been staggering in Brazil. The SUS languished without adequate financing or implementation for years after its conceptualization. Entrenched private interests attempted to block reforms at the outset and high levels of decentralization limited the ability of the center to implement programs and policies that could be applied uniformly across the country. Health care was not the PT's primary focus and for significant periods during the first two administrations of President Lula (2003-2010), the Health Ministry was in the hands of less committed actors from centrist parties.

Unlike Spain where a large middle class defends public health provision as a citizenship right, in Brazil the SUS does not have powerful defenders outside those ideologically committed to the project. While almost all transplants and the bulk of the most expensive complex procedures are performed by public surgeons in public hospitals (and paid for with public money), middle and upper class citizens have private insurance and providers for specialist and primary care and often do not think of the SUS as "theirs" to defend. The constant tinkering since the system's inception has prevented consolidation of certain aspects of the SUS, as layers of bureaucracy have been added and removed and new procedures and policy tools created.

Despite the fact that important reforms were initiated by subnational actors and the central PSDB, as well as health care being relatively low on the policy totem pole once committed actors took the helm in Brasília, this case study still shows that the most equity-enhancing components of health reform have advanced the farthest under the PT at the center. This argument may be somewhat controversial among

Brasilianists, but the evidence is clear both in the statistical and comparative historical analyses. The neediest states and municipalities did not have the capacity to innovate or implement reform under the high levels of decentralization that were in place when health reform began. Equity-enhancing reforms were pioneered first by left-of-center actors at the subnational level, but overwhelmingly in areas with high levels of education and capable local governments.

While the PSDB took the first important steps toward incentivizing diffusion, it was not until the PT arrived in Brasília that equity was mainstreamed as a priority across all ministries and major efforts were made at expanding public primary health coverage. The PT's dedication to the poor has permeated other policy areas, which feed into outcomes. Social exclusion has been addressed from the perspective of race, gender, poverty, and sexual orientation in ways that have increased access to health and other social services for the most disadvantaged members of society.

The SUS is organized fairly specifically through national organic laws and regulations set forth by the Ministry of Health (*Normas Operacionais Básicas*, Basic Operating Norms or NOBs). However, it took several years for the roles and responsibilities of the three levels to coalesce and some aspects of the distribution of responsibilities continue to change over time. The case of Brazil is particularly complex because very few exclusive responsibilities exist at any level. States do not have legal control over municipalities, which are autonomous entities (C1988 Art. 18), and social policy and financing responsibilities are shared between all three levels.

While not all subnational governments do what they “should,” there is less confusion about the territorial distribution of responsibilities than in the past. Despite the protagonism of municipal and state governments in social policy, their autonomy is not as great as it may seem. In social policy, as in other areas, there are few functional limits on the scope of action of the central government. The history of

statism and presidential politics in Brazil often produces strong executives capable of recentralizing policy control. Health care has been no exception.

Brazilianists often disagree about the extent to which subnational governments have political control over the SUS. Some argue it is a completely centralized policy since national health law is binding on subnational units, while others argue that the innovation shown by subnational governments proves that they do, in fact, have authority over health policy. Social policy has become more centralized under both the PSDB and PT central governments since 1994 (Melo 2008: 174). State and local governments, as well as users and providers, have important input into the development of national health policy through various intergovernmental and participatory mechanisms, which are discussed in detail in below. Yet subnational units cannot override the basic provisions of national health law, so for example they could not formally limit access to services or abolish the private health sector in their territory.

As in Spain, the central government has the authority and responsibility to set minimum standards. I argue that the center plays a stronger role in health policy in Brazil than in Spain not only because its hands are not tied once a zero sum transfer of health responsibilities is made (the Spanish case of devolution to the ACs), but also because there are no actors fundamentally contesting the right of the central government to be involved in social policy. The action and inaction of the center have been the primary stimulants for health policy developments at all three levels. Policy authority is shared and all three levels are capable of making decisions that can have a substantive impact on the equity-enhancing nature of the SUS within their territory, but ultimately, the central government holds more cards than the states and municipalities in health policy.

Representatives to the national congress have been considered “ambassadors” of the states because of the history of powerful ties to elite state level politics, which

induce legislators to keep the interests of the states and their own future careers front and center while serving in the national legislature (Samuels 2003). It could therefore be argued that the legislature is an outlet for subnational interests. However, the 1988 constitution gave significant powers to the executive and as the case studies show, while the national congress has substantial legislative authority, there is great latitude in social policy for unilateral action on the part of the national ministries. Federal deputies are directly elected rather than formally chosen by subnational governments (Hooghe, et al 2014, forthcoming), so as subnational power relations shift over time, the relationship of the national congress to the states remains fluid.

At the same time, subnational governments have broad latitude regarding how they fulfill their obligations under national law. They can create new programs and run clinics and hospitals themselves or contract services through private providers. The upper limit for subnational initiative is not clearly defined and innovative states and municipalities in Brazil have taken full advantage, to the benefit of their populations and in many cases, the rest of the country. The precursors for the *Agentes Comunitários de Saúde* (ACS, Community Health Agents) and the *Programa Saúde da Família* (PSF, Family Health Program) were created and diffused by municipalities, supported from the national Health Ministry beginning in the early 1990s (Borges Sugiyama 2007: 4). Once the ACS and PSF became federal programs, municipalities still decided which neighborhoods would receive health teams and new facilities.

States are responsible for training municipal health administrators and have autonomy to determine how and when full devolution takes place, and in extreme cases revoke some health responsibilities. States can also initiate new programs and build new facilities at their discretion. While subnational units have to comply with spending requirements for health and education since 2000, they are not constitutionally

bound to follow the programs developed at the center. As a result, since the mid-1990s the central government has primarily used incentives and conditionalities to entice subnational cooperation (Arretche 2004).

Because of the autonomy of municipalities and the incipient institutionalization of oversight in the SUS, accountability has been one of the most serious obstacles to the realization of equal health access and constitutional rights. State and federal regulators took over management of health services in two municipalities of Rio de Janeiro in 2009² and the state of Bahia revoked medium and high complexity care management (*gestão plena*) for a municipality that year as well. But this process is politically sensitive to intergovernmental power relations. It would be nearly impossible to hold a large municipality like a state capital accountable for major failures. In addition, municipalities are now fully responsible for primary care, but when they fail to provide services, state financed hospitals end up treating those patients.

5.1 Health Inequality in Brazil

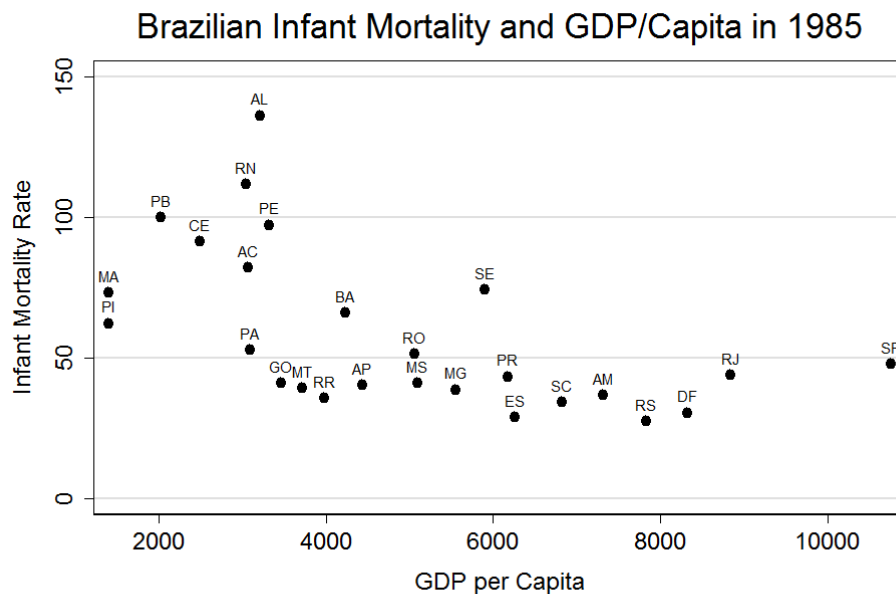
What is the status of health inequality in Brazil? The improvements in Brazilian infant mortality by state dwarf the convergence seen in Spain. Figure A.1 shows average infant mortality rates over time for the Brazilian states, as well as the level of variation (one standard deviation above and below the mean). Figure 5.1 shows that while in 1985, infant mortality rates were very high in poor states, there were many states at various intermediate and higher levels of economic development that had attained similar (lower) levels of infant mortality. By 2010, the relationship with GDP per capita was much more consistent. The distribution of infant mortality across the country is tightly tied to the legacy of slavery and labor repressive agriculture. Regional variation follows a clear North-South pattern, highly correlated with the white portion of the population. While all states have dramatically decreased infant

²*Folha de São Paulo* 2/12/2009 “Fiocruz ‘assume’ gestão da saúde em duas cidades do Rio de Janeiro.”.

mortality, the stratification by income is clear.

The overall decreases have been most dramatic in the areas where infant mortality was highest to begin with, but the per cent declines have been similar across states. Greater policy effort is likely required to decrease infant mortality at lower levels. Still, the value of the large overall drops cannot be overstated—these shifts represent hundreds of thousands of families who did not lose their infants to avoidable illness caused by dehydration or lack of vaccination for common infectious diseases.

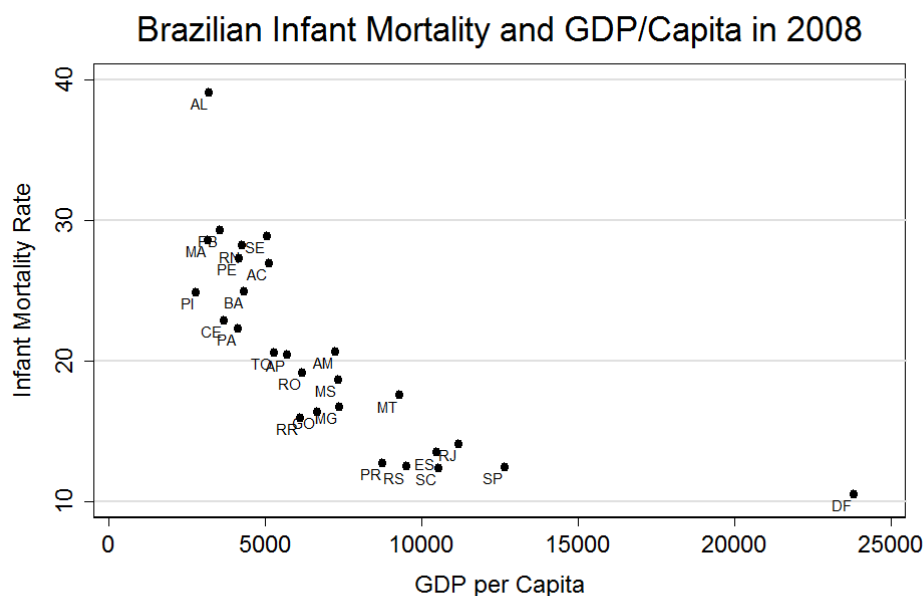
Figure 5.1: Brazilian Income and Infant Mortality Over Time



Source: IBGE and IPEA

5.2 Health Politics Before Democracy

As in Spain and much of Latin America, early health policies were developed to address emerging demands from new industrial working classes and were designed as social protections associated with the risks of the labor market. In Brazil, Getulio Vargas (1930-1945) expanded the sectors covered by social security and old age pensions as part of a broader corporatist project (Borges Sugiyama 2012). Vargas' *Estado*



Source: IBGE and IPEA

Novo ended in 1945 but among other legacies, bequeathed a modernized and professional civil service to the new regime, greatly enhancing administrative capacity at the center. The constitution of 1946 expanded civil liberties and political competition, though the exclusion of illiterates maintained disenfranchisement of a massive portion of the population until the democratic transition in the mid-1980s. The communists were also excluded from political participation at particular moments.

The new capital of Brasília was inaugurated in 1960 during the government of Juscelino Kubitschek, a period of rapid economic growth and development. Industrialization accompanied increased incomes and urbanization, but regional inequalities were enormous and the interior of the country still lagged far behind. Vice president João Goulart, who had clashed with elites in 1954 when he raised minimum wages for industrial workers as Minister of Labor, became president in 1961 after the executive's resignation—despite the military's attempt to prevent him from taking office. Goulart tried to implement land reform in the cities and countryside, education reforms, and fiscal reforms to increase the progressivity and capacity of Brazil's

tax system. The military overthrew his government in 1964, ending political competition. The example of Goulart's attempt at reform is similar to many cases in Latin America where equity-enhancing reform was inhibited by military intervention. These experiences are key to understanding how democracy can enable such reforms simply by eliminating the possibility of an authoritarian veto.

The regime became increasingly repressive over the course of the 1960s. In the early years a series of *Atos Institucionais* (Institutional Acts) were decreed, which removed specific politicians from office, wiped out the political parties that had been hard-won in the mid-forties, and temporarily closed congress. Under the *Atos*, all state and central executives became indirectly elected, as did the mayors of capital cities and any others deemed politically important. A new constitution was passed in 1967, which enshrined the practices the military had begun to put in place during the previous three years, and which governed the country until the late 1980s.

Institutionalization of health policy within the government took place much earlier than in Spain. The first *Ministério de Saúde* (Ministry of Health) was created in 1953 (Lei 1920), separating it from the Ministry of Education. Yet the Ministry of Health was a weak institution for many years and was primarily focused on residual legal management of public health (MS 2012). There were 14 Health Ministers from 1953-1964, yet there were still important moments for the trajectory of health policy.

The nascent *movimento sanitaria* (sanitary movement)³ that emerged in the 1960s was supported by Health Ministers such as Estácio Souto Maior from 1961-1962. The movement developed around awareness of the deep inequalities that persisted and worsened as economic development modernized the country for some, but not

³The term "sanitaria" has been used for specific public health campaigns and movements in Brazilian history. In relation to the SUS, the *movimento sanitaria* refers to a progressive public health movement that emerged from transformations in the medical profession and in civil society during the 1960s, reaching its peak influence with the 8th National Health Conference in 1986 where the framework of the SUS was developed.

for others. Decentralization to the municipalities and a reorientation of the role of the central government in health was advocated for the first time by Health Minister Wilson Fadul in 1963, following his convocation of the *III Conferência Nacional da Saúde* (Third National Health Conference, CNS), an important moment in the development of social pressures around health reform. The Brazilian National Health Conferences have continued to be important moments for defining the trajectory of health reform in the country.

Brazil's bureaucracy has a history of being strong, capable, and somewhat insulated from politics. A group of technocrats that emerged from the management of the public industrial workers' pension system (IAPI) before the 1964 coup had been influenced by universalizing doctrine in Great Britain and vied with those committed to the existing system of contributory social insurance. In 1960 they succeeded in the equalization of social security benefits for all classes of formal urban workers (Weyland 1996: 90). In 1966 the *Instituto Nacional de Previdência Social* (INPS, National Social Security Institute) was created as an umbrella organization to manage the various institutions involved in social security.

For the first time, anyone could receive emergency care at the expense of INPS, though in practice this only meant those in urban centers (Weyland 1996: 96). In 1967 the role of the Ministry of Health was expanded to include more significant public health oversight and implementation, including traditional areas of infectious disease control, but also drug trafficking (MS 2012). As under the Franco regime in Spain, the 1960s and early 1970s were a time of economic expansion as well as regime investments in increased central government capacity.

The late 1960s were also the harshest years of the dictatorship when *Ato Institucional 5* (AI-5) was passed, allowing for the closure of Congress and the institutionalization of repression. In the first decade after the coup, repressive and conservative

military leadership began to consider incorporation of rural workers into the social insurance scheme as a way of shoring up the regime's base of support. In the early 1970s, the same economic boom that was catapulting Spain into the developed world was also experienced in Brazil. Economic growth permitted the resources for the creation of FUNRURAL—a social insurance scheme that covered formally employed rural workers and was free at the point of delivery, financed with a three per cent tax on agricultural production (Almeida 1981).

The health services associated with the social security system went from covering just 10 per cent of the workforce to covering a majority (Weyland 1996; Falletti 2010b). But few health posts existed in rural areas and doctors did not reside in rural communities so even for primary and prenatal care most rural workers had to travel to cities (Barros, et al 1986), which represented an important limit to access for the poor. Convincing doctors to serve in rural areas has continued to be one of the biggest roadblocks for access, quality, and continuity of care for many Brazilians.

The military government from 1964 to 1974 had a statist perspective regarding its role in national economic development, but lacked commitment to equity-enhancing reform. While conservative authoritarians had expanded access to health and social insurance among the employed and their dependents, the regime was not oriented around solidaristic principles nor was it interested in creating public welfare systems. The bureaucratic authoritarian regime was ideologically supportive of the private sector and used public money to subsidize private health expansion (Paím, et al 2011; Paula and Braga 1986). The decision of the military to focus social benefits and investment on private curative care for urban elites and a narrow middle class meant the poor majority of the country saw little benefit during this period (Horn 1985; Weyland 1996; McGuire 2001). As those at the top received more access to care, inequalities in health care increased.

In the second phase of the military regime from 1974-1985, the gradual reformist Ernesto Geisel and his successor João Figueiredo governed the country. Political and civil rights began to reemerge in the process known as “abertura” or political opening (Stepan 1989). Geisel saw social insurance as an important part of ensuring the stability of politics and the sustainability of the existing model of economic development. He created the *Ministerio de Previdência e Assistência Social* (MPAS, Ministry of Social Insurance and Welfare) in 1974, which became an important institutional actor in pushing for extended health coverage.

In 1977 the *Instituto Nacional de Assistência Médica da Previdência* (INAMPS, National Social Security Institute for Health Care) was created. Coverage under INAMPS at this time was quite high but was based on contributory social insurance principles. While originally envisioned as part of the pension system, INAMPS quickly became a major purchaser of health care services. But because it had not been designed as a part of an overall plan for the provision of health care, it functioned primarily as a consumer and did not initially use its weight in the health market to set policy. While the technocratic corp in the newly created MPAS was interested in extending access to care for the Brazilian population, this was not a widely held priority in the military administration as a whole, nor even in the leadership of the MPAS (Weyland 1996: 92). Therefore, pressure for an equity-enhancing approach to the fast-expanding public role in health service consumption was limited.

While INAMPS did eventually attain a group of its own public hospitals, most of its provision was subcontracted. Whereas in Spain the center had a long history of direct health provision, facilitating the decision to directly provide health services in a new universal system, no such legacy existed in Brazil. There was no money and no political will for building a centralized health service from scratch to fulfill the eventual constitutional mandate, so subnational service provision was overdetermined.

From 1970-1980 the use of health services increased dramatically, but primarily through the increase in public consumption of private health services for formal sector workers. Hospital use, in particular, increased substantially (Weyland 1996: 97). Without a clear vision of the public role in sustainable provision directed toward the needy, public health coverage remained largely unplanned and the presence of private interests within and close to the government ensured that beneficial arrangements were incorporated into contracts. The result was an expensive system that paid higher rates for more complex and expensive services, incentivizing expensive curative service provision (Arretche 2004; McGuire 2010; Falleti 2010b; Borges Sugiyama 2012). Because the state contracted almost all services with private providers, with lax oversight and no overall model for the goals of publicly subsidized care (outcomes vs. quantity of procedures), costs skyrocketed during the early 1970s. Extracting the public sector from this expensive relationship has been nearly impossible.

The case of childbirth coverage is illustrative. In just a decade caesarian sections increased from 15 to over 30 per cent of births in large part because of expanded INAMPS coverage. The government paid higher rates for caesarians than for natural delivery, and with little access to other contraception under the natalist policies of the military, Brazilian women took advantage of the surgery to have tubal ligations performed (Barros, et al 1986). This example shows the path dependency of such processes: in a decade Brazil became the world leader in caesarian births—a procedure which, when not medically necessary, increases the risks of childbirth with unwarranted surgical intervention and is much more expensive for a public purchaser. By the time INAMPS modified its financing scheme, the norms among a generation of women and the practices of a generation of providers had shifted. Currently Brazil has one of the highest rates of caesarians in the world at over 45 per cent (Mendoza-Sassi et al, 2010), with those outside the SUS, using private insurance, receiving the

procedure at a staggering rate of 81 per cent (Barros, et al 2011).

As all of this was occurring at the central level, states had their own Health Secretariats, which often provided the primary care the central government did not. While state governments were formally deconcentrated during the military regime (Eaton 2006; Hooghe, et al 2014 forthcoming), they still operated quite independently in a number of areas. This activity by the states reflects the legacy of high decentralization prior to the coup—while centralization certainly increased under authoritarian rule, the states did not all of a sudden cease activity in all previous areas of responsibility, particularly those that were not the primary concern of the central military government. States ran health posts and centers that provided primary care, particularly to pregnant women, mothers, and children and were free of charge, even at times providing medicines to the poor, if these were available (Barros, et al 1986: 22). Yet there were no guarantees—these were not citizenship or employment based benefits and their provision depended primarily on the capacity and initiative of the states. By the late 1980s, states were providing a majority of primary care services (Borges-Sugiyama 2007: 128), yet the central government did three quarters of the spending (Medici 2002: 4)—just one illustration of the distorted priorities and incentives created by the regime.

5.3 Democratic Transition, the Sanitaristas and the Constitution of 1988

The first direct elections in nearly two decades were held for governors in 1982 in an atmosphere of political opening. An amnesty was passed in 1979 (Lei Federal 6683), which, like the Spanish amnesty, pardoned the regime along with the opposition. AI-5 was also lifted in this year. Exiled leftists could return and political prisoners were released. Parties of the left were able to participate after the 1979 *Lei de Partidos Políticos* had legalized parties (Lei Federal 6767). The legal opposition under the military regime, the *Movimento Democrático Brasileiro* (MDB, Brazilian Democratic

Movement), formed the centrist PMDB and won over a third of the governorships⁴. The PT, which had emerged from industrial workers' organizations in São Paulo, was only just beginning to compete and primarily at the municipal level. Yet along with the other newly legalized opposition parties, a movement coalesced in support of direct presidential elections (“Diretas Já!”), which were ultimately unsuccessful.

Economic crisis in the 1980s contributed to growing pressures for a return to democracy in Brazil. The transition began in earnest in 1985 after the indirect election of Tancredo Neves of the PMDB under the electoral college rules of the 1967 military constitution. The PT in parliament boycotted the election on principle and expelled those of its members that participated in the vote, differentiating itself based on discipline and program from the start. The constitution of 1988 was therefore negotiated in a scenario in which the elected officials from the states had much greater legitimacy than the national executive.

As in many other countries, public health in Brazil had been profoundly transformed during the 1960s and 1970s (Nunes 1998). Publications, professional associations, and medical school training in *saúde coletiva* (public health) developed during these years. In Brazil, the Sanitarista movement emerged with a deep commitment to public health and primary care as components of an inversion of social priorities towards those at the bottom of the socio-economic scale. The 1978 Declaration of Alma-Ata was influential in Brazilian public health circles, as it was in Spain.

In her insightful analysis of health reform in Brazil, Tulia Falleti (2010b) explains that universalizing health reforms were successful not because of critical junctures revolving around economic crisis, but because of gradual institutional changes like

⁴Rondônia became a state in 1982, having previously been a Federal Territory, but not in time to elect a governor. As part of the passage of the constitution in 1988, the rest of the Federal Territories were eliminated. Roraima (previously Rio Branco) and Amapá became states and elected governors in 1991, along with the Distrito Federal for the first time. The state of Tocantins was created at the same time and is the only state for which data are not available during the previous period, because it was a part of Goiás rather than a Federal Territory.

those described in the previous section. Universalizing social policies were successful because the military state first penetrated society with early reforms, and then the reformers penetrated the state (40). At the heart of the reform movement were the sanitarias, many of whom were linked to the parties of the left. Sanitaristas worked their way into various government agencies even before the democratic transition, pioneering public primary care projects in the northeast that became models for the future orientation of the SUS, even after they were shut down (Falleti 2010b).

Unlike Spain where the socialists were a major force in parliament by the time the constitution was negotiated and the center right leadership that managed the reform process fully expected the them to govern the country in the near future, in Brazil the left was weak. The PMDB had already aligned itself as a centrist party and was coordinating the writing of the constitution with the hereditary parties of the right under military rule (ARENA). Together the *Partido da Frente Liberal* (PFL, Liberal Front Party, a successor of ARENA) and the PMDB held nearly 80 per cent of the seats in the constituent assembly, as a result of the elections of 1986 (Kinzo 1990).

The drafting process was extended and quite open to the public, resulting in a long and detailed document (Ames and Power 1990). In the constituent assembly the four existing parties on the left showed high levels of party discipline compared to the rest (Mainwaring and Pérez-Liñan 1998). Yet they held only a handful of seats and without the public nature of the process, with the strong participation of social movements and pressures for particular avenues of reform, it is unlikely that health care would have been incorporated as it eventually was. Where in Spain left parties were the clear agents of equity-enhancing reform, in Brazil left parties were weak and the dominant supporters of these policies were civil society organizations. Civil society has historically been stronger in Brazil than in Spain (Encarnación 2003), yet as we shall see, civil society cannot make up for a lack of political commitment to

equity by the actors who control the state.

The sanitarias played a prominent role in the constitutional negotiations, which took place far more directly in the public realm than they had in Spain. Health reform was a major arena of social activism at the time and was a focus of institutional reform. The tradition of National Health Conferences pioneered earlier in the century resulted in the *VIII Conferência Nacional de Saúde* called by José Sarney, the first civilian president elected in 1985. At the time, actors on the right and in the established private medical sector were pressing to prevent health care from being addressed in the constitution. The conference was the first to be open to the public and had 1000 official delegates, half from civil society, and 3000 participants more. It drafted the plan for the SUS that was incorporated into the 1988 constitution, reflecting the orientation of the sanitarias who had become an influential social force by this time (Falleti 2010b).

The goal was for the SUS to be universal, free at the point of service delivery, and financed progressively through taxation. Social movements in Brazil mobilized around the inclusion of provisions for participatory democracy, which impacted health reform as well as other areas of policy making in the constitution. Therefore, while parties of the left were not strongly represented in the legislature, the demands of progressive forces in society for inclusion in the process resulted in committed actors drafting the health guarantees in the constitution, regardless. Decentralization was a central tenet of the sanitaria project, which, as in the case of Spain, associated decentralization with a progressive break from the right wing authoritarian model of centrist governance of the past. This progressive movement supported decentralization of health care in large part because they felt the private health sector had captured the centralized health bureaucracy under the previous regime (Arretche 2004: 167). They were not anticipating a country in which the majority of states and municipalities would

be governed by actors farther to the right than the national executive—the situation that has existed since the mid-1990s. As in Spain, actors crafted institutions with their immediate history as a backdrop—likely an unavoidable reality, but still one that produced less than ideal conditions for equity-enhancing reform.

During the transition period, the central government lacked the fiscal capacity to finance subnational allies (Lopreato 2000) and the transition process produced territorial tensions as subnational units demanded resources without responsibilities, while the center attempted to shift duties downward. In the immediate aftermath of the transition it was subnational governments that came out ahead in fiscal terms, although this does not necessarily imply that the fortunes of equity-enhancing social policies were improved. In addition to substantial new transfers, the states gained political control over the ICMS value added tax. Municipalities gained massive new transfers. In neither case were concrete new responsibilities devolved immediately (Samuels and Mainwaring 2004; Lopreato 2000; Montero 2000: 64).

In 1988 with the promulgation of the democratic constitution, health (not just health care) was enshrined as a universal social right and an obligation of the state (Art. 196). The constitution, however, left the actual design of the health system to enabling legislation that would not follow for several years. The most significant component that never made it into the constitutional guarantee was the creation of an integrated National Health Service (NHS) with full public provision. The private sector, as in Spain, was too established and too powerful. Sandwiched between military rule and the powerful wave of neoliberal reform and economic crisis that swept Latin America in the early 1990s, the passage of a constitution with far-reaching progressive citizenship rights took advantage of a unique historical moment. While the lack of ideological commitment by the governments from 1989-1994 limited the development of the SUS, the victory of a constitutional guarantee placed a formal foundation

against which demands for expansion and access could be made over time.

5.4 Neoliberalism and the PMDB: 1989-1994

Though Tancredo Neves was elected President in 1985, he became ill and died before taking office and his vice-president, José Sarney, took his place. In the midst of a hyperinflationary economic crisis, Sarney implemented the *Plano Cruzado* in 1986, which for a brief period contained inflation and stabilized parts of the economy. The first direct elections for President were held in 1989 and were narrowly won by Fernando Collor, a young and charismatic businessman and Governor of Alagoas since 1982. Collor had filtered through a number of parties and left the PMDB in 1989 in order to run for President from the *Partido da Renovação Nacional* (PRN, National Renovation Party) a center right personalist party created to support his nomination. The rising star and leftist union leader Luiz Inácio Lula da Silva nearly won the elections and the PT's loss helped solidified the trajectory of health reform for the next decade.

For health policy at the national level, the ideological commitment of national executives and their health ministers are of primary importance for policy development. Brazil's presidential system gives a great deal of initiative to the national executive and ministers have great power over the policies that are produced in their respective areas. While during the transition the legislative process was dominant, afterward, executive initiative became central for health policy (Arretche 2004: 156).

Collor's government was characterized by neoliberal reform and the attempt at an economic reform (*Plano Collor*) whose failure deepened the recession. In 1992 allegations of corruption prompted an impeachment process and Collor resigned before the process ran its course, leaving Itamar Franco, his vice president, to run the country. The Collor and Franco governments were bereft of coherent leadership in the Ministry of Health.

The defining characteristic of their terms was the passage of the enabling legislation that created the SUS in 1990, which involved the national congress to a much greater extent than later regulation, and the initiation of decentralization to the municipalities. These were conservative presidents whose Health Ministers had strong ties to the private medical community and were not committed to the progressive goals of the SUS, which had been articulated in the constitution. Large portions of the enabling legislation from 1990 were not acted upon and the President vetoed elements of citizen participation and oversight that were reincorporated by the legislature. From 1990-1995 there was little administrative continuity, with six health ministers at the central level.

An important element of the SUS was implemented in 1990—the creation of the intergovernmental consultation fora. In 1987 the *Conselho Nacional de Saúde* (CNS, National Health Council), which had operated as a professional organization earlier in the century, was revived as a body to assess the Ministry of Health and included appointed members as well as representatives of civil society (Decree 93933). In 1990 the reform of the CNS was enabled with legislation fleshing out its composition. In addition, the health conferences were institutionalized, made permanent and given an official role in consultation over health policy (Lei 8142). Accompanying state level health councils were created across the country and institutionalized (*Conselho Estadual de Saúde*).

In 1982 the *Conselho Nacional de Secretários de Saúde* (CONASS, National Council of State Health Secretaries) was created in conjunction with state level democratization and over the decade began to operate as an increasingly relevant advocate for the concerns of the states. These have revolved primary around issues of financing, though not exclusively. The *Conselho Nacional de Secretários Municipais de Saúde* (CONASEMS, National Council of Municipal Health Secretaries) was created a few

years later. Over time, both have become official interlocutors of the federal government in the coordination and planning of health policy. The importance of these organizations has increased over time.

The failure to move reform forward in the early 1990s illustrates the Achilles heel of a progressive reform championed primarily by civil society actors. After the constitution, legislation would be debated and passed by the legislature, or implemented from the executive, with little opportunity for the influence of actors outside the government and out of favor with the party in power. The Brazilian legislature was dominated by the right and the private medical opposition had easy access to congressional actors, who themselves were not committed to equity-enhancing reform. Without ideological commitment among legislators and members of the cabinet, the failure of equity-enhancing implementation was over-determined.

In the early years, decentralization was the constitutional component of the SUS that advanced the farthest. This is primarily because it was one of the only components over which the goals of the sanitaristas and the neoliberals in government after 1989 coincided. In addition to the ideological challenges posed by the new government, the Sanitarista movement dissipated quickly after 1988 (Borges Sugiyama 2007: 131; Rodrigues Neto 1997). The movement had not been strongly connected to more lasting national social movements and lacked a strong mass base in civil society to sustain it after the transition.

