SOCIOLOGIA
ON LINE

Revista da Associação Portuguesa de Sociologia

New Public Management in the Portuguese health sector: a comprehensive reading[1]

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Keywords: New Public Management; Welfare State; public care provision; uncertainties

Abstract

We present an analysis of the main orientations that have guided the introduction of the New Public Management principles in the Portuguese health sector. Despite of being a result of international dynamics we also equate some national institutional characteristics such as a delayed and unfinished Welfare State and a centralized structure in political decision making that configures in a particular way the Portuguese health sector reform. Five main dynamics are here identified: decentralization of competences, financing and accountability, rationalization of expenses, deregulation of the labour market and internal competition and differentiation in the NHS. One of the most important arguments that we stress is that the health reform pursued in Portugal over the last decades has followed an ideological convergence despite today's growing uncertainties about the future of the Portuguese NHS, moving between Beveridge and Bismarck principles and dealing with an emergent for-profit sector that is allowed to act in competition with public sector.

Introduction

There can be no doubt that nowadays New Public Management (NPM) is central both empirically and theoretically and has become the subject of widespread debate spatially

[1] [1] This paper is a revised version of the presentation at the Institutions and Social Change(s) in Southern European Societies conference (ESA Research Network 27 - Southern European Societies Mid-term conference, Cascais, 1-2 October, 2010) with the title 'Facing international dilemmas: How public care provision has been perceived in Portugal?' It is part of a doctorate research work funded by FCT (Portugal).

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and among key players. However, despite broad scientific production, international discussion on the subject continues to revolve largely around literature on Anglo-Saxon cases (Barzelay, 2000). Thus, in light of a political and scientific context which fosters this debate on the one hand and, a certain lack of reflection on the situation in Portugal on the other, this article contributes with an interpretation of how New Public Management has been conceived and implemented in the Portuguese health sector.

This is a particularly important matter due to newfound uncertainty within a sector that was once standardized. Although it is impossible to forecast the configuration of the NHS in coming years, the Portuguese Social Democratic Party's recent interest in undertaking a constitutional review on the pillars of the Welfare State (health and education) means that (significant?) changes in public care provision can be foreseen.

Both 'administrative philosophy' and 'administrative arguments' must be considered when defining the substantive understanding we strive to give to NPM (Hood, Jackson, 1991). In other words, the wide-ranging dimensions of NPM extend from politics and executive leadership matters, to government measures and configurations in organisations (Barzelay, 2001). Using this as the starting point, the discussion presented is a broad analysis that goes from a politico-ideological focus to the more formal configurations that public organisations take on within this framework.[2]

A comprehensive analysis of NPM must go beyond a simple description of policy measures and more or less systematic changes in the way in which the organisation operates. The context, objectives, policy instruments and choices behind the empirical variations that may be implicit to NPM's generic model (Barzelay, 2001) must be taken into account. Given the empirical diversity inherent to the implementation of the NPM, each country must be seen as a combination of external influences and internal specificities that can sometimes be difficult to unravel. On one hand, one cannot deny the influence of certain

[2] This analysis will be limited to the realm of formal processes that guide organisations and do not encompass the way in which the NPM influences the relational and informal processes that are established therein. It is a reflection that synthesizes the conclusions resulting from analyses made in previous discussions (e.g. Stoleroff & Correia, 2008; Correia, 2009). The main sources of information for the arguments presented were based on the analyses of legislative production, daily observation of organisational contexts, and interviews with professionals, managers and association representatives (professional associations and unions).

political orientations (take for example the case of Thatcher and then Major in England), or relatively common situations of fiscal pressure on countries. On the other hand, another set of processes must be considered and these will be mainly of an institutional nature in this paper, thus enabling us to understand the content of NPM and the way in which it can be put into effect in the case of Portugal.

It is important to underline immediately the very particular configuration of the health sector in Portugal, setting it apart from most countries that ratified the Declaration of Alma-Ata in the late 1970s. The NHS hospital sector has assumed an excessive weight and preponderance over the last 50 years which led Campos (1984) to term the Portuguese health system as 'hospitalcentric'. Not only are most professionals concentrated in public hospitals in Portugal, but the latter also consume significant amounts of the State's General Budget. However, this preponderance is not just manifest in institutional and political 'hospitalcentrism'. For the population, the hospital is the main health care provider (even obscuring the job of primary health care), and even health professionals show their preference for working there (Carapinheiro, 1993). The most direct consequence of this centrality is the hospitals' permeability to the NPM. Thus, the hospital sector will have a prominent place in this analysis as it is here that most policy and organisational changes in the NHS have taken place and also because these changes have been transposed to other sectors such as primary health care.

