DYNAMICS OF THE WELFARE MIX IN SOUTH EUROPE[1]

A. Guillen *(University of Oviedo)* **& M. Petmesidou** *(Democritus University of Thrace)*

1. Introduction: the context of change

This paper examines the changes in the public-private mix in South Europe in the context of European integration. In the expanding literature on Mediterranean welfare over the last decade, many of the shared characteristics of social protection in Italy, Spain, Portugal and Greece are extensively emphasised, as for instance the "delayed" development of welfare state arrangements in these countries, compared to North-West Europe, the key-role of the family/household as a clearing institution for the redistribution of resources, a transfer-heavy social budget with a strong pension bias, an excessive burden placed on women for service provision, and a fragmented and emergency-driven social assistance leaving many of the needy groups unprotected.[2]

South European countries (SE) experienced an expansionary phase of social welfare over much of the 1980s, but soon faced serious fiscal constraints that became even more pressing when these countries embarked on the project to join the European Monetary Union. This considerably stalled the welfare state expansion trends of the 1980s and called for comprehensive social reforms across the board. In this endeavour a common language for institutional change and policy reform embracing guidelines, strategic options, benchmarking and other performance criteria, formed in the various fields of co-ordinated European strategies (e.g. equal opportunities, employment policy and social inclusion, pensions and health), deeply affected the research and policy agenda in all four countries. Nevertheless, we observe significant differences as to how each country responded to Europeanization so far. Different starting points, socio-cultural patterns, institutional structures and reform capacities account for a variety of responses, ranging from a more formalistic absorption process observed in Greece to more profound (though at a differing pace) changes in Italy, Spain and Portugal.

Put briefly, reform efforts and policy options at both the EU and national levels tend to prioritise: the balancing of social expenditure to economic efficiency goals (as reflected, for instance, in the Lisbon Strategy and the OECD policy options); spending constraint linked to the introduction of managed competition in various policy areas; tight performance management methods and the rise of new regulatory practices that monitor target achievement, cost-efficiency and quality of services, under a condition of

---

[1] A slightly different version of this paper is going to be published in a collective volume on *"Welfare State Transformations"* edited by M. Seeleib-Kaiser.

[2] Space limitations do not allow us to consider the geographical and other dimensions on which South Europe as "a family of nations" can be defined. Here we refer to the Iberian peninsula, Italy and Greece. Yet, in a more detailed demarcation of the European South, South France might be included too, as well as the new EU member countries - Cyprus and Malta. Importantly, too, the "new democracies" of the Balkan peninsula (including Turkey) constitute a distinctive area within the European South. Together with Greece, they share a historical tradition of strong statist features and a record of weak of civil society and collective solidarity, characteristics that strongly impact upon welfare patterns, distinguishing the Balkan area from the so-called Latin Rim countries (Italy, Spain and Portugal) (Petmesidou, 1996 & Petmesidou and Papatheodorou, 2006).

permanent austerity (among others see Vincent-Jones, 2000; Pierson, 2001; Taylor-Gooby, 2001; Esping-Andersen et al., 2002; Goodship et al., 2004). Of crucial importance in this new policy configuration is the general trend towards activation (i.e. mobilisation of individuals into paid work), an option that brings into stark relief the shift from redistribution to an "investment-oriented" policy vision.[3] The Lisbon agenda largely reflects these strategic directions for a "modernizing redesign" of European welfare states, that takes into account increased competition and growing market finance of the economy. It underlines the importance of human resource investment and the fostering of inclusion and social cohesion that become all the more crucial as present economic growth patterns are accompanied by intensifying inequalities.

SE countries face pressures and challenges by the new problem constellations shared by most European countries (i.e. new risks and welfare demands, demographic changes and economic constraints destabilizing social welfare). In this respect, they are significantly influenced by the options, visions, and practices promoted by the EU social and employment policy agenda. Yet, given the delayed development of a welfare state and the persistence of serious imbalances and considerable unmet need, reform in South Europe needs equally to further develop and rationalize social protection. The more so, as the sustainability of the well-trodden pattern of interaction between public transfers and welfare support from the family is increasingly becoming all the more difficult because of the excessive welfare burden placed on the family and particularly on women (Moreno, 2004 & Saraceno, 2006).

Obviously, over the 1990s, fiscal pressures from the ERM and the core convergence criteria of the Maastricht Treaty (stipulating a downward trend of inflation, public deficits and debts) were a major policy concern for all four countries. Meeting these macro-economic requirements, however, meant more than a recasting of public expenditure. Indeed in this venture governments found an opportunity for structural changes and sought, with more or less success, the consent of social partners on coordinate reforms in a range of interdependent fields (industrial relations, pensions, social assistance and health care). To one degree or another, this facilitated the introduction of new modes of labour market and social policy governance and more or less improved institutional and administrative capacities. Italy stands out in respect to its potential for promoting social agreements on structural reform that emerged as a combined effect of European integration dynamics and internal socio-political (national and sub-national) pressures during the 1990s.[4] In Portugal and Spain too negotiated agreements have been important vehicles of reform. Though the scope, content, time sequencing and innovation potential of such agreements differ in each country. Furthermore, in Italy and Spain, Europeanization runs parallel to an enhancement of multilevel governance through decentralization and a wider distribution of power among institutions at various jurisdictions, national, regional and local.

---

[3] This supports investments in human capital and skills acquisition in parallel with an explicit attention to early childhood services and other family-friendly policies through a re-mixing of public-private provision (Jenson and Saint-Martin, 2006). It also reconfigures citizenship as contract (Castel, 2003)

[4] In the early 1990s Italy faced a serious economic and political crisis. The corruption scandals triggered drastic changes in the party-political landscape. The "technocratic" governments that were formed pushed through significant changes that led to a more complex and integrated mode of governance between public and private bodies. These conditions also facilitated the emergences of negotiated change processes between the socials partners (see Ferrera and Gualmini, 2004; Radaelli & Franchino, 2004).

In Greece influence from the EU has been strong, though ambivalent. Fiscal constraints and an emerging supranational field of policy regulation significantly affected objectives and priorities. However, in contrast to the other SE countries in which Europeanization triggered off (and legitimised) a rationalization process involving significant changes in the social protection system (see Ferrera and Gualmini, 2000 & 2004; Graziano, 2003; Guillén, Álvarez, and Adào e Silva, 2003), such effects are limited in Greece. What is more, no major platform of social concertation for radical reform has emerged that could tackle inherent distributional imbalances and bring forth administrative and policy rationalization; decentralization is proceeding very slowly (with regard to social policies and programmes); and the scope of multilevel governance is restricted. A tradition of statist-paternalistic forms of social organization -extensively discussed in the available literature (see, for instance, the contributions in Petmesidou and Mossialos, 2006)-, closely linked with highly politicized and conflictual industrial relations in this country are starkly conducive to policy stalemates and reform impasses.

It is outside our scope to delve deeply into the similarities and differences in social protection trajectories in the four countries since the time when the "delayed" welfare state development set in. To mention only that successive changes and reforms (either of an incremental or wholesale transformation mode) triggered a variable degree of combination of statist-clientelistic, corporatist, universalist and market characteristics across South Europe. They also produced different relational dynamics between public administration and private (both non-profit and for profit) organizations, in the four countries (and, in Spain and Italy, across regional jurisdictions too). This significantly increased the degree of heterogeneity of social protection systems in South Europe calling into question a "generic" reference to the South European model.

From this point of view, we briefly review major reform challenges and interventions in South Europe over the last decade or so about, in the first part of the paper. We focus primarily on Spain and Greece and to the extent possible provide comparative background information on Italy and Portugal. In the second and third part we examine funding trends and modes of regulation and delivery in respect to four major social policy areas (social security, employment policy, health and social care). We are particularly interested in how far SE countries, that considerably differ from North-west Europe in regard to historical precedents in administrative capacities, and particularly in social planning practice and machinery, have responded to increasing pressures for new regulatory and financing structures in social welfare, which are prevalent across the EU (emergence of an enabling state and decentralization of service management and delivery; encouragement of partnerships between public-private agents; and the rise of a contractual culture in the public sphere, in parallel with new modes of intervention from the centre through a host of arm's length regulators and auditors).

2. Reform trends and milestones

In all four countries an expansion of social protection (in expenditure and institutional terms) occurred in the decade of the 1980s. In Spain, Portugal and Greece significant changes in the balance of social and political powers, following the restoration of political democracy in the mid to late 1970s, largely contributed to this.

Of the main components of social protection income maintenance is of a corporatist-conservative configuration, while health care (and education) systems are organized along social democratic principles. National health services were introduced in the late 1970s and over the 1980s in all four countries, with varying success though (Guillén, 2002). Initially, social insurance was plagued by a high degree of fragmentation and polarization (particularly in Italy and Greece). Over the last two decades, however, successive reforms in all four countries (varying in scope and effectiveness) attempted to tackle fragmentation and particularism and improve administrative efficiency in social security. Correcting serious imbalances in the face of an imminent financial crisis due to rapid demographic ageing has been an imperative goal of reform efforts for a long time.

Equally important has been the strategic issue of rationalizing funding and improving accounting transparency, for instance, through a clear distinction between contributory benefits and redistributive (tax-funded) measures embracing a range of social assistance cash benefits and services (mostly health care and education), in parallel with promoting equity and efficiency. Social care, on the other hand, is a less developed policy area. Some efforts to expand and improve service provision (e.g. to families and children, elderly people and specific groups in need) has substantially increased per capita expenditure on such functions in all four countries from the 1990 to the early 2000s; yet the gap in respect to EU countries with well developed care provision systems is still considerable (Petmesidou, 2006b: 325-9). As to labour market and employment policy, a confluence of internal trends, industrial relations strategies and external influences have significantly oriented policy innovation towards liberalization and flexibilization measures, while a concern with flexicurity is varyingly incorporated in discourse and practice. In the following paragraphs we very roughly pinpoint major policy developments.

2.1 Greece's wavering responses to reform challenges

(a) Early 1990s: the neo-liberal turn

The fall of the socialist government under pressure from political and economic scandals at the end of the 1980s, and ensuing political instability during the early 1990s greatly affected social policy trends in Greece. New Democracy, that governed the country for a short spell in the early 1990s, used the fiscal crisis and the Maastricht requirements to leverage in changes along neo-liberal lines. The EMU requirements prompted consideration of privatisation (particularly of public utilities) as a primary financial tool for the public sector; a policy persistently followed to the present time. In other fields (e.g. industrial relations, employment and incomes' policy) direct government intervention in collective bargaining (a policy pursued for many decades in Greece) was eliminated, the automatic inflation indexation system for wages was abandoned and new measures were introduced supporting part-time and fixed-term employment and allowing for work time flexibility.

The deepening crisis of social security, reflected in the mounting deficit of IKA (the largest social insurance organization for private sector employees), the rapidly decreasing ratio of employed workers to pensioners, the large public debt and the fast

increasing budget deficit made a reform in the pensions field imminent. Legislation passed in the early 1990s was targeted to these fiscal problems, yet drastic changes for overcoming social insurance fragmentation were postponed. Legal provisions increased pensionable age of civil servants and minimum requirements of working days for retirement under the general scheme of IKA, raised contributions, discontinued the indexing of pensions to wages and introduced cuts in benefits for new entrants (after 1993) into the general scheme.[5] Further, eligibility criteria for invalidity benefits were tightened, without, however, the parallel strengthening of social assistance and rationalization of funding structures (so as to make transparent the boundaries and rules for contributory and tax-funded benefits). Most importantly, inequalities deepened and the number of pensioners living in poverty dramatically increased (Petmesidou 2006a: 41-5.