The unions, which could have provided such a base, focused primarily on issues of health rights on the job and did not take up the call to defend the universalistic project of the SUS (Menicucci 2006: 76). Many of the strongest Brazilian unions represented formal sector worker whose contracts provided private coverage and who perceived little benefit from the new system. This is one of the clear and indirect effects of high inequality—that the natural allies of those in need of public health

services did not see themselves in the same boat as the poor masses. In addition, it shows the ripple effects of the lack of direct public provision in health, as the unions had private health insurance coverage rather than public.

The first round of enabling legislation was passed in 1990 (*Lei Orgánica de Saúde* 8080), but was not implemented by the executive until 1992 (Menicucci 2006: 75). Subnational governments gained fiscal and policy autonomy without the presence of accountability mechanisms designed to ensure management capacity or quality of services and access. The *Norma Operacional Básica* 1991 (NOB SUS 1/1991) that began the process of implementing Lei 8080 contradicted various aspects of the constitutional guarantee, which Brazilian health scholars have interpreted as signifying opposition to the reform from within the bureaucracy (Menicucci 2006).

Financing in Brazil has also continued to come in part from payroll taxes (about 30 per cent), though in a country where those in the formal sector tend to be middle class, this is not as regressive as it was in Spain. The Constitution mandated that 30 per cent of Social Security resources be spent on the SUS, but this was never transformed into practice or law. If this level of spending had been implemented, the Brazilian SUS would be in an entirely different league. As it was, financing was left with no guarantee at all. This is a significant difference between Spain and Brazil, as reformers were pushing the same shift for funding and management to move out of social security. With no strong committed political forces behind the SUS, bureaucrats in the social security administration, worried about losing funding to the new health system, went largely unchallenged.

In the early 1990s Brazil was in the midst of an economic crisis and the Ministry of Health was low on the cabinet totem pole. The Finance Ministry did not support new taxes so even when Health Minister Adib Jatene won new funding for health in 1992, it was almost immediately offset by health cuts from Finance (Arretche 2004:

175). The quality of the limited health coverage provided by the incipient SUS at this stage was hampered by irregular and unstable financing (Menicucci 2006).

Beginning with NOB 1993, municipalities were incentivized to take on the highest level of responsibilities despite the fact that accountability and oversight mechanisms were still incredibly weak. Despite the language of the NOB 1993, financing followed a process like that of the Spanish SNS in the early years, based primarily on previous levels of funding (CONASS 2011). At the height of the influence of the Washington Consensus in Latin America, neoliberal pressures for state cutbacks and market-oriented reforms encouraged decentralization with no strings attached. In addition, central government officials knew that the resources to fully implement the SUS could not be mustered (Bresser Pereira 2011). This rapid decentralization—primarily from the center to the municipalities—decreased the capacity of the central government to address the serious distributional challenges facing the country (Montero 2000: 59). Decentralization of health care under these conditions was decidedly un-equity-enhancing (Weyland 1996).

The NOB 1993 created two bodies that would become increasingly important over time—the *Comissão Intergestores Bipartite* (CIB, Two-level Management Commission) and the *Comissão Intergestores Tripartite* (CIT, Three-way Management Commission). The first was made up of the state Health Secretaries and the national Health Minister, while the second added municipal Health Secretaries. These are important consultative organs that consult and problem-solve on health policy issues for the SUS. In theory they are similar to the Spanish CISNS, but because the Ministry of Health in Brazil has more unilateral authority for health policy making, the role of the CIB and CIT has been less dominant in policy-making.

Under various pressures, states and municipalities began to innovate during these years. They had some revenue and many were strongly committed to health reform,

which they saw going nowhere at the center. The unsustainability of the previous model, based on curative care and excluding the neediest members of society, had been critiqued for decades. For some municipalities, the Cuban community-based family doctor program was a model.

Yet these leftist municipalities that experimented with innovative equity-enhancing primary care programs in the late 1980s and early 1990s⁵—Niterói (Rio de Janeiro), Porto Alegre (Rio Grande do Sul), Curitiba (Paraná), Londrina (Paraná), Marília (São Paulo), Botucatu (São Paulo), Fortaleza (Ceará), among others—almost all had high levels of capacity, as well as commitment. These success stories have been oft-told, picked up by international and domestic reformers, alike. The programs have been particularly important because of their influence on the development of the Brazilian federal policies, yet as we shall see their application under uncommitted or low capacity governments has been quite limited. The *Programa de Agentes de Saúde* (PAS, Health Agents Program) in Ceará is one of the few that arose in a high commitment, low capacity area and became the model for the *Programa de Agentes Comunitarios de Saúde* (PACS, Community Health Agents Program) that was picked up at the central level beginning in 1991 (Borges Sugiyama 2007).

The Minister of Health from 1993-1995 was Henrique Santillo, a pediatrician from a municipality of São Paulo that became one of the earliest innovators in primary care (Ribeirão Preto). Santillo trained in Minas Gerais and was the first Governor (in Goiás) to adhere to the SUS after pioneering an early PACS program in his state. He had been a student activist during the military regime and was involved in the founding of the PT in 1980, though later ran for Governor from the PMDB.

In 1994 his ministry launched the PSF along similar lines as the successful sub-national experiments, over time incorporating most of them, though not all⁶. The

⁵This list comes originally from Terra and Malik 1998.

⁶A few municipalities with high capacity chose to keep their own more generous systems (as

PSF is based on *Unidades Básicas de Saúde* (UBS, local health posts) where a team of doctors, nurses, health agents, and over time other specialists would base their primary care activities. The program shares aspects of the Spanish system, with a particular number of people assigned to each team and, at least in theory, the teams operating as gatekeepers for access to specialist and curative services. As we shall see, because of low financing, stigma, and slow extension, the PSF has never been able to functionally perform this second goal in most areas. In addition, because the Spanish central government ran health provision directly in almost all regions at the time of reform, it was the only game in town and had no competition from alternative regional primary care networks.

For the early years of the SUS, pro-poor developments took place primarily at the subnational level and were limited in scope. In the context of decentralization, the diverse levels of ideological commitment and generally low capacity of subnational units became more salient for social policies. Significant variation in the size of subnational tax bases, administrative capacity, and ideological commitment to equity-enhancing health policy will generally lend themselves to greater regional variation. Federal transfers were skewed towards the poorer states in the North and Northeast (Serra and Afonso 1999). This might have been equity-enhancing if these governments had been committed to pro-poor policies, but at the time they mostly were not.

5.5 The Capable Centrists: Cardoso and the PSDB from 1995-2002

The PSDB emerged from a schism within the PMDB in 1988 and Fernando Henrique Cardoso was a central part of the founding group. A progressive sociologist, he had militated within the PMDB for it to be a moderate pro-democracy party. While the PSDB was clearly promoting a center left alternative to the PMDB, the party was

discussed in Chapter 2), in addition to implementing PSF in other parts of the city (Porto Alegre for example). As we shall see, some municipalities maintained less efficient plans not based on public provision, such as São Paulo. In general, only wealthy municipalities can choose to reject PSF funding in order to pay for their own alternative system. Even in these cases PSF also operates.

born not primarily over ideological conflict but because there were insufficient leadership positions for all the rising stars coming out of São Paulo (Roma 2002). Still, in the early years there were also differences over “good government” and program. While Cardoso had been an influential academic and politician in São Paulo and in the Senate, it was his role as Finance Minister under Itamar Franco that solidified his trajectory in national politics. Cardoso protagonized the *Plano Real*, a set of economic reforms that ended the economic crisis of the early 1990s and marked the beginning of Brazil’s path toward economic stability and development.

The ideology of the PSDB during this period has been the subject of warm, if not heated, debate⁷. The party’s alliance with the right wing PFL in 1994 was unpopular and had an ideological impact on many aspects of governance after winning the presidency. What the party had was an ideological commitment to capable management of public affairs. But what should we make of the fact that Cardoso and his ministers took proactive steps to activate and incentivize equity-enhancing reforms that it could have simply left to the states and municipalities? Or the fact that the PSDB government also carried out a surprising level of land reform? Or that even the *Plano Real* did not abide by IMF orthodoxy and employed fixed exchange rates for several years?

The PSDB’s reform agenda emanated from a commitment to economic stability, growth, and competent state management. Cardoso may personally have believed in these goals as necessary preconditions for achieving equity, but the difference between the ideology of the PSDB after 1994 and the PT since its inception is observable, even

⁷Coppedge codes the PSDB as secular center left from 1990-1994 based on expert surveys (Coppedge 1997) and Huber and Stephens (2012) continue this coding. However, Borges Sugiyama considers the PSDB to be a centrist party during this period, with exceptions for particular politicians that were center-left. Celso Roma (2002: 71) argues that the party became centrist and then shifted right in its second term. This is consistent with the story captured in the Power and Zucco partisan placement surveys conducted with Brazilian legislators (2009; 2012).

with the PT's moderation once in office. The land reform was not part of an overarching attempt to tackle the plight of the rural poor and left the agricultural system largely as it had been (Pereira 2003). The social reforms were still vastly underfunded and were completely in line with the means-tested minimalist programs for the poor that were supported by international financial institutions, thus representing political stances that did not require an ideological commitment to equity.

Still, under conditions of low capacity and economic and social underdevelopment, simply governing with a commitment to increasing state capacity and stability had equity-enhancing effects. Cardoso's government marked an important transition period for the SUS, when for the first time the groundwork for consolidation and expansion was laid. Technocratic governance, policies to stabilize the budget for health, the appointment of several capable Ministers of Health who were not antagonistic to the SUS, and the cost effectiveness of promoting prevention and basic care combined to improve the distributive nature of health policy under the PSDB.

Macroeconomic crisis and state reform dominated the attention of Cardoso's first administration. According to one ministerial *chefe de gabinete*, "Fernando Henrique always cared about redistribution, he just cared about the economy more." In health care, the programs that were the most redistributive were also the least expensive and the most efficient from a neoclassical economic perspective, which explains why there is little contradiction between the economically liberal orientation of the government and its attitude toward health care during this period⁸.

However, Borges Sugiyama shows clearly that implementation of the PSF, the most equity-enhancing component of Brazilian health policy, was statistically significantly higher in municipalities governed by the left—though not in those governed by

⁸In fact, there was substantial disagreement within the Sanitarista movement about whether or not to support the PSF at the outset precisely because the more radical branch believed it was a "programa pobre para pobre," a poor program for poor people (Borges Sugiyama 2007: 157; Capistrano 1999).

centrist parties, not to mention the right (2007: 75)⁹. This is an important finding for two reasons. First, it is commonly held that partisanship does not matter at the municipal level in Brazil because party machines are not programmatic, not even for parties like the PT that are programmatic at the center. Second, one might argue that left parties in municipalities are important for innovation, but not for implementation once central resources are tied to popular policies. Yet Borges-Sugiyama's findings suggest that left partisanship matters even for take up, and that the left is significantly different from the center, which is where she places the PSDB.

While the Cardoso administration chose to support expansion of the PSF, the program was developed and primarily diffused by local left-of-center politicians throughout the 1990s. The limitations of PSDB commitment can be seen in other policy areas, in education and minimum income programs where federal attempts at incentivizing local innovations were clumsy, inadequate, or even counter productive to the development of existing local programs (Borges Sugiyama 2007: 102-103). As part of the state reform of 1995, Planning Minister Luiz Carlos Bresser Pereira designed a model of private non-profit health contracting that would be used extensively, and controversially, in the state of São Paulo.

Still, two of Cardoso's Health Ministers were particularly important—Adib Jatene (January 1, 1995-November 6, 1996) and José Serra (March 31, 1998-February 20, 2002). In stark contrast to the Spanish case where a “short” ministerial term would be two years, after Serra, Jatene's two years in office represent the longest tenure among the eight Health Ministers who served between 1995 and the beginning of

⁹It is a common belief among observers of Brazilian politics that parties may “matter” at the central level, but that municipal and state party machines function differently and are inherently un-programmatic. There is certainly evidence for this at the municipal level, particularly in smaller localities, and among those parties that are thoroughly un-programmatic at all levels. It is a good argument for not trying to extend a theory of commitment to municipalities in statistical analysis. Yet Borges Sugiyama's findings, as well as those in this dissertation, suggest that in states and capitals, as well as nearly everywhere governed by the PT, party and program have been differentiable and important for outcomes.

2007. Turnover in most ministries in Brazil is quite high and in the context of a national process of defining the SUS, this lack of continuity has made the process slower and less cohesive. The longest serving Ministers of Health under both Cardoso and Lula were those appointed at the beginning of their second terms, who served all the way through.

Adib Jatene developed the NOB 1996, which represented a major inflection point in the development of the SUS, though it was not implemented until 1998. Many transfers became automatic based on objective criteria and the distribution of responsibilities was clarified. This norm set the stage for municipalities to be held accountable for quality and access to services in their territory. For the first time the *Piso de Atenção Básica* (PAB, Primary Care Base) was established—an amount of money that was transferred to each municipality directly for primary care provision in their territory. The fixed portion was low (10 reais a person in 1998), but incentivized moving primary care out of ambulatory care facilities and into the PSF. A variable amount was added for implementing the PACS and PSF, strengthening oversight, collecting epidemiological data, regulation of occupational health and safety, public health, and diagnostic testing (Ugá, et al 2003). An intentional side effect of the reforms was to induce the creation of separate Health Secretariats in municipalities, with health funds independent from the general budget, which were required for receiving the transfers and paved the way for slow increases in health administration capacity and accountability. Once again, decentralization and local capacity building were enabled and enduced from the center—a logic of decentralization that never existed for the Spanish regions.

Jatene also strongly defended the creation of the CPMF, a tax on financial transactions destined for health care (Arretche 2004: 175). His dismissal was directly tied to what the administration perceived as incompatibility between his agenda in

health care and the economic orientation of the government (Menicucci 2006: 78). Finally, and perhaps most important for distributive concerns, NOB 1996 paved the way for the PSF to become a model for universal basic care coverage and begin to shift Brazil away from a traditional curative model of care (Duarte de Araújo 2010: 89; Goldbaum, et al 2005: 91). As I discuss in the case study of São Paulo, Jatene struggled unsuccessfully to convince city leaders to adopt the PSF and eventually helped state leaders implement the program in neighboring communities when the capital city refused (Borges Sugiyama 2007; Capistrano 1999: 90).

The context of decentralization and macroeconomic crisis is part of the reason that a committed Health Minister like Jatene would be less successful than later minister José Serra. Although Serra's position as a well-known party leader with national political aspirations made his tenure unique, his Ministry of Health was also embedded in a different structural context than Jatene's had been. By 1998 when Serra became Minister of Health, financial incentives for the implementation of the PSF were in place, oversight mechanisms were better institutionalized, and ongoing health reforms were taking place under a strong national executive who had been successful maneuvering against subnational leaders (Affonso 1997: 25). Still, Serra was a strong Health Minister in his own right (Arretche 2004: 156) and spent twice as long in office as most previous ministers had. He implemented important policies to control drug prices, expand the PSF, and solidify the dominance of the public sector in provision of transplants.

Developed over several years and implemented by Serra, the *Agência Nacional de Saúde Suplementar* (ANS, National Supplementary Health Agency) was envisioned in June of 1998 (Lei 9656) and made operational with Lei 9961 in 2000. Until this time the private health market had been completely unregulated (Albuquerque, et al 2008). For the first time the government was trying to control the outflow of

public resources to private health plan holders who used the SUS. It took several years and numerous court battles to force private insurers to hand over their lists of clients, which eventually the center would use to cross-reference lists of those who received SUS services and then charge the private insurers directly¹⁰. The legislation more broadly regulated the private insurance market and permitted international investment in the sector for the first time (Carvalho and Oliveira 2007). As we shall see, the ANS has offered the possibility of recovering resources for the SUS, but only when agency managers were willing to pursue the issue.

Serra's ministry was integral in developing and passing Constitutional Amendment 29 in the year 2000, which mandated spending on health by states and municipalities, though with a somewhat perverse effect over time in terms of adequate central government financing. Financing from the central government has historically been highly unstable and this measure prevented decreases, but allowed the center to escape the necessary investments for increases in costs and expansion of the system. There are no legal requirements regarding the amount that should be received by each state—no formulas with transparent definition as there are in Spain. Negotiations and the political clout of particular governors and mayors still plays a role.

Amendment 29 set in place a major shift in financing away from the center and toward states and municipalities because it required that they spend a specific portion of their revenue on health, while tying central spending to real GDP growth. This is a regressive reform from a vertical perspective, as most municipalities were already spending close to the required 15 per cent of revenues on health (BNDES 2002) and as the center has fallen behind, have had to take up the slack. In addition, while municipalities adhered fairly quickly, states and the federal government have

¹⁰See for example *Folha de São Paulo* 11/17/2000 “Planos de saúde devem R\$ 2,6 mi ao SUS, diz ANS” and 8/15/2000 “Empresas de saúde se queixam de cobranças para ressarcir o SUS.”

often not met their required spending levels (Campelli and Calvo 2007). Still, spending inequality between the municipalities has declined substantially since the reform (Arretche 2010), suggesting that it forced laggards to catch up. Yet we have little information about the extent to which regions that lagged in spending did so out of lack of commitment or lack of capacity, and the difference matters for the equity enhancing nature of the reform.

Although the Cardoso government was not broadly committed to redistribution, the combination of several committed and effective ministers with the successes in macroeconomic stability, debt containment, and state management reforms ensured progressive advances in health policy during Serra's tenure. The central government learned that simply writing a health system into law would not guarantee its implementation across subnational units and began to incentivize compliance by tying funds for programs like the PSF to conditionalities (Gomes 2008).

While governors lost influence during the 1990s under a powerful national executive who tightened the public purse strings (Samuels and Mainwaring 2004; Lopreato 2000; Montero 2000: 59), health policy remained highly decentralized at the municipal level. Enabling rules for the functioning of the SUS were produced consistently over the course of the decade, but NOB 1996 was particularly important in producing norms that were objective, binding, and delineated clearly the responsibilities of each level (Duarte de Araújo 2010: 83).

However, the reforms of this period have not been unequivocally positive for equity. The Lei Camata restricted subnational payroll spending to 60 per cent of revenue as part of the state reform of 1995. In small municipalities in poor states, these restrictions make it almost impossible to hire qualified health professionals (Benigno 2011). In São Paulo, support for the shift of health provision to the private-not profit sector was partly due to pressures to cut the portion of revenue going to salaries,

in adherence to federal law (Sano and Abrucio 2008: 72). NOB 1996 also put in place the system for tying direct federal funding for health to the different levels of responsibility taken on by subnational governments. Its implementation did not begin until 1998 and once it did, states began signing on at different levels of negotiated responsibility for health. There were two levels: *gestão avançada* and *gestão plena*. The former included state-level funding for management of primary care only, while the latter covered medium and high complexity care as well.

These reforms forced states and municipalities to make investments in human resources and increased administrative and managerial capacity in health care, though the extent of reform varied. Ongoing economic crisis, austerity, and stabilization efforts sapped fiscal resources for social policy from all levels of government for most of the decade, slowing implementation of the SUS. In addition, the state reforms produced increases in administrative capacity and public finances only slowly. While not surprising, it means that major improvements in the quality and accessibility of health services did not appear during the first full decade after the creation of the SUS (Montero 2000: 72).

Fiscal capacity for health policy at the subnational level improved beginning in the 2000s because of economic growth and the contribution that the *Lei de Responsabilidade Fiscal* (Fiscal Responsibility Law, Lei Complementar 101/2000) made to macroeconomic stability (Serra and Afonso 2007). Amendment 29 stabilized subnational health spending to a certain extent. Overall, the national tax burden has increased steadily since the transition, as has the portion of this that winds up in the hands of municipal governments. The push-pull between governors and the center in the immediate aftermath of the constitution is reflected in a major loss of revenue from the center to the states (as a portion of total government revenue) by 1991, which was then ameliorated in subsequent years by a shift from states towards both

municipalities and the center by 2005 (Afonso and Mereilles 2006).

Following the NOBs from 1991, 1993, and 1996, the Serra ministry promulgated the 2001 *Norma Operacional da Assistência da Saúde* (NOAS, Health Care Operational Norm), which increased the responsibilities of municipalities, particularly in the realm of primary care, and further specified norms for oversight and management at the state and municipal levels (NOAS SUS 01/2001; Duarte de Araújo 2010). Because only a small percentage of municipalities had taken on full health management and many wound up with no hospitals at all due to problems of scale, the NOAS promoted the creation of health regions for the coordination of service provision (Teixera 2008: 863), which has become a significant logistical task taken on by the states. The NOAS set out new criteria for states and municipalities to be “habilitados” and permitted to take on greater responsibilities in health, another asymmetric process by which states had differing statuses over the course of the early 2000s. Table A.9 shows the timing of health decentralization under NOB 1996 and NOAS 2001.

5.6 The Rise of the PT: 2002-2011

Lula ran for President four times before finally being elected in 2002. The PT is disciplined even by non-Brazilian standards. The leaders knew that as a small, new party without the backing of the rich and those already in office (with access to the resources of the state), it had to build itself from the ground up. This took place from the late 1980s on, mostly at the municipal level. But one of the most significant strategies of the PT at the center was to build a unique brand that was easily identifiable from the pack, and it did this by acting as a disciplined opposition and voting against nearly everything the PSDB did during the 1990s. The pension reform Cardoso eventually passed in 1998 was weaker and less progressive than the PSDB had wanted because of obstruction in the congress led by the PT (Hunter 2009: 69). Immediately after gaining office, the PT passed a pension reform that achieved

some of these original goals.

While international markets were jittery about the PT, the party has adroitly balanced a disciplined commitment to equity-enhancing social policies within the constraints of the international political economy, producing strong economic growth while dramatically reducing poverty since taking office in 2003. Their fiscal responsibility and economic moderation has left the PSDB in a challenging position. The party had easily been able to differentiate itself to the left of other Brazilian parties and as more capable than the non-PT left. But since 2003, the PT has hegemonically occupied the moderate-left space, leaving the PSDB in an uncomfortable opposition in which it must oppose popular and effective policies in order to avoid being subsumed into the ever-expanding PT tent.

Differences between Cardoso and Lula in the health realm were smaller than some would have expected. For Lula, inconsistency in the commitment of his health ministers, a strong focus on social assistance, and the presence of constraints on fiscal capacity in his second term made his impact on health policy less equity-enhancing. These findings are consistent with general perceptions of social policy continuity between the two administrations (Melo 2008: 162). Still, the party had spent years in opposition fine-tuning a progressive policy platform and planning for the eventuality of a national presidential win. Its leaders were ideologically committed to the goals of the SUS and had been part of the movements that defended it during the transition. Despite the fact that the SUS was not Lula's primary policy focus and none of his health ministers were as politically influential as Serra, his administration hit the ground running and implemented a number of reforms.

Perhaps most important, his administrations mainstreamed an inversion of distributional goals across the board in social policy. The successes in poverty alleviation

under the PT have clear ramifications for health outcomes and policy. The administration discovered after several years implementing *Bolsa Família* (Brazil's now-famous conditional cash transfer program) that the deepest poverty made uptake of social services almost impossible. Working with the poorest of the poor required persistence, resources, and long term commitment (Bernardes 2009).

Over the past decade the PT has methodically addressed the road-blocks that keep the poor from accessing services. This trajectory is illustrated by President Dilma Rousseff's *Brasil sem Miséria* (Brazil Without Misery) program to alleviate the deepest pockets of poverty, once the state realized that *Bolsa Família* was missing many of the poorest people because they were too poor to have papers or stable residences. The government has implemented campaigns for unified citizenship identification in order to help millions of undocumented Brazilians gain access to the social services that could only be accessed with proof of identity (Hunter and Borges Sugiyama 2011). Social services, education, and the health system have been increasingly integrated and the conditionalities of *Bolsa Família* have brought millions of poor families into the health network. Addressing poverty and social exclusion not only impacts health outcomes, but also health policy by forcing administrators to deal with the issues of the poor as the poor become clients.

During the first six months of Lula's presidency a great deal of political energy was spent reorganizing the Ministry of Health in order to integrate an increased focus on primary care, advances in science and technology, and democratic management (Teixera and Paim 2005). The first PT Health Minister lasted the longest in Lula's first term. Humberto Costa was a dedicated party militant for a quarter century before joining the ministry and has gone on to become the first PT senator elected from the state of Pernambuco. As Wendy Hunter explains in her crucial work on the transformation of the PT, Lula had been in a difficult position, needing to reward

party militants for 20 years of effort, but also appease his allies in the congress. During the first two years in office, his cabinet went disproportionately to PT members. In part because of these dual pressures, the PT had engaged in the purchase of partisanship and votes in the legislature to make up for inflexibility in its ability to award cabinet seats to important allies (Hunter 2009).

The Health Ministry was a casualty in these partisan battles and scandals. Costa left halfway through his term in order to run for elected office and his seat was given to the PMDB. Costa had sustained incremental progress in the process of consolidating and improving the SUS (Carvalho 2005), but left his post without successfully achieving the passage of the *Lei de Responsabilidade Sanitária* (Health Responsibility Law, Projeto de Lei 4010/2004), which would have been an important reform for accountability and oversight in the SUS. Costa's replacement, José Saraiva Felipe from the PMDB, chose not to pursue the legislation. Agenor Álvares served for one year (2006-2007) and was replaced by José Gomes Temporão in an effort to secure PMDB support for the second round of Lula's upcoming re-election bid.

Attention to prevention began very slowly in the 1990s and made a significant leap under Lula (de Brito 2011). During his first term important strides were made in increased access to dental services, mobile urgent care, and access to government-subsidized pharmacies (Menicucci 2011). These are some of the same efficiency and coverage extension measures that the most innovative Spanish regions were implementing at the same time. The number of PSF health teams increased by 57 per cent (Freitas 2007), the per capita financing for primary care services (PAB) was increased 50 per cent, mental health facilities were expanded in an effort to de-hospitalize the treatment of mental illness, drug cost control measures were put in place, special programs were instituted targeting HIV/AIDS, women's health, children and adolescents,

black and indigenous populations, and the elderly (Menicucci 2011). Management reforms were also undertaken that simplified the fiscal transfer process and reinforced efforts begun under the Cardoso governments for results-based evaluation with the first *Pacto pela Saúde* (Health Pact) in 2006. In 2005 the Ministry of Health developed a unified set of health outcome indicators that would be used for all states and municipalities to set goals and measure results (Portaria 21, 2005).

The first Health Ministry under Lula spent several years designing the first Health Pact, which was implemented in 2006 and reaffirmed a political commitment to the SUS. Of central importance, the Health Pact institutionalized the PSF as the access point for the SUS and the center-piece of the health system. It includes the *Pacto pela Vida* (Pact for Life), *Pacto de Gestão do SUS* (SUS Management Pact), and the *Pacto em Defesa do SUS* (Pact in Defense of the SUS). The Pact created an institutional framework for generating intergovernmental agreements based on specific goals for health outcomes in each territory and was a major advance in accountability and oversight, as well as participation for states and municipalities in federal health decision-making. As we shall see, it has proved to be a stepping stone for increasing accountability over time.

In 2007 the government began pressuring private insurers to shift their focus toward prevention. Over 100 additional illnesses were added to the list of what providers had to cover. In conjunction with the Health Ministry, the ANS begins a campaign to reduce unnecessary caesarians (public and private). In 2010 the ANS begins requiring that private plans give same sex couples the same rights as heterosexual beneficiaries (ANS 2013). Yet also in these years the ANS almost completely stopped charging private insurers for using hospital beds in the SUS and did not begin trying to recover the under-the-table subsidy until an investigation began in the *Tribunal de Contas*

da União (TCU, Federal Fiscal Tribunal)¹¹.

Under Temporão, health policy was reframed to focus on social causes of health outcomes and pinpoint quality of life issues such as alcohol abuse, unsafe abortion, smoking, obesity, and economic development (Menicucci 2011). Temporão served for a full three and a half years before being replaced at the beginning of 2011 by Alexandre Padilha under the new Dilma administration. At least in the early months of the new government, some health officials in Brasília perceived Dilma to be committed to the SUS in a way that represented a significant break with the past (Oliveira 2011). Unlike Temporão, Padilha is a petista and was trained in Campinas, one of the strongholds of sanitarista medical influence.

Padilha's tenure has already been marked by major efforts in several important areas. The activity of the ANS immediately saw a major uptick, with battles fought with the private sector for the extension of coverage under private plans to the elderly and those who lose their jobs. In addition, under the new Ministry leadership, the ANS immediately began taking the recovery of SUS money from private plan holders seriously. In 2011, the ANS began directly transferring to the *Fundo Nacional de Saúde* (National Health Fund) the money it recovered from insurers whose plan holders used the SUS. The amount was 76.1 million reais, 80 per cent of the total what had been recovered in the entire first decade of the agency's existence (ANS 2013). While welcome, the process confirmed critics' fears that the ANS had previously been unwilling to go head to head with the private insurers over their debts. Until 2011 the only monies that could be recovered were for hospital stays, so in that year Padilha announced that the ANS would begin charging insurers for complex services (such as chemotherapy and other expensive treatments) provided by the SUS to holders of private insurance¹². Regulation has become more complete and hundreds of plans

¹¹*Folha de São Paulo* 6/27/2011 "Após um ano, ANS volta a cobrar planos por uso do SUS"

¹²*Folha de São Paulo* 8/30/2011 "Plano de saúde terá de pagar ao SUS por tratamentos mais

have been removed from the market for violating minimum requirements for basic coverage and patients' rights.

While it is still too early to evaluate results, national health officials and observers suggest that a new decree promulgated in July 2011 could bring about major improvements in the SUS. Decree 7508 fleshes out important elements of the original health law from 1990 that were never implemented. The first draft was written by sanitaria lawyer Lenir Santos. Perhaps most importantly, the decree introduces the *Contratos Organizativos da Ação Pública* (Public Health Sector Organizing Contracts), which make the health pacts negotiated between each level of government legally binding. Until now they have been “gentleman’s agreements,” and national health officials believe that this change will be a substantial one for ensuring accountability (Oliveira 2011). Some of the most extreme inequality in the Brazilian health system stems from lack of accountability for subnational governments that do not meet their obligations in health care (Pinto 2011).

Quality and access in the SUS have suffered as a result of chronic insufficient financing at a level far beyond what has been experienced in Spain. Civil society and legislative effort to fix this problem have been enormous, yet progress has been almost nil until very recently. The original financing for the system was vetoed immediately and Amendment 29 in many ways worsened the problem. Measures languish in various parts of the legislature, where private sector vetoes are powerful and many deputies and senators are themselves medical professionals with little interest in supporting the SUS. While the PT has controlled the presidency since 2003, it has never had anything close to a majority in Congress and regardless, has not had nearly as strong a record of support for the SUS as it has for social assistance, despite the dovetailing of important aspects of these policies.

caros.”

5.7 Multilevel Health Reform in Bahia

The state of Bahia is in the Northeast region and is the most developed of these poor states. Among the state-level case studies it represents an example of a poor state with historically low capacity and low commitment, with a shift to committed government in 2007. Like other states in the region, infant mortality has been very high but has decreased dramatically over the course of the democratic period. It is the largest Northeastern state and variation between municipal policy performance and outcomes in the capital and in smaller localities is large.

In the case study I profile the capital city of Salvador and contrast its experience in health reform and implementation to that in other Bahian municipalities. The Bahian experience at the state level is compared to that in Ceará, another Northeastern state that has had higher levels of commitment and superior outcomes.

5.7.1 Overview

About a quarter of Bahia's 14 million people live in the state capital of Salvador and nearly 80 per cent of the population identifies as Afro-Brazilian, the highest level in Brazil. Salvador was the first state capital in the country and an important port during the colonial period. It is the largest state in the Northeast both in terms of geographic surface area, number of municipalities, and population. There are 417 municipalities in the state, the fourth largest in Brazil in these terms. No other states in the Northeast have cultural capitals the likes of Salvador and despite the economic challenges faced in Bahia, its levels of income and public revenue have been higher than in other comparable states.