We focus on a number of points in this paper so that the presence of NPM in Portugal can be understood. We start by analyzing the meanings and implications of NPM. We then discuss two institutional determinants which interdependently enable us to understand the outcome of applying NPM: the configuration of the Welfare State and the structure of labour relations. As Portugal's institutionalization is not at the same level as most other democracies, these are two very characteristic aspects. Thirdly, we give a simple interpretation of how NPM has generally been applied to the health sector in Portugal. Lastly, we discuss how far NPM in the health sector has taken a reformist shape.

From the Meanings to the Determinants of NPM: An Overview of the Context in Portugal

There is relative agreement in academic literature that the limitations of which the Welfare State is accused were caused by the financial imperatives of the last fifteen years of the twentieth century. In fact, multiple factors - demographic, financial and economic and others - have made it much more difficult to guarantee the premises of the Welfare State. It is now consensual that the way public provision was perceived after the Second World War – and, in particular, health care provision – has become unsustainable (Walby & Greenwell, 1994; Exworthy & Halford, 1999).

It is within this context that New Public Management emerged in the United Kingdom, Australia and New Zealand in the 1980s, later extending at differing rates to most countries with public intervention models (e.g. OECD, 1995; Barzelay, 2001; Gomes, 2001; Gruening, 2001; Bach & Kessler, 2007).

Theoretically, NPM may be understood as resulting from a conception of the State's social functions which was consolidated throughout the second half of the twentieth century. In substantive terms, there is an attempt to make the public sector more adaptable to different contexts, decentralized in decision making and more efficient given the increasing shortfalls in the resources available (Pollitt, 1990). This principle has been applied in every service across the public activity. The process is evident in the health sector and has changed the very notion of public service users: 'patients' have become 'consumers' paying to use resources and shouldering their share of responsibility in the choice and efficient use (i.e. rational use) of services (Lister, 2001).[3]

Management, as scientific knowledge, has been given a certain neutrality – not to say superiority – in the way in which it manages public well-being in face of the current imbalance between public service provision and economic and financial instability. According to Giddens' theorization (1990), this process seems to show a change in the way expert sectors relate to each other. Does this mean that an anti-professional

[3] Although the current wording of the NHS in the Constitution of the Portuguese Republic refers to tendency for services to be free of charge, in fact nowadays it is current practice to pay a so-called 'moderating fee' ('taxas moderadoras') whereby the patient pays an albeit small contribution to some of the services used (for example: consultations, examinations).

ideology is at stake where States strive to put more constraints on professional activity? This debate goes beyond the scope of this paper and is not consensual. Authors such as Harrison (1999) believe that the NPM ideology is not anti-professional as it does not replace doctors' prominent position in managing organisational life. On the other hand, Traynor (1996) believes that efforts to reduce health expenditure are related to a general loss of confidence in medical authority. Similarly, Dent (2005) refers to the introduction of the Health Professions Council in the United Kingdom as of considerable importance to the public's general lack of confidence in medicine. Turner (1996) explicitly uses Giddens' language when he cites ambiguities and tension in the layman's confidence in expert systems. From this standpoint, strengthening management competences may lead to the lay system giving greater social legitimacy to the role played by managers in the management of public assets, and affect medicine's social image to some extent.

As mentioned above, one of NPM's particularities is the high level of consensus in the political spectrum on its application. Indeed, while the right wing believes it to be a solution for the control of public expense by subjecting public services to market competition, the left valorises the decentralized management of public services (Walby & Greenwell, 1994; Exworthy & Halford, 1999). A demarcation is required at this level of discussion. These principles began in the United Kingdom where the model conjugates a very strong historical heritage with liberal Welfare State policies (think of the Thatcher-Reagan relationship; see Mechanic & Rochefort, 1996; Peck &Tickell, 2002 on neo-liberal dynamics); however, NPM does not translate directly into privatization processes. Above all, it relates to processes of uncertainty deriving from cost rationalization (Esping-Andersen, 1996; Ferrera et al, 2000). In fact, this invokes the arguments of authors like Pollitt (1990), Traynor (1996) or Ferlie et al (1996), who believe the NPM ideology is so broad that it can encompass a varied set of political processes ranging from the simple decentralization of organisational management competences to the privatization of public health care providers. As we will demonstrate later in this paper, the transposition of public activity to the rules of private law is one of NPM's fundamental characteristics. Consequently, although NPM can be considered as a way the

Welfare State can defend itself in light of the current challenges facing States, its implementation opens the way for a greater presence of private parties in the sector. Competition between providers and the deregulation of the labour market are two examples that demonstrate the great complexity and uncertainty of the effects produced by these changes.

