Healthcare and clientelism: comparing the Mediterranean and South America

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Abstract
Welfare state literature still lacks systematic comparative research on differences and similarities between healthcare systems in Latin American and their European counterpart, the so-called ‘Mediterranean regime’. The historical development of these welfare states is often explained with reference to the role of clientelism. But on closer inspection, we see that clientelism has been used to theorize only on labor market related benefits in the Mediterranean, while for Latin America the clientelistic account covers also healthcare systems. This peculiarity of the Mediterranean regime has been often explained by the ideological commitment to universalism of left parties in these countries. Why can the development of social security benefits in the Mediterranean be explained by clientelistic party competition, while the development of the universal healthcare system has to be explained by party ideologies? This study proposes an answer to this puzzle. Comparing the evolution of four national health systems that showed similarities in their origins, but followed different paths (Argentina, Colombia, Italy and Spain), it is shown that it was the mix of church ran charities, the regionalization of the public hospitals and the presence of low class unions that allowed Italy and Spain to create National Health Services. In contrast, the presence of charities and regional public hospitals controlled by the political parties together with the existence of middle class unions created the condition for a fragmented system to thrive.

JEL Classification Numbers: I13, I14, I18

Keywords: Clientelism, Healthcare systems, Latin America, Mediterranean

I. Introduction
Following the seminal work of Esping-Andersen (1985; 1990) a debate emerged about whether Italy is accurately placed in the corporatist or conservative welfare state regime. As a result, a new typology was proposed in which Southern European countries form an additional regime of Mediterranean welfares states. In this regime clientelistic political competition was identified as a common characteristic that explains the remarkable fragmentation of labor market related benefits (Leibfried, 1992; Castles, 1995;
This paper extends the analysis of the effects of clientelism to the provision of healthcare services, an aspect that so far has received little attention in the literature.

Attempts to explain the development of the Mediterranean welfare states, mostly focused in Italy, have pointed to the clientelistic political competition as the main source for fragmentation in their social policies (Ferrera, 1995; Ferrera, 1996; Lynch, 2009; Ferrera, Fargion, & Jessoula, 2012; Picot, 2013). However, these explanations only account for clientelism as the main influential variable for the labor market related benefits (i.e. social security). The main deviation of the clientelism literature is the explanation of the universalization of healthcare services (undertook in the 1970s in Italy and 1980s in Spain). In an elegant (but as I will argue below unconvincing) argument, this literature states that the roots of healthcare policy in the Mediterranean countries are to be found in party ideology rather than in clientelism (Ferrera, 1989).

This argument invites a question that has not been addressed so far: Why can the development of social security benefits be explained by clientelistic party competition, while the development of the universal healthcare system has to be explained by party ideologies? This is even more surprising given the fact that healthcare services are used extensively for clientelistic political exchanges in other parts of the world (Gaviria, Medina, Mejía, McKenzie, & Soares, 2006; Auyero, 2002). As these countries show, there is nothing in healthcare services that prevent their use in clientelistic exchanges per se.

To answer the proposed question, it is useful to contrast the development in Southern Europe with similar cases in which a clientelistic logic did influence healthcare system. I argue that the comparison between Southern Europe and culturally rather similar countries in Latin America is useful for this purpose. I

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1 This group of countries has four common characteristics as identified by Ferrera (1996): a fragmented social security, universalistic health provision, low involvement of the state in welfare provision, and high levels of clientelism. Using these characteristics, Gal (2010) expanded the group of countries that can be named as Mediterranean welfare states to include also Cyprus, Israel, Malta, and Turkey.

2 The funding of healthcare services, though important for the total understanding of the effects of clientelism in social policies, is left for future research.

3 There are exceptions: Manow and Van Kersbergen (2009) explain the differences between the Italian and the German welfare states, both classified as corporatist, using the different party composition of the two democracies. At the same time, Hien (2014) uses the characteristics of the conflict between church and state. Nonetheless these studies do not address the Mediterranean countries as a group with specific characteristics. Building on the concept of programmatic party competition, this literature does not account for one of the most characteristic features of the Southern European countries namely the presence of clientelistic party competition.

4 The Italian pension system was built on an occupational basis. For example, the maritime employees had their own pension fund, just as the public transport employees, the industrial workers, among others (Ferrera, Fargion, & Jessoula, 2012)

5 What is more interesting is that the four Mediterranean universal healthcare systems are not entirely universal. Italy has the most universal one, nevertheless, its funding is not entirely made through taxes; whilst Spain has a contribution and taxes based funding structure with a coverage that is not completely universal because the high income population can opt out the system and the public servants have higher benefits. In the same way, in Portugal and Greece persist some sorts of fragmentation
hence compare two Mediterranean and two Latin American countries: Argentina, Colombia, Italy and Spain. These countries present similar political institutions, the same pervasive presence of clientelism in party competition and initially fragmented healthcare systems that started to be developed between the late nineteenth and early twentieth centuries. However, the Latin American countries developed fragmented healthcare systems, in contrast with the universal systems of Southern Europe. Why was this the case?

My research suggests two factors that account for the differences: first, the mix of church-ran charities and the regionalization of the public hospitals in Italy and Spain created incentives for political parties to offer voters a universal and decentralized healthcare system, while in Argentina and Colombia the initial control that political parties exercised on charities and public hospitals eliminated the incentive to universalization. The reason is that any clientelistic political party will always look for ways to improve its possibilities to serve clientelistic exchanges, thus if those possibilities are not present, the party will take advantage of any opportunity to create them.