Infant mortality in Bahia has steadily fallen from about 145 in 1971 to the mid-20s in 2008 (IBGE). The shift is clear, though the problems of subnational infant mortality data reliability exist across all the cases. As in Spain, the largest absolute decline took place before the transition to democracy, in Brazil associated with rapid

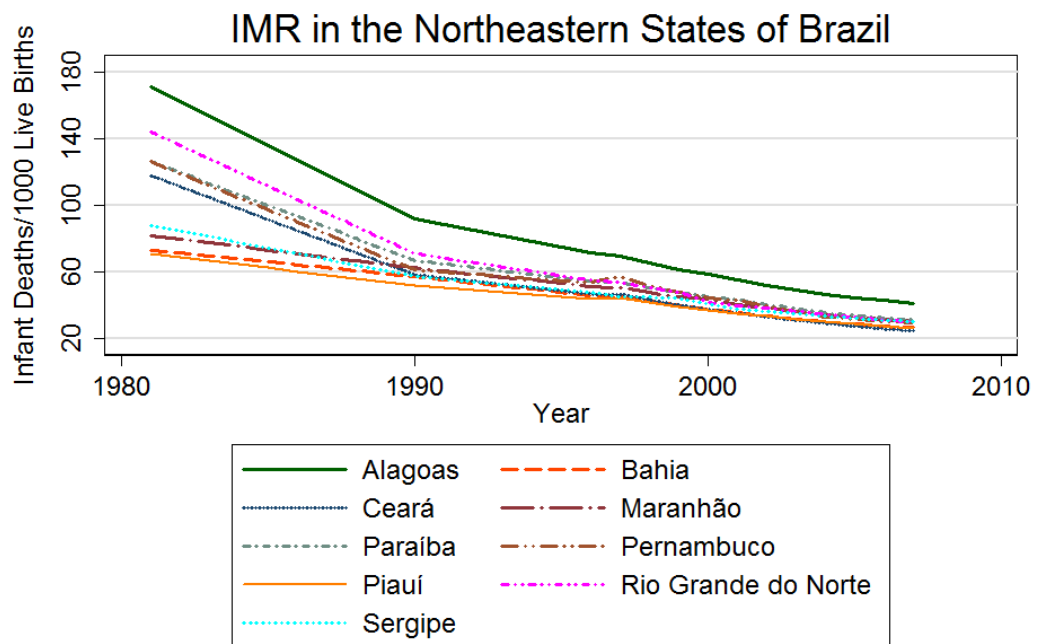
economic development during ISI and the miracle years of the 1960s and early 1970s. Still, infant mortality fell by nearly half from 1997-2008. Within the Northeast, Bahia is not the best performer on infant mortality, as many states began the period with rates near 200 and some had lower rates than Bahia as of 2008. The trends are quite similar overall, as Figure 5.2 shows.

Poverty in the state has been crushing, as it is in most of the Northeast. The rate was steady between 60 and 70 per cent from the earliest data in 1981 until the rise of the PT in 2002. This means virtually no progress was made on poverty for two decades. Poverty in Bahia has decreased steadily and rapidly from 60 per cent to 38 per cent from 2003 to 2009 (IPEA). These results are very similar to the other states in the Northeast—Alagoas, Ceará, Maranhão, Paraíba, Pernambuco, Piauí, Rio Grande do Norte, and Sergipe. Several of these had higher levels of poverty than Bahia and a few now have somewhat lower, but the poverty pattern is quite consistent across the states regardless of differences in state politics—in line with the centralized nature of anti-poverty programs. Figure 5.3 shows poverty rates for the region.

Income inequality, as discussed in Chapter 2, has decreased slightly in the past decade, but the patterns by state are varied. In every state in the Northeast, income inequality began the 1980s in the mid-50s on the Gini Index, rose over the next two decades, and declined to levels that were still slightly above their starting place by 2010. The only exceptions are Ceará and Bahia, where levels at the end of the period are slightly lower than they were in 1981. While a decent case can be made for political explanations—particularly, as we shall see, in the case of Ceará—the differences are likely not reliable from a statistical perspective, unless they continue to decline over the next few years. The rough relationships and patterns are shown in Figure 5.4.

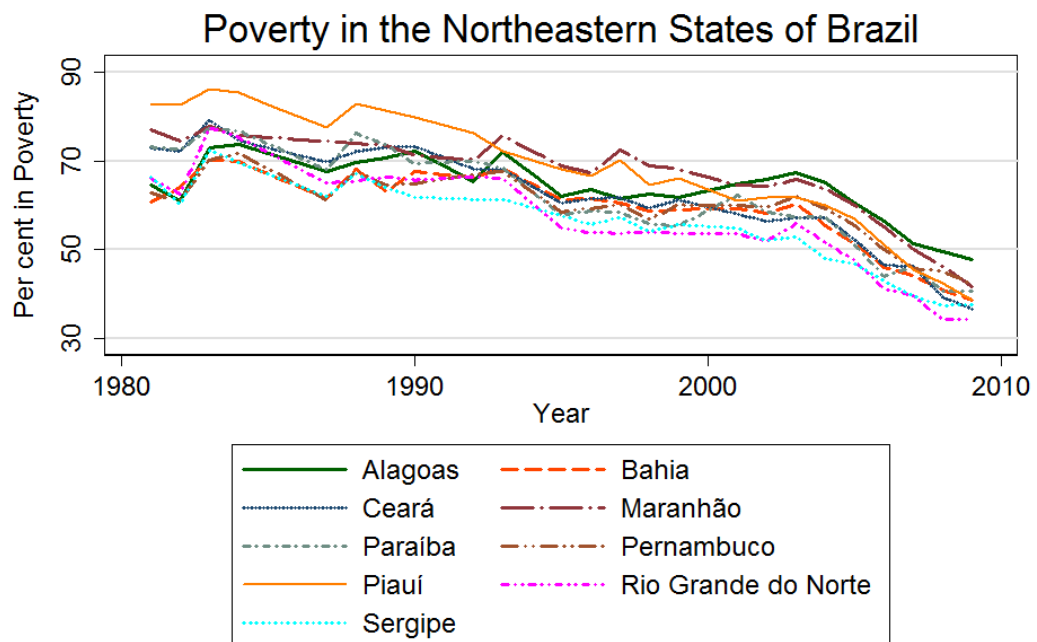
Unlike the poorest Spanish ACs, real GDP per capita in the poor states of Brazil

Figure 5.2: Infant Mortality in Bahia and the Northeast: 1981-2008



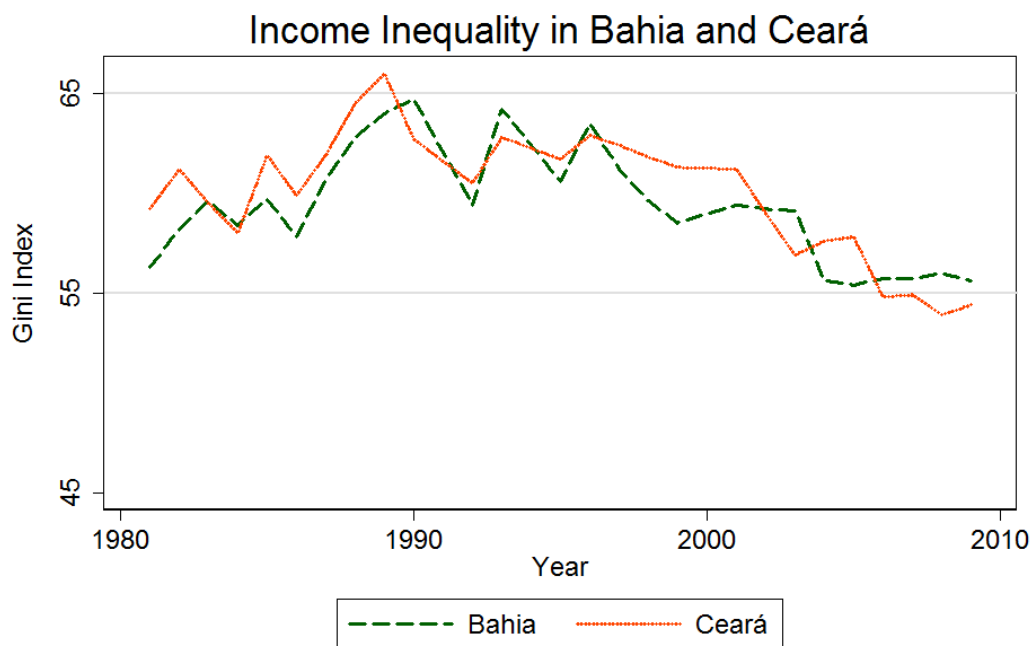
Source: IBGE and DATASUS

Figure 5.3: Poverty in Bahia and the Northeast: 1981-2008



Source: IPEA and DATASUS

Figure 5.4: Income Inequality in Bahia and Ceará: 1980-2010



Source: IPEA

has barely increased and their relative position has worsened. In Bahia, inflation adjusted GDP per capita has increased from 4,230 reais in 1985 to just 4,520 in 2009. Yet as a portion of the national average, Bahia has fallen farther behind. While its income was 86 per cent of Brazil's average in 1985, it was only 64 per cent in 2009. This is primarily because of the large real increase in per capita GDP in the wealthiest states during the same period, with the national average increasing from 4,880 to 7,050 reais (IPEA).

Revenues have tended to be higher for Bahia than other Northeastern states for a variety of reasons. The state economy is fairly large, the entertainment industry in Salvador produces significant wealth (Carnaval and international tourism, as well as UNESCO heritage status for historic neighborhoods since the 1980s), and a variety of natural resources have been discovered and exploited in the past few decades. Revenue

as a portion of GDP in Bahia was 6.6 per cent in 1985 and increased steadily to hit its high point in the early 2000s at around 17 per cent of GDP. The portion has dropped slightly in the subsequent years largely because of fast economic growth at the end of the decade. Levels have been higher in some of the other Northeastern states in recent years but generally because of slower GDP growth.

The role of the international community is incomparable to that in Extremadura and the poorer ACs of Spain. However, the efforts of international actors and the federal government to promote nascent primary care programs in the Northeast, in particular the *Programa de Interiorização de Ações de Saúde e Saneamento* (PIASS, Program for Health and Sanitation Service Coordination), had a significant benefit for Bahia as well as other Northeastern states, despite the lack of enthusiasm of uncommitted state-level political leaders. The equity-enhancing effect of these pilot projects is hard to measure, but the result was positive for the development of the PACS and PSF programs nationwide (Borges Sugiyama 2012; McGuire 2010).

From the 1970s on the state was controlled by the Magalhães family in what was known nationally as *carlismo* (after Antônio Carlos Magalhães or “ACM”), a classic example of the regional family oligarchies that have historically dominated many Northeastern states. There were no left governments until the PT took office under the popular and influential Jacques Wagner in 2007. I compare Bahia at the state level with Ceará, which has had nearly uninterrupted left party rule since the democratic transition but is otherwise a similarly poor and unequal Northeastern state. I profile the city of Salvador and briefly contrast it with smaller municipalities that have had better outcomes under decentralization to tease out the role of commitment and capacity at all three levels.

The state of Bahia is a case that could have begun to do much more with its

devolved health responsibilities, much sooner, if committed governors had taken office earlier. The city of Salvador, on the other hand, is arguably a case where more centralized health policy authority would have produced better outcomes. The decentralization lauded by the sanitarias and built into the constitution did few favors for the state and its largest city and the results are visible in comparative analysis. Yet the social programs designed by committed actors at the center and the health reforms slowly implemented over time were meant to bypass uncommitted actors at the state level (if not the local level) and these have been overwhelmingly successful at improving outcomes in the worst-off parts of Brazil, despite lack of commitment and capacity in the state and many municipalities.

5.7.2 The State of Bahia

The Northeast of Brazil is the region where the slave trade was most intensely concentrated, where large *terratenedes* dominated society, and economic and racial oppression were most intense. By the 1940s Salvador had become a miserable urban slum with food shortages and public health crises caused by the explosion of immigrants from the countryside. In the interior, large landholdings had continuously expanded and rural peasants could not longer survive with sharecropping and subsistence agriculture¹³. There was no public infrastructure and the federal government had exploited land for cacao production that had little benefit for the economic development of the state in the immediate post-WWII period (Dias Tavares 2001).

The trajectory of the state before democracy was dominated by structural factors—its place in the central economy and relative lack of political clout compared to the major economic and industrial centers farther south. As in much of Brazil, instability

¹³In fact, this process was in large part responsible for the explosive growth of the favelas in major urban centers farther south, which are often populated with immigrants from the Northeast who left in search of better opportunity (Marques and Torres 2005).

and political violence hampered modest reform efforts. After the first phase of political opening in 1946, reformists in state government implemented intensive projects of school construction during the post-war period, staffed with professionally trained instructors for the first time. As coffee prices increased and oil was discovered in the state, fiscal capacity increased. Yet political repression was intense and incipient protests were put down with violent force.

Parties on the right dominated the state and competed primarily with each other. Clientelism and corruption in Northeastern politics have been well-documented¹⁴ and were the norm until economic development and political reform at the center began to make such political structures more costly. The last directly elected governor of Bahia was the conservative Lomanto Júnior who, while not one of the plotters against Goulart, successfully negotiated to maintain his seat after the coup in 1964 (Dias Tavares 2001: 477). The indirectly elected Luís Viana Filho continued modest efforts at economic development in the region, focused on the expansion of education in particular, but when AI-5 was implemented and the most conservative sectors of the military took over, his education team was forced to resign (Dias Tavares 2001: 488). These patterns illustrate how authoritarianism prevented even moderate equity-enhancing social reforms, an important part of why democracy has mattered for equity in countries with right wing authoritarian histories.

In 1971 ACM was indirectly elected to succeed Viana Filho and the “ACM” dynasty began. When political parties were legalized in 1979, the *Partido Democrático Social* (PDS, Social Democratic Party, which was not a social democratic party) became the successor party of ARENA and the Bahian governor joined the new (old)

¹⁴Abranches 1978; Malloy 1977; Desposato 2001; Erickson 1977; Chilcote 1990; Lyne 2008; Geddes and Ribeiro Neto 1992; Hagopian 1996; Tandler and Freedheim 1994; Meneguello 1994; Stepan 2001; Fleischer 1996 among many others.

party. Direct elections for the governor were held during ACM's second tour as governor in 1982. For the second time in recent history, a Bahian candidate for governor perished in a plane crash just before the elections. In this case, ACM's chosen successor died and had to be replaced. In 1985 the PDS split over the chosen candidate for the national election against the increasingly popular PMDB and ACM helped to form the PFL, which would remain the dominant force on the right—and in the Northeast—for another generation. It was not until after Lula's second term and the success of targeted anti-poverty measures that conservative electoral dominance at the state level in Bahia was broken.

One of the most interesting dimensions of health policy reform in the Brazilian Northeast is that the strength of private sector veto actors has been limited compared to cases such as São Paulo and all regional governments in Spain. Capacity and commitment has been weak, but the population has been so overwhelmingly poor that substantive markets for private health service provision and insurance never developed. But just as the main veto actors were based in the wealthiest and most developed parts of the country, so were the primary reform movements. Deep poverty ultimately makes civic participation a challenge and the entrenched power relations that grew out of systems of labor-repressive agriculture in the countryside left the Northeast in a weak position from the perspective of civil society mobilization, as well as for the emergence of strong left parties. Yet in the case of Bahia, when reformers eventually came to power they faced less mobilized opposition to health reform than in wealthier states—an unanticipated side effect of near total poverty.

Because the 1988 constitution and subsequent elaboration of the SUS generated both decentralized authority over health policy and new national criteria and programs, we see two possible avenues for equity-enhancing health reform after 1988—local innovation and/or implementation of central policies. Bahia is a case of null

reform for many years, where decentralization allowed state government to do little and the long lag before attempts at increased accountability and oversight from the center meant the guarantees of the SUS were extended even more slowly in Bahia than elsewhere. Still, serious public health problems that limited economic development even for those uncommitted to equity made the Northeast a natural opportunity for testing inexpensive innovations in care focused on prevention, and Bahia participated in several modest federal pilot programs.

The PIASS, which had been piloted in the Northeast in the late 1970s and formed the basis of experience for the PACS and later PSF, was (by design) only implemented in small municipalities with fewer than 20,000 inhabitants (Art 1, Decreto 78307). In fact, the majority of Brazilian municipalities have fewer than 20,000 people. And while the importance of the PIASS as a precursor to later program innovations is clear, its immediate impact was fairly limited. The PIASS was implemented in Bahia in 1977 and expanded quickly, as it did in other states. The internal critiques of the program at the national level, recounted by McGuire (2010), were echoed in Bahia by state administrators (Almeida Formigli 1981).

Conservative ideological opposition to public provision of care alongside economic crisis shut the program down before administrators could tackle the problems they were observing (McGuire 2010: 166). One of the most significant achievements of the PIASS in Bahia was an unintended consequence—it brought to light organizational challenges that would represent roadblocks to public primary care provision and required administrative reforms in the State Health Secretariat, which over time increased capacity¹⁵.

In the late 1980s innovation in inexpensive community based health programs was taking place next door, championed by the committed state government of Ceará,

¹⁵See Almeida Formigli 1981 for a discussion of the administrative reforms within the state health secretariat under PIASS.

and the sanitaria movement was commanding attention in the press and across the country. Yet at the state level in Bahia, under ACM and later his chosen successor, there was no comparable innovation or expansion¹⁶. Infant mortality continued to decline, albeit more slowly than during the 1970s. Real state GDP per capita began its long descent in the mid-1980s, with no recovery in sight.

In 1986 Waldir Pires of the PMDB united forces of the left and opponents of *carlismo* and won the governorship with a broad majority. The opportunity had finally presented itself for a break with the traditional conservative leadership of the region. Yet, as in so many other cases, the possibilities for reform were cut short because Pires chose to leave office after only two years in order to contest the national vice presidency on the PMDB ticket. ACM won the governorship in 1991 for the third time and politics as usual continued. Having been in the federal cabinet for five years with Sarney, then an ally of Collor and supporter of the coalition with Cardoso, with his son the President of the Congress in the mid-1990s, the traditional leadership of the state had gained significant national influence.

Weak fiscal capacity during the 1990s was combined with persistent low levels of administrative capacity and very low commitment to either redistribution more generally or to an equitable and accessible public health system. The result was that the early experiments in primary health provision were supported by the national Ministry of Health and international aid organizations in some municipalities, but without much support from the state of Bahia. In 1993 the INAMPS contracts with private providers were shifted to the national Ministry of Health, where they stayed for a full decade, while in many other states these contracts were taken over directly. State leaders did not request the management of the health infrastructure until 2003 because health policy was not seen as a priority (de Souza 2011). Still, the expansion

¹⁶Jorge Augusto Novis was state Secretary of Health from 1979-1983 and appears to have been supportive of health reforms, but little movement took place in Bahia at this time.

of PSF in rural Bahian municipalities produced a significant drop in infant mortality and other basic health indicators across the state.

Yet the coverage rate of the PSF in Bahia has remained the lowest in the region, largely because uncommitted executives in the capital city have chosen not to implement the program and its coverage has never been more than 20 per cent of the population there. The PSF in general appears to have been more successful in smaller municipalities than in larger ones. However, 70 per cent of doctors are based in the capital city, leaving rural areas and small towns underserved (de Brito 2011). This mismatch of commitment with capacity is one of the most significant problems for the extension of equity enhancing health reform in Brazil. Many small municipalities are interested in expanding primary care, but lack resources to support the necessary investments. The capital cities where population is concentrated have lacked the commitment, and sometimes also the resources, for reform.

During the Cardoso years at the center, Bahia remained under the control of a string of PFL governors affiliated with ACM, who continued to personally name the PFL candidates for state and federal elections into the 2000s¹⁷. While in theory health care offers significant opportunities for patronage politics (Hunter 2009; Borges Sugiyama 2007), the possibilities depend on the structure of policy. States have a lower profile in the SUS than municipalities do, so the incentives for uncommitted Bahian actors to take on greater responsibility for health policy at the state level were slim during these years.

From 1998 to 2006 PSF coverage expanded with oversight and funding moving mostly from the center directly to municipalities administering the program. In 1999 municipal coverage for the PACS (often considered a gateway program to PSF for low-capacity municipalities) tended to be either zero or almost complete. If municipalities

¹⁷*Folha de São Paulo* 4/1/2002 “ACM escolhe candidatos do PFL ao Senado e ao governo da BA.”

did the program, they generally fully implemented it. This is in part because federal funds are more generous the higher the coverage rates, and for implementation there is little sense to only going partway as the administrative costs are similar.

Yet while PSF had been moving at the federal level for several years, in 1999 only four Bahian municipalities had any coverage at all (DABSUS 2013). In 2002 over half of Bahian municipalities still had no PSF coverage, while half of those with some coverage had less than 50 per cent. While Cardoso had done more to expand primary care programs than the neoliberal leadership before them, they had not dedicated the fiscal or organizational resources necessary for more significant implementation. In addition, the resources required from municipalities were substantial, so uptake required a fairly high level of commitment by municipal leaders.

From 1994-2002, the SUS began to be implemented in earnest. Alongside primary care funded through the central government, states and municipalities were being trained—more or less capably—to take on responsibilities in health provision and oversight. In theory, Brazilians had the right to all aspects of health care, free at the point of delivery and guaranteed by the 1988 Constitution. In Bahia, contracts with private providers for care proliferated because capacity levels were too low for the state or most municipalities to run hospitals, ambulatory care centers, or in some cases even manage payrolls.

One side effect of this *terceirização* (contracting out) has been that poor patients sometimes had access to state of the art facilities when the public sector subcontracts with providers who also offer private services. Yet private clinics and hospitals that provided services for SUS clients in Bahia for many years kept separate lobbies and entrances for their public patients, segregating them from private clients, and would provide the precise service contracted but fight demands for standard follow-up and post-operative care (Benigno 2011). Battles for equal rights for SUS clients only

began to shift toward equity at the start of the 2000s and after many years of effort. These victories are not at all consolidated, pointing to another major cost of only partially implementing universal reform in the presence of strong private actors¹⁸.

While the shift toward per capita transfers has been an improvement over ad hoc and politically determined financing in the past, the inequalities in capacity between poor and rich states and municipalities are so gross that failure to direct spending according to actual need is major drawback. In Bahia, 89 per cent of the population relies on the SUS for health care, while in wealthier states like Santa Catarina in the South the numbers are closer to 60 per cent (Benigno 2011), so demand in the public sector is far higher, yet financing is not determined with these criteria in mind.

When Lula took office on January 1st 2003, he had carried the state of Bahia along with most other states. In just three years, over 90 per cent of municipalities had some PSF coverage and the overwhelming majority of these had full PACS coverage. Of the 40 municipalities with no PSF, none were governed by left or center-left parties. The situation of Bahia in terms of health policy shifted swiftly with the election of Jacques Wagner in 2006. Not only was Wagner the first governor on the left in Bahia, he was a high powered member of Lula's inner circle and founding member of the PT. His electoral coalition was broad, which was not entirely popular among his supporters as his vice-president came from the PMDB—a traditional political enemy in the state. The Wagner government began to make substantial investments in administrative capacity, increasing health spending substantially and negotiating increased funding from the center (Benigno 2011).

¹⁸In 2013, the head of an intensive care ward and several other health workers at an indebted hospital in Curitiba were arrested on charges of withholding medical treatment and discharging untreated SUS patients in order free up beds for paying private clients—in at least one case leading to the death of the patient (*Folha de São Paulo*, 2/12/2013 “Justiça do PR decreta prisão de 4 após morte de pacientes em UTI”).

Although there is ideological disagreement among politicians regarding the management of the SUS, there is little organized opposition to the existing model (and a great deal of lip-service paid to it) because open political opposition to the PT project has disintegrated. Though the Wagner government in Bahia has formed alliances, health officials still see the PT as more committed at both at the state and national level (de Brito 2011). From 2007-2011 health spending in Bahia doubled, five new state hospitals were built, the state health secretariat is now staffed by a professional technical corp rather than by “políticos,” and spending by the executive and legislative branches is tracked online and available to the public—a major innovation in transparency implemented from the central government under the PT.

One third of the state’s resources for health care come from the *Fundo Nacional de Saúde* (National Health Fund at the Ministry of Health) and two thirds come from the state budget, funded by the sales tax and vehicle tax (dos Reis 2011). All Bahian municipalities are responsible for primary health services and 62 of the 417 have negotiated responsibilities for medium and high complexity services like hospitals, up from 32 in 2006 (Benigno 2011). The state provides medium and high complexity health services for all municipalities that do not have *gestão plena*.

At the Universidade Federal da Bahia (Federal University of Bahia, UFBA), which historically had a conservative orientation, the reform of the medical school curriculum (passed by Lula at the national level at the start of his first term) did not begin until 2004. Professor Lorene Pinto, who later became the first woman President of the UFBA medical school, was in charge of compiling the results of the participatory process that generated suggestions from the academic community and the public for the new curriculum. The eventual changes, fully implemented beginning in 2011 after difficult internal struggles with ideologically opposed factions, included refocusing the curriculum towards primary care rather than specialized care, producing more general

practitioners, and getting medical students out into the communities that they would eventually be serving (Pinto 2011).

In Bahia, hospital administration and financing is highly decentralized to individual hospitals (dos Reis 2011), so the orientation of doctors and those with training as health officials and administrators has the capacity to influence institutional design as well as the care received by patients. In addition, because getting doctors to work in poor areas has been such an overarching problem for the extension of the SUS and the primary care reform, beginning to train and socialize providers with an orientation toward the goals of equity and access is crucial.

In Bahia, the private medical sector is weaker than in states like São Paulo because of lower levels of economic development and historically weak demand for private health services. There is less organized opposition to the SUS in Bahia, for instance, because in most municipalities the SUS is the only game in town, so regardless of political ideology the mayors support public provision, as it allows them to take credit for new facilities and expanded services. In addition, for private hospitals and clinics, the SUS is often their biggest—and sometimes only—client, so opposing the SUS is not in their best interest.

Yet major challenges persist as municipalities demand rapid decentralization in order to take credit for building new facilities and clinics, when often the local administrations have no administrative capacity at all. Many still have no separate health secretariat with a separate budget independent from the executive and no experience managing payrolls. Whereas in São Paulo decentralization to municipalities occurred nearly all at once, regardless of their level of preparation, in Bahia committed actors in the state government require that municipalities show basic institutional capacity by participating in trainings, separating their health budget, and implementing concrete preparatory measures.

This difference between the two states is an important example both of the relevance of the Brazilian states in equity-enhancing health policy reform and the ways that decentralization without capacity is seen as a problem for committed actors and ignored by others. Capacity has increased some at the state level and is trickling down to the local level as many municipalities take advantage of the health management trainings and other services offered by the state health secretariat.

5.7.3 Ceará: the Outlier

As a state-level comparison in the Northeast, let us consider the case of Ceará, which is located to the north of Bahia, on the coast. The state has been defined by intense droughts and had poverty rates even higher than those in Bahia at the start of the period—over 70 per cent. The white population of the state is 33 per cent—higher than Bahia, but this latter has the smallest white population in the country.

Unlike some other Northeastern states with very few municipalities, Ceará has 184, which improves its comparability with Bahia in terms of logistical challenges faced by state governments in mobilizing reforms across the territory. The city of Fortaleza is large with a relatively high level of economic development and a history of innovation in primary care. The first PT mayor of a capital city, as well as the first woman, was Maria Luíza Fontanele in Fortaleza in 1986.

Improvements in income inequality have not been dramatic, but the drop has been more significant in Ceará than Bahia despite higher levels of poverty and lower income levels historically. In 1985 when real GDP per capita in Bahia was 86 per cent of the national average, in Ceará it was barely half. Albeit with some fluctuation, Ceará has basically maintained this relative position over the course of the past 25 years, with real GDP per capita growing from 2,490 reais to 3,710 in line with the growth experienced in the rest of the country. But the most astounding difference has been in the infant mortality rate, which began the period much higher than in

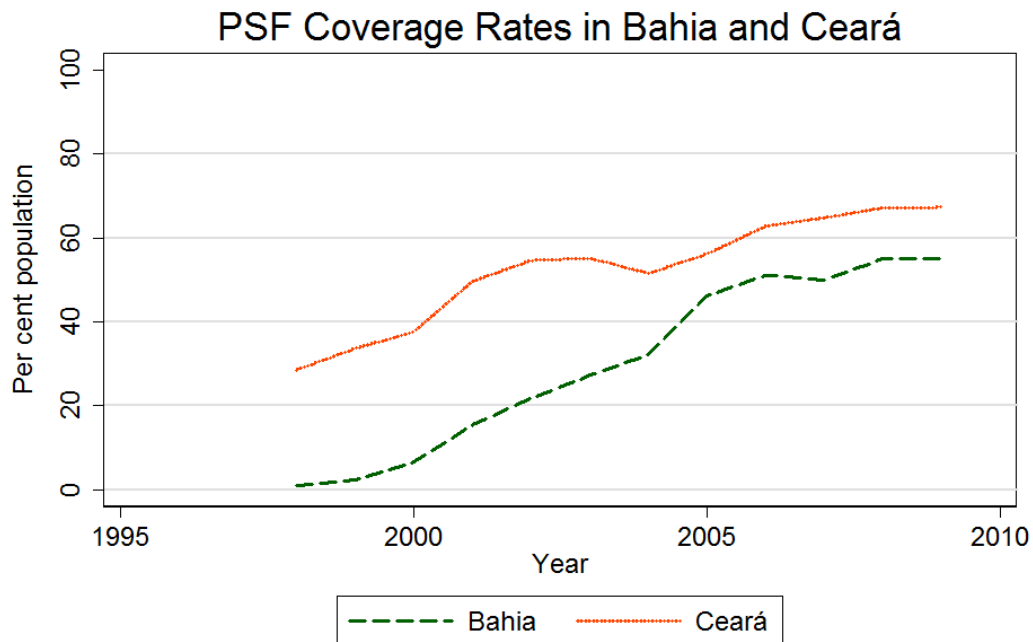
Bahia yet in 1997 was only two thirds that of the latter state.

Why has a poorer state facing similar constraints performed so much better on health outcome indicators? The primary explanation is the presence of high commitment in the state and its capital city, which enabled Ceará's early innovation in primary care provision. The pioneering community health outreach program at the state level became a model for other states in the early 1990s, and for the federal government. Fortaleza was also an early primary care reformer under Fontanele. While Ceará has had its share of oligarchic rule, in 1987 the state elected a "good government" reformer from the PMDB, who left the party for the PSDB when it formed. Tasso Jereissati governed from 1987-1991 and again from 1995-2002. Left parties have traditionally been weak in the Northeast and as a centrist catch-all party in the mid-1990s, the PSDB was home to a number of progressive reformers. Coverage rates for the PSF were much higher in 1998 than Bahia and were still 10 points higher in 2010, with the early higher rates explained by the folding in of the local primary care system into the national model.

What had Ceará done differently? In 1987 the state government under Jereissati implemented an emergency employment program designed to provide work during an intense drought. It was called the *Programa de Agentes de Saúde* (PAS) and sent thousands of women with low skill and education levels into homes around the state to do basic health education on dehydration and breastfeeding, vaccinate children, and collect health information. The case won international awards and was brought to light among international academics through Judith Tendler's work on the reforms (1997). The state was committed and chose women from the communities to do the work. The project succeeded in large part because of its community-based nature and the ideological orientation of the workers and the state toward achieving goals of health outcome improvement among the poor.

Ceará innovated in other areas in addition to health and the policy, economic, and health outcomes over the course of the period show the results. Figure 5.5 shows PSF coverage rates in the two states from 1998-2010. Lack of commitment in Bahia meant this innovation was not picked up, though it was happening right next door. This is one of the most relevant findings of Borges Sugiyama’s work on policy diffusion (2007; 2012). Commitment is required for innovation or uptake. With no national incentives in place and high levels of decentralization, the ball was in the states’ court. With no interest in equity, the ACM dynasty in Bahia was uninterested in health reform. Differences in the economies of the two states meant the pressure for reform was lower in Bahia. Policies did not trickle through until the central government began to prioritize the PACS and PSF at the national level. Only with the federal PT victory in 2002 did major expansion take place in Bahia.

