interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Dossier

Health reforms in Brazil and southern european countries in the twentieth century

A Mediterranean paradigm? Convergence and divergence in the Southern European Health Care Systems

Um paradigma mediterrâneo? Convergência e divergência nos Sistemas de Saúde da Europa Meridional (resumo: p. 16)

¿Un paradigma mediterráneo? Convergencia y divergencia en los Sistemas de Salud de Europa Meridional (resumen: p. 16)

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The concept of a 'Mediterranean paradigm' was raised by Josep Figueras in 1994 as a distinctive Southern European model for the health care systems of Italy, Spain and Greece based on the basis of six factors. The subsequent debate (including Portugal, too) is reconstructed on the basis of pros and cons arguments. The specific contribution of the author to the debate - consisting in the proposal of the concept of 'health macro-region' as an analytic tool to pursue a more comprehensive approach in comparative terms on the basis of a connectionist model - is then presented in details by showing the peculiar characteristics of the Southern European health macro-region. Finally, an historical perspective involving three different kinds of temporality (long, middle and short span) is proposed in order to explain both the substantial similar timing (diachronic convergence) and, at the same time, the significant differences (synchronic divergences) among Southern European health care systems in the way and levels their national health services were implemented.

Keywords: Mediterranean paradigm. Health care systems. Health macro-region. Convergence/ divergence. Temporality.

Giarelli G. A Mediterranean paradigm? Convergence and divergence in the Southern European Health Care Systems. Interface (Botucatu). 2021; 25: e210116 https://doi.org/10.1590/interface.210116

Introduction

The article addresses in the first paragraph the concept of 'Mediterranean paradigm' by reconstructing its origin and the debate about it, and discussing the pros and cons arguments by various scholars. A wider perspective is then proposed in the second paragraph by advancing the concept of 'health macro-region' as an analytic tool to pursue a more comprehensive approach on the basis of a connectionist model, presented first in comparative terms by applying it to the European health macro-regions, and then showing in more details the peculiar characteristics of the Southern European health macro-region. Finally, in the last paragraph an historical perspective involving three different kinds of temporality (long, middle and short span) is proposed in order to explain both the substantial similar timing (diachronic convergence) and, at the same time, the significant differences (synchronic divergences) among Southern European health systems in the way and levels their national health services were implemented.

The debate about the 'Mediterranean paradigm'

The idea of a "Mediterranean paradigm" was raised for the first time in healthcare by an article published in the International Journal of Health Sciences by Josep Figueras Martin McKee, Franco Sassi of the London School of Hygiene and Tropical Medicine along with Elias Mossialos of the London School of Economics[(b)] Figueras *et al*.[1]. The authors responded substantially positive to the question posed in the title of their article: by comparing the recent evolution of the health systems of Italy, Spain and Greece, they in fact identified a series of similar traits and concluded stating that, as a whole, they composed the framework of what they called a real 'Mediterranean paradigm', inclusive of "a distinctive pattern of health and disease, a common historical evolution of National Health Services, shared principles, limited implementation, similar patterns of organization and delivery, and, in recent years, a common crisis and responses to it"[1] (p. 143).

[(b)] Currently, one of these authors (Figueras), is the director of the European Observatory on Health Systems and Policies, whereas McKee and Mossialos are co-directors of the London hub of the Observatory.

Although the authors recognized that "no clear cause/effect relationship can be demonstrated between cultural, political, historical, socio-economic factors and the health systems paradigm"[1] (p. 143), they grounded each of the above six factors in a constellation of shared elements among these countries, showing the foundations of their argument. The pattern of health and diseases was characterized by higher levels of health expectancy and lower levels of prevalence of chronic diseases compared with the other European countries and their socioeconomic development. They guessed this could be related to the 'Mediterranean diet' low in fat and sugar, and to healthy lifestyles.

Historically, the political context leading to the promulgation of National Health Services (NHSs) in these countries is also similar: after more or less long periods of totalitarian rule (fascisms) in all these countries (including Portugal, too), democratic regimes were restored with the passage of new constitutions, and National Health Services were enacted first in Italy (1978), and then in Portugal (1979), Greece (1983) and Spain (1986). Moreover, the founding principles underlying the creation of these NHSs were similar, based on the universalistic idea of health as a social right, entailing the entitlement to free access to health services; and including also the shift in the main source of funding

from social insurance to general taxation, a certain degree of decentralization of the health care system, and the development of a new model of primary health care based on the establishment of health centres on a geographical basis and multidisciplinary team work. However, these principles met limited implementation in the decades after the establishment of the NHSs because of a series of factors involving their peculiar political structure, the pressure of interest groups, and the shortage of management skills to implement change.

