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Improving Efficiency and Containing Costs: Health Care Reform in Southern Europe

ANA M. GUILLÉN

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This Working Paper has been written in the context of the 1998-1999 European Forum programme on **Recasting the European Welfare State: Options, Constraints, Actors**, directed by Professors Maurizio Ferrera (Universities of Pavia and Bocconi, Milano) and Martin Rhodes (Robert Schuman Centre).

Adopting a broad, long-term and comparative perspective, the Forum will aim to:
· scrutinize the complex web of social, economic and political challenges to contemporary European welfare states;
· identify the various options for, and constraints on institutional reform;
· discuss the role of the various actors in promoting or hindering this reform at the national, sub-national and supra-national level;
· and, more generally, outline the broad trajectories and scenarios of change.

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Improving Efficiency and Containing Costs: Health Care Reform in Southern Europe

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ABSTRACT*

This paper constitutes the first detailed comparative study of Southern health care systems. It begins by analysing the reforms they underwent during the seventies and eighties, that is, the introduction of national health services in Italy, Portugal, Greece, and Spain. It deals with the main policy actors involved in the design and implementation of the reforms. The second section of the paper assesses the measures adopted by Southern health care systems in order to contain the cost of health care services in the nineties. It is argued that the character of the cost-containment measures adopted in each country has depended intensely on the successes and failures of the previous set of reforms. The third section considers the impact of the two reform waves on the macro-institutional framework of Southern health care systems, as compared to those of other European Union members. Finally, the main factors accounting for reform trajectories are singled out and the "Southern model of welfare" discussed in what regards health care.

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INTRODUCTION**

All Southern European countries have enacted reform laws during the last twenty years with the intention of turning their social insurance health care systems into national health services. Presently, all four countries are making important structural changes in how health care is provided and financed. However, no comparative study on the reform of Southern health care systems has been done so far. The aim of this paper is precisely to address this issue comparatively in order to find out which have been the results of reform and to single out which factors have been most influential.

Italy, Portugal, Spain and Greece were relatively late in adopting something akin to the national health service model (see table 1). Great Britain introduced its National Health Service in 1946; Sweden followed suit. Norway, Finland and Denmark reformed their health care systems in the same direction in the subsequent decades. So far, it is only the UK, Ireland, the Nordic countries and the Southern ones who have adopted national health services; the rest of Western European countries having remained social insurance health care systems. Moreover, coverage is only universal in Ireland for hospital care and the reforms undertaken in Great Britain since the early nineties make the classification of the British system as a traditional national health service problematic.

Table 1. Dates of introduction of National Health services

Great Britain	1946
Sweden	1946
Norway	1956
Denmark	1971
Finland	1971
Italy	1978
Portugal	1979
Greece	1983
Spain	1986

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Ferrera (1996), building on the existence of a specific welfare model in Southern countries, argues that a significant difference between their health care systems and the more traditional national health services is that reminiscences from the (occupational) past are more marked in the Southern countries. Thus, the criterion of coverage is not fully homogeneous, as it should be in a universal, citizen-oriented system. Moreover, an overlapping between the public and private sectors still persists with negative consequences for the functioning of the systems. This paper will explore such differences.

The ambition of all Southern European countries from the seventies onwards was to move quickly to a national health service directed to all citizens and financed out of general taxation. However, the degree of implementation of the corresponding reform laws has varied a lot among them. While it has been high in Italy and Spain, Portugal and Greece have failed to put into practice many of the legally designed measures (Ferrera 1996; Guillén and Cabiedes 1997). Variations in implementation processes in Southern European countries have affected significantly the next set of reforms, i.e., the so-called "reform of the reform". This is why the first section of this paper is devoted to the analysis of the introduction of national health services in Southern Europe and to their achievements and shortcomings.

The second wave of reforms has entailed the introduction of measures aimed mainly at pursuing increased efficiency and cost-control. The array of changes undertaken in this direction –as it has also been the case in other European countries - is very large and varied and can be divided into measures affecting the demand or the supply side of health care systems. Both have different implications and impacts on equity and efficiency. Measures affecting the demand side have usually proved negative for equity of access and result and not necessarily positive for efficacy and efficiency gains. Conversely, measures applied to the allocation and production side of the health system may result in increased efficiency while being less aggressive with equity (Saltman and Figueras 1997). The second section of this paper deals with the analysis of the "reforms of the reforms". It studies the kind of measures introduced into the health care systems and aims at explaining why they differed from country to country. The influence of the internationalization and European integration processes receives privileged attention.

Finally, the third section is devoted to the impact of the reform processes on the macro-institutional structure of Southern health care systems. In particular, it deals with the changes that have taken place in terms of the criterion and span of coverage; expenditure trends and financing mechanisms; services provided and access to them; and organization/management. Conclusions discuss the most relevant factors having affected the evolution of

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Southern health care systems and the implications for the "Southern European model of welfare".

1. TOWARDS NATIONAL HEALTH SERVICES

This section examines the decision-processes leading to the introduction of national health services in Southern Europe and its implementation with the aim of establishing what the situation was when the second wave of reforms were undertaken.

Portugal was, together with Italy, the first country to pass a law establishing a national health service in the late seventies. Already during the early seventies, a move towards a greater role of the state regarding the provision of health services may be ascertained. During Caetano's *Estado Social*, social security coverage was expanded to new categories of workers, the Ministry of Health and Welfare was re-organized and new health centres were built (Guibentif 1997). In 1971, a health law was passed aimed at securing a unified direction, better planning, and co-ordination of health administration. The government was to take the lead over the private sector. Furthermore, the reform aimed at developing preventive care and at offering citizens a full range of health services (OECD 1994). Even though little change was actually achieved with respect of the previous *statu quo* of the health care system, a move towards greater government intervention eased the way for the developments that were to take place after the 1974 revolution.

In 1974, the overturn of the Salazar regime by army officers was welcome by a large proportion of the population who wanted to see an end to the authoritarian regime and had hopes that the advent of democracy would render positive effects for economic development (Guibentif 1997). The new regime was pushed into expansionary reforms of the social protection system because of legitimisation needs. In the field of health care, soon after the revolution, the role of public sector was increased. Within two years time, central and district hospitals owned previously by the *misericordias* shifted to the public sector, and local hospitals were also integrated in the public system. Already in 1977, medical units offering services for those depending on poor relief had also been incorporated to the public health service. Moreover, social security contributions were reduced in the financing of health services in favour of general revenues, and the health services of the *caixas de previdenza* were placed under the responsibility of regional health administrations rather than under the insurance funds (OECD 1994; Guibentif 1997).

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The new Constitution, passed in 1976, established the right of all citizens to health care and placed the creation of a universal national health service under the responsibility of the state. The law implementing this principle was passed in 1979 (Law 56/1979 of 21st July). The creation of a national health service had been already discussed in the years previous to the revolution and the arrival of democracy opened the way for its implementation. The central aim was to secure universal, free of charge access to the entire population. The accent was put on ameliorating the equity of the system (Pinto 1997).

The 1979 Law set a unified direction of the public health care system and established central, local and regional agencies for health services administration. Social security services and public ones were to be included into the same public network. Insurance funds were no longer to play a role in health services, and to remain in charge solely of income maintenance programs. All the institutions in charge of preventive and health promotion services were to be placed under the centralised control of the Ministry and hospitals were to be also centrally co-ordinated. In the eighties, a large proportion of the hospitals and the beds came to be owned by the government (80% and 84% respectively). Health professionals working for the NHS should all become civil servants. The reform law also stated that access to private services should be only possible in the cases were public provision was available. Primary care was reformed in 1979, so that health centres were to provide, from then onwards, both preventive and curative services and to staff an interdisciplinary team of professionals such as doctors, nurses, psychologists, social workers and environmental health inspectors (OECD 1994).

In spite of this major normative shift within the Portuguese health care system, the impact of the legal reform remained far of its formal intentions. Implementation was only partial and patchy. Despite the universalist thrust embedded in the reform law, several professional insurance schemes were left untouched. This was the case of civil servants, amounting to almost 14% of the population at the time. The same occurred with many other categories of workers, such as bank and insurance employees, persons working for public enterprises, the armed forces, and students. Although to different extents, all these categories were able to resort to private provision of health care and be (partially) reimbursed for it (OECD 1994). Co-ordination between hospitals and regional health care administrations was also far from being accomplished, "free" health care at the point of service was never achieved, and a significant expansion of the private sector took place (Guibentif 1997).

As a consequence of failure at implementation, the Portuguese health care system has remained based on three different tiers, namely, the NHS (in principle accessible to all residents), the insurance schemes for various

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professional categories (covering roughly one quarter of the population, and the private sector (reaching to 17% of the population through private insurance and mutual associations) (OECD 1998).

Unfortunately, there is little information on what was the constellation of factors that allowed for the passing of the 1979 reform Law and on the different positions of the relevant political and social actors regarding this issue. Thus, it is also difficult to figure out which were the problems faced in the implementation process. Obviously, legitimisation needs of the new regime and an already existing consensus among the population could be posed as some of the reasons why the reform was passed. One possible reason for difficulties at implementation may stem from the fact that coverage was much lower in Portugal (66,0% in 1977, according to OECD data) than in Italy and Spain, where it was over 90% when the respective shifts towards national health services were adopted.

Guibentif (1997) forwards three reasons for the implementation difficulties. The first is connected with financial problems experienced by the Portuguese social protection system during the 80s, due to generous commitments embedded in the social security system that were inherited from the previous regime. Nonetheless, such generous commitments were also present in Italy and Spain, where implementation was successful.

The second reason is related to Portugal's entry into the European Community. Access to the EC would have fostered the adoption of expansionary measures in order to close the gap with more advanced European welfare states before actually joining the Community. Still, it would have acted in the opposite direction ever since Portugal became a member because attention was driven to other more pressing endeavours, such as vocational training. The presence of a centre-right party in office from 1985 to 1995, who was not in favour of radical moves but rather of careful incremental ones, is provided as a third reason. To this Guibentif (1997) adds that social protection reform has never been at the top of the agenda in Portugal, contrary to what has happened in other Southern European countries, and a lack of influence of civil society, especially on the part of unions and employer's associations. These are all reasons that may account for the difficulties at implementing the national health service law in Portugal. However, there is little information to be found in the literature on the role played by several crucial actors such as health professionals, insurance funds (it should be recalled that some of them were left undisturbed) and the private health sector. It is not difficult to figure that these were all actors that deeply opposed the reform.

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The situation of the **Greek** health care system in the early eighties mirrored to a large extent that of Portugal prior to the 1979 reform. According to OECD Health Data (1998), the coverage span was of 88.0% of the population in 1983, thus much higher than that of Portugal in 1978 (66.0%). However, both systems had in common several traits such as administrative dispersion, broad territorial inequalities, and variations in both contributory arrangements and the services supplied by the different insurance funds. Similarly to Portugal, outpatient services were provided mainly by the private sector. Even in the hospital domain, the private sector owned more than half of hospital beds (Symenidou 1997).

In Greece there were 80 different health insurance funds of compulsory membership at the beginning of the previous decade, all directed to different professional categories. The rural population, mainly covered by the OGA insurance scheme had access to hospital care but only to limited contracted services with private clinics, so that access to primary services was problematic. IKA insurance, devoted mainly to the urban population, could nonetheless count on a much better supply of services, based on free access to hospitals, contracts with specialists and a network of clinics owned by the insurance scheme itself. The insurance funds covering civil servants, bank employees and workers of public enterprises also provided a broad arrange of health services. These latter and IKA provided dental, ophthalmology and pharmaceutical services at low cost-sharing levels. Contribution levels also varied a lot among the insurance funds (OECD 1994).

