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Is there a Southern European Healthcare Model?

FEDERICO TOTH

Is there a typically Southern European model of healthcare? To answer this question it is not enough to find similarities between the Greek, Italian, Spanish and Portuguese health systems: it is also necessary that these similarities be in some way distinctive. For this reason the author compares these Southern European countries with other Western European countries, in particular those which, like the southern countries, have adopted a national health service. Notwithstanding the eccentricities of the Greek case, this comparison shows how the four healthcare systems share certain characteristics which effectively distinguish them from their Northern European counterparts. These traits are particularly evident in the birth of the national health service, the legacy of the previous health insurance system, the composition of healthcare costs, the rule of private hospitals, the entitlements of patients, and patients' level of satisfaction with the healthcare system.

Different authors agree on the existence of a Southern European welfare state model (Leibfried 1992; Castles 1995, 1998; Ferrera 1996, 2000; Rhodes 1997; Karamessini 2008). One of the distinctive elements of this model is the adoption of universalistic provision in the field of healthcare. Greece, Italy, Portugal and Spain – all countries which in other respects resemble the Bismarckian states – have instead instituted national health services: public systems financed by general taxation for the benefit of the entire population, and which provide the majority of healthcare services.

By analogy with work on the welfare state in general, a number of scholars have shown how the healthcare systems of Greece, Italy, Portugal and Spain share a series of similarities (Saltman and Figueras 1997; Moran 2000; Guillén 2002; Katrougalos and Lazaridis 2003; Petmesidou and Guillén 2008). However, none of these scholars has explicitly argued for the existence of a typically Southern European healthcare model.

The question which motivates this article is therefore the following: do the healthcare systems of Greece, Italy, Portugal and Spain present common traits which distinguish them not just from those countries which have a

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system of social health insurance (countries in continental Europe) but also from other countries which, like those in the south, have adopted a national health service (the United Kingdom, Ireland, and the Nordic countries)?

From a theoretical point of view, the question is relevant for at least two reasons. The first concerns the problem – largely debated but far from being resolved (Moran 2000; Burau and Blank 2006; Wendt *et al.* 2009) – of classifying healthcare systems. As Wendt *et al.* (2009) have recently pointed out, the absence of a coherent and widely accepted classification is certainly the main weakness in international comparative work in the field of health policy. Posing the question whether there is a typical Southern European model would thus be a valuable contribution to the ongoing debate over definition and classification of healthcare models. There is a second reason why the question addressed in this paper is relevant: as many scholars have recognised, the modes through which healthcare services are financed and supplied represent a core element of the overall welfare system. For this reason, investigating the healthcare sector is paramount in order to understand the welfare state as a whole.

Logically speaking, two conditions must hold for us to be able to affirm the existence of a distinct Southern European model. First, the Greek, Italian, Portuguese and Spanish healthcare systems must be substantially similar. Demonstrating that these four countries share certain characteristics is not, however, sufficient: it is also necessary that these characteristics be to some degree distinctive and, within the European context, capable of differentiating these four countries from all the rest. For these reasons, the article will follow a dual path: on the one hand, assessing the degree of resemblance between the healthcare systems of the four Southern European countries, and, on the other hand, comparing these four systems with the systems of other Western European countries (EU-15 plus Norway), and in particular those systems with a national health service, in order to understand whether the four southern countries constitute a distinct group within the family of universalistic systems.

This two-level comparison will take account of those dimensions which have emerged as most relevant in previous studies of healthcare systems in Southern Europe. As it has been previously noted, scholars have identified a number of similarities between the Greek, Italian, Spanish and Portuguese healthcare systems. These similarities include both the financing (Saltman and Figueras 1997; Guillén 2002) and the delivery of healthcare services (Moran 2000; Guillén 2002). Moreover, great emphasis has been placed on the evolutionary path followed by different national systems (Moran 2000; Guillén 2002; Katrougalos and Lazaridis 2003; Petmesidou and Guillén 2008) and the legacy of the previous health insurance system (Guillén 2002; Petmesidou and Guillén 2008). The following sections describe each of these dimensions in some detail. As Southern European welfare systems are often accused of being both less efficient and less generous than their northern counterparts (Ferrera 1996; Katrougalos and Lazaridis 2003; Sotiropoulos

2004), a further section will focus on the entitlements of patients and the overall level of satisfaction towards the healthcare system in the countries under consideration.

