

## Economic crisis and inequalities in health systems in the countries of Southern Europe

Crise econômica e desigualdades nos sistemas de saúde dos países do Sul da Europa

Crisis económica y desigualdades en los sistemas de salud en los países del sur de Europa

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### Abstract

*The current article addresses the issue of health system inequalities in the countries of Southern Europe, specifically Spain, Greece, Italy, and Portugal. The study resulted from a non-systematic literature review, based on the scoping review proposal. We begin by presenting a brief contextualization of the social welfare state systems in these European countries, highlighting the principal specificities and differences in relation to other European welfare state systems. Next, we describe the health systems in the four countries, emphasizing the respective reform processes and the main health inequalities that have characterized them before and during the economic crisis. The crisis and austerity policies have greatly increased the level of dissatisfaction with healthcare provision in these countries, particularly in Greece and Portugal. In this sense, we conduct a comparative discussion of the health inequalities, identifying both common trends and differences. In the four countries, the social gradient (particularly in education, income, and labor) represents the principal determinant of health inequalities, while not ruling out geographic inequalities in access to health services as the result of different levels of economic development in the various regions. Finally, we discuss the recent debate in the international literature on the relationship between different welfare state systems and health inequalities, and precisely the critique of the use of welfare state typologies as a determinant of health and health inequalities.*

*Health Inequalities; Health Systems; Economic Recession; Social Welfare*

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## Introduction

Despite the overall increase in living standards in the 20th century and the introduction of universal health systems, many studies have identified persistent inequalities in all the industrialized countries. Such inequalities have been observed even in countries that are considered “more equitable”, like Great Britain, the Netherlands, and Sweden, whose governments have a long tradition of analyzing and dealing with health inequalities <sup>1,2</sup>. The World Health Organization (WHO) has acknowledged that among the European countries there are “unacceptable inequalities in health status between different social groups in society” <sup>3</sup> (p. 135), while pointing to the central role of economic, social, environmental, and institutional determinants in the production and development of health inequalities <sup>4</sup>. In this sense, social inequalities in health are still a critical issue for the majority of European countries, as evidenced by the British study *Fair Society, Healthy Lives. The Marmot Review* <sup>5</sup>, and the results of the European Commission’s working group published in the *Report on Health Inequalities in the European Union* <sup>6</sup>. The Report points to a significant reduction in health inequalities as measured by life expectancy and infant mortality, while identifying the persistence of some forms of health inequality between various social groups and the different regions and member states.

In the countries of Southern Europe, specifically Spain, Greece, Italy, and Portugal, although the reforms of the 1970s and 1980s introduced universal national health services and the concern for reducing geographic imbalances between different regions, social inequalities in health only became a critical issue in the late 1990s. The four countries still lack a consolidated tradition of analyzing and dealing with social inequalities in health <sup>7</sup>, unlike the countries of Northern Europe.

However, the issue of health inequalities became a priority again in the countries of Southern Europe starting in 2010-2011, when (although with different degrees of severity) the four countries began to feel the first effects of the financial crisis of 2008 and the austerity policies imposed by the Troika (European Commission, European Central Bank, and International Monetary Fund) <sup>7,8,9</sup>.

Various studies have identified the impact of the economic crisis on the most vulnerable population groups, with increasing rates of mental health disorders (e.g., anxiety and depression) and a rise in suicides <sup>8,10</sup>. Such effects have already been observed in Greece, Spain, Ireland, Italy, and Portugal <sup>11,12</sup>. According to several studies, the increase in social inequalities constitutes one of the principal side effects of the structural adjustment policies adopted in the Southern European countries <sup>10,13</sup>.

The current study resulted from a non-systematic literature review based on the scoping review technique proposed by Arksey & O’Malley <sup>14</sup> and organized in five phases: (i) identification of the research questions; (ii) search for relevant studies; (iii) selection of studies; (iv) qualitative data description; and (v) collection, summary, and report of the results. A total of 74 publications were analyzed for this purpose. The collected material resulted from the search performed in Web of Science, PubMed, Scopus, SciELO, and Google Scholar, using the terms “health inequalities”, “social inequalities in health”, “health system reforms”, “impact of the economic/financial crisis”, and “countries of Southern Europe”. The search was done in English and the national languages of the four countries.

