

# Four Decades of Changing Health Systems in Southern Europe: A Comparative Analysis Centered on the Portuguese Case

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## Abstract

Healthcare systems have undergone a wide and deep transformation that is only partly reflected in the growth of the per capita spending relative to GDP. Much more transformations are to be explained.

Southern European countries are usually considered as a relatively homogeneous group with similar social trends in their health care system. Is it really so and to what extent? Are there more than three or four European models and are European societies – with regard to health policies and systems – converging? What are the specificities of Southern European countries?

Our comparative analysis encompasses European countries from the EU and some other countries of the OECD. The data explored are the Health statistics from the OECD and country analysis and data. The Portuguese case serves as a yardstick to get a point of reference. Policy measures and trends will be compared.

The results can be summarized at two or three levels: (1) the changes in demography with ageing population all over Europe, (2) the reorientations of health policies and (3) the new social practices around those health national systems. Some specificities of the different countries or group of countries are to be highlighted. The picture is one of complex change: neither a simple convergence nor clear divergences.

## Introduction

The changes in health systems and health care in the last three to four decades are central to several issues of interest for social scientists, like the reform of the state or the access to public service, and to policymakers and citizens at large. It is worth trying a synthesis of these changes and interpreting them in a sociological and comparative study as we will proceed in the present paper. In Europe, the sweeping changes are very clear in the Southern countries and especially in the Iberian Peninsula. But before presenting the general context and scaffolding the analysis, it is worth tackling some conceptual and theoretical issues in order to clarify the terms we use and the argument developed here as well as some methodological issues at stake.

First of all, it is important to distinguish between health care system and health system. Health system has a broader meaning than health care system, the former includes the later, i.e., health services plus the interactions between different actors and institutions related but not integrated into the health care system like research laboratories and institutes, professional associations, groups and associations of specific illness, regulatory agencies and policy and public administration. While we will discuss the health care system, it is important to keep in mind the bigger picture of the whole social system in which health is embedded (i.e., what we have called the health system, at a first and higher level, plus the overall social system, at even a more general level). A correlated aspect is the distinction between health needs (general need for good life, much related to individual rights and the literature on capabilities (Jenney and Campbell 1997, Nussbaum 2002, Nussbaum and Sen 1993, Sen 2004)) from health care needs (e.g., specific treatments and analyses). Hodgson (2008) adopted this distinction in an institutional and evolutionary perspective while Grossman (1972), in a mainstream emphasis, also distinguished health need (demand for good health) from health care need (derived demand from the first one). While retaining that distinction, our perspective is evolutionary and institutional with some hint at the comparative method.

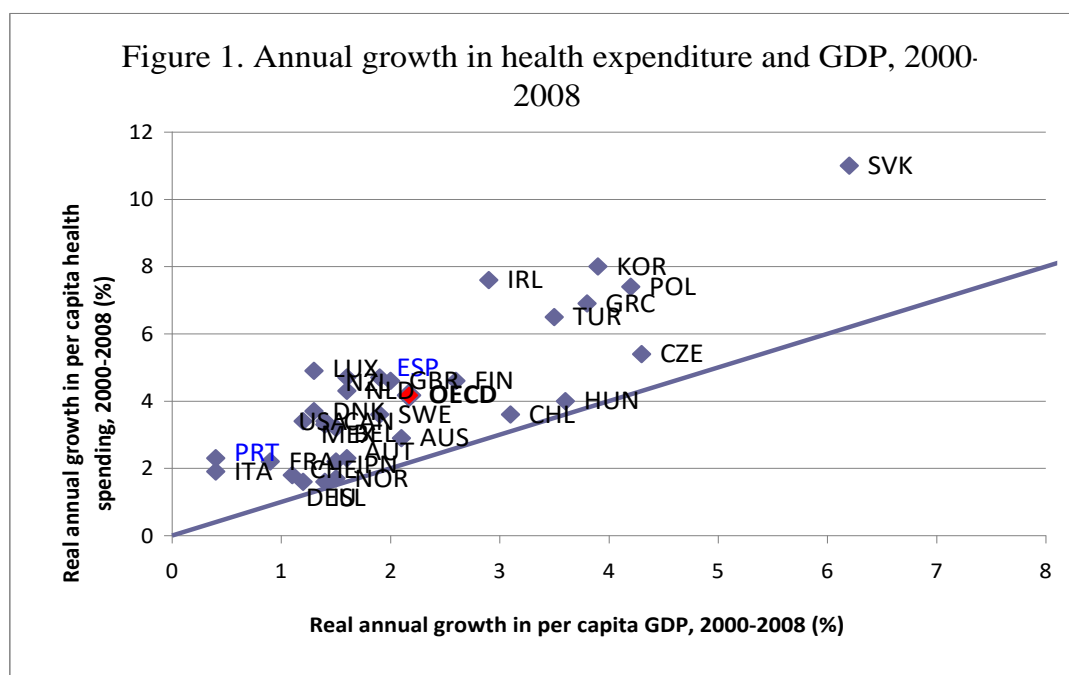
Second, and in contrast to the dominating health economics, focused almost exclusively on the problem of choice (Blaug 1998, Hodgson 2008), we will take a broader view of health through the notions of need and institutions in order to tackle the distinctive nature of health (Jacquinet 2011). Given the sociological perspective adopted here, it makes sense to tackle the problem of health beyond the issue of choice. Moreover, the focus on choice (either in mainstream economics or in the rational choice literature in sociology and political science) is static, as we will insist in what follows, and gives a narrow view of health issues. The demand for health care is internally skewed, namely by doctors and surgeons who define partially what are the needs of the patients and how serious are their illness and what treatment they should follow; there are also externalities (individual decisions have systemic effects, such as in cases of contagion of diseases), asymmetric information and uncertainty (and very often radical uncertainty). Whereas economists recognize the market failure and invoke uncertainty, it is usually narrowly construed, namely uncertainty is generally assumed to be reducible to some form of pre-established or a priori probability distribution (Orléan 2010, Wolfe 2008).