Second, the union movement, representative of the lower classes in Italy and Spain, explains the demand for a universal healthcare system in those countries; while in Argentina and Colombia, middle class unions demanded a fragmented system to maximize their benefits. This happens because it is assumed that unions have the incentive to maximize the payoffs of their members, and the only way for a big group of any given population to maximize its payoffs is by pursuing an equalitarian scheme (i.e. universal healthcare), while a small group can always seek for rent extraction (i.e. differentiated healthcare services) that maximize their share of the total resources.

The four countries were selected because of their similarities in terms of culture, political institutions, and clientelistic practices, whilst they differ in the healthcare system. Nevertheless, the countries differ to a great extent between their geographical pair. This allows ruling out a host of contextual factors as explanations for the development of health care systems. Between the two European countries, the main differences are the timing of industrialization, which occurred first in Italy and later in Spain, and the timing of democratization, during the second half of the 1940s for Italy and the end of the 1970s for Spain. This helps to dismiss an explanation based on geographical policy spillovers.

Deeper differences can be found between the two Latin American countries. First, the composition of the population was entirely different. Argentina had high immigration from Europe which created a fragmented population; while Colombia had nearly no immigration, accounting for ethnically homogeneous people. Second, the levels of economic development were completely different. Argentina was early integrated to the international market and its economy had high and sustained levels of growth in the beginning of the twentieth century; while Colombia was still a mainly rural country with low integration to international markets and almost inexistent industrialization. Third, as a consequence of the differences in development of the economy, the levels of urbanization and unionization among workers were much higher in Argentina than in Colombia.
This work is organized in four sections of which the first one is this introduction. The second section exposes the general argument and the theoretical literature in which it builds. The third section presents the country cases in a comparative perspective. Finally, the fourth section discusses the conclusions and some future work to be done in order to explain in deep the evolution of health care systems.

II. Argument

Ferrera (1989), and Guillén and Cabiedes (1997) argue that the creation of the universal healthcare system in Italy and Spain was the result of the ideologies of the left parties, that first gained access to power in the period before the healthcare reform. This argument is not completely convincing, mainly because the authors describe a clearly clientelistic approach of those parties to the reform. In both cases, the creation of autonomous regions that managed public hospitals allowed the left parties to use patronage and clientelism in the production of health services.

In order to explain the observed outcome in the organization of healthcare services I depart from the ideological explanations of health care universalization (Ferrera, 1989; Guillén & Cabiedes, 1997) and develop a theory based on the clientelistic practices present in the observed cases.

i. Scope conditions

The scope conditions for the studied countries were a fragmented healthcare system and a clientelistic party competition. These concepts are defined in the following lines.

Prior to 1970s, healthcare services were organized in a fragmented way, this means that different groups of the population were entitled to different benefits and, in some cases, were attended at diverse facilities. The social groups were divided by levels of income (with different services for lower, middle and upper classes) or occupational categories (different services for different professions and occupations). The observed initial configuration in the analyzed countries has both elements of differentiation.

At the same time, the four countries presented clientelistic party competition. The electoral competition in any democracy can lie somewhere in a continuum that goes from purely ideological to purely clientelistic. Purely ideological competition appears when the race for votes is done, by political parties, in terms of general programs and principles, whilst the purely clientelistic appears when political parties

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6 In both cases the left parties were ideologically committed to the establishment of a universal healthcare system.

7 It is important to note the difference between the provision and the production of health services. The provision refers to the way in which the insured population accesses the healthcare system and receives treatment, which in the case of Spain and Italy will develop as a universal system that does not differentiate between patients. The production of healthcare services is the way in which the state organizes the supply of those services, in this part there can be clientelistic practices such as appointing practitioners and managers in public hospitals, the use of inputs’ purchase contracts with an electoral goal, etc. Any system can be universal in the provision of healthcare and yet still show clientelistic practices in the production of health services.
compete only on the basis of exchange votes for state services for their specific constituencies (Shefter, 1977). In clientelistic competition political parties maintain and increase the support of their constituencies (i.e. votes) by means of granting public services. The exchange nature of the clientelistic competition makes it unlikely to lead to universal programs, due to the fact that only fragmented programs (as opposed to universal ones), being easier to target to specific groups, are more susceptible to be used in electoral exchange. As a result, the type of social policies implemented by the state under clientelistic party competition, tend to be particularistic and constituency oriented (Piattoni, 2001).

To what extent a specific group can benefit from state services in a clientelistic political environment depends on its capacity to deliver votes. In this regard, better organized and cohered groups tend to extract more benefits from the clientelistic policy exchange. The clientelistic framework has been used in the welfare state literature to explain differences in the national pensions systems of Britain and the United States. Two different studies documented clientelistic political parties using old age and disability pensions to secure votes from their constituencies (Skocpol, 1995; Orloff & Skocpol, 1984).
ii. Independent Variables and their effect

The cases studied vary in two different independent variables: the trade unions, and specifically the socioeconomic characteristics of their members; and the level of control that political parties could exercise of health charities, beneficences and public hospitals. I argue that these variables have to covariate in order to create the conditions for clientelism in the provision of healthcare to appear.
According to (Shefter, 1977) clientelism has two sides. The first one is the supply side, which refers to the possibility of political parties or politicians to use the state apparatus to compete in electoral terms targeting benefits and policies to their specific constituencies. The second one is the demand side and refers to the constituencies’ predisposition to ask for clientelistic practices, this is the case when a constituency can maximize its payoff by demanding particular treatment.