As to health care, less than a decade ago a major reform by the PASOK party founded a National Health System free at the point of delivery and aiming to improve equity and efficiency. Yet many provisions of the NHS founding law of 1983, such as the prospect of unification of major health social insurance funds[6], the setting up of a primary health system, the decentralization of authority and crucial aspects concerning organizational efficiency were hardly implemented. A serious lack of support by major social actors, conflicting interests within the medical community and discretionary privileges and complex ties between the public and private sector account for this. The Act 2071 of 1992, passed by the conservative government, made significant amendments to the 1983 legislation in favour of private provision: it gave the right to hospital doctors to combine part-time employment in the public sector with private practice, introduced co-payments for drugs, allowed insurance funds to contract with private clinics and diagnostic centres, introduced tax deductions for private insurance premiums and also increased per diem hospital reimbursement rates.[7] The latter measure led to soaring deficits of health insurance funds, but the law hardly touched issues of funding, perverse distribution of resources and escalating costs.

(b) The run up to the Euro and the reform agenda

The socialist party in power over the rest of the decade through to 2000s concentrated its effort to bring down inflation and achieve budget consolidation. An attempt to launch a social dialogue for strategic social reform (in spring 1997) did not bear results. In a climate of austerity, significant legislative innovations were introduced in the direction of increasing labour market liberalization and employment flexibility, while in parallel provisions were made for regulating atypical forms of work (in a flexicurity vein) and offering incentives for the regularization of informal employment. Also, for the first time, measures were set up for promoting active labour market policies. The reorganization of the public manpower agency (OAED) was announced and new legislation permitted the establishment of private placement offices.

[5] The replacement rate would decrease to 60% for main pensions and would refer to the gross earnings of the last five years (this condition was ameliorated some years later).
[6] Of which there are about thirty today.
[7] Which were kept very low by the socialist governments over the eighties, so as to discourage private investment in secondary health care.

Wage restraint and liberalization measures were balanced with some rather moderate benefit increases and provisions, particularly as the government confronted rapidly increasing unemployment over the 1990s (10.4% in 1997, 50% of which being long-term unemployment), persistently high poverty rates and a serious deterioration of income levels for a large number of elderly people. In 1996, a social assistance benefit (EKAS) and co-payment reductions for low-income pensioners were introduced in parallel with health insurance subsidies for the young and the aged (long-term) unemployed.

After renewing its term in office (in April 2000) PASOK pressed ahead with further legal reforms. In July 2000, a new ambitious proposal for an overhaul of the NHS, to be achieved within a six-year period, was announced by the Minister of Health. Two laws followed for the establishment of a health inspectors' body, and for administrative deconcentration of the NHS through the creation of sixteen regional health authorities responsible for the supervision of hospital management and health service delivery, while in parallel hospital management and administration were to be reorganized. Although initially on the agenda and widely debated, other major reform issues, such as the development of an integrated system of primary health care in urban areas and the amalgamation of health insurance funds did not succeed to be incorporated into a legislative programme. As a result equity, efficiency and cost-containment outcomes have persistently been poor (see Davaki and Mossialos, 2006), making Greece's NHS highly deficient vis-à-vis Spain and Italy, for instance. This is also the reason why private health expenditure has increased rapidly over the last decade.

Tackling the macroeconomic problems of social insurance has persistently been a pressing priority. Deteriorating demographic trends are expected to increase expenditure on pensions to a maximum level of 24.8% of GDP in Greece in 2050 (twice the rate of the expected EU-25 average). In the face of it drastic measures of benefit reduction and an increase of retirement age were proposed in spring 2001. The plan met with strong trade union opposition and the government was forced to abandon it. A new round of social dialogue began in March 2002, but this time proceeded more cautiously. Once again, legal reform embraced rather short-term ameliorations, placing doubt on the feasibility of a negotiated agreement in Greek society for a reform towards a viable and more equitable system. The main provisions of the 2002 legislation were the unification of public utilities and bank employee funds into IKA (to be enforced in a five-year time period)[8], the setting of state subsidy to IKA at 1% of GDP annually, and some adjustments in the minimum pension conditions stipulated by the 1992 insurance legislation[9]. Also, the law provided for the establishment of second pillar schemes through the creation of occupational funds that would operate on a funded basis under the control of the National Actuarial Authority.[10]

Enhancing activation and flexibilization was the aim of legislation on

[8] A thorny issue, given the fact that this unification would entail substantial curtailment of generous conditions characterizing the so-called "noble funds" of bank employees. It was considered however a crucial requirement for the privatisation and liberalization plan of successive governments in the context of EU integration.

[9] With this Act, minimum pensions will converge for all funds to 70% of pensionable income by 2017.

[10] A provision in line with directive 2003/41 of the EU for the functioning and regulation of occupational pension benefits.

employment promotion enacted in 2000. Wages for part-time workers increased by 7.5%, and an in-work benefit (for up to 12 months) to long-term unemployed, who take a part-time job (of at least 4 hours work per day), was introduced. The law redefined flexible working time arrangements in close connection with provisions for cutting down overtime work and relaxed dismissals conditions for small firms. In parallel OAED was extensively restructured. The part of the organization that remained under state control retained its main functions (strategic steering of employment and training policies, provision of unemployment and other benefits, employment promotion). A network of newly established Employment Promotion Centres (of which there are about eighty) and OAED's local employment offices (about forty) undertook to implement activation measures linked to "pathway" approaches and "individualized support" to jobseekers. Vocational training and labour market monitoring, however, were transferred to two newly established companies under private law.

(d) From 2004 to the present: the conservatives' return to power

Immediately following their electoral victory, the main concern of the conservatives focused on tackling major budgetary imbalances. In the social insurance field the government solely proceeded with enforcing previous legislation for the phasing out of a number of provisions. So far the government has been reluctant to introduce a new round of reform. In order to buy time and find a more propitious moment for an overhaul –that most probably will boost the second and third pillars of the system-, the government has recently commissioned a review of social insurance to ILO experts.[11]

In health and social care, there has been a prolific legislative production by the conservatives. Yet the changes introduced marginally touched upon structural dimensions. The emphasis is placed on some administration components of delivery (e.g. Regional Health and Social Care Authorities were renamed as Administrative Health Regions with some slight changes in their legal constitution). Recent legislation also provided for NHS hospitals and public social care organizations, that had come under the administration and control of the above regional health authorities, to switch to their previous regime as legal entities of public law having their own governing bodies (appointed by the Ministry of Health). These changes came partly as a response to criticisms of bringing NHS hospitals (and public social care organizations) under the control of regional health authorities for every administrative minutia. This is held to create serious obstacles to everyday management. However the relapse into the previous legal regime can hardly guarantee any significant results so far as no decisive changes in the funding side of the system are effected in parallel with cost ceilings and rigorous monitoring processes.

By far the most important reform in respect to the public-private mix concerns the introduction of the private finance initiative (PFI) by Law 3389 of 2005, according to which provisions are made for the private funding of construction and maintenance of social infrastructure (schools, hospitals and welfare centres).

[11] The scenario of pension costs explosion in 2050 becomes even more alarming if we take into account the comparatively low overall employment rate in Greece (60%); a condition that makes the Lisbon employment targets highly unlikely for the country to achieve by 2010.

In contrast to the other SE countries no major reform in the field of social assistance took place in Greece in the last decade. Overall cash transfers exhibit a strong "pension bias" (equally pronounced in Italy, but less so in Spain and Portugal). The few non-contributory (some of them means-tested), categorical benefits are characterized by great gaps in coverage and high fragmentation, while a minimum income scheme is lacking. The social security system is the least effective in Greece and the country exhibited the highest poverty rate (together with Portugal) from the mid-1990s to the early 2000s (see below).

As to statutory social care services they constitute a rather ailing and patchy area of policy in Greece. The analysis of disaggregated service expenditure (addressed towards families and children, the aged, the disabled and other groups in need of care) demonstrates the static condition of a highly deficient, ex-post, reactive mode of public welfare service provision (Petmesidou 2006b). A growing need for welfare service provision -prompted by demographic and family changes, fast increasing unemployment and a new problem constellation related to intensifying (mostly illegal) immigration-, in parallel with available EU funding contributed to the creation of a few new programmes (e.g. home help, daily care centres for elderly people, centres for support to people with disabilities). Supplied services focus on the most deprived and vulnerable groups, and scarcely face the challenge of opening up debate for universal, holistic and user-focused services. Systematic social services departments across first-tier local authorities have hardly developed. Equally absent is a regulatory framework for integrating public, private and voluntary provision.

In a nutshell, Greece had to meet specific wage-restraint and deficit-reduction targets in a short time period without disposing social negotiation mechanisms for managing adjustment. Piecemeal changes have been introduced mostly in line with the need for Greece to approximate its legal and policy framework to a range of hard and soft EU requirements. Adjustments made so far, however, have not added up to wholesale transformations that could substantially change the rules of the game (as happened for instance in Italy over the 1990s or in Spain in a more protracted time span) and tackle pronounced disequilibria in social welfare with roots in a tradition of paternalist and particularistic allocative practices. Needless to say such conditions favour persistent (and even growing) formal and informal privatisation (as is strongly evidenced in the field of health and social care).

2.2 Spain: a smooth, though not costless path of reform

(a) The 1990s: seeking for enhanced efficiency

What is peculiar of the Spanish case is, on the one hand, the early rationalizing reform (1985) of the pension system in comparison to the other SE countries. Besides, significant moves can be ascertained in the direction of narrowing protection gaps in the realms of family and care policies, non-contributory pensions for the elderly and the disabled, and social assistance (minimum income schemes were introduced between 1989 and 1994 at the regional level). Finally, activation measures began to be introduced in the mid 1980s.

As in all EU member states, the Maastricht Treaty initiated a totally different

context from that of the 1980s. In Spain, the public discourse changed abruptly, even though the Socialist party remained in office until 1996. Austerity challenges became even more acute because of the early 1990s economic recession and the public economic effort undertaken to finance the Universal Exhibition of Seville and the Olympic Games in Barcelona. It is hardly news that Spain did homework properly and was able to put in place a smooth and well-organized process of convergence to access the EMU, especially after 1996. However, cost-control and austerity measures left a clear mark on social policy developments.

Unemployment protection policies were the first to be reformed in 1992 in a drastic restrictive way. The minimum period of contribution required for access was expanded from six to twelve months. Payment duration was reduced and replacement rates of previous salaries were decreased. Coverage rates fell dramatically from 80.3% in 1992 to 50.7% in 1995 (Ministerio de Trabajo, 1996: 803). The need to reach the convergence criteria and internal politics account for this move. The introduction of fixed term contracts by the 1983/84 labour reform resulted in a share of over one third of all contracts being temporary in the Spanish labour market. Such a situation meant continuous entries to and exits from the labour market and peaking costs in terms of passive unemployment protection. As a consequence, the National Institute for Unemployment (INEM) went almost bankrupt and retrenchment was necessary. Expenditure growth on activation policies also slowed down for the rest of the decade (Gutiérrez and Guillén, 2000). In 2000, an active integration subsidy was created for aged long-term unemployed. Two years later, a softened version of a most controversial reform aiming at enhancing geographical mobility of workers and avoiding rejection of jobs was passed (CES, 2001 and 2003).

The 1990s also witnessed two waves of labour market flexibilization, to be added to the first wave enacted in 1983-84. The first took place in 1993-1994. Among other measures, these reforms entailed the promotion of job creation through new tax and social contribution exemptions for employers contracting young people, long-term unemployed, people aged 45 and over, and disabled persons. The measures also included the fostering of work-experience and job-training contracts, and the reduction of barriers for certain kinds of redundancies. On this occasion, and in contrast to the 1984 reform, part-time contracts were more vigorously promoted by providing them with more public subsidies (CES, 1994). The 1993 reform also included the legalization of non-profit private employment agencies, so that the National Institute of Employment lost its monopoly in job placement. The second reform round took place in 1996, under the newely elected government of the Partido Popular (PP, of conservative orientation[12]). It was the first consensual labour market reform and promoted the creation of open-ended contracts, modified part-time contracts and drastically reduced the cost of redundancies for the first time since the advent of democracy.

By the mid 1990s, worries about future sustainability of the public pension system in a context of austerity and rapid population ageing had grown so much that a parliamentary commission was appointed. After a year of activity, the commission decided that the existing system, based on intergenerational solidarity, should be kept but forwarded fifteen recommendations for reform in order to secure future viability.