Third, it is important to consider health and health care needs and systems in a dynamic and evolutionary perspective (Hodgson 2008, 2009) where the evolution of the system and the succession of generations of agents, individuals and groups are of paramount importance for understanding change in the sector. A central point in the present paper is the consideration of health need (to be in good health) and health care needs (specific needs for each individual and groups) as varying according to generations and persons all along the life path, from childhood, through adulthood and to retirement. This contrasts with the stable preference hypothesis still dominating (mainstream) health economics and avoids the focus on static analysis that misses central elements of the behavior of agents and patients in the sector.

Fourth, the relevance of policy that creates new paths and influences agents' behaviors must be stressed as it has been in recent literature on health and evolutionary economics (Metcalfe 1994, 2001, Mondragón 1995). Health policy, and the related debate in Europe and the USA, underscores this clearly, i.e., it exercises a strong impact on the sector. First, this policy influence is made obvious through the financing of services, hospitals and the training of nurses and doctors. Second, the state regulates the sector through the authorization of launching and commerciality drugs but also through the regulation of the competition and the legal framework for the

management of hospitals and programs. The state and the legal system are also central to the regulation of the requirements and supply of professionals. Policy measures, cumulatively, participate in the evolution, transformation and adaptation of the sector.

Fifth, with a broader view, we can adopt a sociological approach and obviate the neglect of diversity, so much present in the economic analysis of the health issues. The diversity has to do with age, social categories, professions, classes and organizations (Smith and Christakis 2008). Some health care needs are more acute for specific professions, social classes and older people. Moreover, the systemic character implies that when specificities of traits are accumulated (drug addict having worked in car body painting or buildings' isolation activities), problems are cumulatively more severe for the situation of the patient.



Source: OECD, 2010, Health Data Series (OECD 2010).

### The main global transformations in health care

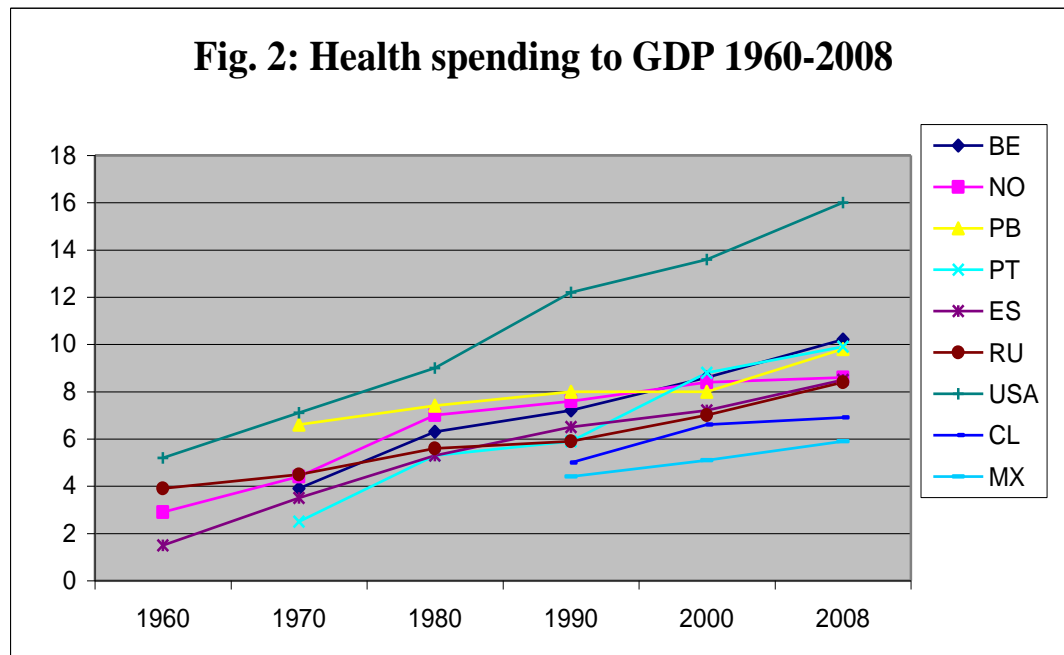
It is important to understand the current situation. By way of illustration and comparison, we can analyze the data summarized in figure n° 1 on the annual growth rates of GDP and health expenditure. The first and obvious point is that real annual growth in per capita health spending in the last decade grew faster than the increase in national product. In other words, we are dedicating more resources each year to health than we can create. In the long run it is not a sustainable (and possible) upshot of political choices. All countries are above the line of equal growth of wealth (X-axis) and health spending growth (Y-axis). The case of Spain is close to the OECD average while Portugal has a worrisome evolution with health spending growth being superior to 2 % (like Italy) and the real annual growth in per capita GDP is inferior to 0,5%. This situation is impossible to sustain not just in the long run but already in the near future, say 5 to 10 years from now. And this has been exacerbated by the financial and economic crisis of 2008-2010 (and beyond). Most countries are concerned with the financial sustainability of the health systems, with few exceptions such as Hungary, the Czech Republic and Chile, countries with rather low foreign debt and a tradition of stringent fiscal and monetary policies. These countries have also higher economic growth rates than Portugal or Italy and henceforth they have room for maneuver in the structure of the public budget. Again in a cumulative and evolutionary perspective, as adopted here, those aspects are much relevant to understand the different paths of those countries.

