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Decentralization of Healthcare to Portuguese Municipalities – Prospects and Expectations

Beatriz Baptista Marques Barbosa

Master in Health Services Management

Supervisor:
MD, PhD, MLaw, FIAHSI, Professor Henrique Martins, Associate Professor, ISCTE Business School, Human Resources and Organizational Behaviour ISCTE-IUL

November, 2022

BUSINESS
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Human Resources and Organizational Behaviour Department

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“A desordem obriga a criar novas formas de ordem”

Osmar Ponchirolli.

ACKNOWLEDGMENTS

Firstly, I would like to thank my thesis advisor, Dr. Henrique Martins, for the dedication he shows to each of his students, and especially for guiding me throughout this dissertation.

To all the municipal executives who participated in the interviews, as well as those who were willing to participate in them.

To my family, especially my mother, who provided me with all the means to integrate this master's program and for always motivating me to reach my full potential.

To all my friends and peers who supported me and always managed to handle the stress that this work caused me.

Lastly, I would like to thank Madalena, Carlota, Luís and Joana for their patience and for trusting in my capabilities even when I had doubts.

ABSTRACT

Processes of transferring competencies of healthcare to municipalities, trigger the need to examine health policies at local level. The Decree-Law No. 23/2019 of 30 January 2019 has boosted a healthcare decentralization movement of some competencies in the management of health services to Portuguese municipalities. The aim of this study is to contribute to a better understanding of this process. This dissertation consists of a literature review and a qualitative study where the object of research is a sample of fifteen semi-structured interviews with representatives of local government to evaluate the perception of this illustrative group about the potential rise from the above-mentioned legislation. The sample consists of the target population selected for the cross-sectional qualitative research in fifteen Portuguese state administrative divisions or municipalities. A total of 15 municipal executives were interviewed, each one representing the municipality where they carry out their functions. Based on the results, it was possible to verify that municipalities do have the capability to deal with the implications of the transferred competencies, since this transition tackles health as a more comprehensive societal concept; municipalities that have already established networks with strategic partners and were gaining expertise in this area are more receptive to and open to this process. Disparities between municipalities are one of decentralization's biggest challenges. In future research, it is vital to clarify the effects of this restructuring at the various of healthcare, as there are few studies on its implementation since this policy was just recently implemented.

Keywords: Healthcare Decentralization, Health Management Policies, Proximity Care, Municipalities, Local Level.

JEL Classification System:

H5: National Government Expenditures and Related Policies.

H75: State and Local Government: Health.

RESUMO

Os processos de transferência de competências dos cuidados de saúde para os municípios, desencadeiam a necessidade de examinar políticas de saúde a nível local. O Decreto-Lei nº 23/2019 de 30 de Janeiro de 2019, impulsionou um movimento de descentralização dos cuidados de saúde de algumas competências na gestão dos serviços de saúde para os municípios portugueses. O objetivo deste estudo é contribuir para uma melhor compreensão deste processo. Esta dissertação consiste numa revisão bibliográfica e num estudo qualitativo onde o objeto de investigação é uma amostra de quinze entrevistas semiestruturadas com representantes da administração local para avaliar a perceção deste grupo ilustrativo sobre a potencial emergente da legislação acima referida. A amostra consiste na população-alvo selecionada para a investigação qualitativa transversal em quinze divisões administrativas estatais ou municípios portugueses. Foi entrevistado um total de 15 executivos municipais, cada um representando o município onde desempenham funções. Com base nos resultados, foi possível verificar que os municípios têm capacidade para lidar com as implicações das competências transferidas, uma vez que esta transição aborda a saúde como um conceito societal mais abrangente; os municípios que já estabeleciam redes com parceiros estratégicos e que estavam a ganhar experiência nesta área estão mais recetivos e abertos a este processo. As disparidades entre os municípios são um dos maiores desafios da descentralização. Na investigação futura, é vital clarificar os efeitos desta reestruturação nos vários sectores da saúde, uma vez que existem poucos estudos sobre a sua implementação já que esta política foi recentemente implementada.

Palavras–Chave: Descentralização em Saúde, Políticas de Gestão em Saúde, Cuidados de Proximidade, Municípios, Nível Local.

JEL Classification System:

H5: National Government Expenditures and Related Policies.

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GLOSSARY OF ACRONYMS

COVID-19 – Coronavirus disease 19

MeSH – Medical Subject Headings

MoH – Ministry of Health

OECD – Organization for Economic Co-operation and Development

PHU – Primary Healthcare Units

RTA – Reflexive Thematic Analysis

SDoH – Social Determinants of Health

SNS – *Serviço Nacional de Saúde*

WHO – World Health Organization

INTRODUCTION

Globally, the tendency towards decentralization in governance can be characterized as a movement across several areas. The goal of increasing the competencies of municipalities, considers the best interest of citizens and more efficient response from Public Administration. Consequently, influenced by a paradigm of proximity-based Public Administration, the numerous decentralization processes that occurred in Europe played a significant structural role, becoming synonymous with strengthening both regions and municipalities in the various sectors of activity (Miranda & Morais, 2020). Thus, municipalities assume competencies in the areas of education, social action, health, civil protection, culture, housing and transport. Regarding the health sector, various healthcare systems around the world have adopted decentralization of health policies and funds as a health reform, since it addresses the problem of the overload of the *Serviço Nacional de Saúde* (SNS; Portuguese for National Health Service) (Alves, Peralta & Perelman, 2013).

The demands of a new Public Administration paradigm direct the Central Government to the role of regulator. In this setting, the decentralization process is put forward, reinforcing that the local management will be more democratic and participatory, while also enabling better resource allocation (Lascoumes & Le Galès, 2012). Thus, the XXI Portuguese Constitutional Government established local government autonomy and democratic decentralization of Public Administration as one of the objectives of State reform. The Government program initiates the processes of transferring competencies to local authorities and inter-municipal entities throughout Decree-Law No. 50/2018 of 16 August, which promoted administrative decentralization. According to Article 13, a range of possibilities emerge for municipalities to play a closer role when it comes to health management. Municipal councils assume the following competencies: to participate in the planning, management and implementation of investments related to Primary Healthcare Units (PHU), namely their construction, conservation and maintenance; to manage, maintain and conserve equipment allocated to primary healthcare, with the exception of medical equipment; to manage the workers inserted in operational assistant careers that integrate the PHU; as well as to provide logistical support service to these units. In addition, it is incumbent on municipalities to participate in programs to promote public and community health, as well as healthy lifestyles and active aging.

The aim of this study is to contribute to a better understanding of healthcare decentralization reform and to monitor the concretization of the process of transferring health competencies to municipalities, implemented by Decree-Law No. 23/2019 of 30 January. With the approval of this legislation by the council of ministers, several processes are expected such as organic

restructuring at Central and Local Government levels. The pertinence of a research study is supported by the need for clarification on the implications, that this process will bear on central and local government, and on the perspectives in the construction Portuguese's future health. Therefore, the importance of monitoring the impact of decentralization on sectoral policies and the capacity of municipalities to deal with the implications of the transferring of health competencies. Influencing factors, opportunities, and threats to the process are also expected to be identified. In this context emerges the present dissertation, which looks to address the following research questions: "Which processes are expected at central and local government level as a result of the decentralization of health competencies?", and "Do municipalities have the capability to deal with the implications of decentralization of health competencies?".

Regarding structure, this dissertation consists of a literature review and a qualitative study where the object of research is a sample of fifteen semi-structured interviews, via Zoom, with representatives of Local Government. Hence, it is an exploratory study of qualitative nature drawn up to analyze the potential arising from Decree-Law No. 23/2019 of 30 January, and to monitor its inherent processes, motivation and implications. According to Bryman & Bell (2011), when applying qualitative research strategies, one seeks an understanding of participant's perspective. Thus, the main objective of this study is to develop a broader understanding of the implications and potentialities that were most underlined by Local Government representatives by exploring their perceptions arising from the process of decentralization of health competencies to municipalities. The paper is structured in eight chapters. After the introduction of the purpose of the study, Chapter 1 provides background information about the theme. The methodology is then presented in Chapter 2, including the literature review process, the characterization of the population and sample, the procedures and instruments, and the ethical aspects inherent to the research. The presentation of the results and the discussion are covered in Chapters 3 and 4, respectively. Chapter 5 describes the possible limitations of this study and how they can be overcome as well as suggestions for future research. Finally, Chapters 6 and 7 concern the conclusion and recommendations, and the bibliographic references, correspondingly, followed by Chapter 8 with the presentation of the annexes.

