8. PORTUGAL

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I. INTRODUCTION<A>

Health politics in Portugal have been deeply affected by its series of regime changes. Prior to the eighteenth century, healthcare was provided as charity for the poor, with the Catholic Church playing a major role. With the establishment of the first Portuguese republic in October 1910, state intervention in the domains of health and public hygiene was strengthened, thus setting limits on the Church (Alves 2010; Catroga 1991). However, in 1926, the army overthrew the democratic regime and reversed recently won constitutional liberties (Catroga and Tavares de Almeida 2011). The coup culminated in what would become one of the longest lasting conservative dictatorships of the twentieth century (1926–74), led for most of the period by the economist Antonio Salazar and called the Estado Novo in its new Constitution of 1933. Under this regime, a 1940 Concordat signed by the government and the Catholic Church gave the Church formal powers in the public healthcare system, reversing the decisions made in the First Republic (Garnel 2010; Chuliá and Asensio 2007; Correia 1938).

A bloodless military coup, known as the Carnation Revolution, began the transition to democracy on 25 April 1974, ushering in yet another regime change. As democracy gradually took hold, popular pressure led to institutions promoting social and political stability, democratic institutions, and European Union (EU) membership as well as a new Portuguese National Health Service (*Serviço Nacional de Saúde*, SNS) that was created in 1979 (Pereira 1990; Oliveira & Pinto 2005).

Main Issues in Portuguese Health Reform<B>

Although the SNS was based on the principle of universal access to healthcare, the Portuguese national health system was fragmented by the fragmentation of pre-existing occupationally based insurance schemes. Despite the goal of universalism, it soon became clear that it would be nearly impossible to integrate the existing schemes into the SNS. Instead, most occupational schemes remained, and even benefitted from increased public funding, which resulted in overlapping healthcare coverage and inequalities in healthcare access (Oliviera 2005; Oliveira, Magone and Pereira 2005).

The main issues facing the Portuguese health system since the late 1980s have been the relationship between public and private provision of services, and the fiscal solvency of the system. New public management reforms led to a growth of public-private partnerships and efforts to introduce private management into public services. Later, as a result of the financial crisis, the Portuguese health system was subject to harsh austerity measures. The terms of the bailout are outlined in the 2011 Memorandum of Understanding (MoU) with the Troika of the European Commission, the International Monetary Fund (IMF), and the European Central Bank (ECB). A key element of the MoU was the austerity measures the government had to implement in order to qualify for loans. The MoU included a broad reorganization of the healthcare system to improve and simplify the financial arrangements of the SNS without sacrificing quality. Many of these reforms were successfully implemented, but there is still insufficient and unequal access to healthcare (Barros et al. 2011; Barros 2012; Simões et al. 2017).

II. THE PORTUGUESE HEALTH SYSTEM<A>

Historical Overview <B>

Development of Public Health Services and the Hospital System <C>

In the early modern period, the Portuguese Monarchy provided little in the form of medical and public health regulation or the development of hospitals. The main institutional channels for healthcare were the *Misericórdias,* religious charities involved in caring for the sick and disabled. During the eighteenth century, the state opened a small number of teaching and public hospitals to increase the provision of charity hospital care. This was expanded in 1860 with the appointment of salaried municipal doctors who were to provide health assistance to the poor. Although constitutional changes adopted after 1820 facilitated systematic hospital reform, political instability slowed progress in developing a full-fledged system of state-run hospitals (Abreu 2017; Correia de Campos 2003).

Government intervention in public health also expanded in the latter half of the 19th century. The deadly epidemics of cholera, yellow fever, and bubonic plague provided legitimacy for the central government's efforts to increase its control over the land and people and prevent communities from migrating, which would reduce tax revenue and military mobilization, both of which were essential to the emerging state. Public health efforts were carried out under the leadership of epidemiologist Ricardo Jorge (1858–1939) who helped shape major public health legislation in the late 1800s (Abreu 2017). At his initiative, the first Directorate-General of Health and Public Beneficence was established in 1899 to improve protection against epidemics. An 1899 decree-law introduced several changes in the organization of public health and welfare services, and a 1901 law provided the framework for new public health regulations.

These initiatives included measures to prevent communicable diseases, improve sanitation, supplying medical care and vaccinations (Alves 2008; Garnel 2010).

Medical Licensing and the Medical Profession<C>

Until the end of the eighteenth century, there was no formal board of medical examiners who carried out the licensing system in Portugal. Before that, governance of medical practice was shared by a chief physician and a chief surgeon who were appointed by and served the royal court. Such royal physicians had a well-defined professional jurisdiction over their subordinate colleagues: no one could exercise medicine legally without having been approved under the authority of one of these officials (Dutra 1991). In the late 1700s, these posts were abolished and replaced by a board of medical examiners with the authority to examine and license anyone wanting to practice medicine. Because of the shortage of qualified health professionals, doctors were often granted a license on the basis of their training with a licensed surgeon or doctor. This meant that any healthcare provider who passed an official examination and paid the compulsory fee could legally practice medicine (Abreu, 2017). Not only was this system vulnerable to corruption, it meant that hundreds of individuals licensed by the state to practice medicine had little formal training (Leitão 1986).

From the end of nineteenth century, medical practitioners were required to members of the Portuguese Medical Association (established in 1898). During the period of the Estado Novo, a 1938 law established the *Ordem dos Médicos* (literally, "Order of Physicians", but still commonly known as the Portuguese Medical Association) to defend the professional training, qualification, and interests of doctors. After the return to democracy and enactment of the 1976 Constitution, a new statute for the Portuguese Medical Association was approved by Law 282/77 of 5 July,

reestablishing the Association's independence from government and responsibilities within the medical profession (Pinto Costa 2009; Lemos 1991).