Moreover, and currently, health budgets are under pressure because of new public management policies of the last two decades and the recent financial crisis, exacerbated, most obviously, in Europe with the Eurozone fiscal and financial problems in Greece, Spain, Ireland and Portugal. With negative or stalling economic growth, cumulative high budget deficits growing internationally, the clear tendency of health care costs incurs difficult choices and rising opportunity costs. The tendency of rising health care costs and the financial pressure on the distribution of wealth and the financial pressure on health systems is best illustrated in the following figure (Fig. n° 1). The average growth of OCDE between 2000 and 2008 is about 2,2% while growth in health spending is above 4%. In the first place, this illustrates the strength of the sector, growing, cumulatively, twice as fast as the overall economy, implying growing transfers year after year. Second, and quite importantly, the political weight of the sector as well the valuation of health services for individuals, professionals and trade unions is very important. After the succession of crises from the 1970s onwards, and especially the recent one that started around 2007 and 2008, the health advantages have been used both by firms to compensate loss of flexibility in fixing wages, especially for higher income employees and by politicians to mitigate restriction measures for the electorate and wage freeze for the workers during recessions to help the disadvantaged (Krugman 2008b).

In most OECD countries and in Spain and Portugal in particular, the spending on drugs has increased substantially with some specificity. First, there was, until recently, much more in Portugal than in Spain, a growing gap between the total price of a drug (paid to the pharmaceutical firm or industry) and the price paid by the patient. The difference was absorbed either by the employer and the state or by the state alone. This triggered increase in sales for drugs heavily financed by the state. On average the drugs are paid or financially supported above 50% by the state in Portugal and Spain. In the case of Portugal, the subsidy can go as high as 100% for drugs used in some chronic diseases cures. Recently, this last September 2010, the Portuguese government lowered the state participation in the final price for drugs.

The context of the last four decades can be highlighted with the description of the evolution of health spending relative to GDP in OECD countries (See Fig. n° 2). In other words, this is the proportion of resources or wealth produced in one year spent on health. First, all countries have seen their share of GDP dedicated to the health sector increase. Second, the situation and evolution of the OECD countries, beyond the general upward trend, are differentiated. In this respect the most salient case over the whole period is the USA with currently more than 16% of GDP of health care spending. In contrast, some countries like the Netherlands (PB) and Norway have managed to limit the increase. Between these extremes, slow and sustained growth at high levels of spending, Portugal and Spain (and, more recently, Chile and Mexico following suite with a time lag of two decades or more) are catching up, starting from a lower bound, less than 2% of GDP in the 1960s to more than 5% in 2008. Here a first contrast appears between the USA and the rest and between European countries – contention in Northern Europe and faster grow of health spending in the South, partly due to a catch up process.

**Fig. 2: Health spending to GDP 1960-2008**



Source: OECD, 2010, Health Data Series.

What are the factors behind these changes? First, and very important, a factor too often neglected, is the better nutrition of the population, this is especially the case of Southern Europe and, with only two decades of data, the Latin American countries: Mexico and Chile. This factor is often dismissed and the focus is excessively made over better medicine (Mokyr 1998, 2002). But, before more and better medicine, it is with better diet that people are healthier and see their life expectancy increase. Then, at the margin but incrementally, medical treatment lengthens life span. The two effects are combined: first, people eat more and do not starve or lack nutrients (of course the excess of food can also be a factor of increase health care spending, namely for esthetics, plastic surgery and diet) then they treat their health problems.

The second factor, related to the first is the increase in health care needs. This is a difficult factor to analyze. While health need is universal and constant, people need to be in good physical and psychological shape to live, work and seize the day. The specific treatments people need (i.e., health care needs) vary from individual to individual, from society to society (in time and space) and from social group to social group. This factor is related to different variables and not the least social variables. Health care needs are changing through time, new diseases, new technologies and new treatments are emerging recurrently at an accelerating rate and diffusing geographically. This expansion is illustrated in the OECD data with the rise of total and per capita spending on health (See fig. n° 2). The doctor in a sense frames the choice of the patient. To give a further example on increasing healthcare needs, consider the importance of the doctor as someone who treats the patient and gives him the information about his health problems, exercising a huge influence of the very specific needs he has. If a patient knows that he has cancer and the doctor imparts him the choices he has for treatment, this is not just a transmission of information. This is an asymmetric relation in terms of information. The doctor, hopefully, can diagnose the patient, knows the historical of the patient, the alternative treatments and their risk. But the problem does not stop here. It is more than a problem of information, one of knowledge with uncertainty and risk. The patient can lie on his past and some of the reasons are not just individual preference. Indeed this is a social situation, with a doctor pertaining to a profession, a class and a patient that does not pertain to the profession and very often from different social backgrounds. Phenomena of shame, manipulation, and passivity, among others, are frequent (Marris 1986). This factor, as we see, is complicated and by itself would deserve a treatment that cannot be made here. But in the case of Spain and Portugal, this factor cannot be neglected, especially in order to compare the situation with other countries.