Figure 5.5: PSF in Bahia and Ceará: 1998-2010



Source: IPEA

This may be the starkest example of the role of commitment, when results can be so different between two states with similar structural constraints and no capacity to speak of. It also suggests that Bahia's current leaders are on the right track in considering that the only way to meet their state's health need is to begin training doctors from small rural communities and then sending them back. The lack of providers in these areas has been one of the most significant limits on health service expansion in the state. The experience of Ceará suggests that providers who come from needy communities are likely to be the most committed to helping them advance.

5.7.4 Capital City: Salvador da Bahia

At the municipal level in Brazil, mayors are the primary political figures for determining local policy. In Bahia, *carlismo* was strong in the capital, as well as at the state level. The city of Salvador is a clear case of the potential negative consequences of decentralized social policy in a system with low vertical accountability. Salvador has among the highest levels of health inequality in Brazil (Benigno 2011) and has never had more than 20 per cent of its population covered by the PSF. Infant mortality has kept pace with the state average largely because hospital and emergency services, limited as they are, are far more accessible in the city than in the interior. In 2002, a sample of public clinics in Salvador (only taken from those participating in the *Programa de Humanização no Pré-natal e Nascimento*, PHPN a federal program to humanize prenatal care and birth experiences) showed only 14.2 per cent of pregnant women receiving basic prenatal care. Of these, a much smaller number were receiving recommended vaccinations and preventive treatment (Nascimento, et al 2007).

The chronic shortage of basic care services means gate-keeping has essentially not taken place and hospitals are overrun with patients who have nowhere else to go. In theory, small municipalities should contract with larger municipalities for services they do not have the scale to provide. However, there has traditionally been no

enforcement or oversight of this process and no costs to municipalities who free ride on large municipalities with many hospitals and specialized care facilities. Salvador's poorly funded and inadequate hospitals therefore serve an overwhelming number of patients who do not actually need expensive curative services, as well as residents from smaller towns that make use of large urban facilities for which Salvador has not managed to gain compensation.

Rather than directly providing or managing municipal hospitals and clinics, Salvador subcontracts almost all of these services with private providers. When these private hospitals get more users than they have been paid for (those from outlying municipalities and those seeking primary care), or simply are not paid for several months, they shut their doors and leave people on the street. The city blames the federal government for not transferring adequate funds and the federal government reminds the city that it is responsible for its own contracts and for ensuring that services it provides to neighboring municipalities are properly arranged. The three-way responsibilities for health policy allow different levels to scapegoat each other to the public, who do not understand the complex distribution of policy responsibilities.

Race continues to be a major social division in Salvador, as it is throughout Brazil and particularly in the Northeast. In 2010, only 20 per cent of whites lived in poverty, while 37 per cent of people of color lived in poverty. Yet the relative status of people of color in the city has improved somewhat since 1991, when the poverty rate among whites was 32 and for people of color 69 per cent (DABSUS 2013).

Except for the one-term government of progressive centrist Lídice de Mata, the city of Salvador has never had a left government. De Mata was a member of the opposition PMDB in the early stages of democratic opening and was mayor of Salvador for the PSDB from 1993-1996, before joining the socialist party in 1997 as the PSDB consolidated its rightward shift. De Mata implemented the *Bolsa Escola* program

when it was first being developed in Campinas and Brasília (Borges Sugiyama 2007), in a narrow opportunity for equity-enhancing reform. Yet she did not have time to institutionalize the program and it was discontinued by the next government.

The mayor of Salvador from 1997-2004 was Antônio Imbassahy from ACM's group within the PFL. Health officials from his administration did not perceive him to be committed to social programs and recounted both his skepticism of the PSF and observed that they had been encouraged to institute PSF teams in certain neighborhoods based on political criteria (Borges Sugiyama 2007: 149).

The mayor from 2005-2013 was João Henrique Carneiro, who changed parties twice during this time, switching from the PDT to the PMDB in 2007 and to the PP in 2011. Beginning with problems in his electoral campaign, Carneiro's administrations were fraught with mismanagement and the city's finances were in constant disarray¹⁹. This period exemplifies the effects of low capacity combined with low commitment, so pressing social needs continued to go unaddressed.

Salvador was one of the last state capitals to apply for *gestão plena* in 2005 during the ambitious tenure of municipal health secretary Luis Eugenio de Souza. After watching health policy ignored for years by the state and municipal governments, de Souza felt the best possibilities for improvement in the city lay with taking matters into their own hands (de Souza 2011), despite the problems of historically low capacity and commitment in city government.

De Souza's team faced what turned out to be an insurmountable barrier to the transformation of the health system in Salvador—lack of administrative capacity and lack of commitment by the municipal executive. There was no history of filling the municipal secretariat with health professionals, which was a challenge for the state and

¹⁹A limited set of examples include being cut off by Petrobras in 2005 for not paying municipal bills (*Folha de São Paulo* 12/1/2005), a state of emergency declared by Carneiro in the health sector in 2008 (*Folha de São Paulo* 05/29/2008), and a 2 million reais fine in 2009 for illegal logging in the Mata Atlântica (*Folha de São Paulo* 08/16/2009).

city because of the existence of only two medical schools to train public health officials (Pinto 2011). De Souza tried to enforce regulations, expand the technical corp working at the secretariat, and improve the salaries of functionaries to attract more qualified personnel²⁰. But the private health sector in Salvador had existed on patronage and clientelism during *carlismo* and resisted enhanced efforts at oversight. Despite central government reforms under Lula that generated resources for improving local capacity, the Salvador health secretariat faced what turned out to be insurmountable obstacles to reform. The small number of committed public servants in the health department were overwhelmed by low morale and lack of support from the municipal executive (de Souza 2011).

Salvador represents a case of almost complete lack of both commitment and capacity at the municipal level. Without commitment by the mayor, committed appointees in health and the bureaucratic corp could make little headway. While the committed actors who negotiated full health responsibilities for the city in 2005 had the best of intentions, this independence now means the state government cannot directly provide any of the needed services in the city. Regardless, because primary care has been in the hands of the municipalities since the early 1990s, the area most in need of reform has long been beyond the reach of state-level actors committed to improving access and quality in Salvador. On January 1, 2013 the next mayor took office, yet the possibilities for reform are slim. The new mayor of Salvador is none other than Antnio Carlos Magalhães Neto—quite literally named—the grandson of ACM.

²⁰Despite the reputation in the welfare states literature of Latin American public servants as an elite group that often fights redistributive cuts to public pensions, in poor or small municipalities the ability to hire capable public servants, particularly with federal limits on personnel spending, is a major obstacle to managing public services. Poor municipalities have poor governments and the retention of qualified personnel is a serious challenge to developing and maintaining administrative capacity. Paraphrasing one Bahian state health official, “you can’t have a mayor who makes nothing and then incentivize doctors to come to your municipality by offering them salaries three times as high as the mayor. That is unsustainable” (Benigno 2011).

5.7.5 Municipal Reform in the Interior

Yet Salvador is not all there is to Bahia, and three quarters of the population live in other municipalities. The only reason that Bahia's average coverage rates for the PACS and PSF are so low is the downward pull of the capital city. In the other 416 municipalities reform has been more significant and the improved outcomes in health are most reflected in these municipal experiences. The PDS (later to split and create the PFL) was almost completely dominant in the municipal elections of 1982 in Bahia, with the PMDB taking a small portion of *prefeituras* (mayorships) and other parties virtually unrepresented.

By 1996 there were still very few parties of the left in any municipal governments in Bahia, but the number of parties had proliferated. The PT was uncommon, but there were a few municipalities governed by the PDT and PSB and several by the PSDB. Parties of the left remain weak in the Bahian municipalities, though the tidal wave of support for the PT nationally has significantly increased the number of PT mayors—with 66 out of 417 in 2008 (and the PSB and other minor parties taking another few dozen). Yet while evidence from particular cases suggests that the PT tends to be particularly programmatic and focused on good government and equity-enhancing reforms in municipal government, at this late stage in the game and given the federal incentives in place, we should not necessarily expect PSF coverage to be tied to partisanship at the local level. Ideology may have played a role in preventing early adoption—with the last Bahian municipalities with no PSF coverage at all being exclusively governed by the right—but as a national strategy, 20 years out, uptake at some level is now almost universal.

One would expect that it might take a few years before primary care implementation could be consolidated and begin to produce results. Of the 37 municipalities in Bahia that in 2011 still had infant mortality rates over 30 (when the state average

was 16.25), only seven of these had any PSF coverage in 2002—eight years after the federal government began subsidizing and promoting the program. And we should remember that by 2002, nearly half the municipal governments in Bahia were implementing the PSF, so 7 out of 37 makes this an outlying group even at the time. Of the top performers on infant mortality, PSF coverage is less uniform because of the importance of income levels and economic development in determining infant mortality. The take home message, then, is that even if municipalities began the period with high levels of infant mortality, if they implemented PACS and PSF early on, they rarely ended up among the worst performers, down the line.

5.7.6 Bahia and the Northeast: Conclusion

With low capacity and low commitment, the case studies of Bahia and Salvador paint a picture of an overdetermined failure for equity-enhancing health reform. The Northeast region overall has been the backbone of clientelistic and oligarchic rule and the legacy of slavery and racial oppression has remained largely unchallenged. While life chances improved with economic development, urban conditions worsened as rural elites concentrated their landholdings mid-century and left increasing numbers of homeless peasants to migrate toward the cities. This trend in land concentration has also fed into the growth of urban slums in the rest of Brazil's large cities, contributing to some of the most significant problems of security and poverty in the world.

Yet Bahia's most recent history, as well as the experience of its neighbor, Ceará, suggest that such an assumption of impotence in the face of overwhelming structural constraints is a mistake. As soon as ideologically committed actors gained power in the state of Bahia, they doubled health investment and provided crucial new infrastructure. They began actively training municipal leaders, organizing new health regions and microregions to facilitate municipal coordination, and required that municipalities create the basic infrastructure to competently manage health care before

devolving greater responsibilities and resources.

In Ceará and its capital, Fortaleza, committed actors came to power early and funded the widespread adoption of a progressive and community-based primary care model that won awards and inspired the central government. The case of Ceará proves that states with minimal capacity can still find creative ways to meet the needs of their population as long as leaders are committed. It also shows the stark lack of commitment in Bahia, where infant mortality and maternal death were shockingly high and leaders chose not to adopt a cheap, effective model that was saving the lives of thousands of babies and mothers just next door. These are the cases that most clearly illustrate the protagonism of commitment, which, if present, can make up for even the lowest levels of capacity.

5.8 Multilevel Health Reform in the State of São Paulo

The state of São Paulo is in the Southeast region and has the highest per capita income in the country after Brasília, the Distrito Federal. São Paulo is a case of high capacity and an intermediate level of commitment. It is a useful case here because it illustrates the way that outcomes are driven both by wealth and by policy, and the difference between the policy choices of actors with a primary focus on equity and those without. São Paulo also illuminates one of the overarching challenges for Brazil (and many other places)—that good governance and high capacity are often concentrated in the places that, in relative terms, need them the least. The state is one of several Southeastern and Southern (mostly white) states where income inequality has decreased significantly over the period and average incomes have grown far beyond the national average, despite inequality being lower and incomes higher to begin with.

I profile the capital city of São Paulo and compare it briefly to other municipalities in the larger metropolitan area that have produced innovative equity-enhancing health policy in the presence of higher levels of commitment, while sharing São Paulo's

high levels of capacity. I also contrast the state with Minas Gerais, another Southeastern state that has varied with São Paulo on levels of economic development and commitment.

5.8.1 Overview

São Paulo is the most populous state in Brazil with over 41 million people in 2012. Despite also being the largest in terms of number of municipalities (with 645), nearly half the population of the state resides in the metropolitan area of São Paulo City. The state was the primary area of Portuguese settlement and later Italian immigration. It is the economic motor of the country, producing a third of the national GDP.

Lacking the legacy of slavery that has haunted the Northeast, São Paulo state partly sidesteps Brazil's most significant source of social stratification and inequality—though immigration by the Northeastern poor to the favelas has been an important source of inequality. The state is the whitest in the Southeast at 68 per cent, lower only than the states of the South, where the populations are almost exclusively descended from European immigrants. The city of São Paulo is significantly more diverse, with large international communities and religious minorities. Yet the descendants of black slaves are highly segregated and tend to be extremely poor, populating the favelas but thoroughly invisible in the posh neighborhoods of the city center.

Infant mortality in São Paulo, as in most of Brazil, has fallen steadily since the 1970s. Yet overall levels have been far lower than in most of the rest of the country. In 1980 rates were in the mid-1960s and had dropped to 11.6 by 2011. Like Bahia in the Northeast, São Paulo has the lowest infant mortality rates in its region and also like Bahia, rates have dropped by nearly half since 1997.

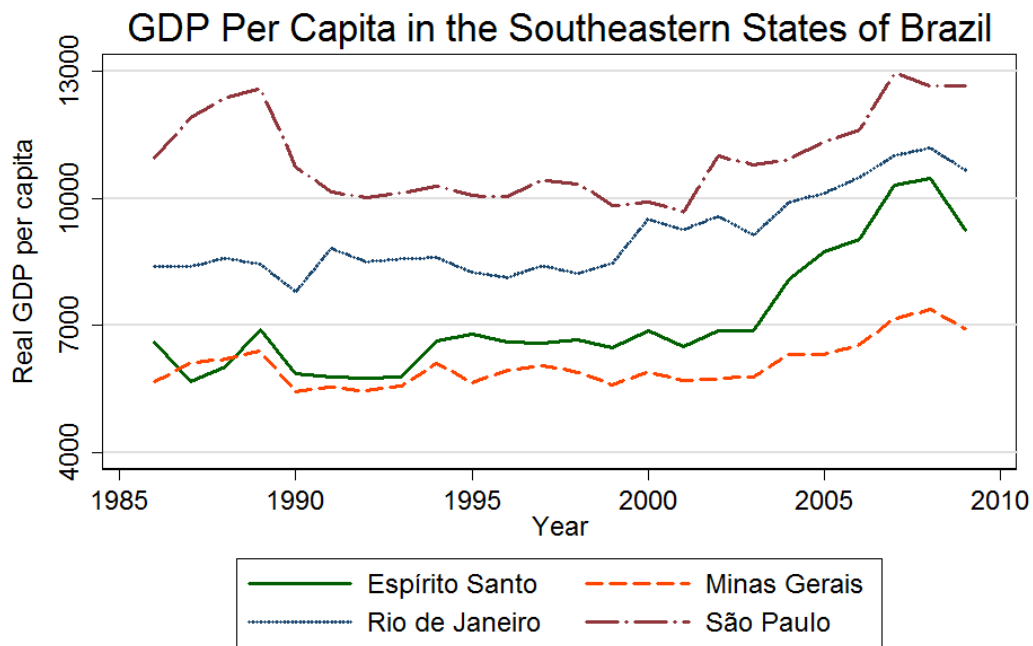
Poverty is much lower than most of Brazil yet has still decreased from 18 per cent in 1981 to 11 per cent in 2009. Poverty rates are lower in São Paulo than the other three states in the Southeast region, though by 2011 not by much, despite starting out

lower. The other three states (Rio de Janeiro, Minas Gerais, and Espírito Santo) had over 30 per cent poverty in 1981 and were all within a point or two of São Paulo by 2011. Poverty among people of color decreased from 52 to 26 per cent between 1991 and 2010, while for whites the decrease was from 36.53 to 15.5 (DATASUS 2013). The drop has therefore been larger for whites in relative terms. Still, the gains overall have been impressive and the absolute racial poverty gap has narrowed.

This state represents one of the few cases where substantive gains in income inequality have been made in recent years, with income inequality in 1981 at .513 and reaching its highest point in 1989 at .557. Inequality barely shifted for 15 years but begins a marked descent in 2003, reaching .489 in 2009. From 1985, real (inflation adjusted) GDP per capita in São Paulo state stagnated and decreased before beginning to increase again in the 2000s. Per capita GDP was 10,760 reais in 1985—2.2 times the national average—and 12,650 in 2009—now just 1.8 times the national average. Rio de Janeiro is quite close to São Paulo in terms of per capita GDP, while Espírito Santo is somewhat lower and Minas Gerais is closer to the national average. Figure 5.6 shows the trajectory of the Southeastern states.

Revenue as a portion of GDP—our quantitative indicator of capacity—is lower in São Paulo than in almost any other state, though *en par* with other wealthy areas. While states certainly have some latitude for increasing their tax revenue, the taxes controlled by the states are fairly regressive, while the direct taxes (and the failure to adequately collect them) are primarily the problem of the central government. Because a large portion of the transfers to the states are made on a redistributive basis favoring poor states, it is not surprising that revenue might be lower in relative terms in São Paulo, particularly given the enormity of its GDP. Over time, revenue/GDP has increased from 7 per cent in 1985 to 10.5 per cent in 2009. Figure 5.7 shows the

Figure 5.6: GDP per Capita in São Paulo and the Southeast: 1985-2009



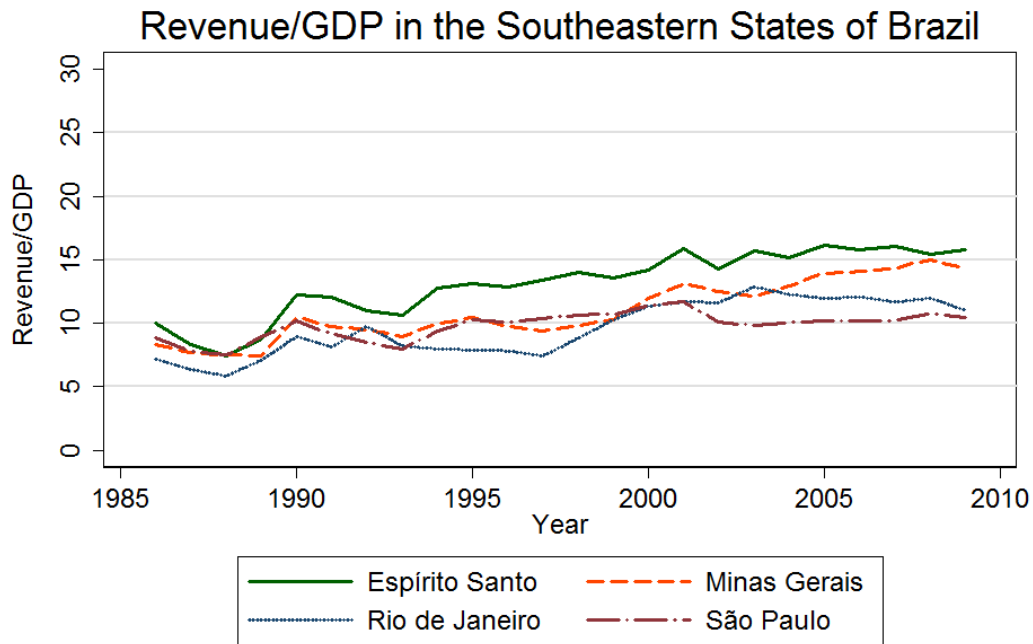
Source: IPEA

trajectory of the Southeastern states.

The state of São Paulo has received little international aid or involvement in issues of public health, though the favelas in the capital city have received some significant attention. As an important state for industry and finance, politics in the state are tightly tied to national politics and party leaders often come from or base themselves in São Paulo. The state government was in the hands of the PMDB until 1994 and then shifted to the PSDB, where it has remained. Therefore, state government has tended to be centrist rather than left or right and policy results have generally illustrated this ambiguity.

Yet in keeping with the broader theory, the lack of actively committed government has left its mark in a number of ways, since the pressure of private sector interests in the state have been very strong indeed. The sanitaria movement has been strong

Figure 5.7: Revenue/GDP in São Paulo and the Southeast: 1985-2009



Source: IPEA

in the Southeast in general and has maintained its influence in professional associations and academia in São Paulo state even after its influence waned at the national level. Some of the most innovative programs in equity-enhancing health reform have emerged from the “Grande ABC” area around the city of São Paulo.

5.8.2 The State of São Paulo

As a major commercial center from early in Brazilian colonial history, São Paulo has benefitted from economic booms generated in other regions. When gold was discovered in Minas Gerais, São Paulo reaped the benefits as trade moved through. The same was true with coffee and sugar cane in the interior of the state during the 18th century. Kubitschek’s industrialization efforts generated a major expansion in the auto industry, centered in São Paulo, which became one of the major hubs for union organization later.

Politics in the state of São Paulo are dominated by the city of São Paulo, despite having the most municipalities of any state. São Paulo has an industrial base and has experienced rapid economic growth in recent years. The state government has had a high level of administrative and fiscal capacity throughout this period. São Paulo state has never had a government of the left but has not faced the challenges of administrative and fiscal capacity that Bahia has. The lack of left government is reflected in São Paulo's status as the state where the most experimentation with private partnerships in health provision has taken place (Sano and Abrucio 2008). At the same time, combining central government commitment and progress in health policy development with a high level of state capacity has allowed access and quality to improve slowly over time.

From 1979 to 1982 the Governor of the state was the military approved ARENA member Paulo Maluf, a conservative politician whose combination of populism, corruption, and grand public works projects in São Paulo have earned him his own brand of politics—"malufismo." In the 1990s he would become mayor of the city of São Paulo for the second time, having first served during the 1960s. As in many Brazilian cases, the vice-governor took over from 1982-1983 while Maluf ran for a national congressional seat.

In 1983 the first directly elected governor took office, the reformist Franco Montoro who had been Minister of Labor and Social Security under Tancredo Neves in the early 1960s. While Montoro inherited an indebted administration after the grand projects of Maluf, he extended basic sanitation and running water to many parts of the state. The cabinet of the Montoro government included many of those who would later govern the state from the soon-to-be-formed PSDB.

From 1987-1991 the state was governed by Orestes Quércia, leader of the dominant conservative branch within the PMDB (Roma 2002). He was followed by Luiz

Antnio Fleury, also from the PMDB, from 1991-1995. During the PMDB governments, public works and infrastructure expansions were costly, but also facilitated economic development and transportation with the interior of the state. The state was at an intermediate level with the preparation of its municipalities for the newly transferred responsibilities of the SUS (Arretche 1998: 125).

In 1996 Mario Covas was elected and governed until his death in 2001. Covas, one of the founding members of the PSDB, instituted broad economically liberal reforms—cutting public sector employment and privatizing state owned enterprises. His public management reforms built state capacity, in the vein of those instituted at the national level. National reforms in 1995 permitted the privatization of basic sanitation, which was undertaken in several paulista municipalities, almost exclusively under PMDB or PSDB control (Araújo and Loureiro 1996).

In 2001 Covas' vice-governor Geraldo Alckmin, another founding member of the party, took his place and was re-elected in 2002. Conservative DEM (the new name of the PFL, see Table A.4) Cláudio Lembo briefly governed when Alckmin stepped down to run for president and was replaced by José Serra, former national Health Minister, in 2007. Like Alckmin, Serra stepped down to run for president in 2010 and was replaced by Alberto Goldman briefly before Alckmin was elected for a third term in office.

The state's overall approach to health policy has been driven by an economically liberal orientation prioritizing the private sector. However, when the mayor of the city of São Paulo refused federal funds for the PSF in order to continue with a market-based municipal basic health plan (PAS) in 1996, Minister of Health Jatene convinced the São Paulo state health secretariat to start PSF neighborhood health teams in outlying municipalities of the larger São Paulo metropolitan area (Capistrano 1999: 90; Borges Sugiyama 2007: 158). Because of concern that the PSF program

would have a stigma in rich regions as a poor service for the poor, the PSF in these municipalities of São Paulo was called “Qualis” rather than PSF. It has been deeply embedded in local civil society, as have most of the PSF programs that have been successful. Qualis has also been cheaper to run—63.60 reais per capita in 1999 versus the official 120 reais price tag of the PAS (Capistrano 1999: 96).

Still, the most important developments in health policy have been the use of the controversial private providers (technically, private non-profits), the *Organizações Sociais de Saúde* (OS, Health Care Social Organizations). The OS were articulated as part of the state reforms at the national level and conceptualized by Luiz Carlos Bresser Pereira with the goal of reducing costs and improving the quality of services by separating provision from financing and oversight (Bresser Pereira 2011)²¹. In the decade and a half since they were introduced, São Paulo state has been the most ambitious in experimenting with the use of OS in the health sector. In 2008 there were 16 in the state, while the next closest state had three and most had none (Sano and Abrucio 2008: 69).

Perceptions of outcomes under the OS are widely divergent because of the intense ideological debate that has surrounded their use (Arretche 2011). Sano and Abrucio find that the OS did not improve efficiency or the burden of bureaucracy as hoped (2008: 64), and that the citizen participation in oversight envisioned by Bresser Pereira never materialized, since the preferences of the *Conselhos* were ignored by state government (77). However, costs are certainly lower and a World Bank assessment suggests that there have been noticeable improvements in service delivery (2008). As we will see in the city of São Paulo, the use of the OS in the PSF

²¹The idea behind the OS, for Bresser Pereira, was that employment that could be done well by the private sector should not be done by public civil servants with sheltered contracts, while being paid high salaries financed by tax-payers. In contrast to the neoliberal view that many have of the OS, Bresser Pereira argues that they reduce elite antagonism toward the welfare state, giving the state more room to fulfill the social commitments of the constitution (2011).

has introduced new complexities into this debate.

As the Basque case in Spain clearly shows, it is possible to create new semi-public non-profit entities in the health sector without increasing inequalities in access and outcomes. Yet the experience likely depends a great deal on what the goals of reform were, and the economic interests of the private medical sector in São Paulo have been at the forefront of reforms in the state. As the Qualis example shows, it is clearly possible to make the national model of primary care provision work even in rich states.

In 2011 the state government, under Secretary of Health Giovanni Guido Cerri, decreed the implementation of a 2010 law (Lei 1131) that would allow public SUS hospitals run by OS to dedicate 25% of their beds to those with private insurance. While the Secretary argued it would be an opportunity to pilot attempts to charge private insurance companies at the door rather than trying to uncover their identity ex-poste²², few other political actors shared this perception. The Ministério Público do Estado (Public Ministry) took the state to court in the Tribunal de Justiça de São Paulo arguing that the move would generate a “dupla porta” or segregated service for those in the SUS and compromise the fundamental mission of the public hospitals. The CNS, the CES (*Conselho Estadual de Saúde*, state counterpart to the CNS), the *Conselho de Secretários Municipais de Saúde do Estado de São Paulo* (Council of Municipal Health Secretaries of São Paulo State) and the *Conselho Regional de Medicina* (Regional Medical Council) all took a stance against the measure for the same reason. The courts ruled against the state government, though the decision is has been appealed²³. Other reforms under Alckmin have moved in a similar direction, raising concerns about segregating the SUS, with some representatives of state

²² *O Estado de São Paulo*, interview with Cerri 7/14/2011. “Os planos não vão querer pagar aos hospitais públicos”

²³ *O Estado de São Paulo*, 9/1/2011 “Justiça suspende lei que destina leitos de hospitais públicos a plano de saúde.”

hospitals defending preferential treatment of those with private plans as a way for public hospitals to finance their SUS operations²⁴.

In terms of equity-enhancing primary care access, municipal authority has been decisive as the primary actor in implementation. Because the city of São Paulo has minimal coverage under the PSF, the state faces a situation in 2012 in which 550 of the state's 645 municipalities have implemented the PSF, yet only 36 per cent of the state population is covered (DAB SUS 2013). In line with the early innovation in many paulista municipalities, PSF uptake was more widespread, earlier, in the state of São Paulo than in Bahia.

5.8.3 Capital City: São Paulo

The city of São Paulo is the sixth largest in the world and the municipality is home to 11.2 million inhabitants. Approximately one fifth of the municipal health institutions are public, while the rest are private (IBGE 2011). The city's leaders exert great influence over national politics and the city thrives on a highly globalized finance sector. State and city government have been dominated by the founding club of the PSDB for the past two decades, with many members cycling between the two.

In the immediate post-transition period the city was governed by a PT mayor, Luiza Erundina from 1989-1993, whose health policy included expanding the services of the health posts and increasing access to the poorer peripheral zones of the city. Erundina was considered a strong left leader and instituted progressive participatory housing policies, but these were discontinued after her successor, Eduardo Suplicy, lost to Paulo Maluf in the subsequent elections. Maluf had been governor of the state and mayor of the city under the military regime and served one term from 1993-1997 for the PP.

Celso Pitta served from 1997 to 2001 but his tenure in office and later political

²⁴*Folha de São Paulo* 11/18/2011 "Lei aprovada reabre polêmica sobre 'dupla porta' em hospitais paulistas."

life were plagued by corruption, scandal, and legal problems, with little left to show for his time as mayor. Pitta was succeeded by Marta Suplicy of the PT, whose work on health care and other social policies is discussed below. In 2005 José Serra was elected mayor but left office in 2006 to run for governor and turned the city over to his vice, Gilberto Kassab. Kassab governed on the right—he was previously a member of the PL, then the DEMs before leaving the party in 2011.

Paulo Maluf had created a municipal primary health scheme based on market principles beginning in 1995 and he and Pitta had maintained this program even when it meant rejecting federal funding for the PSF (Borges Sugiyama 2007: 171). The PAS was more expensive than the PSF and less effective (Capistrano 1999: 97), but it was not until Marta Suplicy's arrival that São Paulo implemented the PSF and scrapped the PAS. The São Paulo model of the PSF integrated the existing OS as service providers, so it was not the public provision model of basic care that the PSF represented elsewhere (Goldbaum, et al 2005: 91; Elias, et al 2006: 634). The PSF represents 45 per cent of primary care services in the city and produces better outcomes than the other programs (Elias, et al 2006: 637).

Yet evidence from São Paulo city suggests that even the PSF can be affected by lack of commitment. A study by Schattan and Pedroso assesses the distribution of health facilities in São Paulo by socio-economic status and find a significant level of inequality, with wealthier neighborhoods having preferential access to the public sector. While this inequality diminished over the course of the 1990s, it was still substantial at the turn of the 21st century (2002: 141).

In Brazil, some of the most innovative local social programs have arisen in the most developed areas (Bichir 2011). In the case of São Paulo, this means that in a large and complex municipality, many municipal programs and services already existed when national programs arrived on the scene. Paradoxically, these challenges

of coordination in high capacity cities may make diffusion of a promising national policy more difficult than if the municipality were a blank slate in that arena, as was the case in Salvador. While in a case like Porto Alegre where the pre-existing primary care program is more generous than the PSF, this is less problematic. But in a city like São Paulo, such conflicts reduce the capacity of equity-enhancing reforms.

Despite these difficulties, in both São Paulo state and city, Renata Bichir finds that the central government under the PT was able to incentivize compliance with its hallmark programs even under opposition governments (2011: 29), although in health care this coverage has been low. This suggests an increase in the salience of commitment at the central level, as Cardoso, then Lula, and now Dilma have developed institutional tools to achieve their policy goals at the subnational level, even under parties of the opposition. The immediate, substantive policy changes that took place in health and social assistance when Marta Suplicy took office also sustain the argument that the differences between the PT and other parties can be significant, even under unlikely circumstances.

Other municipalities of São Paulo, particularly in the ABC region, have long innovated in social policy. A good example is the health policy activism of Celso Daniel, PT mayor of Santo André before he was assassinated in 2002²⁵. São Paulo state housed some of the earliest municipal experiments with minimum income programs, for example (Bichir 2011: 28). As in the case of Bahia, outside the large and complex capital cities, there are capable and committed municipal governments that have improved the distributive impact of the SUS in their territory.