In all the studied cases trade unions were important in the process of expanding the healthcare system. However, not all trade unions played the same role towards social policy. I argue that middle class unions represent the demand side of clientelism. Middle class unions have an interest to pursue fragmented health care policies, because fragmented policies represent an advantage by allowing the maximization of benefits at the expense of lower class workers. If lower class workers are underrepresented or not represented at all, fragmented healthcare systems become more likely. Fragmentation in turn allows political parties for integrating healthcare services into clientelistic exchanges.

As opposed to middle class unions, lower class unions are much better off if they push for a universal benefit. This is the case, because only universalism can maximize the benefits received by their represented workers, as they are a big share of the total labor force. This type of healthcare system is difficult to use for clientelism because its characteristic of universalism rules out the possibility of differentiation between constituencies. Thus lower class unions do not demand fragmentation and do not demand clientelistic exchanges in healthcare provision.

Regarding the supply side, clientelistic political parties can behave and defend completely different social policies. Since these parties maintain the support of their constituencies (i.e. votes) granting them public positions and services, the way in which those parties evaluate a given policy is based on the potential it has to increase their clientelistic power. Thus, the same party can support or oppose the exact same policy under different initial conditions, depending on the policy’s ability to improve the party’s position towards vote exchanging.

In order for a party to use clientelistic political exchanges, it has to control the charities and the public hospitals. If a party does not control the charities, it is impossible for it to provide health services in exchange of votes. Of course, the opposite is true. When a party controls the facilities providing health services, it can exercise particularistic policies to benefit its specific constituency in addition to patronage the positions in the hospital or charity.

8 As it has been shown by other researchers the differences in the type of social policies (in our case the differences between a universal and a fragmented healthcare system) are the result of negotiations between political parties or groups (mostly trade unions and left parties) at least as it is explained by the Power Resource Theory approach (Esping-Andersen, 1985; 1990; Korpi, 1983) and the Party Politics approach (Korpi & Palme, 2003).

9 For the difference between the uses of clientelism in health care provision to different constituencies and patronage in the production of healthcare services see footnote 9.
So even though the clientelistic competition is present, it is only countries that present a way to supply clientelistic policies in the provision of health care and a constituency that demands them where that party competition can survive in the health care system, making it fragmented.

**iii. Dependent Variable**

As shown in Figure 1 the dependent variable is the final healthcare system. As presented in the last subsection, the interests of the two main political actors (trade unions and political parties), combine to create a fragmented or a universal system. The theory discussed in the previous subsections is presented in Table 1. The presented theory was developed by comparing the cases of two Latin American countries and two Mediterranean. In the next section I discuss the case studies.

| Table 1 |
|------------------|----------------|----------------|----------------|
| **Initial Conditions** | **Argentina** | **Colombia** | **Italy** | **Spain** |
| Fragmented Healthcare | Fragmented Healthcare | Fragmented Healthcare | Fragmented Healthcare |
| Clientelistic party competition | Clientelistic party competition | Clientelistic party competition | Clientelistic party competition |
| **Independent Variables** | **Middle class unions** | **Middle class unions** | **Lower class unions** | **Lower class unions** |
| Charity and hospitals controlled by the parties | Charity and hospitals controlled by the parties | Charity controlled by the church | Hospitals controlled by the parties | Charity controlled by the church |
| **Dependent Variable** | Fragmented Healthcare | Fragmented Healthcare | Universal Healthcare | Universal Healthcare |
| **Context** | Heterogeneous population due to high European migration | Homogenous creole population | Homogenous population | Homogenous population |
III. Country cases

This section presents the country cases separated, while the next makes a comparison of those cases. The period will go from 1880s to 2000s. The reason why this period is chosen is because it starts with a moment in which the scope conditions were already present in all the countries

i. Argentina

As all the former Spanish possessions in Latin America, Argentina developed a clientelistic party competition. After 1816, when independence was declared, the unfolding development of wars between the centralists and federalists ended up in the triumph of the later ones. Nonetheless, the election of the new government did not create an independent bureaucracy needed to rule out the possibility of clientelism (Shefter, 1977). In fact “the dominant political group at the time controlled the election of governmental officers” (Salvochea, 2008, p. 292). The existence of clientelism is clear in the development of the healthcare system as it will be shown in this section.

Initial fragmentation of healthcare

At the end of the nineteenth century in Argentina the access to health services was divided in different organizations: beneficences or charities, public assistance, mutuality, and private practices. These organizations attended different sectors of the population. The beneficences and the public assistance attended the poor, the mutuality attended the workers who paid the contributions, and the private practices attended the patients who could afford it.
The Beneficences had a strong presence of women in their direction. They were created in the very beginning of the republican life. In 1823 Bernardino Rivadavia created the Beneficence of Buenos Aires and let the institution be controlled by the high society ladies. Even though the secularization process was deep enough to have disconnected the church from the charities, the discourse for the creation of the beneficences was always based in the Christian charity (Hernández, 2004).