The third factor is the longer life expectancy that is related to nutrition and cumulative care with the body and the soul (see also Fig. n° 3 discussed below). The longer life expectancy is not just related to progress in medicine but also to better and more equilibrated diet (Mokyr 1990, 1998). The fact the elderly people live now much more time than forty years ago is very important to understand the upward trend in health care spending. Not only they live longer but they are subject to more health problems and diseases or accidents. It is a fact that the older is, on average, using more resources than young adults with the increase in medicines, the number of appointments with a doctor increment substantially. Indeed, some cohorts of adults – aged between 18 to 45 years old– do not care much about seeing a doctor unless they have a problem from childhood or they are touched by some sudden complication in their health. It is important to distinguish here a temporary disease like flu from longer lasting diseases (stretching over more than a year for example), or severe diseases, that undermine the life (and work) of an adult, and chronic diseases that need constant medication.

A fourth factor is the growing diversity in the population with different health care needs. The diversity can be seen at the levels of the patients but also at the professionals (see factor number five). Indeed the classification of diseases has been much more complicated and the number of diseases officially recognized as such has increased in the last four decades. With people living longer, the accumulated experiences and problems are expanding the number of complicated cases with several factors and diseases crossing individuals in different ways. An indicator of this is the increase of time the doctor has to dedicate to get informed about the situation and the past of the patient. This is also related, especially in countries like the USA, with the fear of being sued or more generally of being exposed to bad publicity and public exposure in the local news. There is a problem of reputation and status, two traditional social variables at work, relevant for the professional success of a doctor.

Fifth, the supply and type of services has increased and diversified. What has been called “progress” in medicine is not just technological breakthrough but changes in the knowledge base, the technology used and the practice of medicine and nursery.

Finally, the policy factor has to be discussed briefly for being important for explaining not just the trends but also the changes in the composition of the services offered and the acceleration or deceleration of the growth, i.e., the business cycle. Here enters a set of elements of the political sociology and the crucial aspects related to the implementation of policies and all the political debate and choices made at the national (parliamentary) and local levels (regional authorities for health, municipalities and hospitals). If we take the case of hospitals associated with or integrated with universities, the complex web of interactions is evident. The policy aspects are not exclusively confined to health policy narrowly construed but also to regional policy and higher education policy, not to say a word about the professional aspects and the status of doctors working in such organizations with regard to other ones being employed at less prestigious places.

Considering all these factors, it is important to insist on the sociological dimension of the sector with people individually and collectively valuing health and well being. Social aspects like class, elites, reference, status and profession are central to the dynamics of the sector and to its working on a daily basis (Javeau 1980, 2003, Pais 2007).

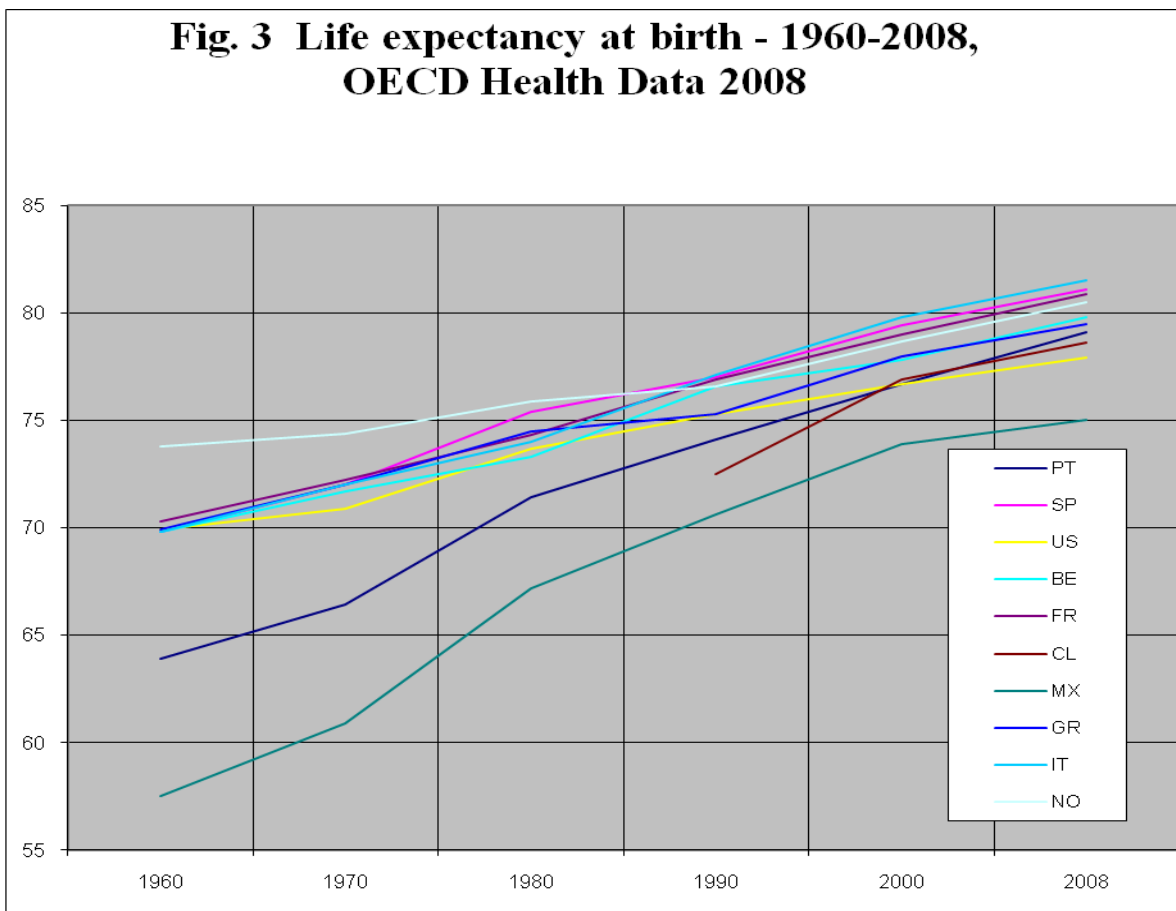
### **Spain and Portugal in comparative perspective**