Introduction of Public and Private Health Insurance<C>

At the beginning of the twentieth century with the installation of a new regime (1910–26) after the Republican's victory in 2010, a flurry of initiatives were implemented to improve public healthcare. Among the most important measures were the establishment of an independent Directorate General of Welfare in 1911 (*Direção Geral de Assistência*), the reform of the University of Coimbra hospitals (1911), the creation of a maternity hospital (1911), the reform of mental asylums (1911), and the restructuring of Lisbon hospitals in 1913 and 1918. Nevertheless, the difficulties that Portuguese public health authorities faced during the First Republic's regime were further exacerbated by Portugal's participation in World War I (Alves 2010; Garnel 2010).

In 1919, the Portuguese state issued a decree creating a compulsory social insurance system covering sickness, disability, old age, work-related accidents, survival allowance, and death (Cardoso & Rocha 2009). The motivation was to address the gaps in social protection provided by mutual aid associations, which had emerged in the mid-19th century (Manuel & Glatzer 2019). Initial efforts quickly ran into trouble because of economic problems, political and social instability, and insufficient financial resources.

First with the establishment of the "Estado Novo" did public and private health insurance become institutionalized. Salazar's Estado Novo, which was officially launched with the new 1933 Constitution, was built on three pillars: the Catholic Church, Portuguese colonialism, and the military. Political stability was enforced, and the central government's inclination to intervene in social and economic affairs was also

extended to healthcare services, especially in private and religious assistance and healthcare institutions (Manuel & Glatzer 2019). The result of these policies, extending into the post-World War II period, was a corporatist and fragmented system of social protection.

1933 marked the establishment of a system of compulsory social insurance, based on occupational affiliation and financed by capital funding . The system was based on income compensation for the household, rather than individual social rights or national solidarity. There were gaps in coverage, however, because the system covered those in the manufacturing and services sectors but excluded others, e.g., agriculture and fisheries. In 1935, the new National Assembly passed a Law on Social Security (*Previdência Social*) that recognized entities as providers of social security providers and codified their competences, including sickness or welfare funds (*caixas*) for agriculture, fisheries, and other sectors. The social insurance system founded during this regime would be extended over time to cover other categories of people (Ribeiro Mendes 1995; Medina Carreira 1996; Chuliá and Asensio 2007: 624ff).

Main Reform Developments of the Postwar Period<C>

During the postwar period, the new corporatist, authoritarian regime coincided with a time of uneven development in healthcare provision. The state's role remained strictly supplementary. The 1940 Concordat between the Catholic Church and the regime had allowed for the incorporation of religious institutions in public healthcare, in opposition to the principles of the First Republic (Samouco, 1993).

A set of reforms affecting healthcare began in the mid-1940s as World War II was nearing its end. The Salazar regime empowered itself to promote the creation of

welfare funds and to expand the coverage of *caixas de previdência* to new beneficiary groups. The 1944 Social Assistance Law sought to overcome inefficiencies in social assistance provision (including healthcare) by setting out a clear regulatory framework, while confirming the state's intent to keep its intervention to a minimum. The new benefit system was based on the principle that benefit entitlement should be linked to employment. A separate social protection system existed in rural areas, but levels of coverage were so low that most parts of the population were not included in any form of protection.

The sanitary reform undertaken by Trigo de Negreiros, Secretary of State for Social Welfare, resulted from the application of the 1945 Decree-Law (n.º 35108) on Reorganizing Social Assistance Services in compliance with the 1944 Social Assistance Law. Social assistance services would be reorganized at three levels of intervention: preventive, palliative, and curative. As of 1954, by Decree-Law n.º 39805, sickness and welfare funds (*caixas*) were to cover the costs of hospital care for their beneficiaries. The number of healthcare beneficiaries assisted in hospitals had increased significantly, growing from circa 152,000 in 1943 to circa 225,000 in 1954 (Decree-Law 1954/39805).

In the years that followed, Salazar's regime concentrated on rationalizing its social policies. Sickness and welfare funds assumed other competencies such as the provision of medical care, allowing the gradual extension of socio-medical services to more citizens via several independent, occupation-based health subsystems. Nevertheless, there was no universal and comprehensive health service, and social inequalities increased due to inefficiencies within each subsystem. Despite the existence of myriad schemes, the 1962 Social Assistance Reform Law (n.º 2115) introduced a "general scheme", which distinguished funds responsible for short-term benefits

(sickness, maternity, and family benefits), with a regional basis and a national federation, from the newly introduced National Pensions Fund, which was accountable for long-term benefits (old age, disability, and pensions). The 1963 Law on Health and Social Assistance Policy (n.º 2120) outlined the state's basic principles in these fields, while maintaining its approach of minimal intervention in delivery. Nevertheless, the number of insured continued to increase. Between 1960 and 1974, the number of subscribers to the general scheme increased from 194,475 to 388,082, and in the ADSE scheme from 179,902 in 1970 to 561,700 in 1974; expenses in current prices from 17,851,259 to 29,091,697 and from 1,472,221 to 5,715,183, respectively, (Barreto and Valedas Preto 1996: 142, 145).

In the late 1960s, Marcelo Caetano replaced Salazar as Prime Minister, ringing in a period until April 1974 known as "Marcelo's Spring" due to its traits of political openness, social policy progress, and economic liberalization. The political softening of the regime, influenced by the arrival of a technocratic elite, allowed for a new awareness regarding the importance of healthcare as a political issue as well as the appeal to guarantee extended intervention by the state. A series of reforms, including clarification of the status of health professionals, development of a qualified medical and technical staff, and integration of medical health and social action, ensued. The government kept its dominant role in the definition and implementation of health policy with the 1971 Decree-Law Organizing the Ministry of Health and Assistance, promoted by Gonçalves Ferreira, State Secretary of Health and Assistance. The background to the reform was concern about high levels of mortality and morbidity. The new law prioritized the public over the private sector as a means to guarantee a more rational allocation of resources and aimed to give to the whole population universal access to a

full range of primary healthcare such as vaccination, childcare, prenatal care, and campaigns related to sanitation and environment. The reforms marked a reorientation because the state now coordinated a healthcare system based on centrally-decided principles but which depended on decentralized delivery. Prevention and proximity were key principles, so the government established the first generation of health centers and health posts in small villages (Gonçalves Ferreira, 1985). Despite a greater public sector role, the reform did not exclude the role of private actors in health service provision (Gonçalves Ferreira, 2015; Lawn, Rohde & Rifkin, 2008).

