The debate on health in Portugal: Governance of Health Care and the welfare modernization Agenda

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Summary

Portugal is facing major changes in the governance of health care. The main goal of the paper is to review the strategies developed in Portugal health care systems in the last three decades to improve coordination among health care providers. The development of Portuguese health policy can be divided into three periods that are linked to the general welfare state development. The initial impetus towards the establishment of a National Health Service, following the classic British model, was weaker, while going creating a system of integration of health services offered by private and non-profit social institutions. During the 2000, in contrast, a series of coordination strategies have been launched in Portuguese Health care systems. The current Socialist government has made a bid to revitalize some of the larger principles that once inspired the creation of the National Health Service, designing a set of strategies aimed at enhancing the universality, equity and quality health system.

The Portuguese Welfare State

Portuguese welfare state development seems to follow the southern pattern and is analysed from the viewpoint of the Southern European welfare state type. The Portuguese case is characterized by a weak institutionalization of constitutional promises of social rights and by a semi-institutionalized welfare state that has been built up in principle, yet not implemented in practice. On the one hand, it is recognized that southern welfare states have during recent decades been catching up the more developed European welfare systems. But in spite of the catching-up effect and the overall pressure towards convergence of social policies in the European Union, Southern European countries seem to maintain a relatively distinct type of welfare state.

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The notions of semi-institutionalized and catching up-effect conceptualize the Southern European welfare state on the one hand as a developing welfare state and on the other hand as following a different path than the more northern European welfare states. The attempts to institutionalize welfare state in Southern Europe occurred simultaneously with the era of welfare state crisis. Consequently, the crisis rhetoric was assumed in Portugal in the initial phases of welfare state development. Thus, the welfare state was declared to be in a state of crisis before it actually even existed. Due to the dynamics of crisis before maturation, Portuguese welfare state has remained to some extent a semi-institutionalized promise until the present day.

2. The creation of the NHS Portuguese and the first wave of health reforms (1974-1989)

The Carnation Revolution in 1974 ended a long period of authoritarian rule in Portugal and opened the door to the democratization of the country. As in other Southern European countries, the democratic Constitution was of a progressive nature while conferring wide social, economic and cultural rights and duties on the citizens.

Despite the remarkable political instability in this period of recent Portuguese history, it can be said that the first three decades after the Revolution of 1974 involved the development of a model health organization to ensure access to health care as a social right. At this stage of democratic expansion of the Welfare State, the main objective of health policy was to reduce barriers in access to health care, increasing public offering of health benefits.

The Constitution that came into force in 1976 aimed at the creation of a welfare state as a political form of transition to a socialist state and society. Although the goal of a socialist, classless society was removed from the Constitution in its reform in 1982, the state's responsibilities to guarantee the economic, social and cultural rights of its citizens were left untouched. Welfare state remained the ultimate goal, but the socialist model was changed to the model of social protection the European Economic Community advocated.

The National Health System

At the beginning of the seventies, within a context of social, economic and of generally unfavourable health indicators, the reform of health system took place. The foundation of the NHS based on the principle that everyone has the right to health protection through a universal, general and free National Health Service. It was a public-integrated model. The insurance and provision functions are merged and health care is organised and operated by the National Health Service. Health professionals are public sector employees paid on salary, although physicians working for the NHS are also allowed to have private practices. Well identified strengths of the public-integrated model are its ability to ensure complete population coverage and to contain the growth of overall costs. On the other hand, such system usually provides weak incentives to improve efficiency and maintain quality and responsibility to patients' needs.