[12] That gained office after fourteen years of socialist rule.

This commission came to be known as the 1995 Toledo Pact, to which both the unions and employers' associations quickly adhered. The Toledo Pact has guided the reform of pensions until present, provided it was renewed and readapted to the socio-economic context in 2003.

In line with the Toledo Pact a new agreement on rationalizing social security was reached in 1996 that turned into law the next year. Among many other measures, the rules to calculate contributory pensions were tightened once again (the first drastic reform in this direction was passed in 1985). As a counterpart, widows' and orphan's pensions were ameliorated (Chulià, 2006). Furthermore, short and/or discontinued contributory careers were allowed to have a non-proportional positive impact in the calculation of the main pension, a measure favouring workers with a high record of temporary contracts. What we can see here is a reduction of core workers rights and a (modest) amelioration of the conditions for non-core ones. More recent pension legislation (of 1999, 2001 and 2006) proceeded along similar lines (CES, 2000, 2002; CES August-September 2006), while successive social pacts further improved protection of non-core labour workers (e.g. peasants in southern Spanish regions, part-time and temporal workers).

In 1995 the average retirement pension surpassed the level of the minimum salary as a result of successive reforms of the public pension system. Presently the minimum retirement pension has reached the level of the minimum salary. Furthermore, a reserve fund was created. As for the private sector, personal plans were introduced in Spain in 1989. They have grown substantially ever since, both in terms of coverage and accumulated capital. Conversely, second tier occupational pensions have not matured much.

Health care services have followed a totally different path. By the early 1990s, the change from health insurance to universal coverage had been completed: the Spanish NHS had become a reality. However, worries about increasing expenditure were also present already from the late 1980s, as health expenditure grew rapidly in the second half of that decade. Such worries were conducive to the establishment of a parliamentary commission (Abril Committee, AC) in charge of producing recommendations for rationalization of health care expenditure and the introduction of cost control measures. The AC did produce a whole set of reform proposals but it was frontally rejected by the population because of only one of them. In particular, the AC proposed to expand the only co-payment existing in the Spanish NHS, namely, 40% of the price of drugs outside inpatient institutions, to the retired population, who are traditionally exempt from it.[13] Thus rationalization had to be put in place in a low-visibility way. The Spanish NHS was reformed in subsequent years by introducing, for example, programme-agreements and prospective funding in hospitals, broader choice of primary doctors and specialists, and some mild managed competition measures (Cabiedes and Guillén, 2001). Overall, attempted rationalizing measures have focused to date to supply-side factors, a condition that kept the level of equity unaffected. In fact, it has not been possible to introduce any co-payments up to present, which is a very peculiar trait compared to the other EU health care systems. Moreover, in 1995, a

[13] This co-payment dates from the early 1970s. Apart from pensioners and users in in-patient institutions also people suffering accidents at work are exempted from it.

list of health care services financed publicly was published. The list was more ample than in the past.

(b) Recent developments: enhancing equity and protecting dependency

The new millennium has also witnessed important changes in the Spanish welfare state. To start with, and still under conservative rule, the process of health care decentralization came to completion in late 2001, so that all seventeen Spanish autonomous regions enjoy their own health care system today. This was coupled with a new agreement on regional financing and a new statute for health professionals. In 2003, a law on Cohesion and Quality was passed aiming at securing territorial equity and quality levels in the provision of health care.

In 2002, the private pillar of pensions was reinforced by increasing tax exemptions (CES, 2003). A new major reform of the labour market has been agreed on with the social partners in May 2006. The main aim of the reform is to reduce temporality in the labour market (CES, June-July 2006).

Last but not least, two other important laws have been passed. The law on gender equality was approved in March 2007. It aims at establishing public and private equality measures for women in the employment and social security spheres, and in access to goods and services and follows closely the recommendations of the EU. Still, the most salient achievement of the recent phase of social dialogue has been the tripartite Agreement on Protection of Dependent People of late 2005. The aim of the law on Dependency is the creation of a National System of Dependency of public character and of universal coverage for all people in need of care. Implementation started in January 2007 and should be fully developed by 2014. It is of the utmost importance for the evolution of the Spanish welfare state from the point of view of establishing the fourth pillar of any well-developed social protection system at the national level. If properly implemented, it may mean the overcoming of the resilient familialism of the Spanish welfare state.

All in all, the Spanish welfare state has undergone major change. This is clearly evident in the realm of health care, where a health insurance model was transformed into a national health service. The change may not be so apparent in the field of pensions. Most international organizations reports issued by the OECD, the IMF or even the EU on the evolution of pensions in Spain talk about mere path dependency with cost-control adjustments. Nonetheless, the present Spanish pension system can hardly be compared to the one existing in the early 1980s. As shown above, changes aimed at reducing first tier pensions did take place, indeed, in two occasions. But reforms initiated in the 1980s and continued to the present clearly show a vocation of internal redistribution within the system. A trend was initiated in the mid 1990s towards enhancing the protection of non-core workers. This trend, even if incipient, should not be overlooked. Labour market policies have also experienced deep changes; the rigid labour market of Francoist times is only a vague memory today. However, the deep fragmentation of the Spanish labour market, the soaring proportion of fixed-term jobs, and the fact that it is young people and women those who are the losers is hardly a reason for rejoicing.

2.3 Bringing Portugal and Italy into the picture

To mention briefly that Portugal and Italy have also substantially benefited from social concertation processes in an attempt to confront the institutional (and financial) predicaments and gaps of their welfare states and meet the challenges of joining the EMU.

In Portugal, the Strategic Agreement of 1996 (under a socialist government that came to power after ten years of centre-right rule) constitutes a crucial landmark signposting the first medium-term pact achieved. It included issues such as incomes policy, working time regulation, tax reductions for low income-earners, expansion of unemployment protection and new tailored employment policies targeted to different social groups (Guillén, Álvarez and Adào e Silva, 2003: 258-61). Yet by far the most important measure was the introduction of a minimum income scheme at the national level in the late 1990s. It bears not only a strong symbolic role but also a paradigmatic one that enabled a path shifting movement starting in the mid 1990s (Adào e Silva, 2003).

In the early 2000s reforms introduced voluntary private pension funds with fiscal incentives[14], and cost-control measures (stricter rules for pensionable earnings, tightening of indexation rules and pension regulations so as to eliminate privileges of public employees). The aim was to secure the fiscal balance of the system at least until 2015.[15] Even if positive in terms of rationalisation, experts fear the impact of these reform measures on poverty rates among the elderly in Portugal, especially considering that the poverty rate in 2001 stood at 20.8% (poverty line defined as 60% of the country's median equivalent household income, Papatheodorou & Petmesidou, 2006: 65), a very high figure, if compared with the EU-15 average of 16%.[16]

As in Greece, the Portuguese national health care system (created in 1979) has not reached the state of a fully-fledged NHS, even though it has departed intensely from a health insurance system. Government shifts tended to bring new reforms with them, some in the direction of deepening the universal spirit of the 1979 law, some others running counter. Despite intense public financial efforts (Portugal ranks very high in the EU regarding public expenditure on health over GDP), the private sector remains broad (particularly in primary care) and several occupational categories are entitled to different packages of services (Oliveira et al., 2005). Co-payments were introduced already in the 1980s and reinforced in 1993. Compared to Spain, the Portuguese NHS did neither benefit from long periods of socialist rule nor from a process of decentralization. In fact, regional governments constituted the engine behind the universalising reforms in Spain.

In Italy the decade of the 1990s constitutes a landmark of reform both in procedural and substantive terms. For the first time, a tradition of conflictual industrial relations gave way to more consensual practices facilitating trade-offs between the social partners that considerably changed the rules of the game in policy practice.[17]

---

[14] Offering an opting-out choice from the public system for certain professional sectors such as bank employees.

[15] Pereira da Silva et al. (2006) estimate that the 2002 reform together with the stabilisation fund (amounting to 4.3% of GDP at the moment) would ensure the balance of the social security budget until 2020.

[16] In 2003, poverty slightly decreased in Portugal (19%), but the EU-15 average remained stable (Guio A.-C., 2005: 4).

[17] Taking into account internal dynamics and external pressures, in the run-up to the Europe, Ferrera and Gualmini

Faced with the prospect of an increasing fiscal imbalance, radical transformations were introduced over the last ten years on the basis of wide social negotiations. The reforms manifest an important shift away from traditional increamentalist policy. They significantly transformed the pension arrangements by tackling extreme fragmentation and high inequalities in the generosity of the system. The PAYG character of the system is retained, but it is gradually moving to a (notional) defined contribution scheme (applied fully to all entrants into the labour market from 1996).

A means-tested social pension is available for the uninsured aged people, as well as top-ups for low-income pensioners. Furthermore, proposals by a number of expert committees in the last decade stressed the need for more comprehensive, universal-type measures. Along these lines an experimental implementation of a minimum insertion income scheme (RMI) took place in the late 1990s but was discontinued when the right-wing government took office in 2001, leaving any initiative in respect to social assistance entirely to local authorities (Saraceno, 2002).

Reform of the Italian NHS (created in 1978) has been a priority for successive governments over the last decade. The goals are both to contain spending and improve the quality and efficiency of services. The course of action embraced provisions such as user charges; devolvement of powers to regional authorities; introduction of managerial criteria in the running of health care facilities; and a "governed competition" mode of steering behaviour of health care organizations (Anessi-Pessina et al., 2004).

Devolution of powers in welfare provision to the regions and municipalities was put in force in the late 1970s. Yet a comprehensive regulatory framework for decentralization was developed at the turn of the century. Since then regional (and municipal) responsibilities in areas such as health, social assistance, and even social insurance (as is the case with legislation passed in the early 2000s allowing the creation of region-specific supplementary pension funds in Italy) have been rapidly expanding, with significant, challenging effects on nationally bounded and standardized social rights (see on this issue Ferrera, 2003).

As in Spain, the increasing importance of the regional and local levels adds more complexity to the Italian welfare system, particularly as multiple variations of institutions, regulations and experimentation practices have emerged in a process of transition for local governance, that is still in progress (Natali, 2006; Bifulco & Vitale, 2006).

3. Finance and expenditure trends

3.1 General trends

In all four SE countries social protection systems are financed largely from social contributions, though there are some differences in national trends. Taxes (as a main source of social protection funding), substantially increased in Portugal and Italy from the mid-1990s to the early 2000s covering over 40% of social expenditure in 2003. In the same period, in Greece, general government funding remained stable at about 29% (well below the EU-15 average, 37%), while in Spain it slightly decreased (from 30% to

(2004) explain the changes as an occasion for Italy "to be rescued by Europe".

28%).[18]

Moreover, Portugal and Greece have relatively high shares of indirect taxes in total tax revenues among EU-15 countries (in the mid-2000s the ratio of indirect to direct taxes was 3:1 in both of these countries; while Spain and Italy exhibited a more balanced distribution, with indirect taxes only slightly surpassing direct tax revenues). In Greece revenue from personal income taxes is the lowest in the EU-15, accounting for merely 4.8% of GDP in 2004 (the corresponding rates for Spain, Italy and Portugal being 6.4, 10.4 and 5.5). Also, the Greek local government levies only 0.3% of GDP in taxes; a feature that exhibited no marked change over the last decade and starkly contrasts Greece to Spain and Italy.[19]

Expenditure trends also differ among SE welfare states, measured both as a percentage over GDP and in per capita terms. As a percentage of GDP, while the EU-15 average clearly reflects the impact of the austerity era and falls moderately from 1993 to 2000 to recover slightly again, it is only Italy that shows a somewhat similar pattern, though decrease in the 1990s is more pronounced than for the average. In Portugal, growth is spectacular, with only a reversal of the trend during the second half of the 1990s. Greece also grows very significantly although departing from higher levels. Spain is the only case in which a pronounced decrease occurs and stays, so that the levels of expenditure of 1993 fail to be recovered in 2000s (see table 1). In per capita terms (as per cent of the EU-15 average, in PPS, figure 1), one can ascertain the pronounced impact of austerity in Italy and Greece and less so in Spain. Conversely, such an impact is not visible in Portugal. What is important to stress, however, is that SE countries markedly under spend in social protection in relation to their wealth (in 2004, GDP per capita amounted to 75 per cent of the EU-15 average in Greece, but per capita social expenditure reached only 67 per cent of the EU-15 average[20]; similarly in Italy the corresponding figures were 95 and 87 per cent, in Spain 89 and 61 per cent and in Portugal 66 and 56 per cent).