Originally a military coup prompted by power conflicts within the incumbent regime, the Carnation Revolution that began in April 1974 (unintentionally) led to a peaceful, though politically turbulent transition to democracy, a new Constitution, and, in 1976, the first democratic elections. The new Constitution included the citizens' right to health and placed strong emphasis on the role of the state, charging the state with "organizing, coordinating, and subsidizing a unified and decentralized social security system" and providing for the setting up of a "universal, free national health service." Between 1976 and 1979, successive governments (four prime ministers during this period) implemented reforms to consolidate Portugal's health system. They also promoted the decentralization of healthcare provision in order to improve services for populations in even the smallest villages. The establishment of district administrations and periphery medical services were a departure from centralized previous approaches. Already in November 1974, hospitals belonging to the *Misericórdias* had been nationalized and transferred into the public domain, as were social welfare medical units and health posts.

The pinnacle of these reforms was the establishment of the national health service. The 1979 Law Creating the National Health Service (56/79) builds on the

constitutional right to health to guarantee all citizens access to medical and social services. As in some other transition countries, the establishment of a new welfare state that provided equal and universal access to health care through a national health service symbolized the move to democracy (Guillén 2002; Pereira 1990; Oliveira & Pinto 2005). However, even though the SNS claimed to be universal, some of the pre-existing occupational health insurance schemes were left untouched, principally the civil servants' schemes. In fact, the SNS continues to coexist with the public and private occupation-based insurance schemes known as health subsystems, however their relative importance has been reduced after the transition to democracy and the founding of the SNS. Just to show the relations, between 1979 and 1994, the number of insured in the general scheme increased from 53,379,057 to 246, 526, 77, while membership in the ADSE increased from 1,136,452 to 1,212,225 (Barreto and Valedas Preto 1996: 141-2). However, it should be noted that these figures are no longer comparable, as the general scheme covers pensions and unemployment and not health, while the ADSE includes the health subsystems.

At the beginning of the 1980s, a center-right coalition government (PSD-CDS-PPM) adopted a liberal orientation that marked a turning point in the health system's trajectory. This reorientation was facilitated by improvement in domestic economic and financial conditions after Portugal joined the European Economic Community (EEC, later EU) in 1986. Accession to the EEC had been a policy goal shared by all political parties (except the Portuguese Communist Party) and represented a new context for both democratic consolidation and economic development. Portugal was entitled to European funding that was used to improve its long-neglected economic infrastructure,

including the health sector, and attend to welfare state reform (Lains and Lobo, 2007; Guillén, Álvarez, and Silva 2003).

In the meantime, the center-right Social Democratic government led by Cavaco Silva after the 1985 elections adopted a program aimed at bringing Portugal to European standards. The Social Democratic Party's win of an absolute majority of seats in the 1987 elections gave it the power to see its program through. The 1988 Hospital Management Law sought to bring entrepreneurial management principles to bear within SNS hospitals in order to increase efficiency. Also in 1988, within the context of a more general income tax reform, limits on the amount of health expenditures, including co-payments and payments to private doctors, that could be deducted from personal income taxes were removed.

These beginnings of what could be called a New Public Management (NPM) approach were cemented by a constitutional revision in 1989, which redefined healthcare from being a constitutional right to universal and free healthcare to one which "tended towards" no cost at the time of treatment and was based on individuals' particular social and economic situation. This shift away from universalism also removed obstacles to privatization within the SNS and allowed the introducing other forms of market mechanisms, as will be discussed in detail below.

[Table 8.1]

III. DESCRIPTION OF THE CURRENT HEALTH SYSTEM<A>

Coverage<B>

The Portuguese SNS covers the whole population, providing access to a broad network of healthcare providers. Some services require a very small compulsory user

fee, but citizens below a certain income threshold and some with certain medical conditions are exempt. Dental care is not included.

The Portuguese health system's structure involves several overlapping tiers of coverage. The first tier is the SNS, which is compulsory. The second tier, covering nearly a quarter of the population, consists of mandatory occupation-based health schemes, known as health subsystems, which are essentially holdovers from Portugal's earlier social welfare system. They include public health subsystems such as ADSE (public servants not covered by other special schemes) as well as private ones set up by unions or employers, and cover all current and retired employees, as well as their spouses. A third tier includes private voluntary health insurance, which has developed since the 1980s (Oliveira & Silva, 2016).

The existence of a significant share of the population that benefits from double coverage has led to some debate about whether it is a problem or not. Some argue that double coverage has benefits, enlarging the group of medical providers available, reducing out-of-pocket prices, and allowing faster access to the health system (Moreira & Barros, 2010). Others argue, however, that inequalities in access exist because only some groups (mainly better off socioeconomic groups) have access to the entire range of public and private medical specialties at reduced cost and benefit disproportionately from tax relief on private spending on health (Oliveira and Pinto 2005; Dixon & Mossioulos 2000).[1]

Access for Migrants<C>

[1] Until 2011, tax relief had been provided at the marginal rate of taxation, and 30% of non-reimbursed expenses was tax deductible. With Troika measures, tax relief was reduced to 10% of non-reimbursed expenses (Oliveira & Silva, 2016).

Legislation on migrants' access to healthcare is ambiguous, mainly because of the existence of numerous laws and administrative rules as well as other guidelines that try to help interpret and clarify legislation and regulations. The law provides migrants ample health coverage as long as they can demonstrate that they have resided in Portugal for more than 90 days. However, the ability to provide this evidence hinders the exercise of their rights (Asensio & Padilla, 2018). Access is organized through temporary registers in health centers and is usually done every time an immigrant requests medical assistance. Undocumented migrants of short duration are considered tourists and have a reduced coverage, which nevertheless includes HIV treatment and prenatal care, among others. The rights of undocumented immigrants are significantly endangered by the failures of the Portuguese health system in terms of organization and lack of resources (Bäckström 2014).