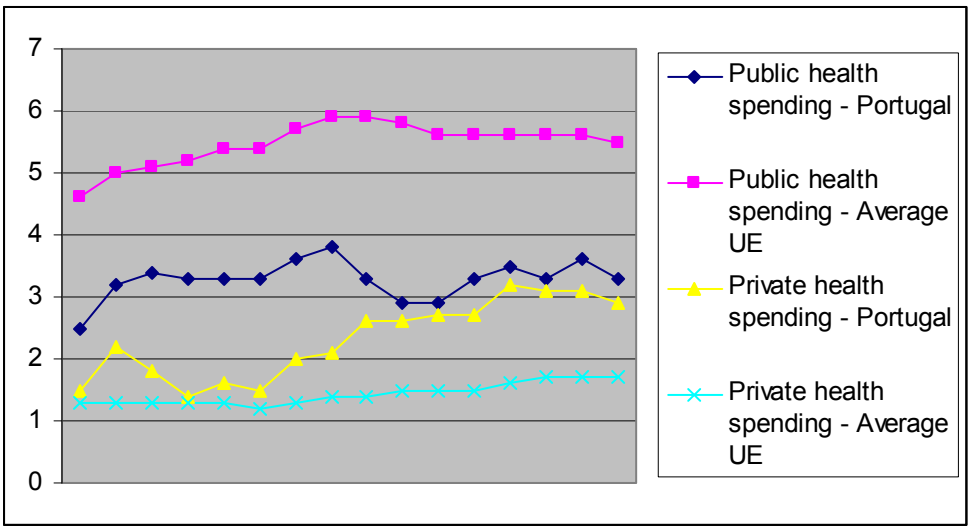
In 1974, district and central hospitals owned by the religious charities were taken over by Government. Charity and private institutions are no longer the owners of health care delivery to the population. Local hospitals followed in 1975 and were integrated with existing health services. In 1977, the Government assumed ownership and responsibility of over 2000 medical units or health posts situated throughout the country.

The 1979 law establishing the NHS laid down the principles of centralised control, but with decentralised management. Central, regional and local bodies were established to this end. The law brought together public health services and the health services provided by the social welfare system, leaving the general social security system to provide cash benefits and other social services.

The law enabling the implementation of this principle was not passed until 1979. By 1979, legislation had been introduced to establish the right of all citizens to health protection; a guaranteed right to universal free health care through the NHS; access to the NHS for all citizens regardless of economic and social background; integrated health care including health promotion, disease, surveillance and prevention; and a tax-financed system of coverage in the form of the NHS.

The public social expenditure jumped from 1.86 percent in 1970 to 4.27 percent in 1980. However, comparing public health expenditure from Portugal in the early eighties with other European Union countries, it is striking its reduced level along with Greece and Spain, the lowest in Europe. By contrast, private health spending in Portugal exceeded since 1982 in more than one point the average private health spending in the European Union (Table 1).

Table 1. Evolution of health spending (public and private) as a percentage of GDP (1974-1989)



Source: OCDE, 2006.

Despite the development of a unified publicly financed and provided health care system and the incorporation of most of the health facilities previously operated by the social welfare system and religious charities, some aspects of the pre-NHS system persisted. In particular, the health subsystems continued to cover a variety of public and private employees. The schemes offered greater choice of provider than would be available under the NHS and a higher reimbursement level when patients resort to private providers. Consequently, the trade unions, which run and managed some of the funds, forcefully defended them on behalf of their members. In addition, private provision has always been available, mainly in ambulatory care. Physicians

and dentists' private offices, laboratory tests, radiology and pharmaceutical products are the main areas of private provision.

Several authors have suggested that the construction of the NHS outlined in the Constitution was never completed due to its legislative component. Many of the formal commitments from institutional change are not implemented later (Pita Barros, 1997). Despite legislative reforms adopted, the lack of commitment by the governments of Portugal with the objectives of reform, coupled with other factors such as weak capacity of state institutions, the absence of a universalist culture and poor economic growth of Portugal during this first phase democratic, help explain why the model SNS formally adopted in Portugal was applied so incomplete and flawed in practice.

The second wave of health reforms (1989-2002)

During the second half of the eighties began to envision a change in the paradigm of international intervention on health, in response to a broader transformation in the prevailing conception of the role of the State. The effects of the economic crisis that hit many European countries and rising public deficit reinforced a new paradigm emerging economic policy, openly unfavourable to the expansion of public spending and the growth of the State's role as provider of public services (Kanacos and McKee, 1998).