To pre-empt some of the conclusions, the following sections demonstrate how the healthcare systems of Greece, Italy, Spain and Portugal, notwithstanding the particularities of each individual national case, share certain common characteristics which distinguish them from other European countries. Amongst the four Southern European systems, the most dissimilar is certainly the Greek system which, as we shall see, represents a decidedly anomalous case from an international perspective. From the comparison with the rest of Europe, it seems clear that the healthcare system which most resembles that of the Southern European countries is the Irish system.

The Historical Evolution

The healthcare systems of Greece, Italy, Portugal and Spain have followed historical paths which are similar in many aspects. After the first laws on compulsory health insurance were introduced in the 1930s and 1940s, these four Southern European countries subsequently decided to establish national health services more or less in the same period (between 1978 and 1986). In all four countries the transition from a Bismarckian system of social health insurance to a national health service was made possible by somewhat exceptional political and institutional conditions.

Timing

One first characteristic which differentiates the Southern European national health services from those found in the United Kingdom or in the Nordic states is their more recent introduction (see Table 1). In the United Kingdom – the first European country to establish a system of this type – the National Health Service was established in 1946; in Sweden in 1953, in Norway in 1956, in Finland in 1963 and in Denmark in the beginning of the 1970s. In the Southern European countries the founding laws of the various national health services were, by contrast, passed more recently: in Italy in 1978, in Portugal in 1979, in Greece in 1983 and in Spain in 1986. Ireland established its national health service in 1979, more or less at the same time as Italy and Portugal.

The countries in the north of Europe, by virtue of their rapidity in adopting national health services, have been considered ‘well-established’ universalistic systems (Saltman and Figueras 1997). The countries of the south of Europe have instead been variously defined as national health services which are ‘in transition’, ‘semi-institutionalised’, or ‘laggard’ (Ferrera 1996; Saltman and Figueras 1997; Katrougalos and Lazaridis 2003), precisely to differentiate them from the former set of countries. In this context one should note that the four Southern European countries were

TABLE 1
MAIN LAWS IN COMPULSORY HEALTH INSURANCE

	Year of first law creating social health insurance	Year of law creating national health service
Austria	1888	–
Belgium	1944	–
Denmark	1933	1971–72
Finland	–	1963
France	1930	–
Germany	1883	–
Greece	1934	1983
Ireland	1911	1979
Italy	1943	1978
Luxembourg	1901	–
Netherlands	1941	–
Norway	1909	1956
Portugal	1946	1979
Spain	1942	1986
Sweden	1946	1953
United Kingdom	1911	1946

Source: Adapted from Flora (1986), Immergut (1992), Cutler and Johnson (2004).

also generally late, in comparison with the majority of Nordic and continental countries, in adopting legislation on compulsory healthcare insurance (see Table 1). The first legislation of this type was in fact introduced in Germany and Austria at the end of the nineteenth century, and before the 1930s in Norway, the United Kingdom and France. Greece adopted its first law on social health insurance in 1934, over 50 years after the first Bismarckian legislation. In Spain, Italy and Portugal the first laws on social health insurance date back to the 1940s, and were adopted under the authoritarian regimes of Franco, Mussolini and Salazar.

The Importance of Critical Junctures

Apart from simple chronological comparison, the laws which established the national health services of these four Southern European countries have a further characteristic in common: the approval of the law was favoured by rather particular political and institutional conditions. In the literature, political or economic conditions which are exceptional and which permit radical changes in policy relative to the past are known as critical junctures (Collier and Collier 1991; Wilsford 1994; Hacker 2002). The argument made by a number of authors – including, for example, Guillén (2002) – is that in the Southern European countries the transition from a system of social health insurance to a national health service happened at the same time as a critical juncture in the political and institutional system. As far as Greece, Portugal and Spain are concerned, there can be no doubt: in all three countries the national health service was established in the years immediately following the transition from dictatorship to democracy. In Portugal, the Caetano regime

fell in 1974 and a democratic constitution was approved in 1976: the national health service was approved only three years later by a Socialist-led transitional government. In Greece the first democratic government after the 'regime of the colonels' was elected in 1974: the Greek national health service was established just a few years later, in 1983, when the Socialists came to power (PASOK had formed the first socialist government in Greek history in 1981). In Spain the national health service was also instituted by the first Socialist government following the transition to democracy. The Spanish constitution was approved in 1978, the Socialists won power in the elections of 1982, and the law which established the service was passed in 1986, during the Gonzalez government's first term in office.