1. BACKGROUND

Health systems are accountable for delivering services that improve, support, or restore the health of individuals and their communities. These organizational structures are responsible to ensure that they reach all individuals equally, as well as their needs. Several countries around the world have integrated decentralization models while reforming health systems, aiming to achieve gains in terms of quality, costs and equity (World Health Organization, 2022).

In order to properly understand the reforms implemented by the XXI Portuguese Constitutional Government, namely the decentralization processes in health, it is necessary to first comprehend the structure and organization of the government and its collegial institutions. Accordingly, to Decree-Law no. 251-A/2015 of 17 of December, the Portuguese Constitutional Government is organized in a systematized logic of shared services. The Government is the supreme entity of Public Administration, and it is composed by the Secretaries of State and the Council of Ministers i.e., the Prime Minister and the Ministers of State. This entity exercises its political, legislative, and administrative powers through carrying out the general policy of the nation and overseeing the Public Administration, which carries out the State's policy. Within Public Administration it is possible to distinguish three main divisions: the Direct Administration of the State or Central Administration; the Indirect Administration of the State; and the Autonomous Administration. The entities of the Central Administration are hierarchically subordinated to the Government (i.e., the central and peripheral services that are to be subject to the power of direction of the respective member of the Government), the entities of the Indirect State Administration are subject to its tutelage, and the entities that comprise the Autonomous Administration are only subject to supervision and control. Autonomous Administration includes the administrative subdivisions of local government (municipalities), i.e., territorially based groups endowed with their own representative bodies that aim to pursue the interests of their respective populations.

The Recovery and Resilience Plan, introduced by the XXI Portuguese Government, highlighted medium and long-term goals and established Portugal's 2030 Strategy, which includes health sector reforms namely in the management of PHU and in the model of healthcare public governance (Ministério do Planeamento, 2021). In Portugal, the 21st Government program officializes the autonomy of local jurisdiction and the democratic decentralization of Public Administration. Thus, a decentralization law was approved, and local authorities have now a critical role on health policies. Local Governments are to develop interventions in line with the following general objectives: set responses to health needs

considering installed capacity and responses to populations at a local level; articulation between entities strengthening the focus on promotion of health; better health educational intervention in communities; articulation at local and national levels in the creation of programs to reduce inequalities (Sequeira, Romana, Fernandes, Pinho, Rodrigues, Isoppo & Sousa, 2020).

Concerning community health, the mission of municipalities is highlighted by the Portuguese Legislation, driven by the celebration of inter-administrative contracts that broaden the scope of competencies to be assumed by the municipalities (World Health Organization, 2021). Municipal Governments can act to improve or worsen health gradients across neighborhoods as they are strategically positioned to influence Social Determinants of Health (SDoH). Hence, local communities and municipal governments play a significant role in eliminating health inequities since they may help strategies by providing vital information about local resources and difficulties. Applying bottom-up, resident-led approaches can empower communities and further positively impact health **(**Cahuas, Wakefield, & Peng, 2015).

Decentralization consists of the process of transferring responsibilities and resources from Central Government to Subnational Government entities (Dwicaksono & Fox, 2018). It **is defined by the cession of power arrangements of specific functions, including its economic, political and administrative attributes, from an upper to a lower tier of government, independent in their geographical range of jurisdiction such as municipalities and councils.** The concept of decentralization in health systems is associated with the notions of accountability, responsiveness, quality and efficiency, which are difficult to evaluate in real context (Panda & Thakur, 2016). Therefore, there is a lack of empirical evidence on the effects of decentralization processes. However, health gains can be quantified through quantifiable health indicators: health systems inputs (e.g., financial, human, and physical resources); health system performance (e.g., changes in service utilization, coverage and quality); and health outcomes (e.g., infant mortality rates, maternal mortality rates and life expectancy). The consequences of decentralization should be analyzed from three perspectives: from a social perspective, decentralized health systems promote citizen participation and health coverage planning; from a public administration perspective, decentralized health systems must ensure capacity to respond to local needs; and from a fiscal perspective, suggests that by means of decentralization Local Governments should provide an adequate level of public services while minimizing waste of resources. Hence, through decentralization, health systems improve health response capacity and equitable allocation of health resources and services (Dwicaksono & Fox, 2018).

In line with other European countries, Portugal has suffered demographic changes namely in the increase of life expectancy and the reduction of birth rate. Consequently, the populations

general age increases, the demand for health care has overloaded the SNS. It is relevant to demonstrate the responsibility to involve municipal agents and mobilize resources. The emergence of health policies at the local level is highlighted and strategies of cooperation and burden sharing must be promoted between Central and Local Government (World Health Organization, 2018). In addition to the above-mentioned factors that influenced the adoption of this reform, Central Governments are dealing with problems regarding retentions of human resources, over-centralized procurement and low standards of service delivery compared to pre-defined national levels. Moreover, this has been suggested has a health reform to increase health systems' dimensions like financing, efficiency and quality of services provided. Since decentralized health services have high process flexibility, it results on better regulation between investment standards and needs (Srivarathan, Jensen & Kristiansen, 2019). Since COVID-19 pandemic, it has been necessary to restructure health policies, as well as to reinforce certain fields of practice. In accordance with Decree-Law No. 23/2019 of 30 January, the following variables of influence for decentralization are listed: individual and community health are a result of environment settings; managing environmental factors influences community health; and communities with high health indicators consumes fewer health resources.

Connecting wellness, sustainability, and social investment to the health agenda is a challenge for health governance. Local communities are the ideal setting to improve health and wellbeing since the social, economic, and environmental circumstances have a direct impact on communities' health. Instead of researchers or funders deciding based on their personal interests, it is up to the community to select which matters should be studied (Hilger-Kolb, Ganter, Albrecht, Bosle, Fischer, Schilling, Schlüfter, Steinisch & Hoffmann, 2019).

To promote population health, intersectoral action is viewed as crucial. Both participatory governance and political integration are necessary to generate local development. Health promotion requires integrated efforts from all parties involved, that is, alliances that continue over time involving various organizations (public and private) and its users **(**Bloch, Toft, Reinbach, Clausen, Mikkelsen, Poulsen, & Jensen, 2014). To promote intersectoral accountability, planning is emphasized as a tool that every municipality should use to implement public health policies into their management systems **(**Synnevåg, Amdam, & Fosse, 2018).

Health status is a benchmark against which to establish whether a society is successful or not. The Healthy Cities movement began from a perspective of co-production and societal responsibility for health. The Portuguese Healthy Cities Network's municipal members are dedicated to deliberate planning to advance health, based on laws that address the social,

physical, and cultural context of the neighborhoods. Plus, the Health Strategy 2020 has promoted the development of cross-sectoral actions for health and well-being in governments and society, recognizing the need for a major strengthening of intervention capacities in the field of Public Health. An increase in decentralization is more and more appropriate considering the rapid urbanization and the requirement to address specific issues at the local level (Loureiro, Miranda & Miguel, 2013).

Many health systems are fundamentally decentralized, with Subnational Governments overseeing the provision and finance of healthcare. The level of decentralization differs significantly between the Organization for Economic Co-operation and Development (OECD) countries. **Decentralization is frequently a result of the central government's desire to relieve budgetary pressures or to enhance the effectiveness of response to citizens. Responsibilities at political, fiscal and administrative levels can be delegated.** So, the transfer of health competencies to municipalities implies the mobilization of material, human, and financial resources. The National Government, which wields significant control over several aspects of the provision of health services, typically makes most decisions regarding the policy aspects of healthcare. Local or Sub-national Governments typically have less decision-making authority in the health sector but more accountability for health contributions. Sub-national Governments can still be given a lot of shared decision-making responsibility, particularly Regional Governments (James, Beazley, Penn, Philips & Dougherty, 2019).

Several opportunities for health systems arise from distributing governance tasks at different levels. Empowerment of subnational agents enables the efficient allocation of resources, as these actors have better understanding of local circumstances. Implementing decentralized strategies includes a scope of requirements such as intervention development, situational diagnosis and periodic review of health indicators and other SDoH. To assess local priorities and tackle health inequities, in accordance with population characteristics, throughout new organizational structures. Hence, accountability between central and subnational organizations must be promoted (Sequeira *et al*., 2020).