The impact of this paradigm shift in Portugal was remarkable. A majority government had not only the consolidated authority but also the political will to enact policy changes intended to change the mix of instruments and the balance of influence in the health care arena. The Government of Cavaco Silva (1985-1995) began to introduce measures of health policy favourable to the expansion of private financing and delivery. New legislation has been approved separating functions of regulation, financing and provision of health care, setting up new models of financing (implying harder budget constraints), improving management, introducing incentives toward productivity and quality improvement, increasing the role of the private sector, and promoting the use of generic drugs. The rapidity with which these reforms were implemented stresses especially given the backlog of several decades had been verified with the previous wave of reforms, based on the paradigm of NHS.

International commitments and in particular those deriving from membership of the European Community, a crucial factor of economic momentum in Portugal, exercised considerable political pressure on Portuguese governments (Abel-Smith et al., 1995). In an increasingly competitive international economic environment, Portugal opted for moderate expansion of expenditure and allowed the private sector to expand their weight within the health system, even if the political discourse stressing continued adherence to the NHS model. Two restructuring processes also occurred in the NHS in the 1990s: the revision of the Constitution, the establishment of five regions of health – Regional Health Administrations- and the creation of "integrated units" between Hospitals and health centres. The trend towards a public contract model has therefore been accelerated.

In 1989, the revision of the Constitution altered the principal of free health care services. The NHS is financed by the General State Budget and access to hospital and primary care, characterised by being "tendentiously free", requires that, in some cases, the user make a payment (payment of moderating taxes).

The Law on the Fundamental Principles of Health (1990) states that the NHS is managed at the regional level, with responsibility for the health status of the corresponding population, the coordination of the health services provision at all levels and the allocation of financial resources according to the population needs. The key principles of this law were: (i) that the NHS was no longer to be seen as the main form of provision, but as one of several entities (both public and private) involved in delivering care to the population; (ii) that the State should promote the development of the private sector and provide incentives for the expansion of private health insurance; (iii) that care provided under the NHS should be "approximately free" rather than free at the point of contact.

After the Constitution's Revision (1989), the "free of charge" has been changed to "approximately free of charge", a term that has been subject to a discussion about its exact meaning (essentially, detailing the legal meaning of the term to make clear that the Constitution did not preclude the existence of

co-payments in the NHS). The NHS is financed by the central state budget and access to hospital and primary care, characterised by being "tendentiously free", requires that, in some cases, the user make a payment (payment of moderating taxes); (iv) that management of NHS facilities could be contracted-out to the private sector.[1]

The Basic Health Act, established in 1990, defines the health system as the network of participating institutions providing health care services in general, constituted by the NHS and by all the public institutions that develop activities of promotion, prevention, and treatment within the health arena, as well as by all the private institutions and all the free professionals that agree to provide one or some of those activities.

A law of January 1993 regulated some of these broad principles, specifically with regard to organization of the NHS. Among the most important changes were: (i) the number of Regional Health Administrations were to be reduced from eighteen to five and these were given greater autonomy and powers to coordinate the activities of hospitals; (ii) Within regions, health centres were to be grouped with hospitals to form "health units" in an effort to assure continuity of care; (iii) full-time salaried doctors were allowed to engage in private practice; (iv) various forms of private management of NHS facilities and of private health care provision in articulation with the NHS were specified; (v) NHS co-payments were to be established taking into account patients' ability to pay; (vi) an "alternative health insurance" scheme was to be created, whereby private insurance companies would receive from the government part-payment of the premium of persons who opted-out of the NHS.