Patterns of health care organization and delivery were characterized by the authors as "lower provision of chronic beds and community services, higher doctor-nurse ratios and a close organizational relationship between the public and the private sectors"[1] (p. 144).The first of these factors was ascribed to the provision of lay care by the traditionally extended family structure; whereas the over-supply of doctors was related to the late introduction of '*numerus clausus*'[c] in medical schools and to medicalisation of health care, with many nursing tasks undertaken by doctors.

[c] A limit on number of places available.

Finally, the general crisis of the public sector and of welfare models also affected the NHSs of these countries, forcing them since the Nineties of the last century to undertake a series of reforms, even because of the widespread populations dissatisfaction with the health care services. These reforms were generally marked by a very different political inspiration with respect to the first ones, since they introduced at least partial forms of managerialism and internal market competition, and fostered a more significant role for the private sector. Furtherly, the authors recognized that, beyond similarities conforming to a common Mediterranean paradigm, there were also significant national differences not only among these countries but also within the same country: especially in Italy and Spain, where the policies of regional decentralization allowed the development of marked differences among the regions.

In the following years, the debate about the 'Mediterranean paradigm' was widened by Maurizio Ferrera[2,3] who disputed the classic classification of Southern European welfare systems as late 'conservative-corporatist' ones by Flora and Heidenheimer[4], Flora[5], Esping-Andersen[6] and Castles[7,8]: in fact, more than 'late cases', these systems can be considered "as a separate cluster in the universe of the welfare states: a 'family of nations' characterized by some specific common traits"[2] (p. 68). He consequently pointed out these specific four common traits: 1) the large imbalances of the income guarantee systems, heavily skewed in favor of pensions to the detriment of unemployment and family benefits; 2) the overcoming of the previously fragmented corporative-occupational health care systems with the establishment of universal NHSs; 3) the low levels of 'stateness' in their welfare systems and a perverse mixture of public/private actors and structures; 4) the persistence of traditional patronage relationship and the development of institutional structures for the particolaristic distribution of monetary subsidies. On the whole, according to Ferrera[2] these common traits delineate a specific fourth type of 'particularistic-clientelistic' welfare system typical of the Southern European countries beyond the other classic three European systems (the liberal, the conservative-corporatist, and the social democratic: cfr Esping-Andersen[6]).

At the dawn of the new century, Ana Marta Guillén[9] of the University of Oviedo, analyzed the policy-making processes that allowed for the turning of the previous Mediterranean health insurance systems into NHSs, underlying achievements and shortcomings of the implementation processes that followed. By adopting a neo-institutionalist approach, she tried to explain this radical shift in terms of 'path deviance', that is a specific pattern of timing and sequence, the concurrence of a series of circumstances, of critical junctures that allowed for the 'defrosting' of the *status quo* and the implementation of new policies that overcame the inherited logic of the overall system ('path dependence'). She identified these series of disruptive circumstances with "the concurrence of democratization of authoritarian regimes taking place at the same time as the economic oil-shocks, the arrival of left-wing parties in office, the appearance of new political actors (including, for example, regions) and the presence of the European Community"[9] (p. 58) which paved the way for path deviance. To these, she also added "the broadly felt need to correct the existing policy"[9] (p. 58) by populations, a diffuse public perception of unjust and diffuse strong health inequalities.

She then stressed the circumstances that could be considered at the origin of the greater difficulties NHSs implementation met in some countries more than in others: particularly, on the whole, implementation was more successful in Italy and Spain, whereas a partial failure in Portugal and Greece. According to her, this could be explained by the uniform structure for service provision and the delimitation of the services financed out of public revenues in Italy and Spain, along with a more universal health care coverage of the population, a devolution process to regional health authorities in both countries, and an increased proportion of public expenditures on health care as a percentage of the Gross Domestic Product[9] By contrast, in Portugal and Greece a stable coalition of interests in favour of NHS was not achieved due to changing and unstable governments, health insurances were not suppressed, and doctors continued to be paid largely on a fee-for-service basis. Therefore, the decisive factors allowing for path deviance were much more effective in Italy and Spain than in Portugal and Greece.