This situation triggered the establishment of a national health service in 1983. The perception of broad inequalities in health care resources among regions, of mounting differences among the insurance funds, and of lack of co-ordination among the numerous administrative departments in charge of the provision of health care opened the way for the reform. Conscience grew on the fact that developments during the 70s had early 80s had rendered privileged groups in an ever better position *vis à vis* the health system. It was thought that the establishment of a national health service would smooth out all these inequalities, acting above all from the supply side. The Socialist Party (PASOK) gained office at the beginning of the eighties thanks to a great extent to its commitment to the construction of a full-fledged welfare state. In 1983, the Greek National Health Service (ESY) was created by Law 1379 (Venieris 1997a). The reform was based on the introduction of state responsibility for the care of all citizens, entitled to the same range of services, which were to be financed out of taxes. Regions were to be in charge of finding out the needs of its populations and to provide for them. Family doctors and health centres for primary care were to be established. In a four-year period after the passing of the

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reform, 186 new health centres were built and the number of hospital doctors and nurses increased dramatically (Symenidou 1997).

The reform nationalized the hospital sector and prohibited the supply of private services by public doctors. Some efforts were also done at ameliorating the supply of primary care in rural areas. However, key provisions of the 1983 reform were never put in practice. Health services have remained in the hands of the insurance funds to a very large extent. Decentralization of authority, the shift towards general revenues and the institutionalization of family doctors were all aspects that remained broadly untouched (Petmesidou 1996; Symenidou 1997). Attempts at decentralization in the early 90s were met with strong opposition from public doctors. Primary care in rural areas has remained short of equipment and medical staff, while no moves may be ascertained to the updating of primary care in urban areas.

Also in parallel with the Portuguese case, the Greek NHS met many difficulties for its implementation, above all because a stable coalition of interest behind it was not achieved and the necessary public funds needed to put it into practice were not allocated. Definition of priorities for reform and planning were not either present (Venieris 1997a). Resistance on the part of doctors to the introduction of the 1983 reform package and frontal opposition by the insurance funds, especially the better off ones, were the main forces impeding a more decided implementation process on the part of the government (Symenidou 1997). Doctors were not interested on the restructuring of the primary care level, because such care is usually rendered either by hospital out-patient services or private ones. In turn, the richest insurance funds did not want to lose their privileges and autonomy. Furthermore, the state of the economy was also problematic during the 80s. In 1985, rationalising measures had to be introduced. The thrust towards universalism, and past decisions regarding expansion of social security benefits quickly resulted in large deficits. Under these circumstances, it was difficult to allocate more resources for the public health service (Venieris 1997a)

Spain and Italy have been most successful among Southern European countries in turning their social insurance health care systems into national health services. Just before reforms were introduced in both countries (in 1978 in Italy and in 1986 in Spain), and despite the time gap, both health care systems showed similar characteristics. The organizational structure of the two systems was fragmented, although to a much larger degree in Italy than in Spain, posing difficulties for a co-ordinated and unitary direction. In Italy, the *sistema mutualistico* was based on a multiplicity of organisms with varied regulations, the health funds. Three main types of insurance schemes could be distinguished: a general scheme insuring all employees of the private sector; a number of

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special schemes for public employees, for the self employed and for particular occupational categories; and a special scheme insuring against tuberculosis (Ferrera 1989). In the Spanish case, several special regimes existed, together with an independent regime for public servants. However, regulations regarding the procedures for access to assistance and beneficiaries rights were, though not totally homogeneous, less differentiated than in Italy.

The resemblance was remarkable also in other aspects. As a result of coverage extension a very large part of the population was entitled to health care services: over 90 per cent in both countries. Also in both countries only workers and their dependants were insured for health care services. Therefore, part of the population had to resort to assistential health care (poor relief), such as some unemployed and their dependants, young people in the search of the first job, some autonomous workers, and some elders lacking contributory careers. In the two cases the health systems were not financed out of general revenues but mainly out of fees and contributions. Some other similarities may be pointed out, such as the lack of general planning, the slight emphasis on preventive care, the expansion of the hospital sector at the expense of increasingly deteriorated primary health care networks, and a very deficient co-ordination among the levels of assistance. Furthermore, regional disparities in the distribution of human and material resources existed in the two countries as well as an overlapping between public and private sectors.

Despite the common departure, the 1978 reform in Italy and the 1984/1986 reform in Spain came to be different in character. In the Italian case the reform led to the abolishment of all special regulations and the suppressing of the health funds. A single unitary scheme --the *Servizio Sanitario Nazionale* -- was established in its place which covered all citizens and offered all health care services (Law 833). The 1978 reform aimed at endorsing the system with efficiency, promoting prevention services and reducing the barriers among the different levels of care. The parliament was charged with the elaboration of the national health plan, and the state was to fund the regions, that, in turn, were to transfer resources to the new local health units. These latter, the basic organizational piece of the NHS, were to be managed by an elected body.

As Ferrera (1989) notes, what made the Italian reform possible, --and this is true of the Spanish case as well-- was, in the first place, the establishment of the ordinary regions in the early seventies. This set an institutional obligation for a broad structural re-organization and it provided political parties with new incentives. As soon as they were born, regions began to fight against the central administration in order to force it to accomplish the transfer of responsibilities over health matters foreseen by the Constitution. But, as the Italian regional elections had revealed the strength of the left in the local councils, the central

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government, and especially the Christian Democratic Party, tried to delay the institutional transfers and to stop the reformist thrust. However, counter-reformers tried in vain. The unions, the regions and the left (especially the Communist Party) together created such a pressure for reform that a law was passed in 1974 contemplating the transferral of jurisdiction for hospital assistance to the regions and fixing the liquidation of the health funds for 1977. The strengthening of the PCI and its inclusion in the majority coalition in 1976 had a crucial importance, for this party, ideologically committed to the reform, dominated many of the regional governments for which the transference of health responsibilities was advantageous.

The weakening of the medical profession due to increasing bureaucratization and to internal conflicts greatly reduced the strength of the counter-reformist front. Finally, the gradual loss of credibility and viability of the health funds because of their lack of efficacy and efficiency helped in the same direction (Ferrera 1989). Thus, the role played by the health funds and the doctor´s associations was radically different from the Portuguese and Greek cases, allowing for the implementation of the reform and the inclusion of all citizens in the national health service. The pressure exercised by the regions is another element of differentiation, for this actor was absent in Portugal and Greece.

Nonetheless, the implementation of the 1978 reform in Italy quickly led to sharp increases in health expenditure. From 1978 itself until the end of the eighties, but especially from 1983, a great number of measures were undertaken in order to curb down expenditure. These measures included the introduction and further intensification of co-payments for pharmaceuticals and prescriptions, controls on the prescriptive behaviour of doctors, and two waves of restrictions of the therapeutical catalogue. Co-payments for diagnostic tests and specialist consultations were also established and increased during the eighties. Some services such as dental care and optical treatments were no longer provided by the NHS. Moreover, controls on applications for cost-sharing exemptions were tightened by the passing of detailed legislation, which took into account levels of income, age, work and family status, types of illness and so forth (Ferrera 1991, 23). Finally, expenditure ceilings were imposed on the regions and the central state took full responsibility for the national health budget. In this way, cost-control mechanisms were already established in Italy during the eighties.

In **Spain**, as I have argued elsewhere (Guillén 1996b), during the transition to democracy period (1975-1982) no move may be ascertained in the direction of a radical change of model of the Spanish welfare state. Coverage rates and expenditure augmented in all policy areas and democratization allowed for a whole range of "new" actors to participate in the policy-making process.

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Moreover, aspirations to reform the health care system in the direction of the Scandinavian universal model were already present in the seventies. Such a move was viewed by the unions, the left and a large proportion of the population as equivalent to "becoming real Europeans". Nonetheless, reform was not possible in this period because of the existence of more pressing endeavours, above all the reform of the political institutions. The advent of the oil shocks also posed difficulties for radical expansion and added uncertainty to the situation. Furthermore, the character of the process of political transformation, which was based on consensual decisions, meant that time was needed in order to achieve agreements. This constitutes a crucial difference with the Portuguese case where decisions meaning a departure from the previous situation were more easily reached because of the radical rupture that democratization meant. Also Greece resembled more the Spanish case than the Portuguese one in this respect. In Spain, reforms had to wait until the mid-eighties, some time after the Socialist had gained office in 1982. Primary health care was deeply reformed in 1984 and, in 1986, the initially projected national health *service* was reduced to a national health *system*, which unified the public sector and aimed at protecting the entire population gradually. Both in Italy and Spain reforms led to the decentralization of the health system, but while in Italy this process meant the conferring of administrative responsibilities to all the regions and local powers, in Spain wholly independent health services (with their own budget and accounting system) were created. However, the process of decentralization has been asymetrical in Spain, so that only seven regions have received powers, the remaining ten being managed centrally. Consensus on the reform of the health care system was reached in the mid-eighties, under the second Socialist cabinet, only by forgetting many of the fundamental aspects of the initial plan of reform of the government. The General Health Law (Law 14/1996) opened the way for the creation of a National Health Service, understood as the grouping of the services of the autonomous regions suitably co-ordinated by the state.

The final draft of the reform law was less ambitious in other crucial aspects. It contemplated a gradual increase of coverage; the unification of the public sector without any modification of the system of *conciertos* (contracts with private and non-profit providers); the partial, rather than total, financing of the NHS through the state budget; and a very undetailed definition of the basic structure of the NHS in order to allow the development of thoroughly independent regional health systems. The General Health Law was debated for eight months in parliament and was finally passed in 1986 (Guillén and Cabiedes 1997; Rodríguez and de Miguel 1990, 238-243). It can be said that, all in all, the new law produced little change in the short term, although its consequences for the future were crucial.

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The reasons for this initially ambiguous result in the Spanish case are related to the composition of the reformist and the counter-reformist fronts. In fact, the former was only slightly more powerful than the latter, so that the reform was enacted but with some deviations from that initially planned. On the reformist side, neither the unions (the socialist UGT and the communist CCOO), nor the small Communist Party (PCE) could exert much pressure. The unions had failed to reach agreements on the reform of social protection with the occasion of the tripartite social pacts. Moreover, a confrontation between the socialist UGT and the socialist executive took place in 1985 because of the enactment of a restrictive pension reform and misunderstanding deepened ever since, thus diminishing the influence potential of the socialist union. In turn, the Communist Party (PCE) was deeply divided internally and had lost a good deal of electoral support since the late seventies (Guillén and Cabiedes 1997).

As for the *statu quo* coalition, both the health bureaucracy and the physicians, especially the latter, were able to defend their views. The INSALUD, in charge of the management of health care at the national level, had developed gradually into a very powerful, extensive, and rather autonomous bureaucratic institution, difficult to control. Its anti-reformist position is not surprising given the fact that, in order to achieve co-ordination with the Health Ministry, the INSALUD was to be reduced by the reform to a mere resource administrator, deprived of planning and economic programming powers. Physicians, in turn, although converted into salaried employees to a very large extent, had enjoyed a very broad delegated power during the Dictatorship. In fact, the medical profession had led the way for the improvement of the health system in the sixties and seventies, lobbying at INSALUD, at the Ministry of Health, and at the hospitals. Under the shadow of an expanding public sector, the share of power given to health professionals and expert physicians had been tremendous. Under democracy, although deprived largely of their delegated power and having to face unemployment, physicians managed to create new active associations. Furthermore, they managed to unite against a reform that would mean the loss of benefits obtained thanks to the overlapping of the public and private sectors. The strikes and conflicts organized by the medical profession during 1987 are good indicators of their organizational power (Rodríguez and de Miguel 1990).

The strength of the anti-reformist coalition in Spain, together with the division of the cabinet, accounts for the fact that the projected National Health Service was put into practice in an incremental way during the second half of the eighties. Already existing high levels of coverage and the inclusion of the insured in a unified institution, (the Health Services of Social Security, *Asistencia Sanitaria de la Seguridad Social*) since the late sixties eased implementation, for the Spanish reform did not have to deal with powerful

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independent health funds. The economic positive cycle also helped by allowing public expenditure growth. Additionally, Spain became a member of the European Community in 1986. This new political status fostered the introduction of expansionary measures in order to meet EC recommendations and to narrow the gap with the more developed European welfare states.

Consequently, in the late eighties, the new territorial organization was put in place little by little, health centres were built to substitute the old *ambulatorios*, and co-ordination with the rest of the public networks began to be attained. From 1989 onwards, the system began to be financed out of the public budget. Also in 1989, the "decree of universalization" was passed, thus ending the process of extension of coverage by incorporating former beneficiaries of poor relief. Financing came to be done each time to a larger extent out of tax revenues, so that the proportion at the end of the eighties had reached almost 70 per cent.