This is in line with the reform trends in many European countries, which have regarded **decentralisation** as an effective means to improve service delivery, to better allocate resources according to need, to involve the community in health decision-making and to reduce inequities in health. In practice, very little progress has been made in implementing these changes. In practice, however, responsibility for planning and resource allocation in the Portuguese health care system has remained highly centralised, even after the current

[1] Reis, "As questões que se põem aos sistemas de saúde", *Gestão Hospitalar*, p.21-30.

five Regional Health Administrations (RHA) were established in 1993. RHA are appointed by the Ministry of Health. In theory, the creation of the RHA conferred financial responsibility: each RHA was to be given a budget from which to provide health care services for a defined population. In practice, however, the RHA autonomy over budget setting and spending has been limited to primary care, since hospital budgets continued to be defined and allocated by the central authority. It is also the case that the Minister of Health appoints hospital administration boards.

Since the mid-1990s, reforms have been introduced gradually and the system has been moving towards a public-contract model, with the private sector being given an increasing role. The growing complexity of the health care arena was reflected in the political arena. Rapid organizational change created a growing pluralism: in this period, major reforms were introduced focusing on the recognition of a greater role for the **private sector in providing health services,** mainly public financing (Antunes, 2002: 204-206). Providers to the NHS are organised into three networks: the primary health care centres, the hospitals and the long-term care units. Besides the NHS, there are several "corporatist" health insurance sub-systems financed through social contributions. They cover about one quarter of the population (mainly public servants and employees of private financial institutions) and health care is provided either directly by the insurer or through contracts with public or private health care providers. People covered by these subsystems usually also have access to the NHS services. In fact, about one forth of the population benefit from double or triple coverage via the sub-systems inducing a waste of scarce resources.

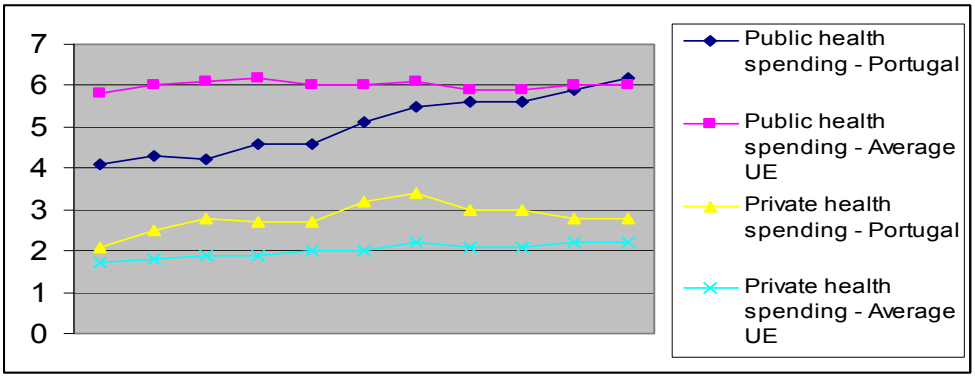
Following the replacement of the Social Democratic government in late 1995 by a Socialist administration there has been a change of emphasis in health reform. At the beginning of the nineties, the manifestos of political parties were based on a non-exclusive NHS, without violating its universal nature, its character and its predominantly public social utility. However, the inefficiencies that were accumulating, translated into uncontrolled costs and unsuspected inequities, led analysts to seek remedial measures of the main paradoxes of universality (Gouveia, 2000).

Approved only with the votes of the right, the statute of the NHS, ratified in 1993 at the Assembly of the Republic, not elicited the rejection front of the opposition party to government, the Socialist Party (PS). And thus, without explicit support of the Socialist Party, were adopted legislative measures for opening up the system to the private sector. The program's electoral PS 1995, with which the Socialist Guterres became prime minister, admitted health management by the private sector, public enterprise hospitals, the separation between funders and providers, and competition between public funders, Mutual and private. The programme of the Social-Democrats (PSD, liberal-conservative) was less explicit, referring in general to create alternatives to traditional public model and the transformation of public funding exclusively in mixed financing. The PP Party (right of PSD) defended the separation between financing and delivery, the existence of a universal health insurance funded by the State Budget and policyholders, competition between public and private providers, and corporate governance of hospitals. For his part, the Portuguese Communist Party (PCP) claimed the maintenance of NHS in its original form, albeit with more autonomy for hospitals. Advocate equally by the continuity and expansion of free, as well as the abolition of so-called "moderators tickets."