By function, as a percentage over total social expenditure, SE welfare states concentrate expenditure on old age and health care, at the expense of family policies and unemployment (with the exception of Spain in this latter case). As figures 2a and 2b show, such bias (in comparison with the EU-15 average) has not been significantly corrected from 1993 to 2004. However, in 2004, Greece reduced the gap in old age with the EU average (Italy did not). Spain also reduced its peaking expenditure on unemployment and was closer to the average.

3.2 Social security

In general, in SE countries, pensions are extensively based on the public pillar.

[18] This entails a certain degree of contradiction. In fact, one of the major moves in finance patterns in Spain has consisted in the so-called separation of financial sources mentioned earlier. Such separation was agreed on the Toledo Pact of 1995. The idea is that contributory economic transfers are to be financed out of social contributions, while non-contributory transfers and welfare services (health, education, care) should be financed out of general revenues. The separation has been almost completed.

[19] Other pronounced features for Greece are: the complexity of tax laws because of continuous and piecemeal revisions and amendments that render the system chaotic; the numerous loopholes for tax allowances, exemptions and preferential conditions; the large size of an untaxed informal economy and the absence of a strong and uniform tax enforcement mechanism keeping tax compliance low (OECD, 2001).

[20] Both figures are measured in Purchasing Power Standards (PPS).

Major problems arise in respect to the adequacy and sustainability of the Greek pension system. Particularly as it is the most fragmented system, in South Europe, riven by extensive inequalities among the numerous schemes for main and auxiliary pensions, lump sums and assistance benefits, with different rules, contribution rates, level of provisions and state subsidies. Theoretically the system provides a very generous average gross replacement rate (to be reduced though for entrants after 1993). Yet this can barely be realized due to considerable contributions evasion practised by firms as well as by individuals because of strong disincentives built into the system and a tendency among the self-employed to underreport their income in order to pay fewer contributions. Consequently a large number of pensioners receive very low pensions.[21]

Conversely, in Spain, the reforms guided by the Toledo Pact of 1995, and its renewal in 2003, have had a positive impact on the future viability of the first pillar. The stabilization fund has come to amount to 40,334 Euros in March 2007 (*El Mundo*, 1 March 2007, p. 45). This will allow the system to run without deficits until 2020 (CES, 2006: 591-92). Besides, the separation of financial sources (social contributions only devoted to contributory benefits) and intense immigration, together with employment growth, played a prominent role in balancing the accounts of social security in Spain in the last six to eight years, so that surpluses and the amelioration of the dependency ratio are more than significant (Rodríguez Cabrero, 2004).

Adequacy of minimum pension benefits is low in Greece, given the high rate of poverty among pensioners and particularly among old-age women: in 2001 the poverty rate stood at 30.2% among households whose head was a pensioner, and 33.0% among old-aged women living alone, compared to a national average poverty rate of 21.8% (Papatheodorou & Petmesidou 2006: 70-2). Equally high is poverty among pensioners in Portugal: in 2001 the corresponding rates were: 24.2% for households headed by a retired person, 37.7% for old-aged women; national average poverty rate 20.8%. On the other hand, in Italy and Spain, due to substantial reforms in pensions and the broader field of social security over the 1990s (including the introduction and/or coordination/rationalization of various non-contributory benefits for the elderly and the disabled), poverty rates among the elderly were considerably lower (13.4% and 20.7% respectively among households headed by a retired person; the corresponding national rates being 19.1% and 17.2%, ibid.).

The second pillar (occupational pensions) has scarcely developed so far in Greece. It currently amounts to a little less than 0.3% of GDP. The same applies to Portugal and Spain. Conversely, the corresponding rate for Italy is 8% of GDP.[22] It is rather difficult to assess the importance of individual retirement savings in SE countries as these take different forms. Voluntary (third pillar) pensions are provided by the life insurance industry in Greece. Life insurance is not much developed in all four countries, while other forms of saving tend to be more important (only 8% of savings concern life insurance in Italy and 10% in Spain, while mutual bonds and direct equity cover 70%

[21] On the basis of data offered by the Association of Employees in Social Protection Services, in 2005 roughly about two thirds of pensioners (excluding peasants) received a pension equal to 500 euros or less, to which a social assistance benefit of up to 149 euros was added (http://www.popokp.gr/deltia_typou/syntakseis2005.html); the latter increased to 195 euros in 2007.

[22] A major reform of occupational pensions took place in 1993 in Italy, while in 2004 further tax advantages were provided particularly in the case where employees transfer their annual contribution from the state severance pay fund (TRF) to an occupational pension fund.

and 49% of savings in these two countries respectively, Association of British Insurers, 2004: 13). Moreover, personal pension products, e.g. funded pensions (based on the EET[23] model, as for instance this has developed in the UK) have only recently been introduced in Spain and Italy and are absent in Greece and Portugal (ibid.: 12). As to life-insurance schemes, lump sums are preferred to annuity benefits in all four SE countries.

The percentage of the working population contributing to personal pensions ranges from about 2% or less in Italy, Portugal and Greece to about 22% in Spain (Association of British Insurers, 2006: 13). In Greece total premiums stood at 2.14% of GDP in 1999, they slightly decreased in the next two years, but have been increasing afterwards reaching 2.17% in 2005 (EU-25 average being 8.5% in 2005; Association of Greek Insurance Companies, 2006: 13-4). Fast expansion trends of the life insurance industry are observed lately in all four countries: between 2004 and 2005, total life premiums increased in real terms by 8.1% in Greece and 9.7% in Italy (well above the EU-25 average, 6.5%), while Portugal exhibited an astonishing rate of 43.1% (European Insurance & Reinsurance Federation, 2006: 29). It is most likely that demand for private pension savings in SE countries will further grow in the future. This, however, very much depends on prospective pension reform in each country and the extent to which this may entail substantial cuts in the state-managed PAYG system, the fiscal conditions concerning long-term and medium-term savings products and tax incentives.

3.3 Health

Health expenditure as a proportion of GDP rose steadily from 6.6 % in 1980 to 10% in 2004, in Greece. This latter country, together with Portugal, spends more on health care than Italy and Spain (8% and 8.7% respectively, see table 2). Greece stands out, however, as regards private health expenditure. This rose from 2.9% of GDP in 1980 to approximately 5% in 2004, while in the other three countries private expenditure ranged between 2.2% to 2.7% of GDP. What is more, private expenditure in Greece is primarily constituted by out-of-pocket payments (roughly about 96% of total private health expenditure or 46% of total health care financing). On the basis of this characteristic, Greece ranks first among EU-15 countries, and third after the US and Mexico among OECD countries.[24]

Furthermore, as table 2 shows, between 1990 and 2004, private health expenditure per head (in US$ Purchasing Power Parities) increased more rapidly than public health expenditure particularly in Spain, Italy and Greece, while in Portugal public expenditure per capita almost doubled. Private expenditure over total health expenditure (figure 3) has grown in Italy during the 1990s to decrease in 2000s. It has also grown in Spain, not dramatically, but the trend has not been reversed in 2000s. Contrarily, the proportion of private expenditure has fallen most intensely in Portugal

Figure 4 depicts the differences in the financing mix of health care systems. In

[23] Contributions Tax-**E**xempt (E), Investment Growth Tax-**E**xempt (E), **T**axation of benefits (T).

[24] The household expenditure data aptly illustrate this point. Expenditure on health rapidly increased over the last two decades: from 5.7% of total household expenditure in 1993/94 to 7.2% in 2004/05 (of this, two-thirds concern direct payments to physicians and the rest drugs expenditure, including co-payments, and hospital care; data from the National Statistical Service of Greece).

2004, in Greece a little over 20% of total health expenditure was financed by taxation (with indirect taxes accounting for a large part of it). In the other three countries taxation covered more than two thirds of health expenditure. In Greece, out-of-pocket payments account for 46% of expenditure; the proportion is much lower in the other three countries. To mention also that extensive reliance on out-of-pocket payments and indirect taxes makes the system highly regressive in Greece. Social insurance contributions are an equally important source of funding (29.5%) in Greece, but are negligible particularly in Italy and Portugal. In Spain, the separation of financing sources began to be implemented in 1998. The aim is to finance health care services fully out of taxes, so that the process is close to completion but still under way.

3.4 Labour market policies (LMPs)

In Greece public expenditure on labour market policies as per cent of GDP is the lowest among EU-15 countries (0.5% in 2003). Equally low is per capita expenditure measured in US$ PPP (figure 5), and the gap with high spending countries in the EU (e.g. Sweden) is still large. On the other hand, Greece exhibits the highest share of passive measures in total LMP expenditure among the four countries; this share further increased from the late 1990s to the early 2000s (from 70% to 79%). What is more, expenditure on active labour market policies in real terms (per capita) declined by an annual average of about 10% from 1998 to 2003, while compensation/support of unemployed persons slightly increased in real terms (per capita) by a yearly average rate of 0.15%. Over this period unemployment was persistently high and of a long-term duration. In the other SE countries, activation measures seem to have acquired a more prominent role: annual average growth in expenditure on such measures (in real terms per capita) amounted to 6% in Spain and about 10% in Italy and Portugal between 1998 and 2003. Among the four SE countries, Italy exhibited the highest share for active labour market policies in the early 2000s (52% of total LMP expenditure).

As to the composition of active LMP expenditure, we observe the following trends in the late 1990s – early 2000s. In Greece training measures declined in importance and accounted for 29% in 2003, employment incentives stood at 16%, integration of the disabled at 20%, while a comparatively large share (35%) concerned start-up incentives (due mostly to the high percentage of self-employed in the labour force, 25.5% in 2006). In the other three countries employment incentives and training measures accounted for the largest share (63% in Spain, 87% in Italy and 82% in Portugal). Undoubtedly, the resources for training courses and employment subsidies have increased in the last decade in all four countries, due to the assistance by the EU structural funds, while the European Employment Strategy guidelines have set specific priorities in these countries that lacked an indigenous planning dynamics. Particularly in Greece, given the paucity of national resources for employment policy, the total budget is still meagre as are also the policy outcomes so far (very low activity rates, particularly for women and people aged between 55 and 64, comparatively high unemployment, mostly for women and the young, and alarmingly high long-term unemployment).

Briefly, fiscal reforms in SE countries have persistently been confronted with a difficult balancing task: to implement austerity measures and, at the same time, try to rationalize and reconfigure revenue and social expenditure structures, as well as secure

resources for coverage expansion, given considerable unmet need due to serious gaps in the protection of old and new risks. Judging from the persistently high poverty rates in Greece and Portugal reform trajectories seem to have been wanting so far. Contained optimism could be expressed for the other two countries though.

4. Delivery and regulation

Over the last fifteen years, significant reforms to expand the scope, accessibility and universality of welfare services in SE countries were more or less accompanied by attempts to reform delivery and regulation of services (among others, see Capano, 2003; Torres & Pina, 2004; Ongaro, 2006; Tavares & Alves, 2007; and Borghi & van Berkel, 2007). Change dynamics reflect concerns of new governance strategies (i.e. decentralization, contracting-out, networking and introduction of New Public Management techniques in the public sector). Yet, as extensively documented in the relevant literature, such concerns were persistently filtered by the "legalistic administrative culture", that traditionally characterized SE countries, as well as by a host of specific socio-political and cultural factors.