In Italy, in contrast to the other three countries, the national health service was not approved on the back of regime change. Yet again, the transition from a scheme of social insurance to a national health service was made possible thanks to particular political and economic circumstances (Ferrera 1989). On the economic front, reform was made possible by the extremely serious financial difficulties faced by the sickness funds; many of which were on the brink of bankruptcy and had asked the government to take on their debts (France and Taroni 2005). As far as the political system is concerned, the years between 1976 and 1979 were for Italy the period of so-called 'national solidarity'. These were dramatic years marked by the struggle against terrorism. During this period the minority Christian Democratic government had need of the external support of the Communists, and it was precisely the Communist Party which raised the issue of healthcare reform – and more specifically the implementation of a national health service – as an essential condition for its support of the government (Ferrera 1989).

The creation of a national health service in the Southern European countries was thus made possible thanks to two important factors: (1) the process of democratisation (important for Greece, Portugal and Spain, but not for Italy); and (2) the role played by parties of the left, in power for the first time (important for Spain, Greece and Italy, less important for Portugal). It is important to note how this last factor – the decisive role played by parties of the left – is not specific to the countries of Southern Europe: national health services have been introduced by governments of the left in a majority of countries which have this model: in New Zealand and the United Kingdom by Labour governments; in Norway, Denmark and Sweden by social-democratic governments.

The Legacy of the Social Health Insurance Model

Between 1978 and 1986, the four countries of Southern Europe – emulating the United Kingdom and the Nordic countries – moved from a system of social health insurance to a national health service. When one thinks of transitions from one model of healthcare to another, one expects that the model eventually adopted will finally substitute, and thereby eliminate, the

previous model. It is not always thus: the solutions finally adopted often flank and superimpose themselves onto pre-existing ones. Models used in the past leave their legacy – at the structural level, but also on the cultural level – that successive configurations tend not so much to eliminate but rather to absorb and re-employ (Skowronek 1982; Stark 1996; Lanzara 1998; Streeck and Thelen 2005). In Greece, Portugal and Spain this was precisely what happened: the system of social health insurance was not completely dismantled, and one finds even today certain elements alongside the national health service which are a clear legacy of the previous system. In Italy, instead, the reform of 1978 abolished all the sickness funds and absorbed them into the newly-born national health service.

Greece

The Greek case is the most evident example of ‘stratification’: whilst the original design of the 1983 reform called for their abolition, the sickness funds have never been eliminated. This has been credited to the pressure exercised in the years immediately following the reform by defenders of the status quo, namely the trade unions, the sickness funds themselves, and those registered with the most generous sickness funds (Davaki and Mossialos 2005; Mossialos and Allin 2005). In Greece the sickness funds survive until the present day, with functions similar to those they exercised in the past. Healthcare is thus guaranteed in part by the national health service and in part through the sickness funds, of which there are approximately 30, covering almost 95 per cent of the population (Petmesidou and Guillén 2008). The largest fund is IKA (Idrima Kinonikon Asfalisseon, representing employees in the private sector), which covers almost half of the Greek population: the other principal funds are those representing agricultural workers (OGA – Organismos Georgikon Asfalisseon), the self-employed (OAEE – Organismos Asfaliseos Eleftheron Epangelmaton), and public employees (OPAD – Organismos Periqalchs Asfalismenwn toy Dhmosioy). Membership in a sickness fund is compulsory for all workers, and the benefits extend not only to the individual member but also to his or her family. The funds are financed in part by general taxation in addition to employee contributions. As far as membership benefits are concerned, there are profound differences between the different funds, and the fact that funds can be more or less generous naturally raises the question of the equality of treatment of citizens (Nikolentzos and Mays 2008). One must conclude that the Greek national health service is such in name only, and in reality is a perfect hybrid between the national health service and the social health insurance models.

Portugal

As in Greece, Portugal also exhibits a dual structure, where certain categories of workers enjoy privileged conditions thanks to membership in

specific sickness funds. Following the 1979 reform, the majority of the sickness funds were merged with the newly-created national health service. Certain funds have, however, survived until the present day. These funds (the so-called *subsistemas*) cover only certain classes of workers: public employees, the armed forces, police, post and telecommunications employees, and employees in the banking and insurance sectors. The entire Portuguese population therefore has a right to the services offered by the national health service, yet beyond this basic coverage, those who are registered with the *subsistemas* enjoy additional coverage which allows them to use private suppliers who are not registered with the public service. The *subsistemas*, an evident legacy of the previous social insurance system, currently covers between 15 and 20 per cent of the Portuguese population and are financed in part by employee contributions and in part by general taxation (Barros and de Almeida Simões 2007).