As we can see, NPM is intrinsic to the Welfare State itself and this is the first determinant to understanding its configuration. Within this theoretical model, the State must be understood to act in the general interest of a country and regardless of the interests of different groups and social strata (Santos, 1987, 1992). Thus, its role is both to provide and regulate services (Mishra, 1995) and it increasingly works on the principle of contracting public services out to other bodies that can replace this activity (Mozzicafreddo, 2002). In other words, the provision function is progressively changing to a function of regulating the activity of private bodies.

This is a particularly sensitive matter in Portugal due to the configuration of the Welfare State itself – and which led Santos (1987) to define it as a 'semi Welfare State'. It was a late and unfinished process for which true consensus was never reached among the political parties involved.[4] In fact, when the Portuguese NHS was implemented (Health Act: Law nr. 48/1990, Assembleia da República, 1990), other countries with this social model were already arguing that it was unsustainable and contradictory. Two factors support the assertion that the Portuguese Welfare State is an unfinished process: first, it was never founded on a sustainable relationship between accumulation and distribution of wealth, besides not being protected by an overparty's structure that could truly avoid the influence of the different party's cycles (Santos 1987); secondly, the population had not truly assimilated its institutionalization. This idea encompasses the line of discussion on the poor turn-out of voters characterizing Portugal within Europe (according to Freire & Magalhães, 2002; Viegas & Faria, 2009).[5]

[4] Consider for example the Constitutional Court's intervention during the 1980s after the Democratic Alliance (coalition government between the Social Democrat Party and the People's Party) tried to do away with the first documents that regulated the NHS (see Carapinheiro & Pinto, 1987).

[5] This trend towards absenteeism in very diverse forms of civic involvement contrasts with a significant involvement in forms of associativism which are closer to citizens. It is important to recall here all the

Given these characteristics of the Portuguese Welfare State, it can be argued that the institutionalization of the 1974 democratic regime was often a more cumulative process than a breach with the structures characterizing the dictatorship. The legislative milestones in 1971 are an example of this; although they were a move towards creating a universal public health service that was not a charity, this cannot be interpreted as an early form of the Welfare State, but as strengthening the social side of the dictatorship (Carapinheiro & Pinto, 1987). There was also a strong trend in the State at that time towards professionalizing health care providers and creating a new model of funding and health care provision that would cut all ties with its corporative base (see Carapinheiro & Page, 2001). In fact, the current configuration of the Portuguese health system with its prominent 'hospitalcentric' character is the result of legislative milestones in the 1960s (i.e. Decree-Law nr. 48357, Ministério da Saúde e Assistência, 1968) that noted the need for investment in hospital infrastructures. Furthermore, the said document already made initial references to the improved management of hospitals although it was not embodied in any kind of anti-professional ideology:

> *the idea that economic techniques have nothing to do with hospital governance and that the funding problems affect the integrity of the medical profession is not true. It is generally accepted that the processes of economic management are essential to guarantee the material resources for the community, which ultimately means more and better patient care assistance.*' It adds that: '*The State clearly takes responsibility for all services, both medical or administrative, as well the administrative and technical management for achieving the objectives and results of joint work, and that it is one's obligation to achieve with maximum efficiency the most economic use of the actions put at their disposal*. (Decree-Law no. 48357: 601)

Despite the problems mentioned regarding the institutionalization of the Welfare State in Portugal, the model has fundamental contradictions which are in fact evident in the current context of financial constraint. Thus, when the State's ability to accumulate wealth diminishes, the need for its distribution among the population tends to increase. Moreover, the very attribution of social rights follows a generalized orientation

different types of community and/or family solidarity that are characteristic of Portuguese society and which Santos (1987) called a 'welfare society'.

towards intensification, and political parties may become hostages of the cumulative trend of these processes (Santos, 1987, 1992).

The second determinant in the configuration of NPM characteristics, associated to the Welfare State, concerns the bargaining structure in each country, i.e., their 'industrial relations system'.[6] Although we do not wish to develop this matter, it is important to consider the participation and involvement of other parties (e.g. unions and professional associations) as well as the government itself so as to understand the outcome of the policies and organisational changes. Starting yet again from the democratic transition as one of the fundamental milestones in the configuration of the processes that now mark policy measures, Stoleroff (1988, 1995, 2009) refers to the importance of the politicized and corporative heritage of the trade union structure during the dictatorship, as well as the very political configuration after the revolution on 25th April 1974, when explaining how a real 'system of industrial relations' was never achieved in Portugal. The model was above all 'formal' and 'legal', and not qualitative.[7]

Similarly, Barreto & Naumann (1998) argue that democracy in Portugal is based on a mainly centralized governmental structure; it therefore comes as no surprise that the implementation of measures introducing NPM involved centralized governmental decisions (namely via the regulatory tool available to executive power: the 'decree-law'), much more than negotiating processes with the whole party-political field (the 'Laws' approved in the Assembly of the Republic) where government action is more exposed to pressure from other influential groups, such as the various types of professional associations: professional orders and unions. In fact, in a later study, Stoleroff (2007) concludes that the changes that have been implemented in the Portuguese public administration – particularly in the case of health and education – are characterized by a tendency towards a centralized structure as opposed to one that participates in decision making.