In 1881 the government presented an organic law to create the National Department of Hygiene (Isumani & Mercer, 1988). Under the new agency, the government developed the public assistance organized in public hospitals. The public hospitals attended free of charge only the poor that show their certificate of poor (Certificado de Pobre). If the patient was not able to prove his condition of solemn poor, then he would pay a progressive fee according to a classification of occupations (Hernández, 2004).

The development of mutual societies in Argentina was extensive. They were the response of the immigrant workers to the lack of protection by their employers and the state. The initial wave of immigration in Argentina, mainly comprising Italians and Spanish, was the result of a migratory policy that offered them access to land. Nevertheless, the local elites bought their land, expelling the immigrant to the cities and forcing a process of urbanization (Solberg, 1970). The immigrants created mutual societies based on their origins and since the system was successful, the Argentinian workers started the creation of mutualities segmented by occupation.

In this way, Argentina had a complete but fragmented healthcare system at the end of the nineteenth century. The beneficences and the public assistance for the poor, the mutualities for the workers and the private practice for the wealth population.

Expansion of the mutualities as political exchange

During the first decades of the twentieth century the conflict between workers and employers escalated. The first unions were created and were the reflex of the main ideologies present in Europe. Three ideologies can be identified: anarchism, communism and socialism. The communists and anarchists were highly combative and were immerse in acts of sabotage (Hernández, 2004).

Two main responses by the government are distinguishable here. First, the sanction of the law of residence (Ley de Residencia). Second, the first labor legislation was passed grating a paid day-off in 1905, the regulation of the work of minors and women in 1907, and the accident insurance in 1913 (Levaggi, 2006).

The national unions

The law of residence gave the government the ability to expulse, without trial, the immigrants involved in criminal acts. This law was widely used by the government to suppress the anarchist and communist unions, which membership mainly comprised European immigrants (Belloni, 1960). This lead to the

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10 The first mutualities were the French in 1853, the Spanish in 1857 and the Italian in 1861 (Hernández, 2004).
creation of a bad image of the immigrant and to an exclusion of the immigrants form society and politics (Solberg, 1970). Thus, leaving the road free to the socialist unions that were willing to achieve the reforms demanded through institutional means and with national and middle class membership (Zimmermann, 1992).

The socialist unions and their political party, the socialist party created in 1896, tried to incorporate middle class sector during the period 1915-1943 (Perelman, 1961). In this process they favored solutions that benefited the middle segments which lead to an immobilization in the healthcare legislation. In 1922 a law project was presented to create a social security, but as expected this project was contested by the mutualities. Their main argument was the experience in managing workers’ resources for 60 years.

The socialist party, although with ideological tendencies to universalism, supported instead a project of stimulus to the mutualities. The project exempted all the mutualities of the obligation to pay taxes and tariffs. The project was backed by the socialists and became a law, mainly because socialists saw the mutualism, created by their allied unions, and universalism as two sides of the same coin (Hernández, 2004).

*Consolidation of the fragmentation under Peron*

Under the first period of Juan Domingo Peron as president, the public system was expanded. The expansion was the result of the new paradigm in the government of public health. In the new paradigm, the attention of patients\(^{11}\), the control of sanitary conditions\(^ {12}\) and the social medicine\(^ {15}\) were main concerns. This conceptualization of healthcare forced the government to expand the basic assistance network, creating public hospitals at all levels of complexity. In fact, between 1946 and 1951 the number of beds was almost duplicated passing from 66 thousand to 114 thousand (Hernández, 2004).

Peron’s government followed a strategy of control and cooptation of the unions. This government favored and supported the affiliation to the unions by new workers. The strategy of cooptation also included the creation of new mutualities and pension funds (*Cajas*). The number of unionized workers passed from 877 thousand to 2.2 million between 1946 and 1954 (Doyon, 1975) and the government settled with the unions labor legislation specific for each sector. Depending on the favorability to the Peron government, the union would receive more or less benefits. For example, between 1944 and 1946 were approved among others labor legislation for farmers and agricultural workers, journalists, the pension fund for industrial workers, and the subsidy for the medical attention of railway workers (Hernández, 2004).

\(^{11}\) Attention of the sick.

\(^{12}\) Attention to the environmental conditions to fight the spread of illnesses.

\(^{15}\) Attention to the social conditions favorable to diseases.
All the population under a fragmented system

The legacy left by Peron’s government is still present. In 1970 a law making mandatory the affiliation of each worker to the mutuality of his sector was passed. This law expanded considerably the coverture of the system, but it left workers as captive affiliates of the mutuality of their economic sector. For the retirees the government created in 1971 a specific mutuality. Given the fact that this population has a higher cost than the rest, the contributions of the retirees are supplemented with contribution of active workers (OPS, CEPAL, & PNUD, 2011).

As conclusion, the high fragmentation of the healthcare system in Argentina last till today. Even though during the 1990s some reforms intending liberalization of the sector were passed, the existence of different mutualities (Obras Sociales) is predominant. In this way, the current system has the same three pillars that it had at the end of the nineteenth century: Public provision for the poor, mutualism for the employees and private practices for the wealthy.

ii. Colombia

Colombian party politics has been characterized by clientelistic competition. Ever since the Spanish rule, Latin America developed a system characterized by a vertical social organization, with elites that used their political and economic power to provide favors and decisions in exchange of political support allowing the development of a clientelistic party competition (Martz, 1997). This means that the political development and the development of policies in Colombia can be “attributed to patron-client relations” (Schmidt, 1974, pp. 429-430). Those relations are reflected in the creation of a fragmented healthcare system.