The new Government set up a Commission to produce a report on reform of the health system. In 1996, under the first socialist government of Guterres and at the initiative of the Parliamentary Committee on Health, held a meeting on health policy which left two important conclusions of consensus: (i) the NHS should continue and be strengthened as important piece social protection scheme, and (ii) the NHS needed to introduce far-reaching reforms aimed at achieving more efficient management, a more equitable and better control of expenses. The National Plan for Economic and Social Development for 2000-2006, while recognizing that Portugal was among the EU countries with a lower relative weight of the component in financing public health expenditure, reaffirmed the central position of the State in the production and supply of health services, albeit in close collaboration with the private sector

(doctors, pharmaceutical laboratories, diagnostic services and private clinics)[2].

Table 2. Evolution of health spending (public and private) as a percentage of GDP (1990-2000)



Source: OECD Health Data 2002.

Between 1994 and 2003, the NHS underwent new re-organisation characterised by new ways of functional organisation in particular, the creation of Hospital centres and groups, local systems of health, and through new models of hospital management such as contracting services and entrepreneurial management of hospitals. In 2003, the first steps towards the restructuring of the primary health care network and constitution of the new Continued Care Network were taken. In 2004, the National Health Plan 2004-2010 was published. This is a strategic document for health policies that sets out a strategic and priority plan for the sector.

4. The third wave of health reforms: Portuguese Welfare Modernization (2005-2008)

As mentioned above, since the nineties the Portuguese Health System has shown considerable dynamism on the speed with which international proposals for reform have been incorporated into the internal political debates and have even found reflection in formal legislation. It represents a break with regard to the historical pattern prevalent in the past, characterized by the

[2] Plano Nacional, 2000.

considerable delay in introducing changes that are adopted by Western European countries.

Consolidated universal coverage, guarantees of efficiency, quality and social participation, as well as reducing inequalities have been erected on the fundamental principles on which NHS strategies are articulated in the boot of the twenty-first century, in order to improve level of health care, motivate professionals, adequately respond to the changing needs of the population (aging, new ways of living and sick), meet the preferences of individuals, both individually and socially, facilitate innovation and ultimately , realize the primary strategic objective, which is nothing more than to achieve greater health benefits for the entire population.

National Health Plan: A Program based approach

Two types of policy feedbacks started to operate in Portugal. Collaborative arrangements have indirectly resulted from broader reform measures aimed at fostering market competition. Improvements in Health Strategies have significantly reduced the structural obstacles to coordination. The resulting inter-organizational interdependencies pose critical problems for both market and hierarchical coordination. There are two main solutions to this problem[3]: (i) coordination power can be transferred to front-line professionals; and (ii) organizational units can be expanded or merged, in order to internalize previous inter-unit organizations. These two strategies correspond well with the process of organisational restructuring of the National Health Plan.

When the socialist Government won elections, the socialist José Sócrates created the High Commissioner of Health (ACS) to articulate and manage public policies arising from the National Health Plan 2004-2010. Under the slogan "A health policy for Portugal," the new socialist executive has opted for strengthening the welfare state and in particular health through three main Strategic interventions: to improve the quality of life of the citizens, to create a caring society where health resources are distributed according to the need of its citizens, and to promote cohesion of the Health System.

[3] Sharrpf, 1988, The Joint-decision making trap, *Public Policy and Administration*, 66, 239-78.

National programmes developed by the Directorate General of Health are key tools for NHP implementation. There is a national scheme with a regional and local focus. It is based centrally, as a main support and it has agents at different action levels.