To sum up, the situation at the late eighties was such that major steps had been taken in the implementation of national health services in Italy and Spain, while Portugal and Greece had advanced much less on putting reform into practice. Full homogeneous population coverage and a move towards financing via state revenues had been attained in Italy and Spain, the first especially in Italy and the second much more so in Spain. Conversely, the Portuguese and Greek systems had expanded public coverage but provision still remained to a large extent in the hands of insurance funds and the private sector, thus constituting what could be labelled "three tiered systems". Let us now turn to the second set of reforms.

2. REFORMING THE REFORMS

This section is aimed at analysing how Southern European health care systems were reformulated in the 90s under the pressures stemming from the Maastricht criteria of economic convergence. It is understood here that internationalization has not had a unilateral effect on the health care systems of the South. Rather, this is a two-direction road, in the sense that there have been diverse perceptions among each countries policy-makers of what kind of challenges internationalization was posing on the existing institutions. Also, different social policy institutional sets have reacted in different ways to external pressures and have had an influence on the kinds of cost-control and efficiency oriented policies adopted. Moreover, internal politics have been of outstanding importance for the way in which policy reforms have been both passed and implemented.

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Demonstration effects and policy-diffusion mechanisms also have to be taken into account when analysing the evolution of Southern health care systems. Since the British reform of the NHS was enacted in the early nineties, winds have swept across Europe on the benefits of managed competition, which has become a sort of new paradigm for gaining efficiency while preserving equity within health care systems. Managed competition entails the separation between the financing/purchasing functions and the providing ones, so that competition among providers is enhanced, while maintaining universal access and public financing. For this purpose management techniques of private character are introduced into health institutions. The following pages include a discussion on how and to what extent such paradigm has been incorporated into Southern health care systems

In **Portugal**, despite the broadly unsuccessful attempt at implementing the 1979 reform, or maybe because of it, moves towards a greater efficiency of the system can be ascertained already during the 80s. In 1981, flat-rate co-payments were set for consultations and diagnostic tests and also for drugs and hospital care in the next year (in this latter case cost-sharing was related to earnings). Charges for drugs grew during the rest of the decade, the other charges having been suppressed in 1983. All these charges were found to go against the Constitution's provisions in 1987, but an amendment of the Constitution taking place in 1989 opened the way for their reintroduction in the near future (OECD 1994).

In the mid-eighties, some other measures were undertaken in order to curb down expenditure on drugs. In 1986, the size of drug packages was reduced and doctors were not allowed to write more than one item per prescription. These measures were not very successful; they aroused patient dissatisfaction, they made the number of consultations to grow and they did not have much impact on expenditure control. Consequently, they were abolished two years later. However, since the late eighties greater controls were set on doctors prescriptions. In 1988, national regulations were established for private providers regarding the use of medical sophisticated equipment (OECD 1994).

As was also the case in all Southern European countries, debate on reform of the health care system in Portugal started in the late eighties. The overall perception was that one of the main aims of the 1979 reform, that of achieving a better redistribution, had not been attained (Pinto 1997). Other problems perceived consisted of inequalities among regions, user´s dissatisfaction, inefficiencies in the organization and management of the NHS, and mounting costs (European Commision 1995).

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In the early nineties, several reform measures were both proposed and enacted by governments of conservative orientation, under the pressure of the European integration process. Some of them bore a radical orientation, such as endorsing the private sector with a greater role and fostering individual responsibility. Reform legislation was passed in 1990 and 1993 respectively. The 1990 Law supported the development of private services, which were to be licensed and controlled by the government. Thus, the NHS was no longer considered as the main provider of health care services but rather as one among several entities, either public or private.

Private health insurance underwent considerable growth already during the 80s, so that 5% of the population was covered by private schemes at the end of the decade. This growing trend was fostered by the fact that, since 1990, the ceiling on tax deductions on all private health expenditure (including private insurance and co-payments within the NHS) were removed. Doctors working for the public service were offered increased salaries if they agreed on working solely for the NHS, but few accepted (OECD 1994). Half of the doctors working for the NHS are also engaged on private consulting. The fact that NHS doctors have few salary incentives, for their pay is not based on performance or work effort but rather on seniority, and the high prices of private services set up by the Medical Association may explain this double engagement. Conversely, a good number of independent doctors also work for the NHS. In this way the overlap between the public and the private sectors is really pronounced (OECD 1998). This overlap, together with substantial tax savings on private expenditure, and problems of access to the NHS may account for the expansion of private care in Portugal. Moreover, NHS coverage allows for the use of private care services in some cases. This situation has led to the flourishing of private services while some public hospitals and health centres suffer from lack of equipment and good professionals.

Since 1993, when two other reform laws were approved, the approach has been to increase the extent of regional deconcentration and, within each of the five health regions, to group together health centres and hospitals as 'units of health'. In addition, the NHS is now allowed to provide services directly, while there is a move away from public to private insurance. Private insurers receive payment from the government for each member, at a rate below the average cost per head of the National Health Service. They are then free to contract with providers of care. The system thus contains incentives for insurers to contain costs. Moreover, management of public centres is to adopt a model more akin to entrepreneurial practice. Full-time salaried doctors were allowed by the 1993 reform to engage in private practice, if this does not interfere with their public duties (European Commission 1995).

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The implementation of these reform laws would entail a radical move towards the privatization of the Portuguese public health care system. Nonetheless, very few provisions have been put into practice so far. One of the most controversial measures included in the 1993 Law was the incentives for patients to opt out of public insurance into private one for their entire life span. This measure did not succeed firstly because of lack of interest on the part of private insurers. Secondly, the replacement of the Social Democratic government for a Socialist cabinet in 1995 meant a change in the direction of health care reform towards a reinforcement of the NHS capacities. The Socialist government seems nevertheless to be committed to endorse public health care institutions with more autonomy and to insist on the introduction of managed competition devices between public and private providers (Pereira et al. 1997).

All in all, a lot of legislative activity has taken place in Portugal, but only a few measures have been implemented so far, so that the Portuguese NHS has remained almost untouched. Furthermore, as regards the measures that have been actually put in practice, these have tended rather to incorporate already produced changes than to generate reform. This may have been due to the declared belief among politicians that an increase in public health care expenditure so as to reach the EU mean is desirable and to the power enjoyed by the medical profession (Pereira et al. 1997). Thus, reform aimed at cost containment has been scarce in Portugal in recent years.

However, some moves may be ascertained. The most salient one may be the increase of patient cost-sharing introduced in 1992, although co-payments have not been raised since that date. Also, it has been agreed that NHS contracted services should rise below inflation rates and waiting lists for specialist care have grown (Pereira et al. 1997). Some experimental measures have been also undertaken regarding the use of diagnostic-related groups for hospital budgeting. Nonetheless, hospital budgets have remained broadly based on historical costs and overspending is automatically covered by government allocations.

A very relevant social pact was reached among the unions and the government in December 1996, providing a basis for a gradual reform of the health care service. The Pact acknowledges the need to facilitate access to public services and plans to endow the local level with more responsibilities and decision capacities. Health professionals are to be paid increasingly by productivity standards and abuses at prescription are to be controlled. Evaluation criteria for performance of public institutions are also to be set up. In 1997, a parliamentary commission also produced proposals for the reform of the health care system in the direction of achieving more clear-cut pattern of relations between the private and the public sectors. Out of these proposals, some

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contracting agencies, that purchase services for patients, have been established as a pilot experiment. Moreover, three hospitals were to be turned into public enterprises in 1998.

To sum up, health reform in Portugal has followed a "pendulum strategy" that has resulted in a health care system that never quite reached the status of a full fledged national health service neither could it be characterised presently as a social security model. Both sets of reforms –that establishing a national health service and those related to cost-containment and re-organization of management - have suffered from poor implementation. As Pereira et al. (1997) note, increased access and improvements in care coverage are among the assets of the existing health care system. However, inefficiencies persist together with an ambivalent situation of a perception of peaking expenditure and actual patterns of spending as if there were no limits. Consensus seems to exist on the need to redefine the role of the state in order to endow the government with stronger regulatory capacities, to implement a separation between financers and providers/purchasers, to deepen the decentralization processes, and to develop performance-based payment systems for providers. So far, resistance to these changes on the part of health providers has been very strong and the government has acted very cautiously regarding implementation. At the moment, discussion on the financing and the future of the health care system is taking place and no clear agreement has been reached so far.

In the **Greek** case, Matsaganis (1991, 280) has shown how the fragmentation of social health insurance, and the particular ways in which sickness funds' financial services are organized, were still a major source of inequity and inefficiency at the beginning of the nineties. The permanence of the insurance system is due to a large extent to corporate interests and to the worries of the rich insurance funds of reforms implying a levelling of their services. Thus, the Greek health care system remained very complex in institutional terms and heavily relying on path dependency.

Such was the situation when a conservative government was elected in April 1990 and the re-organization of the social protection system had come to be considered as a top priority not only by the new government, but also by both policy-makers and pressure groups. Moreover, external pressures for the rationalization of the social protection system stemmed from the European Community conditions for loans. As early as July 1990, an agreement was reached among the three main political parties (the Conservative, the Socialist and the Left Coalition) regarding the introduction of efficiency measures into the health care system. However, the reaction of the trade unions was both very quick and intense so that strikes and demonstrations took place already in

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September, and the government was forced to forget about radical reform (Venieris 1997a)

A second attempt at reform was made in 1992, this time rendering results, at least as far as legislative action is concerned. Amendments of the 1983 NHS Law were passed which were based on neoliberal ideology. Consequently, the role of the public sector in the provision of health care was reduced in favour of the private one. Hospitals that had been already nationalized remained under the public sector, but non-profit private hospitals became eligible for public provision and state subsidies. Doctors working for the public sector were allowed to combine their activities with private ones. Still, very few of them (around 150) decided to adopt the new part-time contract. Also according to the new legislation, primary health care centres were to be financed by local bodies, and provisions were made for free choice of doctors and hospitals (be it public or private) on the part of patients (Venieris 1997b, 93-94).

During the early nineties, several regulations were aimed at modifying organizational aspects, improving emergency services, management of hospitals and primary health care. In 1991, tickets were established on out-patient care services (1,000 Drs., with a lot of exemptions) and drugs (fixed at 25%, and 10% for the chronically ill), which meant an increased burden for the family budget. Family budgets are also strained because of the existence of corruption even within public hospitals, where doctors receive "informal extra payments" as a way to get preference treatment (European Commission 1995; Symenidou 1997). Changes adopted in the early nineties regarding the financing of health care have also meant a lot of strains for the insurance funds. Hospital and outpatient fees paid by the funds were raised dramatically, making them face almost bankruptcy (Venieris 1997b, 94).

The return of the Socialist Party to government in 1993 meant another turn in health policy, so that many of the changes introduced by the Conservative cabinet were reversed in order to reinforce the NHS. Thus, restrictions on private practice for doctors were re-established and primary health care centres were replaced under the hospital budgets. The Ministry of Health engaged on the elaboration of a thorough reform proposal of the health care system. A foreign committee of experts, headed by professor Abel-Smith, was appointed and produced a full set of proposals for reform in 1994. The committee severely critisized the behaviour of those health professionals accepting bribes or gifts from patients or pharmaceutical firms. It was also concerned with the absence of incentives for health professionals because of bureaucratic regulations, centralization of management, and the poor state of public health and preventive care (Venieris 1997b).

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The proposals of the expert's committee also included several measures aimed at endorsing the system with more efficiency and fighting users' dissatisfaction. Among them were the development of preventive care, an amelioration of primary services through the creation of a network of family doctors, and a whole range of measures regarding the introduction of cost control devices and new management techniques along entrepreneurial lines. The bulk of the reform proposal was aimed at unifying the many insurance funds into one single organization and separating the financing, purchasing and providing activities of the health care system (European Commission 1995).

