

Papaelias, Theodore

Article

Globalization and welfare state: The effect on health systems

SPOUDAI - Journal of Economics and Business

Provided in Cooperation with:

University of Piraeus

Suggested Citation: Papaelias, Theodore (2011) : Globalization and welfare state: The effect on health systems, SPOUDAI - Journal of Economics and Business, ISSN 2241-424X, University of Piraeus, Piraeus, Vol. 61, Iss. 3/4, pp. 48-64

This Version is available at:

<https://hdl.handle.net/10419/96186>

Standard-Nutzungsbedingungen:

Die Dokumente auf EconStor dürfen zu eigenen wissenschaftlichen Zwecken und zum Privatgebrauch gespeichert und kopiert werden.

Sie dürfen die Dokumente nicht für öffentliche oder kommerzielle Zwecke vervielfältigen, öffentlich ausstellen, öffentlich zugänglich machen, vertreiben oder anderweitig nutzen.

Sofern die Verfasser die Dokumente unter Open-Content-Lizenzen (insbesondere CC-Lizenzen) zur Verfügung gestellt haben sollten, gelten abweichend von diesen Nutzungsbedingungen die in der dort genannten Lizenz gewährten Nutzungsrechte.

Terms of use:

Documents in EconStor may be saved and copied for your personal and scholarly purposes.

You are not to copy documents for public or commercial purposes, to exhibit the documents publicly, to make them publicly available on the internet, or to distribute or otherwise use the documents in public.

If the documents have been made available under an Open Content Licence (especially Creative Commons Licences), you may exercise further usage rights as specified in the indicated licence.

Globalization and Welfare State: The Effect on Health Systems

By

Theodore Papaelias

Professor in Economics, TEI of Piraeus,
250, Petrou Ralli & Thevon., 12244 Aigaleo, Greece, thpap@teipir.gr

Abstract

The appearance of the national state is the most important event in the passage from the Middle to the New Ages. The rapid growth of commerce and cities strengthens the exchanges between different regions of Europe, primarily, and the rest of the world, secondly. The cottage industry transforms into handicraft and that into manufacture. The industrial revolution in the 18th - 19th century creates an intense social issue. The consequence is the emersion of the welfare state since the early 1880. After the 1929-33 crisis, the state intervention enforces the welfare state as the dominant regime throughout Western Europe, and establishes a standard for many countries. After the oil crises in 1973 and 1979 and the rise of liberalism, the welfare state confronts a sharp criticism. The fall of existing (real) socialism accelerates the evolutions and the prevalence of globalization leads to its decline. Health systems are the main, perhaps, expression of the welfare state. The paradigms of Bismarck and Beveridge dominate in most countries of the world (whereas, the liberal model in the U.S.A.). The expenditure on health amounts already to 9% or more of GDP, in 1980. But after this decade, a decrease begins, particularly in the public shareholding. This decay leads to a continuous reduction of public expenditure and to the increase of private insurance. The health systems, for a variety of reasons (adverse demographic evolutions, decline in income share of Europe in world GDP, e.tc.), will suffer eclipse.

JEL Classifications: I10, I30.

Keywords: Welfare state, Globalization, Health system, Liberalization, Paradigm of social construction.

1. Social state: rise and decline

The appearance of the national state is the main characteristic of the transition from Middle Ages to New Ages. It could be argued that the gradual development of the national state¹ resulted to the collapse of feudalism, making this institution obsolete and inappropriate for rising new issues. On the contrary, the gradual decay of feudal relations made possible the emergence of the national state. Thus, the national state started to prevail in the west countries within the

15th century. In most cases it was converted or tended to be transformed into absolutism². Initially, the social evolution was “natural” an imitation of tour de force (feats) of the ancient world. On this basis, most of it was matured and, in this sense, *Humanism* and *Renaissance* aroused (a return to the commercial word of Antiquity against the marshes of the idiocy of rural life)³.

Therefore, the path that some thinkers of the Historical School have identified followed⁴: *family or household economy (geschlossene Hauswirtschaft)*, *urban economy (Stadtwirtschaft)* and lastly, *national economy (Volkswirtschaft)*.

Trade, due to discovering and inventions was broadened and, without the effects to be completely perceived, the competition extended the European market, the demand was multiplied and gradually the *cottage industry* was converted to *handicraft* and this to *artisanship* and later to *industrial*. In the meantime the “blooming” of science has led to speed changes in technology. People in 16th or 17th century might have as a paradigm the Antiquity, but regarding the technological evolution, a simple comparison would have proved that the most advanced years of ancient world were technologically “undeveloped”, compared to the achievements of the West. Correspondingly, the industry revolution has firstly started quietly (meaning that social evolutions were not predicted) and after years, when one compared 1850 to 1800, he could easily understand the darkness (the Erebus) that has intervened.