[6] Based on Parsons' structural-functionalism, Dunlop (1958) perceives a system of industrial relations as an autonomous model, i.e., a social subsystem, with specific relational processes and players that cannot be explained by other imposed social systems united by an ideology that defines the rules and functions in the work place.

[7] This is so even though it is repeatedly argued that Portugal's framework of labour regulations is too heavy to deal with the current imperatives of the labour market (MTSS, 2007).

It is important to note that besides these institutional constraints, the abovementioned problems of participation in decision making derive from the actual decentralized nature that is implicit in NPM. From this perspective, transferring competences to the other parties involved (especially at the organisational level) means central power is partially freed from its responsibilities in terms of regulation, thus leaving negotiation to workers' representatives and employers. This decentralization of the negotiation *locus* as a consequence of the decentralization of competences alters the paradigmatic processes of collective bargaining which is characteristic of a centralized model of public functionalism.

The strong evidence of obstacles to multi-participation in decision making in a framework of decentralized competences corroborates the conclusions reached by authors such as Katz (1993), Traxler (1995) or Alaluf & Prieto (2001). Specifically with reference to the Portuguese health sector, Stoleroff et al (2008) believe that as labour relations at a micro level are surrounded by a great variety of management strategies, it can be foreseen that unions' greater or lesser ability to adapt to decentralization implies first and foremost the recognition that the hospital sector nowadays is ruled by a new and distinct working logic and this does not necessarily mean a trade union crisis.

Characteristics of NPM in the Portuguese Health Sector

Following this general description of the meaning of NPM and its determinants, our analysis now turns to the main measures that brought about its implementation in the Portuguese NHS. But the reader must first understand the context of these changes. Although government intervention in the sector intensified considerably from 2002 onwards, when legislative evolution is examined we can identify 1988 as the year when political power fulfilled its first intentions of introducing the principles that are still associated to NPM today:

> *the hospital-system development clearly points towards its own dynamics, which underlies a very complex unit and produces goods and services and their management must necessarily be based on a compatible support; and in no way whatsoever can a blocking situation [caused by state intervention] be allowed as is evident at the present time. (…)*

> *And that is consistently supported by an internal structure that does not disregard the principles of entrepreneurship and is clearly based on the unavoidable integration of hospital activity into the country's economy, which requires the hospital's assimilation of a good deal of unknown rules of management, non-existent in the traditional public services.* (Decree-Law no. 19/88: 248-20, Ministério da Saúde, 1988)

In other words, political intervention in Portugal through New Public Management is not a recent manifestation. Even though these changes were only systematically felt years later, it is important to note the convergence of internal political concern with the measures taken to some extent throughout Europe in the late 1980s.

As each health system is an original synthesis of particularities and universalisms (e.g. Powell et al, 1999 quoting Carapinheiro & Page, 2001), it can be said that the current Portuguese health system was built on the basis of relatively well identified internal political periods (Carapinheiro & Page, 2001; Carapinheiro, 2006) in conjunction with the general trend towards rationalization which marked European countries in the 1990s (Mechanic & Rochefort, 1996). From this standpoint, the introduction of NPM mechanisms in Portugal was not an exclusive process; however, it does have specific characteristics which derive from institutional determinants such as those mentioned above.

Stating that political periods can be identified in the construction of the Portuguese health system does not imply a turbulent process among the different parties elected to office over the last twenty years. Notwithstanding some specificities, the following descriptions illustrate what has been referred to above e.g. the ideological convergence of right and left wing parties on the matter of NPM. We refer of course to convergence between parties considered to be in the centre (Socialist and Social Democratic Parties), not being at stake any ideological convergence of political parties further apart from the Portuguese ideological mainstream.

1. Decentralization of Competences

As we have seen in the general principles of NPM, the fundamental change in hospital management involved the decentralization of competences from the central

(government) and regional (regional health administrations) levels to the local level (hospitals). From this perspective, the Board of Directors of each hospital is accountable for the management of its assets and also financial and administrative management. The Chairman of the Board – not necessarily a doctor – and the remaining executive members are ministerial appointments, while non-executive members – Clinical Director and Director of Nursing – are selected by them from the most qualified professionals for those purposes and appointed after ministerial approval. Although not mandatory, there is still a tendency to propose the most qualified professionals in the respective field for these positions. Once the governing body has been formed, the Board appoints a director for each medical area (service or department) from among the most qualified doctors in the professional career.