Initial fragmentation of healthcare

Between the end of the nineteenth century and the 1920s the access to health services was divided in different organizations: beneficences or charities, accidents insurance, public assistance and private practices. These organizations attended different sectors of the population with a clear overlap between the beneficences and the public assistance. Both the beneficences and the public assistance were directed to the people with no capacity of payment or work, the health insurance attended the workers whose employers paid the contributions, mostly the biggest companies, and the private practices attended the patients who could afford it.

The Beneficences, as in the Argentinian case, were intended to attend the poor. The administration of the beneficences was done by the Church but it was not detached from the political life of the country. In the context of La Regeneración there was a close alliance between the Church and the Conservative

13 The first institution of this sort was the Beneficence of Cundinamarca in 1869 (Restrepo & Villa, 1980).
14 La Regeneración was a political movement that appeared in Colombia in the last decades of the nineteenth century. It was a conservative response to the liberal radicalism that was instated in the country with the...
party, which was the party in power. The success of *La Regeneración* was the new Constitution of 1886, based on conservative ideas (Abel, 1987). Freedom of religion was accepted, but the predominance of the Catholic Church in education and health services was constitutionalized and developed with the *Concordato* (Cruz, 2010).

The first law stating accidents insurance for workers was passed in 1915 (Arenas, 2007). The project was aimed to cover the entire working population regardless of their wage and the sector of the economy. However, during the debates in the Congress the scope of the law was changed, leaving out the agricultural workers and the ones with high wages (Hernández, 2004).

The public assistance was present since the second half of the nineteenth century. Nevertheless, under *La Regeneración* the concept of a state administered health services was confused with the concept of Beneficences. This was the case because the state had seats in the Beneficences’ Administrative Boards and founded part of their function from the public budget.

It was only during the 1920s that the concept of public assistance started to develop due to the influenza epidemic of 1918 that made the country to mobilize resources to attend the sick. The high mortality made evident that the need of a system capable of attending the population that couldn’t afford private doctors and was not attended by the Beneficences. In the 1925 the Congress approved a law that made the state responsible of providing enough facilities to attend the poor. Nonetheless, this law had a slow developed due to the opposition of the regional politicians. The regional powers were protecting their prevalence in the administration of public resources for health assigned to the beneficences (Hernández, 2004).

At this point, the general set up is clear. Clientelism was present and the initial healthcare system was fragmented. The next subsection will present the development of multiple schemes for different professions, their consolidation in on system for public and other for private employees and will conclude with the current system of health insurance.

*More fragmentation as a political exchange*

The level of development in Colombia during the 1920s was unequal. Some growing sectors, including textiles and coffee exports, and the state owned services like the telegraphs and railways, employed formal workers with all the law guarantees. The workers in these sectors where able to organize in unions, 

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15 The *Concordato* was a treaty between the Colombian government and the Catholic Church that stated the functions of each part. With this treaty the government left the public funded health and education services in the hands of the church.
while the vast majority of the rural workers and the small business workers remained informal. This shaped the Colombian unions as representatives of the emerging middle class and defendants of that class’ interests, in detriment of the lower class workers\(^\text{16}\).

In response to the demands of the new unions, the Congress started to pass legislation creating different healthcare services for each one of the occupational categories. There were different schemes named Cajas for each one of the following groups: post officers, telegraph operators, central bank employees, police officers, army, military and railway workers (Hernández, 2004). It is clear that the employees of these sectors were specialized and in general they had a higher income than the average blue collar worker.

This equilibrium was the result of the individual negotiations with each group. Nevertheless, many law projects were presented to create a national healthcare system, but they never made transit through Congress. The explanation to this is that such a system would rule out the possibility of political parties represented in Congress to mediate in the specific sectors labor conflicts and consequently gain the support of their organized workers (Hernández, 2004).

**Consolidation under fragmentation**

The dispersion of services all state administered created the necessity of consolidation. In 1946 a law creating two regimes was approved. This law divided the employees in two categories, public and private. Both systems were public and were paid by contributions of the employers and the employees. Nevertheless, the law, just as one for accident insurance in 1915, excluded the rural workers\(^\text{17}\) (Hernández, 2004).

The exclusion of large segments of the population allowed the survival of the beneficences and the slowly growing scheme of public assistance created in 1925. While the persistence of private schemes for the population with high income continued to thrive.

This system with five providers, beneficences, public assistance, two contributory schemes (private and public employees) and private practice, survived till 1993. In this year a wave of liberalization in all public services took place.

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\(^{16}\) In fact, different studies have shown that union members have a low support for redistribution and that powerful unions increase income inequality in developing countries (Zárate, 2014; Haggard, Kaufman, & Long, 2013; McGuire, 1999).