However, the rise of industry, extreme suddenly, created inevitably an extensive working class and consequently, the *working issue* was set on the agenda.

These evolutions (1750-1850) raised the following three questions: *firstly*, the *individual freedoms*, that after the American and the French Revolution were root as a belief on the whole society. The absolutism seemed incompatible to the people's needs (and their convictions), because everybody, from the pauper till to the great capitalist, was under pressure.

Secondly, there was the *social matter* (as a result of the industrialization) and *thirdly*, and more complex, the *problem of nationalities* (the terms of ethnic - later *the principle of nationalities*- initially was in favour of one state- nation, its expansion and the enslavement of other genders had slightly covered the subject). The irredentist was often connected to the social issue, so were the political freedoms with the latter. At the beginning, the *Spring of the People* (1848/9) hid in some way the complex reality that was deformed by the asymmetric industrialization of Europe. In these years the third matter started to be solved. In the 19th century several nations established⁵ and after the end of the war in 1918 even more.

Nonetheless, after 1850, the most insightful never doubted about who would be the opponents (workers-bourgeois). So, in general, until the first quarter of the century, were “solved” nearly two out of the three issues (civil liberties and the matter of nationalities).

Regarding the other problem (the working class) Bolsheviks⁶, Fascism and Nazism tried to give their own answer in the next time. At the part of the West, where parliamentary system still remained, catalytic role for the solving of the problem procedure played the unification of Germany. The union of German people (unification under Prussia, 1871) and the simultaneous try for rapid industrialization in order to reach or exceed the rest of Europe (mainly Britain and France), created a huge social problem. *Bismarck*, the pivotal statesman in this era, without close liaison to liberals (industrialists and part of the bourgeoisie), in order to impose social peace was initiated in two ways: on one hand, imprisoned the leaders of the newly established Social Democratic Party, on the other hand he implemented a wide-range social policy⁷, undoubtedly the widest on a global scale had ever been emerged. The *welfare state* arose at the decade of 1880 and soon its logic started to influence the whole continent.

The next wave came along the 1929-33 crisis. *Keynes'* views will give a new impetus. The positions of state intervention during the time 1936-1980 will impose across Europe, and not limited to, the Welfare State as the main reply not only to the existent socialism, but to the unbridled liberalism. The ascending of the governments of *Thatcher* and *Reagan* in the years 1979 and 1980 respectively in Britain and USA will become the start of the end of an era. Since then, the decay is clear and has been the target of next governments. The fall of existent socialism (1989-90) will give the final strike (as no longer exists an opposite part). Globalization will prevail and the *welfare state* tends to be history⁸.

2. Health System: Mechanism of inequalities shrinkage

The Health System⁹ which is based on the principles of Bismarck is consisted of funds. The employee, depending on its occupation (the Historical School and the *ex cathedra socialismus* has significantly influenced), is subsumed at the correspondent fund. Initially, the fees were paid by the employer and the employee; next the state was participating too.

The next important step was the *Beveridge plan*¹⁰, which started to function in Britain after 1948¹¹.

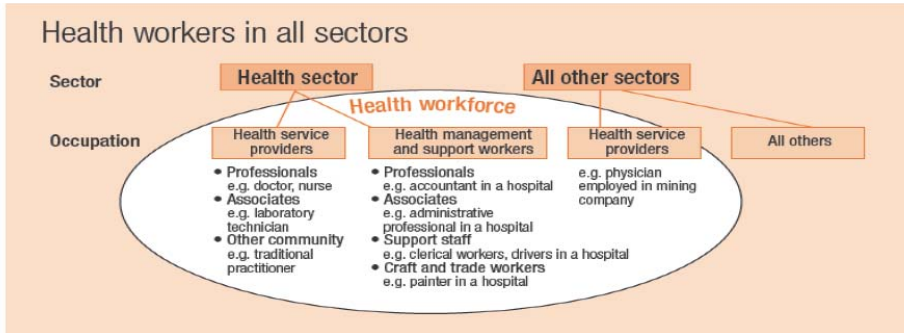
At the countries of former existent socialism there was exclusively state care (System Semashko, from the commissioner to USSR where the referee was¹²).

The liberal or open Health Systems operate on the basis of market mechanism (classic case: USA)¹³.

According to ISCO 88 the employees at the Health sector and at all organizational levels¹⁴ are classified as follows:

FIGURE 1

Classification of health workers according to World Health Organization



Source: The World Health Report (2006).

Having taken the data into account (life expectancy, infant deaths, cost in relation to GDP e.tc.) the liberal system lags. For many people, in reality, it is not a real Health System.

According to OECD (2008) the health expenditure as a proportion of GDP at 2007 (before the recession) at USA was 16%, while the average of OECD was 8,9%¹⁵. The Scandinavian as well as the Western Europe countries spent between 9% and 11%.