Spain

Certain components of the social health insurance system have also survived the creation of Spain's national health service, albeit to a lesser degree than in Greece or Portugal. There are two principal legacies of the previous system, the first of which concerns the coverage of the population: the Spanish national health service does not cover the entire population, but only 99.5 per cent thereof. Spain is an exception in this respect, for all the other national health services implemented elsewhere in the world (and thus not just those in Southern Europe, but also in the United Kingdom, the Nordic countries, and in New Zealand) cover the entirety of the population. The 0.5 per cent of the population excluded from the national health service is composed of high-income self-employed professionals who are not obliged to register with the social insurance system. This exception has a historic explanation: these professionals were not obliged to insure themselves against the risk of sickness even before the 1986 reform; and they retained the same treatment after the creation of the national health service.

The second anomaly of the Spanish system concerns the treatment of public sector employees. At the time the national health service was created not all sickness funds were abolished: three survived, and are still active today. MUFACE (Mutualidad General de Funcionarios Civiles del Estado), MUGEJU (Mutualidad General Judicial) and ISFAS (Instituto Social de las Fuerzas Armadas) cater for ministerial employees, personnel active in the judicial system, and the armed forces respectively. Their members – about 5 per cent of the population (Durán *et al.* 2006) – enjoy privileged treatment compared with other classes, being able to choose – at no additional cost – whether to be treated by the national health service (as with the rest of the population) or by private insurance companies. The majority of those covered opt for private care (Lopez-Casnovas *et al.* 2005). One must therefore conclude that in Spain healthcare is not

technically a citizenship right: for at least a part of the population this right is still tied to their occupation.

In virtue of the above-described characteristics, Greece, Portugal and Spain constitute an exception when viewed in international perspective: in these three countries a national health service was established whilst certain sickness funds were not only kept alive, but indeed continued to operate according to the principles of the old social health insurance system. In all other countries equipped with a national health service – Italy, the United Kingdom, the Nordic countries – this has not happened: professional sickness funds were abolished and replaced by the public service. How can the exceptionalism of these three countries best be explained? The most plausible explanation concentrates on the degree of institutionalisation of the preceding system (Petmesidou and Guillén 2008). At the time of transition to a national health service, the social health insurance systems operating in Greece, Portugal and Spain were already more than 30 years old, and thus already mature. Dismantling such a system is more difficult than intervening to change a less consolidated system. Over the years, the social insurance system had in fact generated diffuse legitimacy, consolidated its political clientèle, and conferred privileges on certain classes of workers who consequently had no interest in supporting reform. In Greece, Portugal and Spain the implementation of the national health service thus revealed itself to be more difficult than elsewhere precisely due to the existence of a strong coalition opposed to reform (Guillén 2002).

Italy

As far as Italy is concerned, the debate is different, because – as was already noted – the sickness funds prior to the 1978 reform were facing a period of profound organisational and financial crisis (Ferrera 1989). Indeed, the system was fragmented into numerous sickness funds and lacked unified regulation: there were many different contribution rates and often drastically different benefit packages (France *et al.* 2005). Coverage of the population was high but still incomplete, as 7 per cent of the population was not covered by insurance (Ferrera 1995). In addition, the large deficits of the sickness funds led to a financial crisis, which prompted the government to intervene (Ferrera 1989; France and Taroni 2005). The social health insurance system as a whole had therefore lost not only its social legitimacy but also its economic viability, and for that reason was more easily substituted by a national health service.

Composition of Healthcare Expenditure

In order to test the claims made in the previous section – namely that the national health services in the south of Europe are different from those in the north by virtue of their maintenance of aspects of a previous social

health insurance system – it is helpful to examine the composition of healthcare expenditure. Table 2 shows, for the EU-15 countries plus Norway, the different sources of financing (general taxation, compulsory health insurance contributions, voluntary health insurance payments, and out-of-pocket expenses) which collectively determine total health spending.

Examining the data, it is not difficult to divide the countries of Western Europe into three families. The first of these includes the countries of continental Europe (Austria, Belgium, France, Germany, Luxembourg and the Netherlands). As is well known, a social health insurance system persists in these countries; it is therefore unsurprising that these countries should finance their healthcare systems primarily through compulsory health insurance contributions. The share which derives from general taxation is low, whilst private expenditure is – with due exception made for Luxembourg – rather high, running between 18 and 31 per cent of the overall figure.

The second family is composed of the Northern European countries (Denmark, Finland, Norway, Sweden, the United Kingdom and Ireland). All these countries have a public universalistic system, which for convenience we shall call a national health service (even if this label is not used in all the countries considered). The ‘northern’ national health services finance healthcare in large measure through fiscal contributions, with over 80 per cent of the global healthcare costs. The share of private expenditure is less than in the other two families.