5.8.4 Minas Gerais: A Contrast in the Southeast

The state of Minas Gerais is a useful contrast to São Paulo. Its government has also been dominated by the PMDB and PSDB and it is also a large state with many

²⁵Daniel's widow, Miriam Belchior, was also a part of this reformist group in the ABC region and is now Minister of Planning under Dilma.

municipalities. It does not have São Paulo's vast wealth—per capita incomes are much closer to the Brazilian mean. This is true of very few states, most of which are far above or far below the mean. Income inequality decreased from .568 in 1981 to .513 in 2009, with a bump in the 1990s, as elsewhere. The trajectory in income inequality improvement has been most pronounced in the South and Southeast and with the case of Minas Gerais, is clearly not true only for very wealthy states.

Within the South and Southeast, Minas Gerais has the largest number of poor municipalities (Giovanella, et al 2009: 50). Infant mortality in the state is lower than the national average and has been over time, yet is higher than the average for the southern part of the country. Unlike São Paulo, which is overwhelmingly white, Minas Gerais is just under 50 per cent white. While the state government of Minas Gerais has been governed by centrist parties, parties of the left have had a more significant presence in local government, earlier. In particular, the capital of Belo Horizonte had early left government, beginning with Patrus Ananias in 1993 and remaining in the hands of the PT and PSB for the past two decades. PSF coverage for the state has been boosted by the over 70 per cent coverage achieved in the city by the early 2000s.

Belo Horizonte, the capital and home to 2.4 million inhabitants, was an early innovator in primary care expansion, as well as participatory budgeting—a hallmark of municipal PT government. The city took on full health management in 1994, several years before the federal implementation of NOB 1996 (after which point most municipalities began taking on broader responsibilities). The commitment of leftist municipal executives and their orientation toward expansion and consolidation of the SUS meant that from the late 1980s the capital city was pursuing equity-enhancing policies in health. In 1994 specific projects were already being developed at the municipal level directed at lowering infant mortality—the *Projeto Vida* (Malta and Merhy 2004).

In Minas Gerais the implementation of PSF and other community primary care programs revealed the need for reorientation of medical training—as in Bahia—and the new curriculum was implemented in 2003. Once again we see that politics in the state were driven by commitment in the capital city, with demand for reform coming primarily from expansion of the PSF in Belo Horizonte (Giovanella, et al 2009: 138). Minas Gerais now has the highest number of doctors specifically trained in family health as a specialty, yet still only has half as many as would be needed to fully cover the state population (Giovanella, et al 2009: 231). The contrast with Bahia, which could not overcome opposition to curriculum reform until 2011, is notable. Opposition by the medical profession was high in Minas Gerais as well (Giovanella, et al 2009: 237), but unlike Bahia where there was no political backing for reform until 2007, in Minas Gerais the government was pushed to implement reform much more quickly.

5.8.5 São Paulo: Conclusion

While the state of São Paulo has one of the highest levels of economic development, income inequality is relatively low, and the legacy of slavery is weaker than in the Northeast, the lack of ideological commitment to equity-enhancing reform in health has still hampered reform. The health sector is strong in São Paulo city and state, unlike in Bahia, yet tight ties between private medical interests and state and municipal political leaders have created continuous pressure to focus the energies of the public sector in ways that benefit these groups.

Even though many leaders from the PSDB have not been especially antagonistic to a pro-poor agenda, the most equity-enhancing reforms have still taken place in housing, transportation, and primary care implementation during brief windows of PT government in the capital city. Many of the municipalities in the state have been innovators in equity-enhancing health policy, making a substantive difference for the

most vulnerable members of society for a subset of the state population.

The case of São Paulo is a particularly clear illustration of why we should not assume that capacity-building can be an end unto itself in a broader process of equity-enhancing reform. Capacity in the state and city of São Paulo have done relatively little for those living in the favelas, without an accompanying commitment to equality. In the city of São Paulo we saw that even the public health resources designed to help the poor, first and foremost, were more highly concentrated in wealthy neighborhoods. Still, the experience of the city of São Paulo also requires that we keep in mind the increasing capacity needs for the same level of reform, the larger a city grows. Implementing reforms in an enormous city with enormous slums, when large numbers of bureaucrats must be involved for successful policy implementation, certainly complicates the task.

The municipalities of the ABC metropolitan area around São Paulo show what can be achieved when high capacity is combined with high commitment. And the case of Minas Gerais illustrates what can be done with just an intermediate level of capacity. The state has a smaller white population, sits almost precisely at the Brazilian mean in terms of GDP per capita, and has higher levels of poverty. Yet primarily because of a long history of committed government in the capital city of Belo Horizonte, social policy innovations and health reform have been considerably more equity-enhancing than in São Paulo.

5.9 Chapter Conclusion

Brazil is an excellent case for exploring the contrasting expectations of those who see decentralization as a glass half full versus those who see it as a glass half empty. Decentralization did indeed create the opportunity for municipalities with high levels of civic engagement, committed public officials, and sufficient administrative and financial resources to implement innovative policies. Even some very poor areas

under committed government were able to improve outcomes considerably. The PT was able to win the presidency in 2002 in large part because it had the opportunity to establish itself and gain experience in government at the municipal level. Both Cardoso and Lula drew on successful subnational experiences to develop the national social programs that have become models internationally. But decentralization has also allowed for municipalities like Salvador to neglect health policy without being held accountable. Commitment and capacity were both scant in the neediest regions until very recently, the result of which has been bigger improvements in areas that were already doing better.

One of the most challenging obstacles for equity-enhancing health reform in Brazil has been the timing and sequence of democracy, health decentralization, and commitment at multiple levels. Support for reform peaked in the mid-1980s—as it did in Spain. Yet in Brazil the democratic transition was just beginning and the advocates of reform spent their capital ensuring a pro-poor definition of the health system in the 1988 constitution. This victory was not inconsequential, but the movement for health reform did not have a strong basis of support in other social movements and left parties were far weaker than in Spain.

After the transition, neoliberal actors won control of the government and implemented health legislation more or less on their own terms. From 1989-1994 the central government was uninterested in accountability and responsibilities were transferred to subnational actors with little regulation or oversight. For the most part, the constitutional guarantee remained unimplemented and unfunded. This situation changed significantly under the PSDB beginning in 1995, though far reaching reform of the health system was not part of the centrists' platform. When the PT came to power in 2003, many equity-enhancing policies were implemented in the Health Ministry as part of a broader process of mainstreaming social justice criteria into government

management. Discrimination based on race, gender, and sexual orientation was tackled seriously for the first time. Yet health reform was not a top priority for Lula, who was invested in social assistance and education reforms. Advances have therefore been steady, but slow since 1994.

Ultimately, only a central government can implement equity-enhancing policy reforms across the national territory. Therefore, when subnational governments fail to prioritize social policies for the poor, such policies will only be implemented if those governments are sidestepped or incentivized to change their behavior. In Bahia during the 1990s, the state government was uninterested in pro-poor health programs, so it was the central government with international partners that helped small and rural municipalities implement community health programs. From the mid-1990s on the central government has attached conditionalities to transfers for health and incentivized equity-enhancing programs with additional funding. Since federal requirements for minimum spending levels were instituted, inequality in health spending across Brazilian municipalities has sharply diminished (Arretche 2010), though there have been drawbacks to this process as well.

The efforts of the central government under the PSDB and the PT have been clearly oriented toward regaining authority vis-à-vis subnational units. In the case of the PSDB the concerns were primarily around issues of economic stability, while for the PT they have been dominated by concerns for the ability to implement a social agenda across the country. The governments of both parties have produced equity-enhancing reform in large part because of these efforts to hold subnational units accountable for good governance and equity-enhancing social reforms. Despite the role of subnational units in innovation, this study therefore affirms the findings of other case studies of health decentralization—that equitable results are most likely

when central government regulations limit the scope of policy autonomy of subnational units. Tables A.10 and A.11 show the outcomes on ACS and PSF under differing levels of commitment and capacity over time in Bahia, Salvador, São Paulo, and its capital city.

What are the prospects, then, for the SUS? The formal territorial division of responsibilities in health is settled and has been for some time, which narrows the scope of possible reforms. As former Planning Minister Luiz Carlos Bresser Pereira explains, while exclusive central government financing of health care would be the most equitable, this option was never considered because the decentralized nature of the SUS—decided early on in the constitution and enabling legislation of 1990—made it impossible (2011). While the conditions necessary for pro-poor health reform—commitment and capacity—have been steadily increasing at the central level, tough questions for the SUS have not been tackled.

Financing has become more regressive over time, municipalities are stretched thin, and the center has still not made a commitment to increasing its share in health spending. Private health spending now outstrips public and the relationship between the public and the private sector creates structural problems for the SUS that will have to be addressed. In particular, the fact that the most expensive treatments are almost exclusively provided by the SUS with no reimbursement from private health plans is unsustainable. Finally, the understanding of what “universal” means is still not a settled question and the courts have been increasingly forcing the government to cover procedures and services it has denied to patients.

While serious challenges clearly exist for the SUS, there are many indicators that the system will become more equitable over time. This study shows a steady improvement in commitment and capacity at the national level over the democratic period. Economic growth in Brazil has been strong and increased funding for health is not

a politically or structurally insurmountable problem. The inclusion of broad social citizenship rights in the constitution of 1988 has given legal recourse over time to demands for expanded social programs. Most Brazilians know that they have the right to health care and that the state is responsible for ensuring universal access. The PSF has finally been institutionalized as the core program for extending coverage and organizing access to care. Health policy makers have consistently shown a holistic understanding of health and a preventive approach to care, which bodes well for the sustainability of the system. For Dilma, equity-enhancing health policy finally appears to have gained a powerful defender and the reforms implemented under Padilha just in the past few years suggest potentially significant improvements in subnational accountability and the public/private relationship in health.

For Brazil, enhancing equity in health will require increasing the capacity of subnational governments and ensuring that political actors at all levels are committed to the SUS. While the case study clearly shows that less developed countries with high levels of decentralization and asymmetric subnational political power and formal authority can still successfully implement equity-enhancing health reform, the limitations are also clear. Left parties were far weaker in Brazil and there were no alternative sources of commitment as there were for a few regions in Spain. The weakness of ideologically committed actors combined with low fiscal and administrative capacity made it impossible to fully implement the generous guarantees of universal health protection enshrined in the new democratic constitution. Because a universal system of public care was not quickly established, the already strong private sector was able to block implementation as it was attempted, piecemeal, over the years. Yet the constitutional mandate has remained the standard for defenders of the SUS and there has been no overall backsliding—access, coverage, and quality of care for the neediest members of society have improved steadily over time. The opposition to

reform has largely been manageable because of impressive economic growth that permitted increased spending without clear costs to other policy areas or actors. As the economic crisis has slowed the economy, we shall see whether Brazil has the capacity to sustain an unconsolidated SUS.

6 COMPARISON

In this chapter I come full circle, back to the overarching comparison of the two country cases taken up in Chapter 1. In depth comparative historical analysis allows us to tease out the complexities of multilevel reform with several paths to reform. The countries themselves were chosen precisely because there were important opportunities for comparison across, as well as within the cases.

In order to gain leverage on this complex causal story, I chose a single policy area in order to pinpoint concrete changes in the territorial distribution of authority. Because I argue that starting points constrain the options available to reformers and define whether a given policy will be equity-enhancing in its particular distributive context, it was also helpful to choose countries in which the starting points were fairly similar. Both Spain and Brazil had third wave pacted democratic transitions in which the status quo prior to reform was right wing centralized authoritarianism and fairly high, yet inegalitarian, health coverage under a Bismarckian contributory social insurance model. Leftist reformers in both cases supported decentralization at the outset of reform, but in both countries center-right actors governed through the transition period and the early years following constitutional health coverage mandates. The primary care models have important similarities, as well as differences. What then, are the differences and similarities in institutions and reform processes that can teach us something about what to expect for equity-enhancing reform under decentralization?

In the pages that follow I present a comparison of the two countries in terms of commitment, capacity, and the territorial distribution of authority, as well as the role

of timing and sequence of reform. I consider rival explanations and show that they do not adequately explain the variation in equity-enhancing health reform in Spain and Brazil.

6.1 Territorial Distribution of Commitment

Actors committed to equity-enhancing reform produced innovative and quite similar primary care reforms in both Spain and Brazil. However, commitment differed in three ways that impacted health reform under decentralization between Spain and Brazil. First, in Spain committed actors were powerful across the country and had an absolute majority in the central government when the constitutional mandate was implemented, while in Brazil committed actors were state and municipal leaders from new parties without a long history of societal support. Second, committed actors won the central government in Spain early after the transition and before anyone had attempted to implement the constitutional health mandate. In Brazil, committed actors did not win the central government until 15 years after the constitution and long after the structural framework of the health system had been established and put in motion. Third, committed actors have been strongest in Spain in poor regions and those dominated by minority nationalists, while in Brazil committed actors have historically been strongest in the states with higher incomes than average and high levels of education.

For Spain on the first dimension, the absolute majority of an historic left party with a large following and a long and venerable history created a solid foundation for moving quickly with a large scale reform, which proved difficult and incomplete even under these auspicious circumstances. The EU can be considered a supportive supranational context for domestic commitment, as moderate social democracy in Europe does not have the same influence on international investors that it does in Latin America. In Brazil the strength of committed actors was weaker overall and

only strong enough for reform in a sprinkling of municipalities and states at the outset. This meant that early health reform was piecemeal and primary care coverage was only extended in a few parts of the country.

Even more important was the fact that because of where committed actors were strong subnationally in Brazil, the places that innovated—except for the case of Ceará—were not the parts of the country that most desperately needed reform. However, as the infant mortality rates in Brazil clearly show, the gains made even in these higher income areas were substantive and represented a major improvement in life chances for millions of people. Still, we can see clearly that improvements in income inequality have been distributed unevenly in Brazil (See Figures A.9 and A.10). Those states that have overall had the best performance on income inequality are also those that have lowered it the most. In the Northeast, income inequality in many states is still higher than it was in 1980, while in richer and whiter parts of the country inequality has dropped far more substantially. If Brazil cannot impact income inequality in the most unequal and poverty stricken parts of the country, an important facet of territorial inequity persists and may even have been exacerbated by better access to basic health services for the poor in the richer regions. Clearly, it is much better to be a poor person in Santa Catarina or Mato Grosso do Sul than in Pernambuco or Bahia.

In Spain, the minority nationalist ACs have been higher income than average. The Basque Country and Navarre are outside the common fiscal regime, but Catalonia pays a great deal into the central system and resents it. In both countries, the largest population centers have been in places with fairly poor records on equity-enhancing health reform, which is important to keep in mind when comparing outcomes by region. Madrid, Valencia, and Catalonia are home to the biggest Spanish cities and yet

have been overall poor performers in health provision. Similarly, in Brazil health reform is universally recognized to have advanced the farthest outside major metropolitan areas. Our judgment of outcomes should be somewhat more pessimistic in both cases because of this distribution.

The territorial distribution of commitment matters because the interests of particular regions are impacted differently by a given model of territorial distribution of resources. The redistribution that Sweden, Denmark, Austria, or Germany do in the EU, and which left of center forces in those countries support, requires a higher level of commitment than when left of center forces in poorer countries support the same policies. This is true at the domestic level as well. It is one thing for actors in Extremadura or Bahia to support equity-enhancing reforms from which their population will benefit, and quite another if those central policies mean that the governments of Catalonia or São Paulo see their own resources diminished by central efforts.

This is also part of the reason that ACs in Spain such as Castilla y León have conservative governments that behave differently from those in Madrid or Catalonia. Castilla y León is a net beneficiary both of EU funding and of Spanish regional finance. Its leaders have historically not been committed to equity-enhancing reform, but it is not especially costly to accept a model of the state that generates benefits for their AC. In Brazil, the social programs discussed here have for the most part been fairly inexpensive, which has helped to prevent large-scale opposition by the wealthiest states. The situation is also distinct because Brazilian states have own sources of revenue (primary the sales tax) that are quite regressive from a territorial perspective but which mean the fortunes of the states are not as directly in the hands of central policy makers as they have historically been in Spain.

6.2 Territorial Distribution of Capacity

In addition to the significant differences in commitment, capacity has also been an area of divergence between Spain and Brazil. Spain is a middle income developed country while Brazil is a high income developing country, yet at every step of the way Spain has had advantages in both fiscal and administrative capacity. Still, some differences that appear to be problems of capacity I argue are fundamentally problems of commitment.

Brazil is a far larger country where the legacy of slavery meant that small-holding was minimal and forced labor was the norm in the Northeast. In these areas, basic human development lagged long into the 20th century. In both countries, the regions with the lowest levels of administrative capacity, education, and human capital are those where large landholding was the norm.

While a modern bureaucracy developed at the central level during the Vargas era in Brazil, this administrative capacity did not trickle through to most lower levels of government. In Spain modernization of the bureaucracy took place earlier, which may be part of why health provision under authoritarianism had a significant public component in Spain but not in Brazil.

Aside from the overall differences in level of economic development, the most significant difference for capacity is Spain's presence in Europe. Europe supported efforts at improving the living conditions of the rural and urban poor and treated investments in education and health as desirable. But in addition, the poor regions of Spain began receiving EU structural funds in 1987. The resources directed at economic development in the poorest parts of Spain were on a completely different level than the sporadic efforts at development of the North and Northeast undertaken (with some international support) in Brazil. While EU structural funds are not aimed at social policy, economic development, infrastructure, and training all form part of

the foundation for sustaining equity-enhancing policies.

In terms of domestic fiscal capacity, Spain's higher level of economic development and wealth certainly matters—GDP per capita in comparable international units was nearly three times higher in Spain in 2011 (IMF 2013). Yet high inequality has created a vicious cycle in Brazil in which elites have been able to protect a tax system that is highly regressive and apparently untouchable. While taxation in Spain has become more regressive over time, in Brazil it was never progressive and does not appear likely to become more so, despite the fact that the state collects a high level of taxes mostly from indirect sources.

This is the sense in which I argue part of Brazil's capacity problem is actually a commitment problem. There are important untapped resources available for financing social policy, yet so far attempts at more progressive taxation have been unsuccessful. Brazil spends only half of what Spain spends as a portion of GDP on a similar health mandate. The pension system has only been partially reformed, so the lion's share of social spending still goes to a privileged set of middle and upper-middle class civil servants and industrial workers. Clearly Brazil has a competent bureaucratic apparatus capable of collecting taxes. In Spain, the same privileged workers have special benefits in health and pensions, yet because of higher levels of commitment at key moments, the money for health was found and spending on special groups' health benefits is less than four per cent of total health spending.

6.3 Territorial Distribution of Authority

There have been important similarities and differences in the structure of decentralization itself in Spain and Brazil and these have indeed been relevant for differences in outcomes, particular as they interact with timing and sequence. The two cases were chosen in part because they shared important features of the starting points prior to

decentralization and health reform, yet some important differences remain and variation over time has been significant. In addition to the differences in timing of health devolution, the overall distribution of social policy and fiscal authority has varied in important ways.

The 1978 Spanish constitution set a specific group of competences off limits for devolution, named some as exclusive responsibilities of the ACs, and paid relatively less attention to municipalities. Residual responsibilities (those not granted to the center) could be transferred to the ACs, but this was not necessarily automatic. Public health provision and health planning responsibilities were devolved to all ACs in 1981, while overarching health responsibilities came later and asymmetrically. Unemployment and social security have remained centralized for the most part. Education has been devolved in a similar fashion as health, with the center retaining an important role in setting minimum requirements and frameworks for curricula and structure.

Some features of social assistance have traditionally been considered a part of social security while others part of social services. Social services and poor relief have historically been a responsibility of the provinces and Catholic charity. This vision did not change with the constitution. Authority over social assistance was granted to the ACs (C1978 Art. 148) and was generally not a contentious point for actors at any level. It has remained a residual policy area in many ACs, concentrated in the provincial governments in some and almost nonexistent in others. Only a few ACs have developed comprehensive social assistance programs and these have often not subsumed or replaced those that operated at lower levels.

Fiscal autonomy in Spain has been considered fairly low, as the ACs have little authority over taxation. Central actors and Catalan nationalists have managed to devolve large portions of the tax base without actually giving much new authority to the ACs—taxes are mostly still set at the center yet are collected over AC bases in

differing proportions.

The Brazilian constitution of 1988 granted residual policy authority to the states—consistent with their historically powerful role—and “complementary and supplementary” policy making authority to both states and municipalities in the realm of social policy (Art. 6). This meant that everyone and no one was responsible for social policy (Souza 2004), yet it left great room for innovation because there were few formal limits on what any particular level could do. While in Spain there is much judicial wrangling about multilevel governance, in Brazil it is not so much that the rules were not clear as that there were fewer rules. While there is great conflict over who should pay for policies, there is no existential conflict over whether the center has a right to legislate social policy or the states and municipalities the right to innovate in models of provision. As in Spain, social security and unemployment are centralized. But in Brazil, the center plays a larger role in health and education.

From this brief summary, there are three areas of divergence that are relevant for equity. The first is that the baseline level of authority of the center in health policy is more significant in Brazil. Lack of conflict over the reference community means there is less opposition to central initiatives by powerful potential veto actors in the states. Subnational health secretariats are hierarchically subordinate to the central Ministry of Health—mostly in the realm of financing but also in terms of accountability and implementation of centrally designed initiatives—none of which is true in Spain.

Second, the role of the center in Brazil is much more important for social assistance than in Spain. Central actors in the mid-1990s began creating federal social assistance programs, often conditional cash transfers based on earlier federal or subnational pilot programs, which were applied directly in the municipalities. In Spain at the same time that health reform was taking place, the PSOE tried to introduce a central law that would integrate and expand social assistance at the federal level (Moreno 2001:

78), yet at the time it was blocked in the courts on the grounds that the center was overstepping its territorial authority. While the center eventually won its case (Sentence 146/1986), the moment for reform had passed and the ACs had become dominant protagonists in social assistance¹.

It was only after the Basque Country began a “war on poverty” in the late 1980s—including a minimum income guarantee—that the center added a non-contributory pension (NCP) to its social security system. Minimum income guarantees have been implemented in many ACs, while attempts to top up the NCP have also been widespread. However, under the PP at the center, all ACs who tried to top up the NCP were taken to court for invading central government authority. While the center lost, it used its absolute majority to change social security legislation specifically to make such top ups illegal (Law 52/2003). During the 1990s the management of IM-SERSO, the branch of social services within social security, were devolved (Moreno 2001) and the ACs now directly manage the NCP in the social security system, but do not have political authority over the program.

Arguably, the wording of Spanish basic law on who is responsible for social assistance is about as muddy as Brazil’s constitutional division of responsibility for social policy, so why have outcomes in Brazil been so different? Unlike Spain, Brazil has no powerful regions that fundamentally oppose the principle of central government action on social assistance². Brazil also has no central parties that feel the unity of the Brazilian state is threatened by subnational policy initiative. In addition, the

¹The most the center was able to do was to pass a 1985 law that Spanish municipalities with more than 20,000 inhabitants were required to provide basic social services (Law 7/1985). Yet most Spanish municipalities have far fewer than 20,000 people and the average is near 5,000. In 1987 multilevel agreements were signed to provide financing for social services, which was equally split between ACs and the center, with some also coming from municipalities. The Basque Country opted out, because it rejects conditional funding from the center on principle (Moreno 2001).

²If Brazil’s flagship social assistance program, *Bolsa Família*, were more expensive or states had to help pay for it, opposition might be higher.

lack of ideological discipline in parties, as well as the history of credit-claiming for government benefits means that even actors uninterested in equity do not face strong party or electoral pressures to actively oppose central programs for the poor³. In Spain, on the other hand, the right faces significant pressure not to take up policies viewed as leftist, on ideological grounds.

The third difference in the nature of decentralization between the two countries returns us to the health policy realm. The lack of clear delimitation of social policy competences in Brazil means the process of health decentralization has been more gradual and has not necessarily had a static institutional content. In Spain, ACs had lower levels of authority in health policy at the outset, but when they gained authority it was a clear and definitive process that shifted responsibility from the center to the AC.

In Brazil, the states and municipalities were granted broad latitude to create policies on their own under the 1988 constitution. The asymmetric decentralization in health has not been a fundamental shift from center to states in most cases, but a negotiation of new responsibilities within a given institutional context. While central legislation prevents lower level actors in both countries from refusing to cover basic minimum provisions, increases in the role of the Brazilian states and municipalities does not always impede action by the center⁴.

These differences in the structure and content of decentralization made it easier for the central government in Brazil to establish itself as an actor in health policy after the empowerment of subnational units and also gave it greater leeway in crucial

³There is also evidence that municipalities, at least, have been able to claim some credit for *Bolsa Família*, as they are the face of the programs implementation (Niedzwiecki 2014 forthcoming)

⁴The demarcation between states and municipalities in medium and high complexity care is more clearly zero-sum—states provide these services directly in municipalities that have not taken on those responsibilities and once they do, states no longer have authority to offer those services in the municipality.

support areas such as social assistance, which also influence health. As we shall see in the next section, however, the importance of timing and the necessity of a strong role for the center meant that in Spain the alignment of influences was more favorable for reform in the crucial early years.

Yet in both countries a common impediment to equity-enhancing reform has been the inability of the center to establish accountability mechanisms that allow it to step in if citizens are denied their constitutional rights at lower levels of government. When the courts are the only recourse, citizens have little protection indeed. For both countries part of the problem comes from the very nature of shared authority. In Spain an additional weakness has been the inability to condition resources for health, while in Brazil the problem was first a lack of commitment and later a lack of fiscal capacity. The new contracts currently being negotiated in Brazil under Decree 7508 should help to consolidate the guarantees of the SUS, but over the period considered here, central actors have been unable to realize important facets of constitutional protections in health for those living under uncommitted local and intermediate governments.

6.4 Sequence

A crucial difference between Spain and Brazil has been *when* increases in regional authority took place in relation to the implementation of health reform. In Spain, central health reform took place when only two ACs had control of health competences (Andalusia and Catalonia). In Brazil, states and municipalities already had broad authority in social policy when central actors began implementation of the constitutional mandate for health care. The actual variation in outcomes has depended on the combinations of commitment and capacity present at different levels at important moments in the reform process. Because of the lack of conflict over the reference community in Brazil, pre-existing decentralization did not hinder central implementation nearly as much as simple lack of central commitment—at least initially.

In Spain, however, Catalonia fought the center in the courts from the first moments over authority to implement countrywide health reform. Andalusia did not because of ideological overlap with central actors and weaker minority nationalism. The high level of variation in primary care coverage in early Spanish decentralizers, compared to the higher average and far more uniform implementation of the reform in ACs under central control is a testament to the cost of devolution before full reform implementation (See Figures A.5 and A.6). Of the ACs governed by conservative parties in Spain since the mid-1990s, there is a significant difference in the coverage rates from 1995-2002 in those ACs with early devolution and those without. The reform was popular and was not rolled back under conservative governments when full coverage had been achieved under left central actors prior to devolution (see Table A.7).

The fact that authority over health policy clearly lay with the center under the constitutional mandate for health care in Spain meant that until health was devolved, ACs did not innovate in health policy the way Brazilian states and municipalities did. Yet in Brazil, health care was an important social concern but no one was given clear responsibility for it under the new constitution and no action was taken at the center at the outset. The first reforms implemented by the center from 1990-1993 institutionalized the basic framework of the guarantees of the SUS and devolved greater responsibilities away from the center (primarily toward municipalities for primary care). Subnational actors in Brazil faced great uncertainty about the commitment and capacity of the center and had a constitutional prerogative to go their own way, so many did not wait around for the central government to act. In Spain, if all ACs had been given open-ended authority in health prior to central reform and central commitment had been lacking, we likely would have seen subnational innovation before central innovation.

The clear importance of sequence in these two cases brings into question the common assumption that decentralization has been good for equity in Brazil because it permitted progressive actors to cut their teeth first at the local and municipal level. If subnational avenues in Brazil had not been open and progressive reformers had not pushed for decentralization, those actors likely would have continued to operate at the central level as they had in the 1980s, prior to decentralization of social policy. While the PT clearly grew from the ground up, they came quite close to winning the 1989 elections in Brazil. There is no reason to assume that their failure to win the central government until 2002 was somehow predetermined and that without subnational avenues, the party could never have risen to national prominence.

Such assertions make a spurious assumption about the counterfactual—that if there had been greater centralization, there would simply have been no avenue for the emergence of committed actors at any level and the reforms would not have taken place at all. It seems just as possible that if shared authority in social policy had not been written into the 1988 Constitution, that the *sanitaristas* would not have scattered back to state and local government and would have continued to militate at the center. While there is no way to test a counterfactual in such cases, it is clear that actors take the territorial distribution of authority into account and that the need for committed social and political actors to operate at the local level made them unavailable to maintain the centralized pressure they had been exerting in Brasília prior to 1988.

6.5 Timing in International Context

Spain's presence in Western Europe muted the impact of neoliberal pressure from US-influenced international financial institutions. The role of this supportive context in forming partisan attitudes toward the welfare state in Spain is clear. Yet among Latin American countries, Brazil was the most insulated from neoliberal pressures

because of the size of its domestic market and the history of independence among its civil servants. And even in Spain the 1990s were a time when neoliberal ideology was influential in setting the general context of elite expectations about the possibilities for reform. These pressures included policy decentralization and deregulation (management “decentralization” to individual hospitals and clinics).

I therefore argue that the timing of reform in relation to neoliberal pressure in the 1990s is an important part of why health reform has been more successful in Spain than Brazil. In Spain the democratic transition took place while support for progressive primary care reform internationally was at its peak. The USSR had not fallen and the Washington Consensus was not yet hegemonic. The ink on the Declaration of Alma Ata was still drying. The Spanish fiscal system was at its most progressive when health reform was implemented. Support for progressive health reform was high internationally and in Europe in the 1980s, yet liberalizing pressures pushed EU countries toward a focus on indirect taxation starting in the 1990s and the tax structure in Spain became less progressive. Spain took advantage of what turned out to be a brief window of opportunity. The result was that health reform had been implemented, funded, and consolidated before neoliberal pressures appeared.

In Brazil, the same tendencies existed at the same time, but these fell at a different point in the reform process. Support for progressive health reform also peaked in Brazil in the mid-1980s, but at this point the democratic transition was only just shifting into high gear. Brazilian reformists were at their strongest at the same time health reform was implemented in Spain, but this resulted primarily in a progressive health guarantee in the Brazilian constitution of 1988. In both countries health reform was not taken up until several years after the new constitutions, but in Brazil this meant the early 1990s at the height of neoliberal influence, which reformers at the time say was a relevant pressure (Bresser Pereira 2011).

Opponents of reform were trying to roll back the Spanish SNS in the early 1990s as well, yet because it was consolidated and popular and the center-left held the government, the actual effect on policy was limited. Attempts to constrain financing generated forceful push back countrywide—for example in the outrage over the proposals put forth in the *Informe Abril* in 1991.

The international context was therefore not as dissimilar as one might expect, yet because the Spanish democratic transition happened a decade earlier and committed actors won government immediately, health reformers were able to implement their agenda before the international context soured. Brazil was not so lucky, with neoliberals in government to implement the health mandate when international views had shifted toward residual government social provision and an international economic crisis was limiting fiscal capacity everywhere. Table A.12 illustrates the patterns of reform in both countries in the international context.

6.6 Models of Reform and Elite Strategy

Primary health care in Spain and Brazil offered a particularly useful place for analysis of the possibilities for equity-enhancing reform. The reforms were relatively cheap and highly effective and were often supported by international actors who in other arenas had been antagonistic to redistributive reforms. If primary care is cheaper and more effective, all governments faced with cost containment pressures should support expanding primary care at the expense of hospital and specialist care.

Yet primary care has been one of the most ideologically contested components of universal health reforms and one of the slowest to be implemented, even though it is the least expensive care to provide. Parties and actors on the left have been the overwhelming protagonists of primary care reform in both countries, at multiple levels. The innovations in primary care in Brazil at the state and municipal level in the early years after the transition originated almost exclusively under governments

on the left. Primary care was not implemented by the neoliberal central governments in Brazil that took the first steps to enable the constitutional mandate for the SUS. Actors on the right were vocally opposed to the 1984 primary reform in Spain, despite overwhelming agreement among medical professionals and the public that primary care was the weakest part of the health system and desperately needed reform.