At the proportion of Physicians per 1000 inhabitants Hellas was the first with difference (5,4 against 3,1 of the average of OECD and 2,4 of USA). Korea, Mexico, Turkey, Austria and Spain developed quick rhythms of physicians augment in relation to Greece -but this is due to the low base of boot- (OECD, 2009).

Important role to the effectiveness of the System has the number of nurses per inhabitant.

Diagram I in the Annex indicates the relation of the physicians' number and life expectancy (however not totally linear, the correlation is clear: larger number of physicians' – longer life expectancy).

Diagram II in the Annex presents the spectacular improvement (prolongation of life expectancy) in the post 1960-2007 period, when all countries aimed at providing high (quality) level of health services and there was apotheosis of *welfare state*.

However, the perception change (the paradigm of the state intervention) that started to dominate with the rise of liberalism (1980 onwards) and the trend towards globalization had as a consequence the Health System to be considered expensive, since it absorbs a large proportion of the available resources.

The decay of welfare-state, the taxes rate reduction, which burden the higher and middle income strata, means less revenues (to the budget) and therefore fewer expenses. So, from 1990 onwards, there is an endogenous tendency to de-

crease the state's share in the health expenditures. It is presumed- *Diagram III* in the Annex- that between 1990 and 2005 (before world crisis) the public expenditures tend to remain stable or even declining, while the needs, due to the population ageing, are multiplied.

According to our estimations, in 2020 public expenditures will not exceed 60% of the total expenditure in most countries, tending to be further shrunk, while in 2005 they were ranged around 73%. Consequently, the lower social strata (*humiliores*) are increasingly being forced to finance on their own (personal income) their health expenditures (individual expenditure will be, therefore, expanded and the Health System will be turned into the American model). It should be noted that on the official data no other expenditure outside the system is included (under the table payments, e.tc.), which over time tend to be increased.

Under these facts, the civilians, constantly deprived of health care, seem to be resent towards the falling Health System (the decadence is close). So, for instance in 2003, according to the Eurobarometer, only 13% of EU citizens (of 15) remained satisfied. The 31% wanted changes and the 38% radical reconstruction of the System. Other sources- *Table I* in the Annex- showed similar point of views in 21 European Union countries.

3. Globalization: Reasons, tendencies

There are three ways for organizing the society in the most famous civilizations, at least since 4th millennium B.C. (Papaelias 1998, 2003). The first regards the *nomadic life*, the second refers to the *city-state* and the third to the *empire*.

According to the *first system*, the social affairs are simple' almost all the civilizations passed this phase: the *leader* and the *crowd* (Der Führer und die Horde). It is a common organization, which one could find in lots of species within nature. The individual has a wide range of freedom. The *second paradigm* (under the sense of Kuhn¹⁶) has to do with evolution, but also with the transformation of the previous. The emigrants, on account of many reasons, are installed, initially temporarily but later permanently, in a place. Usually, a group of tribes, in which is added in course others, constitute the first communities. Many civilizations remain at this phase of assembly. When the prerequisites are followed (land beyond a critical limit, communities with relevantly common interests e.tc.) it arises, not randomly, an impetus, so that the dynamic is being continued. The union creates the *city*, which can be accomplished voluntarily or forcibly.

The settlement consist the prehistory of the city (το *άστυ*) and after a long time, when the exact conditions of establishment of city-state are forgotten, various myths are built¹⁷. The founders were heroes protectors and were apotheosized (*Panathenaea* was the main celebrity of the habitants of Athens).

This structure prevailed for centuries at the Mediterranean area. However, on grounds, like Egypt, Mesopotamia, Middle East a *third paradigm* appeared. In the Greek region, at least until the 5th century, it was not appeared any tendency to constitute an empire¹⁸. The small and semi-infertile plains on the south of Thessaly did not allow the creation of a prolonged state (hegemony). So, the perception of partition (the concept of segmentation) of the *platonian ideal, of Aristotle's measure* (το μέτρο) predominated in the Greek territory.

On the contrary, in the near East (not to mention in Far East) empires were set up¹⁹. The enlargement trend was endogenous and in the unavoidable conflict between cities-states and empire, the latter lost, initial, as had crossed the "limit". On the other hand, in Macedonia on account of the united of the ground and the kind of social constitution was formatted a kingdom, which subjugated the declining cities-states of southern Greece at the beginning and afterwards managed to be imposed to the East²⁰. In the West, respectively, Carthage will lose its forces in the struggle (decline as the deciduous in the winter), while Rome will achieve. Consequently, in antiquity co-exist the *three paradigms of social formation*²¹. The Roman hegemony in the (almost) then known world will indicate that the empire constitutes the most effective way of administration: a single law, freedom to do and move, nearly the same trading customs from Scotland to Persian Gulf (a precocious Laissez faire et laissez passer).