In a second article written along with the Greek colleague Maria Petmesidou[10], the two authors first recognized that Southern European NHSs, having been the last to join the NHS model of organizing health care in Europe during the late Seventies and the early Eighties, when compared to the traditional ones – British and Scandinavian – highlighted two important differences: 1) they were already mature social insurance health care systems when this transformation took place, entailing greater challenging difficulties, and this was something novel in the European welfare history; 2) since very shortly after the establishment of their NHSs the austerity era began, bringing the new challenges of efficiency and cost control, these countries had to face a serious 'density of historical timing'[10]

> Thus, while traditional NHS were constructed during a period of protracted economic growth and stability – the so-called golden era of the welfare state – the context of the Southern European countries was rather that of retrenchment and profound questioning of the role of the state in public provision[10]. (p. 107)

Then the two authors compared the recent reforms in the Spanish and Greek health care systems in order to assess whether they actually corresponded to the principal characteristic of the Southern model of welfare as a combination of the three models of Esping-Andersen[6], namely liberal in means-tested social care, conservative-corporatist in income maintenance, and social democratic in health care[11]. Therefore, the article addressed the question of whether the austerity policies, with the retrenchment measures adopted in both Spain and Greece since the Nineties, hindered the implementation of the social democratic principles at the base of their respective NHSs. Their answer was differentiated:

> Spain and Greece manifest two highly contrasting health reform trajectories in Southern Europe. Spain can be more or less considered 'a successful case' of simultaneously implementing devolution and an NHS consolidation plan through a protracted, incremental process that, nevertheless, steadily built up a new system. In Greece an ambitious reform brought into existence a national health system, yet many of the initial aims have not been implemented even now. Most importantly, health care financing and provision remain highly fragmented, a condition that barely secures equity in access, supply and quality of services[10]. (p. 108)

In fact, the transformation of the Spanish health care system from a health insurance model into a national health service was an implementation process of an incremental character as opposed to happening immediately in Greece (and also in Italy and Portugal), put in practice little by little with the gradual full universalization of coverage, the suppression of occupational health funds, and the inclusion of all the citizens in a single unified institution. Parallel to organizational reforms, the decentralization process was gradually implemented according to negotiations between the central and the regional autonomous governments (*Comunidades Autonomas*), since not all of them (only seven out of seventeen) obtained responsibilities immediately. However, since 2002 the devolution process was completed, greatly enhancing innovative reforms by the autonomous regions but, at the same time, resulting in the upsurge of certain comparative grievances and in a significant expenditure increase.

In Greece, on the other side, a fully-fledged NHS was never realized. Many provisions of the NHS founding reform law were hardly implemented, such as the "unification of major health social insurance funds, the setting up of a unified system of primary care, the decentralization of decision-making and administration and crucial aspects concerning organizational efficiency"[10] (p. 109). The main obstacles to building a truly NHS were considered by the authors, in according with the available literature[12] "a serious lack of support by major social actors, conflicting interests within the medical community, discretionary privileges to particular social insurance funds, and complex ties between the public and private sector fostering corruption and waste of resources"[10] (p. 109).

Therefore, the conclusion of the authors is that divergent trajectories occurred in the two countries, thus rendering the definition of a 'Southern model of health care' quite problematic to apply to them. In fact, "Spain exhibited a socio-political dynamics conducive to a piecemeal, protracted, but steadily proceeding transformation. Moreover, historically characteristics that powerfully promoted multi-level governance in Spain operated as a strong rationalization factor in social and, particularly, in health care expenditure"[12] (p. 120); whereas "Greece exhibits a peculiarly resilient fragmentation in health funding and serious inequities in access to services and their quality level. This no significant improvement in the allocative and distributive efficiency of social expenditure is recorded in this country as a result of the (admittedly partial) 'path shift' to a universalist NHS. Due to strong 'veto'-points in a statist-clientelistic constellation of socio-political interests, institutional reform over much of the 1990s and 2000s persistently bypassed the thorny issues of unification of the numerous sickness funds and system rationalization"[12] (p. 120).