2. METHODOLOGY

This chapter includes the methods used to perform a brief review in order to contextualize and prepare the interview questions and also to inform discussion results. This chapter contains a summary of the interview methods carried out to collect municipalities' perspectives, that is, throughout the perspective of municipal executives.

2.1. Literature Review

To support the study within a conceptual framework, a narrative review of the scientific literature on the topic was conducted through a database search. The databases used in the search process were PubMed and BMC Health Services Research. Other theses available in ISCTE-IUL's open repository, were accessed.

Regarding the database search, the search strategy was based on the combination of words that could be indexed as MeSH terms (Medical Subject Headings) to obtain eligible articles. The use of MeSH terms ensures greater precision and specificity in the search, since it allows access to articles that have specific biomedical concepts indexed. An advanced search was performed that included the following search descriptors and their Boolean operators: (Healthcare Decentralization[MeSH Terms]) AND (Health Management Policies[MeSH Terms])) AND (Local Level[MeSH Terms]) OR (Municipalities[MeSH Terms]), and (Healthcare Decentralization[MeSH Terms]) AND (Health Management Policies[MeSH Terms])) AND (Proximity care[MeSH Terms]) OR (Municipalities[MeSH Terms]).

To synthesize the obtained research results, the following inclusion criteria were defined: a time frame of 2010 to 2022, articles in free full text, in Portuguese/English languages. In addition, only texts that contemplated reviews or systematic literature reviews were selected. Next, it was considered as exclusion criteria articles that: were duplicates; did not have a clear or specific objective; were not available; were comparative studies, conferences, or clinical trials. A total of 24 articles were obtained.

According to the results obtained through the database search, a total of 24 articles that met the previously defined criteria were selected. To visualize this process clearly, following the authors Siddaway, Wood & Hedges (2019), an adaptation of the PRISMA diagram was constructed (Figure 1. – PRISMA diagram demonstrating the results of the literature review).

The national legislation, as well as several studies on decentralization and on the evolution of public policies, in the health sector, and its significance of health for a sustainable local development, were examined to establish a referential framework.

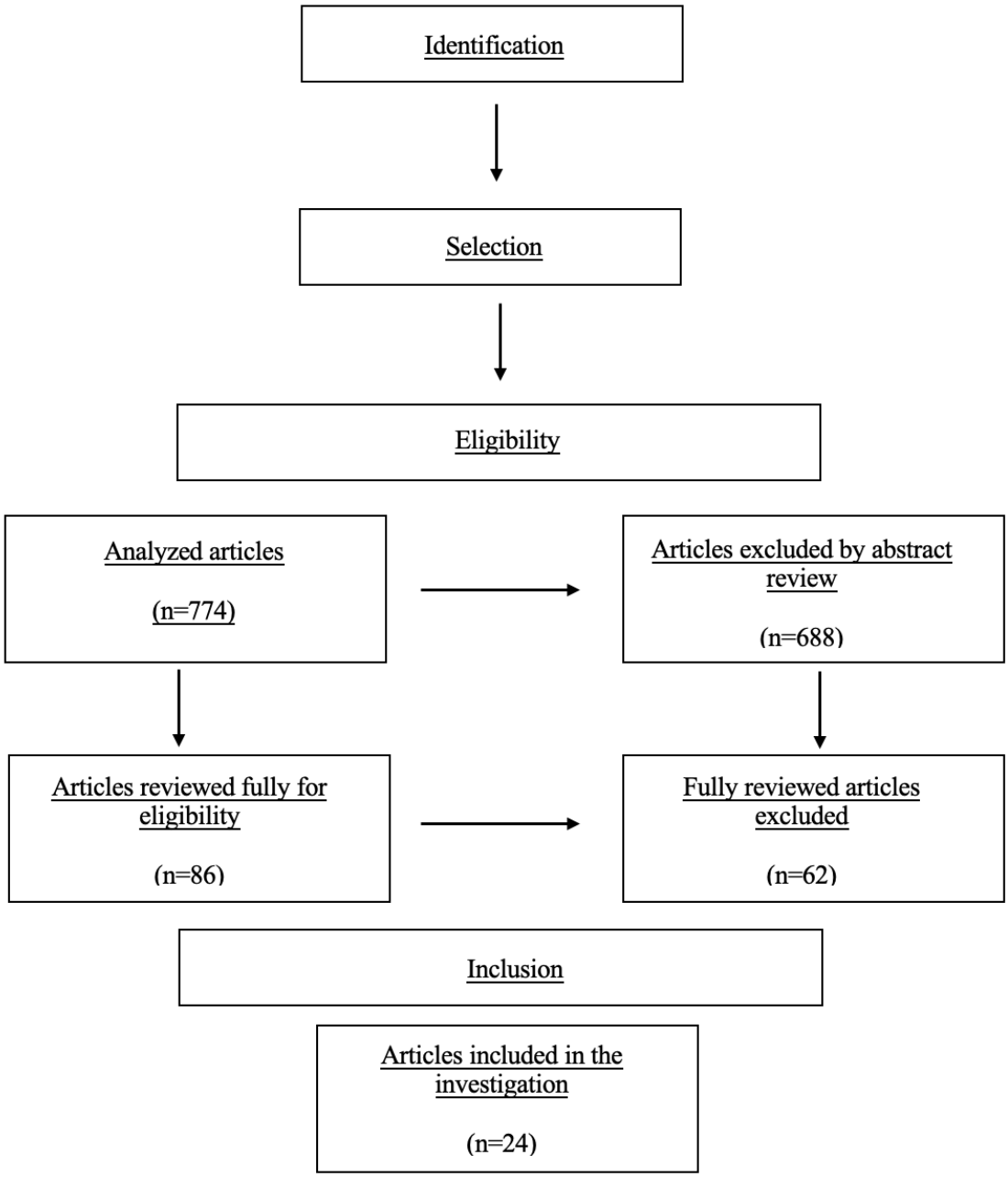

Figure 1. – PRISMA diagram demonstrating the results of the literature review (Source: The Author)

2.2. Interviews to Portuguese Municipalities

2.2.1. Population and Sample

Considering the qualitative nature of the research design, the sampling selection method is purposeful, which means that, it is important to be strategic when selecting the target population to be interviewed and participants are to be identified in accordance with the research drive. In

purposive sampling, the researcher does not intend to randomly sample research participants. The researcher aims to select participants' experiences and perspectives in a strategic way, to obtain pertinent answers to the stated research questions. Hence, the unit of analysis is chosen on its importance to comprehend a social phenomenon (Bryman & Bell, 2011). Therefore, an illustrative sample was selected by convenience, so that the spectrum of obtained data could be broader, and the interviewees were purposively chosen based on their potential contribution of theoretical understanding of a subject.

The sample consists of the target population selected for the cross-sectional qualitative research in fifteen Portuguese state administrative divisions or municipalities. Regarding territorial size, geographic area, demographic density, and health and social indicators, the fifteen municipalities included in the sample present different characteristics. Moreover, the political leadership varies. There are both socialist and non-socialist majorities, as well as varied coalitions. The object of study is a sample of fifteen semi-structured interviews with representatives of Local Government in order to evaluate the perception and vision of this illustrative group.

A total of 15 municipal executives were interviewed, each one representing the municipality where they carry out their functions. In addition to the above, other selection criteria were employed such as age and profession. Both men and women, aged between 35 and 65, who held local management positions in the city council, namely in one of the following positions, were interviewed: President; Vice-President; Alderman for Social Development and Health. Of the total 15 interviews, 5 Presidents, 3 Vice-Presidents, and 7 Alderman for Social Development and Health were interviewed.

The initial sample was made up of local and national health governance organizations. However, the study was redirected, and the scope was expanded to local representatives because no responses were obtained from central entities, namely divisions of the Ministry of Health and Public Administration. Several attempts to contact the National Association of Portuguese Municipalities were also made without success. Additionally, several parish councils were approached to get their opinions; nevertheless, the response was unfavorable because those organizations do not perform health-related duties and the interview requests were forwarded to the municipal councils of reference.

2.2.2. Procedure and Instruments

An organized literature study and a qualitative research methodology are combined in this dissertation. A qualitative approach was selected to address the research questions since it is

the methodological approach that is most suitable for research that entail understanding social processes. So, data collection will occur through qualitative methods, semi-structured interviewing, where the interview process is adaptable. The use of semi-structured interviews provides flexibility to this process as the questions may not be asked in the order listed and the interviewer is free to add new questions as he listens to the interviewees' responses, producing knowledge on the subject (Hennick, Hutter & Bailey 2020).