The current article begins with a brief contextualization of the welfare state in the countries of Southern Europe, highlighting the principal specificities and differences in relation to other European welfare state regimes. The article then describes the health systems in Greece, Spain, Italy, and Portugal, focusing on the reform processes and main health inequalities in countries before and during the economic crisis. The health inequalities will be discussed next, underscoring common tendencies and differences between the four countries.

## Study context

Concerning the welfare state in advanced capitalist societies, Esping-Andersen <sup>15</sup> identified three “welfare regimes” that were consolidated during the expansion of Keynesian capitalism: Social Democratic, in the Scandinavian countries; Conservative, in other countries of Continental Europe; and Liberal, in the Anglo-Saxon countries. Replying to various criticisms, the author argued that the welfare state in Southern Europe is a variant of the Conservative type of regime <sup>16</sup>.

According to several authors, Esping-Andersen's analysis failed to highlight the specificities and characteristics proper to the welfare state in the countries of Southern Europe, and they defended a new approach to identify the distinctive aspects of the social protection systems in these countries<sup>17,18,19,20,21,22</sup>. According to Ferrera<sup>17</sup>, one of the principal characteristics of the Southern model in social Europe was the introduction of dualist social protection during the period of great economic expansion (1945-1975), with highly generous provisions for the central market categories (public employees and workers in large industries) and modest protection schemes for peripheral categories (precarious workers, self-employed, and employees of small companies). In this shaping of the welfare state, the family model, characterized by close kinship ties and inter-generational solidarity<sup>23,24,25,26</sup>, assumes the role of compensation and reduction of risks and needs through the provision of welfare, primarily ensured by women. This characteristic, typical of the countries of Southern Europe, has been identified as a central element in what has been called the "welfare society"<sup>27</sup>.

In addition to the historical and sociopolitical factors that influenced the development of the welfare state in the countries of Southern Europe, other factors definitely contributed to shaping them as the fourth welfare state model: corporatism, accentuated by the experiences with authoritarian governments, the influence of the Catholic Church, and fierce partisan political competition, as discussed by various authors<sup>15,17,18</sup>.

Another distinctive trait of the social protection model in Southern European is the health systems characterized by a universalist theoretical approach, despite their institutional fragmentation<sup>17,24,28</sup>. During the final expansion of the welfare state in the 1970s and 1980s, the four countries of Southern Europe did in fact establish universal national health services based on citizens' rights and inspired by the Beveridge Model. However, the transition in health systems based on insurance for a national health service occurred at different paces and produced varying levels of coverage in the respective countries<sup>29</sup>. Spain and Italy developed public health systems based more on universalist principles and promoted regionalization of their national health services<sup>30</sup>. In Greece, and to a certain extent in Portugal, the health systems remained fragmented between the public and private subsystems, at least in the first phase of the transition<sup>31,32</sup>.

The common characteristics of the national health systems in Southern Europe include: (i) incoherence between universalist promises and their actual implementation, especially for financial reasons; (ii) inefficiency and low levels of management competencies that led governments to promote various reforms, purportedly intended to increase the health systems' efficiency; (iii) the role played by the family and kinship and neighborhood networks, attempting to compensate for the lack of institutional support (support services, especially home care, etc.) to offset the lack of social care provisions under the national health system; (iv) lack of respect for users' rights under the respective health system, for example patients' rights and users' right to information. According to the *Euro Health Consumer Index 2015*<sup>33</sup>, health systems in Southern Europe need to close the gap separating them from the Scandinavian countries and other countries of Continental Europe in the area of patients' rights and users' right to information; and (v) lack of channels and mechanisms for participation, responsible for the low levels of citizens' involvement in health decisions<sup>34</sup>.