The Middle Ages has operated vice versa: from the time when the nomads and the semi-nomadic swarms crashed the empire, the medieval world was created a few centuries later: this structure consisted by semi-autonomous states (baronies), which functioned as quasi cities-states. Nevertheless, they differed from these, due to the fact that they were mostly agricultural settlements and in most cases introverted, in opposition to cities-states of Antiquity which were commercial- craft businesses and extroverted.

From the wreckage of medieval world²² will emerge the national state that tended, predictably, towards autocracy. The antagonism that existed inside a relatively unified space²³ (depending on the Greek cities) and the attempt for unification had as a consequence the development of market or free economy (free in relation to the existing restrictions)²⁴. Therefore, after the 16th century, the commercial capitalism tends to prevail, where the economic power belongs to the people of the cities, while the feudal lords implement the policy. In the long-run, however, as the English case and the French Revolution showed, this was not possible to longevity (prosper), because the economic conditions come to conflict with the political conceptions. The industrialization, result of the competition (between the states) on the technical improvement (resulted the development) for higher profits and dominance, empowered the mechanisms, which endogenously crushed the small producer in favour of the big one. The emergence of oli-

gopolies was inevitable. Despite the prevalence of the existent socialism after 1945 the competition expanded, as the rivalries of the systems focused on the quantities of the consumer goods, which the system could provide to its citizens²⁵. The road to globalization, visible in the 19th century²⁶ was halted, in some way, by the two world wars and the middle war period crisis, to come again with accelerated rhythms after the conflict. It was clear that, as in the army, only the large formations had a future²⁷. In this sense, the *welfare state* which was created to shrink the weaknesses of the civil system (capitalism) had become a brake and globalization started to compress it suffocatingly.

4. Globalization effect on health system

Health Systems are based on the principle of social solidarity. Assumed that as long as people participate in a community they lose part of their freedom but in the meantime they receive security. Consequently, the middle and lower economic strata, in order to qualify for the care that society defines as minimum, must be covered by a Health System. This is and the main reason for creating it. The upper class (*the honestiores*) apparently not affected by any Public Health system or Education. Under these conditions they maintain a critical position towards enlargement (and improvement) of the public health system (and education), since the creation and operation every system (by definition) comes to a diametrical *antithesis* with the financial rewards or (and) limits the horizon of their action²⁸.

According to liberals, the state should take part in the economic activity at the minimum, providing fundamental operations, having as basic mission the accomplishment of “*order and security*” inland and the protection of the defense outland²⁹.

The prevalence of globalization, unavoidable as noted above, has as a result the transfiguration of ideologies. The welfare state, developed on the ground of national space, emerged from the industrialization and the civil belief for equal chances (Liberté, Egalité, Fraternité) and, consequently, from the confrontation for mitigation of the negative effects of the capital accumulation (uneven distribution of wealth and expansion and maintaining of poverty). Its function is being implemented inside the framework of the specific (national) entity. Therefore, its existence into globalization regime contradicts this and for this reason tends to dissolve. Europe, in which it has been developed, is being transformed and thus the principles, that were gained as a post war prize (γέρας), are lost.

Since 1950 in Western Europe occurred the experiment of voluntary union, the creation of a supranational constructs (a kind of regime), the EEC. (In Antiquity or in Middle Ages when the violent reunification failed, it was often pro-

posed the voluntarily one, like the Ionian League (*κοινόν Ιώνων*), the Achaean League (*Αχαική Συμπολιτεία*), e.tc.)³⁰. The common substrate, namely the associated customs and traditions and the similar level of technology and therefore development, gave the impression at the years of innocence (1950-80) that the tendency for integration would be stable.

A theory on “(*constant*) *progress*”³¹ was embraced (the ideological background), which had been emerged as a quintessence after the age of Enlightenment. So, efforts were made through the mechanisms of the community to dominate a single European space³². Despite the continuous endeavors, there were, at least till 2004, four (4) systems of welfare states³³ and any diminution of the deviations will take many years.

5. Future evolution: a comment

The economic transformations after the 18th century were rapid. Initially (18th, 19th), the industrialization predominated in Western Europe and North America. In the first half of the 20th century, it was expanded to most countries of the world. At the beginning of the 21st century, all areas are attempting to be developed, i.e. to be industrialized. In the former Western World, cradle of the system of market economy, fundamental changes have occurred. While once the working class has prevailed (manual and skilled workers) the majority of workers are employees now.

At the beginning of the 20th century, the biggest part of GDP of the developed countries originated from the manufacturing (mainly heavy Industry). In 2010 the biggest part of GDP comes from the services. This has huge social and political effects. The perception (education, condition of employment e.tc.) of the worker diverges from the one of the employee (the *weltanschauung* between the two deviates seriously). The self-employment augments or its maintenance to other regions in high rates strengthens the small and middle class (consists mainly by these strata). These variations (rise of the middle class) with the catastrophes of the World War II had as a consequence the widening of the *welfare-state*.