TABLE 2
COMPOSITION OF HEALTHCARE EXPENDITURE, 2006

	General taxation (%)	Mandatory social insurance (%)	Private insurance (%)	Out-of- pocket (%)	% public expenditure	% private expenditure
Austria	31.5	44.7	7.3	16.5	76.2	23.8
Belgium	12.7	56.4	10.2	20.7	69.1	30.9
Denmark	79.9	0	5.7	14.4	79.9	20.1
Finland	61.1	14.9	5.3	18.7	76.0	24.0
France	5.1	74.6	13.6	6.7	79.7	20.3
Germany	9.3	67.5	10.0	13.2	76.8	23.2
Greece*	23.2	29.5	2.1	45.2	52.7	47.3
Ireland	77.6	0.7	9.3	12.4	78.3	21.7
Italy	77.1	0.1	2.6	20.2	77.2	22.8
Luxembourg	20.6	70.3	2.6	6.5	90.9	9.1
Netherlands	4.0	77.7	12.3	6.0	81.7	18.3
Norway	71.1	12.5	0.8	15.6	83.6	16.4
Portugal	69.7	0.8	6.7	22.8	70.6	29.4
Spain	66.1	5.2	6.7	22.0	71.2	28.8
Sweden	81.7	0	n.a.	n.a.	81.7	18.3
United Kingdom	87.3	0	n.a.	n.a.	87.3	12.7

*Data refer to 2004.

Source: OECD (2008).

The third family is made up of Italy, Portugal and Spain. As with the Northern European countries, the principal source of financing for these countries is general taxation, yet the value of private expenditure is higher, at between 22 and 29 per cent. With a distribution of costs which is very similar to that of Italy, Ireland could quite easily belong to this third family. This is not true for Greece, which constitutes, at least within the European context, an anomaly which cannot be subsumed under any of the three preceding families. In Greece the public share of healthcare spending is markedly lower than in other countries; the shares which derive from general taxation (23 per cent) and from healthcare insurance (29 per cent) are in broad terms equivalent. This is confirmation of what was hinted at earlier, or rather the fact that the Greek system is a hybrid between a national health service and a system of social health insurance.

The differences running through the three families just described are even more evident if one considers public, private and overall healthcare expenditure as a percentage of gross national product (see Table 3).

One notes how the healthcare systems of Northern Europe, in overall terms, cost less: on average 8.6 per cent of gross national product. The social health insurance systems cost considerably more, at 9.8 per cent of GNP. The Southern European systems (including Greece) find themselves in an intermediate position, with an average cost of approximately 9.2 per cent of

TABLE 3
HEALTHCARE EXPENDITURE, % GNP (2006)

	Total health expenditure, % GNP	Public health expenditure, % GNP	Private health expenditure, % GNP
<i>Continental Europe (CE)</i>			
Austria	10.1	7.7	2.4
Belgium	10.4	7.2	3.2
France	11.1	8.9	2.2
Germany	10.6	8.1	2.5
Luxembourg	7.3	6.6	0.7
Netherlands	9.3	7.6	1.7
<i>Average CE</i>	<i>9.8</i>	<i>7.7</i>	<i>2.1</i>
<i>Northern Europe (NE)</i>			
Denmark	9.5	7.6	1.9
Finland	8.2	6.2	2.0
Ireland	7.5	5.9	1.6
Norway	8.7	7.3	1.4
Sweden	9.2	7.5	1.7
United Kingdom	8.4	7.3	1.1
<i>Average NE</i>	<i>8.6</i>	<i>7.0</i>	<i>1.6</i>
<i>Southern Europe (SE)</i>			
Greece	9.1	5.6	3.5
Italy	9.0	6.9	2.1
Portugal	10.2	7.2	3.0
Spain	8.4	6.0	2.4
<i>Average SE</i>	<i>9.2</i>	<i>6.4</i>	<i>2.8</i>

Source: OECD (2008).

GNP. There is also confirmation of the principal difference between the northern and southern national health services: in the latter, private expenditure is considerably higher, corresponding to 2.8 per cent of GNP (2.5 per cent excluding Greece), whilst in the former it is on average 1.6 per cent.