Why such opposition to what seemed a common sense reform? Primary care is inexpensive for middle and upper class individuals to purchase privately and not a money maker for providers or medical equipment manufacturers, so there is little demand for government intervention except to ensure access and coverage for the poor. Because the Spanish strategy was to push through a comprehensive and generous reform quickly, with solid funding, the improvements in primary care were felt immediately across the country, even though the institutional transformation of clinics took longer. This reform model was only possible because the vast majority of the ACs were still under direct health provision by the central government.

One of the key differences between Spain and Brazil was that early implementation of the constitutional health mandate began under committed actors in the former and uncommitted actors in the latter. The PSOE had prepared reforms in a number of areas of social policy, but health was the most successful. The strategy of Ernest Lluch in the Ministry of Health in 1983 was to push through a progressive health reform that accomplished all of the major goals of the socialist program—universality, public provision, financing from the general budget rather than social security, and a reorientation toward primary care. The legislation was written without broad consultation of opposition groups or the private sector because the PSOE anticipated that these actors would attempt to water down equity-enhancing components of the legislation. The center was unable to avoid a protracted battle with these groups once the legislation was proposed, but because it started from an ideal point that was

public and popular, the compromises that were forced along the way—partial funding still from social security, no elimination of dual practices, the governments’ right to subcontract services in the private sector, no full universality, and keeping the system tied to social security status—were publically viewed as failures, rather than treated as a legitimate compromise.

While the PSOE was never able to modify the role of the private sector, which was far too powerful and entrenched by the onset of reform, it was able to attain almost universal coverage and almost full funding from the general budget within a few years—items that were largely seen as the completion of progressive promises that had not been conquered at the original moment of reform. Despite fiscal pressure at a difficult economic moment toward the end of the 1980s, the tax reform of 1977 had put Spain on much more solid footing. Greater domestic fiscal capacity and high commitment at the center, combined with the revenue from the EU that began in 1987, allowed the Spanish SNS to be extended fairly quickly. Under the Franco regime, social security health provision had been largely public, while in Brazil it had been almost exclusively private. Spain could expand its health provision within a personnel and administrative infrastructure it already owned and had operated for years. In Brazil most had to be built from scratch.

In Brazil, the staunchest reformers in the health arena were not political actors or parties because the left was small and weak. Rather, they were a broad set of professional and civic organizations committed to public health, who reached their highest level of influence in the drafting of the constitution itself. Because the Brazilian reformers wanted health care highly decentralized—in contrast to the Spanish socialists—there was little opposition when the neoliberals in government at the center after the transition acted first to devolve greater responsibilities to the municipalities. At this point there was no national movement and no party that championed the

original *sanitarista* goals, which were very similar to those in Spain. In localities and states where reformers were strong, equity-enhancing reform took place. Elsewhere, it did not. Fiscal and administrative capacity handicapped whatever reform efforts might have taken place in the poorest states and municipalities.

Fundamentally because of a lack of fiscal capacity and central government commitment (the same factors whose presence was so enabling in the Spanish case), the guarantees of the SUS were never achieved. Still, the promise of the constitutional mandate represented a goal to be struggled toward, for committed actors. The clear role of the formal guarantee undercuts assertions that formal victories are insubstantial if not enabled and acted upon—a common critique of Southern European and Latin American politics. In contrast, these cases show that the formal guarantee acts as a doorstep, ensuring that reformers have a legislative leg to stand on whenever they mobilize enough strength for action.

Because the formal guarantee existed, the distance between what had been attained and what had been promised could be measured. In Brazil, once more committed actors were in central government, the task was to increase accountability for all three levels of government. The center had to start actually funding local health secretariats, as well as coordinating and planning health policy. This happened slowly over the course of the late 1990s and early 2000s.

At the same time, training for subnational providers began in earnest, though this was primarily a state-level task and so in uncommitted states happened to a lesser extent. Here the example of Bahia vs. São Paulo is useful, as in São Paulo the state devolved extended health responsibilities to most of its municipalities all at once without regard for their levels of capacity, while Bahia under the PT beginning in 2007 required that its municipalities create an institutional support structure and participate in training before taking on greater responsibilities in health.

Ultimately, Spanish reformers were willing and capable of taking on entrenched private interests in a way that was not possible in Brazil. The outcome was a much more complete extension of reform in Spain both in terms of coverage and access. Implementing reform piecemeal over time permitted private interests in Brazil to consolidate their role in health provision, making elements of equity-enhancing reform far more contentious and difficult later. The presence of the constitutional mandates has been a crucial enabler for reform in both cases. Reforms have been most equity-enhancing across the country when devolution of health was limited and controlled from the center.

From a strategic perspective, there are two interesting processes of note. First, the private for-profit health sector has attempted to block reform in both countries. The key to overcoming opposition in Spain was to provide a high quality service and get it in place quickly so that users would quickly realize the benefits of reform and become advocates for the system moving forward. Call it shock therapy for the private health market. Fears were high early on, but once the change took place all actors adjusted.

In Brazil the fact that reform was slow and partial and early implementers were not willing to challenge the private sector meant that while middle and upper income Brazilians use SUS hospitals for major surgeries and transplants, they do not use it for primary care, which carries a stigma as a poor service for the poor. Committed actors in Brazil recognize this problem and have begun to put great emphasis on making sure people know that the quality services they receive are coming from the SUS (in both country, user satisfaction is very high), and to build its reputation and popularity across the population. But this is an uphill battle. It is far easier to maintain support than to build it from below. In the meantime, the Brazilian SUS is far more vulnerable to economic crisis and elite political abandonment than is the Spanish SNS.

Still, in some respects Brazilian reformers have been fighting a guerrilla public health war and winning by stealth. Increases in spending have been implemented at times of economic growth and expansion, the reforms have been moderate and inexpensive at the outset, and ultimately demands for better and higher quality access and services have built as citizens become accustomed to what resources are in place versus what they know has been promised. High inequality and poverty make it hard for elites to argue that cheap, common sense public programs with clear results could somehow be overstepping the bounds of the state.

Yet it is unclear whether this model can be sustained and the quality of the SUS in primary care is far from adequate for most users with access to private care. Perhaps a model of basic universalism in health will be adequate in a country with such high poverty, but as poverty continues to decrease and the population continues to age, public health care will get more expensive and it will not be so easy to ignore the costs of expanding coverage. As economic growth has slowed, we may see the SUS put to the test sooner rather than later—as we are seeing in Spain.

The second strategic difference of note is that the programs that were innovated in Brazil and became the backbone of primary care reform may only be possible under conditions of high poverty and low economic development. The PACS program in Ceará was successful because unemployed community women with low levels of education were seen as legitimate health agents to share basic sanitation information, carry out health education, vaccinate children, etc. While there is an argument to be made for a shift away from the assumption that highly trained, elite medical practitioners offer the best hope of quality care, once basic health care requires more than safe drinking water and vaccines, a different model will likely be demanded.

This is a surmountable challenge and one that Brazil has already proven itself capable of managing, as higher income municipalities—for example those outside São

Paulo using the Qualis/PSF model—have successfully modified the model with good results. While continuing to improve health outcomes and access to quality care in Brazil will certainly become more expensive than it has been to tackle the most easily prevented health challenges, the highly participatory and community-based model that is the foundation of the PSF and health policy making more broadly should serve Brazil well as it moves forward. The innovations in health provision in the Basque Country suggest that even the wealthiest areas can lower costs without sacrificing coverage, but that this requires a population open to being re-educated on how to achieve and maintain good health—a struggle in any community.

6.7 Alternative Explanations

There are several obvious differences between Spain and Brazil that are often put forth to explain poor policy performance in cross national comparisons. In particular, federal and electoral institutions in Brazil and Spain might well have implications for the successful implementation of equity-enhancing reforms.

The Brazilian upper chamber is a functional body of territorial representation with a veto in central policy making, while the Spanish upper chamber is not. Yet despite the presence of the Senate, in Brazil asymmetric influence of strong governors and intergovernmental bargaining outside the legislature is common, as it is in Spain. Still, we might expect the intense malapportionment in the Brazilian legislature⁵, which carries a territorial logic into the allotment of seats in the lower house (as well as the Senate), to hamper equity-enhancing policymaking. But as it turns out, the Spanish lower chamber is nearly as malapportioned as the Brazilian lower chamber (Samuels and Snyder 2001), granting nearly a third of available seats to provinces regardless of population. The structure of federal institutions themselves has therefore not been a major part of the story about differences in outcomes. While Brazil has much higher

⁵Stepan 2000; Ames 2002; Samuels 2003 among many others.

malapportionment than Spain in the upper chamber, giving traditionally conservative actors based in rural areas even greater sway over policymaking, the strength of minority nationalism in bilateral intergovernmental bargaining has a similar effect in the Spanish case, from a veto actors perspective.

The differences in the electoral and political systems are substantial. Spain has a parliamentary system while Brazil has a presidential system in which the executive has a separate mandate from the legislature. In addition, the closed list proportional representation and highly disciplined party structure in Spain is a far cry from the open list system with famously undisciplined parties in Brazil. Yet even these differences cannot explain variation in reform outcomes. While the implications of having a presidential or parliamentary system has been much discussed in relation to democracy and veto actors⁶, under multilevel governance the arguments must be expanded to take account of the level at which veto players are operating.

In Brazil, the pro-reform actors at the center have generally been stronger in the national executive than in other federal branches or other territorial levels of government. Neither the PSDB nor the PT, the two parties that began extending equity-enhancing health and social policies across the country, had anything close to majorities in the legislature. Presidentialism in Brazil may have permitted more autonomy for reform minded presidents than would have been possible in a parliamentary system with the same distribution of legislative seats. The legislature has often been the most conservative brake on executive attempts at equity-enhancing reform during the past two decades. Under a parliamentary system Cardoso and Lula might never have been. Even if these leaders did emerge from a coalition government, they may have had greater difficulty implementing many of their progressive policy reforms given the weakness of their own parties in the legislature.

⁶Linz 1985; 1990; Mainwaring and Shugart 1997; Tsebelis 1995; 2011.

While Spanish institutions are quite different, this variation does not appear to have been especially consequential for equity-enhancing health reform. Central coalition allies in the legislature—minority nationalist parties on the right for central actors on the left and right from 1993-2000—generated pressures for regressive reforms (for the country and poor ACs) that could not be ignored without causing the government to fall. In line with Tsebelis' assessment of how presidential and parliamentary systems can produce similar numbers of veto actors under certain conditions (1995), we see that this institutional difference cannot explain variation in outcomes between these two cases.

From a multilevel perspective where equity-enhancing reform demands a relevant role for the central government, Brazilian presidentialism has been particularly important. The central state has become a more powerful actor under both Cardoso and Lula. Subnational units are no less democratic and their institutional status has not changed, but capable actors at the center with urgent reform agendas—primarily economic for Cardoso and social for Lula—pushed these presidents to search for ways to increase their leverage vis-à-vis subnational units.

The increased protagonism of central executives has been equity-enhancing for social reforms. It has not stopped capable and committed subnational actors from innovating and experimenting, topping up or expanding access and programs, or even eschewing central funds tied to particular models of service provision. Yet the combination of macroeconomic reforms and increased transparency and accountability have made it harder for subnational authoritarians to maintain clientelistic control over their states. Cardoso and Lula incentivized uncommitted actors to take up equity-enhancing reforms and stabilized the country's economy. Strong presidentialism has therefore not been a brake on equity-enhancing reform in post-1988 Brazil.

The lack of disciplined parties and the additional pressures created by open list

proportional representation might be a different story. In Brazil, while the parties on the left are somewhat more programmatic than other parties, outside the PT discipline is fairly weak⁷, party switching is high, and personalism intense. Yet once again the challenges for democracy are more clearly established than the challenges for equity-enhancing reform.

In Spain, party discipline is high (Montero 2005), yet under multilevel governance this discipline has often created roadblocks to common sense reform in the realm of fiscal and health policy. While in the early years after democratization, pacting among major actors on important reforms was common, this tendency has crumbled over time (Encarnación 2008). Multilevel governance under high party discipline has meant that actors in the ACs often take one stance when their analogous party is in power at the center, and overnight change their position when a new party comes to power. The same has been true of the center, particularly for the PP, which has supported decentralizing Statute reforms for non-nationalist ACs while blocking identical clauses for Catalonia.

In Brazil, on the other hand, the PT has been able to spread its policies country-wide at the municipal level despite having weak representation in municipal governments vis-à-vis other parties, holding few governorships, and having nothing close to a majority in the legislature. Why? The policies of Lula and now Dilma have been incredibly popular and other parties, which if more disciplined might have to reject such alliances, have been eager to jump on board with the PT program. Paradoxically, lack of discipline in Brazil may have permitted ideological flexibility for center right parties to adopt equity-enhancing policies and form government with the left. I do not argue that these are costless alliances, but given the PT's disproportionate strength in the presidency, the policy results suggest that it has been a winning

⁷While the DEMS have been fairly disciplined in their opposition since 2003, the party is in the process of imploding.

strategy for equity and one that might have been much more difficult with greater discipline in other parties. The PT has been able to maneuver in this system without fundamentally altering its own internal standards or organizational rules, which remain highly disciplined and ideological (Hunter 2009).

What lessons should we take, then, from the inability of these oft-cited culprits to explain variation in outcomes between Spain and Brazil? First, that the need for a strong center for the extension of equity-enhancing reform requires that we modify our expectations of particular institutional arrangements, particularly under multi-level governance. Second, the relationships are probabilistic and not deterministic and there are simply cases in which constraints that may not be ideal for democratic development are not so nefarious for equity-enhancing reform given particular constellations of power.

6.8 Conclusion

In this Chapter I have argued that institutional differences between the two countries have been far less important for variation in reform outcomes than differing levels of commitment and capacity. This should be a hopeful sign for reformers, since commitment and capacity are far more easily influenced by political effort than are electoral systems and federal institutions. However, to some extent equally uncontrollable historical accidents of timing have had an important influence—in particular, where the transition to democracy and the first attempt at reform fell in relation to international ideological support for neoliberalism. World region has mattered some—the PT in the Latin American context was much more timid about antagonizing private actors than the PSOE had to be in the context of the EU. And clearly EU structural funds enhanced the capacity of poor ACs in Spain. Yet being in Europe did not keep Spain from being affected by pressures for neoliberal reform. Because Spanish reform was swift and well funded, it was quickly consolidated and was more

insulated from early demands for retrenchment.

Because I chose a set of cases with comparable histories and subnational variation in health authority, I could not compare federal and non-federal cases. Yet this has presented the opportunity to assess the conditions under which equity-enhancing reforms are more or less feasible in the least likely cases—in particular, asymmetric territorial authority with ethno-linguistic or racial heterogeneity and limited fiscal capacity. Avoiding high levels of decentralization in health policy and financing poses less of a democratic challenge in non-federal countries.

Timing and sequence have been important for both cases. In Spain the absolute majority of the socialists at the center, prior to health devolution for most ACs and at a moment when the international context was also favorable for reform, greatly facilitated the process. In Brazil the SUS was created in a context of economic crisis and support for neoliberalism both internationally and within the conservative central government, after significant authority had been given to subnational units. Because reform was delayed at the center and states and municipalities were empowered to provide health services, innovation and experimentation took place in committed and capable subnational units. Yet major improvements in the worst off regions of the country had to wait until committed actors reached the central government.

The pace of reform has lined up almost precisely with the strength of commitment. In Spain the left prioritized health policy and had an absolute majority, so reform happened immediately and the SNS was extended and consolidated quickly. In Brazil, Cardoso's Health Ministers represented a major improvement over the previous government and took important steps toward fuller implementation and financing of the SUS. Lula's governments overall were more committed so the social policy network became much more equity-enhancing, but health policy was not the primary focus. Only in 2011 did a major shift in focus toward health commence, and at this point the

Ministry was beginning a race against the clock as worldwide economic crisis began to substantially impact the Brazilian economy.

While Spain was quite successful in implementing reform, the challenges of conflict over the reference community and the center's weakness in holding ACs accountable present clear limitations for equity. Quality, access, coverage, and spending vary significantly across ACs and since 2003 it has become increasingly difficult for the central government to enforce health policy even in the areas theoretically under its authority. While these problems illustrate the likely consequences of highly decentralized social policy control, the experience of Brazil suggests that if the center is not emptied of authority and cares about equity, accountability can be developed over time.

The importance of formal legislative victories is also made clear in these cases. In Brazil, the presence of the constitutional mandate for health has meant that the problems that arose from failure to implement health reform early could be overcome once committed actors were in place in the central government. The pace of primary care extension has been quite similar in both countries and took two decades to be fully extended in Spain. In Brazil, the PSF has only been solidified as the national model for care in the past few years and extension continues to be very slow in the places that did not attain high levels of coverage fairly quickly. Luckily, the poorest states have the best coverage. Unluckily, this is not where the bulk of the population resides and does not bode well for building a broad multi-class coalition in defense of the SUS.

Commitment has been the single most important element of reform, and it has been far more important for equity-enhancing reform when concentrated at the center than when it has been dispersed at the regional level. The interaction of commitment with the timing and sequence of reform gave Spain an important leg up in consolidating a comprehensive reform, quickly. Yet in the end, in the face of prolonged economic

crisis that has eaten into both fiscal and administrative capacity, both health systems have proven vulnerable. The Spanish SNS will likely be cut back even further before conditions improve, while the steady pace of expansion in the SUS in Brazil will almost certainly slow down.

7 CONCLUSION

As part of a growing body of empirical scholarship on multilevel governance, this dissertation uses statistical and comparative historical analysis to assess the impact of multilevel governance on health reform in Spain and Brazil. I focused on the conditions for generating equity-enhancing reforms even under “hard” conditions—recent legacies of authoritarian rule, asymmetry in regional authority, ethno-linguistic or racial heterogeneity, and limited fiscal capacity. This approach suggests that leverage over complex causal problems can be gained by carefully unpacking the timing and sequence of reform at multiple levels of government. For distributional questions, hypothesized relationships will be conditioned by multiple factors and the same policies should have different effects on different regions, depending on their relative position within the country and sometimes even the international community.

While this is a question of academic interest, the findings should be of greatest value for reformers contemplating the design of institutions or policies. I therefore close by summarizing the findings with this application in mind. Both countries attempted broadly similar health reforms with varying levels of decentralization and asymmetry in regional authority over health. In Spain both commitment and capacity were strong at the center and in many ACs at the moment when health reform was first attempted. This resulted in faster and more complete implementation, which in turn solidified public and political support and safeguarded the system against retrenchment for many years. The logic of decentralization was unrelated to the goals of the reform and as a result allowed the quality of reform to be dictated in part by the levels of commitment and capacity in those ACs with authority over health.

In Brazil commitment and capacity were much weaker at the moment when health reform was first attempted and early decentralization took place without oversight or accountability mechanisms. The reform was not funded for several years and then inadequately, which led to piecemeal implementation, the consolidation of powerful private health actors opposed to expansion of the system, and the creation of a stigma among the middle and upper classes. Yet overall the system has remained more centralized than in Spain, which has permitted committed central actors to improve access and quality even in states and municipalities without committed or capable governments. While the PT government since 2003 has been committed to equity-enhancing reform, health has not been the focus of the executive and this lack of prioritization has made progress slow.

In Spain the current economic crisis has generated impulses for dismantling the SNS, while in Brazil economic belt tightening now threatens to halt the slow but steady progress made in the SUS in recent years. What, then, are the conclusions one can take away from the experiences of these two countries?

1. Multilevel governance has always existed and policy makers and academics could produce more effective policies and more useful theories by explicitly accounting for its influence. In particular, public finance impacts regions differently depending on their distributive profile and position within the country and the international economy. The way multilevel interests interact with the institutions of the state influences policy outcomes and the results are not always intuitive.

2. Ideological commitment to equity is necessary for the creation and implementation of equity-enhancing health reform. In both Spain and Brazil the extension of citizenship-based rights to even the most basic health services has

required high levels of ideological commitment and been strongly opposed by conservative political and economic interests at the moment of reform. Only in one region out of 44 has commitment come from a sense of solidarity with a territorially defined community—from nationalism. In all other cases of the creation and implementation of equity-enhancing health policy, left or center-left partisanship was the source of commitment. Even in the Basque Country, the PNV has been in coalition with the left from 1986-2009.

Commitment has been most important for the policies that should have been the least contentious—cheap, effective primary care coverage. Higher levels of curative health service consumption are not better for health, which makes equity-enhancing health reform different from social assistance, for example. Shifting from a model of care in which highly paid medical equipment producers, hospital administrators, surgeons, and specialists dominate provision to one in which nurses, community health agents, health educators, and general practitioners offer low-intensity and preventive care eliminates economic benefits for powerful societal actors. In addition, middle and upper class users do not demand public primary care as they do access to more expensive treatment. This explains the seemingly incongruous findings in both Spain and Brazil, where public coverage of hospital and ambulatory care advanced much farther, much faster, than universal access to primary health care, with much less opposition from elites.

Successfully consolidated reforms can be maintained in the absence of high commitment, though as we see in the case of Spain, even the most popular programs can be retrenched when economic pressure is intense and commitment low.

3. A capable and committed central government is necessary for countrywide equity-enhancing reform. Fiscal and administrative capacity tend to be lacking in the regions with the poorest and most vulnerable populations. High

levels of policy authority will disadvantage these regions compared to higher capacity regions, even if the level of regional commitment is held constant. Since commitment is not constant, we have seen that in Spain when the center had little authority, if regional commitment was lacking, even the highest capacity regions did not make good on their health policy responsibilities.

In Brazil, low capacity and low commitment have mostly been concentrated in the same regions, contributing to stagnant levels of inequality in the worst off regions while the biggest improvements have taken place in the areas that were already doing the best. And like Spain, some of the richest regions have invested the least in extending universal access to care. Yet because of a strong and committed center, access to primary care is high in the lowest capacity areas, many of which do not have committed governments.

This means that regardless of how unsavory central political leadership is at a particular moment, weakening central government authority to redistribute resources and hold regional actors accountable for citizenship rights will limit capacity for successful equity-enhancing reform, potentially leaving the neediest members of society with little protection (depending on the commitment and capacity of their region). This is one of the most significant challenges of multilevel governance.

4. Not all decentralizing reforms are made equal. Among policy makers there have been two different logics behind decentralization—one that is pragmatic and determined by policy goals and one in which a particular territorial distribution of authority is a goal in and of itself. If the former is subordinated to the latter, decentralization will likely produce unintended consequences. Since decentralization processes appear to exhibit increasing returns, creating vested interests and new regional veto actors, failure to consider the potential drawbacks of increased devolution can be costly for reformers concerned with equity.

Early progressive reformers in both countries supported very high levels of decentralization of policy control, in addition to the creation of democratic regional institutions, because of their particular historical context transitioning away from right wing authoritarian centralization. In Spain these early reformers largely failed to achieve early health devolution because the conservative forces governing after the transition were Spanish nationalists with an ideological preference for centralization, whereas in Brazil they succeeded because the neoliberals in power after the transition also supported decentralization. Yet the success of equity-enhancing reform in Spain is partly due to the fact that most of the country had centrally controlled health provision when equity-enhancing reform was implemented.

In Spain, decentralization in health was first driven by minority nationalism and then by a conservative central strategy for retrenchment, rather than a logic of effectiveness, capacity, or efficiency in health provision. The result was that coverage and access varied considerably once health responsibilities were devolved. Poor ACs did better if they remained in the central system longer, as did those whose local governments were ideologically opposed to public health provision.

In Brazil, the first significant wave of health decentralization took place between 1988 and 1993 and also had no orientation toward guaranteeing equal access or coverage. Later reforms took place under more committed central leadership that tied new responsibilities to the implementation of oversight mechanisms, regulation, basic minimums, and successful capacity building. Decentralization of health under this logic has been far more equity-enhancing for health care.

5. In multi-national states, finding arrangements that satisfy territorial veto actors is a key part of ensuring the capacity of all regions to implement equity-enhancing reforms. Ongoing conflict over the legitimate territorial

reference community for redistribution or other public policies saps capacity for reform at the center, in the affected regions, and often in other regions as well. This conflict also divides committed actors along a territorial dimension.

Hindsight is 20-20 and actors themselves change over time, so accommodating the self-rule strivings of minority nationalists in a way that does not sacrifice the capacity of the center to implement equity-enhancing reform in the rest of the country is easier said than done, yet this is the ideal balance for the long-term sustainability of reforms. The compromises made among elites at the moment of democratic transition do not always facilitate this process. In Spain this was the cost of peace, yet the fact that some actors had a vision of their territorial community that was incompatible with the vision of others has been a source of ongoing political and violent conflict.

While I would reject the notion that there exists an objective “ideal” territorial arrangement for multinational states, I do suggest that political actors in Spain have tended to underestimate the cost of ongoing conflict. Keeping Catalonia in the common fiscal regime has meant a large and powerful region successfully demanding across the board increases in regional authority that reduce the equity-enhancing capacity of the center and disadvantage poor regions. Asymmetric arrangements with the Basque Country on fiscal matters has largely eliminated conflict along this dimension.

5. Shock therapy is not just for neoliberal reform. While some opponents of equity-enhancing social policy reform are ideologically antagonistic to equity itself, many act out of uncertainty about how their professional or economic interests will be affected by reform. If reforms can be implemented and consolidated quickly, actors adjust and markets find ways to operate under new conditions. Yet when reform is incomplete and is always on the table but never consolidated, opposition can become entrenched and uncertainty lingers. The OECD countries are full of former opponents of health reform whose opposition shriveled once the shift was consolidated.

6. Integrating social policies expands the equity-enhancing possibilities of each component. The most innovative regions in both countries have been integrating not only the different components of health care provision, but integrating health care with social services and social assistance, as well as with education in some circumstances. This requires changes in the way state agencies function but has led to increasing coordination and a more holistic approach to the idea of “welfare.”

7. Equity-enhancing policies do not have to be more expensive. Committed actors under fiscal pressure must prioritize spending, but the notion of “rationalization” or “cost-cutting” often provokes strong negative reactions from the traditional bases of support for left parties. Yet empirical evidence has increasingly shown that the shift of social care (the prevention of illness, the care of young children, social care for the elderly) from families to markets has had some important social costs under existing models of care provision. Many of these social costs manifest themselves in worse health outcomes related to stress, isolation, and the replacement of social bonds with institutional ones. Public providers therefore have a unique opportunity to think creatively about how to protect families from risk, support women’s equality, provide a solid starting point for the young, and create the foundations for reducing socio-economic inequality without supporting a logic of ever-increasing consumption.

In part because of economic necessity and in part because of a broadly framed constitutional guarantee of the protection of “health” (rather than a right to health care), Brazilian reformers have gone the farthest in thinking about the protection of health as a process that must be embedded in community and empower users to be protagonists of their own health outcomes. This shift requires confronting the most powerful economic interests in medicine and often other areas such as the hospital management, construction, and insurance industries. Paradoxically, the shift has been easier along some dimensions in regions that were so poor they had never established

powerful private medical interests. This suggests that poor countries and regions may have a unique opportunity to develop equity-enhancing social policies that have a different logic from the consumption-based market models that dominate in most advanced industrial countries.

Finally, these shifts also require transformations in areas that feed into social policy—in the case of health, the reform of medical school curricula has been an important focus in Brazil. Helping socialize young medical professionals toward a different model of care plays an important role in the sustainability of reform.

8. Primary care is not just for the poor. While evidence in support of primary care as an organizing model for the most efficient and effective public health systems has grown in recent years, the framework has often focused on an assumption that this is a model for poor countries. Yet outside of utterly desperate cases, the most serious modern health problems are increasingly shared across rich and poor countries, alike. And the health problems of the poor in rich countries are often not so different from those in middle-income and developing countries. As the British NHS undergoes radical reform and the United States searches for a way to lower health care costs and cover 50 million uninsured Americans, rich countries are just as much in need of a new model for health care as Spain and Brazil were in the 1980s.

8. History matters, but democracy has created the conditions for incremental progress, even in the hardest cases. Aside from the hard-to-measure qualities of democratic society itself, one of the clearest health contributions of the democratic transitions in these two countries has been the constitutional mandate for equal access to universal health coverage, guaranteed by the state. These have been formal rules that often do not look substantial when financing is scarce or legislation has never been implemented. Yet in both countries the role of the constitutional mandate has been clear and present. It has given reformers an anchor against which to

make demands for state action. Citizens are gaining an awareness of the gap between their social rights and their political reality. This has been a useful tool for reformers in both countries, and in Brazil meant that the legislative foundation existed for action, whenever committed actors were able to make headway. For some aspects of the original 1990 legislation, the lag was 21 years.

Progress in both cases has been steady until now, but the current world economic crisis will put both systems—one consolidated and one still expanding—to the test.