This operational logic is common to both legal statutes currently applicable to Portuguese public hospitals: public administrative sector (PAS) and public business entity (PBE). Without elaborating on technical specificities, it should be noted that despite differences above all in terms of financing the activity, the PAS today does not resemble the definition given in the Council of Ministers Resolution nr. 124/2005, namely: an 'excessively expensive, rigid and costly' sector (*Presidência do Conselho de Ministros*, 2005). Indeed, there has been a convergence with the business-based models and the hiring of staff is the only remaining area that is centralized due to the need for regional authorization (RHA).

One of the arguments that political power has embodied in the adoption of the NPM logic is the need to speed up and simplify decision making, i.e. the de-bureaucratization of the health systems. An action model has been sought that can adapt to the demands placed by exposing the public activity to the dynamics of the private sector. However, it should be clear that, contrary to what might be thought at first glance, the decentralization of management competences to the organisational level, whereby the functioning of hospitals and business operations converge, is perfectly compatible with Weber's fundamental principle of bureaucratic reasoning i.e.

the normative control of activities (e.g. Walby & Greenwell, 1994; Hoggett, 1996).[8] For this purpose, an analytical division must be made between the 'overseeing(A) – management(B)' level and that of 'management(B) – profession(C)'. The first represents the relationship between the Ministry responsible and the hospital's governing body, while the second represents intra-organisational operations specifically with regard the hospital's governing body and the professionals. This demarcation immediately highlights the central role that hospital management assumes in the current management framework for public services: while on one hand it is directly accountable to the Ministry for organisational performance, on the other it must ensure that professionals accept and adhere to administrative procedures, in the knowledge that meeting this objective is a complex task (e.g. Goss, 1963).

Particularly in a generalized context of budgetary constraint, it is easy to understand the extent to which the "overseeing-management" relationship requires the bureaucratic control from the Ministry in relation to hospitals. Each hospital Board of Directors must be rigorous in their efforts to meet pre-defined objectives and their disrespect of these goals is contemplated under the law through their dismissal. However, even though hospital management regulations permit dismissal, there is no knowledge of its application as yet. This is despite the fact that there are occasional reports in the media of PBE hospitals having significant financial shortfalls. Since it is impossible to know the reason for not punishing these public managers, an analysis has been made of the evolution in health expenditure between 2002 and 2009 (Correia, 2009) to testify to the increase in spending in the sector. However, this is a deceptive rise, lowering spending on PAS and increasing transfers to the State's business sector (which includes the legal models of the hospitals managed as companies or partnerships made with the private sector – PPP). We should not forget the political implications that a dismissal of this kind could have, given that the government would have been responsible for the appointment. In fact, even after a change of government, it has been usual to

[8] Weber (1982) associates the following attributes to bureaucracy: the guarantee of organization stability by establishing routines, impersonal professional relations, specialization and respect for formal hierarchies.

complete the 3 year mandate – with the exception of the occasional resignation from the Board.

Returning to the need to further the bureaucratization of hospital management due to the decentralization of competences, the predefinition of indicators in the contracts between the hospital and the government is the best example of the way in which this Weberian principle is applied to NPM. The hospital organisation and resulting activity are understood to be quantifiable and foreseeable so as to address inefficiency in the sector.

Also from the intra-organisational perspective i.e. in the 'management-profession' dimension, an argument can be made for the need to further processes of this kind. As in the Ministry-management relationship, the Board of each hospital defines indictors and hires the activity of each service with their respective department heads. In Portugal, it has been usual to create departments that group similar medical areas. Decentralized groups are formed for the management of assets and financial and administrative management within the hospital. Their directors are responsible for negotiations and contracting with the Board of the hospital. As this logic is similar in every way to the actual constitution of the Board in each hospital, the same arguments are made for the greater need for the bureaucratization of processes therein. Moreover, the introduction of control mechanisms must also be considered e.g. biometric control, body of specialized managers, professionals' accountability for spending, performance appraisal, etc, the aim of which is the general increase in the administrative control over the professional activity.[9]

In short, it is understood that if the decentralization of competences is to run well, lower level of decision making must be subjected to the control of higher levels. It is only in this way that a balanced Ministry-management-professionals relationship (A=B=C) can be conceived, and deviations between contracted performance and actual performance be avoided.

[9] It is important to understand that only the principles that have supported the introduction of NPM principles are described and not their effective influence on professional relations, which is beyond the scope of the article and is in itself an object of study (on this see for example Carvalho, 2009).