Despite the limitations and difficulties identified in recent years, Greece, Spain, Italy, and Portugal have reached levels of life expectancy (among other favorable indicators of rising health standards) that place them among the top-ranking countries of the world. The overall improvement in living conditions and healthcare has resulted from socioeconomic development in recent decades and favorable health standards in the Mediterranean countries. Still, these health indicators hide situations of internal heterogeneity, i.e., inequalities in the distribution of material resources, education, social status, and access to healthcare. All this obviously produces disparities in the exposure to important risk factors. In this situation, already quite complex, the impact of the current financial crisis (considering both the direct short-term effects and the indirect medium and long-term effects<sup>35</sup>, resulting from budget cuts in public healthcare systems) may have accentuated the health inequalities, subsequently reducing access to and use of preventive services and further affecting vulnerable individuals with fewer resources and less social capital.

## Health systems in the countries of Southern Europe: reform processes and inequalities

This section of the article presents the principal stages in the reform process implemented in the countries of Southern Europe, identifying the various forms of social and geographic inequalities and the reforms' impact on the production of inequalities. For the analysis of health inequalities, aimed at highlighting differences and similarities between the four countries, six thematic lines were used:

- Inequalities and social gradient;
- Geographic inequalities and access to health services;
- Economic crisis and increase in families' out-of-pocket health spending;
- Reduction in public investment in healthcare;
- Health systems' decentralization;
- Impact of economic crisis on the most vulnerable groups.

### Spain

With the reestablishment of democracy in 1977, Spain created the Ministry of Health and Social Security, which absorbed the other existing health institutions and services. In 1986, the *General Health Law* established the National Health System and accelerated the process of transfer of health responsibilities to the country's 17 Autonomous Communities<sup>36</sup>. This reform process contributed significantly to the expansion of health coverage. However, various studies have detected geographic inequalities in access to and use of health services, with a pattern of inequality between regions with higher socioeconomic status (in the north), displaying better health indicators, and the south and west, with higher rates of chronic diseases<sup>37</sup>.

The *Bernat Report* had a major impact, underscoring the geographic inequalities in health, stating that "*the perception in Spain is that 17 different health management systems coexist*"<sup>38</sup> (p. 48), a view based on the observation of differences in the provision of services, coverage, and clinical practice between the 17 Autonomous Communities.

The current financial crisis has certainly not helped relieve this situation. Austerity policies and privatization of services implemented during this period have actually led to an increase in social inequalities both in the use of health services and in health status itself<sup>39</sup>.

In addition to geographic inequalities, health inequalities associated with socioeconomic factors such as education, income, and work status have persisted over time<sup>40</sup>. For example, evidence has shown an association between social class and chronic diseases, more prevalent in persons with less schooling, as well as inequalities associated with risk factors like smoking and alcohol consumption<sup>41</sup>. Inequalities and risk factors have also increased in the case of obesity, showing a prevalence of 10% among non-manual workers, compared to 18% in manual laborers<sup>42</sup>. There are also class differences in the majority of the cardiovascular risk factors<sup>43</sup>. The recent economic crisis has also been incriminated in rising suicide rates<sup>44</sup>.

It is important to emphasize the increase in socioeconomic inequalities in health as the result of dual coverage (public and private services) for the most privileged social strata, who have better access to specialists and preventive practices (for example, dental appointments and mammography tests) when compared to other population groups, who tend to use emergency services and primary care more often<sup>45</sup>.

The private health system has grown steadily since the late 1990s<sup>45</sup>, a trend that has been even faster since the onset of the current financial crisis. The crisis thus provided an ideal scenario for the Spanish government to promulgate *Royal Decree-Law 16/2012*, which "*breaks with the universalist model, with serious losses or rights*" and implements a system based on voluntary insurance, or in the case of unemployment, on social security<sup>46</sup>. According to Navarro<sup>47</sup>, the substantial cuts in public health are accelerating the growth of private spending, with further segmentation of the Spanish health system, including private healthcare for the wealthier social strata and a public system that treats lower-income strata. According to Legido-Quigley et al.<sup>48</sup>, the current health system reform hides the underlying interest of siphoning public funds to the private sector.

## **Greece**

In 1983, Greece created its National Health Service (*Ethniko Systima Ygeias*), adopting the principles of universality and equity. The previous health system had been financed by some 300 social security funds. But the reform of 1983 was only implemented partially, and the unification of the social security funds was abandoned, and the Greek health system did not become universal.