A TABLES AND GRAPHS

Figure A.1: Infant Mortality in Brazil

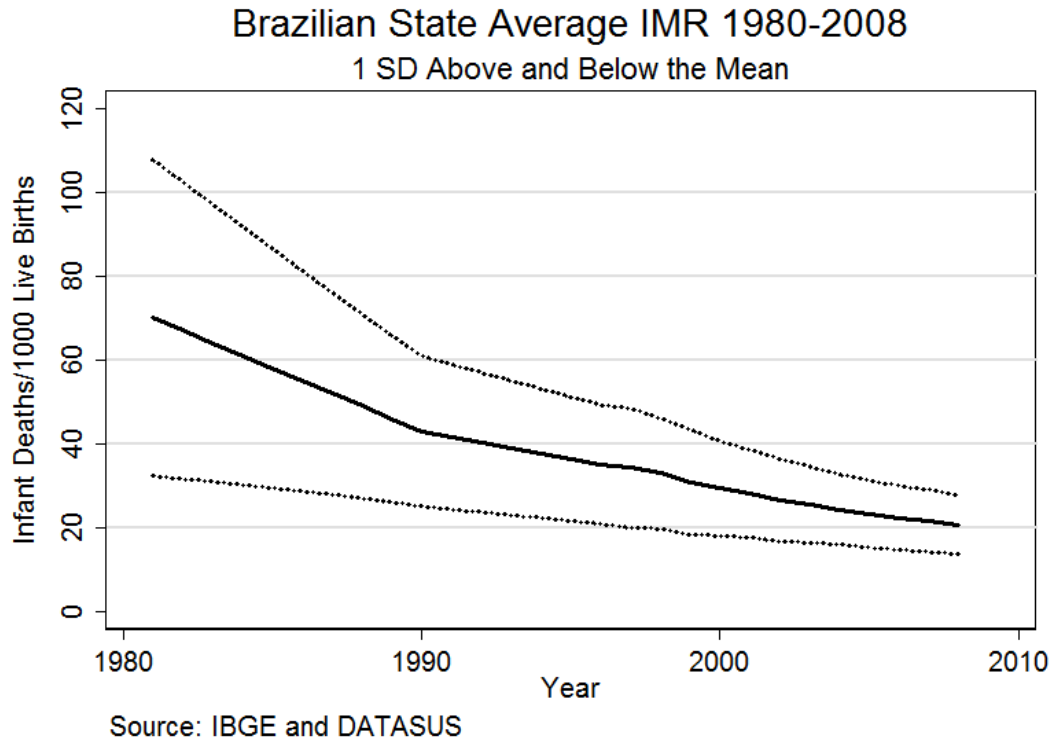
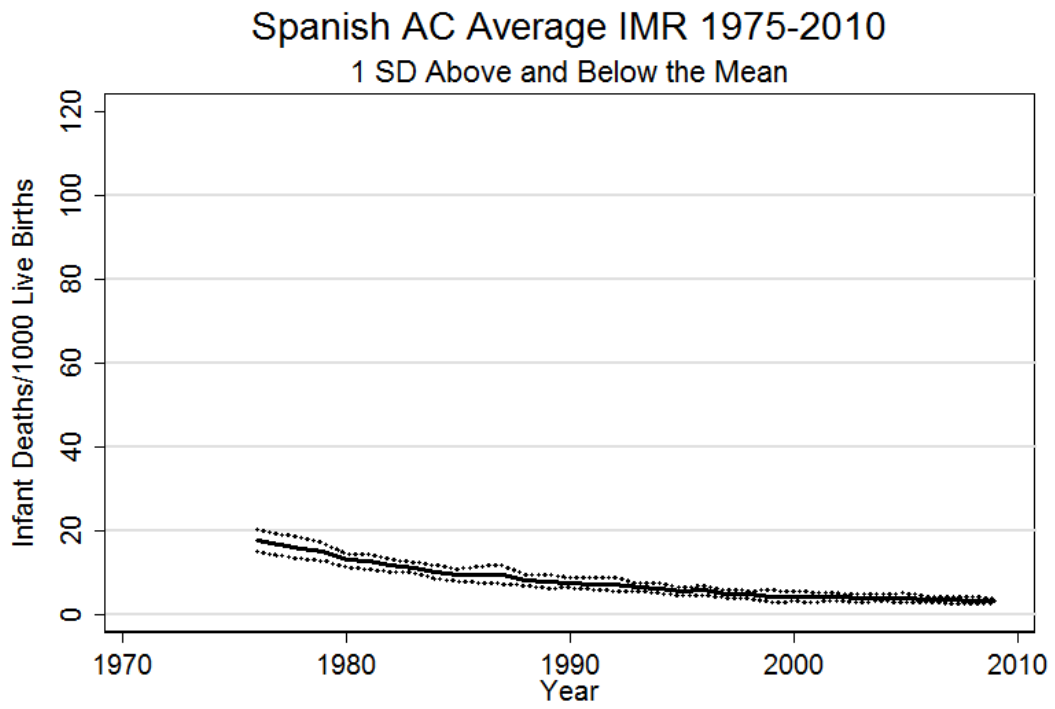
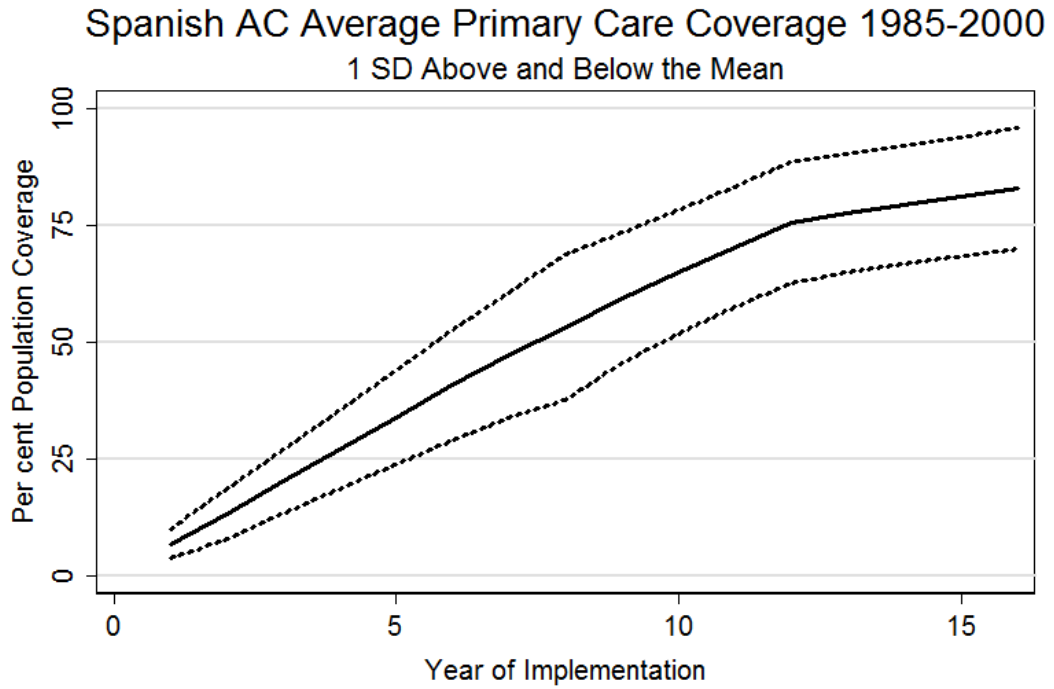


Figure A.2: Infant Mortality in Spain



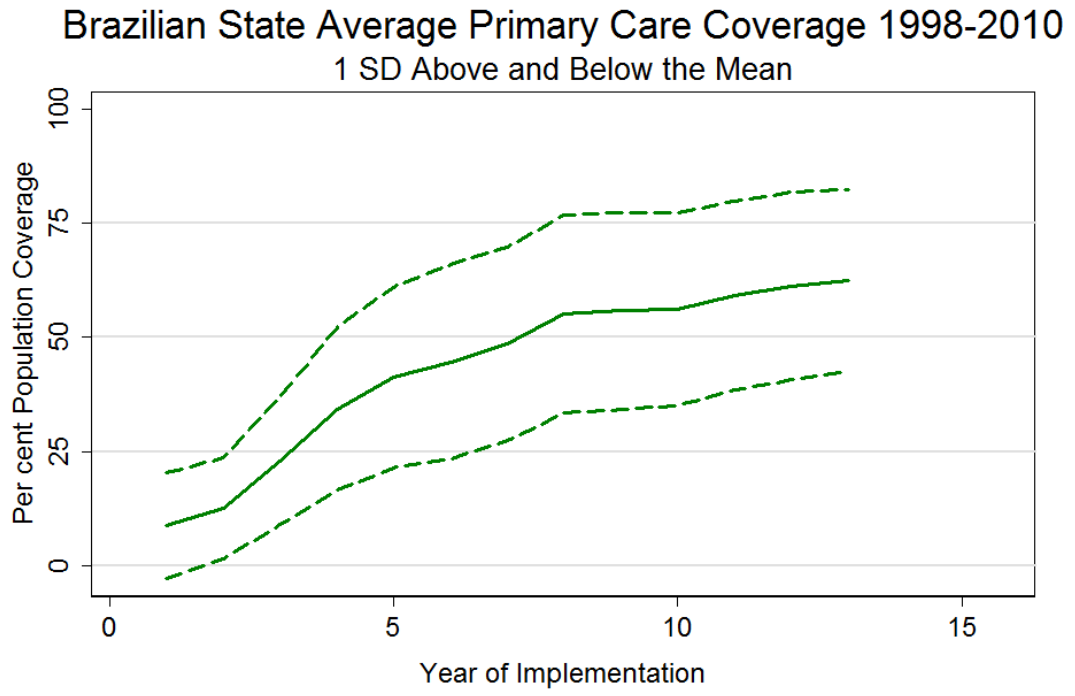
Source: INS

Figure A.3: Primary Coverage Rates in Spain



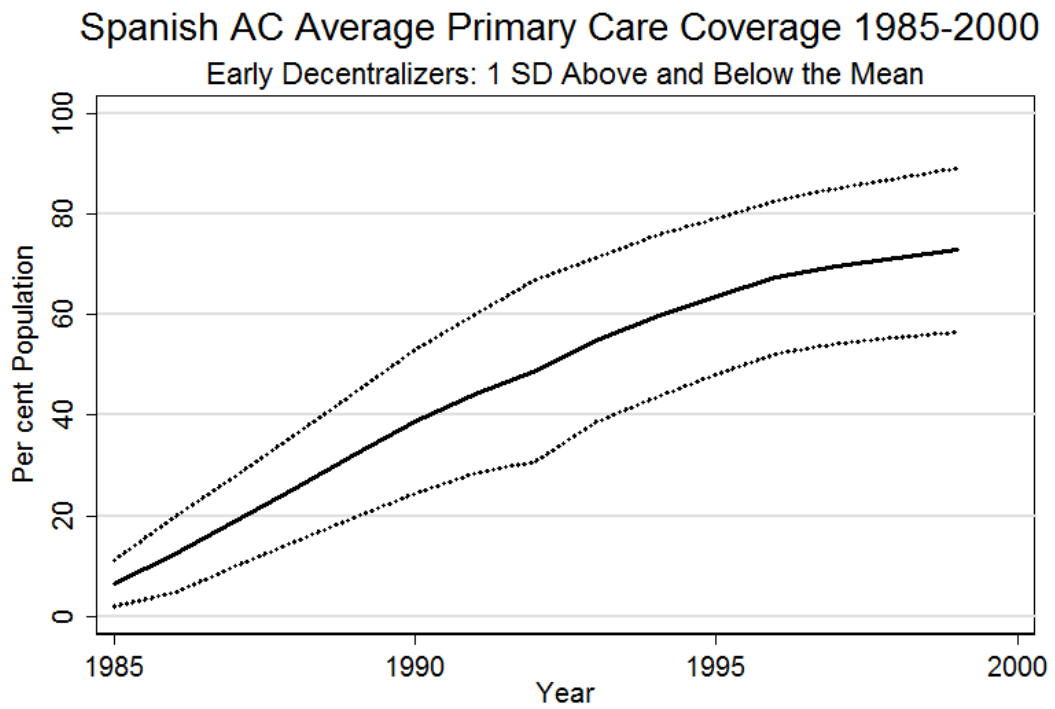
Source: González, et al 2004; López-Casasnovas, et al 2001

Figure A.4: PSF Coverage Rates in Brazil



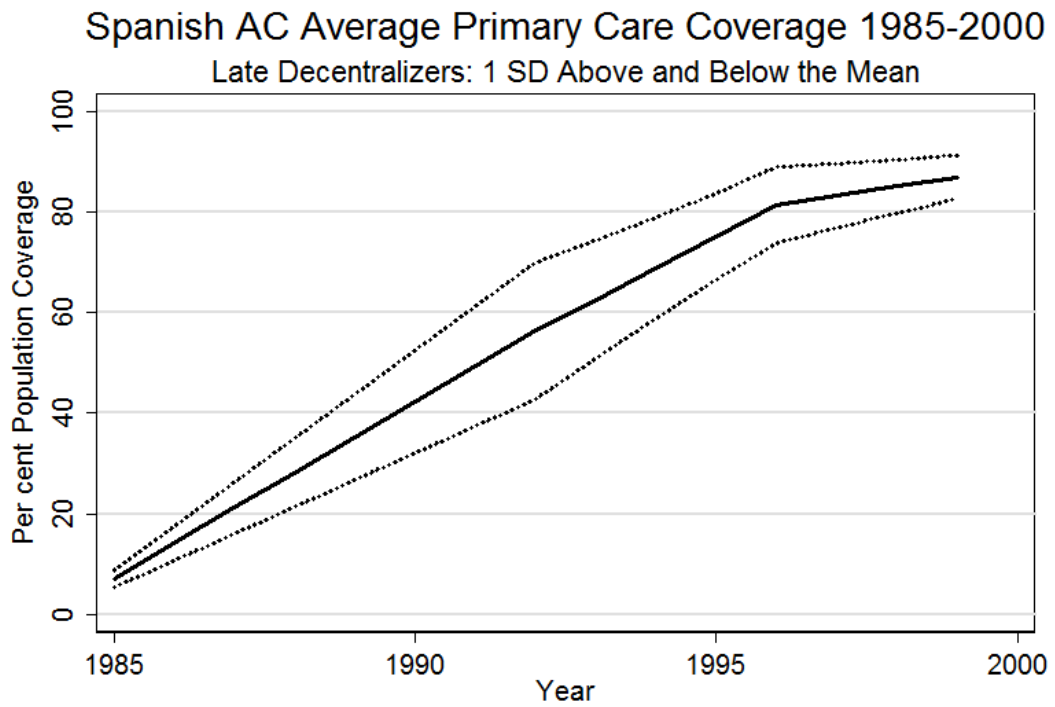
Source: DAB-MS

Figure A.5: Primary Coverage Among Early Decentralizers



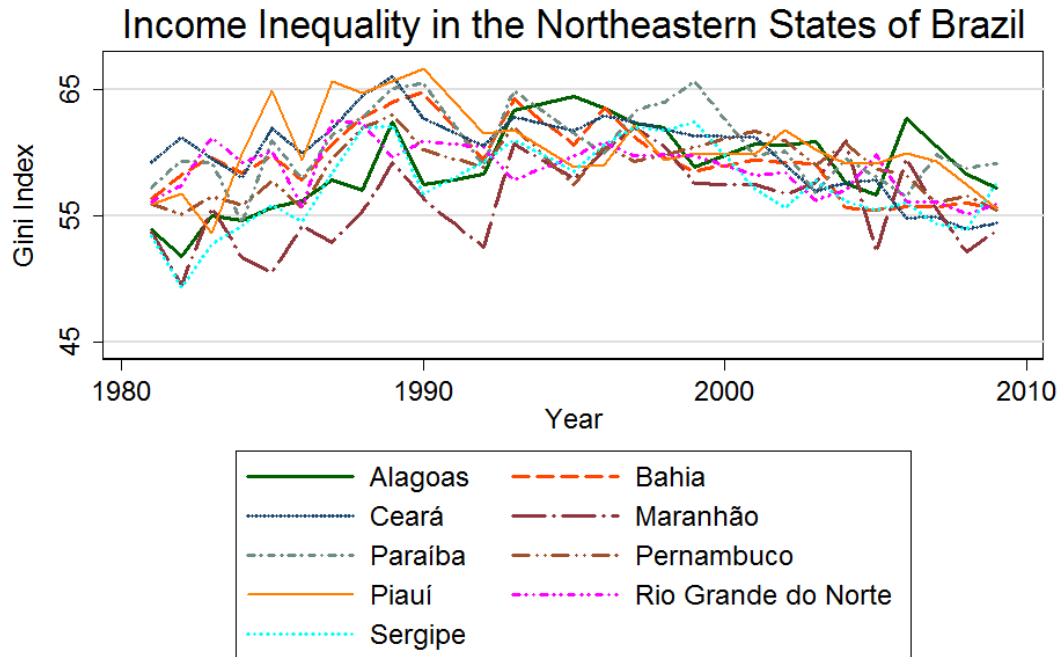
Source: González, et al 2004; López-Casasnovas, et al 2001

Figure A.6: Primary Coverage Among Late Decentralizers



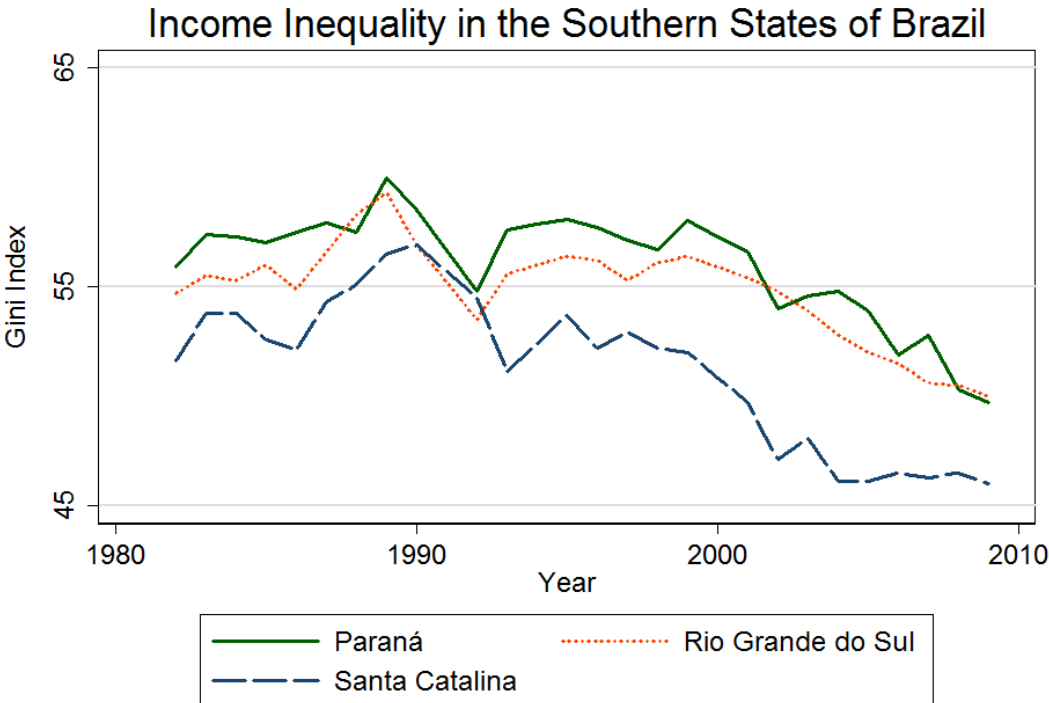
Source: González, et al 2004; López-Casasnovas, et al 2001

Figure A.9: Northeastern Ginis 1981-2009



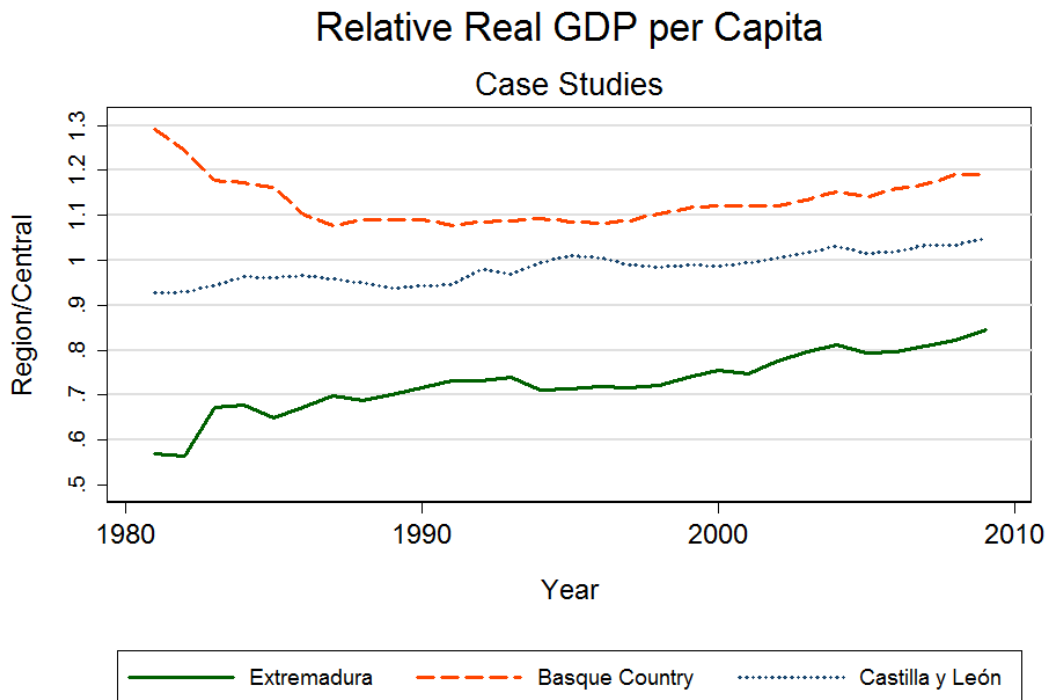
Source: IPEA

Figure A.10: Southern Ginis 1981-2009



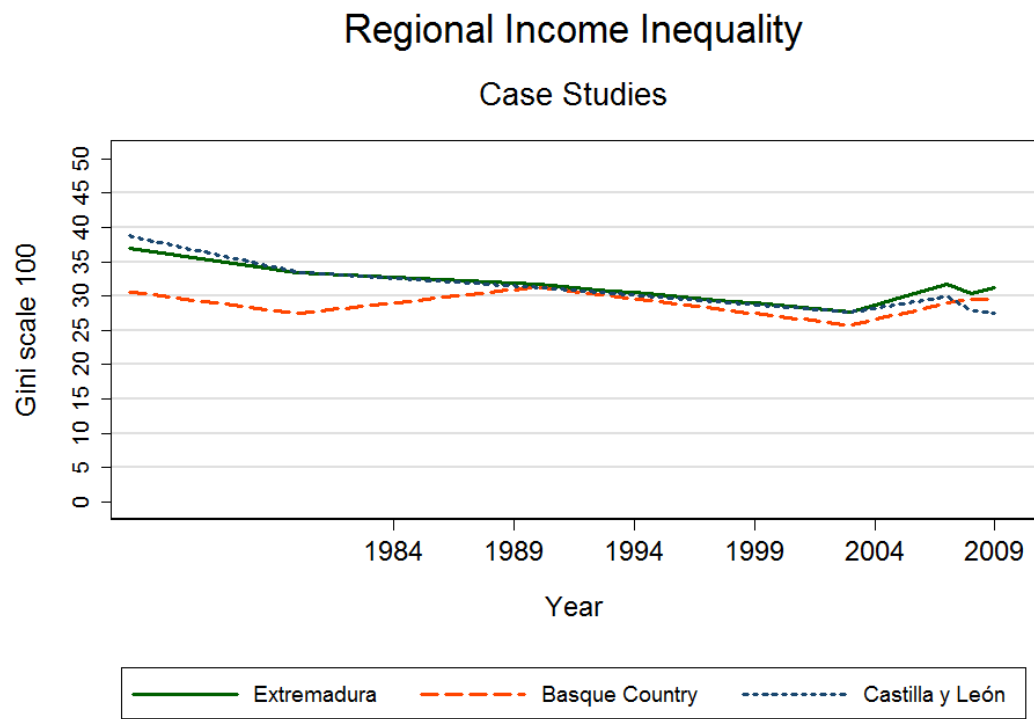
Source: IPEA

Figure A.11: Income: Extremadura, Basque Country, and Castilla y León



Source: Author's calculation

Figure A.12: Gini: Extremadura, Basque Country, and Castilla y León



Source: Goerlich and Villar 2009

Figure A.13: IMR: Extremadura, Basque Country, and Castilla y León

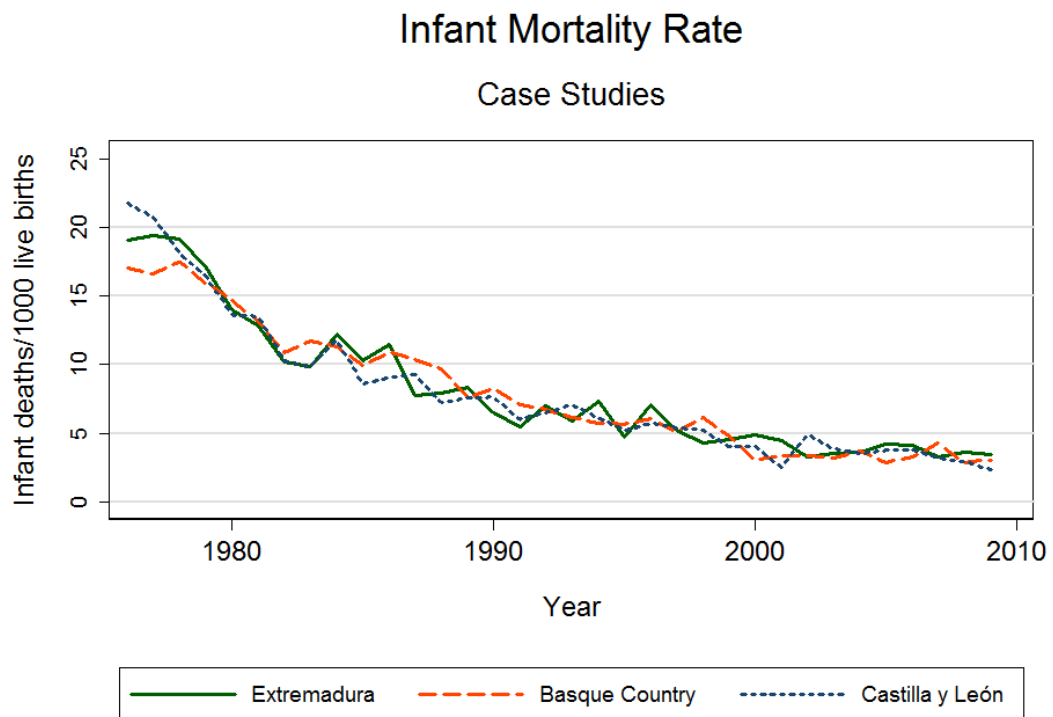
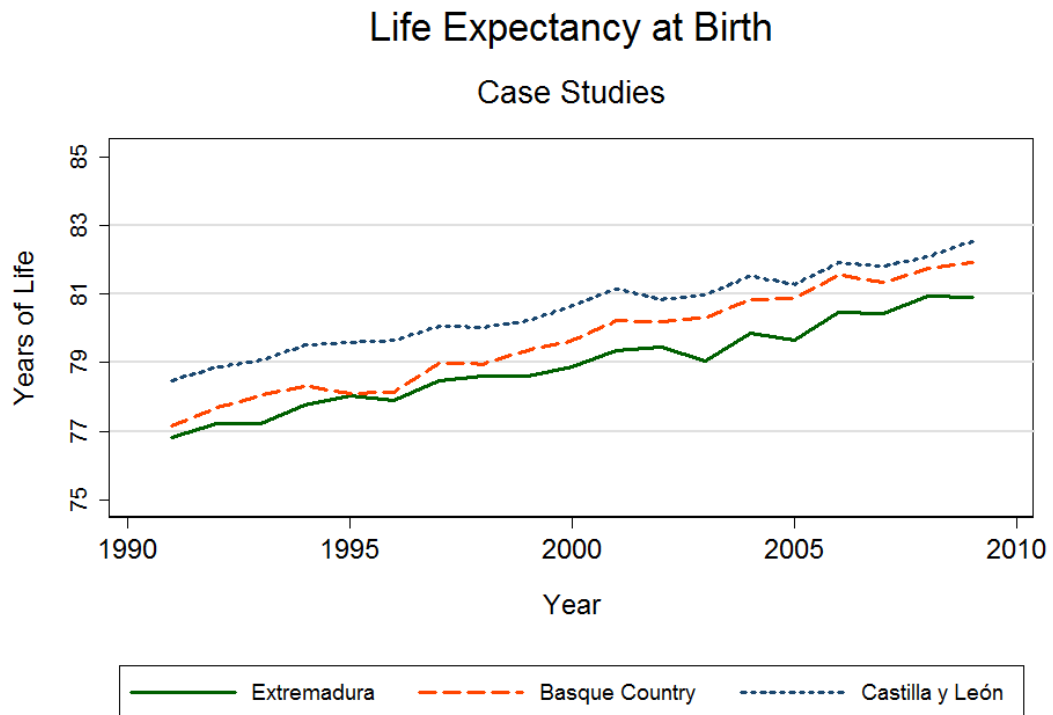
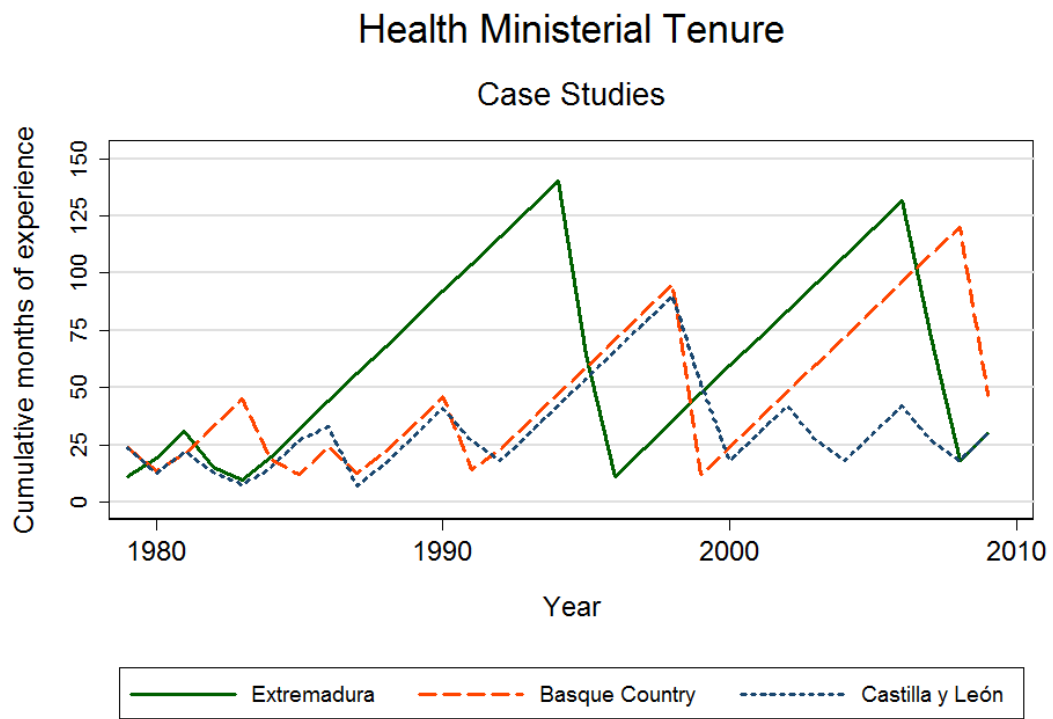


Figure A.14: LEB: Extremadura, Basque Country, and Castilla y León



Source: INEBASE Basic Demographic Indicators

Figure A.15: Health Ministers: Extremadura, Basque Country, and Castilla y León



Source: Author's calculation

Table A.1: Commitment, Capacity, and Decentralization in the Spanish ACs

<i>Variable</i>	<i>Time Period</i>	<i>Center</i>	<i>Extremadura</i>	<i>Castilla y León</i>	<i>Basque Country</i>
Authority	Constitutional Mandate (1978)	✓✓	-	-	-
	Enabling Legislation (1984-1986)	✓✓	✓	✓	✓
	Implementation (1987-2002)	✓✓	✓	✓	✓✓
	Consolidation (2003-)	✓	✓✓	✓✓	✓✓
Commitment	Constitutional Mandate (1978)	+/-	+/-	-	+/-
	Enabling Legislation (1984-1986)	++	+	+	+
	Implementation I (1987-1995)	+	+	-	+
	Implementation II (1996-2004)	-	+	-	+
	Consolidation (2005-2011)	+	+	-	+
Fiscal Capacity	Constitutional Mandate (1978)	+/-	-	-	+/-
	Enabling Legislation (1984-1986)	+	+/-	+/-	+/-
	Implementation I (1987-2001)	+	+	+	+
	Implementation II (2002-2007)	+	+/-	+/-	+
	Consolidation (2008-)	-	-	-	+/-
Administrative Capacity	Constitutional Mandate (1978)	+	-	-	+
	Enabling Legislation (1984-1986)	+	-	-	+
	Implementation I (1987-2001)	+	+/-	+/-	+
	Implementation II (2002-2007)	+	+	+	+
	Consolidation (2008-)	+	+	+	+

Table A.2: Commitment, Capacity, and Decentralization in the Brazilian States

<i>Variable</i>	<i>Time Period</i>	<i>Center</i>	<i>Bahia</i>	<i>São Paulo</i>
Authority	Constitutional Mandate (1988)	✓	✓✓	✓✓
	Enabling Legislation (1990-1993)	✓✓	✓✓	✓✓
	Implementation (1993-2010)	✓✓✓	✓✓	✓✓
	Consolidation (2011-)	✓✓✓	✓✓	✓✓
Commitment	Constitutional Mandate (1988)	-	-	-
	Enabling Legislation (1990-1993)	-	-	-
	Implementation (1994-2010)	+/-	+/-	+/-
	Consolidation (2011-)	+	+	+/-
Fiscal Capacity	Constitutional Mandate (1988)	-	-	+
	Enabling Legislation (1990-1993)	-	-	+
	Implementation (1994-2010)	+	+/-	+
	Consolidation (2011-)	+/-	+/-	+
Administrative Capacity	Constitutional Mandate (1988)	+	-	+
	Enabling Legislation (1990-1993)	+	-	+
	Implementation (1994-2010)	+	-	+
	Consolidation (2011-)	+	+/-	+

Table A.3: Spanish Parties

Parties in AC Cabinets 1977-2010						
<i>Party Name</i>	<i>Year</i>	<i>Code</i>	<i>Community</i>	<i>Activity</i>	<i>Notes</i>	
Partido Andalucista (PA)	1978-	SL† green	Nationalist (Andaluz)	Andalusia	The only minority nationalist party to join government in southern Spain.	
Partido Aragonés (PA)	1978-	SCR†	Nationalist (Aragonés)	Aragon	Originally the PAR, has governed in coalition with both PSOE and PP, and alone. Declared itself nationalist and changed its name in 1990.	
Unión Renovadora Asturiana	1998-1999	XCR	Regionalist	Asturias	Created from an escision with the PP of Aragón.	
Bloc per Mallorca (BLOC)	2006-2011	SL† green	Nationalist (Catalan)	Baleares	In coalition with PSM-EN.	
PSM-Entesa Nacionalista	1998-	SL† green	Nationalist (Catalan)	Baleares	Formed from independent socialist and green parties in Menorca and Mallorca.	
Unió Mallorquina (UM)	1982-2011	SCR†	Nationalist (Balear)	Baleares	Dissolved in 2011 over corruption scandals.	
Euskadiko Ezkerra (EE)	1977-1993	SL†	Nationalist (Basque)	Basque Country	Independentist, communist coalition between EIA and EMK. In 1982 was refounded as a socialist party, EE-IPS. In 1993 formed a permanent coalition with the PSE-PSOE.	
Partido Socialista de Euskadi (PSE-PSOE)	1977-1980	SCL†	Federalist	Basque Country	Envisioned a cuatri-provincial territory including Navarre, supported the right to self-determination, and ran with the PNV in the 1977 general elections as the Frente Autónomico.	
Partido Socialista de Euskadi (PSE-PSOE)	1987-1993	SCL	Federalist	Basque Country	By 1987 had clearly differentiated itself from Basque nationalism.	