To mention briefly that, in Italy and Spain, devolution and reforms in a "federalist" orientation aimed to respond to a particular configuration of politico-historical demands by some regions, rather than being propelled primarily by efficiency and flexibility concerns as, for instance in the UK and other Anglo-Saxon countries (Torres & Pina, 2004: 452-3). Also, in South Europe, more often than not, the involvement of non-state actors in welfare delivery is sought as a solution to poor (or absent) public provision, in certain areas, rather than as a reaction to "too much state involvement" in social welfare (Borghi & van Berkel, 2007: 99), as is the case in most North European countries.

Furthermore, of crucial importance for the effective implementation of new governance techniques is the availability of institutional capacities and resources promoting bureaucratic entrepreneurship, managerial autonomy and accountability in policy processes. Reforms along these lines, however, have followed a slow and frequently cumbersome path in SE. The legalistic administrative tradition largely accounts for this, limiting considerably the public sector capacities for implementing strategic management, evaluation and systems' control mechanisms. These conditions constitute a common background, against which, however, different configurations of organization and delivery patterns in each country is recorded. In addition, devolution of welfare services, in Italy and Spain, increases opportunities for innovative strategies in response to different regional contexts and capacities. To stress also here, that some important ingredients of new governance, particularly the separation of politics from administration/execution, accompanied by the proliferation of independent bodies overseeing and auditing service outcomes, have only partly been introduced in SE countries. Although a host of independent bodies and agencies operate in these countries, as indicated in our analysis, these only marginally function with a clear mandate to scrutinize policy results and performance. Besides, as is starkly put into relief by the Greek case, expanding private provision (e.g. in health and social care) may not be matched by increasing public regulation and control. Equally in Spain, nationwide monitoring and evaluation procedures have not developed systematically;

and this condition seriously limits benchmarking and performance measurement in most welfare sectors (Torres & Pina, 2004: 454-5).

4.1 Social security

In Spain devolution of welfare services to regional governments has gone furthest among SE countries. Yet the contributory income-maintenance system has remained in the hands of the central state.[25] The system is managed by a single institution (the National Institute of Social Security, INSS) whose Treasury is in charge of collecting all social contributions. The Spanish pension system has undergone a significant process of reduction of its complexity. Numerous new insurance funds ("special regimes") were incorporated until the early 1980s with the aim of closing coverage gaps. However, from then onwards a trend towards convergence among funds together with a very substantial reduction of the number of funds has been the norm. Presently, the Spanish Social Security is split between seven funds (general regime, autonomous workers, agrarian workers, miners, seamen, household service and labour accidents). Existing negative differentials in access rules and provisions for the self-employed are being upgraded by a law project, currently in parliament. As noted above, both the second and third pillars have undergone substantial development. This has been due to two reasons. The first is related to the enactment of the restrictive reforms of 1985 and 1997, both reducing the replacement rate. The second consists of the introduction of fiscal exemptions for the creation of personal pension schemes, already in force since the late 1980s, intensified in the late 1990s and again in 2003.

Contrarily, in Greece the state pension system is made up of approximately one hundred thirty social insurance funds operating on the basis of labyrinthine rules and great differentials in provisions. They constitute self-governing bodies managed by representatives of employees, employers and the state, while the Ministry of Labour and Social Solidarity provides general supervision. On the basis of recent legislation only four (second pillar) occupational funds have so far been established. They are run by the social partners on the basis of capitalization. The National Actuarial Body has monitoring and control powers over them. As in the other SE countries, the expansion of funded occupational and personal pension schemes very much depends on the extent of generosity of the public system in the future. Moreover, closer integration of insurance markets in the EU will also impact upon personal pension savings.

4.2 Health and social care

Health care is organized along the lines of a national health service in Spain, decentralized at the regional level. The system departs from the characteristics of a national health service from the point of view that coverage has become universal but it is not as yet recognized as a citizenship right. In fact, insurance (or poverty) constitutes still the criterion for access. Furthermore, public servants may benefit either from public or private provision, at their own choice, in both cases publicly financed, while the rest of the population cannot make such a choice. Some 200,000 people belonging to the highest income bracket remain outside the system.

[25] Non-contributory disability and retirement pensions are the responsibility of regional governments.

Devolution of health powers to regions began in 1981, so that seven regions had gained them at the end of the 1990s. Decentralization to the ten remaining regions was completed in 2002. Devolution has entailed a very agile process of innovation. Most regions directly manage service delivery; while others rely on indirect or "contractual" management systems where service providers are allocated a package of resources in a way that resemble a capitation formula (in some regions –e.g. Catalonia-, both models are in force). All doctors are state salaried employees and patients are referred to higher levels of care by primary doctors (gate-keeping). A positive list of services financed publicly was established in 1995, but regions may add services to the list. National health surveys are conducted on a regular basis for monitoring performance, and quality differentials are kept low. Still, some system imbalances may be ascertained. While Spain counts on one of the best transplant systems of the world, dental care (other than extractions) is not included among public health services and psychiatric care shows deficiencies in terms of access and coordination. The existence of long waiting lists constitutes another negative aspect and it is most probably one of the main causes of the increase of private expenditure in the late 1990s.[26] Deceleration of public health expenditure growth in the 1990s may well cause problems in the near future because of its negative impact on the incorporation of the latest technologies. Improvements in management, increased patients' choice, and cost control measures on health care services and drugs were introduced in the 1990s and 2000s, with limited success in the case of controlling expenditure on pharmaceuticals. However, as mentioned earlier, no new co-payment was created.

Greece starkly contrasts to Spain. A noticeably mixed system of service delivery by public and private providers characterizes both primary and secondary health care. Primary care is largely provided by private physicians. Most primary care doctors are specialists. There are very few GPs in the country and a gate-keeping system is absent. Within the public sector, IKA runs primary health centres (about one hundred) for its insured population. Physicians in IKA health centres are salaried staff, but they can pursue private practice as well. Other social insurance funds contract physicians (on a fee-for-service basis)[27] for primary health consultation. Primary care is also provided in the outpatient departments of hospitals, the 1000 rural health posts and the 200 semi-urban and rural health centres.

Successive reforms of the NHS (including the establishment of regional health administrations) hardly brought about any significant changes in delivery and regulation, as the fragmentation among purchasers and the issue of effectively regulating transactions were not tackled. On the other hand, the private health market is steadily growing. Health insurance funds, the NHS and life insurance firms purchase a wide range of services from private providers either by fee-per-item or per diem. Also, most non-core services (e.g. catering, laundry, maintenance and security) of the NHS are outsourced to private suppliers. Patients, under the social insurance schemes can choose a public or private contracted hospital.

What is more, the private sector comprises the largest part of new medical

[26] Also private insurance has grown from 3% of total health expenditure in 1993 to 4.3% in 2004 (OECD, 2006).
[27] Except of OAEE (the Social Insurance Fund for the Self-Employed, excluding the professions), which pays its contracted doctors on a capitation basis

technologies of the system (84.4% of radiology laboratories and 74.7% of nuclear medicine laboratories, Davaki & Mossialos, 2006: 297). High technology services required by NHS patients or the health insurance funds are largely purchased from private providers on a contractual basis. These transactions, however, are not systematically monitored and controlled and, most importantly, they foment discretionary privileges and complex ties between the two sectors. Consequently, waste of resources, inflated demand and low efficiency are the major predicaments of the system.[28]

As for hospital performance monitoring, only very crude indicators of process outcomes are available (e.g. length of stay, occupancy rate and admission rate). There is no systematic mapping out of the population health condition and Greece hardly figures in relevant international statistics. Health information systems are very slowly being introduced and the inadequacy of available information is reflected in incomplete medical records, absence of quality assessing techniques and reporting methods on resources and outcomes of care, as well as of measures for cost-effective prescribing (ibid: 294-8). In an effort to contain pharmaceutical costs, co-payments were introduced in the early 1990s and a positive list of drugs in the end of the decade. Yet the list was abandoned recently, on the ground that no substantial cost reduction was achieved.

In respect to social care, both in Greece and in Spain, widespread and uniform provision of first-stop systematic services addressed to all the population has scarcely developed. The only difference lies in the fact that social care is in the hands of regional (and also local) governments in Spain, which has enhanced expansion and innovation but has also increased territorial heterogeneity of provision in the absence of basic national legislation[29]. There has been a clear expansion of such services in both countries, but, similarly to the other SE countries, provision departed from comparatively very low levels. Intervention when problems are compounded often leads to institutionalization with dubious results; not to mention the serious deficiencies in institutional settings due to lack of resources. Particularly wanting is preventative work as well as prompt response to crisis situations for supporting families, lone elderly people (as well as persons with long-term disabilities) in the community (Petmesidou, 2006b; Rodríguez Cabrero, 2004).

To the extent that care services have been expanding in the last few years there is a great diversity of programmes (and modes of co-operation) across public and private for-profit and non-profit institutions, with most action depending on initiatives by local political personalities and councils, in parallel with the degree of activity of communities, NGOs and other local actors. Furthermore, EU-wide policy orientations, such as the reconciliation of family and work and encouraging women to work, have guided most recent policy measures, largely funded under the CSFs (e.g. establishment

[28] A draft law currently under discussion in the Parliament aims to introduce a new regulatory framework for NHS procurements. Roughly about 9000 tenders take place within the NHS yearly by about 290 different bodies, for the procurement of 500,000 items of medical technology and 11,000 types of pharmaceuticals, while providers amount to over one thousand Greek and foreign firms. Proposed legislation intends to develop a more integrated and better-monitored system. Given the absence of cost ceilings, the yearly budget for medical technology and other procurements by NHS hospitals is always in deficit (e.g. in the last year total purchases amounted to 2.5 billion euros, compared to a budget initially set at 1.5 billion).

[29] Similar trends characterize Italy as well (see Bifulco & Vitale, 2006 for significant differences in the regulatory mix concerning social care services in a northern and southern region of Italy).

of day-long schools and centres of creative activities for children during their off school ours, day care centres for frail elderly people, as well as centres for early diagnosis, counselling, support, education and training of disabled people). Particularly in Spain, the recent laws aimed at protecting dependent people and enhancing gender equality may hopefully change the situation in the near future.

Long-term care provision is of a mixed type too in both countries. Social insurance funds exhibit high inequalities as to the range and quality of services offered in Greece. For instance, IKA provides therapeutic care in contracted private clinics for the chronically ill. Yet, per diem cost is kept low and the quality of services deficient. Thus, extra care needs to be provided by the patient's family or by privately (often informally) paid nurses. The situation is not very different in Spain, with the exception of some regions were specific programmes have been developed.

Notwithstanding excessive strains, the family continues to be the main provider of care in South Europe. Over the last decade or so, a rapidly expanding informal market is witnessed in these countries. Increasing demand for care services, due to changing family patterns and growing female employment rates, combined with demographic ageing and a steadily increasing number of lone elderly people, is met by female migrant labour (either as co-residing or day-care minders). Thus a mode of informal privatisation in care arrangements is emerging where the family still plays a coordinating role but care tasks are undertaken by foreign minders. To this has significantly contributed the arrival, in SE, of large numbers of female immigrants (legal or illegal) from the former Eastern bloc since the late 1980s. Particularly in Italy and Greece it is mostly female migrant workers from Albania, Bulgaria, Poland and Romania[30] that constitute a cheap care labour reserve (Bettio et al., 2006; Cavounidis, 2006). In Spain, foreign minders are mainly women migrants from Latin America. Equity concerns and the sustainability of such care arrangements raise serious questions. The more so as statutory care remains patchy and no major foci of specialized care development, regulation and coordination are formed.

4.3 Employment policy

EU influence on national structures in respect to employment policy is significant. Transformations have affected particularly the organization and delivery of employment services and vocational training. Given the fact that these two policy sectors have been, for a long time, at the centre of various EU directives and rules (as well as of actions by the European Court of Justice), they constitute areas in which more or less extensive transformations (through legal reforms) have taken place in SE countries, in order for them to adapt to EU requirements. Equally important is the issue of flexibilization that to one degree or another informs policy choices in these countries. On the other hand, adaptation to the European Employment Strategy flagships of "employability" and "activation" has taken place in a softer mode of gradual accommodation of such policy orientations within national rhetoric and practice.