Some experts have already indicated their disagreement with these proposals for change. For example, Matsaganis (1998) argues that applying the new "paradigm" of health care reform, i.e. quasi-markets British style, to the Greek case is highly inappropriate. The reasons forwarded by Matsaganis refer to exportability problems to a system that is very different from the British one in organizational terms and also working in a totally diverse cultural environment. In fact, the Greek health care system is a much more fragmented one and relies heavily on private provision and these are traits that would pose difficulties to the introduction of the fundholding experience. This is why a more piecemeal change, which would deal with the inefficiencies of the existing system would be preferred.

So far, little steps have been taken in order to adopt the recommendations of the Abel-Smith committee, and the bargaining process for the passing and implementation of proposals is still under way. Once again, doctors oppose the introduction of reform and the government is facing difficulties to build a stable coalition of interest around reform. In parallel to the Portuguese case, the Greek system has followed a winding strategy for reform and has lacked implementation results. As a consequence, as has also been the case in Portugal, the Greek Health Care system has remained fragmented in insurance terms and also heavily relying on the private sector of provision, when compared with the other Southern European counterparts, i.e. Spain and Italy. The thrust towards a reinforcement of the private sector and cost-sharing has been nevertheless less marked in Greece than in Portugal in recent years. The common developments shared by both countries seem to be clearly linked to the ability of the medical profession to block reforms. A climate of consensus among relevant actors in order to pass reforms and implement them has been for this reason also very difficult to reach in both cases.

In **Italy**, developments in the direction of cost-control during the eighties were due to the upsurge of a crisis of legitimisation of the Italian welfare state related to the perception of growing inequalities and inefficiency. Within the Italian welfare state, big differences in protection levels existed between formal

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and informal workers, and between the aged and the non-aged. Moreover, contribution rates diverged among occupational categories, and many people had access to the system through clientelistic means. These inequalities were already present before the eighties, but peaking public deficits led to a sharp increase in taxation in this decade. This resulted in a situation in which the blame for the country´s financial trouble was placed on what was thought an inefficient and unfair system of welfare. In fact, the 1978 health reform was responsible to a great extent for the growing health care deficits of the eighties, due to the design of the financing system and the organization of management. The need to balance the economy led politicians to introduce cost-control measures during the eighties and the debate around the "reform of the reform" already started. However, due to political instability, no agreement was reached (Ferrera 1997).

The measures undertaken during the eighties, even though unpopular, achieved a better control of demand and also financing improvements. Nonetheless, and despite increases in contributions, national accounts became increasingly unbalanced during the decade, so that public deficit was alarming at the beginning of the nineties. In 1992, the lira underwent dramatic difficulties, conducive to devaluation and its exit form the Exchange Rate Mechanism. Italy´s credibility at budget adjustment was at stake. Furthermore, fraud on exemptions for cost-sharing had grown to worrying proportions This situation triggered the adoption of radical policy changes in the health care system, among other domains of social policy (Ferrera 1997).

Since 1992, major reforms of the health care systems were passed. Co-payments and the system of exemptions were considerably tightened in 1993-94. More significantly, two legislative decrees approved in 1992 and 1993 meant a sharp turn from the 1978 health care legislation (Decree-Laws 502/1992 and 517/1993). Previously, in 1991, the political management committees of the local health units were abolished and uniform levels of care were fixed from the centre for all regions. The previously elected bodies running local health units were substituted for professional managers depending on a private contract, only renewable at the face of satisfactory performance. The same provisions were applied to hospitals. Both public hospitals and local health units were allowed to be turned into "public enterprises", obliged to operate with balanced budgets. And, also very relevant, responsibility was taken away from the local level in order to empower regions. Regional governments have gained significant management, planning, financing, and organizational capabilities, to the point that the NHS can now develop into 21 different and independent health care systems. In fact, implementation of the 1993-94 reform is being done at different speeds in the regions and legislation gives them discretion regarding the kind of measures adopted.

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Conditions for employment of the NHS staff are also being changed in Italy in a direction more akin to private contracting, as part of a program affecting all civil servants. Personnel training programs and increased information for patients are being fostered. Hospital doctors may now choose between either full-time or part-time commitments, the latter being able to practice privately within the public system. Maximum waiting times have been set for treatment of several pathologies. Also, patients have become allowed to choose between providers, be it public or private, accredited by the regions. These providers are to be reimbursed on the basis of tariffs.

According to the 1992-93 reform, the government remains in charge of the definition of the national health plan. Also, the state is to guarantee the provision of a standard basic set of services for all residents, and is to allocate funds to the regions (based on capitation, interregional mobility, the state of infrastructures, and technological needs). The role of the executive is thus intensified *vis à vis* the parliament, in order to avoid the blocking of decisions that was the commonplace during the eighties. State transfers are not to cover all health expenditure, so that regions must collect themselves social contributions (taxes or co-payments) in order to finance their services. In this way, the reform includes incentives for cost-containment and efficiency by means of managed competition mechanisms (European Commission 1998). The 1992-93 reform has started to be implemented in 1994 and is still under way.

The crucial developments of the nineties have been possible because of the concurrence of several factors. In the first place, external pressures stemming from the Maastricht Treaty and the conditions to join the EMU were always in the background. Secondly, the reform of the electoral system towards a majoritarian model and the crisis of the traditional parties –due to corruption scandals and internal divisions-- led to a situation of very intense renewal of the political elites. The parties included in the traditional *Pentapartito* that had formerly ruled the country almost disappeared. The repeated presence of "technical" cabinets in power during the nineties was also of crucial importance because their autonomy was enhanced by lack of partisan control. The amelioration of the public administration capacities also helped. All these moves resulted in higher stability allowing for a more agile decision-making process and to the passing of a large set of reforms aimed at financial adjustment and the meeting of the Maastricht criteria. Social policy changes were an important part of the adjusting endeavours (Ferrera and Gualmini 1998).

In sum, unlike the Portuguese and Greek cases, health care reform has taken place decidedly in Italy in two occasions. The implementation of the 1978 reform was possible because of the existence of a strong coalition in favour of turning the social insurance system into a national health service. Also, because

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of the deep dissatisfaction of the population with the existing system, and th weak position of the doctors and health funds. Attempts at rationalizing reforms during the eighties failed because of political instability, unable to cope with persistent economic imbalances. Finally, in the nineties, the already existing conscience on the malfunctioning and inequalities of the welfare system, together with pressures stemming form the European integration process, pushed in the direction of reform thanks to the attainment of a stable political environment.

In **Spain**, worries about the quick increase of health care expenditure began to intensify among political elites at the end of the eighties, so that they started to pay attention to the British White Paper. Expenditure growth in Spain during the second half of the eighties was substantial; in fact it was the highest in the European Union (European Commission 1995). The decentralization process was connected to this development for both the budgets of INSALUD-Direct Management and independent regional health care services were determined largely by past expenditure, which offered little incentives for restraint. In the late eighties, there was growing concern among policy-makers about mounting patient dissatisfaction, long waiting lists and inefficiencies in management. But the main worry was expenditure control.

This perception of the situation --the need to rationalize the system and to introduce cost control measures-- was reinforced by the approval of the Catalan Law of Health Care in 1990, which included several internal market devices. As it was usually the case, an autonomous region was able to take innovative measures in advance of central state proposals. As early as January 1991 a parliamentary commission was appointed with the aim of assessing the introduction of cost control measures into the Spanish National Health Service. Seven months later the "Abril Report" --named so after the director of the Commission-- was published.

The media reactions to the proposals of the Abril Report were disproportionate to the actual cost control measures it put forth. The proposal to introduce a ticket on pharmaceuticals for the previously exempted retired population was the factor triggering rejection of the whole report. Both the unions and the population showed their total refusal for any cuts concerning public health care services.

The rejection of the Abril reform proposals influenced the character of the policy-making process during the nineties. In Spain, in the early nineties, most of the reforms and cost-control measures introduced into the health care system have followed a hushed, tentative and piecemeal strategy. The approval of a positive and negative list of services financed by the public sector in 1995,

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although being far from restrictive, can be considered as a disguised cost-control measure, for future inclusion of new services will have to be negotiated. Something similar can be said about the establishment of a negative list of pharmaceuticals in 1993 and 1997. The tentative introduction of prospective budgeting for hospitals, together with other rationalizing measures, have followed the same strategic principle. In fact, many of the proposals of the Abril Committee have been put in practice.

Regarding expenditure control, the *Programa de Convergencia,* established a reduction of spending on health care of 1% of GDP for the period 1992 to 1996, which was further extended for four more years. Under the programme, the overall health care budget is linked explicitly to GDP growth. The allocation of funds to the regions is based largely on population, although the latest agreement reached in 1997 takes into account to a certain extent age composition, patient mobility and medical teaching costs. Regions have undertaken to avoid incurring deficits but have been given greater powers to levy taxes so as to supplement revenues from government, encouraging at the same time a more responsible attitude to expenditure growth (Cabiedes y Guillén 1997).

Measures aimed at increasing efficiency and the quality of care have differed from one region to the other. In Catalonia, and some other regions, contracts with GP co-operatives specifying terms for the supply of services have been developed together with the integration of primary care teams with hospitals. In Valencia, long-term monopoly concessions have been granted to private operators for the provision of hospital care. In 1993, the INSALUD-Direct Management has introduced a system of *Contrato Programa* (programme agreements) to regulate relations with hospitals. According to the INSALUD Strategic Plan (1998-2000), the introduction of quasi-markets has started in all the regions it is responsible for. Measures have also entailed the modification of the remuneration of doctors in order to make their contracts more flexible and allow for the intensification of hospital services (European Commission 1998; CES 1998).

Short after the Conservative Party gained office in March 1996, after 14 years of Socialist rule, several measures were quickly approved. A decree was passed on the autonomy of management of health care institutions, thus opening the way for the re-organization of publicly operated hospitals into various types of public firms. The initial text of the decree was more radical and intended to allow for the conversion of public hospitals into private enterprises. The reaction of the Socialist opposition was so intense that the text of the decree was changed a day after its publication. So far, a good number of new hospitals have adopted the form of public foundations or public enterprises in order to endorse them

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with greater managerial flexibility and autonomy, especially in the decentralized health systems (Catalá and de Manuel Keenoy 1998). In April 1997 and December 1998, legal normative was passed allowing for the conversion of existing hospitals into public foundations, both at the INSALUD-Direct Management territory and within the regional independent services.

In Spain, very limited use has so far been made of direct charges, except in relation with prescribed drugs, for which a fee of 40% of the price has been charged since 1978 for users within active ages. A decree on the flexibilization of pharmaceutical services (opening hours and conditions for the establishment of new community pharmacies) was also passed in 1996 in order to increase competition among providers of pharmaceuticals. Market-style incentives to individual patient-based demand have consisted in Spain of the introduction of free choice of general physician and paediatricians since 1993 and, since 1994, of specialist doctors in the INSALUD territory. Specific measures have also been undertaken for the shortening of waiting lists, starting in 1996.

Measures introduced in the early nineties seem to have curbed expenditure growth (growth in real spending over the period 1990-95 averaged 3% a year as opposed to over 8% a year over the preceeding five years) and have led to some incentive to increase efficiency. Still, problems remain over the formula to for allocating funds between regions, which needs to take proper account of underlying differences in patient characteristics. Most of the latest measures undertaken in Spain in the direction of rationalization of expenditure and increased managerial efficiency were fostered by the recommendations of a parliamentary commission formulated in 1997. However, one of its relevant proposals, i.e., that of achieving the legal recognition of the right to health care on the basis of citizenship, has not been undertaken.

In sum, the establishment of a national health service in Spain was attained in an incremental way. Some aspects have been more successful than others, as for example full financing via taxes and virtual universalization of coverage. It should be noted though, that coverage universalization has been attained *de facto* in Spain, but not *de iure,* for it has not been recognised as a citizenship right so far (Freire Campo 1998). The second wave of reform of the Spanish health care system, that proposed by the Abril Committee in 1991, was so clearly rejected that it fostered the adoption of a totally different political strategy. While the reform of the 80s was openly debated, most of the measures introduced in the system during the 90s were either put in practice in a silent way or in such a quick one that the social and political actors had hardly time to react. This was the case with the measures adopted by royal decree in 1996, soon after the Conservative government took office and with the latest legislation on public foundations. The Conservative government has to deal with

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a very active opposition on the part of the Socialist Party, the unions and user´s associations, which explains why any hints at the privatising of the NHS is very hard to pass.