Spain and Portugal have grown above average in terms of per capita or the total spending in health care relative to GDP and this is not due to the entrance of countries such as Mexico and Chile, with lower average, pushing down the general average. Indeed, Spain and Portugal are converging to other, EU, countries with Spain being above Italy and Japan in average spending dedicated to health care. Portugal is close to these countries also. This means that Iberian countries have dedicated increasing resources to the health system, much more than many countries and that the sector is a priority sector for public policy and public spending, with different types of measures.

Even if Portugal and Spain do share a similar path of evolution, catching up the Northern European countries in terms of levels of spending in health and the intensity and scope of use of technology, techniques and treatments, there are considerable differences. The dynamics of the professions is different; in Spain the doctors and surgeons are more controlled than in Portugal. While there exist similar schemes for health benefits for employees, in Portugal and Spain, several

sectors are differently organized. To take an example, the Armed Forces, the Ministry of Justice's employees have still their own health care system not integrated with the rest of the population and even the public administration. Hospitals of the Army are still much closed to the public, the access reserved mostly to military members, their family and mostly the retired military individuals and their family. This has put some constraints on the functioning and the reform of the health system in Portugal, more than in Spain. The Portuguese system is much more stratified or fragmented and departmentalized, a neat contrast with the Spanish rather recent evolution of the years 2000-2010. A sociological explanation has to do with the military culture and the colonial war of Portugal in the 1960s, having increased the population with rights on the use of military hospitals, something that we do not find in Spain, Greece or Italy.

To pursue the comparison further and the evolution of the social structure in a rather simple way, we now take a look at the life expectancy at birth from 1960 to 2008 for some OECD countries. There is a clear upward trend for all the countries with most Western Europe converging at about 80 years-old, getting above the US in the last 15 years. Moreover, the trend is showing signs of leveling off. In the European Union, Portugal was much lower than the average of the Union (64 versus 70). Note that, compared to 1960, the situation is more dispersed in the EU in 2008. Portugal converged substantially, closing partially its gap relative to Spain and the Northern European countries. Spain was in the EU average and stays slightly above in 2008. Compared to the EU, Portugal is still at the lower quantile showing that Portugal, while converging, has not caught up as could have been expected, though the country is still above the US and Chile.

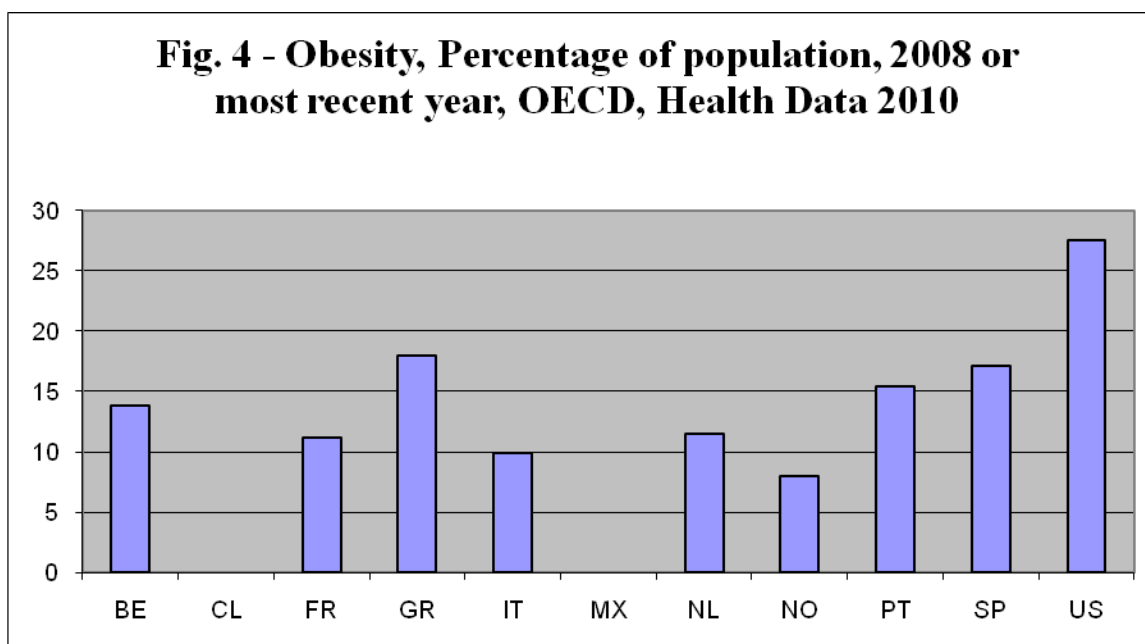


Source: OECD, 2010, Health Data Series.