Since 2001, the right of access to SNS is guaranteed to all foreigners regardless of their nationality, economic status, or legal situation (Administrative Order n.º 25360 of 16 November 2001). Foreign nationals must obtain an SNS health card. Undocumented immigrants can obtain a temporary beneficiary card, which can be obtained if they present a certificate stating their place of residence. The fees that immigrants must pay for health services correspond to official rates for Portuguese citizens. However, those who do not contribute to the Portuguese social security system pay higher fees for medical treatments. Thus, there has been notable legislative progress, but there are still many structural and institutional constraints, as well as competing local definitions of relevant legislation, causing variation in administrative practice. These problems mean that undocumented immigrants may not have full access to medical care, especially during periods when migrant inflows are high.

Financing<B>

In 2016 total health expenditure in Portugal amounted to 9% of GDP or US$ 2,667.7 per capita PPP, as compared to the OECD average for 2016 of 8.8% of GDP and US$ 3,715.2, respectively. The OECD estimates that 65% of total health expenditure was financed by government schemes, 1.3% by compulsory contributory health insurance, 5.9% by voluntary healthcare payment schemes, and 27.8% by out-of-pocket payments (OECD 2019a).

General taxation is the main source of financing for the health system overall, in particular the SNS. Special health insurance schemes that cover particular professions or economic sectors are financed only by their beneficiaries as a percentage of their salaries. Private voluntary insurance schemes can be basic (basic package of services) or more expensive (a broader set of services, including higher ceilings of health expenses) and are purchased either by employers or individuals. The very high level of out-of-pocket payments come from unreimbursed payments to service providers, as well as co-payments in the form of user fees (*taxas moderadoras,* "moderating fees"). Since 2019, the user fees have been eliminated for SNS health services, but as they formerly comprised only about 2% of the SNS budget, the percentage of OPP will not be much reduced.

[Figure 8.1]

Administration and Governance<B>

The Minister of Health is responsible for the SNS, the national health service, as well as the planning, organization, coordination, and regulation of public health coverage. The Ministry is in charge of health policy oversight, implementation, and evaluation and is responsible for developing its strategic guidelines, defining public

health and policy priorities, coordinating all aspects of health provision, specifying the planning and regulation of the health system, defining its organogram, and supporting general leadership for the overall management of the healthcare system and issuing the National Health Plan and the National Strategy of Quality in Health.

The Ministry of Health comprises several institutions, some of which are under its direct administration, for example, the Directorate-General of Health (DGS) and General Inspectorate of Health-related Activities (IGAS); some under indirect administration, for example, Central Administration of the Health System (ACSS) and National Authority of Medicines and Health Products (INFARMED); and some organizations with public enterprise status such as the Health Regulatory Agency (ERS) and the National Health Council (CNS).

The ACSS implements the decisions of the Ministry of Health under its supervision and coordinates, monitors, and controls the allocation of SNS resources, its human resources policies, and facilities management. It also sets the budget allocation across regions and areas of provision, defines hospital capacity and the service network, and develops the contracting procedures within the sector. This entity also defines the main financial and activity targets and monitors their flows in the system. Finally, it develops information together with Shared Services of the Ministry of Health (SPMS) to support monitoring, assessment, and policy implementation within the system.

Although the Portuguese health system is a centralized governance and financing model, five Regional Health Authorities (ARSs) are responsible for the regional implementation of national health policy objectives and for supervision of the management of primary, specialist, and hospital care of the population under the framework defined by the ACSS (ACSS 2013).

Provision and Payment of Services<B>

The SNS, through a network of hospitals and local health centers, provides most of the outpatient specialist care and hospital day-case and inpatient care. The public hospitals belong to the state and have administrative and financial autonomy. State-provided healthcare is only free of charge for certain groups (e.g. children and the elderly). Patient co-payments ("moderating fees") were charged to prevent overutilization of services. Until they were eliminated in 2019, the level of co-payment varied from €0.40 for complementary treatments to €18 for emergency room care[2]

Hospital care<C>

According to the OECD (2019b), in 2016 Portugal had 3.4 hospital beds per 1,000 inhabitants, as compared to an OECD average of 4.7. Eurostat (2019) lists 233 public hospital beds, 69.9 not-for-profit private beds, and 39.3 for-profit private beds per 100,000 inhabitants. In 2016, around 49% of hospitals (111) were publicly owned, while 51% were owned privately (114: 59 for-profit and 55 not-for-profit hospitals) (OECD 2019b).

The hospital sector in Portugal consists of both public and private services. All hospitals of the SNS are under the control of the Ministry of Health, together with the respective Regional Health Authority, while private hospitals, both for-profit and not-for-profit, have their own management rules. Some of the SNS hospitals remain part of the public administration, but the majority are public enterprises, endowed with a certain measure of autonomy and expected to be run as business enterprises. To achieve horizontal service integration, most SNS hospitals are organized in 21 hospitals centers, combining two or more hospitals in a single legal unit based on their area of

[2] https://www.theportugalnews.com/news/government-to-scrap-fees-in-the-nhs/50009, accessed on 29 May 2020.

geographical influence. To achieve greater integration between primary and hospital care for a given population, some hospitals are organized into 7 large local health units. There are also 3 oncology institutes.

The private sector has been permitted to manage public hospitals since 1990 on a contract basis. The government also allows private actors to build and maintain healthcare buildings under specific conditions guided by rules governing public–private partnerships. The portfolio of services of each hospital is thus operated through a contract program, according to the respective Strategic Plan, considering what the Hospital Referral Networks recommend for each specialty. Most hospital services are provided according to the integrated model directly run by the SNS (Dispatch 6696/2016), but the SNS also contracts out services to private and other non-state actors. In addition, patients may choose to be treated in a private hospital when 75% of the maximum waiting time for surgery has gone by. The use of this provision has cut waiting times by over 43% since 2006 (ACCS 2013).