Contrary to the conclusions of Petmesidou and Guillén[10] that "the 'path-shifting' trends have not so far converged into a common style of national health care system in Southern Europe" (p. 121) due to "differences in the resilience of historical legacies, in the dynamics of the internal political process as well as in the potential for converted social reforms" (p. 121), a more recent dossier edited by Enrique Perdiguero Gil[13] based on four essays of comparative analysis of the health reform processes in Greece, Italy and Spain argues that

> [...] there were, of course, differences in the health reforms of the three countries due to the peculiarities of each one. Nevertheless, the findings of the four studies support the existence of a Mediterranean paradigm of health reform and open new paths for micro-level studies that will allow a better assessment of how the historical peculiarities of the health systems of the southern European countries can help overcome the current critical situation of healthcare in these countries[13]. (p. 20)

The concept of 'health macro-region' and its application to the European context

From my point of view, I already tried to assess the existence of a specific Mediterranean paradigm in health care by outlining its peculiar characteristics on the basis of an approach centered on the concept of 'macro-region', borrowing it from the macro-regional systems theory proposed by the American anthropologist and sinologist G.W. Skinner and his colleagues[14] with the aim of going beyond the usual borders of the nation-state as dominant spatial and political unit of comparative analysis in a time of globalization. The idea of a 'health macro-region' I proposed[15] is based on the need to expand the analysis beyond the 'health care systems' understood as complexes of resources, organizations, institutions and social actors existing in a given societal context for the prevention, cure and maintenance of health, even according to a plurality of medical paradigms: the concept of 'health system' is in fact more inclusive, because it transcends the health care system as it includes, in addition to it, the complex of

connections that it establishes with the external nature, the resources of the ecosystem and the way they are used by the social division of labour (ecological connection), with the other social, political, economic and cultural subsystems of the society (structural connection), with the person in life world relationships and her/his experience of health-illlness (phenomenological connection), and with the internal nature of the human beings, their physical and mental health (bio-psychic connection), according to the model of 'the quadrilateral' already proposed by Ardigò[16].

Therefore, the model of 'health system' I elaborated[17] is an attempt to redefine the comparative analysis in a wider and more comprehensive perspective on the basis of a connectionist and multidimensional approach including also the ecological, socio-structural, socio-relational, and biopsychic factors influencing and being influenced by the health care system. By applying this model to the European context, I therefore developed a classification of European health systems, articulated in four main macro-regions (figure 1): 1) the Northern Macro-region, including the Scandinavian (Sweden, Norway, Finland, Iceland, Denmark), United Kingdom and Irish health systems, based on comprehensive models of national health services (apart from Ireland, that is a social insurance system); 2) the Central-Western Macro-region, including the health systems of French-speaking countries (France, and Belgium) and German-speaking countries (Germany, Austria, Holland, Switzerland and Luxembourg), based on historically highly developed insurance models of compulsory social health funds; 3) the Central-Eastern Macro-region, including the health systems of Poland, Czech Republic, Slovakia, Hungary, Slovenia, Romania, Bulgaria, Estonia, Latvia and Lithuania, based on models of post-socialist health care systems currently in transition after their inclusion in the European Union; and 4) the Southern Macro-region, including the health systems of Italy, Spain, Portugal and Greece, founded on peculiar models of national health services and on ways of interacting with the respective societal systems substantially different from those of the Northern Macro-region[(d)].

[(d)] We will refer here to the European Union in a broader sense, including the countries considered preferential partners such as Norway, Iceland and Switzerland, as well as the United Kingdom after Brexit. We will not instead consider the Balkan countries of the former Yugoslavia and Albania, given the complex transition they are still going through; nor the ex-Soviet Republics of Ukraine, Moldova and Belarus, given their continuing link with Russia, a Eurasian country: both would probably deserve separate treatment as further health macro-regions.