The demographic change is considerable for the period, with longer life expectancy and lower fertility rates, the population in the EU and Portugal and Spain is getting older. People live more time and the proportion of elderly population – namely retired persons – has increased significantly,

putting pressure on health care spending and pension schemes (Amable 2003), a debate that is gaining momentum in Europe, in France lately, but less in Portugal and Spain.

Another aspect of health that is showing signs of concern is obesity that duplicated between the 1980s and 2008 for most OECD countries. The US in 2008 is above 27% while it was around 13 to 15 in the 1980s. In Southern Europe, Greece, Spain and Portugal are above the EU average and the situation has deteriorated. Nutrition habits and consumption of food are changing, and this is a more recent phenomenon in Portugal and Spain than in Germany or France. The dynamics between the countries is different. In figure n° 4, we can see the situation of Portugal and Spain above 15% of the population. This phenomenon is relevant, especially to understand coronary diseases and the evolution of those cases and cardiovascular problems in Portugal and Spain. In the former case, the evolution of cardiovascular complications is worrisome and the increase of unbalanced diet is a factor of risk for the adult and the young population.

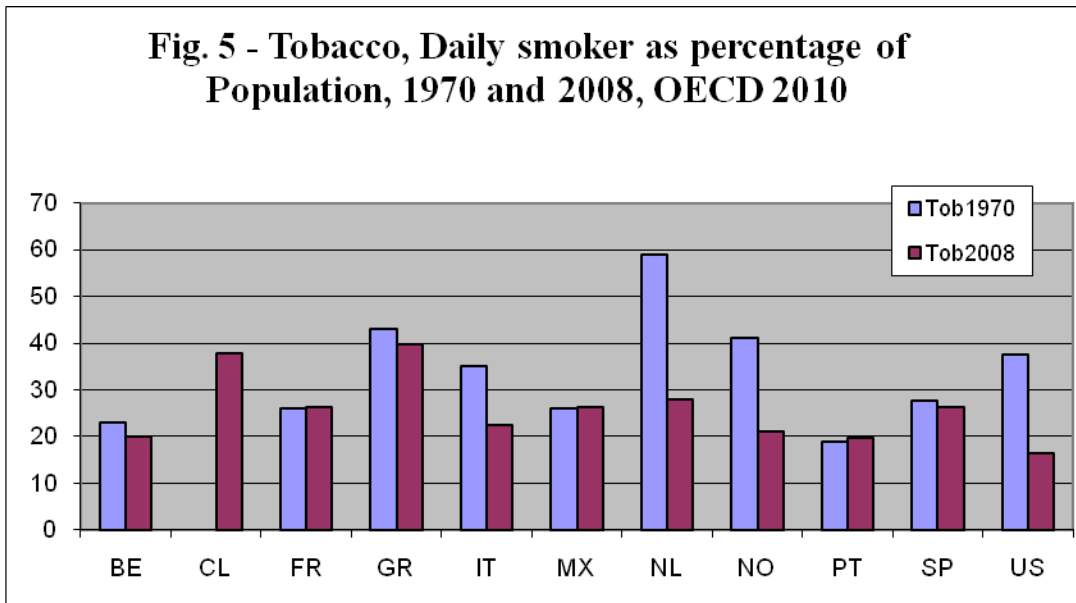


Source: OECD, 2010, Health Data Series.

One more illustration is the problem of tobacco, where the evolution in the US and Northern Europe is one of decrease of heavy or daily smokers (see Fig. n° 5). The recurring policy in these countries seems to have an impact. At least, people seem to take consciousness of the problem related to smoking, much more than in Portugal and Spain where such effectiveness in the policy is not recognized. In Portugal and Spain, as much as in the other European countries, the policy against smoking has been important. In countries like Norway, the Netherlands and the USA, policy measures for prohibiting smoking were implemented in the 1980s with clear effects on the reduction of the number of daily smokers. Moreover, the pharmaceutical industry and action in schools have been made relentlessly. These measures were associated with strong social support and fines for those that do not respect smoking bans and non-smoking areas, something that was much absent until recently (say 2008) in Portugal and Spain. The situation in Mexico parallels the evolution of Spain and Portugal, which could give cultural reason for the differences between Northern and Southern Europe and North and South America.