†= minority nationalist coding

Spanish Parties continued

Parties in AC Cabinets 1977-2010					
<i>Party Name</i>	<i>Year</i>	<i>Code</i>	<i>Community</i>	<i>Activity</i>	<i>Notes</i>
PSE-EE	1993-	SCL	Federalist	Basque Country	Fusion of the PSE-PSOE fused with EE.
Eusko Alkartasuna (EA)	1986-	SL†	Nationalist (Basque)	Basque Country	An escision from the PNV. The two parties have governed together several times since.
Eusko Alderdi Jeltzalea-Partido Nacionalista Vasco (EAJ-PNV)	1895-	XCR†	Nationalist (Basque)	Basque Country, Navarre	Historically dominant force in Basque politics and has governed with the left for most of the democratic period (1987-2009).
Herri Batasuna (HB)	1978-2003	SL†	Nationalist (Basque)	Basque Country	Historical core of the sector of the unreformed <i>izquierda abertzale</i> , tied to ETA. Illegalized by the Spanish courts in 2003.
Agrupaciones Independientes de Canarias (AIC)	1985-1993	SCR†	Nationalist (Canarias)	Canarias	Formed part of the CC in 1993
Agrupación Tenerifeña de Independientes (ATI)	1983-1985	SCR†	Nationalist (Canarias)	Canarias	From an escision with the UCD and formed AIC with other small parties in 1985.
Coalición Canarias (CC)	1993-	SCR†	Nationalist (Canarias)	Canarias	Formed from most of the small center-right and centrist Canarias nationalist parties.
Partido Regionalista de Cantabria (PRC)	1978-	SC†	Regionalis (Cántabro)	Cantabria	Formed to defend the creation of a uniprovincial AC during the transition.
Unión para el Progreso de Cantabria (UPCA)	1991-2003	SCR	Personalist	Cantabria	Formed by Juan Hormaechea, in 1994 sentenced with his cabinet for corruption and misuse of public funds.
Convergència i Unió (CiU)	1978-	SCR†	Nationalist (Catalonia)	Catalonia, Spain	Dominant force since transition, a federation of the CDC (1974) and UDC (1931). UDC is XCR, but coalition is mostly secular.

†= minority nationalist coding

Spanish Parties continued

Parties in AC Cabinets 1977-2010					
<i>Party Name</i>	<i>Year</i>	<i>Code</i>	<i>Community</i>	<i>Activity</i>	<i>Notes</i>
Iniciativa per Catalunya Verds (ICV)	1987-	SL† green	Nationalist (Catalonia)	Catalonia	Split from IU and combined with Els Verds in Catalonia.
Partit dels Socialistes de Catalunya (PSC-PSOE)	1978-	SCL†	Nationalist (Catalonia)	Catalonia	The only case in which the PSOE affiliate is a minority nationalist force.
Partit Socialista Unificat de Catalunya (PSUC)	1936-1997	SL	N/A	Catalonia	Marxist, the PSUC was an important regional actor during the transition and later integrated into ICV.
Esquerra Republicana de Catalunya (ERC)	1931-	SL†	Nationalist (Catalonia)	Catalonia, Valencia, Balears	Pan Catalanismo, independence for all Catalan lands.
Bloque Nacionalista Galego (BNG)	1982-	SL†	Nationalist (Galicia)	Galicia	Has an independentist wing but has traditionally militated for greater autonomy.
Coalición Galega (CG)	1983-	SC†	Nationalist (Galicia)	Galicia	From sectors of the UCD, has run in coalitions Terra Galega and Compromiso por Galicia.
Partido Gallego Independiente (PGI)	1977-1983	SC†	Regionalist (Galicia)	Galicia	From sectors of the UCD, joined CG.
Partido dos Socialistas de Galicia (PSdeG-PSOE)	1977	SCL	Regionalist (Galicia)	Galicia	A “galleguista” party, but not independentist.
Partido Riojano Progresista (PRP)	1982-	SCR†	Regionalist (La Rioja)	La Rioja	Born from struggle for uni-provincial autonomy from Castilla y León. Renamed PR in 1990.
Convergencia de Demócratas de Navarra (CDN)	1995-2011	XC	Regionalist (Navarro)	Navarre	Formed from a sector of the UPN in 1995.

† = minority nationalist coding

Spanish Parties continued

Parties in AC Cabinets 1977-2010					
<i>Party Name</i>	<i>Year</i>	<i>Code</i>	<i>Community</i>	<i>Activity</i>	<i>Notes</i>
Orhi Mendi	1979-1983	SL†	Nationalist (Basque)	Navarre	Municipal party from Sangüesa, had both foral representatives and one cabinet portfolio in the pre-autonomic body for Navarre.
Unión del Pueblo Navarro (UPN)	1979-	XCR	Regionalist (Navarro)	Navarre	Supports special fiscal rights, but identifies as “constitutionalist” and has governed in coalition with the PP.
Alianza Popular (AP)	1977-1989	XR	Nationalist (Spain)	Spain	Formed during the transition primarily by ex-franquista ministers, became the PP in 1989.
Izquierda Unida (IU)	1986-	SL green	Federalist	Spain	The PCE proposed the creation of the IU in 1986 to manage growing cleavages within the communist left, includes several small parties.
Partido Comunista de España (PCE)	1921-	SL	Federalist	Spain	Has not been a powerful electoral force in the ACs or the center since the transition.
Partido Popular (PP)	1989-	SCR	Nationalist (Spain)	Spain	Formed from a more moderate AP in 1989, one of the two dominant central parties.
Partido Socialista Obrero Español (PSOE)	1979-	SCL	Federalist	Spain	One of the two dominant parties, operates in the center and the ACs through federal affiliates.
Partido Socialista Popular (PSP)	1968-1978	SL	Federalist	Spain	Absorbed into the PSOE in 1978.
Unión del Centro Democrático (UCD)	1977-1983	XCR	Nationalist (Spain)	Spain	Born from reformists inside and outside the Franco government in the final years of the regime, governed through the democratic transition.

†= minority nationalist coding

Table A.4: Brazilian Parties

Party of State Governors 1982-2010			
<i>Party Name</i>	<i>Year</i>	<i>Code</i>	<i>Notes</i>
Partido dos Trabalhadores (PT)	1980-	SL†	Known for discipline and program, the dominant party on the left.
Partido Socialista Brasileiro (PSB)	1947-	SL†	Coppedge codes SCL until 1986. The party was illegal under the military regime.
Partido Democrático Trabalhista (PDT)	1980-	SCL†	Only Brazilian member of the Socialist International.
Partido Popular Socialista (PPS)	1992-	SL†	Formed after the fall of the USSR when the Partido Comunista Brasileiro reformed.
Movimento Democrático Brasileiro (MDB)	1965-1980	SCL†	Legal opposition during military rule, became the PMDB in 1980.
Partido do Movimento Democrático Brasileiro (PMDB)	1980-	SC†	Successor to the MDB and the largest party in Brazil.
Partido da Social Democracia Brasileira (PSDB)	1988-1994	SCL†	Split from the PMDB in 1988.
Partido da Social Democracia Brasileira (PSDB)	1994-	SC	Party begins to shift right in national government with PFL and PDS? Considered SCR after 1998.
Partido Social Cristão (PSC)	1985-	XC†	Member of the “Brasil Novo” coalition that supported Collor in 1989.
Partido Social Trabalhista (PST)	1996-	SCR†	Formed in 1988 but immediately split into several other parties, re-formed in 1996.
Partido Social Democrático (PSD)	1945-2002	SR†	Refounded in 2011 by dissidents from various other right parties.

† = coded by Coppedge 1997

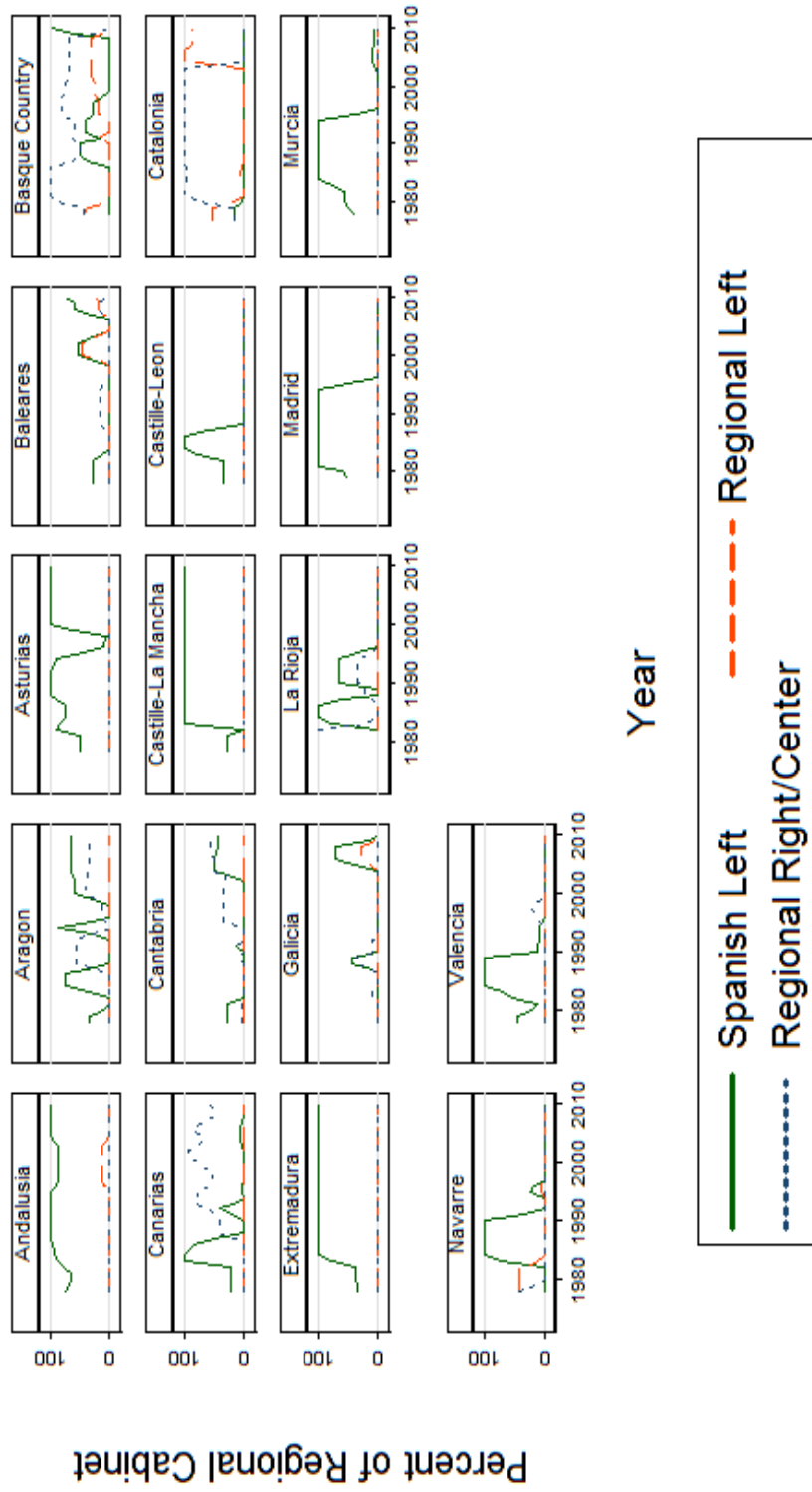
Brazilian Parties continued

Party of State Governors 1982-2010			
<i>Party Name</i>	<i>Year</i>	<i>Code</i>	<i>Notes</i>
Aliança Renovadora Nacional (ARENA)	1965-1979	SR†	Official party of the military regime.
Partido Progressista Reformador (PPR)	1993-1995	SR	ARENA successor, formed by the PDS and PDC for one election cycle and then formed the PPB.
Partido Progressista Brasileiro (PPB)	1995-	SCR†	ARENA successor, formed by the PPR in 1995, changed name to PP in 2003.
Partido da Frente Liberal (PFL)	1985-2007	SR†	ARENA successor, formed from a split with the PDS and changed name to DEM in 2007.
Democratas (DEM)	2007-	SR	Previously the PFL.
Partido Democrático Social (PDS)	1980-1993	SR†	ARENA successor, dissolves in 1993 to form the PPR with the PDC.
Partido da Reconstrução Nacional (PRN)	1989-2000	P†	Formed around Collor in 1989 and became the PTC later.
Partido de Reedificação da Ordem Nacional (PRONA)	1990-2006	SR†	Formed the PR with the PL in 2006.
Partido Liberal (PL)	1985-2006	SR†	Held the VP position during Lula's first term.
Partido da República (PR)	2006-	SR	Formed from the PL and PRONA.
Partido Trabalhista Brasileiro (PTB)	1945-	SCR†	SCL before the military regime, the party was refounded after the transition as a nationalist party by Vargas' daughter.

† = coded by Coppedge 1997

Figure A.7: Left and Minority Nationalist Parties by Autonomous Community

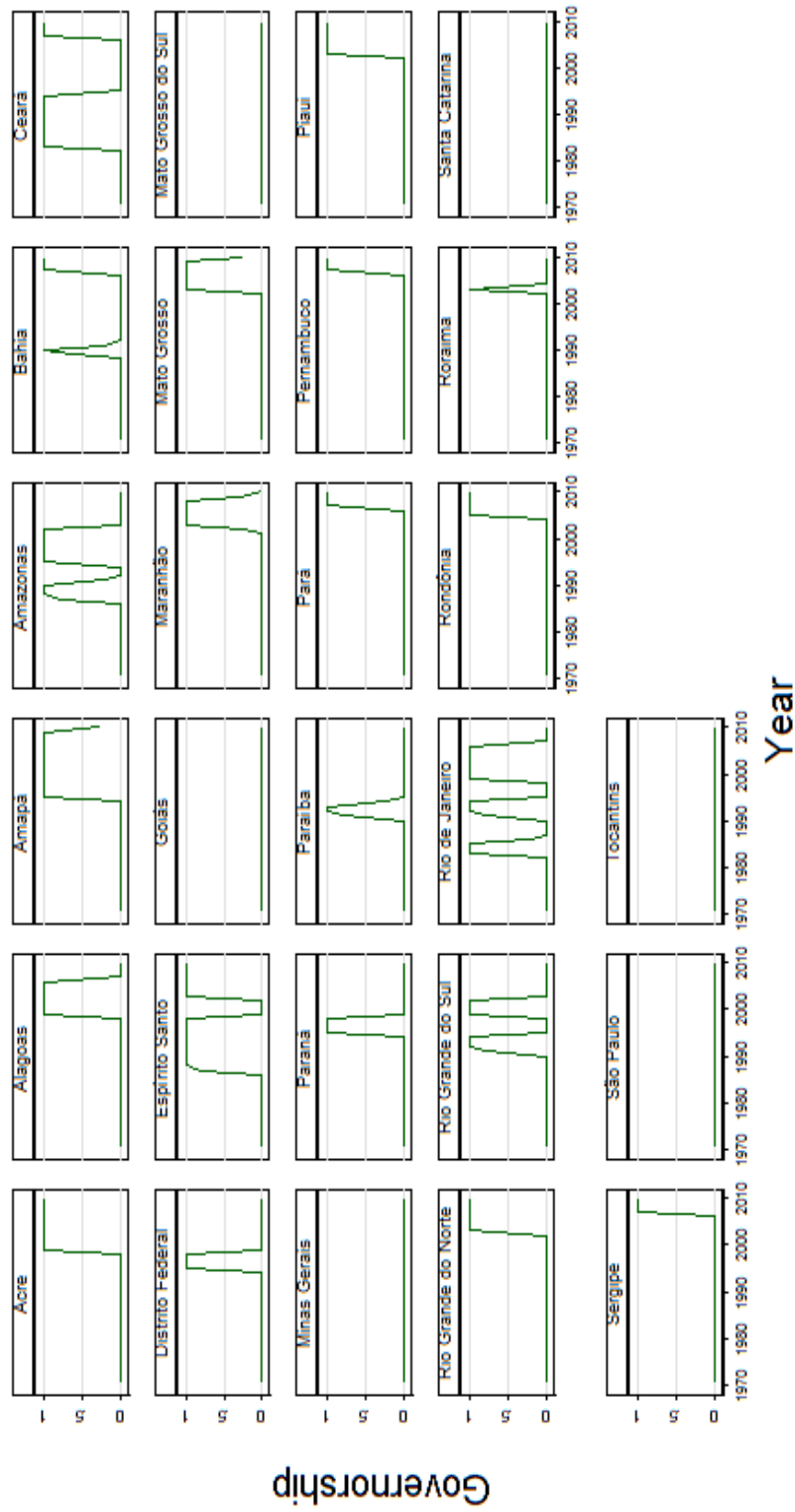
Partisanship in Spanish AC Government



Source: Author

Figure A.8: Left Parties by State

Left Parties in Brazilian State Government



Source: Author

Table A.5: Impact of Spanish Health and Decentralization Policies

Year	Actors	Policy	Spain	Extremadura	Castilla y León	Basque Country
1978	Most	Spanish Constitution	+	+	+	+/-
1978	UCD+ (center)	Creation of health maps and territories	+	+	+	+
1978	UCD+ (center)	Creation of INSALUD	+	+	+	+
1979	UCD+ (center) PNV+& ERC+(AC)	Highly decentralizing Basque and Catalan Statutes of Autonomy	~	+/-	+/-	+
1981-1983	UCD+ (center) & all ACs	Rest of the ACs created, most are <i>vía lenta</i> , some with special status	~	~	~	~
1983	PNV+ (Basque)	Creates Osakidetza, begins centralizing provincial hospitals	+	~	~	++
1984	PSOE+ (center)	Primary Care Reform	++	++	++	++
1986	PSOE+ (center)	General Health Law creates SNS	++	++	++	++
1986	Most (center)	Spain joins the EU and ACs begin receiving Structural Funds	++	+++	++	+
1988	PNV/PSE (Basque)	First to insure the poor and create RMI	+	+	+	++
1989	PSOE+ (center)	SNS extended to the poor	++	++	++	+
1990	PNV/PSE (Basque)	Youth dental coverage (PADI)	+	+	+	++
1991	PSOE+ (center)	Informe Abril suggests rationing	+/-			
1997	PP/CiU/PNV (center)	Decentralization of health management, increased options for private contracting	-	-	-	-
2001	PP (center)	Unilateral devolution of health to INSALUD GD ACs	+/-	+/-	+/-	~
2003	PP+ (center)	Cohesion and Quality Law	+/-	+/-	+/-	+/-
2005	PSOE (Extremadura)	Youth dental coverage (PADI)	+	+	+	~
2006	PSOE+ (center)	Youth dental coverage & Dependency Law	++	++	++	+
2011	PP (center)	Cuts to SNS, copays, proof of residency	-	-	-	-

Table A.6: Impact of Spanish Fiscal Policies on Equity-Enhancing Health Reform

<i>Year</i>	<i>Actors</i>	<i>Policy</i>	<i>Spain</i>	<i>Extremadura</i>	<i>Castilla y León</i>	<i>Basque Country</i>
1977	UCD/PSOE (center)	Tax Reform, introduction of IRPF	++	++	++	++
1978	UCD+ (center)	40% copay on drugs for non-elderly	+/-	+/-	+/-	+/-
1980	UCD+ (center)	LOFCA regulates AC finances, creates FCI, CPFF, guarantees minimum resources for social policy	+	+	+	+/-
1981	UCD+ (center) PNV+(AC)	Renewal of the Foral Regime in Vizcaya and Guipúzcoa	+/-	-	-	++
1989	PSOE+ (center)	Health funded from general revenue	++	++	++	~
1993	PSOE/CiU (center)	Devolution of 15% of income tax revenues with compensation for poor ACs	-	-	-	~
1997	PP/CiU (center)	Devolution of another 15% of the IRPF, minor taxes, and the property tax	-	-	-	~
2001	PP (center)	Devolution of 33% of IRPF, 40% alcohol, tobacco, petrol, 100% of electricity, 35% of VAT, with normative authority over part of the IRPF and some minor taxes	-	-	-	~
2006	PSOE (center)	IRPF made more regressive	-	-	-	~
2009	PSOE (center)	AC finance reform equalizes per capita resources, new compensatory funds created	+	+	+	~
2009	PSOE (center)	Devolution of 50% of IRPF, 58% alcohol, tobacco, petrol, and 50% VAT facing Catalan demands	-	-	-	~
2011	PSOE (center)	Reinstates property tax only high values	+	+	+	~
2011	PP (center)	Increased progressivity of IRPF	+	+	+	~
2012	PP (center)	Deep cuts to health and social spending	-	-	-	-

Table A.7: Primary Care Reform and Commitment in the Spanish ACs

<i>AC by date of health devolution</i>	<i>Health</i>	<i>Dominant Ideology < mid-1990s</i>	<i>Coverage in 1992</i>	<i>Dominant Ideology > mid-1990s</i>	<i>Coverage in 2000</i>	<i>Relative GDP/cap 2009</i>	<i>Relative Health Spending/cap 2009</i>
Catalonia	1981	Center-Right†	33%	Mixed†	67%	1.13	1.03
Andalusia	1984	Center-Left	54%	Center-Left†	71%	.77	.90
Basque Country	1987	Mixed†	47%	Mixed†	67%	1.19	1.21
Valencia	1987	Mixed	50%	Center-Right†	71%	.87	.95
Galicia	1990	Center-Right	23%	Mixed†	51%	.83	1.04
Navarre	1990	Mixed	80%	Center-Right	100%	1.16	1.17
Canarias	1994	Mixed†	55%	Center-Right†	94%	.88	1.03
Aragon	2002	Mixed†	64%	Mixed†	90%	1.16	1.12
Asturias	2002	Center-Left	56%	Center-Left	90%	.97	1.18
Baleares	2002	Center-Right†	45%	Mixed†	84%	1.14	.92
Cantabria	2002	Center-Right	31%	Center-Right†	82%	1.09	1.01
Castilla la Mancha	2002	Center-Left	70%	Center-Left	93%	.82	1.06
Castilla y León	2002	Mixed	67%	Center-Right	92%	1.05	1.01
Extremadura	2002	Center-Left	68%	Center-Left	93%	.85	1.16
La Rioja	2002	Mixed†	69%	Center-Right	88%	.95	1.06
Madrid	2002	Center-Left	53%	Center-Right	87%	1.31	.91
Murcia	2002	Center-Left	41%	Center-Right	89%	.82	1.12

†= minority nationalists form part of AC cabinet

Table A.8: Spanish Partisanship, Capacity, and Primary Reform Coverage

Spain—Extremadura—Castilla y León—Basque Country										
<i>Presidente</i>	<i>Year*</i>	<i>Presidente</i>	<i>Capacity</i>	%	<i>Presidente</i>	<i>Capacity</i>	%	<i>Lehendakari</i>	<i>Capacity</i>	%
Suárez UCD	1978	Ramallo* UCD	Low	-	-	-	-	Rubial* PSE+	High	-
González PSOE	1983	Rodríguez Ibarra* PSOE	Low	-	Madrid* PSOE	Med	-	Garaikoetxea PNV	High	-
González PSOE	1985	Rodríguez Ibarra PSOE	Low	~8.5	Madrid PSOE	Med	~8.4	Ardanza* PNV	High	~5.9
González PSOE	1987	Rodríguez Ibarra PSOE	Low	~25.5	Aznar* PP	Med	~25.1	Ardanza PNV/PSE or EA	High	~17.6
González PSOE+	1991	Rodríguez Ibarra PSOE	Low	59.5	Lucas* PP	Med	58.6	Ardanza PNV/PSE or EA	High	41.1
Aznar PP+	1999	Rodríguez Ibarra PSOE	Med	91.8	Lucas PP	Med	91	Ibarretxe* PNV/EA	High	67
Zapatero PSOE	2007	Fernández Vara* PSOE	Med	100	Herrera PP	Med/ High	100	Ibarretxe PNV/EA	High	100
Zapatero PSOE	2009	Fernández Vara PSOE	Med	100	Herrera PP	Med/ High	100	López* PSE-EE	High	100
Rajoy PP	2012	Monago PP	Med/ Low	100	Herrera PP	Med	100	Urkullu* PNV	High/ Med	100

~ = Interpolation

* = Commencement of executive's term

Table A.9: Health Authority in the Brazilian States

<i>State</i>	<i>NOB 1996 Avançado</i>	<i>NOB 1996 Plena</i>	<i>NOAS 2001</i>
Acre	-	-	10/15/2003
Alagoas	-	7/3/1998	4/17/2002
Amapá	-	-	2/13/2004
Amazonas	-	-	2/13/2004
Bahia	4/9/1999	-	10/19/2003
Ceará	-	1/2/2001	4/17/2002
Distrito Federal	-	10.20.1999	6/17/2002
Espírito Santo	-	-	11/23/2004
Goiás	-	3/16/2001	6/17/2002
Mato Grosso	-	-	8/29/2002
Mato Grosso do Sul	-	-	8/29/2002
Maranhão	-	-	11/17/2004
Minas Gerais	5/17/1999	-	12/3/2002
Pará	-	6/27/2001	6/10/2002
Paraíba	5/16/2001	-	8/13/2002
Paraná	-	12/7/1999	8/14/2002
Pernambuco	-	-	8/2/2004
Piauí	-	-	4/30/2004
Rio de Janeiro	-	-	8/13/2002
Rio Grande do Norte	-	-	9/19/2003
Rio Grande do Sul	5/17/1999	-	12/18/2002
Rondônia	-	-	4/17/2003
Roraima	-	-	11/28/2003
Santa Catarina	-	12/9/1999	7/10/2002
São Paulo	4/9/1999	-	7/22/2003
Sergipe	-	-	7/11/2002
Tocantins	-	-	11/26/2004

Source: MS

Table A.10: Bahian Partisanship, Capacity, and PSF Coverage

Partisanship, Capacity, and Population Coverage of ACS/PSF								
Brazil—Bahia—Salvador								
<i>Pres.</i>	<i>Capacity</i>	<i>Year*</i>	<i>Governador</i>	<i>Capacity</i>	<i>ACS/PSF % coverage</i>	<i>Prefeito</i>	<i>Capacity</i>	<i>ACS/PSF % coverage</i>
Figueiredo ARENA	Low	1983	Carneiro PDS	Low	-	Figueiredo Castro PFL	Low	-
Sarney PMDB	Low	1987	Pires PMDB	Low	-	Kertész centrist	Low	-
Sarney PMDB	Low	1989	Moraes Coelho PSDB	Low	-	Guimarães PMDB	Low	-
Collor PRN	Low	1991	ACM PFL	Low	~/-	Guimarães PMDB	Low	0/-
Franco PRN	Low/Med	1994	Imbassahy PFL	Low	~/0	Lídice de Mata PSDB	Low	0/0
Cardoso PSDB	Med	1995	Souto PFL	Low	~/0	Lídice de Mata PSDB	Low	0/0
Cardoso PSDB	Med	1999	Borges PFL	Low	56.67/1.06	Imbassahy PFL	Low	22.41/0
Cardoso PSDB	Med/High	2002	Alencar PL	Low	71.76/16.00	Imbassahy PFL	Low	20.77/1.94
Lula PT	Med/High	2003	Souto PFL	Low/Med	76.26/21.98	Imbassahy PFL	Low	22.67/2.78
Lula PT	Med/High	2007	Wagner PT	Low/Med	82.93/51.12	Carneiro PMDB	Low	35.77/14.84
Dilma PT	Med/High	2011	Wagner PT	Low/Med	82.36/58.07	ACM Neto DEM	Low	30.03/17.84

~/=Programs implemented but precise data unavailable

* =Commencement of governor's term

Table A.11: São Paulo Partisanship, Capacity, and PSF Coverage

Partisanship, Capacity, and Population Coverage of ACS/PSF									
Brazil—São Paulo State—São Paulo Capital									
<i>Pres.</i>	<i>Capacity</i>	<i>Year*</i>	<i>Governador</i>	<i>Capacity</i>	<i>ACS/PSF % coverage</i>	<i>Prefeito</i>	<i>Capacity</i>	<i>ACS/PSF % coverage</i>	<i>ACS/PSF % coverage</i>
Figueiredo ARENA	Low	1983	Montoro PMDB	High	-	Covas PMDB	High	-	-
Sarney PMDB	Low	1987	Quércia PMDB	High	-	Quadros PTB	High	-	-
Collor PRN	Low	1991	Fleury PMDB	High	0/-	Erundina PT	High	0/-	0/-
Cardoso PSDB	Med	1995	Covas PSDB	High	0/0	Maluf PP	High	0/0	0/0
Cardoso PSDB	Med	1999	Covas PSDB	High	3.2/1.5	Pitta PTB	High	0/0	0/0
Cardoso PSDB	Med/High	2001	Alckmin PSDB	High	11.4/7.8	Suplicy PT	High	4.8/5.7	4.8/5.7
Lula PT	Med/High	2003	Alckmin PSDB	High	22.2/15.7	Suplicy PT	High	22.4/15.9	22.4/15.9
Lula PT	Med/High	2007	Serra PSDB	High	28.5/23.3	Kassab DEM	High	27.5/25.2	27.5/25.2
Dilma PT	Med/High	2011	Alckmin PSDB	High	33.7/27.4	Kassab PSD	High	34.4/28.9	34.4/28.9

~ = Programs implemented but precise data unavailable

* = Commencement of governor's term

Table A.12: Timing and Sequence of Reform in International Perspective

<i>International Context</i>	<i>Year</i>	<i>Spain</i>	<i>Year</i>	<i>Brazil</i>
International Support for Health Reform	1975	Transition Begins	1974	Abertura begins
	1979	General Elections		
	1978	Constitutional Guarantee	1980	Political Parties Legalized
	1981-1984	Devolution to Catalonia and Andalusia	1982	Elections for Governors
	1984	Primary Care Reform	1985	Return to Civilian Rule
	1986	Creation of SNS	1986	VIII Conferência Nacional de Saúde
	1987	Devolution to Basque Country and Valencia	1988	Constitutional Guarantee
Economic Crisis and Neoliberalism	1990	Devolution to Galicia and Navarre	1988-1993	Increased role for subnational units
	1990	Devolution to Canarias		
	1991	<i>Informe Abril</i>	1990-1991	Creation of the SUS
	1990s	State taxes become less progressive	1991-1994	Central primary care incentivization
	1990s	SNS consolidation	1993-1998	SUS implementation and financing
Economic Boom	2002	Devolution to last 10 ACs	2000-2001	Accountability and financing reforms
	2002	Decentralization of health financing		
	2006-2007	Ley de Dependencia, youth dental coverage	2006	Pacto pela Saúde
Economic Crisis	2009	Progressive health financing reform	2011	Attempts at SUS consolidation

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