The recasting of national employment service frameworks facilitated a mixed model of service delivery by public and private providers in all four countries. In

[30] For Greece we should also add the ethnic-Greek repatriates from the ex-USSR and Albania.

Greece, the restructuring of the Public Manpower Organization in the early 2000s signalled a transformation (in the direction of liberalization) in service delivery, largely instigated by EU priorities and the need to manage in a more effective way EU funding for employment promotion and social inclusion. In parallel, private employment agencies increased. To this contributed also legislation passed in the early 2000s that eased conditions for companies to "lease" workers for short periods from temporary employment agencies.[31]

In Spain, private non-profit employment agencies were allowed to function in 1994, but they have not proliferated. Private non-profit temporary employment agencies (ETTs) were introduced in 1985, shortly after the first wave of labour market flexibilization. Their number grew steadily until the end of the 1990s (410 in 1999) to decrease again (341 in 2004). In 2004, ETTs managed 14.6% of all fixed-term contracts. The success of ETTs is probably based on their ability for rapid response, which the public system of intermediation tends to lack (CES, May 2005). Overall, intermediation in job finding is still underdeveloped in both Spain and Greece. Legal-administrative limitations and deficiencies in public placement services and a not fully-fledged non-state sector account for this. As a result, informal contacts and relational capital remain basic assets within specific social groups.

In the field of training, the newly established OAED's subsidiary private firm, in Greece, is responsible for the management of a wide range of vocational education programmes (funded both by EU and national sources). These are delivered mostly by private bodies (i.e. the accredited Centres for Vocational Training). In the early 2000s, for the first time, quality criteria of performance by private vocational centres were taken into account in the accreditation process, implemented by the National Accreditation Organization. However, so far regulation of the vocational training system is underdeveloped. A mechanism for systematic collection and elaboration of information on the programmes' effectiveness in respect to employment promotion is absent. Similarly any information for evaluating the impact of in-firm training programmes is lacking, as is also a systematic research on the links between the labour market and secondary and post-secondary vocational training schemes. Overall, a system for assessing needs in the vocational training sector is still at an incipient stage.[32]

Compared to Greece, the public vocational training system has advanced significantly in Spain. Thanks to its reorganization in cycles it has gained in flexibility and it allows many students to obtain an alternative education to that offered by universities and to build sensible career itineraries. Conversely, in-firm training (for the employed) and occupational training (for the unemployed) have shown less positive developments. The programmes are run by the social partners, are co-funded by the EU, and they have been devolved to regions only three years ago. Most unfortunately, medium size and small firms, which are legion in Spain, tend to benefit little from either in-firm or occupational training.

[31] In 2006, over 80% of temporaries "leased" by companies were young unemployed between 19 and 35 years of age, and over 50% of such temporary recruitments were of one-month duration (data obtained by the Ministry of Labour).
[32] The establishment of the National Council for Linking Vocational Education and Training to Employment, in 2005, is expected to contribute to this direction in the future.

5. Concluding remarks

As the above analysis has shown, the public-private welfare mix in South Europe has undergone important changes since the early 1990s. Contrary to North European countries, where governments' withdrawal from direct responsibility in welfare provision (as a reaction to too much state) has for some time been at the forefront of concern, in SE countries we often witness trends running in opposite directions. Supranational fiscal discipline measures, domestic austerity conditions and neo-liberal ideological overtones impact negatively on public social expenditure trends -as indicated, for instance, by the contraction of public health spending in Greece, Spain and Italy in the last decade and growing private expenditure and procurement. Equally expanding is informal privatisation, particularly in social care, due to people's increasing welfare needs under conditions of low public coverage and weakening of the ability of the family to provide support. At the same time, however, extensive unmet need (reflected in comparatively high poverty incidence in these countries) creates strong pressures for public intervention in certain welfare areas, and this condition widens the scope of institutionalised rights (to mention, among others, the right to a universal minimum income guarantee introduced in Portugal in the late 1990s; and the law, put before the Spanish Parliament recently, for the protection of frail and dependent persons).

In an nutshell, concern about redefining the activities and purpose of government is evident in all four countries through strategies of outright privatisation of public utilities, recasting of various public bodies like, for instance, the National Employment Services and establishment of a range of more or less autonomous agencies for planning, research and inspection functions in various policy areas. However, the extent to which such strategies trigger off wide-range and systematic reforms in welfare arrangements and embed regulatory mechanisms into everyday routines greatly varies among SE countries and regional jurisdictions.

Undeniably, a core criterion for assessing ongoing reforms in South Europe is how to balance social equity and long-term viability of social protection with macro-economic parameters and an increased diversity of demand patterns and modes of governance of social welfare. In this respect, as the above analysis has shown, SE countries are facing a daunting task, to tackle extensive inequalities and inefficiencies of their old regimes and at the same time enter into unchartered territories of more diversified yet highly regulated welfare mixes. How successful this attempt will be in the future remains to be seen. At the current state of knowledge, however, a concern looms large about the overwhelming influence in these countries by a discourse (and practice) that largely frames aspects of social welfare -previously expressed in the language of need, vulnerability and redistribution – in terms of workfare and market competition. In the absence of well-developed safety-nets and universal guarantees, there is a danger that such an orientation may pre-empt equity and redistribution criteria with detrimental effects on social cohesion.

References

Adào e Silva, P. 2003: Putting the Portuguese welfare system in context. In: F. Monteiro; J. Tavares; M. Glatzer; and A. Cardoso (eds.), *Portugal: Strategic Options in a European Context*. Boston, MA: Lexington Books.

Association of British Insurers 2004: *European Pension Reform and Private Pensions*. London: ABI.

Bettio F., Simonazzi A. & Villa P. 2006: Change in care regimes and female migration: the 'care drain' in the Mediterranean. *Journal of European Social Policy*, 16/3, 271-85.

Bifulco L. & Vitale T. 2006: Contracting for welfare services in Italy. *Journal of Social Policy*, 35/3, 495-513.

Borghi V. & van Berkel R. 2007: New modes of governance in Italy and the Netherlands: the case of activation policies. *Public Administration*, 85/1, 83-101.

Cabiedes, L. & Guillén, A. 2001: Adopting and adapting managed competition: health care reform in Southern Europe. *Social Science & Medicine*, 52, 1205-1217.

Capano G. 2003: Administrative traditions and policy change : when policy paradigms matter. The case of Italian administrative reform during the 1990s. *Public Administration*, 81/4, 781-701.

Castel R. 2003 : *L'insécurité sociale*. Seuil : Paris.

CES, Consejo Económico y social, 1994-2006, yearly publication: *España 1993-2005. Economía, Trabajo y Sociedad. Memoria Sobre la Situación Socioeconómica y Laboral*. Madrid: CES.

CES, Consejo Económico y Social, May 2005: *Observatorio de Relaciones Industriales*. "Una década de Empresas de Trabajo Temporal", no. 81. Madrid: CES.

CES, Consejo Económico y Social, June-July 2006: *Observatorio de Relaciones Industriales*. "Acuerdo para la mejor del crecimiento y del empleo", no. 92. Madrid: CES.

CES, Consejo Económico y Social, August-September 2006: *Observatorio de Relaciones Industriales.* "Acuerdo sobre medidas en materia de Seguridad Social", no. 93. Madrid: CES.

Chulià, E. 2006: Spain: Incremental changes in the public pension system and reinforcement of supplementary private pensions. In: Anderson, K.M.; Immergut, E.; and Schulze, I. (eds.), *Oxford Handbook of West European Pension Policies.* Oxford: Oxford University Press.

Davaki K. & Mossialos E. 2006: Financing and delivering health care. In: M. Petmesidou & E. Mossialos (eds), *Social Policy Developments in Greece*. Aldershot: Ashgate.

Esping-Andersen G., Gallie D., Hemerijck A. & Myles G. 2002: *Why We Need a New Welfare State?* Oxford: Oxford University Press.

European Commission 2003: *European Social Statistics. Social Protection, Expenditure and Receipts. Data 1991-2000*. Luxembourg: Office for Official Publications of the European Communities.

European Commission 2007: *European Social Statistics. Social Protection, Expenditure and Receipts. Data 1996-2004*. Luxembourg: Office for Official Publications of the European Communities.

European Comission 2003 & 2005: *General Government Data.*

European Insurance & Reinsurance Federation 2006: *European Insurance in Figures in 2005 (CEA Statistics No 24)*. CEA: Brussels.

Ferrera M. & Gualmini E. 2000: Reforms guided by consensus: the welfare state in the Italian transition. In: M. Ferrea and M. Rhodes (eds), *Recasting European Welfare States*. London: Frank Cass.

Ferrera M. & Gualmini E. 2004: *Rescued by Europe. Social and Labour Market Reforms in Italy from Maastricht to Berlusconi*. Amsterdam: Amsterdam University Press.

Ferrera M. 2003: European integration and national social citizenship. Changing boundaries, new structuring. *Comparative Political Studies*, 36/6, 611-52.

Goodship J., Jacks K., Gummerson M., Lathlean J. & Cope S. 2004: Modernising regulation or regulating modernisation? The public, private and voluntary interface in audit social care. *Public Policy & Administration*, 19/2, 13-27.

Graziano P. 2003: Europeanization or globalization? A framework for empirical research (with some evidence from the Italian case). *Global Social Policy*, 3/3, 173-94.

Guio A.-C. 2005: Income poverty and social exclusion in the EU25. Statistics in Focus (Population and Social Conditions), No13.

Guillén, A. 2002: The politics of universalization: establishing National Health Services in Southern

Europe. *West European Politics*, 25/4, 49-68.

Guillén, A.; Álvarez, S.; & Adào e Silva, P. 2003: Redesigning the Spanish and Portuguese welfare states: the impact of accession into the European Union. *South European Society and Politics*, 8/1, 231-269.

Gutiérrez, R. & Guillén, A. 2000: Protecting the long-term unemployed. The impact of targeting policies in Spain". *European Societies*, 2/2, pp. 195-216.

Jensen J. & Saint-Martin D. 2006: Building blocks for a new social architecture: the LEGO™ paradigm of an active society. *Policy & Politics*, 34/3, 429-41.

Moreno, L. 2004: Spain's transition to new welfare: a farewell to superwomen. In: P. Taylor-Gooby (ed.), *New Risks, New Welfare: The Transformation of the European Welfare*. Oxford: Oxford University Press.

Natali D. 2006: From Italy to Europe: a review of recent Italian literature on social policy. *Journal of European Social Policy*, 16/3, 287-92.

Bronchi C. 2001: Options for reforming the tax system in Greece, Institut Européen de Coopération et de Dévelopment (IECD), Economics Department Working Paper, No 231, Paris.

Ministerio de Trabajo y Asuntos Sociales 1996: *Anuario de Estadísticas Laborales y de Asuntos Sociales 1995*. Madrid: Ministerio de Trabajo y Asuntos Sociales.

OECD 2005: *Health Data 2005*. Paris: OECD.

OECD 2006: *Health Data 2006*. Paris: OECD.

Ongaro E. 2006: The dynamics of devolution processes in legalistic countries: organizational change in the Italian public sector. *Public Administration*, 84/3, 737-70.

Oliveira, M.D.; Magone, J.M.; & Pereira, J.A. 2005: Nondecision making and inertia in Portuguese health policy. *Journal of Health Politics, Policy and Law*, 30/1-2, 211-230.

Papatheodorou C. & Petmesidou M. 2006: Poverty profiles and trends. How do southern European countries compare with each other? In: M. Petmesidou & C. Papatheodorou (eds), *Poverty and Social Deprivation in the Mediterranean. Trends, Policies and Welfare Prospects in the New Millennium*. London: Zed Books.