One reason for explaining the negative reaction to the "reform of the reform" may relate to what could be labelled "developmental time". Spain was the last Southern country to introduce a national health service in 1986, while this reform also meant a broad decentralization process. The cost containment proposals of the Abril Committee arrived five years later than the General Health Law and only three years after the official attainment of universal coverage. In short, and in comparison with other European countries were the process was much more smooth, the Spanish health care system had to face a concentration of developmental challenges in a very short period of time. Such a circumstance accounts both for the resistance against further change and also for some of the difficulties in the reform process. This could be argued to a greater extent also of the Portuguese and Greek case, were the concentration of developmental challenges has been even more demanding. As for the Italian case, cost-control measures and restructuring of management of the system were much more acute because of the development of a deep conscience among most political and social actors and the population in general of the existence of great imbalances and inequalities.

The exam of the "reform of the reform" shows that it has adopted very different profiles in Southern health care systems. A summary of reform measures can be found in table 2. While Italy has introduced radical changes on both the supply and the demand sides of health services decidedly, Spain has only touched them slightly. No co-payments (with the exception of the already existing one on pharmaceuticals) have been introduced in Spain, and only free choice of doctors within the public system has been enacted. Managed competition is now being introduced at the INSALUD-Direct Management territory, and it has also been established in some of the regional health care systems, the most salient case being that of Catalonia. These developments are due in both countries to the need to convey with the Maastricht and EMU criteria and the perception among policy-makers that internationalization pressures had to be met by balancing public accounts. However, while demand-side reforms affecting equity (above all increased cost-sharing) were possible in Italy due to welfare state de-legitimisation, the opposite took place in Spain, where socio-political actors and the electorate have remained much more committed to a universal model free of charge than their Italian counterparts so far. Thus, the set of reforms has focused on the supply side in Spain, where measures have been introduced in a piecemeal and tentative way.

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Table 2 . Measures undertaken by Southern health care systems affecting the demand side

	Italy	Spain	Portugal	Greece
Increased cost-sharing at the point of use	X	O	X	X
Increased cost-sharing for drugs	X	O	X	X
Market-style incentives to individual patient-based demand	X	X	Xni	P
Individual choice of insurer	O	O	Xni	O
affecting the supply side				
Global budgeting	X	X	X	X
Removing services from public financing	X	O	O	O
Modification of reimbursement for hospitals	X	X	Xni	P
Practice guidelines	X	X	P	O
Modification of remuneration of doctors	X	X	P	P
Turning hospitals into public firms	X	X	Xexp	P
Public sub-contracting of services by health institutions	X	X	Xexp	P
Increasing intensity of services	X	X	P	P

Legend: X=yes; O=no; Xni=passed but not implemented; Xexp=pilot experiments; P=proposed

In the Portuguese and Greek cases, the "reform of the reform" has had a different character (see table 2). Because of lack of implementation of the first set of reforms and the persistence of heterogeneous systems of provision, the measures adopted have rather impinged on the demand side than on the supply one so far. Though not put in practice, Portugal is the only case having passed a reform entailing such a radical measure affecting demand of health care as allowing life-long individual choice of insurer. Demand-side reform has been focused on the increase of co-payments in both Portugal and Greece, although much more intensely in the former. As for the supply-side, most measures have been either only proposed or are starting to be timidly introduced. Moreover, despite the fact that these systems may use global budgeting as a means to control health expenditure in the public sector, the permanence of health funds and the broad private sector, pose difficulties for state action in this respect. Resistance on the part of powerful doctors' associations, who benefit from the overlapping of public and private sectors, is one of the main reasons for the lack of more decided changes on the supply sides of the Greek and Portuguese health care systems. Another reason stems from the fact that, although also suffering from pressures stemming from EU integration, conscience persists in these countries that there is still enough room for increasing the level on health care expenditure.

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Finally, the "reform of the reform" of Southern health care systems has been grounded to a significant extent on the British managed competition paradigm, proving the presence of policy-diffusion mechanisms. But how has all the reform process affected the structure of health care systems? The next session deals with changes in coverage spans of population and services, expenditure mechanisms and financing trends and re-organization of Southern health care systems.

3. THE IMPACT OF THE REFORM PROCESS

In accordance with the gradual introduction of national health services in Southern European countries, the **coverage span** has become formally universal in all of them. Within the domain of the European Union, the majority of countries have established universal coverage irrespective of whether the chosen model is a social insurance system or a national health service. The only exceptions are Germany and the Netherlands, for in the rest of the member states coverage rates exceed the 98 per cent threshold (see table 3).

While Southern European health care systems coverage rates were well below the average for the EU-15 (with the exception of Italy) in 1960, the differences were much narrower in the mid seventies. The gap was closed during the following decades, so that in 1995 all four countries exceeded the European Union average (see graph 1 in the annex). When compared to other social security health care systems, such as those of Germany, France and Belgium, coverage rates also show smaller figures in Southern countries (Italy excluded) till the moment in which national health services were introduced (see graph 2 in the annex).

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Table 3: Health care coverage. European Union (1960-1995)

	1960	1965	1970	1975	1980	1985	1990	1995
Austria	78,0	92,0	91,0	96,0	99,0	99,0	99,0	99,0
Belgium	58,0	68,5	97,8	99,0	99,0	98,0	97,3	99,0
Denmark	95,0	95,0	100,0	100,0	100,0	100,0	100,0	100,0
Finland	55,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
France	76,3	85,0	95,7	96,0	99,3	99,0	99,5	99,5
Germany	85,0	85,8	88,0	90,3	91,0	92,2	92,2	92,2
Greece	**30,0**	**44,0**	**55,0**	**75,0**	**88,0**	**100,0**	**100,0**	**100,0**
Ireland	85,0	85,0	85,0	85,0	100,0	100,0	100,0	100,0
Italy	**87,0**	**91,0**	**93,0**	**95,0**	**100,0**	**100,0**	**100,0**	**100,0**
Luxembourg	90,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
Netherlands	71,0	71,0	86,0	75,0	74,6	73,4	70,7	71,8
Portugal	**18,0**	**32,0**	**40,0**	**60,0**	**100,0**	**100,0**	**100,0**	**100,0**
Spain	**54,0**	**55,0**	**61,0**	**81,0**	**83,0**	**90,0**	**99,0**	**99,5**
Sweden	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
UK	100,0	100,0	100,0	100,0	100,0	100,0	100,0	100,0
EU Average	72,2	80,3	86,2	90,2	95,6	96,8	97,2	97,4

Source: OECD Health Data, 1998

Despite these general trends, the evolution of Southern countries as regards coverage rates for health care has differed among them. Italy has always shown coverage rates higher that the EU average for the whole period (1960-1995). On the other extreme, Portugal had the lowest coverage rates within the EU until the second half of the seventies, when the national health service was created. Coverage rates in Spain and Greece have grown more incrementally from the sixties to the nineties, but while Greece kept under the figures for Spain until the late seventies, the situation was reversed thereafter, so that Greece attained full coverage six years before Spain (see graph 1 in the annex).

However, these data may be misleading. The prevalence of some of the traits of the previous social security model may be ascertained all four Southern countries, although to different degrees, so that formal and actual coverage rates differ. In 1978, Italy included the whole resident population within the national health service. In Spain, coverage reaches 99.7% of the population. However, two important peculiarities should be pointed out in this latter case. On the one hand, a population group consisting of roughly 200,000 people included in the highest income bracket do not have rights to public health care services (Freire Campo 1993, 79). On the other hand, health services for civil servants are managed by independent mutual associations. Civil servants have the right to choose between either public or private provision, in both cases publicly financed (Guillén and Cabiedes 1997).

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The situation in Portugal and Greece regarding the coverage span of health care services differs substantially from that of Italy and Spain. In Portugal, occupational compulsory insurance schemes for public sector employees remained in place during the eighties. With the privatization of major public firms some of these insurance funds shifted to the private sector. Still, insurance for civil servants and the military remained in the public sector (around 18% of the population). Moerover, several sources show that around one quarter of the population has no effective access to the NHS (Pinto 1997, 142).

The Greek health care system is also distant form the NHS model. Access is still divided into two broad subsystems, i.e., IKA for urban areas and OGA for rural ones. There exist many other insurance programs of a smaller entity. And, what is more relevant, services and conditions of access vary among the different insurance schemes differ (Matsaganis 1991). The main effect of the 1983 reform was the nationalization of the hospital sector. This meant that the non-insured became entitled to hospital services as a citizen´s right. Elderly people depending on a social pension are insured by OGA for both primary and hospital care. The so-called "certified poor" are covered by the public system in the same terms as the civil servants. IKA has also decided to insure the unemployed youth that are too old to be covered by their parent´s insurance. All in all, the situation in Greece is such that everybody has access to public health care of some sort, but for some that merely means access to public hospitals, because of the lack of development of public primary care.

As for the **services provided** by Southern European health care services, and despite the existence of some differences, the public health systems in the EU are very similar in the extent of services provided (European Commission 1995; MISSOC 1997). Spain constitutes an exception within the EU for, in 1995, a decree was passed consisting of a detailed and explicit list of health services provided and financed by the NHS. Additionally, services not covered by public provision were singled out in a negative list, which was not restrictive (Guillén and Cabiedes 1997). In Italy, lists of drugs and treatments that can be prescribed have been drawn up recently and also the publication of Service Charters has been made compulsory (European Commission 1998).

In Portugal, private provision of health care services is still very broad. The NHS provides for most hospital stays, primary services and mother and child care, while dental care, laboratory tests and X-Rays are supplied by the private sector in very large proportions. These latter services are usually reimbursed to patients (Pinto 1997, 143; Pereira et al. 1997, 4). The private sector is also very broad in Greece.

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Another relevant characteristic of South European health care systems regards the relations between the public and the private sectors. As Ferrera (1996, 24) notes, while traditional national health services have placed most physical health care resources under the public domain, Southern systems have not strengthened enough their public networks so as to crowd out private provision. Moreover, peculiar relations have arisen between the public and the private sectors: national health services contract out services to private centres. The proportions of public expenditure being dedicated to provision by private centres amounted to almost 40 per cent in Portugal in 1987 and to 37.5 per cent in Italy in 1989, having decreased to 25 per cent in 1994 in this latter country. In Spain, *conciertos* (contracts with private providers) amount to around 11 per cent of public expenditure, while in Greece it is estimated that it reaches 27%.

As regards **expenditure trends**, growth of expenditure on health care as a percentage of GDP has been much more marked in Southern European countries than the average for the European Union during the eighties and nineties. Growth took place mainly in the second half of the eighties in Italy and Spain, while Portugal and Greece witnessed dramatic increases in the early nineties (see table 4 and graph 3 in the annex). The only exception is Italy in the nineties, where a considerable decrease took place thanks to the introduction of severe cost-control measures. In general, this has resulted in a process of approximation to EU standards in expenditure, so that public expenditure on sickness as a percentage of GDP was, in 1997, of 5.3 for Italy, 5.8 for Spain, 4.9 for Portugal, and 4.3 for Greece (E15 average 6.5%) (OECD Health Data 1998).

In 1993, expenditure on sickness per resident in relation to GDP per head was close to the E12 average in all Southern countries except Greece, whose expenditure was by far the lowest in the EU. Only the Netherlands, France and Germany were above the E12 average (European Commission 1995, 73). This is proof of the narrowing of the gap between Southern countries (maybe with the exception of Greece) and their European counterparts in expenditure levels during the last fifteen years.