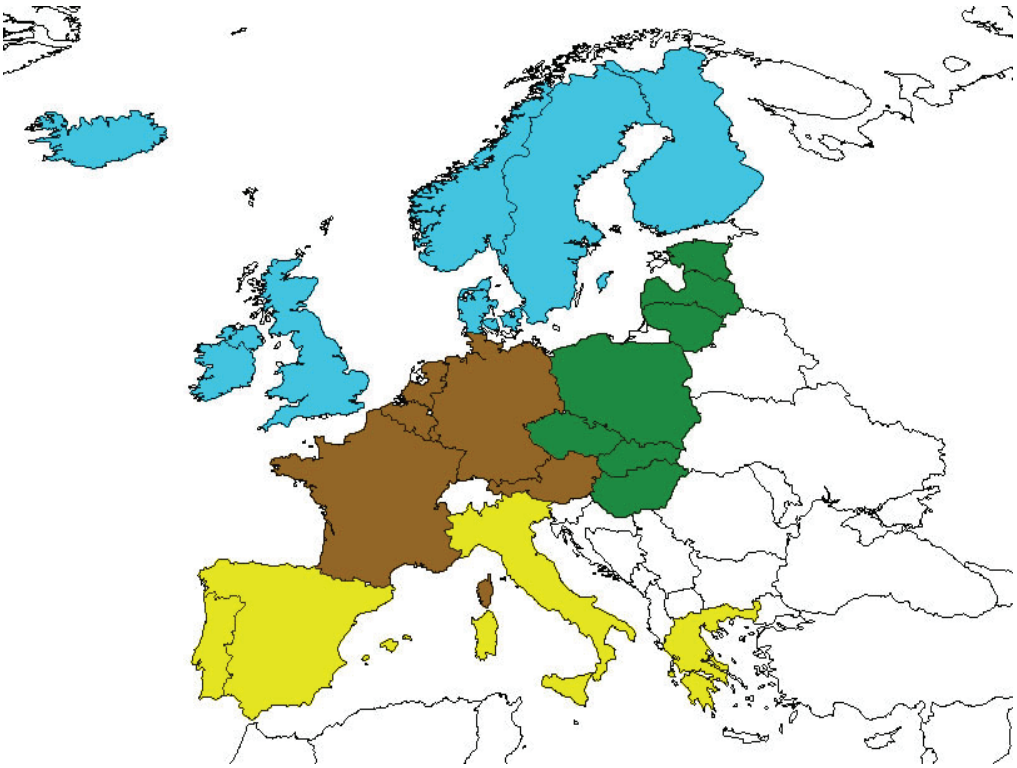

Figure 1. The four European health macro-regions.

While not obviously hiding the significant differences of historical, political, economic, cultural and social nature existing within each macro-region, I nevertheless believed to be able to use the category of 'macro-region' as indicative of a specific 'family'[e] of health systems (and not only health care systems) that share the same 'pattern of connections', characteristic of a given macro-region:

> [...] for 'connection pattern' I mean a specific set of interrelated health systems properties. In this way, we can compare different health systems considered as different patterns of connections, in order to better understand the actual differences between the various macro-regions and interpret them according to a sociological approach[15]. (p. 28)

The heuristic value of the hypothesis was therefore given by the fact of being able to provide a key for comparative analysis of European health systems, certainly not that of providing a new typology of health care systems that went beyond the classic ones[f]; or, even less, of welfare systems: with which only partially coincides. The choice to include in the same Northern Macro-region health care systems in some respects quite different such as the British and Scandinavian ones was made at the time following Roemer[19], who joined them on the basis of their character of comprehensiveness and universalistic coverage: today this choice appears more questionable, given the divergent trajectories that these systems have largely followed in the last two decades, and it would be necessary to split the Northern Macro-Region into two different ones, the British[g] and the Scandinavian.

[e] The idea of a 'family of nations' as an analytical tool for identifying dimensions of affinity between historical cases (which can however also be grouped differently on the basis of other dimensions) was advanced by Castles[7] in the comparative political field, and taken up by Ferrera[3], as well as by himself (Castles[8]), as regards to the Southern European model of welfare state more generally; Smith[18] spoke instead of 'families of area cultures' to indicate the formation of homogeneous cultural areas as potential intermediate contexts of identity construction for the social actors between national particularism and globalizing universalism.

[f] The classic typology of European health systems identifies the three models of the Bismarckian one (the oldest, based on compulsory social health funds, established in Germany in 1883), the Beveridgian (based on a national health service, established in the United Kingdom in 1948), and the Semashko (a centrally planned national health care system established in the post-revolutionary USSR during the Twenties).

[g] Even within the British Macro-region, we can recognize significant differences between the respective NHSs of England, Scotland, Wales and Northern Ireland (Giarelli[20])

But what was the specific 'pattern of connections' between the health care systems and the health systems of the Mediterranean or Southern Macro-region I identified? Using the proposed approach, I tried to picked out, for each of the four significant connections, the properties o variables more suitable to represent the peculiar characteristics of the macro-region and the most proper and feasible qualitative or quantitative indicators[h] to compare them with the other macro-regions.