They require local and regional management, information systems and appropriate resources for their operations and assessment. Although these are vertical programmes at central level, their implementation to the periphery should be planned in an integrated way, considering the existing needs and resources.

Apart from coordinating the implementation of the National Health Plan as a whole, the High Commissioner of Health has been devoting special attention to four areas that the current Government elected as priorities: Cardiovascular Diseases, Cancer, AIDS and Health of older People or citizens in a situation of dependency. These are the priorities in public health research conducted recently and have shown the great importance that the social and economic acquired in the explanation of health inequalities. Moreover, the National Health Plan defines strategic guidelines with a view to sustaining –politically, technically and financially- what might be described as a national intent, providing it with uniform features and facilitating coordination and inter-collaboration among the multiple sectors, which give inputs to Health policies. The efficient management of health programmes, better vertical coordination of the institutions involved and effective actions of health promotion was conceived as key instruments to improve the health conditions of Portuguese society.

The first Strategic Line: Improve health and quality of life to the Portuguese Citizens

The NHS bet for a more caring, capable of designing health policies, more progressive and committed to the development of public services and welfare, particularly with a comprehensive perspective in primary health care. Investing in health, not only in treating the disease was defined as one of the key points of the agenda of the XVII constitutional Government, which began in March 2005. Promoting health is considered a strategic social investment

because it depends on the country's future and its ability to social and economic development.

Thus, while the governments of Durão Barroso and Santana Lopes (PSD) paid more attention to the management reforms, and between public health services, the hospital management, identifying priority as improving the efficiency and corresponding control growth of spending, the Government of Socrates (PS) has focused on promoting public health. Without wishing in any way minimise the importance of management reforms-whose intermediate targets are often a guarantee of sustainable health system itself- the socialist government has placed in a broader context social concerns (Correia Campos, 2004). In this regard, the Government has endorsed the concern expressed by Maynard (2005) to indicate that European health systems that are characterized by decades of successive reforms, leaving a spring of issues to be resolved, there is little evidence on the impact that reforms are effective in improving the health of populations, inequalities in health or access problems and even the overall efficiency of systems.

The second strategic line: Ensuring the rights and duties of citizens' health

The second strategic line of the new health policy of the present Government has been promoting guarantees the rights and duties of citizens in relation to health, and some others based on a set of fundamental values such as human dignity, equity, ethics and solidarity. The recognition that, despite having reached a high level of fairness, the NHS inequalities still visible, has become a challenge for the government of Socrates, who took the commitment to foster a more caring and more equitable, an offer of technical services of higher quality and more humanized.

The third strategy: To promote cohesion and quality of the Health System

At the heart of the discourse on ways to enhance the cohesion and quality of the health system is the concept of "governance in health", under which means the driving ethics System, with the aim of ensuring health benefits

measurable and assessing more fairness in the results, more transparency for all actors, more efficiency and flexibility in responding to the needs of patients and users and more clinical excellence. In particular good governance in health quality goes through:

1) ensure the centrality of the citizen in the system, starting with democratic values (public service, participation, equity), and promoting social inclusion. This concern is evident in the impetus given to developing a network of continuing care, horizontal and with the support of civil society organizations, devoted primarily to the needs of the elderly and citizens in a situation of dependency;

2) planning the organization and re-organization of the Health System in a strategic and integrated manner, depending on the health needs of the population and the best available evidence on what works. "The NAP is the instrument of this strategic planning entrusted to the High Commissioner for Health, in collaboration with the NHS and other providers and public actors, social and private;

3) promote decentralization in the management system in accordance with the principles of autonomy and responsibility, as well as promote organizational reforms to improve management in providing health care. The reform of the regional management of the NHI, with redefining the role of the ARS and the extinction of the 18 sub-regions of Health, is part of this project. Also reform under way, the level of primary health care, or the spread of public enterprise in the hospital sector (as a model that no produce non-wanted incentives) represent examples of how it intends to move forward in this area;