This analysis of healthcare expenditure offers us certain valuable points which it is useful to bear in mind. The first of these is that the Southern European healthcare systems greatly resemble the national health services of the north, but have an element of private expenditure which is much greater (and in this respect they are more similar to the social health insurance systems). The second is the confirmation that the Greek healthcare system represents a mixed case, half way between a national health service and a social health insurance system. The third conclusion concerns Ireland, which displays values which, at least as far as the composition of healthcare expenditure is concerned (see Table 2), are extremely similar to those of Italy. Fourth, of the three families described above, the most dissimilar is naturally the first family composed of countries of continental Europe. These countries have remained faithful to the principles of social health insurance, and are thus financed and organised in a profoundly different manner from the universalistic systems: therefore the remainder of the article is dedicated to a comparison between national health services in the north and south of Europe.

The Delivery of Healthcare

Ferrera (1996) claims that one of the principal differences between the Southern European healthcare systems and those in the north is that the first have traditionally left greater space to the private sector. As was seen in the previous section, this is absolutely true as far as the financing of the system is concerned: the share of private healthcare expenditure in the four countries of Southern Europe is much greater than in the north. Are the Southern European systems also more privatised insofar as the delivery of healthcare services is concerned?

The answer to this question is certainly affirmative if we consider the relationship between public and private hospitals. Private hospitals supply around 20 per cent of the hospital beds available in Italy (Anessi Pessina and Cantù 2007), 23 per cent in Portugal (Oliveira *et al.* 2005), 29 per cent in Greece (Boutsoli 2007), and 34 per cent in Spain (Instituto de Información Sanitaria 2006). In this respect, the health systems of Northern Europe are clearly more 'public': beds in private facilities are less than 5 per cent of the total in the United Kingdom and in Finland, 2 per cent in Norway, and only 1 per cent in Denmark (Grosse-Tebbe and Figueras 2005; Johnsen 2006; Vuorenkoski 2008). Only in Ireland is the number of private beds equal to the levels of the Southern European countries: the percentage of beds in private facilities is 12 per cent, to which should be added an additional 15

per cent of private beds in public hospitals (HSE 2008). As far as hospital delivery is concerned, it is therefore evident that the Southern European countries entrust much more to the private sector than in Northern European countries (with the exception of Ireland).

The differences between the southern and northern national health services are nevertheless much less marked if we take into consideration other elements of the supply of services, starting with the organisation of primary care. In Spain, Portugal and Greece basic medical treatments are provided by primary care centres, which are distinguished from other forms of group practice by their multidisciplinary nature, including not only general practitioners but also other professional figures such as specialist doctors, nurses, physiotherapists and laboratory technicians. Primary care centres are also found in Finland and Sweden. In Italy general practitioners instead practise on a largely individual basis, and, moreover, are not public employees but rather independent professionals employed on a contractual basis by the national health service. The same is true in Ireland, the United Kingdom, Denmark and Norway, whilst in Spain and Portugal family doctors are in large part public employees, just as in Sweden.

Still considering general practitioners, one element capable of profoundly affecting not only the doctor–patient relationship but also the relationship between different healthcare providers is the existence of an obligatory gatekeeping mechanism. By gatekeeping I mean the principle according to which – with exceptions for urgent cases – patients may gain access to secondary care only with an appropriate referral from their general practitioner. This principle has been adopted by national health services in Italy, Portugal and Spain as well as in the United Kingdom, Ireland, Norway, Finland and Denmark. Gatekeeping mechanisms are by contrast not obligatory in Sweden (although here a referral is required for certain types of hospital admittance) and almost absent in Greece.

We turn now to non-hospital medical specialists. In Portugal the majority of outpatient consultations are made by private doctors, often contractually linked to the public service (Barros and de Almeida Simões 2007): the same happens in Denmark and Norway. Although it is less common than in these countries, the public healthcare system in Italy, Greece and Spain contracts out part of its specialised care and diagnostic exams to private suppliers. Similar forms of contracting out are also found in the United Kingdom, Finland and Sweden.

We turn finally to hospital-based doctors. In all national health services, both those in the south and those in the north, physicians who work in the hospitals are employees who are paid a fixed salary. In Italy, Spain, Portugal and Greece, doctors who work in public hospitals are allowed to operate a private practice outside of their working hours (which naturally generates a mixture between the public and private sectors). This is by no means a Southern European particularity – doctors employed in the public health systems of Ireland, Finland, and the United Kingdom are also allowed to

operate a dual practice (García-Prado and Gonzalez 2007; Vuorenkoski 2008).