When applying qualitative research strategies within a cross-sectional design the approach tends to be inductive, consequently inductive approaches frequently align with constructivist methodologies (Bryman & Bell, 2011). Accordingly, this methodology will be carried throughout fifteen semi-structured interviews with municipal executives or representatives of local governments who hold positions in Portuguese municipal councils.

Based on the theoretical concepts that arose in the literature review, an interview script was developed, which was used as the primary instrument for gathering qualitative data (*Table I.* – Interview script). This interview guide is composed by fifteen open-ended questions that were grouped into two major categories to address the following topics: Decentralization Processes in Health Governance (Q.1 – Q.10) and the Report of Decentralization Processes (Q.11 – Q.15).

Table I – Interview Script (Source: The Author)

Broad Topic	Specific Topic	Author	Question
	Organic Restructuring	Julião & Nunes, 2020; Panda & Thakur, 2016; Hilger-Kolb et al., 2019	1.Why do you think this movement is taking place?
			2. Which health competencies are transferred to the municipalities?
			3. Do you consider that the development of a new organizational model, namely a public administration model of proximity, could promote citizens' access to health care?

Decentralization Processes			4. Do you consider that the stakeholders, at the Central Administration level, are prepared to manage this process? What about local stakeholders?
	Situational Diagnoses	Weiss et al., 2016; Srivarathan et al., 2019; Synnevåg et al., 2018	5. What are the main advantages and disadvantages of the transfer of competencies in health?
			6. Identify opportunities for improvement arising from this process.
			7. Describe possible threats to this process.
	Decision making and Implementation	Jansson & Tillgren, 2010; Loureiro et al., 2013; Synnevåg et al., 2018	8. Decentralization in health occurs at the political, fiscal and administrative levels. Taking these levels into consideration, which interventions can be implemented?
			9. To promote intersectoral health policies, which instruments should support the development of interventions at the local level?
	Decentralization Outcomes	Alves et al., 2013; Holen-Rabbersvik et al., 2018; Julião & Nunes,	10. This process implies the mobilization of human, material and financial resources to municipalities. Do you consider that these resources can be mobilized?

Report of Decentralization Processes		2020; Panda & Thakur, 2016	11. How can the municipality's capacity to deal with transferred health competencies be evaluated?
	Monitor and Evaluation		12. Which metrics can assess the health levels of a municipality?
			13. How do you monitor the concretization of decentralization?
			14. How do you monitor the impact of decentralization?
			15. Do you consider that municipalities are organized to provide health services that respond to citizens' expectations and needs in good time?

Regarding the interviews process, the interviewees had previously received an Informed Consent Form (Annex A – Informed Consent Form) attesting to their voluntary participation in the study, and that the study's goals and applicability had been explained, having given their consent for the data's recording, processing, and manipulation. The interviewing took place between April and July 2022, and between August and September 2022, their transcription and analysis were completed. The interviews were performed through Zoom due to Covid-19 pandemic scenario and to take the least amount of time from the municipal executives as possible. None of them topped an hour in length, lasting about 30 to 45 minutes each.

Concerning data analysis, a thematic analysis method using semantic or descriptive coding was applied – *"Reflexive Thematic Analysis (RTA) is an easily accessible and theoretically flexible interpretative approach to qualitative data analysis that facilitates the identification and analysis of patterns or themes in a given data set"* (Byrne, 2022, p. 1392). Thematic analysis's reflexive method emphasizes the researcher's active contribution to knowledge creation. It is described as a reflection of the interpretive analysis of the data performed by the

researcher at the interface between the dataset, the theoretical presuppositions of the study, and the researcher's analytical abilities (Byrne, 2022).

RTA method involves six phases which include a flexible set of principles that should be employed to fit the evidence and the research questions. In this order, initial codes were created as the author became familiarized with the information gathered through the interviews. Subsequently, codes reviewing, and improvement resulted in the definition of themes and sub-themes and their further examination (Terry, Hayfield, Clarke, & Braun, 2017).

In conclusion, the main instruments applied during this study were the interview script and the content analysis method, Reflexive Thematic Analysis. In addition to these, the following resources were required: computer with *Zoom* application; Microsoft Excel 2021; Microsoft Word 2021; external hard drive and Informed Consent Form.

2.2.3. Ethical Aspects

Throughout the research process ethical issues emerge. In light of this, it is crucial that the researcher uphold ethical standards during the entire investigation. Adopting transparent techniques while designing research reduces the likelihood of bias. Evidence-based solutions are developed through systematic review to advance and support the survey's purpose. However, the literature review must respect copyrights and be correctly referenced (Bryman & Bell, 2011).

According to Hennick, Hutter & Bailey (2020) conducting interviews incorporates a set of ethical premises such as confidentiality, privacy, minimization of harm (for the participant), manipulation and data protection. In agreement with Law No. 58/2019, of 08 August, to ensure data protection and security, guaranteed by the General Data Protection Regulation, an Informed Consent Form (Annex A – Informed Consent Form) was distributed and signed by the interviewees. This form attested to the interviewees' consent for: informed, voluntary participation in the study; and for recording and subsequent data processing. It also assured the interviewees that confidentiality, privacy and anonymity would be kept. So, the information that was disclosed does not allow the identification of the participants and consequently their organizations. Moreover, the fact that the interviewees are top managers holding public office at the municipal level makes it even more pressing that their identity be kept confidential.

Due to the unstructured nature of the semi-structured interviewing, the research direction course can easily be changed, based on the collected information. The lack of structure promotes the prospect of authentically comprehending the processes of a social system, according to the point of view of individuals under study. Qualitative research methods seek an

understanding of participants' perspective and depend on the interviewer's analytical skills. Thus, one of the main ethical issues posed by this method is that it has a subjective nature since it depends on the knowledge and expertise of several individuals. Furthermore, the use of the content analysis technique associated with the qualitative nature of the data can raise issues related to problems of generalization, i.e., the ability to apply the results obtained to all similar situations (Bryman & Bell, 2011).

To minimize the risk of error associated with the selected sample, target population must present characteristics of heterogeneity to achieve greater data variation. Plus, data saturation criteria were applied to end the interviews after the fifteenth interview was completed. Therefore, the number of interviews was established when the researcher reached a point of theoretical saturation, where comments and patterns started to reoccur and little new information was produced (Bryman & Bell, 2011).

Following Bryman & Bell (2011), throughout this investigation, all the principles listed in the Code of Ethics were taken into consideration and respected. The Code of Ethics is regarded as a model of excellence, rigor, and integrity. Thus, it serves as a guide for the researcher when it comes to acceptable behavior while conducting the research. It functions as a harmonizing tool for the work that is being developed; its adoption permits the management of the relationships that have been established; and it requires compliance to a wide variety of ethical standards and norms that have an impact on and impose themselves on research activities.

3. RESULTS

In all, a total of 15 complete interviews were conducted with 15 individuals. They had a mean age of 51.0 years (range: 35-65 years) and the majority were female (n=9).

3.1. Answers to the Interview Questions

Table II – Results from the interviews (Source: The Author)

QUESTIONS	RESULTS
1. Why do you think this movement is taking place?	The entire sample (n=15) mentioned the fact that municipalities are receiving more authority in various sectors – *"Decentralization is emerging as a transversal trend in a variety of fields, such as health and education."; "Furthermore, this movement confirmed the potentiality of municipalities to manage other areas"*. There is general agreement among the interviewees that the macro-objective of this process is to develop an integrative health governance model that provides solutions while effectively utilizing resources. Moreover, to simplify bureaucratic processes at the level of the Ministry of Health (MoH), through delegation to the city councils, so that it can concentrate on its primary task of electing health policies.
2. Which health competencies are transferred to the municipalities?	All interviewees are aware of the transferred competencies, including those related to treasury and patrimony, fixed assets (building, maintenance, and conservation), material resources (non-medical equipment), and human resources (operational assistants). Although, concerning the development of Health Promotion Programs, most