From 1970 onwards the entrance of countries of former “undeveloped” world in the global market, on the one hand, and the constant growth of *welfare-state*’s cost, on the other hand, led the system to crisis. A large part of the capital is directed from the developed countries to the poor ones, where salaries are low.

Initially, the re-entrance of the profits to Metropolis did not seem to disturb the system seriously. The collapse, however, of the existent socialism and at the same time the acceptance of the system of free market (with the institutional framework and the perception which it draws) creates a new kind of primitive *accumulation*.

The capital may remain in emerging economies increasingly. Taking into account the growing obsolescence of the work and the technical improvement in developed countries, a “de-accumulation” is visible. The development of new countries makes the commodities, which are being produced in the developed countries, increasingly expensive and thus less competitive.

In the first place – on account of the social pressure- the electoral clientele demanded for such energy. It was a matter of time before the occurrence of the crisis, which in the first phase seemed to be as financial, meaning that it reaches the superstructure. Soon it will be converted to economic crisis.

Since the freedom of trade is maintained (*laissez passer*), alongside the capital and the employees became commodities “for liquidation” -the emigration proves it³⁴⁻, two opposite flows will appear for a long time: Capital from the developed countries to the less developed and working labour from the poor to the rich countries. The tendency for equation (on account of osmosis) would impoverish the weak members of the centre (but not only).

Under these circumstances, the welfare state has no future and the first victims will be the Health Systems. This means that, at least in the medium-term, the situation in the field of healthcare will be significantly getting worse to almost all the developed countries.

Endnotes

1. Spain preceded it, superficially, more spectacular and became initially the most powerful kingdom, on account of the war of *Requonquista* between 10th and 15th century. This state, however, did not come from a radical transformation of the feudal structure (part of their logic was maintained), but as a restoration of a primary medieval *hegemony*, like the Byzantium or the one of *Charlemagne*. In England, despite *Magna Charta* (1215), the king until *Cromwell* will remain, even though not an absolute monarch, however powerful. France in the Hundred Years' War initially strengthened the kingship, but the later weaknesses of the house of Valois (Maison capétienne de Maison capetienne de Valois) and the Reform undermined the king. It was *Richelieu* who would create the autocracy and the weakness of the opponents of monarchy at the sling (*Fronde*) which allowed this type of government until the French Revolution.

2. A popular approach: Anderson (1974).

3. As *Marx* and *Engels* have noted in the *Communist Manifest*, describing the general urbanization that the industrial revolution provoked.

4. Bücher K. (1901). *Die Entstehung der Volkswirtschaft*, Tübingen.

5. Greece, Serbia, Bulgaria at the Balkans, Italy and Germany in the center of Europe created states.

6. Essentially, October Revolution seek to solve simultaneously and the three issues (nationalities, freedom and social matter).

7. The measures taken by *Bismarck* besides the education, the political marriage e.tc. were directed to the social field: in 1883 foundation of a health system, in 1884 laws about working accidents, in 1889 insurance system.

8. More details next.

9. According to W.H.O.: “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. A health system includes:

- a) human resources
- b) building, venues and all kind of medical infrastructures and equipment
- c) materials and economic resource, meaning the funding of the system
- d) technology (use of methods and products of technological innovations) and
- e) the management of the system

10. Landmarks in the evolution of British health system

1911	Establishment of “National Health Insurance Organization”
1942	Presentation of Beveridge system
1946	Passage of law “NHS Act” for England and Wales
1948	Foundation of National Health System (NHS)
1962	Implementation of hospital program and insert of the term of Prefectural General Hospitals
1973	Formation of Regional Health Authorities (RHAs)
1982	Operation of District Health Authorities (DHAs)
1991	Operation of Family Health Service Authorities (FHSAs)
1999	Renaming from DHAs to Health Authorities and operation of Primary Care Groups (PCGs) / Development of National Institute of Clinical Excellence (NICE)

Source: (Ifantopoulos and others, 2004).

11. More specifically the main variation of these two systems are summarized in the following:

In the case of *Bismarck* system the main characteristics are:

- Total healthcare coverage
- Contributions by employers and employees (based on the salaries/ wages) initially and later participation of the state (three-part share)

- Compulsory insurance of the employees to the insurance funds, which are non-profit
- Ownership of factors of production to public or private sector

In the case of Beveridge system one could notice the following characteristics:

- Total coverage to all citizens
- Funding through tax-system (Redistributive character)
- The ownership and the control of the means of production belong mostly to the state.