[h] The methodological choice made here was that of a qualitative-quantitative integration or mix, in order to better represent the complexity of each property.

In this way, for what concerns the ecological connection, its more significant variable that I considered - beyond the usual mention of the warm-temperate climate and of the Mediterranean diet – consisted in the utilization of natural resources by the social division of health work, understood not only in professional, therapeutic and paid sense but also in a wider sense, including unprofessional and unpaid care work. The specific pattern of human resources identified was a configuration of professional resources strongly biased in favor of doctors compared to nurses in relation to the population; and a significant role played by unprofessional family assistants ('*badanti*'). It's interesting to note that this imbalance in terms of human resources, and particularly the predominance of doctors over nurses was combined with an equally evident curative bias of these health care systems, still heavily biased towards hospital expenditure and with the lowest levels of preventive health expenditure compared to the rest of Western Europe.

In fact, with regard to the structural connection, the variable considered was the health expenditure: traditionally, until the 1990s, the total healthcare expenditures of the countries of the Southern Macro-region were among the lowest in Europe, especially in Greece and Portugal. However, in the last decades, these two countries have significantly increased their health expenditures, and the total health expenditure of the Mediterranean Macro-region has reached the same levels and, indeed, sometimes even surpassed that of the other European macro-regions. But if we look at its composition by disaggregating it, we discover that what has remained really low, compared with the other European macro-regions, is the public health expenditure, the lowest in Europe. On the other side, the level of private health expenditure is the highest, on average about 30% of the total health expenditure, with a peak of over 50% in Greece. If we consider that the great majority of these private expenditures is based on out-of pocket payments, we understand that it mainly affects families. Moreover, these data did not include the phenomenon of the 'hidden payments' which, especially in Greece, continues to affect the public hospital sector in order to get better and faster performance from doctors: but that it appears to be present, to some extent, in all four countries of the macro-region, along with the reluctance of the physicians to invoice their private services (fiscal evasion), which is obviously not considered in the context of official statistics.

Regarding the phenomenological connection, the variable considered, given the traditional deficit of 'stateness' of the Mediterranean societies, was the relevant social role of the extended family and of the other social networks in terms of caring and management of the illness episodes, Figueras *et al*.[1] already highlighted the low number of nurses together with "the existing shortage of social and community health care services in these countries. This is due to the significant role of lay provision in the care of the elderly and chronically ill, which has been ascribed to the family structure and the role of women in these societies" (p. 139). In the case of the Greek family, for

example, the definition of 'compulsory altruism'[21] has been used to indicate the central role of caregiver played by the woman in the family context and its strong interiorization by the women themselves. In spite of the most recent processes of urbanization and modernization of the Mediterranean societies and the consequent decline of the extended family and the increasing number of women into the workforce, the central role played by the family and by the women within it in the caring of the sick members remain a fundamental tenet of these societies, testifying the lasting of a solid link of primary solidarity among kin groups and between generations.

Even the role of the social networks, both of informal (friends, neighborhood, etc.) and formal (voluntary associations, advocacy organizations, self-help groups) type, is particularly relevant in the health systems of the Southern European societies, where both the State and the market are quite weak: they are also frequently strictly interconnected with the National Health Service since the third sector, or nonprofit sector, plays a complementary role with the public sector, combining themselves in an original 'welfare mix', Ascoli and Ranci[22], which represents another peculiarity of the Mediterranean paradigm.

Finally, the bio-psychic connection was represented by the epidemiological variable related to the level of health among the people, according to both indicators of life expectancy at birth (LEX) and its corrected version based on the years lost due to illness represented by healthy life expectancy (HALE): the Mediterranean macro-region had in fact the highest life expectancy at birth in Europe after Central Western Europe (78.7 years against 78.9), higher than both the Northern one (78.6) and well above the Central-eastern (72,9). Specifically, it was 79.7 years old in Italy, 79.6 in Spain, 78.4 in Greece and 77.1 in Portugal. Things change little if we consider its modified version on the basis of the distribution of prevailing health status in the population (HALE): the Mediterranean macro-region was again just below the Central-western one (71.4 years versus 71.5), followed by the Northern one (71.3) and by the Central-eastern one (65.1), the most penalized in terms of years lost for disease. Again more specifically, the HALE became 79.7 years for Italy, 79.6 for Spain, 78.4 for Portugal and 77.1 for Greece.