	of the interviewees expressed uncertainty about what will be the actual role of the municipality.
3. Do you consider that the development of a new organizational model, namely a public administration model of proximity, could promote citizens' access to health care?	The generality of the participants claims that, although it has the potential to have an impact on the population's health, for the time being this process will only relieve the MoH from logistical burdens resulting in an optimization of health resources and responses. However, the community's health outcomes may later be reflected through Local Government's expertise in social diagnosing – *"Municipalities developed experience in working with Social Determinants of Health to improve community health levels."*
4. Do you consider that the stakeholders, at the Central Administration level, are prepared to manage this process? And what about local stakeholders?	The integral sample (n=15) described the process of decentralizing health competencies as one of negotiation between Local Governments and the Central Administration. In this approach, Central Government assigns administration responsibilities to the municipalities, who then negotiated inter-administrative agreements with the parish councils. Therefore, it is generally agreed that the local authority's vision and dynamism will have an impact on the development of the transferred competencies. This issue of subjectivity is a cross-cutting concern for the local managers interviewed, except for one municipality. In this context an outlier was presented, a municipality that was already developing major investments in population's health. Through this outlier, it was verified that most advanced municipalities consider that *"the municipality's social innovation exceeds the speed of administrative processes at the Central Government level."* This group finds it

	difficult to improve action because of the centralized processes' inherent slowness.
5. What are the main advantages and disadvantages of the transfer of competencies in health?	The advantages that interviewees highlighted the most were: 1. Responsiveness to administrative processes and to populations' needs – *"Due to an overly centralized state regime and all the related bureaucracy, the administrative processes at the central level are extremely slow."*; "*Because each public institution has unique administrative practices, the response to logistical and support issues can be expedited."; "The cooperative structure of local management allows for a quicker and more effective response to citizens.", "Process speed helps the Local Government respond more promptly to citizens."* 2. Proximity to the local territory – *"Understanding the local environment and population supports the anticipation of needs."; "Knowledge of the sociodemographic area should be the foundation for a concerted intervention that distributes resources in accordance with needs."* The disadvantages that interviewees highlighted the most were: 3. Lack of resources or insufficient funding package – *"Due to a lack of resources, decentralization does not occur in many sectors."; "Real values must be included in the specifications and the corresponding financial resources, or the city councils will*

	suffer a significant increase in the volume of expenses." 4. Lack of practical/technical knowledge – *"To support the logistics that support a clinical part, it is necessary to know this environment, the municipalities will have to equip themselves with the know-how and experience that can help manage these components."*
6. Identify opportunities for improvement arising from this process.	Four major opportunities were identified by the interviewees: organic restructuring of services – *"Decentralization implies reorganizing the healthcare support system, such as removing tiers to promote more productive and fluid contact", "Releasing the MoH from bureaucratic procedures so that it can focus on elect and monitor health policies."*; harmonization of public policies – *"All municipal stakeholders who play a role in the health sector are involved in the definition of the municipal health strategy."*; establishment of intersectoral collaborations – *"Promoting partnerships with both public and private organizations to improve population health."*; and resource rentabilization/coordination – *"The decentralization of competencies provides for a more flexible, rational, and efficient management of resources"*.
7. Describe possible threats to this process.	Four major threats were identified by the interviewees: increasing demand from citizens – *"The decentralization of health competencies can be interpreted by the population as raising the quality of health services in the community.*"; Local Government corruption – *"As local power increases, so does the risk of corruption at the same*

	level."; municipal asymmetries – *"Territorial asymmetries play a significant role in highlighting inequalities across municipalities.";* and the lack of scientific data – *"A barrier to this process is the absence of data to support this transition"; "it is necessary to produce locally-based knowledge."*
8. Decentralization in health occurs at the political, fiscal and administrative levels. Taking these levels into consideration, which interventions can be implemented?	The interventions most mentioned by the interviewees were the following: 1. Political – 47% of the sample (n=7) agrees that – *"From a decision-making perspective, the transferred competencies are reductive, since they address mostly operational and administrative difficulties."; "Transferred responsibilities do not result in real change in the care delivery model. Municipalities assume competencies of support and assistance, which do not translate into decision-making power."* 2. Fiscal – 80% of the sample (n=12) states that – *"The discrepancies between central and local management result in big constraints for the municipality. For instance, as municipalities with their own fleets of vehicles do not receive any funding, those that rely on taxis for transportation do receive the corresponding amount. Or, as building insurance is not common at the central level, this item is transferred to the municipality with a corresponding sum of 0."; "The transferred funds do not reflect reality as the true needs of the municipalities were not considered."*;

	"Another example, is insurance and occupational medicine of operational assistants, which are not taken into consideration, since the assigned value to the transferred human resources is not real." 3. Administrative – 40% of the sample (n=6) suggested that – *"Since the biggest complaint of population is the deficient attendance in the PHU, administrative technicians could be included in the human resources to be transferred. Hence, city council's involvement could be advantageous by boosting these resources through outsourcing."* This would require organic restructuring of these units and of the city council, as the administrative technicians are part of the functional units' staff.
9. To promote intersectoral health policies, which instruments should support the development of interventions at the local level?	Health indicators and the harmonization of the Local Health Plan with the National Health Plan were the instruments most frequently mentioned by respondents. The fact that 33% of the sample (n=5) cited '*resistance from strategic partners'* as a challenge to supplying data is significant – "*Every three months, the municipal council asks indicators from the group of health centers, but these are never given.*"
10. This process implies the mobilization of human, material and financial resources to municipalities. Do you consider that these resources can be mobilized?	The whole sample (n=15) ensures resource mobility – *"Regarding the transferred human resources, the ownership of contracts can be transmitted among several Public Administration entities. As for material and financial resources the process is even simpler."* It is also generally agreed

	that the Central Government should continue to *"oversee the employing of specialized human resources"*.
11. How can the municipality's capacity to deal with transferred health competencies be evaluated?	All municipalities (n=15) claim to have prior expertise in the health sector, by creating solutions using their own resources. However, in many municipalities the health working groups (Clinical and Community Council) are pro-forma which explains why these are worried about the acceptance of managing health competencies, since they are less familiar with it. Local communities that make up the Portuguese Healthy Cities Network already work together with intersectoral partners on strategic planning and health development. Thus, it is possible to conclude that there are disparities in terms of their knowledge, experience, and health intervention development among the municipalities.
12. Which metrics can assess the health levels of a municipality?	The overall sample agrees that the Portuguese Government *"has minimal culture of evaluation, but this procedure should be incorporated in order to analyze health outcomes"*. The access to a range of social and health indicators indorses a holistic perspective on population health – *"Socio-economic and environmental indicators are other sectors of society where the population's health is revealed"*.
13. How do you monitor the concretization of decentralization?	As for monitoring of the concretization of this process, 73% (n=11) showed doubts on how to proceed, the remaining 27% of the sample (n=4) disclosed that they had established an internal team that had conducted an earlier diagnosis of the equipment and buildings transferred and had prepared a gradual investment plan. Additionally,

	they enabled the Regional Administration of Health to be questioned about decentralization procedures.
14. How do you monitor the impact of decentralization?	Most of the interviewees hold responsible the Decentralization Monitoring Commission. Claiming that, this should be *"overwhelmingly technical to make up for the lack of technicality in the body entity it will implement",* and function *"in defense of the Municipality (certify that the amounts transferred correspond to reality and make requests for clarifications of Decree-Law No. 23/2019 of 30 January) and the user (check that the functions are being correctly performed by the municipality).*
15. Do you consider that municipalities are organized to provide health services that respond to citizens' expectations and needs in good time?	Municipalities are considered to be prepared by 60% of the sample (n=9), regarding health in its broader sense, that is, considering various levels of community health; 27% (n=4) agrees, despite some obstacles, that municipalities have the capability to deal with the proposed changes; and the remaining 13% (n=2) agrees that municipalities are not ready as *"it depends on the size, development, maturity and commitment of the municipality, and whether conditions are met."*

From the aggregated material of the interviews, it was additionally possible to identify the following ideas:

- The transfer of competencies to the municipality only occurs when the Decree-Law No. 23/2019 of 30 January is signed.
- Even though some municipalities have not signed the respective legislation, all of them claim to have prior expertise in this field, by creating solutions using their own resources.

- When the interviews were conducted, 47% of the sample (n=7) had already accepted the transfer, meaning that 8 municipalities had not yet reached an agreement with the Central Administration.
- Decree-law No. 23/2019 of 30 January, has several discrepancies namely in terms of financing and municipality's involvement.
- 53% of the sample (n=8) used the expression *"poisoned gift"* to describe the delegation of these competencies to municipalities, since they consider that – *"the government is passing a problem and not responsibilities"*, *"the Central Administration imposed the negotiation process since neither the municipalities nor local experts were involved."*, and *"the acceptance of the transfer of competencies should only occur, when all items are explained."*
- Local Government representatives present these justifications as primary reasons why municipalities have been extending the signing of the abovementioned legislation – *"Several municipalities were reluctant to accept these competencies without having its discrepancies and implications clarified."*

3.2. Content Analysis

From the perspective of the interviewees, the process of decentralization of health competencies to municipalities was driven by the following influencing factors: political; legal; and related to the pandemic context.