Outpatient Care<C>

The OECD (2019b) estimates that the number of practicing physicians in 2014 was 4.4 per 1,000 inhabitants, as compared to an OECD average of 3.3. Of all 46,036 physicians, OECD categorizes 23,748 as generalist medical practitioners and 23,725 as specialist medical practitioners.

Primary healthcare (family care, prenatal and postnatal care, prevention, and promotion) is mostly performed by the public sector, i.e. SNS, which is the central pillar of the system. Primary healthcare is delivered to the local population through health centers, family health units (USF), and, to reach the more rural and isolated parts of the country, mobile units. While the SNS offers a broad range of services, dental care,

diagnostic services, physiotherapy, and dialysis care are most commonly provided in the private sector based on contractual arrangements with the SNS. There is also an interactive web and phone helpline (called *Saúde 24*) that functions 24 hours/day that supports the provision of integrated primary care (Simões at al. 2017).

Nursing and Long-term Care <C>

The number of nurses per 1,000 inhabitants in Portugal (6.3) is below the EU average (8.6) (WHO, 2017), which indicates one of the lowest ratios in Europe. In 2014, there were 66,340 nurses, of which 59% were employed in the SNS (Simões at al. 2017). The growth in the number of nurses is a result of the policy adopted in 1998 to create a training program for nurses and open a nursing school per district. In fact, nurses are the professional group with the largest number of workers, accounting for about 1/3 of the total number of SNS workers (38,089), followed by medical personnel (26,645, 22%) and operational assistants (24,600, 20%) (ACSS 2016).

The National Network of Continuing Integrated Care (RNCCI) offers universal coverage in all forms of continuous, rehabilitation, palliative, and nursing care for people with limitations of either mental or physical nature. The long-term care system is decentralized into three levels – central, regional and local. Despite the existence of regional asymmetries, the number of nursing home beds increased over the years. The long-term and maintenance units were the setting with the highest proportion of beds (56%) in 2016, followed by the medium-term and rehabilitation units (31%), convalescence units (UC) (10%), and palliative care units (UCP) (3%). However, the number of individuals waiting to be admitted to RNCCI increased from 1,400 in 2016 to 2,450 in 2017 (Lopes, Mateus, Hernández Quevedo, 2018).

Gatekeeping and Cost Containment<B>

Within the Portuguese SNS, patients may only consult a specialist with a GP's referral. This controls access to medical care as well as healthcare costs. SNS patients are required to register with a GP in their residential district. GPs typically have about 1,500 patients registered at their practice. The gatekeeping system is expected to reduce health costs as GPs avoid the redundant use of specialist consultations as well as numerous diagnostics. Patients with less severe conditions or with the necessary financial means may choose private insurance that covers hospital stays and specialist care in ambulatory care.

Until 2017, a high proportion of SNS users were not registered with a family doctor, and patients bypassed the referral system by visiting emergency units. That would result in patients being referred to specialists within the same hospital by the emergency services. According to Ministry of Health data (ACSS 2016), more than 1 million Portuguese citizens, representing 10.5% of all SNS users, did not have a family doctor in 2015. In 2017, the Portuguese Registration of Users (UNR) was launched to eliminate duplicate registration, identify vacancies in GPs' lists, and allocate patients to GPs.

Improving the Quality of Care, Medical Outcomes, and Prevention<B>

Despite significant improvements regarding the health status of the population and health outcomes, there remain some significant challenges. Between 2011 and 2016, treatable mortality was reduced from 94.76 to 88.86 per 100,000 inhabitants but remains above the average of 85.96 for the region. While infant mortality has been remarkably reduced sine the 1970s, between 2011 and 2016 it has fluctuated around an average of 2.95 per 1000 live births. Similarly, life expectancy at birth for males and

females increased slowly from 80.10 in 2011 to 81.60 in 2017 (Eurostat 2019). Improvements in healthcare have been associated with economic growth and the increase in available healthcare resources. However, the negative impact of the financial crisis on household incomes, the remaining weaknesses in Portugal social safety net, as well as uneven geographic and socio-economic access to private healthcare constitute areas of concern (Simões et al. 2017; Nunes and Ferreira 2018).

Patient Rights<B>

The Portuguese Republic's Constitution includes a fundamental right to health protection that must be guaranteed by means of a universal and general health service. Patients' rights and obligations spelled out in various laws and regulations were consolidated and clarified in the 2014 Patient Rights Law. The law covers the main legal provisions around patient norms and requirements, including the rights to respect and dignity, to be informed on healthcare decisions, to a second opinion, to accept or refuse procedures and care, to privacy and access to records and data, and to maximum waiting times for specific procedures. It also sets out patients' responsibility to look after their own health status, follow all healthcare delivery system rules, and avoid unnecessary expenses for the SNS.

Public Perceptions of the Health System<B>

As we see in Figure 8.2, satisfaction with the health services in Portugal has been considerably lower than in the Southern European region and in the EU in general. Low public satisfaction can be explained by citizens' experience with barriers to access in the SNS, and in particular with the austerity measures that have recebtly been introduced (Popic, Schneider and Asensio 2019). Difficulties in registering with a GP,

staff and equipment shortages, as well as long waiting lists mean that many patients resort to private providers. Patients also face financial constraints when they have to buy medicines and pay for dental and eye care in the private sector, reflected in the high level of out-of-pocket payments. In addition, the distributon of physicians and clinics is very skewed to the urban coastal areas, leaving the inland rural population with uneven access (Simões et al. 2017).