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Table 4: Public expenditure on health care (% of GDP)

	1962	1967	1972	1977	1982	1987	1992	1997
Austria	3,1	3,5	3,3	5,1	5,1	5,4	5,6	5,7
Belgium	2,2	3,0	3,7	5,5	6,2	6,2	7,1	6,7
Denmark	3,8	5,0	5,4	5,6	7,9	7,2	7,1	5,0
Finland	2,3	4,0	4,4	5,5	5,4	6,0	7,4	5,6
France	3,0	3,9	4,7	5,4	6,3	6,5	7,0	7,7
Germany	3,0	4,1	5,3	6,8	7,1	7,1	7,8	8,1
Greece	1,6	1,8	1,9	2,5	3,3	3,4	3,4	4,3
Ireland	2,9	3,8	4,8	5,8	6,5	5,4	5,5	5,3
Italy	3,1	4,1	5,3	4,9	5,5	5,7	6,5	5,3
Luxembourg				5,2	5,8	6,1	6,1	6,5
Netherlands	2,1	3,7	4,7	5,5	6,3	6,0	6,8	6,1
Portugal	0,8	1,2	2,1	3,4	3,4	3,5	4,4	4,9
Spain	1,0	1,9	3,0	4,2	4,7	4,5	5,8	5,8
Sweden	3,5	5,2	6,5	8,3	8,8	7,9	7,7	7,1
UK	3,4	3,9	4,1	4,8	5,1	5,0	5,9	5,7
EU Average	2,6	3,5	4,2	5,2	5,8	5,7	6,3	6,1

Source: OECD Health Data 1998

Table 5: Per capita health expenditure, ECUs, PPP

	1980	1985	1990	1995
Austria	419	588	835	1119
Belgium	428	675	1047	1359
Denmark	590	877	1107	1370
Finland	359	623	985	952
France	492	778	1081	1478
Germany	456	708	922	1551
Greece	**137**	**217**	**300**	**496**
Ireland	329	418	523	835
Italy	**415**	**598**	**974**	**970**
Luxembourg	500	743	1313	1786
Netherlands	453	650	913	1248
Portugal	**149**	**194**	**379**	**577**
Spain	**231**	**343**	**606**	**763**
Sweden	701	988	1266	1233
UK	356	535	754	969
EU Average	401	596	867	1114

Source: OECD Health Data, 1998

Conversely, public health care expenditure per head in ECUs at purchasing power parities was still, and with the exception of Italy, well below the EU average in the rest of the Southern countries (see table 5 and graphs 4 and 5). Nevertheless, growth in health expenditure per head was significantly higher than the EU average between 1990 an 1996 in Spain, but especially in Portugal

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and Greece. This is proof of the trend towards the narrowing of the differences among the less developed health care systems of the South and their European counterparts (European Commission 1998, 131).

Table 6: Public expenditure on health care over total

	1977	1982	1987	1992	1997
Austria	69,8	75,4	75,9	73,3	72,0
Belgium	83,6	85,9	83,1	88,9	87,6
Denmark	84,7	88,8	87,9	86,7	65,0
Finland	78,8	80,0	79,6	79,6	77,0
France	77,0	79,0	76,4	74,6	78,4
Germany	78,7	78,3	77,6	78,5	77,4
Greece	**73,7**	**91,3**	**79,6**	**76,1**	**74,8**
Ireland	79,5	80,5	73,1	75,1	75,0
Italy	**86,8**	**78,7**	**77,7**	**76,3**	**69,9**
Luxembourg	91,4	93,0	93,0	92,8	91,8
Netherlands	74,0	76,0	73,6	77,4	72,0
Portugal	**70,0**	**56,2**	**51,5**	**59,6**	**60,0**
Spain	**75,6**	**79,4**	**79,7**	**78,7**	**78,7**
Sweden	91,3	91,6	89,9	87,2	83,3
UK	90,0	87,6	84,6	84,5	84,5
EU Average	80,3	81,4	78,9	79,3	76,5

Source: OECD Health Data 1998

Another measure indicating successful conversion into national health services is that of public expenditure on health over total. In this case, once again Southern countries show significant differences. Portugal has the lowest share of public health care expenditure in GDP among the 15 EU countries. In 1997, 60% of health care expenditure was public in Portugal, while Italy reached 70%, and Greece and Spain spent 75% and 79% respectively. The proportions were not much higher in the traditional national health services: 84.5% in the UK; 83.3% in Sweden; 65.0% in Denmark and 77.0% in Finland (see table 6). When compared to the EU average, public expenditure on health over total in Southern countries is at the same level or even higher from the seventies to the nineties, with the clear exception of Portugal, where it is much lower (see graph 6 in the annex).

Differences among Southern countries are also notorious regarding the **financial sources** of the cost of health care. In Spain, public financing of the health budget has occurred, each time to a larger extent, through state revenues that have come to represent 92% in 1997. Moreover, it is foreseen that it reaches 100% in 1999, so as to comply with the provisions of the 1995 Toledo Pact regarding the separation of the financial sources of the income maintenance and

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health care systems. In Italy, the shift has showed a much smaller entity until 1997 when contributions still account for almost half of total revenue (European Commission 1998). However, in 1998, it was decided that the Italian system was to be financed totally out of taxes, 30% of them constituting transfers from the central state and 70% regional revenues. In Greece, hospitals are financed broadly by tax revenues whereas outpatient care remains financed by the insurance funds, so that estimations for 1998 state that almost half of public health expenditure is financed out of taxes. In Portugal, the NHS is neither financed mainly out of general taxation. In 1991, taxes amounted to 55.2% of total health care financing, while the share of social insurance contributions was of 6.0%, and that of private payments of 38.8% (Pereira et al. 1997).

From the financial side, Ferrera (1996) notes that that none of the Southern European health systems share the tax-financing approach typically followed by the British and Scandinavian health services. The relevance of public expenditure versus private health expenditure, as well as its financing through taxes, seems consistent with the concept of equity within a national health service. However, differences among Southern countries are notorious in this respect, as noted above. It should also be noted that the cost is not financed totally out of taxes in some traditional health care systems. For example, in the United Kingdom in 1989, 79% of the cost of the NHS was financed by general tax revenues, and 16% through insurance contributions. In Finland, the proportion of tax financing reaches around 80% since 1972 (Saltman and Figueras 1997, 122). These percentages are lower than that of the Spanish or Italian NHS.

The proportion of **user co-payments** also varies a lot among Southern European health care systems. As Pinto (1997, 143) notes, the Portuguese health care system has never been free at the point of use. Patients using public services have to pay flat rate co-payments for consultations and diagnostic tests. Tickets on pharmaceuticals also exist. For those depending on insurance schemes the situation is different for they are able to purchase care wherever they wish, be it the NHS, contracted services or private ones. Insurance funds pay for contracted services on a fee-per-item basis. Private services are either reimbursed to users or co-financed by their respective insurance funds. In 1995, consumers paid out of their pockets more than 45% of all expenditures in health care, the highest value in all OECD countries (OECD Health Data 1998).

After the 1983 reform, and especially after the 1993 one, Italy has also introduced a lot of tickets. Cost-sharing affects diagnostic procedures in public hospitals and specialist visits. In order to curb down expenditure, charges have been raised significantly by the central government in the 90s, and also by some regions. Private expenditure amounts to 30 per cent of total health expenditure

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in Italy (this figure includes co-payments). User's contributions are lowest in Spain and Greece. In Spain, they only exist for pharmaceuticals. In Greece, no co-payment exists for inpatient hospital care, the rest of the tickets being low. Some funds have co-insurance for diagnostic services (Abel Smith and Mossialos 1994).

The **labour regime of health professionals** in the public sector has also remained peculiar in Southern Europe. Significant proportions of them work in public consultations in the morning, as salaried civil servants, and in private practice in the afternoon, on a fee-per-item of service or a contractual basis. Incentives such as an extra payment have been introduced in some of the systems in order to assure that health professionals are only working for the public system. However, incentives do not avoid the overlapping between the public and the private sectors. In fact, the same patient is sometimes treated in a public institution in the morning receiving a lower standard of care, and treated again by the same practitioner in a private setting in the afternoon, receiving then a better attention. However, this peculiarity of Southern systems should be further researched. There are no reliable data available on the numbers of physicians that work both for the public and the private sectors. It is estimated that the proportions are of 15% in Italy, 20% in Spain and Greece, and 50% in Portugal. Thus it is difficult to make a comparison with the traditional national health services and to figure out whether this aspect can be considered as a salient feature of Southern health care systems. It is equally difficult to find out whether there is a homogeneous pattern of such practices in all Mediterranean countries, although the size of the private sector in Portugal and Greece as compared to Italy and Spain makes one think that overlapping is much more severe in the former.

In sum, and in general, it can be defended that the Southern Model as defined by Ferrera (1996) has persisted to a great extent regarding the macro-institutional characteristics of Southern European health care systems, although some *caveats* should be pointed out. Coverage entitlements remain not fully homogeneous, although heterogeneity is minimal in Italy, little pronounced in Spain, and very broad in Portugal and Greece. Financing out of taxes also shows disparities, being maximum in Spain and Italy, and relatively low in comparison with the traditional national health services in the rest of the Southern countries, where is reaches roughly to half of the public budget. The proportion of public expenditure over total expenditure on health care does not diverge significantly from that of traditional health care services, at least according to OECD data, and with the exception of Portugal. Still, the perverse overlap between the public and the private sectors persists. However, this relationship has been rephrased in a very different way in Portugal and Greece as compared with the evolution in Italy and Spain during the nineties. Thus, the "Southern model" of health care

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seems to have lost some of its defining and differentiating characteristics in Spain and Italy, when compared to the traditional British and Scandinavian national health services. Portugal and Greece are following a different evolutionary pattern that does not allow to classify them merely as less developed national health services or health insurance systems, for they have become a mixture of them in which the private sector plays a very relevant role.

Finally, **cost-control measures** have clearly had an effect on expenditure levels in Italy, where expenditure over GDP has sharply decreased, and to a lesser extent in Spain, where it has decelerated. Expenditure in Greece and Portugal continues to grow as a percentage of GDP and in per capita purchasing power parities. It is only too early to evaluate whether **market incentives and entrepreneurial devices** included in the "reform of the reforms" have rendered Southern health care systems more efficient. Also, reforms are too recent to know whether they have produced an impact on equity levels.

Something can be said about the **devolution process** that has taken place in Italy and Spain, having supposed a dramatic change in the organization and management of the systems. An attempt was done in Greece in very recent years with no success so far (Venieris 1997a). In January 1993, a law was passed in Portugal establishing five health regions with maximum autonomy. These five administrative health regions were to substitute the previously existing eighteen ones. The law foresaw that "units of health" comprising all health centres and hospitals of each health area would be created (OECD 1994). So far, there is little information on how this process has evolved, but it has entailed centralization rather than the opposite.

Both in Spain and Italy, the decentralization processes were foreseen in the Constitutions. In Spain, the process began in 1981, when capacities were devolved to Catalonia. Between that date and the present, seven regions have received capacities, while ten of them have remained under the control of the National Institute for Health Services), so that central authorities manage health care for around 40 per cent of the population currently. Conversely, in Italy, the process of decentralization was carried out all at once for all the regions in 1978, at the same time as the national health service was created. In both countries, there exist "special status" regions enjoying a broader range of capacities and "ordinary status" ones, which makes the functioning of the system complex.

In Spain, the devolution thrust has rendered both assets and liabilities. Organizational and institutional change has been greatly enhanced, so that central services have followed in many cases innovations introduced at the regional level. For example, the Basque Country and Valencia introduced universal coverage for their citizens a year earlier than the INSALUD-Direct

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Management. Decentralized health care services were also the first to establish individual health cards to substitute the pre-existent ones held by heads of families. However, decentralization has also resulted in a significant increase of expenditure. Moreover, from the point of equity, although territorial differences were present before the devolution process started, they have been accentuated ever since. Regional financing of health care remains one of the most delicate issues and agreements are difficult to reach (Cabiedes and Guillén 1997). The main source of financing is a block grant transferred by the central government according mainly to capitation criteria. The latest pact on regional financing, signed in 1997, only contemplates in a limited way differences among regions in age structures of the population, morbidity and mortality patterns and other causes of health care expenditure.