As for political factors, respondents identify as their main concern the fact that the political cycle (short and medium term) lags behind the health promotion cycle (medium and long term) – *"Frequently, the implementation does not follow the rhetoric"*. Different timings between the political cycle and the health promotion cycle result in a misalignment of priorities between health and management. These priorities, such as the alignment of the strategies of the Local Health Plan with the National Health Plan must be in harmony to improve general levels of health in a community.

Regarding the legal aspects, *"the transfer of competencies intends to pursue the attributions of the municipalities"*, as stated in Decree-Law No. 50/2018 of August 16, which concretized the concepts of administrative decentralization, subsidiarity, and Local Government autonomy. The participants in the interviews largely concur that this legislation confers legitimacy of action to municipalities.

In relation to the pandemic context, the interviewees who represent larger city councils and

have more experience in the health sector share the following opinion – *"The Pandemic was the most unlikely and successfully executed test that decentralization in health could have shown he country", "It was the municipalities that solved the population's health problems. Due to the decentralized nature of the approach, Covid-19 Vaccination Centers were established at a remarkable speed."* However, representatives from municipalities with smaller scale and action in healthcare agree that – *"The Pandemic was the example that decentralization can accentuate inequalities between municipalities, as different response capacities underscored inequalities in access and situations of increased vulnerability", "Municipalities that did not work as much in partnership did not respond as effectively."*

After detailed content analysis of the qualitative data, four major themes can be identified: ***"Perspectives on the motivation for the legislation"***; ***"Existing barriers to the acceptance of legislation"***; ***"Existing opportunities arising from the legislation"***; and ***"Preparedness and maturity of the municipality to deal with the legislation"*** (*Table III.* – Summary of themes/subthemes emerging in the qualitative interviews).

Table III – Summary of themes/subthemes emerging in the qualitative data (Source: The Author)

Perspectives on the motivation
Influencing factors;
Prospect value.
Existing barriers
Lack of resources/Insufficient funding package;
Shortage of technical knowledge.
Existing opportunities
Responsiveness to administrative processes;
Proximity to local territory.
Preparedness and maturity
Intersectoral collaborations;
Municipal development.

4. DISCUSSION

4.1. Discussion of Results

Comprehending the outcomes in the context of decentralization phenomena is the objective, such as helping to improve knowledge of this health reform and its consequences for national and local levels of government. Furthermore, it is aimed to monitor the effects and municipalities' capability to manage the transferred competencies. The results raise the following hypotheses in light of the themes and sub-themes that were discussed.

The transfer of competencies is a reference point for an articulated and integrated management model of primary health care in the municipality through the promotion of efficacy and efficiency in the management of health care resources; the creation of synergies and potential as a result of the local community's involvement in the provision of health care; and the promotion of coordination between the various levels of public administration (Decree-Law no. 23/2019, of 30 January).

As stated by the respondents, the *"influencing factors"* which justify the motivation for the legislation under study, concern political, legal, and pandemic-related issues. Other variables, in the opinion of the Associação Portuguesa de Medicina Geral e Familiar (2017), have impacted the decentralization trend in this sector. The high centralization of Portuguese society has led to a concentration of wealth and political power. Decisions about governance are frequently insufficient and ineffective since they are made by remote central authorities with little knowledge of the demands. Moreover, 19% of the Portuguese population is over the age of 65, which primarily impacts smaller municipalities and leads to regional imbalances. New resources must be made accessible to fulfill the demands of the expanding older population and allow outreach professionals to provide continuity of care. Resource management becomes more effective thanks to the paradigm of proximity-based Public Administration. The action of PHU should be based on the sociodemographic background of the community they serve in order to address inequities by means of corrective political measures are required.

As for the *"prospect value"* associated with health decentralization, the sample presented different viewpoints. The Decree-Law no. 23/2019, of 30 January has some provisions that are ambiguous and cause local stakeholders to question about finance and the specific actions that municipalities will take, which is why a greater percentage of the sample views the transfer of competencies as a negative connotation (*"poisoned gift"*). This group's greatest concern is that not enough financial resources will be allocated to the unique needs of each municipality, which will lead to more issues and costs for the city councils. The objections put up by Local

Government representatives prevent them from signing the framework law on decentralization. The most mentioned *"existing barriers"* to the acceptance of the legislation were: *"lack of resources/insufficient funding package"* and *"shortage of technical knowledge"*. Regarding resources and funding package, studies have shown that one of the most relevant decentralization outcomes is health expenditures. Decentralization, according to economic theory, may encourage competition across jurisdictions to boost attractiveness and put pressure on Local Governments since citizens judge Local Governments' performance based on the behavior of their neighboring counterparts. As a result of increased competition, local policymakers raise healthcare spending rather than cutting taxes, which benefits health. In healthcare, decentralization does not arise to control or reduce expenditures, but as an incentive to provide better and possibly more expensive services. The transfer of political and financial power to lower governmental levels appears to raise health care costs while also enhancing health outcomes **(**Alves, Peralta, & Perelman, 2013).

According to Portuguese legislation, practically all costs, except for those associated with medical experts and logistical support services for medical equipment, which remain under the purview of the SNS's Administration, are transferred to the Local Government. As for maintenance expenses, an annual transfer of a sum to municipalities will be included in the Decentralization Financing Fund, to pay for the conservation costs of the facilities, which corresponds to the sum of the values calculated for each building, according to an exact formula (Value per square meter (Vm2) × Gross area of the building) (Miranda & Morais, 2020).

Moreover, local stakeholders' reluctance to ratify the decree-law, regulating the transfer of health competencies, may be explained by the *"shortage of technical knowledge"*. As a result of the transfer of ownership, municipalities are required to ensure the efficacy of interventions and create ideal operating and safety conditions, in parallel, at central level, the MoH is required to verify these conditions to protect the rights of users and healthcare professionals (Miranda & Morais, 2020). All this demands for proper coordination of Local and Central Administrations, as well as the training of a technical and specialized consulting workforce. **Evidence reveals that there is a gap in knowledge-based practice at the local level due to several factors, including the fact that local stakeholders frequently lack access to or possession of the requisite skills and information.** Local stakeholders' capacity to promote health could be improved by raising their knowledge and skill in this area. Since local health promotion activities have progressed from being occasional and behavior-related to being systemic and focus on health indicators it is critical that local stakeholders develop the necessary skills to handle with these technicalities (Jansson & Tillgren, 2010). Local actors play a supporting role in decentralization efforts. When involved politicians and proximity

professionals had a solid theoretical knowledge of their position as community health advocates and the required abilities to put this philosophy into practice, the likelihood of accomplishing policy or program objectives improved. Research has shown that the best practices in public health should be based on a combination of practitioner experience, user-based experience, and the evidence from existing studies **(**Weiss, Lillefjell, & Magnus, 2016).

The authors, Bodkin & Hakimi (2020), contend that for health promotion initiatives to be implemented sustainably, organizational capacity, strategic planning, political support, and public health impact must all be considered. Beyond political or economic stability, sustainability means maintaining a program. At the organizational level, maintaining program activities inside an organizational framework implies certification that the objectives and methodologies change over time to meet environmental demands. So, some of the most mentioned *"existing opportunities"* arising from the legislation are its proximity to the environment and its availability to respond to support procedures. The literature has demonstrated that social determinants, along with behavioral issues, have a significant impact on the health condition of an individual and a community (Weiss, Lillefjell & Magnus, 2016). SDoH consist of elements that affect the circumstances of birth, development, aging, and living. The concept of SDoH emerged from academics' efforts to precise mechanisms by which individuals from various socioeconomic classes experience variable levels of health and illness. Acknowledging the importance of these variables, has driven the acceptance of SDoH as a foundation for knowledge-based policies. Promoting and enhancing public health at all levels has proven to be successful when SDoH are addressed at the political and organizational levels. Therefore, it is crucial to concentrate on elements that enable the implementation of policies for health promotion and, also the creation of a framework for bettering local activity (Weiss, Lillefjell & Magnus, 2016).