Still at the level of service delivery, the Greek health system represents – amongst those countries which have a national health service – a peculiar case. This is due to the fact that in Greece, as has been previously noted, certain sickness funds continue to operate. Both the national health service (ESY – *Ethniko Systima Ygeias*) and the largest of the sickness funds (IKA, which covers half of the Greek population) have their own medical personnel and facilities (hospitals, ambulatory care centres, primary care centres). ESY, on one hand, and IKA, on the other, are therefore responsible for two parallel production structures: ESY manages the majority of outpatient departments (above all in rural zones) and hospitals; IKA, whilst having some of its own hospitals, is primarily known as an owner of primary care centres (Mossialos *et al.* 2005). In contrast to other national health services, in Greece the management of public healthcare facilities is not unified, but instead divided between two subjects, both publicly owned (ESY is responsible to the Ministry of Health, IKA to the Ministry of Employment). Exaggerating slightly, we may say that in Greece it is as if there were not one, but two parallel national health services.

To conclude, it emerges from this rapid overview of the organisation of the providers of healthcare that the national health services of the four Southern European countries do not constitute a particular organisational model. This is so for two reasons. First, there are substantial differences between the health systems of these countries. For example, the public health facilities in Greece are managed in part by the national health service and in part by the sickness funds. Second, the southern national health services do not seem to demonstrate distinctive traits: they are organised more or less according to the principles adopted by national health services in the north of Europe. The only relevant difference concerns hospital production: in the southern countries (but also in Ireland) private structures make up a considerable share of total hospital activity: in the countries of the north the role of private hospitals is much less significant.

Patient Entitlement and Satisfaction with the Public Service

In the preceding sections we have come to the conclusion that private healthcare expenditure is higher in the south of Europe than in the north. This begs the question: why in Southern European countries is there a greater propensity to turn to private suppliers and pay out of one's own pocket? There are two possible answers.

The first can be found in the range – be it broader or narrower – of public health services available. One may therefore hypothesise that the northern national health services offer their contributors a more generous healthcare package than that offered by the Southern European systems, where the

population would be thus forced to pay from their own pockets for elements not guaranteed by the public service. Yet is it really the case that the Southern European national health services are less generous than their northern counterparts? At least on paper, the national health services of Greece, Spain, Portugal and Italy are highly comprehensive, at levels entirely comparable to those of the public systems in the United Kingdom and the Nordic countries (MISSOC 2008). The problem, in Southern European countries, is that rights guaranteed on paper are not always honoured in practice. Long waiting lists often limit access to services which are formally guaranteed by right. Waiting times – which constitute an implicit rationing of the services offered by the public system – are an extremely serious problem in all four of the Southern European countries (Boutsioli 2007; Barros and de Almeida Simões 2007; Durán *et al.* 2006; France *et al.* 2005). Of course, the problem of waiting times also affects the Northern European national health services, yet in these countries the problem has been tackled decisively over the last few years by the assignation of new funds, reinforcing patients' rights, and fixing maximum waiting times that the public system is obliged to respect (Glenngård *et al.* 2005; Johnsen 2006; Oliver 2005; Pedersen *et al.* 2005; Vuorenkoski 2008). In Southern Europe measures of this nature have either not been adopted or have been interpreted in a rather lax fashion.

A second explanation can be found in the level of satisfaction demonstrated towards the public system. It is eminently plausible that in those countries in which the public system offers services of high quality, there is no reason to incur extra costs by turning to the private sector. Naturally the more the public system is perceived as 'low quality', the greater the temptation to turn to private suppliers (it should be evident that this second explanation encompasses the second, since the degree of satisfaction depends also on the range of services offered and the speed with which these are carried out). If this is true, the countries in the north of Europe – where private spending is lower – should demonstrate levels of satisfaction with their different public systems which are greater than those in the south. This is indeed the case. Confirmation of this comes from all opinion polls on the subject carried out over the past dozen years (Mossialos 1997; Eurobarometer 1999, 2002; WHO 2000). The survey data indicate unequivocally that, within the national health service model, those most satisfied with their healthcare system are the citizens of the Nordic countries. The four countries of Southern Europe by contrast systematically score the lowest levels of satisfaction. The health systems of Ireland and the United Kingdom generally register levels of satisfaction only slightly higher than the Southern European countries. The same conclusions were also reached by the recent 'Euro Health Consumer Index 2008': from the patient's point of view, the best healthcare systems are those in continental Europe and in the Nordic countries; the United Kingdom and Ireland occupy an intermediate position, whilst the

countries of Southern Europe score the worst (Health Consumer Powerhouse 2008).

Conclusions

By way of conclusion we may now attempt to answer the question which motivated this article: is there really a Southern European healthcare model? On the basis of what has been discussed in the previous sections, what is certain is that the health systems of Italy, Portugal, Spain and Greece are connected by certain significant commonalities. These can be summarised as follows.