The Greek Ministry of Health launched a new reform in 2000, the main objectives of which were decentralization of the system, strengthening primary healthcare, and the establishment of new forms of collaboration between the public and private sectors<sup>31</sup>. But it only proved possible to partially decentralize the health system, with the creation of 16 regional health authorities. The government was also unsuccessful in inducing the merger of countless health insurance funds, the principal factor leading to inequalities in health. The government's program also left out the creation of primary care centers in urban areas and the promotion of a family medicine system<sup>49</sup>.

By 2010 there were still some 30 insurance funds in Greece. Each fund was subject to its own legislation, with differences, and there were differences in the contribution rates and the conditions for granting benefits, resulting in "inequalities in access to and financing of services", as pointed out by Economou<sup>50</sup> (p. xviii). The Greek government substantially subsidized health plans for public employees and the military<sup>31</sup>, benefits that were steadily reduced as a result of the agreements with the Troika<sup>51</sup>. The situation changed in 2011 with the creation of a unified fund, the National Health Services Organization (EOPYY), proposed under various reforms since 1968 but which never made headway. The new fund was designed to serve the vast majority of the population (workers, dependents, and pensioners). But due to the country's deep crisis, unemployment increased rapidly reaching 27.3% by 2013<sup>51</sup>.

Another important factor contributing to inequality is the steady growth of private health spending by Greek families (out-of-pocket payments), estimated as the highest in the European Union<sup>47,52</sup>. The significant increase in direct private spending is the most regressive form of financing and has resulted in an increase in inequalities in the Greek health system, particularly affecting the poorest and most vulnerable social groups<sup>53,54</sup>.

Although there is no official study on inequalities in access to health services, some studies have analyzed the issue indirectly. According to one such study in 11 countries of the European Union, Greece, Ireland, Italy and the Netherlands show the highest absolute and relative inequality indices in men, and Greece, Spain, and Ireland have the highest indices in women<sup>55</sup>. The relationship was also studied between economic status and use of oral health services, emphasizing the association between higher income and more dental consultations<sup>56</sup>.

More recent studies have analyzed the effects of the recent economic crisis on health and health-care, pointing to increasing rates of mental disorders, suicide, infectious diseases, and deteriorating self-rated health<sup>57,58</sup>.

There are also major geographic inequalities in Greece. Some underprivileged regions lack the necessary infrastructure and staff to meet the population's needs, both in hospitals and rural health clinics. The geographic distribution of private clinics and diagnostic centers is also highly unequal, mostly concentrated in Greater Athens and Macedonia<sup>49</sup>.

## **Italy**

The 1978 reform in Italy introduced a universal health system (*Servizio Sanitario Nazionale*) and proclaimed the promotion of equity and the reduction of geographic inequalities in the supply of services<sup>59</sup>. However, when the country began measuring health differences more systematically in the late 1980s, the inequalities appeared immediately. Longitudinal studies in Torino, Florence, and Livorno<sup>60,61</sup> showed a linear relationship between rising mortality and increasing social disadvantage, whatever the indicator used, both at the individual level (schooling, social class, housing conditions) and geographic level (poverty rates, income rates, etc.).

According to several studies, the regions of southern Italy have worse disease prevalence rates in all the health dimensions analyzed<sup>62,63,64</sup>.

Other studies have detected social inequalities in access to primary prevention and early diagnosis<sup>65</sup>. Studies consistently show that the risk of dying increases as schooling decreases, both in men and women<sup>64</sup>.

Still other studies have found evidence of unequal distribution in health and disease between native Italians and immigrants. The health inequalities affecting immigrants result mainly from the system of social relations, i.e., in the discomfort resulting from the relationship with the societies receiving the immigrants<sup>66</sup> and in the more precarious and unhealthy working conditions to which the latter are exposed. Health inequalities for immigrant women include: (i) higher incidence of low birth weight newborns; (ii) higher infant mortality; and (iii) less use of prenatal services<sup>67</sup>.