2. Financing and Accountability

Following on from point a), the hospital activity involves a dual contractualization in the NPM framework: between the Ministry and the hospital and between the hospital and its services. Contractualization is a contractual relationship between two parties where there is a pre-definition of the service to be provided (e.g. average time before patient is admitted to hospital, average wait before surgery; re-admission rate; number of consultations; death rate) and the respective payments are forecast accordingly. It is therefore a way of delegating the activity from both the central power to the Board of each hospital and also from the Board to the medical services/departments.

This way of financing the sector by the activity which effectively takes place is a significant change from the previous model. It goes from a retrospective to a prospective budget in which non-compliance with the contracted activity penalizes budget allocation in the following year. Yet again, it is very clear that this is the general principle of operations and the way in which these measures have in fact been implemented.

This brings us to the argument that despite very restricted criteria, the implementation of the NPM model in Portugal deviates from its normative principles. This has been seen in relation to the managers and the fact that they are not being responsible for the enormous budgetary shortfalls in some PBE hospitals. But the same tends to occur in relation to department/service directors – except in sporadic cases not known to the public. This demonstrates that although NPM is associated to greater transparency e.g. the budget and some performance indicators are available on the hospital websites for public consultation, the appointment processes – of Boards and middle management – do not allow rigorous public appraisal of their assumptions and arguments because it is a very politicized sphere.

From the professionals' standpoint, forms of accountability are also defined. It is not that clinical practice under the aegis of NPM is different from the traditional public model. The doctors continue to present themselves as a professional group and there are no attempts to make individuals accountable except in cases of gross negligence. Other forms of control such as biometric control (attendance) were generally boy-

cotted across the country without managers proposing any way of suppressing this behaviour. From this stance, the *locus* of professional influence continues to be the Service Director, just as it was in the past. However, there is another way of making doctors accountable which involves raising their awareness. Thanks to the introduction of computerized instruments managers expect to raise doctors' awareness of the cost that each medical act represents for the NHS and, on the other hand, make them consider that choosing less expensive medication may be of significance to the patients.

Another process contradicts what could be viewed as a context in which medicine is under a deeper administrative control. In fact, doctors not only are not simply against rules and instruments from management, as some responsibilities on that field are being given to them. This is not a homogeneous dynamic, which is a factor for an internal differentiation in medicine. For now such is not felt outside profession and in particular in relation to management, but internally there is an evident difference among medical areas. Some are presenting self determined structures within hospitals embracing decision like hiring professionals and other administrative staff, managing their financing or deciding the organisational structures of that service/department. Transplantation (liver or heart) is a clear example of such processes due to how that procedure is financing by State as a specific procedure added to the regular medical activity.

3. Rationalization of Expenses

We have seen how the emergence of NPM has resulted from financial imperatives. The rationalization of the public activity has thus become one of the key points of this whole process. The rationalization of expenses is felt at different levels:

First and obviously, the whole orientation of making public services more efficient, creating indicators for performance and outputs at many levels (human resources, financial, assistance etc.).

Secondly, what is termed the 'evidence-based principle' applied to medicine (e.g. Exworthy & Halford, 1999). Accordingly, clinical expenses tend to be negotiated with the Boards by demonstrating the cost/benefit ratio for specific medication, equipment

or techniques. This is a very curious aspect in that the doctors do not tend to feel constraints on their professional autonomy, demonstrating the need to deal with the managers. They have the notion that the approval of expenses nowadays always involves adopting arguments that testify to the improved performance of the hospital or that serve a wide number of patients. From this perspective, significant situations (in representative terms) where therapeutics have been refused on financial grounds are not public knowledge. Nevertheless, hypothetically this is possible in hospitals where the budget is channelled to other domains.

Thirdly, the rationalization of expenses can be identified by means of the legal constitution of 'hospital centres'. These centres represent a concentration of physical, financial and human resources whereby different hospitals in the same geographical vicinity come together in a single group under one direction. The hospitals disappear as individual legal entities, permitting the centre's internal technical specialization in accordance with the existing resources in each hospital, the mobility of professionals between these hospitals and the Board's greater capacity to negotiate economies of scale.

Fourth, rationalization also takes place through the closing of services (this has occurred mainly with maternity hospitals and health centres) in accordance with quantitive criteria e.g. number of births per year. Despite all the protests from the public and even the national leftwing party on the quantitive grounds for these decisions, it is a fact that this policy has even been implemented in other sectors like education where the closing of around 700 teaching establishments was recently approved leading to the relocation of roughly 10,000 pupils.