[Figure 8.2]

IV. POLITICS OF HEALTH REFORM SINCE 1989<A>

Overview<B>

The 1989 constitutional revision changed the constitutional guarantee of healthcare: healthcare would no longer be "free of charge" but "tending to be free of charge," with consideration of each citizen's socioeconomic status. Responsibility for healthcare, furthermore, was a shared between the state, individuals, and organizations. This paved the way for a number of post-1989 changes, including an increase in the participation of private actors in the SNS system, the introduction of private practice in public hospitals, and management reforms in public hospitals, and new fiscal incentives for voluntary private health insurance, as well as an option for opting-out of the SNS.

As the commitment to a universal and free SNS is widely supported and fraught with symbolic significance (Cabral and Silva 2009; Guillén, Álvarez, and Silva 2003), the moderate party elites who managed the consolidation of Portuguese democracy had to cope with a complex heritage. Hence, the legacies of the revolutionary aspects of democratization are reflected in the left-wing perspective of Portuguese politics, including the fact that the two main political parties, the Social Democrat Party and the Socialists, both claim attachment to a socialist tradition, even though they occupy

center-left and center-right positions on the political spectrum, respectively (Fishman 2011; Jalali 2007; Costa Lobo, Costa Pinto & Magalhães 2016) Nevertheless, although the SNS was had been founded with a strong commitment to universal and free access, this has not actually been achieved. The health subsystems founded in the era of the Estado Novo remain, and options for voluntary insurance and opting-out, as well as tax deductibility of private insurance, co-payments, and private services all undermine the ethics of universalism. Furthermore, both of the two dominant political parties, the left of center Socialists (PS) and the right of center Social Democrats (PSD) have supported market-conforming policies for the SNS. As we will see, they have differed in their approaches, but have largely agreed to move in the direction of a public-private mix of service providers—despite the importance of the NHS as a symbol of the break with Portugal's authoritarian past and triumph of the socialist vision of the Carnation Revolution (Oliveira & Pinto, 2005; Oliveira, Magone, Pereira 2005).

[Table 8.2]

1990 Basic Law on Healthcare<B>

In 1987 and 1991, the Social Democrats led by Prime Minister Cavaco Silva won an absolute majority of seats, which permitted the party to govern alone for two legislatures characterized by further democratic consolidation, accession to the EEC, economic development, and, most important for health policy, the integration of the private sector and market incentives to the SNS (De Giorgi & Russo, 2018). Following several laws and the 1989 Constitutional revision—which moderated the unconditional right to universal and free healthcare—the Cavaco Silva government, with the support

of the Socialist Party, introduced the centerpiece of its health system reform program, the 1990 Basic Law on Healthcare.

In addition to what is stated in the Constitution regarding the right to health protection, the 1990 law sets out the general structure of and principles guiding the Portuguese health sector. The goal was to facilitate the development of the private sector as a partner to the public sector and to promote efficiency by increasing healthcare costs for patients. The law guaranteed the decentralized, regional basis of healthcare management services, facilitated private healthcare development, allowed the option of private management of public healthcare units, and opened a possibility for patients to opt-out of the SNS system.[3] The law also promoted the integration of primary care and hospital care through the creation of health facilities or centers. In practice, the system's new regulatory framework altered the financing structure and spurred the growth of SNS contracts with the private sector and allowed the participation of private entities in the promotion and protection of public health, providing the state with regulatory functions.

Within this new regulatory framework and with the many decree-laws that would follow, the SNS would cease to be the main healthcare provider, and the state would facilitate the expansion of the private healthcare and insurance sector. Moreover, SNS performance would be strengthened to better respond to patient needs. Importantly, SNS care would remain nearly cost-free, thus legitimizing individual SNS co-payments.

1992 Decree-Law on Moderating Fees<C>

[3] In 1988, a change to the tax code stimulated the purchase of private medical services by allowing full deductibility for health expenditures, including co-payments and doctors' fees. In addition, tax deductibility was extended to health insurance premiums, but as it was included in a general cap for insurance premiums, the stimulus to purchase voluntary insurance for individuals or companies was small (Bentes et al. 2004: 38).

Until 1981, all SNS-provided care, except for pharmaceuticals and hearing and ocular prosthesis, was free at point of service. Initially, user charges, also called moderating fees, were set applying only to health center services and some diagnostic tests. As the name implies, moderating fees are intended to "moderate" costs by incentivizing rational use of SNS resources and control of public expenditure. The 1992 Decree-Law on Moderating Fees extended the system of user charges to emergency services, consultations, and complementary means of diagnosis and outpatient therapy. The law also established exemptions for some patients (namely chronic patients with a salary less than the minimum wage, pregnant women, children under 14, and pensioners). It further stated that the proceeds from these fees were SNS revenue, contributing to an increase in the efficiency and quality of the services provided. The law made recourse to the principles of "social justice that impose that people with higher incomes and who are not chronically ill or at risk, pay part of the health care provided by them, so that others, most needy and unprotected, have nothing to pay."[4]

1993 Decree-Law Approving New SNS Statute<C>

The 1993 Decree-Law Approving New SNS Statute revised and laid out in the organization, purpose, and functioning of the SNS in order to accommodate the changes introduced by the 1990 Basic Law on Healthcare. Only the parties of the right side of the political spectrum supported the new SNS statute, as it was a clear departure from the original principles of the SNS. This meant that the Social Democratic government—now lacking its absolute majority and the charismatic leadership of Cavaco Silva—passed the law without the explicit support of the Socialist Party. The 1993 Decree-Law opened up the SNS and health system to the private sector and included provisions for

[4] Lei de Bases da Saúde. Lei n.º 48/1990, de 24 de novembro.

further decentralization to regional administrations. Doctors were now explicitly allowed to maintain both public and private practices. In addition, the law included provisions for local health units and other provisions envisioned in the Basic Law.

1993 Decree-Law Creating Regional Health Authorities<C>

As also laid out in the 1990 Basic Law, health policy decision-making was to be decentralized to the regional level. The 1993 Decree-Law Creating Regional Health Authorities allocated powers and reinforced assignments to five autonomous regional health authorities (*Administrações Regionais de Saúde*, ARS). The ARSs were to ensure coordination of activities between local health centers providing primary care and hospitals. The 18 district health authorities continued to operate alongside the five new ARSs, but this did not always go smoothly.