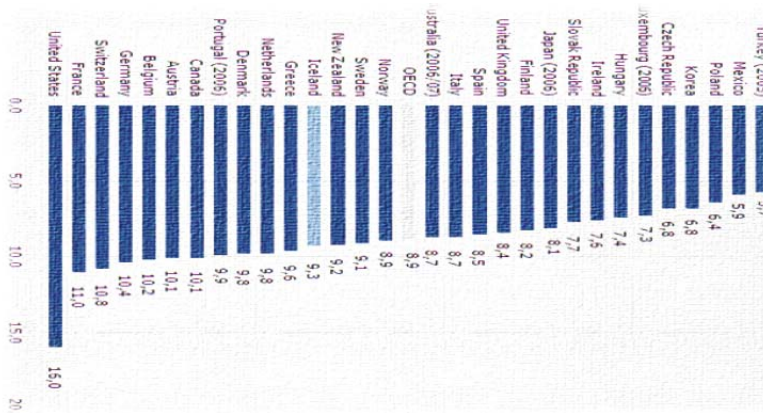
12. There was central leadership (mentoring) which coordinated and controlled the health institutions. At every democracy there was also a “ministry” which had the responsibility of the organization and administration (but subject to the central). At the prefectures there was also a regional management e.tc. The system operated on the basis of central planning. Local fees contributed to the governmental fund.

13. The basic characteristics:

- The consumer-patient choose the insurance and healthcare body (consequently may not be insured at all),
- The production factors belong to private citizens
- Private insurance prevails
- Healthcare coverage is funded by personal or employer’s shares
- The prices of the services e.tc. are being defined according to demand and supply
- The supplier is free to the limit of the reward, his location e.tc. For the situation at USA among others: Department of Health & Human services (2009).

14. The basic organizational levels are usually three: The *elementary*, which has to do with the “welcome” centers of the patients (first contact with a health care provider) it usually concerns the Health Institutions, the family practitioners e.tc., the *secondary* (mostly hospital healthcare, larger part of people is being covered) and the *tertiary* (therapy of specialized cases, refers on a very bigger number of people). Further there is the self-healthcare (help provision by people inside the family or groups outside the Health System).

15. Health expenditure as GDP proportion:



Source: Atlas of Health in Europe (2008).

16. Kuhn K. (1962).

17. Of Romulus and Remus in Rome, Theseus in Athens, to Thebes Cadmus e.t.c. are some of widely known.

18. A reason was the recent appearance of the Greek genders, in relation to those of Middle East. But determining factor was the ground and the climate.

19. The Sumerians were absorbed by the Akkadians and these by the Babylonians, those by the Assyrians e.t.c. so that the empire of Cyrus and Darius which was created included the whole known East.

20. The Peloponnesian War had as result the failure of imposing *hegemony* of a city on the others, meaning a quasi-empire.

21. In essence, in mature and late Antiquity coexisted simultaneously with the empire (the third system of organization) only the primitive (*the first*): the nomads of East and Africa. The first hordes with their barbarian invasions will dissolve the empire, while the second swarms will create the Arabic world.

22. Important role will play the barbaric invasions (Magyars, Normans, Saracens) of 9th, 10th and 11th century.

23. In the first place it seemed to appear variations in the west part of the empire after 4th century. The unification by the *Charlemagne* brought the centripetal forces back. Consequently, the view about the start of modern Europe within this period is not entirely unsupported.

24. In the period between the 12th to the 16th century, the cities began to reinforce themselves, (so to be imposed) over the countryside and the ideology of feudalism.

25. The world market became the target. The freedom of international trade expanded the deviations, contrary to the theory of the Orthodox Economics, to the benefit of the strongest.

26. See Keynes's views in *The Economic Consequences of the Peace* (1923) for the pre-existing of the war situation, or more analytically of Schumpeter in *Capitalism, Socialism and Democracy* (1942).

27. This explains the American Civil War: on one hand, a pre-capitalist perception (rural-hand-craft), introvert, which was connected to the South, on the other an industrial imperialism (extrovert, to the international market), which was the vital interest of the Northern.

28. The pharmaceutical industries, the insurance companies and the suppliers or the service providers (individuals or companies in general) belong to the core of the private system. Hence, the monumental reaction to establish health systems in the U.S.A. is inevitably.

29. The core team consists of the top and the highest strata of the middle class, meaning the mastermind authority (*ordo senatorius*). Every state intervention was considered to restrain the activity horizon of these classes.

30. In the modern period the First and the Second World War proved the unfruitful of the violent association. Already since 16th century, against one "great power" the rest constructed Confederation (Balance of Power). The sequential treaties of Augsburg (1555), Westphalia (1648) and Utrecht (1713) e.tc. confirm it.