Fifth, we underline the increasing introduction of private entities in public care provision. Governments have used two mechanisms to transfer their care provision function to the private sector: the setting up of hospitals as Public Companies using public capital (PC) – which do not currently exist – and the so-called Public-Private Partnerships (PPP). In the first case, the State is the majority shareholder in the hospital and contracts its activity within the logic of private management. As we have already seen, contractualization requires compliance with a set of indicators by means of payment of

agreed specified amounts. In the second case, although various kinds of public-private partnerships can be included, in the hospital sector the State has built hospitals and contracted the management out to private entities for set periods of time.

4. Deregulation of the Labour Market

There was previously found to be a rise in individual contracts for professionals in the health field as a result of the freezing of professional careers. This situation has arisen with doctors, nurses and technicians in the areas of health technologies, albeit with distinct implications.[10] Previous studies (Stoleroff & Correia, 2008) have shown how the 'atomization' of labour relations involves greater levels of uncertainty. Uncertainty not only for the professionals but also for trade unionism and for the actual NHS. The uncertainty for professionals is easily recognized in that the knowledge a person holds is the main source of power in the demand/supply relationship in the labour market. In the case of doctors, the lack of professionals in relation to labour market requirements means that individual work contracts can prove more advantageous at the individual level than the conditions provided by the professional career. But this is not uniform across the profession, as there is a greater need for some specialist areas e.g. anesthetists, than others. Despite strong opposition from the unions (and from the Order in the case of nurses) with considerable mobilization in general strikes and demonstrations, the excess of professionals in relation to demand in other professions has led to individual work contracts providing worse conditions than the rules in force for the professional careers. Situations of low salaries, the prevalence of short term contracts (e.g. from 3 months to 1 year), working as a service provider, in addition to other problems arising from not allocating time for professional training are just some of the examples of what is today an increasingly representative method of contracting for the public sector.

[10] Due to the lack of statistics on the nature of contractual ties of workers belonging to the Ministry of Health (following consultation of http://www.recursoshumanos.min-saude.pt/ accessed on 25 October 2008), see the data presented by Santos (2003), which states that from 2000 to 2002 there was an overall rise of 88 per cent in term contracts and of 52 per cent in service provision contracts, above all with significant increases in the Ministry of Health, Central and Local Administration. Although these data are not specific to the health sector and are not updated, they confirm the generalized trend in the reconfiguration of contractual ties in the public administration.

According to the authors, the uncertainty for trade unionism results from the actual decentralization of competences to the hospital level. This opens up the possibility of the results of negotiation being different for each employer entity. Finally, the uncertainty for the NHS is related to the internal differentiation of the Portuguese health system analyzed below.

5. Internal Competition and Differentiation in the NHS

One of the fundamental implications of opening the management of public services to the scientific domain of management is the exposure of public services to the private sector's competition rules. The ideology is essentially that public service provision tends to be more efficient and rational with competition among public providers and between public and private providers (Ferlie et al, 1996). Turning to Santos' reflection (1987: 24 – 25), these changes in public intervention are associated to Max Weber's discussion of rationalities. From this viewpoint, while the action of the States in modern capitalist societies has followed principles of bureaucratic rationality, expressed in greater focus on the normative control of activities, the current processes of change in question demonstrate that this rationality is increasingly linked to the outputs previously confined to the capitalist rationality of the business sector.

Competition among public providers and between public and private providers obviously comes in the context of the individualization of labour relations. Indeed, one of the general trends identified is that it is only individually perceived factors (fear of changing to a private entity and of being subjected to market rules, the ideological bond to the NHS and public functionalism, etc.) that stop workers transferring to the private sector, besides the ability for private entities to compete to attract human resources. The most direct effect of this for the NHS is the argument of greater uncertainty mentioned above (Cf. Stoleroff & Correia, 2008). It opens up the possibility for internal differentiation in a sector built on the principles of standardization of care provision. Thus, if a hospital's negotiating capacity to attract human resources (in accordance with budget available for example) is a variable, the quality of some public

providers may lose out to other more competitive providers in the public or even the private sector.

This takes us to a debate developed in another context (Correia, 2009) which raised the question of understanding of how these changes can lead to a reconfiguration of the way the public activity is conceived. Given that the Portuguese NHS was constructed on the basis of a totally or partially de-commoditized activity (Cf. Santos, 1987), exposure to market rules of competition seems to lead to a totally or partially commoditized activity, which essentially defines the private sector. The systematic transfer of hospitals to business models, i.e. to a logic that is framed in the principles described above, is in fact indicative of this exposure to the commoditization - total or partial – of the public activity. According to 2008 data, over 60 per cent of NHS hospitals had already adopted business models (Correia, 2009), and this is an ongoing process.