Other measures that followed from the 1990 Basic Law include a 1993 decree-law regulating the creation and operation of private for-profit and nonprofit healthcare entities to ensure quality control and issuing rules that allowed drugs prescribed by private doctors to be partially reimbursed by the Ministry of Health.

1993 legislation also provided for opt-out agreements that transferred the responsibility for healthcare coverage out of the SNS and into the private market. However, the legal framework governing opting-out agreements was incomplete and as a result only was applied to a small number of patients belonging to some subsystems. The tax deductibility of health insurance premiums was made more attractive when a separate cap for health insurance was introduced in 1999 (Bentes et al. 2004: 35, 38).

2002 Law Approving New Legal Framework for Hospital Management<B>

The origins of the 2002 law establishing a new legal framework for hospitals go back at least as far as the Socialist government led by Antonio Guterres beginning in 1995. The Socialists had won the 1995 election, but narrowly failed to achieve an absolute majority, thus running a minority government. While this was a constraint on the government's ambitious healthcare reform plans,[5] positive economic conditions and a sound fiscal situation left by the previous government provided certain advantages. Among the multiple changes introduced during the Guterres government were a series of measures clearing the way for a major overhaul of the hospital sector.

A 1998 decree-law (151/98) amended the legal statute of *Hospital de São Sebastião*, establishing it as a corporate entity with autonomy over its administration, finances, and assets (Ministério da Saúde 1999). This marked the first time that a public hospital was given such a status. In 1999, a decree-law (374/99) sought to improve hospital management by establishing a framework to facilitate the creation of "joint responsibility units" (CRIs) within hospitals. In the same year, another decree-law revised legislation relating to public enterprises more broadly, laying the foundations for the creation of new "entrepreneurial public entities" (EPEs). Only a few months after Guterres's December 2001 resignation following the party's poor showing in local elections and just weeks before the March 2002 legislative election, a Council of Ministers Resolution (41/2002) announced the still-Socialist government's plans to bring the EPE idea into the hospital sector and convert hospitals into enterprises that would be more capable of balancing the goals of equity and effectiveness and using resources efficiently. Thus, despite the early criticisms of introducing a new public

[5] Guterres's political strategy was to create nine administrative health regions with elected regional assemblies, improving quality though a purchaser provider-split, reducing waiting times, creating a user's card for members of occupational schemes so that the SNS would be able to charge for the services rendered, promotion of generic drugs, and capitation payments for GPs.

management approach, the Guterres government endorsed a number of its management principles.

In the election, the Social Democrats obtained 40.2% of the vote and 105 seats, followed closely by the Socialists (37.9% of the vote and 96 seats). The President of the Republic appointed José Manuel Durão Barroso (PSD) to form a new government, and the next day Barroso signed a coalition pact with the right-wing CDS-PP. The new government inherited a fiscal crisis coupled with an economic recession. After a period of strong economic expansion, in the 1990s, GDP growth stalled. In 2001, Portugal was the first EU member to violate the Stability and Growth Pact with a budget deficit that exceeded 3% of GDP. The state thus faced pressure to cut public spending and to implement structural reforms to transform the SNS into a mix of health services, directed towards the needs of healthcare users (Ministry of Finance, 2003). According to an OECD Economic Survey for Portugal (OECD 2001) the public health system was beset with several problems: overlapping insurance schemes, inflexible management procedures and lack of accountability, insufficient coordination across public health institutions, an ineffective remuneration system for doctors, and inadequate competition among healthcare providers and in the market for pharmaceutical products.

The coalition government initiated an ambitious reform program to overcome these deficiencies, aiming to further improve the health system while limiting health expenditure pressures. New public management (NPM) principles again guided the government's reform program, which included contracting out, enhancing managerial autonomy, and improving transparency and accountability.

The groundwork had already been laid for one part of the coalition government's healthcare reform program. In November 2002, relatively soon after the Social Democrats won the election, the National Assembly passed the Law Approving New

Legal Framework for Hospital Management (27/2002), changing the 1990 Basic Law on Healthcare to, among other innovations, allow the establishment of health entities as "sociedades anónimas de capitais exclusivamente públicos," i.e. autonomous corporations (SAs) with only public capital/assets. The idea was that the new arrangements and the new "Hospital SA" form would contribute to reducing public expenditure on hospitals and raising efficiency by introducing greater independence, agility, and entrepreneurial management to public hospitals. With the law's passage, hospitals integrated in the National Healthcare Provider Network could henceforth be managed under different forms: purely public, public enterprise, Hospital SA, or purely non-profit and for-profit private under contract with the SNS. The law also allowed two different and parallel labor statutes for professionals working for the SNS: statutes that apply to state employees and those that apply to individual contract work. Furthermore, the new framework permitted remuneration according to procedures and services provided and based the value of these on a standard price list that would be centrally formulated. The rules governing healthcare professions were also liberalized somewhat but remained under the supervision of the health department.

By mid-December 2002, 31 public hospitals had been converted via individual decree-laws (272/2002 to 302/2002) into "Hospital, SAs", and new boards were appointed which, most of the time, were chaired by non-health related managers (Correia de Correia de Campos 2004). Notably, each of these decree-laws contains an explanation of the reason for the transformation, explicitly stating that the conversion was not to be confused with privatization, since the statute guarantees that the hospital's assets would remain public.

According to a Ministry of Finance report, the new legal framework would transform the SNS into a "mix of health services, where public, private and social

entities coexist and act in an integrated manner, directed towards the needs of healthcare users" (Ministry of Finance, 2003). This means that patients would choose the health services they preferred, thereby improving quality and patient satisfaction.