Pereira da Silva, C.M., Vaz-Paralta, S.S. & Marcos, S. 2006: Presentation of the recent retirement reforms in Portugal". *Revue Française des Affaires Sociales*, 1, 253-270.

Petmesidou M. 1996: Social protection in Southern Europe: trends and prospects. *Journal of Area Studies*, 9, 95-125.

Petmesidou M. 2006a: Tracking social protection: origins, path peculiarity, impasses and prospects. In: M. Petmesidou & E. Mossialos (eds), *Social Policy Developments in Greece*. Aldershot: Ashgate.

Petmesidou M. 2006b: Social care services: 'catching up' amidst high fragmentation and poor initiatives for change. In: M. Petmesidou & Mossialos E. (eds), *Social Policy Developments in Greece*. Aldershot: Ashgate.

Petmesidou M. & Mossialos E. (eds) 2006: *Social Policy Developments in Greece*. Aldershot: Ashgate.

Petmesidou M. & Papatheodorou C. 2006: Comparing poverty phenomena in the Mediterranean area. In: M. Petmesidou & C. Papatheodorou (eds), *Poverty and Social Deprivation in the Mediterranean. Trends, Policies and Welfare Prospects in the New Millennium*. London: Zed Books.

Pierson P. (ed.) 2001: *The New Politics of the Welfare State*. Oxford: Oxford University Press.

Radaelli, C. & Franchino 2004: Analysing political change in Italy. *Journal of European Public Policy*, 11/6, 941-53.

Rodríguez Cabrero, G. 2004: *El Estado del Bienestar en España: Debates, Desarrollo y Retos*. Madrid: Editorial Fundamentos.

Saraceno C. (ed.) 2002: *Social Assistance Dynamics in Europe*. Bristol: Policy Press.

Saraceno, C. 2006: Social assistance policies and decentraliation in the countries of Southern Europe. *Revue Française des Affaires Sociales*, 1, 97-118.

Tavares L. & Alves A. 2007: The future of Portuguese public administration and a new agenda for public administration sciences in the 21st century. *Public Administration*, 84/2, 389-406.

Taylor-Gooby P. (ed.) 2001: *Welfare States under Pressure*. London: Sage.

Taylor-Gooby P. 2004: New risks and social change. In: P. Taylor-Gooby (ed.), *New Risks, New Welfare*. Oxford: Oxford University Press.

Torres L. & Pina V. 2004: Reshaping public administration: The Spanish experience compared to the UK. *Public Administration*, 82/2, 445-64.

Vincent-Jones P. 2000: Contractual governance: institutional and organizational analysis. *Oxford Journal of Legal Studies*, 20/3, 317-51.

TABLES & FIGURES

Table 1: Social protection expenditure (% GDP)

Country	1991	1996	1998	2000	2001	2004
Austria	27.0	28.6	28.3	28.2	28.6	29.1
Belgium	27.1	28.0	27.1	26.5	27.3	29.3
Denmark	29.1	31.2	30.0	28.9	29.2	30.7
Finland	29.8	31.4	27.0	25.1	24.9	26.7
France	28.4	30.6	30.0	29.5	29.6	31.2
Germany	26.1	29.3	28.8	29.2	29.3	29.5
Greece	21.6	22.9	24.2	25.7	26.7	26.0
Ireland	19.6	17.6	15.2	14.1	15.0	17.0
Italy	25.2	24.3	24.6	24.7	24.9	26.1
Luxembourg	22.5	21.2	21.2	19.6	20.8	22.6
Netherlands	32.6	29.6	27.8	26.4	26.5	28.5
Portugal	17.2	20.2	20.9	21.7	22.7	24.9
Spain	21.2	21.5	20.2	19.7	19.5	20.0
Sweden	34.3	33.6	32.0	30.7	31.3	32.9
UK	25.7	28.0	26.9	27.1	27.5	26.3
EU 15	26.4	27.9	27.2	26.9	27.1	27.6

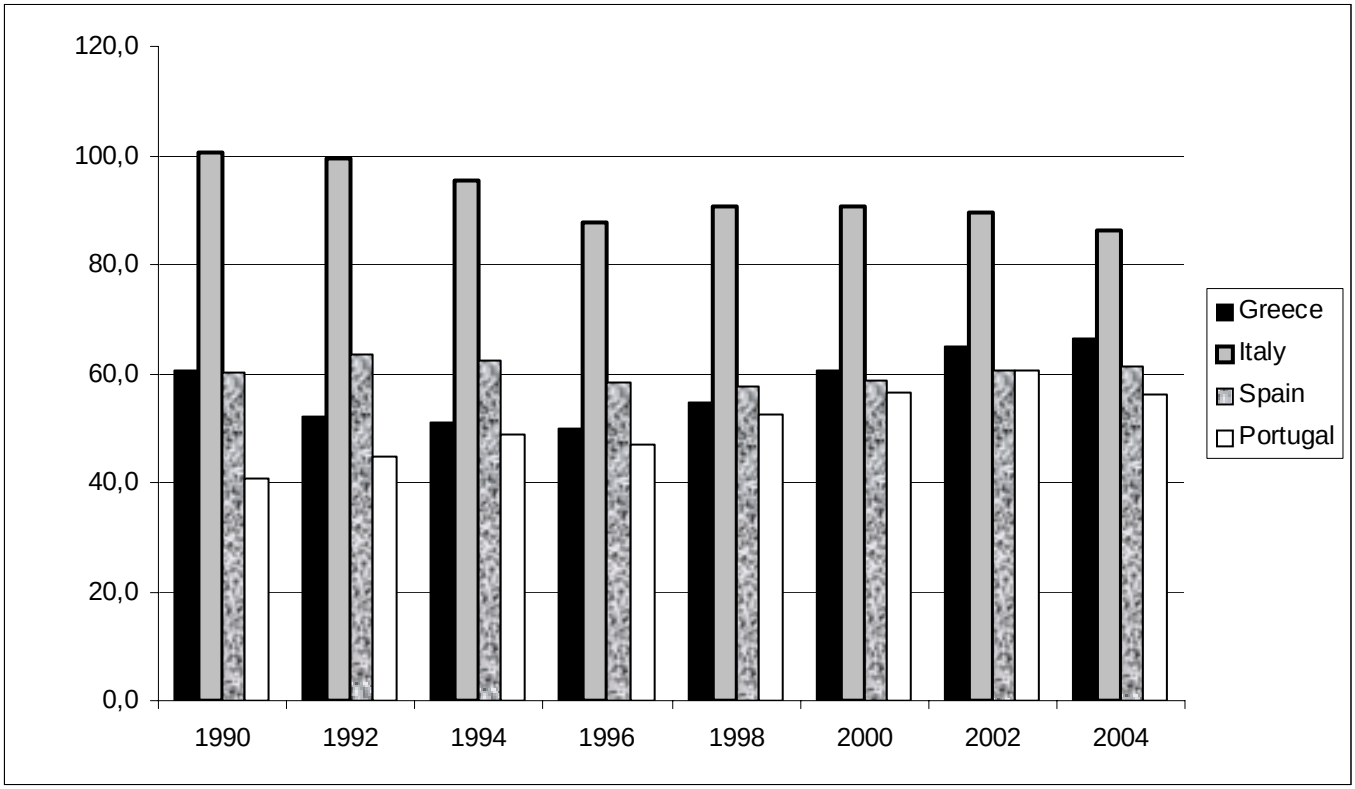
SOURCE: Own elaboration, based on European Commission (2003 & 2007)
2004: provisional

Table 2: Health expenditure trends

	1990		1995		2000		2004	
	Health expenditure as per cent of GDP							
	Total	***Private***	***Total***	***Private***	***Total***	***Private***	***Total***	***Private***
Greece	7.4	3.4	9.6	4.6	9.9	4.7	10.0	4.7
Italy	7.7	1.6	7.1	2.0	8.1	2.3	8.7	2.2
Spain	6.5	1.4	7.5	2.1	7.2	2.0	8.1	2.4
Portugal	6.2	2.1	8.2	3.1	9.4	2.6	10.1	2.7
	Health expenditure per capita (PPP US$)							
	Public	***Private***	***Public***	***Private***	***Public***	***Private***	***Public***	***Private***
Greece	453	391	650	600	850	766	1141	1021
Italy	1097	290	1104	430	1521	562	1852	615
Spain	688	185	861	332	1055	465	1484	610
Portugal	442	232	686	410	1145	479	1335	489

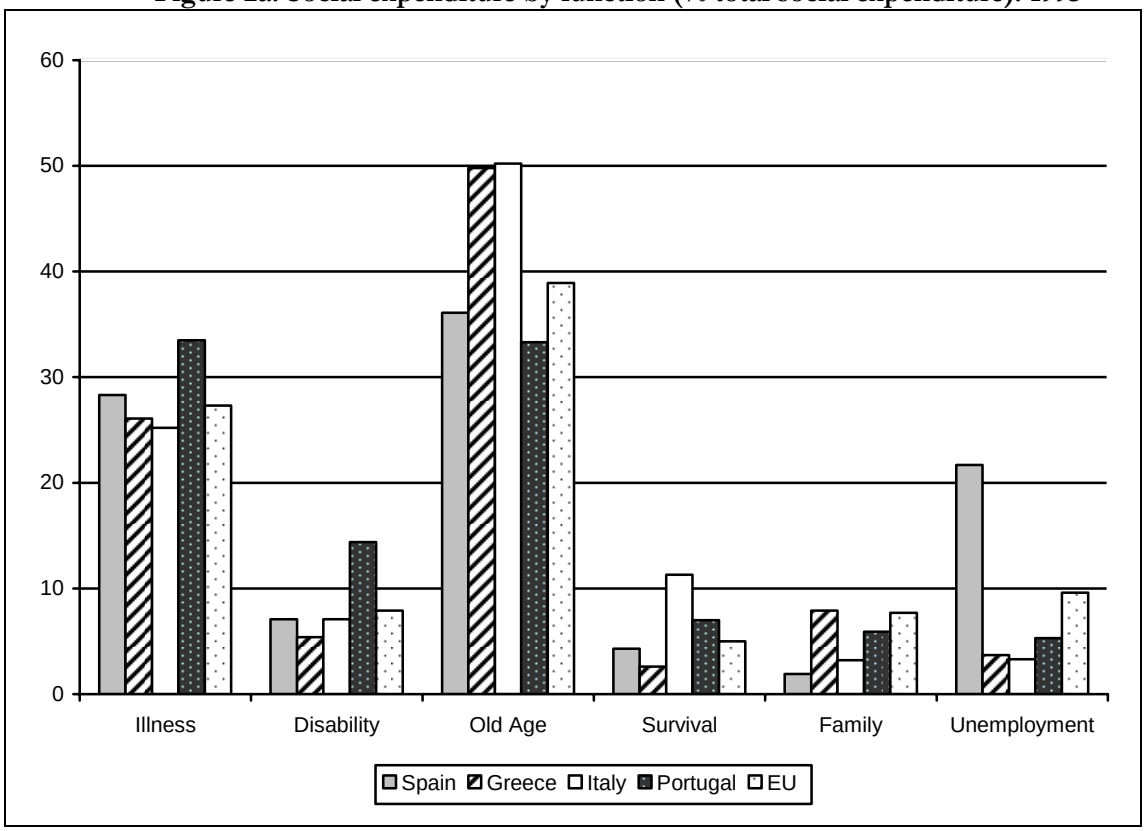
Source: OECD (2006)

Figure 1: Total social expenditure per head in PPS as per cent of EU (15) average