Can we can conclude that all this demonstrates, once again[23], the limited impact of health care systems on citizens' health? The paradoxical pattern of connections of the Southern European Macro-region in fact show a strong relationship between low levels of public health expenditure and a more general deficit of 'stateness' (structural connection), an orientation still strongly curative of the health care systems based on a high ratio of doctors/population (ecological connection), an important caring role of the family and social networks (phenomenological connection) and general health levels of the populations among the highest in Europe and in the world. Overall, awaiting confirmation about this paradox that only further and more complex researches will allow, we can however hypothesize that the complex network of environmental, socio-structural, socio-relational and bio-psychic factors that represent the health system of this macro-region still need to be further and better explored.

An historical perspective: diachronic convergence versus synchronic divergences

A first attempt towards the direction of a deeper understanding of this complex network of factors at the origin of the Mediterranean paradigm could be to analyze it in diachronic perspective by looking at the historical interplay of structure and conjuncture in order to being able to explain both 'path dependency' and 'path deviance'[24] In the first case, in fact, we can hypothesize that structural forces dominate, therefore social change is most likely to be incremental only. The concept of 'path dependence', as Kay[25] put it, is

> [...] neither a framework nor theory nor model [...] it does not provide a general list of variables that can be used to organise [...] inquiry, nor does it provide hypotheses about [...] links between variables [...] Path dependency is an empirical category, an organising concept which can be used to label a certain type of temporal process. The application of this label to a phenomenon is a form of explanation; it competes with alternatives[25]. (p. 554)

Despite these theoretical limitations and its difficulty to being operationalised empirically, I believe path dependency remains a valid and useful concept for sociological studies, too. However, as always Kay[25] suggests, its proper application demands sensitivity from scholars to other temporal dynamics that may operate in social development: therefore, if we identify path dependence with the '*longue durée*' of the School of the *Annales* founded by Marc Bloch and Lucien Febvre, we have to also look to the intermediate time of the conjuncture and to the short time of the events, the '*histoire événementielle*'.

In this perspective, the pattern of four connections of the Southern European Macro-region represents the first temporality, the long span of the '*longue durée*' of the network of environmental, socio-structural, socio-relational and bio-psychic factors establishing path dependence for the social actors insofar its structure is not questioned by them, and their actions are hemmed with it since "the crucial feature of a historical process that generates path dependence is positive feedback o self-reinforcement [...] each step in a particular direction makes it more difficult to reverse"[26] (p. 21) social institutions are hard to change because individuals and organizations adapt their behaviour accordingly, thereby making the institutions self-sustaining. In this case, strong conjunctural forces will likely be required to move the individual and organizational decision-making out of the established paths, to unlock it from the 'lock-in' effects path dependence produces. If "history matters"[27], path dependence explains only stability and not change: and during the Seventies and Eighties of the last century all the four Mediterranean countries experienced a similar significant change with the establishment of NHSs in place of their previous already mature social health insurance systems. Guillén[9] well explained the powerful social forces behind this social change: the processes of democratization after the more or less long experience of authoritarian regimes, the arrival in government of left-wing parties, the pressures towards regionalization, and the public perception of strong health inequalities. These were the conjunctural forces which were able to force the 'lock-in' effects of path dependence giving rise to a second type of temporality, the middle span of NHSs reforms.

However, the pace and the degree of implementation of these reforms varied significantly, as even Petmesidou and Guillen[10] showed: in Italy, a radical shift by the NHS reform took place, that brought to the immediate abolishment of the social health insurances (*mutue*); in Spain, the process was much more gradual and incremental because of a less strong coalition of forces, but favoured by the devolution process and the external circumstance of the adhesion to the EU; in Portugal, a strong coalition of physicians and occupational health funds supported by right-wing parties opposed the NHS reform, establishing a 'three-tiers system' based on public, occupational and private providers; in Greece, a similar coalition of forces opposed the NHS reform, that was only very partially implemented, maintaining a strong role of the occupational funds. All this shows that the constellation of structural factors of the '*longue durée*' continue to work even during the middle span, and its effects in continuing to condition social actors and their actions depend on how strong are the opposing conjunctural forces. The periodical counter-reform attempts to re-establish a social insurance system in both Italy and Spain confirm this underground work that occasionally openly manifest itself.