According to Leite (2020), the SNS will need to implement a new management model, where health management will be done on a smaller territorial basis, to incorporate population-based metrics that assess effective health gains in the entire population. The SNS will be reorganized to put patients at the heart of care, starting with proximity responses. As a result, the SNS's first line of defense is now controlled using a population health perspective but coordinated centrally to maintain systemic alignment – *"The objectives must be short, medium, and long-term, must be accompanied by an action plan and resource allocation, and must be specific to the locality, but aligned with the national objectives of the National Health Plan. Only then will it be possible to have a strategic alignment at the national level properly adapted to local specificities"* (Leite, 2020, p.173). Due to the over centralization of power, which translates into bureaucratic slowness in decision-making, political power is undergoing

reorganizations. As a result, the system's organizational structure needs to change to a territorial perspective. In line with the decentralization of competencies, a vision of territorial management in collaboration with the municipalities emerges – *"Municipalities could become responsible in this context for non-clinical areas such as infrastructure management, for hiring non-clinical staff, and even as partners in public health programs and promoting population wellbeing"* (Leite, 2020, p.170). Additionally, a rise in user complaints about waiting times and attendance issues supports the recommendation to hire more non-clinical staff such as administrative technicians to boost the SNS's ability for quick response. Given that the administrative technicians are part of the PHU's personnel, this transfer of human resources implies organic restructuring.

Municipalities are thought to have characteristics that put them in a crucial position to address population health due to their proximity governance models and responsibilities in several sectors **(**Holen-Rabbersvik, Eikebrokk, Fensli, Thygesen, & Slettebø, 2018). Since many health factors are linked to the local governmental level, intersectoral intervention on the SDoH is required to address socioeconomic inequalities in health. Thus, to improve responsiveness to users' necessities, it is crucial to forge cooperative relationships at the local level through *"intersectoral collaboration"*. Implementation of intersectoral policies continues to be difficult despite increased support for it. Instead of creating concrete action plans, strategies of intersectoral implementation generated abstract rhetoric. Intersectoral policymaking produced spread responsibilities since it produced abstract language and legitimized generalizations. Accordingly, reliance in a single strategy to promote consistency across all municipalities led to the reluctance to identifying more specific action (Holt, Rod, Waldorff & Tjørnhøj-Thomsen, 2018).

Worldwide, the benefits of cooperation between Local Governments and communities are becoming recognized. More and more municipalities use supported bottom-up programs to try to effect SDoH to improve community health indicators. Municipalities play a significant role in the creation and preservation of regional public services. Although, there are differences between them in terms of the Local Government's industry, political leadership, and administrative organization (Cahuas, Wakefield & Peng, 2015). The *"municipal development"* itself regarding the health sector is another aspect that varies between municipalities, translating into varying levels of health, service provision, and scientific advancement. Given all these disparities between municipalities, it is unclear whether decentralization will increase or decrease these inequities. Regional disparities in health care are linked to income inequality as well as local stakeholders' political actions. Studies have revealed that decentralization has been supported by political and economic considerations since healthcare efficiency has increased

and inequities tend to decline. Moreover, the decrease of local asymmetries related to population's health indicators will be enhanced throughout a culture of proximity management between primary health care and city councils **(**Alves, Peralta, & Perelman, 2013).

4.2. Decentralization Movement to Portuguese Municipalities

In Portugal, since decentralization at the regional level, i.e., the establishment of Health Administrations in the five administrative areas (North, Center, Lisbon and Tagus Valley, Alentejo, and Algarve) the previously totally centralized SNS has been developing around this organizational model which defends strategies considered to improve the effectiveness and articulation of the entire Public Administration structure. In essence, the health of the populace should be a greater social concern for city councils (Miranda & Morais, 2020).

Since the 1980s, here have been certain trends for Central Government to pass over several attributions to municipalities, but these procedures are always challenging to implement, which is one of the reasons why decentralization experiences have been occurring in a fragmented and individualized approach, that is, from sector to sector, separately, to make changes in accordance with what has been learnt from previous processes (Barroso, 2013).

As a result of decentralization, health and education indicators can be improved, and the European Union can get closer to its goals, that require strategic convergence of the multiple involved actors. Decentralization in the education sector occurred prior to decentralization in the health sector, however, it is currently possible to establish a comparison between both sectors. When examining the transfer of competencies in education from the Central to Local Government level, a conceptual framework based on the reconfiguration of Central Government's role is evident in the acceptance of local government as a place where the various levels of regulation converge, permitting the articulation between control regulation *"top down",* and autonomous regulation, *"bottom up"* (Barroso, 2013). This implies organic restructuring that involves redefining Central Government's part, that is reducing its role as a direct provider of public services and reforming Public Administration.

In the case of the education sector, the Central Administration's involvement in the actual supply of the educational service should be reduced, but its control over the mechanisms and procedures for evaluation should be strengthened, translating into a function that is primarily evaluative. It was possible to reach some transversal conclusions to other decentralized areas through the transfer of educational competencies. It was noted that while Local Government demonstrates essential skills and competencies in this area, Central Government finds it increasingly difficult to relate with local issues and opportunities that arise at a territorial level.

Therefore, decentralization is a solution to the issue of proximity of the center to the periphery with its main goals being to consider local specificities, bring the decision-making location closer to the application location, encourage user participation in the management of public services, reduce state bureaucracy, unleash creativity, and prompt pedagogical innovation (Batista, 2016).

4.3. Understanding Decentralization under the Lens of Theory

According to Dwicaksono & Fox (2018), the effects of decentralization should be analyzed from the following perspectives: social perspective; Public Administration perspective; and fiscal perspective. Thus, based on the conceptual framework provided by the cited authors and on the themes and sub-themes emerging from the qualitative investigation, the following conceptual model of the implications resulting from the decentralization of competencies in the health sector was developed (*Table IV.* – Conceptual model of the implications of decentralizing health competencies).

Table IV – Conceptual model of the implications of decentralizing health competencies (Source: The Author; Dwicaksono & Fox, 2018)

Perspectives	**Effects**
Social Perspective	*"Proximity to local territory"*
Financial/Economic Perspective	*"Lack of resources/Insufficient funding package"*
Administrative Perspective	*"Responsiveness to administrative processes"*
Political Perspective	*"Shortage of technical knowledge"* *"Municipal development"*

Since the subthemes *"Influencing factors"*, *"Prospect value"*, and *"Intersectoral Collaboration"* are dimensions that correspond with all perspectives at once, they were not included in this conceptual model.

From a social perspective, Municipal Governments can intervene to alleviate or exacerbate health gradients between neighborhoods because they are strategically located to SDoH. Applying bottom-up, resident-led strategies can thereby empower communities and further improve health. From a financial/economic perspective, one of the major obstacles to the implementation of decentralization processes is *"lack of resources/insufficient funding package"*. However, Local Governments have the opportunity to allocate resources more effectively since they have a greater understanding of the population's requirements. Decentralized health systems are believed, from an administrative perspective, to provide responsiveness and flexibility in management systems to fulfill local demands and better align with the fundamental principles of PHU's provision. As a result, they can guarantee their capability to meet local needs. As for the political perspective, *"Shortage of technical knowledge"* and *"Municipal development"*, allude to regional asymmetries brought on by these two dimensions, which result in disparities in the capability of the municipalities themselves. There is a need for more uniform and homogeneous regulatory frameworks that are independent of each municipal executive's perspective, vision or political ideology (Dwicaksono & Fox 2018).

5. LIMITATIONS AND FUTURE WORK

Since this policy has been recently introduced, there are few studies on its implementation and a clearer understanding of responsibilities at different levels of the system, is in order. Decentralization in health systems is a recent movement, which could translate into a lack of theoretical studies. Thus, one of the main limitations of this study is the lack of targeted scientific papers on this topic. Empirical proof of the consequences of decentralization processes is insufficient. Additionally, there is a knowledge gap between research and practice whenever actual policy and action are developed and carried out without fully utilizing the most recent data. Advanced research was conducted in multiple search engines and benchmarking strategies that are being employed by other countries in the field of decentralization were used to fight the absence of scientific evidence supporting the decentralization procedures. Nevertheless, according to Lascoumes & Le Galès (2012), one of the drawbacks presented by these processes is that decentralization does not occur at the same rate at all nations that declare this purpose, nor is it a uniform model that can be applied to all countries, as each place customizes the healthcare decentralization process to fit its own history, culture, and tradition.