Another critical issue is the health systems' own responsibility for the production of inequalities<sup>68</sup>. According to Costa et al.<sup>59</sup>, the main threats come from the new institutional arrangements implemented by the national and regional health systems, referring to the following: (i) possible discrimination introduced by rules providing for new mixed management formats and public-private care; (ii) transfer to the local communities of revenues and management of social services for the elderly, people with disabilities, and users of mental health services, where this decentralization process could increase the geographic inequalities in the availability of resources for social interventions; and (iii) new inequalities in the use of specialized services (especially high-complexity), varying according to social status, while access to primary care remains basically egalitarian.

More recent studies have confirmed the tendency towards proliferation of disparate health systems, influenced by the characteristics of the respective regional social protection systems. Bertin & Carradore<sup>28</sup> identified seven heterogeneous groups of Italian regions as the result of a cluster analysis based on institutional and socioeconomic variables and criteria, e.g., the predominant financing system (public versus private), the role of different actors in the provision of services (government, private, and third sector), and the governance or modality of control for the different regional systems. These developments can contribute to an increase in inequalities in social protection for citizens residing in different regions of the country, including inequalities in access to health services. Granaglia & Compagnoni<sup>63</sup> point to significant differences between the regions of the south versus center and north of Italy in relation to infant mortality (5.3% versus 3.3%) and avoidable deaths, such as a mortality from diabetes in individuals less than 55 years of age and breast cancer mortality. These data are corroborated by the recent Health Consumer Powerhouse study<sup>33</sup>, underscoring marked regional variation in quality of healthcare.

### **Portugal**

Since Portugal established its National Health Service (SNS) in 1979, the country has faced various problems, including underfinancing, concentration of resources in the hospital sector, lack of coordination between primary and secondary care, and inequalities in access, due to the private sector's strong presence<sup>69</sup>. An important stage in the reform was ushered in by the *Basic Health Law* of 1990 and the *Statute of the National Health Service* of 1993, incorporating some elements of the neoliberal policies in vogue at the time. The larger role assigned to the private sector in the provision of care and financing led to differential access to health services and refocused the problem of inequality.

Another significant stage was the approval of the *National Health Plan 2004-2010*<sup>70</sup>, providing for a series of interventions to strengthen the health system: (i) creation of the first Family Health Units in 2006 the Groupings of Health Centers in 2008, whose mission is to provide primary care to the population within a given geographic area; and (ii) the establishment of the Network of Comprehensive Continuous Care in 2006 to meet the needs of patients with chronic illnesses and in situations of dependency and whose current health status does not require hospitalization.

Implementation of the above-mentioned health policies and the country's economic and social development contributed to the improvement of the Portuguese population's health. The report by the WHO<sup>71</sup> that assessed the Portuguese health system's performance emphasized significant improvements in the population's health indicators, such as: (i) higher life expectancy; (ii) a fall in infant mortality (the highest in the European Union in 1980, but now one of the lowest); and (iii) a decrease in the mortality rate in individuals less than 65 years of age. Still, no similar progress was seen in other indicators like disability-free life expectancy and potential years of life lost<sup>71</sup>.

Although the equity principle has guided Portugal's health policies for the last 30 years, various studies<sup>72,73,74,75,76,77</sup> have detected inequalities favoring the higher socioeconomic strata in both access to and use of specialized services and health status. Mackenbach et al.<sup>74</sup>, in a study in 22 European countries in the late 1990s and early 2000s, showed that in Portugal, health inequalities as perceived by the population (both men and women) are the highest among 19 European countries, especially when associated with level of education, and are equally significant, although not the highest, when associated with level of income. This relationship between health and socioeconomic variables was confirmed by other studies in the first decade of the 21st century<sup>73,78</sup>.

Inequality in access also depends on the concentration of health resources, especially in medium and high-complexity specialties, in the districts of Oporto, Coimbra, and Lisbon. Thus, regional inequalities in access to medical specialties and hospital care did not decrease from 2000 to 2009<sup>73,76,79</sup>.