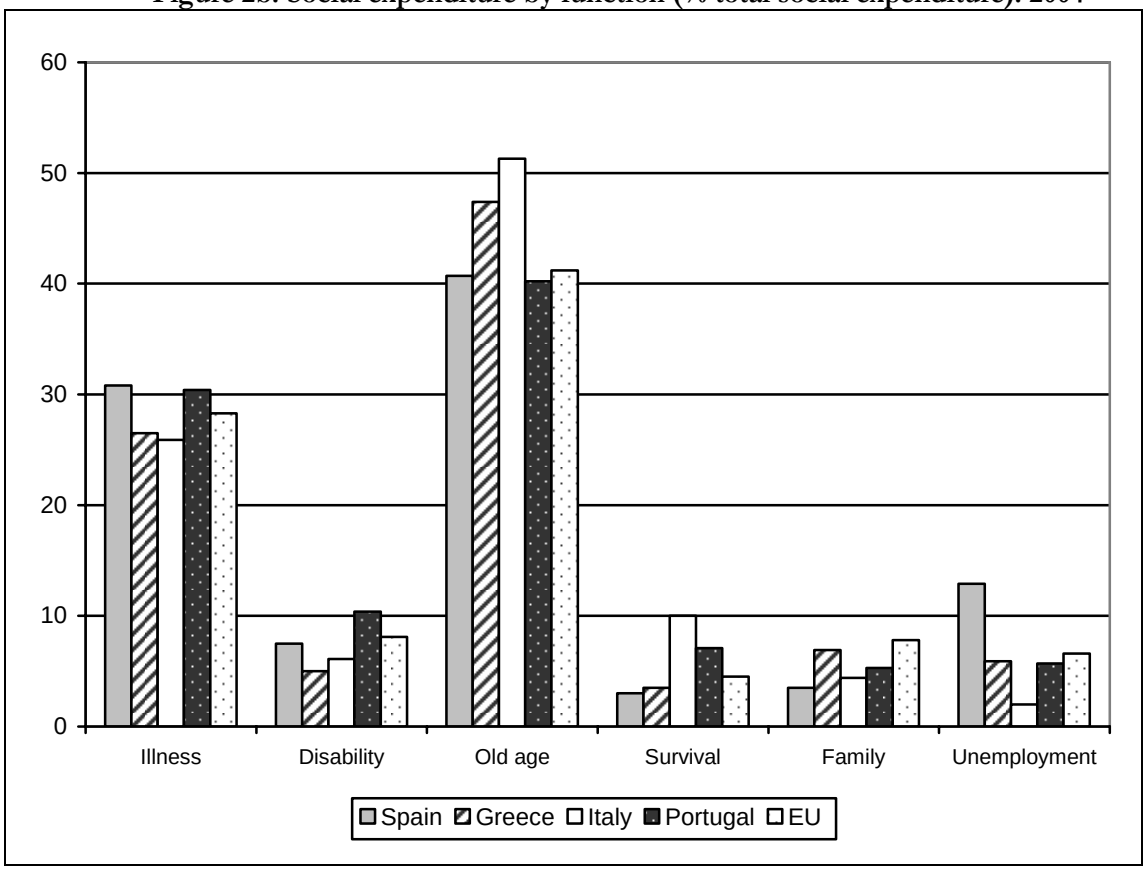
Source: ESSPROS data base of Eurostat (electronically accessed at http://europa.eu.int./comm/eurostat/)

Figure 2a: Social expenditure by function (% total social expenditure): 1993



Source: Own elaboration, based on de European Commission (2003)

Figure 2b: Social expenditure by function (% total social expenditure): 2004



Source: Own elaboration, based on de European Commission (2007)

Figure 3: Private expenditure as a percentage of total health expenditure (Source: OECD Health Data, 2005)

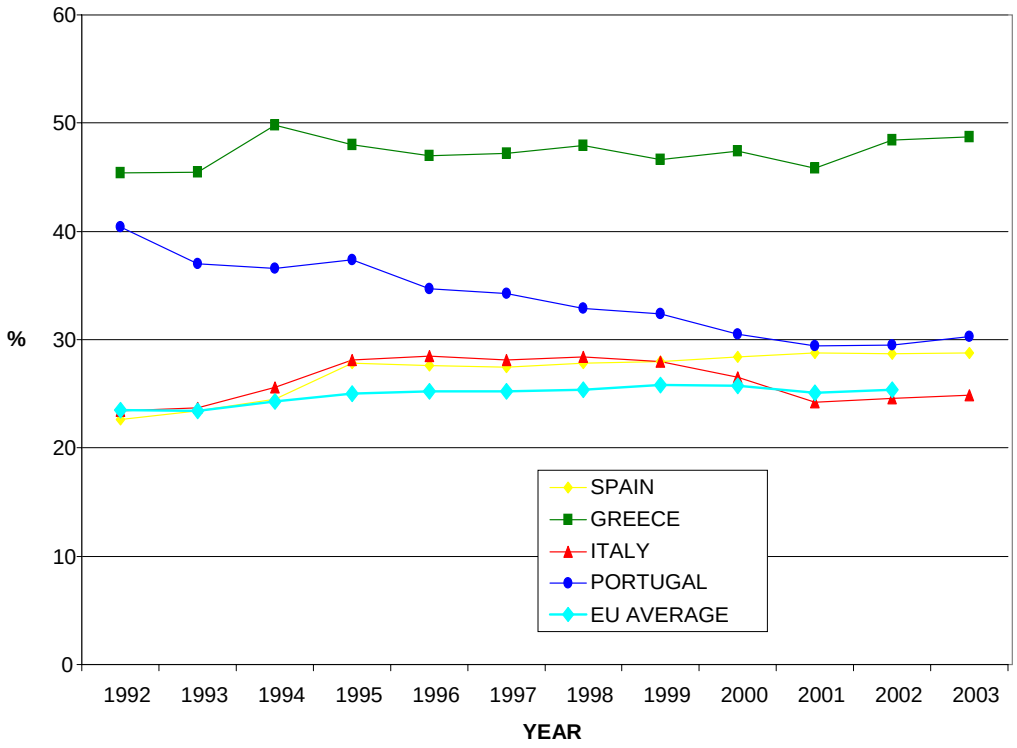
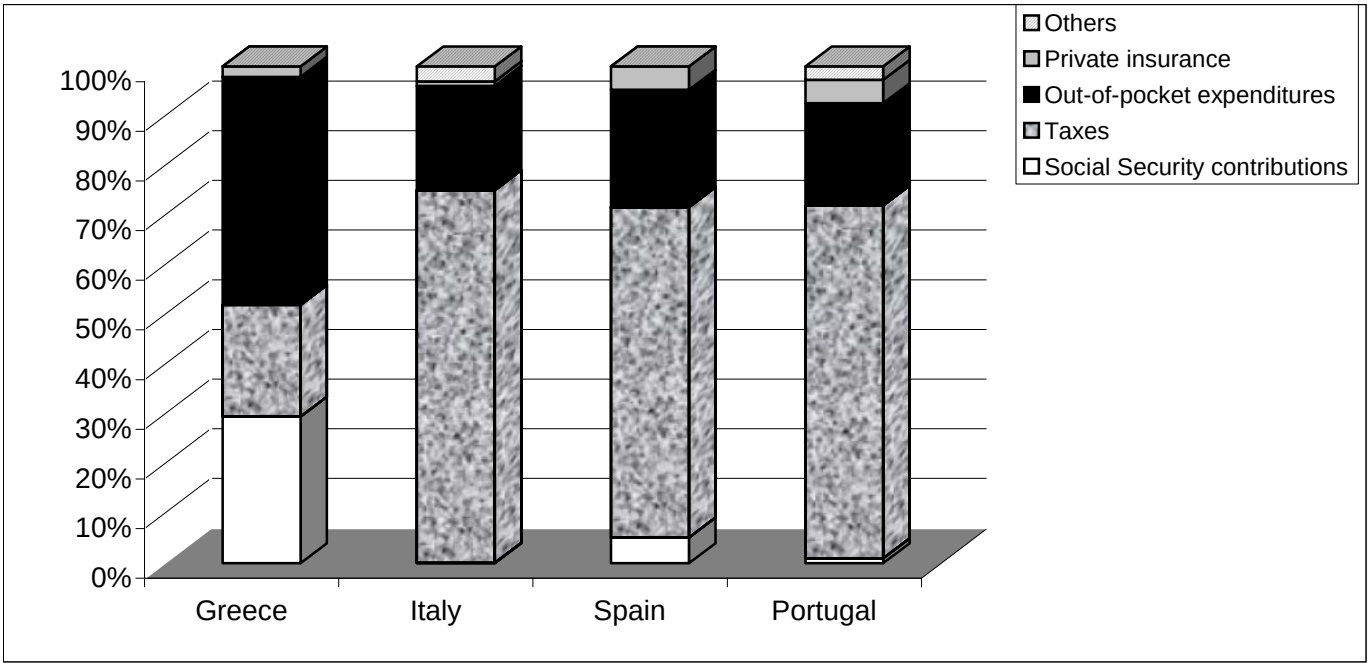
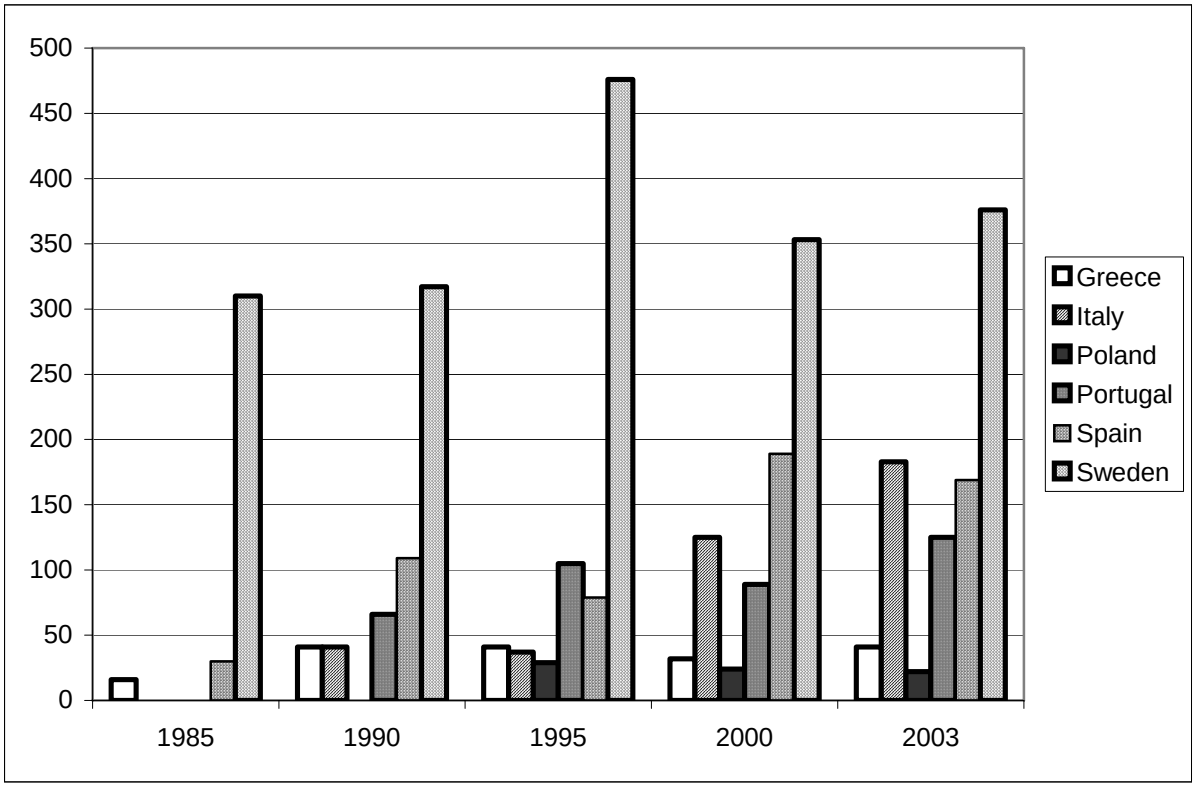


Figure 4: Differences in health care financing among SE countries



Source: OECD (2006)

Figure 5: Public active labour market programmes in SE countries (expenditure per capita in US$ PPP) [A high-spending North European country –Sweden-, and a country of EU enlargement –Poland-, have been included for comparison]



Source: OECD data electronically accessed at http://www.oecd.org/statsportal/