4) strategically invest in information systems of health, facilitating the modernization of management services providers and ultimately the lives of citizens who use them. To develop skills and content, promote the spread of information technology and communication (ICT) and combat the so-called "info-exclusion";

5) have an influence cross (with other ministries and public entities) along with the various stakeholders (NGOs, Portuguese Institute of Social Solidarity, the private sector, media, associations of patients, users and professionals), enabling act on determinants of health beyond the reach exclusive of the Ministry of Health, since they are related to the adoption of healthy lifestyles. This goal is articulated on the assumption that, among the determinants of overall health, weight factor "system organization" is very small, so a quality of governance can not be limited to reforms in health management.

Ultimately, in line with what it proposes Braithwaite (2005: 1032), the Government has pursued since the beginning of the term alignment of NHI to citizens; development of a strategic planning determined by the health needs of the Portuguese ; Providing a better service in a context of humanization of the relationship with users of health care, improving equity in access and in health, which means ensuring that access and health benefits will be carried out equal effective, as well as increasing the efficiency of the system with the increasing use of new information technologies. All these strategies make up a bet decided by achieving higher levels of legitimacy and social sustainability of the NHI, both among the plaintiffs as among suppliers of health services.

5. An end point?

The Portuguese Health System has a complex identity as a result of the legacies of the dictatorial period and the revolutionary phase. Initially designed as a universal, general and free national health service, leaving space for the development of private initiative, the system was changed in the aftermath of the revolution that toppled the dictatorship, which stressed universalism as the ideal to be pursued by the state.

The need to revise the generous NHS established by the last dictatorial governments, as well as by the first revolutionary and constitutional governments, became evident when recession hit the Portuguese economy. These reforms have in fact reinforced the mixed legacies of the NHS system.

The reform of the NHS, as has been conceived and developed since 2005, has not aroused little resistance ideological and political. The progress of this

reform under the reconfiguration of the Welfare State Portuguese can become a crucial test to show the actual capacity of the reformist government of Socrates, not only by the commitment and political will to reform demands, but above all because, more than any other sector, health policy can reveal to what extent it is possible to "rescue" in Portugal, at the beginning of the XXI century, a draft social state based on universality, equity and quality of public services policy and financially viable. The reform is seen by some analysts as the last chance for salvation of the SNS, and accordingly, abandonment or the possible failure of reform that has been unfolding in these last three years tends to be seen as a triumph of liberal and right generally speaking, those who bet on a weakening of the welfare state.

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1 On the legislative process that concluded with the adoption of this Act Bases, see Pedroso Lima et al. (2001).

2 As concerns Correia de Campos (2002: 1080), "the SNS never reached the attribute of gratuity. Public funding of health care has been supplemented by contributions strongly supported by families, businesses or services (about 40% of total expenditures).”

3 Decree Law 401/98, December 17, came to create the possibility of opting-out subsystems, namely mechanisms of comprehensive health coverage for segments of the population defined criteria for occupational, geographical or other. Organisations like the SAMS - the Union's Bank of the South of the Islands - the social work post-CTT-and PT (Portugal Telecom) voluntarily

withdrew from their members of universal coverage by the NHI in exchange for an annual subsidy per individual covered.

4 The Plan sets out goals for 2010 relating to the incidence of neoplastic diseases, cardiovascular and infectious as well as related goal of active ageing. Available at: www.dgsaude.pt/upload/membro.id/ficheiros/i006756.pdf

5 See Programa do Governo Constitutional XVII, 2005-2009 (2005: 75-81) (www.portugal.gov.pt/NR/rdonlyres/631A5B3F-5470-4AD7-AE0F-D8324A3AF401/0/ProgramaGovernoXVII.pdf).

6 Correia de Campos, A. and Francisco Ramos, 2004, "Ma saúde do Defic da Saúde", or economic.

7 Maynard, A. 2005, "European Health Policy Challenges", Health Economics, 14, pp. 255-263.

8 IPSS - Portuguese Institute of Social Solidarity.