In Italy, decentralization has also brought about innovation and expenditure increases, growing differences among the regions and welfare tourism. As France (1995) points out, one of the central problems of the Italian NHS was the lack of co-ordination ("weak vertical hierarchy") among the three tiers of government, i.e., the central authorities, the regions and the local health units. Thus, tensions among the different governing bodies have been the commonplace in recent times, with central authorities accusing the health units of overspending and acting inefficiently, and the latter claiming that the budgets are systematically underestimated. This situation was radically changed by the reform of 1993-94. This problem of confrontation between financers and revenue raisers, on the one hand, and spenders/deliveres, on the other is still the case in Spain. This is why in both countries current reform points to an increased fiscal co-responsibility, so that accountability and transparency is enhanced in regional health expenditure

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INTERPRETING THE REFORMS

Several reasons account for the introduction of national health services in Southern Europe. In the first place, the passing of reforms was eased by the processes of democratization that Southern countries started around the mid seventies. This was the case of Portugal, Spain and Greece. Legitimisation needs of the new regimes and an already existing consensus among the population and socio-political actors constituted a powerful reason for expansionary reform. Moreover, democratization allowed interest groups to exercise pressure. Reform itself took place very quickly in Portugal, only five years after the overturn of the authoritarian regime. This was due to the radical character of its transition to democracy, while the attainment of consensus needed some more time in Greece and Spain.

Secondly, the perception of the existence of broad inequalities in health care resources among regions, of mounting differences among the insurance funds, and of lack of co-ordination among the numerous administrative departments in charge of the provision of health care also opened the way for the reform. Change was also fostered by the idea that welfare services were to reach European levels and all the population should benefit from it. In all countries, conscience grew on the fact that developments during the 70s had early 80s had rendered privileged groups in an ever better position *vis à vis* the health system. It was thought that the establishment of a national health service would smooth out all these inequalities.

Thirdly, the presence of left-wing parties in office when reforms were enacted was also of significant importance. Such parties were very keen on the idea that welfare services (not necessarily cash transfers), should become universal. In the Italian case, a country already enjoying democracy since the post-war period, reform was possible by the formation of a strong coalition in favour of reform: the unions, the regions and the left, especially the Communist Party. The weakening of the medical profession due to increasing bureaucratization and to internal conflicts and the gradual loss of credibility and viability of the health funds helped in the same direction. The role played by the health funds and the doctor´s associations was radically different in the Portuguese and Greek cases, for even though they could not effectively oppose the passing of the reform, they strongly disagreed with it. Health care reform was less radical in Spain than in Italy, due to the absence of such a strong coalition in favour of reform as the Italian one.

Finally, the pressure exercised by the regions is another element of differentiation, in this case between Italy and Spain on the one side, and

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Portugal and Greece, on the other, for this actor was absent in the latter. Spanish and Italian regions were one of the key actors who made pressure for reform, because the introduction of a national health service was coupled with decentralization of the systems, which would allow them to play a protagonist role in the direction and provision of health care. As soon as they were born, regions began to fight against the central administration in order to force it to accomplish the transfer of responsibilities over health matters foreseen by the Constitutions.

But, which were the factors allowing for implementation of reform in Italy and Spain, and for its partial failure in Greece and Portugal? Economic conditions in subsequent years from the introduction of the reforms were of crucial importance. Additionally, preparations for joining the European Community and actually having to act as members of it also eased implementation in Spain and Greece, and less so in Portugal. This new political status helped the introduction of expansionary measures in order to meet EC recommendations and to narrow the gap with the more developed European welfare states. It should not be forgotten though that proposals of reform and consensus on the introduction of national health services was reached in Portugal, Spain and Greece much before becoming a member of the EC was even at stake.

In Italy, implementation was almost immediate to the passing of the law because of the existence of a strong coalition in favour of it. Contrarily, Greece met many difficulties for implementation, above all because a stable coalition of interest behind it was not achieved and the necessary public funds needed to put it into practice were not allocated. Moreover, health funds were not suppressed. Resistance on the part of doctors and frontal opposition by the insurance funds, especially the better off ones, were the main forces impeding a more decided implementation process. In the Portuguese case, doctors have also successfully resisted change.

Another possible reason for difficulties at implementation in Greece and Portugal may stem from the fact that coverage was much lower in Portugal, and also a bit lower in Greece than in Italy and Spain. The continued presence of conservative governments in Portugal during the second half of the eighties and early nineties may also explain difficulties at putting into practice a universalist reform. In Greece, the PASOK was in power from 1981 to 1989, but, after that, alternation with the conservatives rendered continuity at reform problematic. This situation diverges with the experience of Spain, where the Socialist Party was in office from 1982 to 1996.

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Explaining difficulties at reform implementation and the consequent differences with the traditional national health services still existing in Southern countries may relate to what could be labelled "developmental time". Southern countries had not completed full expansion of their social security health care systems when the oil-shocks came about, thus rendering any expansionary reform difficult. Moreover, shortly after, they had to implement their universalist reforms almost at the same time as pressures from the process of European integration and the internationalization of the economy began to grow. This meant that cost-control measures had to be introduced much before the reforms leading to the introduction of national health services had been put in practice, thus leading to a problematic and difficult situation. More significantly, the economic, political and social conditions of their inception are very different from the ones present in Britain or the Nordic countries.

As for the second wave of reforms, pressures stemming from the Maastricht treaty and internationalization of the economy have affected all Southern countries and led them to the introduction of rationalizing reforms. The need to balance the economy has pushed all of them to incorporate measures in the line of cost-control and managed competition, emulating somewhat the present paradigm on health care reform. All these moves have varied in intensity among Southern countries due to internal politics and to the situation inherited from the previous reform.

The exam of macro-institutional characteristics of health care system in Southern Europe shows that differences still exist between the South and the traditional national health services, although these differences are decreasing. Also, a lot of differences may be ascertained among Southern health care systems themselves, differences that seem to be deepening in recent years. While Italy and Spain are walking decidedly on the road towards national health services, the private sector seems to be gaining relevance in Portugal and Greece while social insurance continues to exist. Thus, the Southern model of welfare, at least in what regards health care, does not appear homogeneous. This exam has also shown that it is difficult to continue considering Southern health care systems as belonging to a "rudimentary" model of welfare, as Leibfried (1993) has labelled them, when the levels of expenditure, the coverage spans and the array of services provided are considered.

As for the "reform of the reform", while Italy has acted on both the supply and demand sides of health services, Spain has put the accent on the supply side though more timidly, and Portugal and Greece mainly on the demand side. How these sets of programs are going to affect the equity and efficiency levels of Southern health care systems is yet to be seen.

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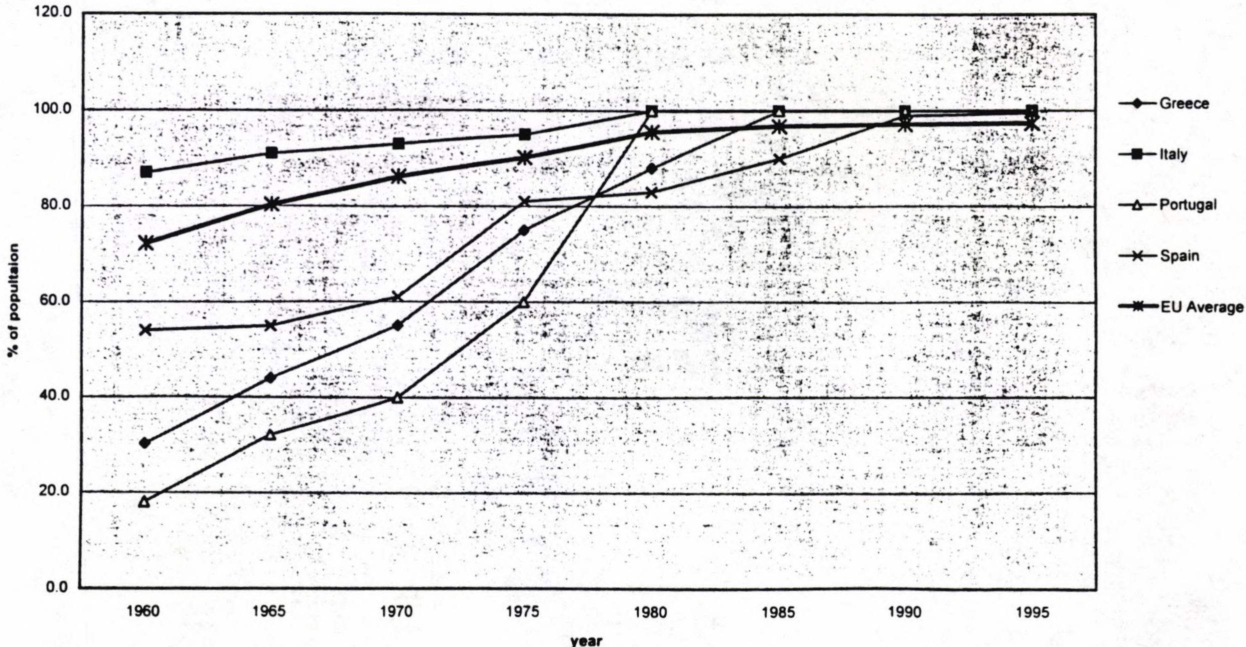
Graphic 1: Evolution of health care coverage. Southern countries and EU average



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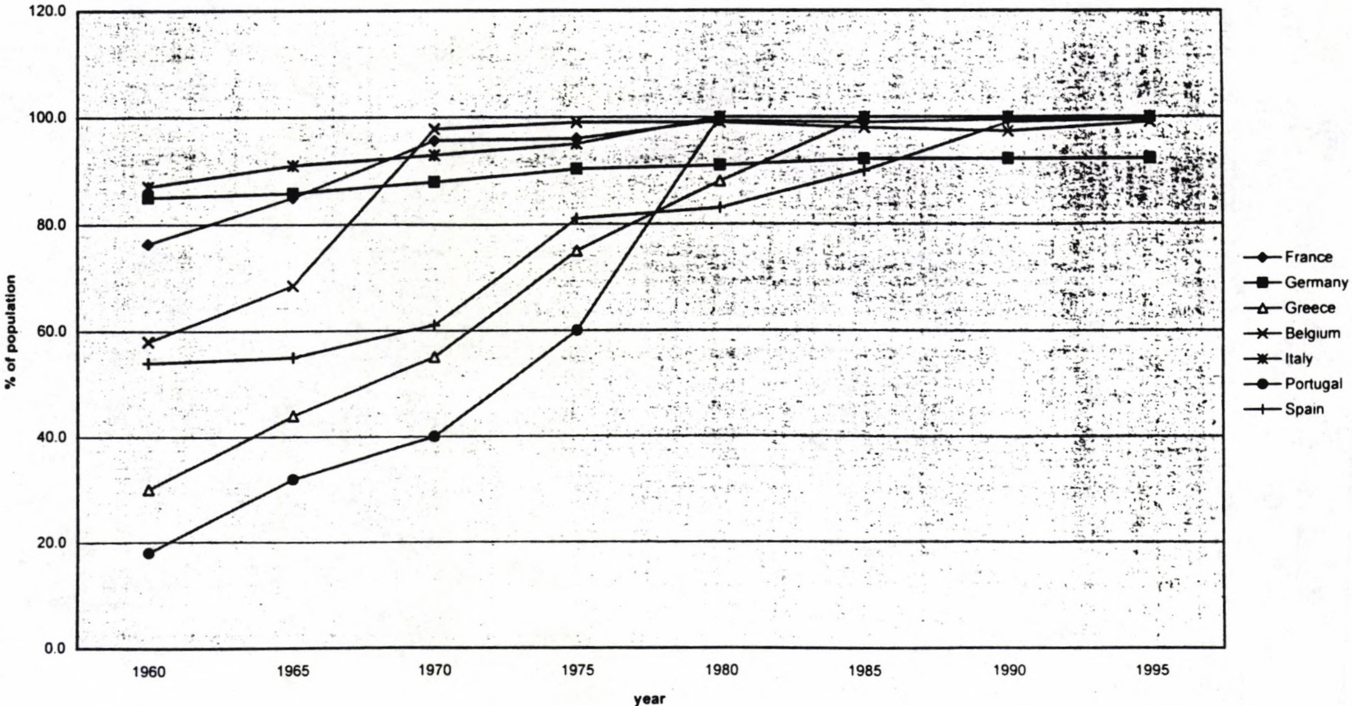