\(^{17}\) Here again the influence of the rural political elite that administered the beneficences was important. The local patrons defended their ability to control the health service in the regions, mostly because the urban population was not the source of their votes. Also to this contributed the influence of the coffee growers guild, which was managed by the growers elite with close ties with the Conservative party, but with a membership that included hundreds of thousands of small farmers that perceived the contribution scheme of the Social Insurance as detrimental to their finances, when compared to the free attention they received in the hospitals funded by the beneficences.
**Fragmented liberalization**

In 1991 a new Constitution was enacted. One of the consequences of the new Constitution was the derogatory of the *Concordato* which let the church out of the administration of the beneficences. Nevertheless, the beneficences had lost a big part of their importance given the growth during seven decades of the public assistance scheme.

Under the new Constitution, the right to healthcare was recognized. This lead the government to present a law project to expand the services to all the population.\(^\text{18}\) The new scheme liberalized the market of health insurance. It unified the regime under which public and private employees were to be insured, but it let different companies to offer the insurance and hire doctors and hospitals in the free market. At the same time, a new scheme was created for the poor, the subsidized scheme, which operated in the exact same way as the scheme for employees; the only difference was that the state paid the contribution.

Since the new scheme would insure the usual clients of the regional patrons, the political equilibrium was to maintain the old system and allow it to sell services to the insurance companies of the subsidized regime. At the same time, it was stated that it would be the regions, and not the central government, the managers of the affiliation to the subsidized system.

Under the new regime for health insurance, the benefits were fixed. This let space for the private practices to survive by selling extra services and better attention.

Concluding, the presence of strong clientelistic party competition in Colombia allowed the creation of different schemes for the poor, the middle classes and the upper class. In each period, the system reproduced itself with different names and different schemes.

**iii. Italy**

The presence in Italy of clientelistic competition has been widely documented (Hopkin & Mastropaolo, 2001; Caciagli, 2006). In this case, the strongest party, *Democrazia Cristiana* followed a strategy of creation of as many particular policies as possible, in order to maintain political support among their fragmented constituencies. This lead to an increase in the demand for more particular policies by excluded groups, as well as a high level of dependence of the beneficiaries in their political patrons (Warner, 2001; Piattoni, 1998). But in this special case, the clientelistic relations acted in a very different way. The creation of autonomous regions and the pressure from the Socialist Party created the conditions to create a national healthcare system.

\(^{18}\) In 1993 only 36% of the population had right to access health services under the two social insurance schemes (Arango, Casa, & Restrepo, 2002).
Charities, private practice and mutualities

From the period from 1861 to 1920s the healthcare in Italy was highly fragmented. Three main institutions can be identified: Church and private owned charities, private mutualities, and the always present private practice. As expected each one attended a segment of the population. The charities attended the poor, the mutualities attended the affiliated workers (and sometimes their families) and the private practices attended those who could pay.

Extravagant fragmentation of the mutualities

In the end of 1861 mutualities in Italy were limited in number, mostly because of the lack of guarantees to association. After this year, there was an explosion of this sort of association (Società di Mutuo Scorsso). In the period from 1862 to 1904 this associations passed from 443 to 6,347 and affiliation passed from 110 thousand to 900 thousand. The growth in number and affiliation to these mutualities was part of a secular and liberal movement intended to take from the church the attention of ample sectors of the population (Tomassini, 1999).

The first legislation regularizing the mutualities appeared in 1886. La legge Berti, as it was known, granted juridical recognition to the mutualities, as long as they provided insurance against illness, work disability, old age and dead (Bertini, 2004). In 1917 followed the legislation that made mandatory the insurance against work disability, old age. This insurance was mandatory only for the industries mobilized by the war efforts and other formal industries; this comprised around a million new affiliates. And finally, in 1919 the mandatory affiliation for all formal employees with a contribution shared with the employers was made law, this was intended to attend a mass of 10 million workers (Tomassini, 1999).

Less fragmentation: between the fascism and the postwar

The big dispersion of many mutualities was solved under the fascist government. Under this period, some regulation was passed creating incentives for more mutualities. For example, in 1926 the government decides to incentive the creation of mutualities per union and already in 1929 there were already 1,107 mutualities of this kind (Tomassini, 1999). In this model, there were mutualities for the employees of individual business, others for a specific union and other for occupation branch like the Istituto Nazionale di Assistenza per i Dipendenti degli Enti Locali created in 1925 for employees of the local governments. As it is clear the fragmentation reached was impossible to coordinate.

To this problem, the fascist government answered by expanding the responsibilities of the mutualities and creating encompassing ones. In 1930 it was made mandatory that the healthcare was provided to all the dependents of the affiliate. To this followed the creation of the Ente Nazionale di Previdenza e Assistenza per i Dipendenti Statali in 1942 for all the public employees and the Ente mutualità fascista - Istituto per l'assistenza di malattia ai lavoratori in 1943 that changed its name in 1947 for Istituto Nazionale per l'Assicurazione contro le Malattie. The last was intended to insure all the private employees and their families. Finally, the charities attending the uninsured continued in the hands of the
church, although in 1923 the right to hospital attention for the poor was approved by Royal Decree (Donatini, et al., 2001).

All this developments added up to create a spectacular fragmentation of the system that was not only present in the fact that there was no unified benefit, but also different procedures:

“In the early 1970s, as a result of these historical developments, Italy had nearly 100 health insurance funds. Each fund had its own regulations and procedures. Some provided direct care through their own facilities and others indirect care, reimbursing patients for the cost of care delivered by private physicians and facilities. Coverage was not only segmented across largely diverse funds but also characterized by important limitations. About 7% of the population was not covered by insurance in the mid-1970s, including many unemployed people (those who had previously worked within the informal economy). In addition, self-employed people were only entitled to use hospital services” (Donatini, et al., 2001, p. 14).