Other studies, drawing on the results of national surveys, concentrated on the contribution of the various health subsystems to the production of inequalities. According to Bago D'Uva<sup>76</sup>, beneficiaries of private subsystems are more likely to use medical services and specialties or to use them more intensely when compared to beneficiaries of the SNS. Even today, the Portuguese health system is characterized by the simultaneous presence of the SNS and various subsystems of care that guarantee dual coverage for a portion of the population, some 20 to 25%<sup>32,79</sup>, such as: (i) the public sector social protection subsystem for civil servants (ADSE), used by some 10% of the population, while mostly financed by taxpayers; (ii) the subsystem of the voluntary insurance sectors; and (iii) the private health insurance subsystem.

According to Barros et al.<sup>32</sup>, the fact that a large proportion of the population enjoys dual coverage through different typologies of health subsystems reveals clear inequalities in healthcare access.

The significant rise in user fees at all levels of care, implemented since January 2012 in the wake of the financial crisis, has further increased barriers to healthcare by the Portuguese population<sup>80</sup>.

## Discussion

Studies in recent years have attempted to determine whether health inequalities vary between European countries with different welfare state systems. Some studies have found that the systems in Southern Europe have the most serious health inequalities, while the Scandinavian countries and the other Continental European countries tend to show smaller differences<sup>2</sup>. Most worrisome is that such inequalities have increased in all four countries of Southern Europe, although to different degrees, during the economic crisis starting in 2008<sup>81</sup>. Compared to other nations of the European Union, the four Southern European countries made large-scale cuts in public employment by failing to replace retirees, freezing new hiring, and even (in the case of Greece) firing tenured civil servants. In the four countries, the responses to the economic crisis (that is, the recipes imposed in the case of Greece and Portugal or strongly recommended by the Troika in the case of Spain and Italy) were similar, a sort of single recipe, as pointed out by Guillén & Pavolini<sup>82</sup>. The austerity measures in the health sector varied from freezes to severe cuts. The mean annual cutback was the most severe in Greece, followed by Portugal. In Italy, the decline in public spending in health was intensified in 2014. In Spain, the reduction was moderate until 2011, after which it also increased<sup>29</sup>.

These data corroborate previous analyses identifying welfare states as an important factor the health of populations, as long as they consider health determinants<sup>82</sup>.

Meanwhile, other researchers have correctly criticized the widespread use of Welfare State typologies for purportedly overlooking the diversity of social and health policies between countries with such regimes<sup>49,82</sup>. For example, epidemiological research has been questioned for having used the Esping-Andersen typology in a surprisingly acritical way<sup>21</sup>. Bramba<sup>21</sup> contends that a more critical approach is needed to classify welfare regimes, which are actually "ideal types".

From this perspective, studies should prioritize a comparative analysis of more similar countries in terms of welfare state provision, identifying similar and different areas, exploring the potential contributions to comparing national diversities in health and health inequalities<sup>21</sup>. This would allow overcoming some simplistic generalizations by studies on welfare state systems and observing the

diversity of paths taken by different countries which in some cases could lead to questioning the validity of the same Mediterranean model (i.e., Southern Europe) in relation to healthcare<sup>83</sup>.

In the case of the social protection regimes in Southern European countries, our analysis has highlighted common characteristics and trends in their health systems and the inequalities, as well as some significant differences between the four countries.

Although to different degrees and in different dimensions, the common characteristics include inequalities in access to and use of services, in morbidity and mortality associated with social and economic variables such as work status, housing, income, schooling, and social capital<sup>6,84</sup>.

Another key aspect is the steady increase in out-of-pocket spending in health as a percentage of total health spending in all four countries, markedly in Greece and Portugal: 24.5% in Italy, 30.1% in Spain, 34% in Portugal, and 39.4% in Greece<sup>85</sup>, despite acknowledgement of the right to health and universal and free access for all citizens, as proclaimed by the respective national health services. Such data reveal growing privatization of health services. As the state reduces its global financial responsibility for healthcare, a substantial share of the cost is shifted to families and individuals through the proliferation of private health plans, with rising out-of-pocket payments by families, resulting in more unequal national health systems. Low and middle-income groups have been disproportionately affected by such conditions, significantly limiting access to healthcare<sup>29</sup>.