31. Meaning that despite the shocks (strong fluctuation), history moves in a positive direction, towards to the best (reduce of the inequities, elimination of illiteracy, communicable diseases, extension of life expectancy e.tc.). The enthusiasm, the thrill for the accomplishment of the six (6) was continued with the expansion of the nine (9) in 1993, of ten (10) in 1981, of twelve (1986), e.tc. With the possible exception of Greece, which along with Italy were considered the cradle of the West Civilization, the enlargements concerned, at least until 2004, a relevantly homogeneous space. One could say that the last enlargement (Romania, Bulgaria in 2007) may deviates lightly, inserting in E.U. countries which did not possessed a very wide range of European background (in the sense of culture, common history e.tc.). See among others: R.G. Collingwood (1946) *The Idea of History*, E.H. Carr (1961) *What is History?*

32. Even nowadays is often repeated the aim that Europe should become something similar to the USA. The latter, however, did not arise from joints of various civilizations with relatively asymmetric interests and priorities. Nonetheless, we should not ignore the intense anti-federal spirit which exists in many states of America.

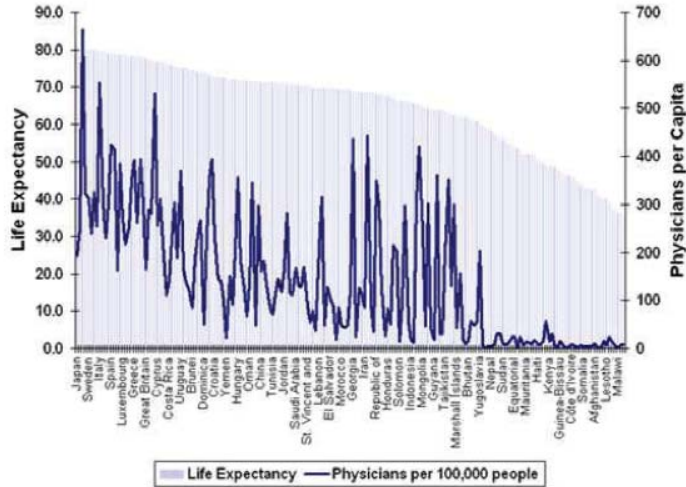
33. The *Scandinavian*, which regards the countries of the peninsula and Denmark, the *Anglo-Saxon* (mostly Britain, Ireland), the *Central-European* (Germany, the Netherlands, Austria, e.tc.), and the *Mediterranean* (Iberian, Hellas, Italy). The new countries (after 2004) at their majority have as a target the Central-European.

34. Initially this was from the village to the town (decade 1960 and after). Hence the massive urbanisation the inevitable impoverishment (pauperism, slums e.tc.): from the countryside to Bombay, from the jungle to Rio de Janeiro' Cairo and the city of Mexico will go under ("sink") by the villagers. Then, the free moving (*laissez passer*) -due to globalization- is converted to external (the rural urban migration is transformed to emigration): from Kabul to Athens and from Cote d' Ivoire to France e.tc.

APPENDIX

DIAGRAM I

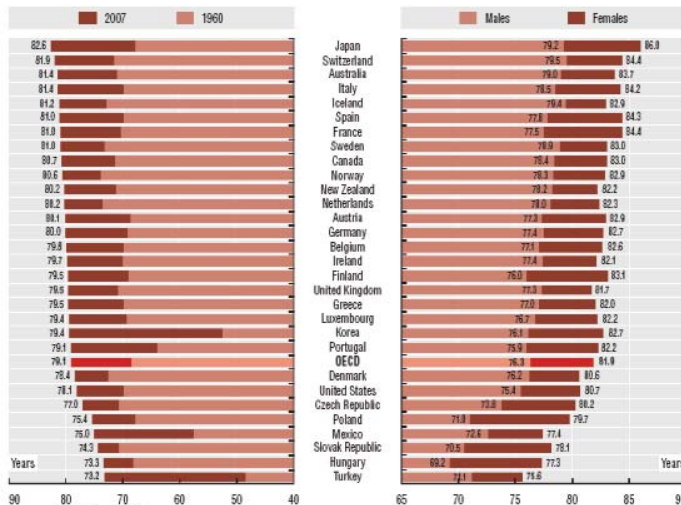
Life expectancy correlation of the physicians' proportion to 100.000 habitants



Source: World Health Organization (2008).

DIAGRAM II

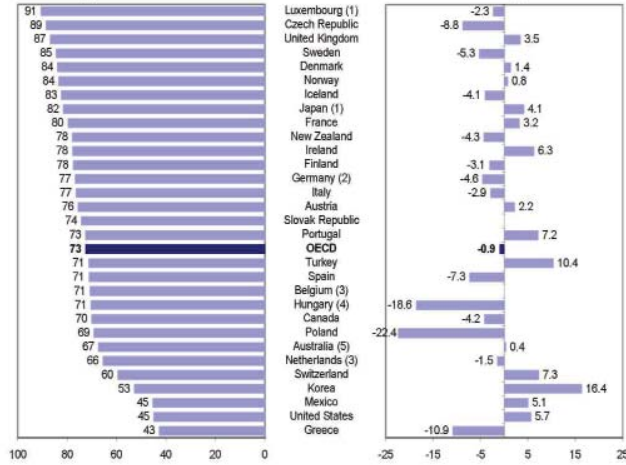
Life expectancy evolution 1960-2007 variations between men and women



Source: OECD, 2009.