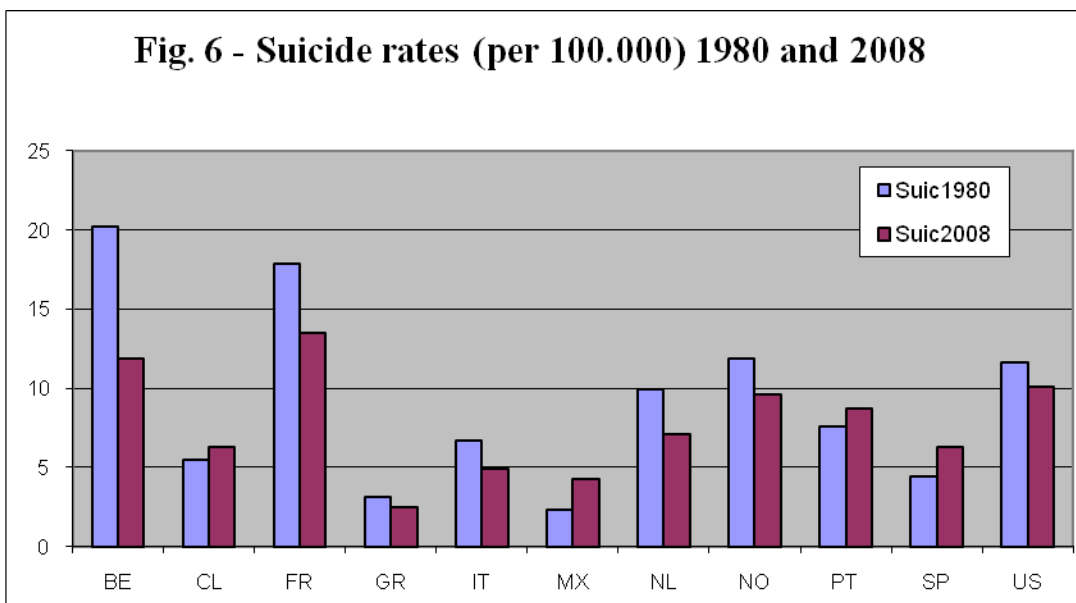
The effect of tobacco on health is considered as negative. It catalyzes other health problems like breathing, cardiovascular attacks, etc. But the overall effect on the health spending is not clear. People who smoke heavily have a lower life expectancy and do not live as long as the non smokers. They, in a sense, have a shorter life and because of that they lower the burden of the system henceforth they “save” years of weak health when dying younger. On the other hand, living less time, they contribute to less of the national health and it is a loss in terms of wealth and social

interaction. The social and psychological aspects were well characterized by Peter Marris in his classical study *Loss and Change* (1986).



Source: OECD, 2010, Health Data Series.

A final illustration of the changes in the health sector can be given with the analysis of suicide rate, a classical analysis has been done by Émile Durkheim as a hallmark of (classical) sociology (Durkheim 1951). Here we will focus on comparisons between countries and their evolution and relate it to the health policies followed from the 1980s to the present. First of all, countries with high suicide rates (Belgium, France, Norway, the USA, or other countries above the 10 per hundred thousand), mostly Northern countries, have seen a decrease in the suicide rates. Without further data it is difficult to appreciate the cause of the decline. It is, however reasonable, to consider that policies are responsible for part of the decrease. In most countries, programs have been designed and implemented to tackle the issue, offering attendance, specific actions and measures for target groups (teenagers, unemployed, etc.).



Source: OECD, 2010, Health Data Series.

In contrast to EU's northern states, Spain and Portugal have seen their rate increase like Chile and Mexico, suggesting some similar cultural factors such as the modernization and urbanization and the weakening of social relations. Invoking, in the present case, social capital (Hyypä 2010) would be too obfuscating a factor, hiding some more concrete and specific factors (Smith and Christakis 2008). Indeed, social capital has been used and abused (used with lack of discernment or critical thinking) at such a point that it can serve to explain anything... thus nothing in particular (Fine 2001, 2010). An interesting social inquiry would be to decompose the factors related to this social phenomenon.

Now we will look at the professional aspects of the sector, namely the nurses and doctors. In countries like Spain and Portugal, the importance of nurses, as a percentage of the total population, is 5,8 and 5,3%, respectively, in 2008, much lower than countries like France (8,21, in 2009), Ireland (13,61, in 1999) and the USA with 10,78% in 2008 (OECD, Health Data 2010). Unfortunately, for doctors, the data are scater and not always reliable, but comparing the relative importance of nurses and doctors gives an idea of how health care services are administered. In Spain and Portugal, doctors are more numerous than nurses and their relative importance is higher, indicating that most of the services work with doctors while in countries like Ireland, France and the USA, the relative importance of nurses is higher (OECD 2010). This has a considerable implication. In the latter case, more services are executed by nurses, especially preliminary and primary care and check-up analysis, relieving the doctors from some of the tasks like automatic diagnosis, administration of vaccines, and administration of surgery logistic. Still, even in these cases, doctors supervise less the administrative task (left also more often to nurses or employees) than participating in the effective management of taking decisions and organizing services.

In the Portuguese case, the hierarchy, especially between doctors and nurses and other employees, and within each professional group, is higher and more rigid. The administrative burden of doctors is higher. Even with the introduction of e-health, things at this level are slow to change. Processes in hospitals are changing, especially in the private sector where the doctor is either responsible for a unit or service or practicing surgery or "medical acts" (and paid by medical act or by hours worked). This is also true for public hospitals, with the introduction of new public management and the creation of new legal structures in Portugal (hospitais SA e hospitais EPE).

In all the counties, the number of nurses has increased. And in most countries the number of doctors has increased, with one of the few exceptions being Portugal, with a slight decrease of doctors, especially in the public sector because of retirement, and the increase in the private sector is not compensating much, despite the increase in medical graduate (from 5,8 in 2000 to 10,4 per hundred thousands in 2008). This contrasts with the case of the USA staying at about 6,5 and Spain decreasing from 9,2 to 8,9 per hundred thousands between 2000 and 2008. These differences illustrate that the spending paths are different and that the role of professional groups is different. In the case of the USA, with a stagnant proportion of doctors, the factors of the increase of spending have much to do with the system of financing health care and the recourse to private insurance companies that have inflated the cost of specific interventions while driving out part of the population out of the system (most unprotected are unemployed or with much less shorter contracts that do not provide stable health care insurance (Krugman 2008a).