Finally, by looking at the third temporality of the short span, of the events of the '*histoire événementielle*', we can well see the dialectic of structure and conjuncture at work. From the 1990s onwards, all the four Mediterranean countries experienced serious problems of financial deficit, inefficiency and low levels of management of their NHSs, beside the permanence of relevant health inequalities which were further amplified by the great international financial and economic crisis started in 2007: in response to them, all countries tried to adopt some forms of austerity policy and managed competition. But once again, these attempts to rationalize their health care systems were thwarted by the 'mechanisms of reproduction'[27] by which the institutions are reproduced, and pressures for departure from the path are deflected or absorbed: "each country has emphasized different aspects of the paradigm, and the degree and rhythm of implementation of reform has varied"[28] (p. 1205). As these two authors show, "the crucial factor explaining the different paths of policy adoption and adaptation is the character of the initial health care system"[28] (p. 1205). However, even here the mechanisms of reproduction have been more or less strong, producing significant synchronic differences: because of the power of the medical associations and social health insurance funds in Portugal and Greece, combined with their three-tiered systems of coverage, "the adoption and adaptation of the managed competition paradigm was partially successful in the Italian and Spanish case, while it was almost not existent in Portugal and Greece"[28] (p. 1215).

Conclusions

To conclude, we could say that if we look at the Southern European health macro-region in historical perspective, we become able to explain both its diachronic convergence and synchronic divergences on the basis of the constant dialectic of structure and conjuncture[29] in fact, whereas the first one (diachronic convergence) is the result of the continuous operation of the mechanisms of reproduction of the network of factors at the origin of the Mediterranean paradigm (the pattern of four connections), the second ones (synchronic divergences) are related to specific conjunctural factors existing in each of the four countries and favouring or opposing political reforms and social change. The results in terms of path dependence or path shift strongly depend on the outcomes of this dialectic. This in turn shows that whereas the concept of health macro-region is particularly useful to analyze and explain the long-term historical processes at the origin of the mechanisms of social reproduction, a diachronic analysis of the short and middle-term processes is the necessary complement in order to fully understand social change.

Conflict of interest

The author have no conflict of interest to declare.

Editor
Antonio Pithon Cyrino
Associated editor
Lina Rodrigues de Faria

Submitted on
02/25/21
Aprovado em
06/25/21

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O conceito de um "paradigma mediterrâneo" foi levantado por Josep Figueras em 1994, como um modelo distinto do Sul da Europa para os sistemas de saúde da Itália, Espanha e Grécia, com base em seis fatores. O debate subsequente (incluindo também Portugal) é reconstruído com base em argumentos prós e contras. A contribuição específica do autor para o debate - consistindo na proposta do conceito de 'macrorregião da saúde' como ferramenta analítica para buscar uma abordagem mais abrangente em termos comparativos a partir de um modelo conexionista - é então apresentada em detalhes. mostrando as características peculiares da macrorregião da saúde do Sul da Europa. Finalmente, uma perspectiva histórica envolvendo três diferentes tipos de temporalidade (período longo, médio e curto) é proposta para explicar tanto o tempo substancialmente semelhante (convergência diacrônica) quanto, ao mesmo tempo, as diferenças significativas (divergências sincrônicas) entre os sistemas de saúde da Europa Meridional na forma e níveis de como seus serviços nacionais de saúde foram implementados.

Palavras-chave: Paradigma mediterrâneo. Sistemas de saúde. Macrorregião de saúde. Convergência/divergência. Temporalidade.

El concepto de un "paradigma mediterráneo" fue levantado por Josep Figueras en 1994, como un modelo distinto del Sur de Europa para los sistemas de salud de Italia, España y Grecia, con base en seis factores. El debate subsecuente (que incluyó también a Portugal) se reconstruye con base en argumentos de pro y contra. La contribución específica del autor para el debate, que consiste en la propuesta del concepto de la 'macrorregión de la salud' como herramienta analítica para buscar un abordaje más incluyente en términos comparativos a partir de un modelo conexionista, se presenta entonces en detalles, mostrando las características peculiares de la macrorregión de la salud del sur de Europa. Finalmente, se propone una perspectiva histórica envolviendo tres diferentes tipos de temporalidad (largo, medio y corto espacio) para explicar tanto el tiempo substancialmente semejante (convergencia diacrónica) como, al mismo tiempo, las diferencias significativas (divergencias sincrónicas) entre los sistemas de salud de Europa Meridional en la forma y niveles en que se implementaron sus servicios nacionales de salud.

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