First, the national health services of all four countries had a similar genesis, insofar as both the timing of their creation and the method of transition to the universalistic model was concerned. The Southern European health services were created more recently (between the end of the 1970s and the beginning of the 1980s) in comparison with their northern counterparts, thus profiting from particular political and institutional conjunctures.

A second characteristic trait of Southern Europe concerns the legacy of the previous social health insurance system. Notwithstanding the introduction of a national health service in these countries, there are still clear traces of the previous social insurance system in Greece, Spain and Portugal (but not in Italy). Certain of the professional sickness funds are still in existence, and these flank and are superimposed upon the national health service system, creating disparities of treatment between citizens. In Spain the remaining sickness funds cover only certain categories of public employees; in Portugal members of the *subsistemas* represent 15–20 per cent of the population; and in Greece almost 95 per cent of the population belongs to such a fund.

A third distinctive element of the Southern European national health services emerges from the analysis of healthcare expenditure. It was noted how private expenditure is considerably higher in the four Southern European countries – and in particular in Greece – compared with the northern national health services. The health systems of Southern Europe can thus be distinguished by the greater space they grant to private operators.

The Southern European health services are also more ‘private’ than their northern counterparts insofar as production is concerned. Take, for example, the distribution of beds between public and private hospitals: in the Northern European health services, the private sector has a minimal share of beds; in the southern health services, private facilities instead have a much greater role, managing between 20 per cent (in Italy) and 34 per cent (Spain) of total beds available.

The four Southern European countries share a further characteristic: the low level of satisfaction citizens have in their dealings with the health

system. All the polls carried out over the past 10–15 years confirm that citizens in these four countries are the least satisfied with the operation of their health system of all those in Western Europe. This partly derives from the long waiting times necessary before receiving specialised treatment.

In summary, the national health services of Southern Europe share a series of common traits which make them substantially different from those of Northern Europe. It therefore may make sense to speak of a Southern European model of healthcare. At this point one can discuss whether the four Southern European countries should be considered a free-standing model of healthcare (different both from the continental and the northern models), or whether they should instead be considered a sub-group of the broader family of national health services. In favour of the first of these hypotheses – that Southern Europe constitutes a separate healthcare model, in certain respects intermediate between the social health insurance and northern national health service model – are two of the distinctive characteristics just mentioned, namely the common genesis and clear legacy of the social health insurance system (which in the northern health services is almost entirely absent). In favour of the second hypothesis – that the Southern European systems are a sub-group within the family of national health services – one may argue that certain of the characteristics of the Southern European countries are also found, though in greatly reduced measure, in the countries of the north. Either of the hypotheses thus appears plausible: the choice is therefore left to the reader.

Whether one is in favour of the first or advocates for the second of these hypotheses, two clarifications seem necessary. The first concerns the problematic positioning of Greece. The Greek system constitutes – at least in the European context – a *sui generis* case. As has already been recalled, the Greek system is a mixed system half way between national health service and social health insurance model. Logically speaking, it should not therefore be considered a national health service. In financing, the Greek anomaly lies in the extremely high levels of private expenditure (47 per cent of the total) which is for the most part out-of-pocket expenditure. In production, the Greek system is distinguished from all others by the fact that the public services are not responsible to a single body but rather to two separate authorities: the national health service on the one hand, and IKA (the largest sickness fund) on the other. For these reasons, notwithstanding the resemblances with other Southern European countries, it would be more useful to treat the Greek healthcare system separately (the alternative is to consider it an ‘exaggerated’ example of the Southern European type).

The second clarification concerns the Irish healthcare system, which, in truth, has not been given much space in the present article. The Irish system is, however, the most ‘southern’ of the ‘northern’ national health services. The similarities between Ireland and the Southern European countries emerge above all at the level of the composition of healthcare expenditure

(the Irish figures are almost equal to the Italian figures, see Table 2), the number of hospital beds, and the level of user satisfaction. If the Greek case can be considered an 'exaggerated' one, Ireland may be a 'feeble' case of the Southern European model: the Irish healthcare system manifests certain of the traits of the Italian, Portuguese and Spanish system, although in more attenuated form. Grouping Ireland with the Southern European countries would, however, confirm the hypothesis that the peculiarity of these countries derives in large part from their more recent establishment: the Irish national health service is indeed the youngest of the northern health services, having been created in 1979 (and thus contemporaneously with the Italian and Portuguese health services).

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