In Short: From General Features of the Implementation of NPM in Public Portuguese Hospitals to Future Trends

Going back to an idea presented at the start of this paper (Barzelay, 2000), it is important to understand to what extent the characteristics of the instruments resulting from NPM in Portugal can or not infer real administrative reform. If we systematize the main contours of the measures implemented in this framework, it is the unequivocal convergence between the public and private sectors around the principles governing private law that stands out. Accordingly, the rationalization, efficiency, accountability, transparency and output orientation of NPM are dimensions that were formerly characteristic of capitalist models and which are transposed to the public sector. The basic principle is therefore that the public good can be managed better using business processes. This is the basis for the intervention in public care provision by the public power in Portugal, i.e. both centre left and centre right parties that have been in government since the democratic Revolution in 1974. The so called business approach in hospitals – and also in the primary care network - in which the legal models of care provision are changed as if they were any other kind of business has been assumed as one of the

main forms of intervention in the sector. It should be noted that governments have the power to change the legal status of hospitals and no kind of multi-participative involvement is required unless it is in their interest. As one of the basic consequences of the change in hospitals' legal status is the growing decentralization of competences to the organisational level, the government is indirectly decentralizing a union action traditionally turned towards the central power.

Convergence with the dynamics of the private sector is not only found in the organisational operation of public service providers. There has been a steady increase in individualized employment in a labour market that was formerly standardized by professional careers and clear contractual ties. Strictly speaking, this change cannot only be seen as the degradation of working conditions because in some cases – albeit few – it provides a new opportunity to negotiate working conditions on an individual basis. The difference between the vulnerability and strength in labour negotiations depends increasingly on the position held in relation to the supply and demand of jobs. This situation is found between different professions (e.g. medicine on one hand and nursing on the other), but also in terms of the distinct kinds of expertise within each profession (e.g. the current great lack of anesthetist). The most direct consequence is a situation of internal differentiation in a previously standardized NHS.

These changes seem to legitimate the idea that intervention in the public administration can be interpreted as a true reform. As a result of the challenges facing countries with Welfare State models today in the current financial and fiscal context, the characteristics of the NHS in its tardy conception and implementation in Portugal are divergent from those which it has assumed in recent years (essentially since 2002). The certainty of a steady internal differentiation in the NHS resulting from competition among public service providers and between public and private providers contrasts with the new uncertainties that are on the horizon. Portugal is facing a political moment of possible change from a Socialist to a Social Democratic government. The internal committees of the Social Democratic party have already approved a constitutional revision in which, among other things, the expression 'tend to be free of charge' is removed from the text regulating the NHS. Contrary to what is suggested in less pru-

dent interpretations, this does not seem to indicate the end of a public health service. However, there can be no doubt as to the trend towards accentuating internal differentiation in public care provision and the broadening of the sphere of action of private service providers. This can occur either through giving private entities concessions to manage public hospitals or through competition between the private and public sectors whereby the former steadily increase their hold over medicine and the provision of care. This is not therefore straightforward privatization, but it does become easier to implement the logic of privatization.

In short, the Portuguese NHS today seems to be characterized by its lack of definition on the total or partial commoditization of public service provision. If we consider the three broad models of public activity currently applied in Europe: (I) the Beveridge model – found in Denmark, Finland, Iceland, Norway, Sweden and the United Kingdom –, where financing is tax based and with mainly public service providers; (II) the Bismarck model – in Austria, Benelux, France, Germany and Switzerland –, in which financing comes from social security and there are public and private service providers; (III) and the mixed models in the Southern European countries – Greece, Italy, Portugal, Spain – which result from articulations of these two former models (Savas et al, 1998), recent policies show that Portugal is moving away from the Beveridge model which underpinned the constitution of its NHS albeit with the above mentioned limitations. One is the extension given to the private sector in terms of financing and provision (premises of the Bismarck model). The other and more important transformation is a growing deregulated market. Public-private competition is one unequivocal characteristic that is arising from inside the Portuguese NHS, which needs further explanations. Is a too recent dynamic for any sustainable reflection and prediction of its effects on the future of public care in Portugal.

From the medical standpoint, these political changes have not proved anti-professional. A significant part of the hierarchical framework prior to NPM remains unchanged and medical authority continues to be predominant in the running of organisational life. More important, in some medical specialties is seen a process in which management responsibilities are being embraced by medical professional projects and

then strengthening medical autonomy in hospitals. From the hospital managers stand point, is followed mostly a logic of complementarity rather than contradicting medical decisions. It is perhaps financial imperatives that could most prejudice the basis of this relationship given that the pressure for normative behaviour leading to standardized outputs could give rise to two distinct professional logics: management and treatment.

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