It is important to insist on two aspects of the current transformation of the health care system: the information system and the knowledge base. As we will see there are pervasive features that touch at central policy and management issues. The first central aspect of the reform, regulation and management of the health care system has to do with the information system, hierarchically organized in a complex combination of subsystems, and very often the combination does not even exist or is very weakly integrated. Below the national system that includes several databases and information of professionals, patients and entities such as hospitals and association of patient of specific illnesses. It is important to look at the use of the information of the patient and see how it is retrieved, kept, controlled, accessed and transferred. When someone goes to the hospital, he or she presents a user card and the entrance is registered, the doctor or nurse fill in the diagnostic and the treatment and the relevant information that the patient is willing to give. Portugal, much more than Spain has invested much in e-government and in an electronic registry of information for any patient or user of the national system (Gomes, Jacquinet and Curado 2010). The results must still

be analyzed, but even though progresses are undeniable, there are several weaknesses that have to be tackled. One is the dissemination of data bases, their unconnectedness, the repetition of the same input information (identity, social security number, address, etc) is constant. In a year's time, a patient may give 5 to 6 times information that can take each time between 5 to 15 minutes to filled up the files and items required at the hospital or health unit. This is the reason behind the RES measure, the electronic health registry (registro electrónico de saúde) that was designed in 2009 and 2010 and that is currently implemented in its initial phase.

For example, the notion of e-health, that individual could get easy access to information, appointment and diagnostic is far from being concrete (Andreassen, *et al.* 2007, Eysenbach 2001, Wilson and Lankton 2004). In the public sector in Portugal, there are still much people that must wait several months to get an appointment with a doctor and even more to get a surgery in a public hospital. Waiting lines, while decreasing, are still a reality of the Portuguese health care system (Deloitte 2011).

The discussion of the diffusion of information technologies to retain relevant information or build a knowledge base are related to the issue of e-health and the use of IT can be seen as a way to buttress the activities of the professionals and organizations of the system of health and the patient. The technologies can also be part of an answer to the problem of the waiting lines. But taken too narrowly, technologies can create new problems and leave unresolved several important aspects of health care that policy makers are neglecting, like the long run good treatment of the patients and the way medicine can buttress their autonomy. In addition to that, problems of scarcity of doctors in public hospitals or in certain areas of specialization are not resolved easily. There is here a need to integrate information about the whole population (to identify needs and trends) and the evolution of health professionals (the cohorts, their distribution between generations, etc.). There is also an ageing problem for doctors and nurses, often related to different specialization dynamics that is not adequately appraised. In other words, what is needed is the organization of the information about the health care system and the implementation of a prospective analysis.

The second aspect of the health care system has to do with the knowledge base, the management of knowledge and the knowledge economy. Indeed much of the activity of the sector is based on information and knowledge: professional have to learn what health and disease the patients have, how to cure the latter, what are the technologies and treatment available, what are the characteristics of the patient, etc. All this has to be organized in an efficient way and that a doctor could access in a timely way to the data of an injured while making an urgent diagnostic. The notion of e-health that we have hinted at is part of the current proposals in which Portugal is at the front of the experiments. Social and legal aspects are intertwined in the functioning of an information system about the patients. For the building of the knowledge base, from the faculty to the research lab and the hospital, the interaction is very complex and deeply social in the sense that the outcomes are much influenced by phenomena like classes, professions, social groups and policies.

## **Conclusions**

According to the data used, the recent evolution of the health sector in OECD countries is characterized by an overall increase in spending but different policies and some diverging paths, especially with respect to specific measures and response to health problems. Iberian countries in this perspective are spending ever more on health care but with some distinctive aspects of its structure and the implementation of policies.

Until recently, several policies were more or less designed on the criteria of other countries with much less attention paid to the impact and the control of the effects of the measures defended and the characteristic of the population in terms of health characteristics and issues. Now the rhetoric, without disappearing, is much more related to the study of outcomes and the impact of policies.

Much work is needed, especially in studies of specific subfields of the health system. The field of e-health is one that has propelled Portugal – and to a less extent Spain – to the fore of adoption of new techniques. Even if some initiatives are more than a fad, the overall picture is encouraging, especially if the forthcoming measures are much more linked to the impact study with focus on some important outcomes without falling in the caricature of medical processes.

There are some common ground between the two Iberian countries, especially with regard to the catch up process leading to convergence with the Northern European countries, in terms of relative spending, life expectancy, and basic treatment. Despite this convergence, within Europe some differences are notorious like the suicide rate, the importance of nurses in the system, all indicating social and cultural variables being at work.

Still, a concern must be made about the stabilization policies in Southern Europe and their impact on health policy. Most probably the spending growth in health will be stalled and the structure of health services will be reorganized. The future will tell us what those changes will be.

## Data

All the data used here, especially those used in the figures, comes from the OECD Health Data Series for 2009 and 2010, unless otherwise stated. The abbreviations used are as follow: PT, Portugal; SP, Spain; US, USA; BE, Belgium; FR, France; CL, Chile; MX, Mexico; GR, Greece; IT, Italy; NO, Norway; NL (or PB), Netherlands (OECD 2010).

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