DIAGRAM III

Public expenditure at OECD countries 2005 and the change from 1990



Source: OECD Health Data, 2007.

TABLE I: Characteristics of respondents and satisfaction with the health system in 21 European Union countries, World Health Survey for 2003^{a,b}

Country	N	Female %	Age under 65 years %	High School complete %	Very Satisfied %	Fairly Satisfied %	Neutral %	Fairly dissatisfied %	Very dissatisfied %
Austria	1055	62.4	85,7	37,0	70,4	21,7	4,0	2,4	1,5
Belgium	1012	56.4	83,4	75,2	50,3	39,1	6,0	3,0	1,6
Czech Republic	935	52.7	79,6	67,1	10,4	42,6	27,9	17,1	2,1
Denmark	1003	52.6	76,6	46,3	54,4	37,9	3,0	3,8	1,0
Estonia	1012	63.7	77,2	53,4	2,3	25,7	31,9	26,1	14,1
Finland	1013	55.4	71,7	47,5	19,6	58,1	8,5	10,9	2,9
France	1008	59.9	86,4	70,3	37,6	46,5	10,6	4,0	1,4
Germany	1259	59.6	74,7	31,3	19,8	45,2	15,8	13,6	5,5
Greece	1000	50.0	70,1	47,3	16,7	31,3	24,8	13,1	14,1
Hungary	1419	58.4	75,9	48,6	8,0	25,7	44,2	15,1	7,0
Ireland	1014	54.7	84,7	70,0	32,3	37,5	9,6	8,1	12,6
Italy	1000	57.4	77,3	52,7	7,2	41,8	24,2	15,9	10,9
Latvia	856	66.7	71,0	49,3	3,7	28,8	27,6	28,9	11,1
Luxembourg	700	51.1	85,0	55,3	28,6	47,3	11,7	11,0	1,4
Netherlands	1091	67.5	84,7	68,1	28,2	49,7	8,5	10,8	2,8
Portugal	1030	62.0	68,9	21,5	3,9	46,7	21,7	19,5	8,1
Slovakia	2519	61.3	93,1	82,3	1,3	26,2	42,3	21,8	8,4
Slovenia	585	53.7	78,4	54,0	10,6	41,2	27,5	13,6	8,1
Spain	12023	58.7	67,5	29,1	10,8	44,5	30,0	9,4	5,3
Sweden	1000	58.4	73,7	57,9	28,9	38,9	13,0	16,5	2,7
United Kingdom	1200	63.2	71,0	41,5	35,4	39,2	9,3	9,9	6,3

a) Numbers may not add up to exactly 100% due to rounding errors.

b) Satisfaction data are weighted by post-stratification sampling weights.

Data from the World Health Survey for 2003.25

Source: (Bleich, *et al.*, 2009).

References

- Anderson, P. (1974). *Lineages of the Absolutist State*, Verso, London.
- Bleich, Sara N., Ozaltin, Emre and Murray, Christopher JL. (2009). *How does satisfaction with health-care system relate to patient experience?* / WHO. -: Bulletin of the World Health Organ.
- Bücher (1901). *Die Entstehung der Volkswirtschaft*, Tübingen.
- Department of Health & Human services, *Centers for Medicare & Medicaid Services*, Baltimore, Maryland, (2009).
- Hellenic Statistical Authority, various years.
- Kuhn, T.S. (1962). *The Structure of Scientific Revolutions*, University of Chicago Press.
- OECD Health Data*, various years.
- Marx, K., Engels, F. (1848). *Manifest der Kommunisten Partei*, Dietz Verlag, Berlin.
- Papaelias, Th. (1999). *The genesis of globalization: effects and evaluation of intervention measures*. 3rd Scientific Conference with subject: "Globalization and Social Economy", 22-24 October, Messologi, pp. 198-211.
- Papaelias, Th. (2003). *The community in the context of globalization*, 4th Scientific Conference with subject: "Globalization and Social Economy", 6-8 June, Messologi, pp. 188-201.
- Papaelias, Th. (2006). *Supply and demand of specialties on the Greek educational system*, Dionikos, Athens.
- Ifantopoulos and others, (2004). *Satisfaction measurement of the provided health services at a Children Hospital of Attica*, Archives of Hellenic Medicine. - Athens : [s.n.], May 5, 2006. - pp. 73-82.
- World Health Organization, *The World Health Report 2000. Health Systems: Improving performance*, Geneva, (2000).