Geographic inequality in health is another critical issue, observed in all four Southern European countries. Differences exist between: (i) the economically more developed regions of the north of Spain as compared to the south and west; (ii) the underfinanced regional health systems of the Peloponnesus, Central Greece, and the Aegean and Ionian islands when compared to Greater Athens and Macedonia; (iii) the regions of south and central Italy and the wealthier regions of the north; and (iv) the districts of Oporto, Coimbra, and Lisbon and the other districts in the countryside of Portugal.

Another interesting issue in the four countries, although with different levels of acceleration and scope, is decentralization of the national health systems. The cases of Italy and Spain are paradoxical – both with a higher degree of regional decentralization in the financing, management, and provision of health services – while evidence shows that decentralization has not helped reduce the historical difference in performance between the various regional health systems. On the contrary, such inequalities appear to have increased in recent years<sup>38,86</sup>.

The article has identified potential inequalities induced by the reform processes at the national, regional, and local levels. These feature the institutional arrangements introduced in the health systems and the new relations between the public and private sectors in services provision. For example, the experiences introduced in Italy (treatment of private inpatients in public hospitals, or intramoenia) and in Greece (afternoon and evening rules allowing physicians, hospital employees, and public health centers to exercise liberal private practice in the same facilities after their normal work shifts). The justification cited for this strategy is to facilitate access to specialized services and bolster the public sector's competitiveness in relation to the private sector, by increasing its efficiency. Meanwhile, the result is a kind of professional practice that generates inequalities by creating two categories of citizens within the same public services: (i) those that opt for public services and are included on a long waiting list and (ii) those that opt for a service with copayment whereby they receive treatment within just a few days.

An example of how health systems produce inequalities is the rising proportion of users' health expenses covered by copayments and user fees. The procedure is already consolidated in the countries of Southern Europe (especially Greece, Italy, and Portugal), introducing financial hurdles to access and further aggravating inequalities in public healthcare<sup>47,87</sup>. In Spain, the only fee for use of health services is for pharmaceutical products. The introduction or increase in user fees for primary care and/or appointments with specialists can worsen the health outcomes and fuel the increase in the use of intensive services and resources such as emergency care<sup>11,88</sup>.

Finally, the negative repercussions of the financial crisis and austerity policies have particularly affected the countries of Southern Europe. One issue that has received relatively little attention is the impact of these policies on social inequalities in health. Budget cuts and on-going privatization plans in hospitals and primary care centers are leading to steady deterioration in the quality of services, while increasing waiting times, besides increasing the requirement of copayments for medicines and other health services. According to a report by the Organization for Economic Cooperation and



Development (OECD) <sup>89</sup>, the increase in inequality has been particularly evident in countries that have implemented deep budget cuts, like Spain, Greece, Italy, Ireland, and Portugal. The negative consequences of the crisis tend to concentrate in people that lose their jobs and the population's most vulnerable groups. Higher rates of precarious employment and lower per capita health spending have a negative effect on people's mental health <sup>12</sup>. The decrease in healthcare access is particularly evident in Greece and to a lesser extent in Italy, Spain, and Portugal, but in all four countries the barriers to access are higher in the elderly over 75 years of age <sup>29</sup>.

## Conclusion

The article aimed to describe the paths taken by health systems reforms in Spain, Greece, Italy, and Portugal and analyze the main forms of health inequalities identified in these countries before and during the economic crisis of 2008, based on a systematic literature review. In the context of the European welfare state, the article provides an overall profile of the national health services in the four countries, established in the 1970s and 1980s, but still displaying some differences in their criteria for access, equity, and financing. Economic crisis and austerity policies increased the dissatisfaction with healthcare provision in all the countries, particularly Greece and Portugal. The crisis sparked a drastic cutback in public spending in Greece, a significant decline in Portugal, a perceptible contraction in Spain, and a moderate reduction in Italy.