One of the limitations of qualitative research is its subjective nature, as the interpretation of the findings by the researcher affects the conclusions. Additionally, a common critique of qualitative data is the researcher's lack of transparency regarding content analysis and the methods used to draw findings. These studies are also challenging to reproduce in different contexts due to their unstructured nature (Bryman & Bell, 2011). In order to surpass the restrictions that come with qualitative research, a Reflective Thematic Analysis method was used to conduct the content analysis of the collected data. By employing this technique, the researcher was able to discriminate the themes and sub-themes that emerged from the subjects covered by the interviewees (Terry et al., 2017).

During the sampling process, some limitations arose since the initial concept was to interview representatives from Central and Local Government entities. However, as no response were obtained from Central Government representatives (Ministry of Internal Administration and Ministry of Health), the sample was redirected to Local Government representatives only. Parish councils were also contacted, but they forwarded the inquiry to the city council of reference with the explanation that the parish council lacked expertise in the health sector and that, while occasionally developing support actions for the PHU, the city council itself is ultimately responsible for delegate these interventions. Multiple attempts were made to contact the National Association of Portuguese Municipalities without success. More local councils could have been included in this qualitative analysis. However, a heterogeneous

sample was selected, with representatives from different organizations with distinct maturities that accurately reflects the range of situations on the field.

Though, municipalities from all around continental Portugal were chosen, with a variety of features, only when repetition of the themes and sub-themes was observed without any new information arising did the interviews interrupted, by mobilizing saturation criteria (Bryman & Bell, 2011).

For future research studies, the comprehension of how institutional mechanisms and determinants affect the performance and outcomes of the health system within the broader context of decentralized governance mechanisms is advocated (World Health Organization, 2021). Furthermore, in order to improve the accuracy in the collected data, in future research it is suggested to transform the interview guide into a survey that can be applied transversally to all 308 Portuguese municipalities.

The decentralization of health competencies has highlighted the emergency of clarifying the effects of this restructuring at the various of healthcare, as there are few studies on its implementation since this policy was just recently implemented.

6. CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

The prospects for smarter health are broad. The moments of change that are currently happening, as the utilization of resources made available by the Recovery and Resilience Plan (Ministério do Planeamento, 2021) and the social and political inequalities in many countries, have an impact on the Portuguese Healthcare System. Globally, one of the major changes in several healthcare systems is the decentralization of health competencies at the political, administrative, and financial level (James, Beazley, Penn, Philips & Dougherty, 2019). Decentralization arises in response to the SNS's overburden. The overall objective is to develop projects of innovation and improvement, with more realistic and quantifiable solutions that enable the community to become more involved, especially through increased participation in health care management and in strengthening the accountability for the quality of the health services provided (Miranda & Morais, 2020). In 2019, the framework for decentralizing health competencies to municipal authorities was materialized (Decree-Law no. 23/2019, of January 30), following the framework law for the transfer of competencies to local authorities and intermunicipal entities (Law no. 50/2018, of August 16).

To respond to the research questions, *"Which processes are expected at Central and Local Government?"* and *"Do municipalities have the capability to deal with the implications of decentralization of health competencies?"*, a qualitative study was conducted involving fifteen municipal executives allowing several conclusions to be drawn.

Regarding the first research question, various organic restructuring processes are inherent, both at local and central level, to circumvent the different ways of working between Public Administration entities, but also to clarify all the discrepancies and inconsistencies in the legislation (Decree-Law No. 23/2019, of 30 January). The SNS is intended to be proactive rather than reactive (Leite, 2020). Hence, proximity management models that stimulate the understanding of citizens' needs must be supported. Currently, according to Leite (2020), the separation between social and health policies results in a fragmented and ineffective SNS, which is only focused on the disease process and does not understand each citizen as an individual with specificities. It is crucial to develop specialized policies that address sectoral challenges from a holistic perspective, as improvements in community health come from being able to observe society from a wider perspective. This logic of health gains should be used to construct a more comprehensive notion based on metrics that reflect the actual health improvements in the entire population. Based on a paradigm of proximity-based Public Administration, and through

population-based indicators which are crucial to lessen the burden of disease and enhance population well-being, the SNS can be reorganized to place patients at the center of care generating better outcomes. The SNS's current management model will have to undergo a significant transformation in order to incorporate these indicators. As a result, according to the WHO (2021), the management of SNS's first line of response must have a holistic vision of the system, that will require centralized coordination of health policies development methods. Different municipal councils have a large amount of flexibility to create a pattern of health services within their jurisdiction since decentralization entails the spread of authority and political control.

Throughout this dissertation, examples of the fundamental organic restructuring processes at the two levels of governance have been described (restructuring the work organization of health managers, granting the management team the opportunity to make strategic partnerships and decisions, implementing new models of financing health units that prioritize health gains over production, etc.).

Regarding the second research question, from a general perspective it is possible to conclude that the municipalities have the capability to deal with the implications of the transfer of health competencies, since this transition tackles health as a more comprehensive societal concept. However, it should be highlighted that municipalities who had already established networks with strategic partners and were gaining expertise in this field are more receptive to and open to this process.

In light of the fact that municipalities with less experience in health management have more concerns managing the transferred skills, it is argued that the concepts of equity and decentralization go hand in hand, since socioeconomic and/or socio-demographic characteristics influence the conditions in each municipality. That said, one of the biggest challenges to decentralization is disparities between municipalities. As a result, the interviewees' top reasons for opposing decentralization were the lack of financing and resources, as well as the lack of technical expertise of local stakeholders.

On the other hand, the responsiveness to administrative procedures and the proximity to local territory were the prospects for decentralization that were most frequently noted. According to the literature, decentralization can take many different forms, including political, administrative, and financial decentralization, nonetheless in the setting under study, the decentralized health skills primarily take place mostly at the administrative level (James, Beazley, Penn, Philips & Dougherty, 2019).

Through the research carried out, it was found that more developed and *'matured'* municipalities, which were already networking with social partners, are more receptive to

accepting the transfer of competencies regulated by Decree-Law No. 23/2019, of 30 January.

Throughout this dissertation, the decentralization reform in health and its implications for both national and Local Governments were made clearer. Additionally, it was possible to monitor the effects and the capacity of municipalities to handle it. With regards to the objectives, it is considered that they were generally satisfied, enabling the production of impartial findings.

6.2. Recommendations

In conclusion then, healthy population uses less health resources, is more productive economically, and politically and civically more active (Leite, 2021).

Based on the results obtained throughout this research study, the following recommendations for the Central and Local Governments are suggested.

For the Central Government:

- To adjust the transfer of the financial amount to the volume of competences transferred, as well as to the diversity and specific features of local contexts;
- To transfer the competence of managing and hiring non-clinical staff such as administrative technicians, to boost PHU's ability for quick response (considering that the administrative technicians are part of the PHU's personnel, this transfer of human resources implies significant organic restructuring);
- To clarify, at the level of the legal framework, the distribution of competencies between the municipalities and the PHU, as a guarantee of stability in the execution of competencies by the municipalities.

For the Municipal Governments:

- To overcome the financial constraints that may arise from decentralization;
- To make strategic as well operational decisions without the constant bureaucratic requirement to obtain superior authorizations;
- To develop partnerships that they consider will increase the efficacy of outcomes (coordination with other entities such as PHU, Public and Private Hospitals, etc.);
- To survey and map the transferred equipment and infrastructure to determine its condition and suitability for current needs and future demands;

- To record the charges related with each service provision contract that is passed over to the municipal council's staffing charts;
- To provide technical/practical expertise (technological *'Know-How'*) to the local stakeholders.

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8. ANNEXES

8.1. Annex A – Informed Consent Form

Consentimento Informado – Entrevista Semiestruturada

Declaro que aceito participar no estudo da autoria de Beatriz Baptista Marques Barbosa, orientado pelo Professor Doutor Henrique Martins, no âmbito da dissertação de Mestrado de Gestão em Serviços de Saúde do ISCTE Business School.

Declaro que me foram explicados os objetivos do estudo e que aceito participar numa entrevista que visa explorar a questão da descentralização da governação em saúde para os municípios. Desta forma, dou autorização para a gravação (áudio e vídeo) da entrevista a realizar via zoom. Autorizo que os dados obtidos na entrevista sejam transcritos e utilizados para fins de académicos e de investigação.

Subscrevo que será garantido o sigilo da minha identidade, ao longo deste estudo, a menos que o autorize por escrito.

_____

(o entrevistado)

_____

(o entrevistador)