Clientelism, unions and the long way to reform

The first attempt to reform the system was done in 1948 starting with a proposal of a parliamentary commission intended to expand the health insurance to all the workers, their dependents and retirees. This proposal was rejected by a coalition dominated by Democrazia Cristiana in close alliance with the bureaucracy of the state owned mutualities and the practitioners. Democrazia Cristiana controlled the mutualities, allowing the party to use them as a source of clientelism (Ferrera, The politics of health reform: Origins and performance of the Italian health system in comparative perspective, 1989).

During the next years the health reform was present in the political debate. In 1956 the Comunist Party demanded a national healthcare system and in 1957 the union Confederazione Generale Italiana del Lavoro, with close ties with the Communist Party, proposed a law project with the same purpose. Nevertheless, it was only until 1965 when under the center-left coalition the government committed with a national health system in the five-year plan. It would take more to suppress the mutualities and the day came in 1968, when a hospital reform was passed allowing the regions to control these institutions19 (Ferrera, The politics of health reform: Origins and performance of the Italian health system in comparative perspective, 1989; Luzzi, 2004).

19 The public hospitals were at this point autonomous and that created perfect political conditions for the reform. First, it was in the interest of the left to contest the autonomy of hospitals because there were clear left regions where they could exercise some clientelism through the hospital network, and that would be evident in the 1970 elections for the ordinary regions. Second, the young professionals, mainly constituents of the socialist party, wanted a less hierarchical system that allowed them to enter find better paid jobs in the public hospitals. Third, the mutualities, and their allied Democrazia Cristiana, wanted to have some control over the costs of the medical services they bought from the hospitals, thus making an abolition of the autonomy a logical way out (Ferrera, The politics of health reform: Origins and performance of the Italian health system in comparative perspective, 1989).
Finally, after the 1970 elections the newly created ordinary regions started to campaign for a national healthcare system. The incentive was obvious, the regions controlled the hospitals, which were a source of patronage and clientelism, and the national health system would be paid by transfers from the central government (Luzzi, 2004). The mutualities at this point were not a threat, mainly because the hospital’s reform did the opposite of reducing costs. This weakened the financial position of the mutualities and paved the way for the approval of the law that paid their debt with the hospitals in 1974; this law contained a schedule for the liquidation of the mutualities in 1977. With this state of matters, the parliament approved the national healthcare system in 1978 (Ferrera, The politics of health reform: Origins and performance of the Italian health system in comparative perspective, 1989).

In conclusion, the existence of a source of patronage in the local public hospitals together with the clientelistic party competition created the right incentives for a reform to the healthcare model. The change in the balance of power that appeared with the autonomous ordinary regions and a new left-center coalition made his change to be in the direction of a national health system.

iv. Spain

Spain is a particular case in terms of clientelism. Before the civil war, clientelism was widespread (Beramendi, 1999; Beramendi, 2003; Beltrán, 2012). During the Francoism, the clientelism had a different way of creating clientelistic nets in a system that was not competitive and extremely particularistic (Cazorla, 1992). This was possible because of a low union membership, during the first years after Francoism, evidencing the general lack of organizational capacities in the population. Finally, under the context of democratization, with a wide middle class and modern society, traditional parties had difficulties using clientelistic strategies. In fact, the repetitive attempts the of conservative party to use clientelism were not enough to guarantee they could stay in office, as it was clear in the electoral results of 1981-1982.

Nevertheless, after the socialist party started using clientelism, the practice reappeared, as it can be seen in the implementation of the agricultural subsidies policy (Hopkin & Mastropaolo 2001).

Initial Fragmentation

Healthcare in Spain has a long history. In 1883 a commission (Comisión de Reformas Sociales) comprising all the political parties was created. The goal of this commission was to study the conditions of the working class and propose legislation to improve them. From their recommendations, and following some political debates, in 1900 is introduced the accidents insurance, with a limited coverage. But it is in 1934 when a real first effort to establish a net of public health providers was done. With the

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20 The agricultural subsidies were granted to farmers if they met a minimum number of working days per year. The working days were certified by the local authorities, and they used this power to secure votes. (Hopkin & Mastropaolo 2001).
approval of the law for sanitary coordination (Ley de Coordinación Sanitaria) the republican government intended to expand the number of public hospitals in managed by the regions.

At this point it is fair to say that the fragmentation was evident. A small number of public hospitals together with church run charities attended the poor. Some workers had access to accident insurance, but most of them depended on the good will of the employer, who was expected to pay for the accidents. Finally, the wealthy classes could attend private practitioners and hospitals paying for their services.

**Fragmentation under the Francoism**

The Francoist regime was characterized by a strict labor legislation and deep political control of workers. This created differentiation depending on occupation and political affinity with the regime. The unions were functional to a corporatist/fascist regime. The general model was based on contributions of the workers to a health insurance, as stated in 1942 by the law creating the obligatory health insurance (Seguro Obligatorio de Enfermedad). Nevertheless, since most of the population was still occupied in the rural sector, the expansion of this system was limited (Rodríguez, 1998).