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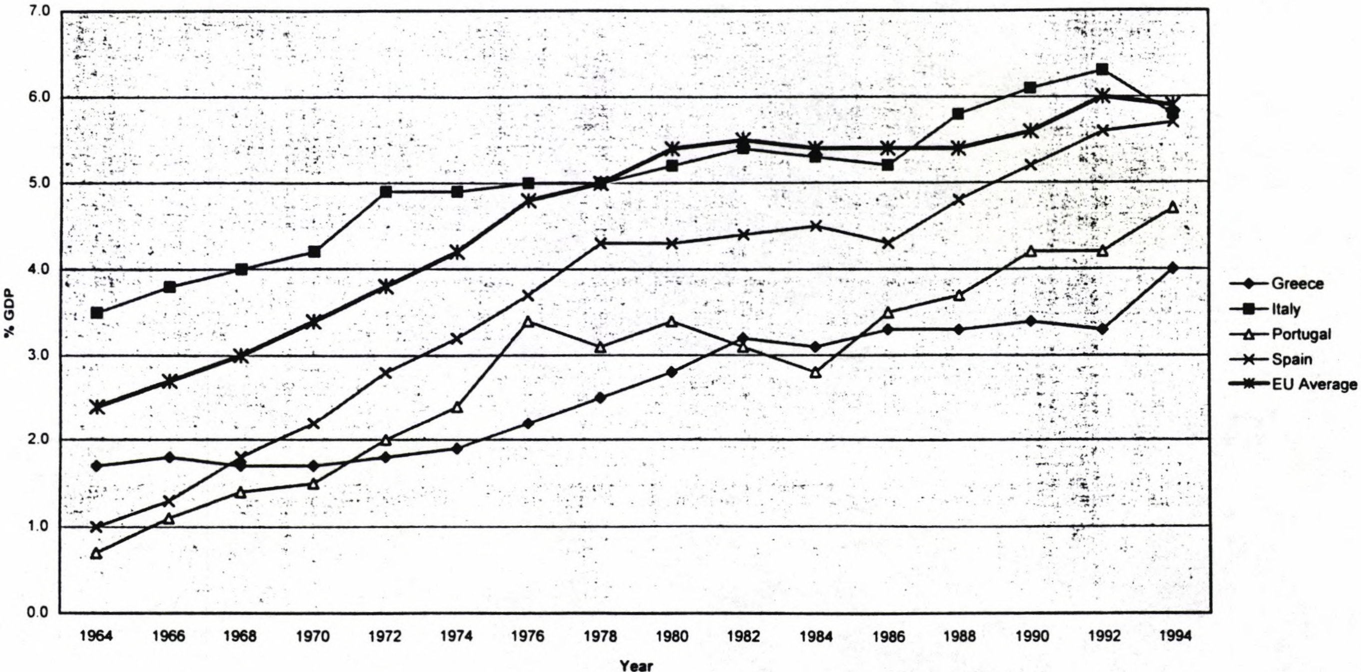
Graphic 3: Current public health expenditure (% of GDP)



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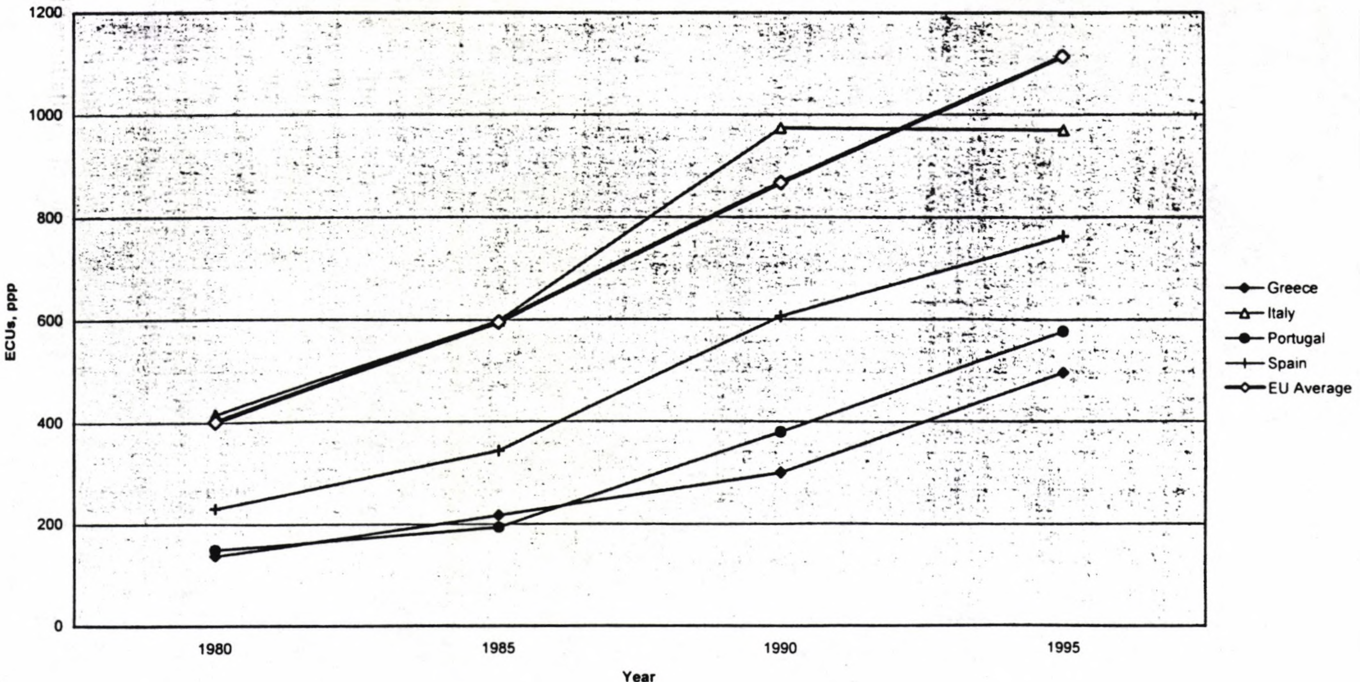
Graphic 4: Public expenditure on health. Per capita ECUs, ppp



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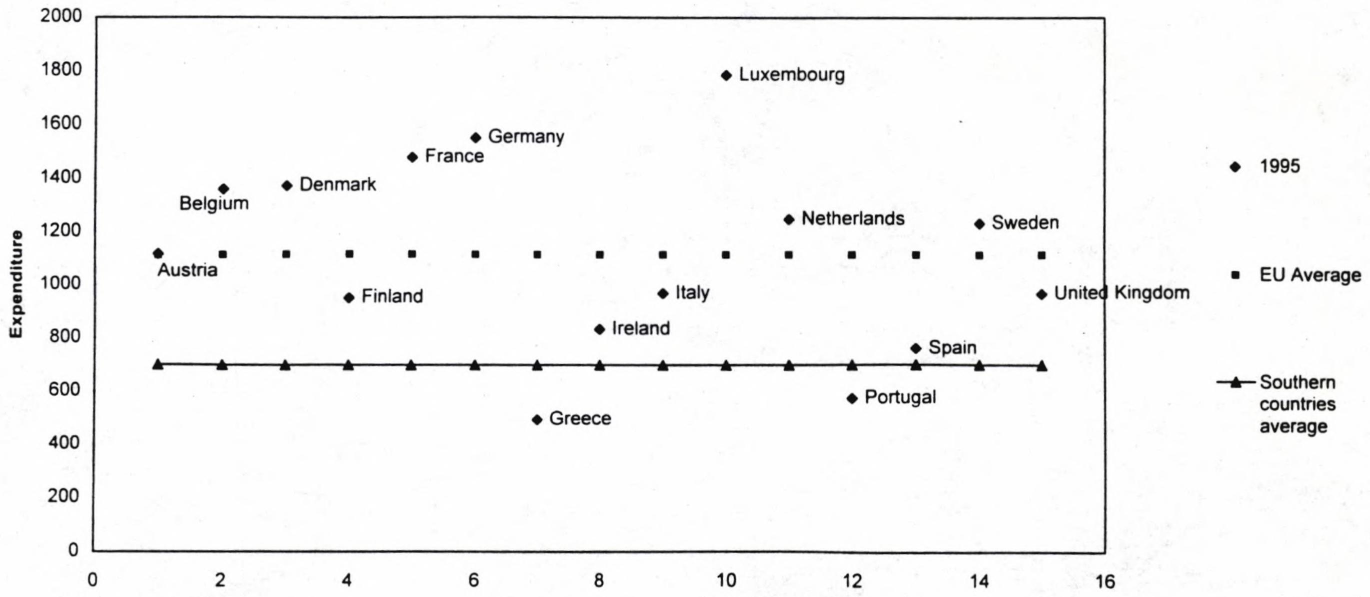
Graphic 5: Public expenditure on health per capita, ECUs ppp, 1995



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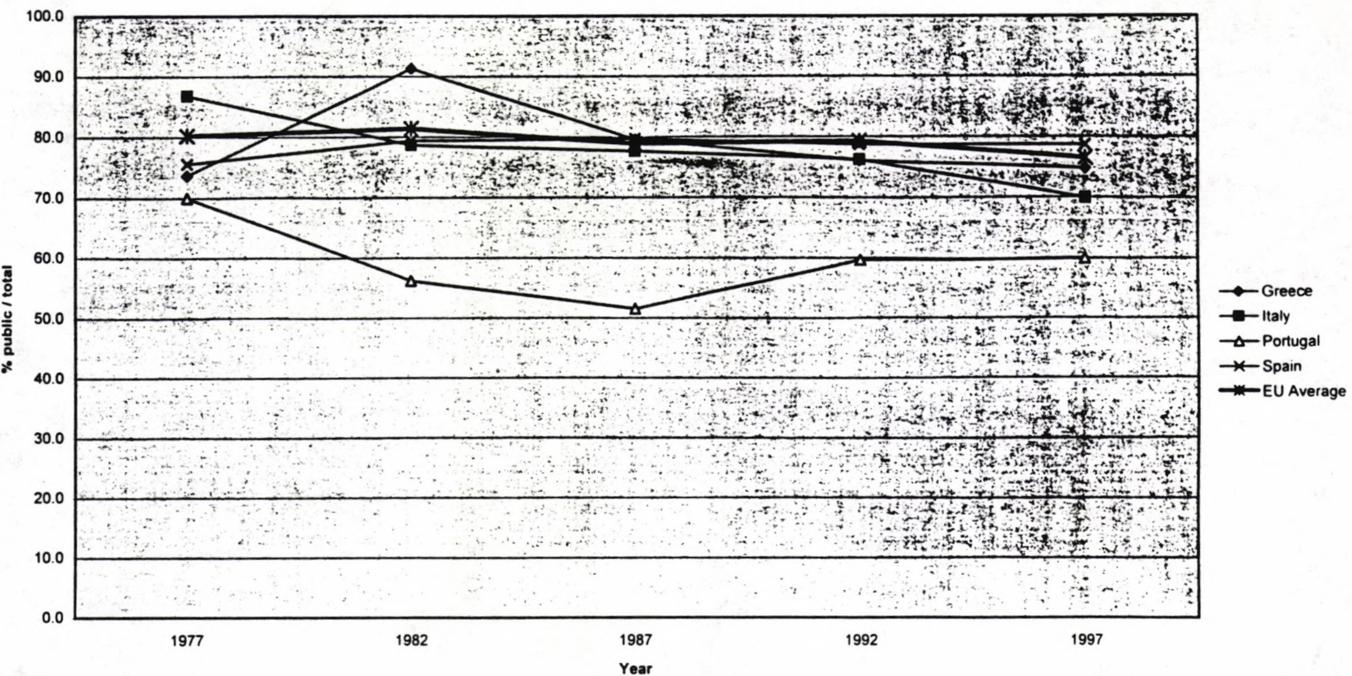
Graphic 6: Public expenditure on health care over total



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