Such developments have obviously increased the inequality in health due to individuals' differential ability to take out private insurance and complementary health plans on the market. In the four countries, the social gradient (particularly in education, income, and work status) is the principal determinant factor in health inequalities. Another critical issue in the four countries involves geographic inequalities in access to health services as the result of different levels of economic development in the various regions.

One question we sought to examine, and that has received little attention in the international literature, involves the potential inequalities generated by health systems reforms and the austerity policies still under way.

The recent debate in the international literature has focused on the relationship between different welfare state regimes and health inequalities. The use of welfare state typologies as a determinant of health and health inequalities has been criticized for overshadowing important differences in economic and social policies between the welfare states.

Finally, the findings presented here should be viewed as preliminary results of a research in progress. The characteristics and specificities of the reforms adopted by the countries of Southern Europe during this period of financial turmoil call for further studies and new analytical perspectives. Future studies based on systematic literature reviews should allow reaching even more solid conclusions on the impact of such austerity policies on health systems and social inequalities in health.

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## Resumo

O presente artigo versa sobre a questão das desigualdades de saúde nos países do Sul da Europa, mais especificamente Espanha, Grécia, Itália e Portugal. O estudo resultou de uma revisão não sistemática da literatura, baseando-se na proposta da scoping review. Inicialmente, é apresentada uma breve contextualização dos estados de bem-estar social desses países do Sul da Europa, destacando as principais especificidades e diferenças em relação a outros regimes europeus de bem-estar social. Em seguida, são descritos os sistemas de saúde dos quatro países, ressaltando os respectivos processos de reforma e as principais desigualdades de saúde que os tem caracterizado, antes e durante a crise econômica. A crise e as políticas de austeridade aumentaram muito a insatisfação com a prestação de cuidados de saúde, nesses países, particularmente na Grécia e em Portugal. Nesse sentido, são discutidas, comparativamente, as desigualdades de saúde, evidenciando as tendências comuns, assim como as diversidades. Nos quatro países em análise, o gradiente social (em particular educação, rendimento e condição laboral) representa o principal fator determinante das desigualdades de saúde, sem subestimar, contudo, as desigualdades geográficas no acesso aos serviços de saúde, como resultado dos diferentes níveis de desenvolvimento econômico das diversas regiões. Finalmente, é discutido o recente debate, presente na literatura internacional, sobre a relação entre diferentes regimes de estado de bem-estar e desigualdades de saúde e, precisamente, sobre a crítica ao uso de tipologias de estado de bem-estar como determinante de saúde e de desigualdades de saúde.

*Desigualdades em Saúde; Sistemas de Saúde; Recessão Econômica; Seguridade Social*

## Resumen

El presente artículo aborda la cuestión de las desigualdades en los sistemas de salud en los países del sur de Europa, específicamente España, Grecia, Italia y Portugal. El estudio resultó de una revisión no sistemática de la literatura, basada en la propuesta de la scoping review. Comenzamos presentando una breve contextualización de los sistemas del estado de bienestar social en estos países europeos, destacando las principales especificidades y diferencias en relación con otros sistemas europeos del estado de bienestar. A continuación se describen los sistemas de salud en los cuatro países, destacando los respectivos procesos de reforma y las principales desigualdades de salud que los han caracterizado antes y durante la crisis económica. La crisis y las políticas de austeridad han aumentado considerablemente el grado de insatisfacción con la prestación de asistencia sanitaria en estos países, en particular en Grecia y Portugal. En este sentido, realizamos una discusión comparativa de las desigualdades en salud, identificando tendencias y diferencias comunes. En los cuatro países, el gradiente social (particularmente en educación, ingreso y trabajo) representa el principal determinante de las desigualdades en salud, sin descartar desigualdades geográficas en el acceso a los servicios de salud como resultado de diferentes niveles de desarrollo económico en las distintas regiones. Finalmente, se discute el reciente debate en la literatura internacional sobre la relación entre los distintos sistemas del estado de bienestar y las desigualdades en salud, y precisamente la crítica al uso de las tipologías del estado de bienestar como determinantes de la salud y las desigualdades en salud.

*Desigualdades en la Salud; Sistemas de Salud; Recesión Económica; Bienestar Social*

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