Two main periods can be identified: from the civil war to the end of the 1950s, and from 1960s till the end of the dictatorship. In the first period, the health services had three main providers. These were Beneficences, charities and social security. The Beneficences were divided in two, a strong and politicized one in the central government, and weak local ones which were control by the center. The social security was based in mutualities were workers could get the obligatory health insurance (Rodríguez, 1998).

In the second period, from 1960s on, the Spanish welfare state began to grow, with a large number of particularities, mainly due to the fact that it was not the result of a democratic process, but an authoritarian one. The economic crisis of the end of the 1950s, created the conditions for a change in the strategy for economic growth. The new strategy would favor urbanization and industrialization, which created the need for some social policy reforms.

In 1963 a habilitating law was passed allowing the executive to legislate on social insurance. The principles of the law were to be equality in contribution and state funding. Nonetheless, with the law on social security of 1966 (Ley General de Seguridad Social), the old fragmented system was sustained, but a special impulse was given to the creation public providers, which would in the end generate a near to universal coverage. The new policies included public assistance and the creation of the Fondo Nacional de Asistencia Social, which were intended to provide the health services to the population that had no access to the social security scheme.

At this point the fragmentation of the system was still in place. Nevertheless, the large proportion of the facilities state owned up 70%, product of the implementation of the public assistance scheme for the uninsured, created a near to universal coverage (Guillén & Cabiedes, 1997). With the democratization process the creation of the National Health Service will come.
Democratization and universalization

During the dictatorship the political power and the definition of social policies was in hands of the elite and the rightist politicians. In the case of the health services also the practitioners were influential and played important roles in the administration (Guillén, 1992). In contrast, with the democratization the interest groups were able to exploit their power position; this was the case of the unions, mainly representing low class workers, like the communist Confederación Sindical de Comisiones Obreras or the socialist Unión General de Trabajadores (Guillén & Cabiedes, 1997).

Both, the socialist and the communist parties pushed for the creation of a National Health Service. This position was met with the interest of the newly created autonomous regions (Autonomías) in the expansion of the public resources for hospitals, on which they were guaranteed management in the Constitution and a law passed on 1981 (Guillén & Cabiedes, 1997; Guillén, 2002).

In 1982 a socialist government was elected with an absolute majority. Part of their electoral program was the creation of the National Health Service, with decentralized management and founded by the public budget. In 1983 a parliamentary commission that included representatives of the regions was created and produced a legislation draft that was presented a year after. The proposal created ample debate and opposition of the practitioners and pharmacists, who were interested in keep their ability to continue selling services to the system (Guillén & Cabiedes, 1997).

The solution was to keep the system of Conciertos in which the private hospitals sign contracts with the health system management to provide services. In the same way, being afraid of the possible effects on the public finances, the contributions were kept in place and were supplemented with resources from the state budget. The result was the creation of a National Health Service with a mixed founding a not entirely public. Nevertheless, the road to universalization was completed.

IV. Conclusion

The four cases studied showed similarities that allowed their close comparison, but also presented differences that were exploited in terms of their social composition, their economic development, the characteristics of the unions, and the initial organization of their health services. The proposed analysis leads to the conclusion that it was the mix of church ran charities, the regionalization of the public hospitals and the presence of low class unions that allowed Italy and Spain to create National Health Services. In contrast, the presence of charities and regional public hospitals controlled by the political parties together with the existence of middle class unions created the condition for a fragmented system to thrive.

The scrutiny of the cases clarifies that not all trade unions play the same role towards social policy. Depending on the characteristics of the unionized workers the role of the union varies significantly.
Middle class unions, present in the Argentinian and Colombian cases, pushed for fragmentation of services, maximizing their benefits. In the same way, lower class unions present in Italy and Spain pursued for universalization of healthcare.

Clientelistic political parties behave and defend completely different social policies depending on the specific conditions in which they perform. In the Argentinian and Colombian cases the political elites controlled regional charity schemes, which included the administration of public resources, allowing them to exchange votes for services at the regional level. In Italy and Spain, this was not the case for the incumbent party; charity institutions were run by the church and public hospitals were run by the right (Spain) and the Christian Democracy (Italy), thus taking out Social democratic parties out of the clientelistic exchange.

In addition to the incentive to take from the church the health services (and using them as means of recompensing constituencies for votes), there was the decentralizing reform in Italy and Spain. This reform created autonomous regions that could be taken over by the incumbent political parties and in both European cases, the autonomy included the ability to take over the management of the public hospitals. In this set up, the incentive of providing a state health service met the perfect institutional arrangement for its clientelistic competition. This mix created the conditions to move from a fragmented system, to a universal system paid by general taxation to the central government and managed by the local politicians at the regional level.

Nevertheless, there are still open questions that I intend to answer in future research. Why Spain has the same funding system that is prevalent in Colombia, while the provision is dramatically different? Is the move of the Colombian fragmented system towards an equalization of services a sort of universalization in the Spanish fashion? Can the presented theory be applied to the National Health System of Costa Rica?

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21 In the Colombian case the membership of unions was constituted by middle class public servants and white collar private employees. In the case of Argentina, despite the fact that union membership was concentrated in lower classes, most of the blue collar workers members of the unions were immigrants, with no political rights, thus letting only middle class national workers as the only source of votes for political parties.

22 In both cases the central state financed the beneficences. 26 See (Hien, 2014)
References