2002 Decree-Law Defining the Legal Framework for Public–Private Partnerships <B>

Another part of the Barroso government's ambitious reform plans involved setting up new kinds of public–private relationships, also part of the NPM toolkit. It was thought that they would facilitate better coordination of healthcare services, respond better to patient needs, and improve quality. More practically speaking, such arrangements would mobilize private investment in the health system, sharing both risks and benefits. The 2002 Decree-Law defining the legal framework for Public–Private Partnerships defined the principles and instruments for setting up such arrangements for the design, construction, financing, maintenance, and operation of healthcare units at all levels of care that form part of the SNS.[6]

The decree reinforced the idea that the public and private sectors should work together to achieve common goals. Public–private partnerships were to be an ideal vehicle for enhancing efficiency at "no additional cost" to the public purse. The first such partnerships were launched between 2003 and 2006 in four hospitals (Cascais, which opened in 2009; Braga, in 2011; Loures, in 2012; and Vila Franca, in 2013) that provide healthcare to 15% of the population. Subsequently, no other has been launched in the health sector, although a proposal existed in 2019 for one in Lisbon. Various studies cited in Simões et al. (2017) indicated that the cost of such partnerships to the

[6] The PPP in the health sector were implemented in 20th August 2002 with the publication of Law n.º 185/2002 where the Government had as a goal the development of the cooperation with private sector.

public purse had been underestimated and that there was little to no evidence of these hospitals' greater efficiency or other advantages or disadvantages.

2005 Decree-Law Transforming Hospital SAs into Public Enterprises<B>

The results of the February 2005 legislative elections were remarkable not only because under the leadership of José Sócrates the Socialists won, obtaining their best result ever, but also because they gained an absolute majority of seats in the Parliament. Moreover, while the three left-wing parties together obtained 58.9% of the vote, the right-wing parties of the previous governing coalition scored their second worst result (36.1%). This was a significant episode in Portuguese politics since it initiated a series of reforms inspired by NPM, mixed with a pragmatic and modernizing political agenda. Improving the healthcare system, particularly increasing efficiency, was on the political agenda in the context of gaining and ensuring political and macroeconomic stability (Correia de Campos 2004, 2008). However, more ambitious plans for directly grappling with some of the main weaknesses of the Portuguese health system—specifically calls for revising the user fees, decreasing the tax deductions for private expenditures and insurance, and eliminating the subsystems—were quickly abandoned (Asensio and Popic 2019).

A set of reforms focusing on hospital facilities was approved and aimed at improving the configuration of the hospital system. Some of the measures redefined the existing SNS supply of hospital services, and some modified the management and payment systems of public hospitals.

With the 2005 Decree-Law Transforming Hospital SAs into Public Enterprises, the Socialist government converted the 31 Hospital SAs created by the previous government into "entrepreneurial public entities" (*entidades públicas empresariais*,

EPEs), a legal form introduced already in 1999 during the Socialist government under Guterres (Decree-Law 558/99) (Costa and Lopes 2005). These changes were deemed necessary in order to bring public hospitals into the public enterprise sector, giving the Ministries of Finance and Health more oversight and influence over hospital activities, in addition to enhancing performance, efficiency, and quality at SNS hospitals and possibly reducing costs. The political goal was to make it clear to the populace, especially voters, that the hospitals were not being and would not be privatized. Another decree-law later in the year (233/2005) went further, converting two public hospitals into EPEs and creating four hospital centers with EPE status though mergers. Efforts to gradually restructure hospitals, hospital centers, and local health units using the EPE legal form continued well beyond this government. In addition, in the context of macrolevel structural reforms outlined in the Restructuring Program for the State's Central Administration (PRACE) through Decree-Law 200/2006 passed in October 2006, health services were further reorganized and rationalized by closing, merging, and restructuring hospitals and other healthcare units.

2007 and 2008 Decrees on Family Health Units and Health Center Clusters<B>

In the meantime, in the face of opposition, in November 2006 the governing Socialists pushed through an austerity budget for 2007, aimed at enabling Portugal to meet the EU deadline for reducing the budget deficit from 4.6% of GDP to 3% by 2008. The government actually exceeded its goal, shrinking the deficit to 2.6% of GDP, and was then able to continue its reform efforts.[7]

[7] In May 2008 Parliament approved a controversial measure standardizing the €200 subsidy for each child born in Portugal, mirroring similar measures introduced in other European countries with falling birth rates.

One of the key organizational reforms (re-)introduced by the Socialist government is the creation of family health units (*unidades de saúde familiar*, USFs) that are intended to bring family doctors and primary care closer to patients. Already in 2005, via a decree-Law (88/2005), the government had repealed the previous government's law (60/2003) creating a primary care network, citing a lack of autonomy, among other reasons, for its failure. The same decree-law reinstated an earlier one (157/99) that foresaw creation of local health centers and such family health units until new legislation could be drafted. Finally, the 2007 Decree-Law Providing Legal Framework for Primary Care and Family Health Units (298/2007) filled the legislative gap with guidance on the organization and functioning of USFs. These USFs, having organizational and operational autonomy, would be composed of multi-professional teams providing personalized healthcare to a defined population. To attract and keep the professionals that should form these units, the decree-law also included provisions for applying elements of performance-based pay mechanisms.

To round out the organizational reforms, the 2008/28 Decree-Law Regulating Health Center Clusters provided the framework for establishing administratively autonomous public service entities (*agrupamento de centros de saúde*, ACESs) responsible for delivering healthcare to persons residing in a specific jurisdiction. As clusters of one or more health centers, ACES were intended to provide services contracted by the regional health authorities (ARSs), operating on a decentralized level. They would also guarantee better access to health services than the previously existing primary care network. There are also mechanisms that ensure that different functional units within an ACES work together properly and efficiently.

2007 Charter of Rights to Healthcare Access for SNS Users<B>

A chronic shortage of health practitioners, especially GPs, resulted in increases in the maximum intake at medical schools and nursing schools.[8] Despite these measures, the lack of personnel exacerbated waiting times in the health system. The 2007 Charter of Rights to Healthcare Access (Law 41/2007) did not directly solve the problem, but it did lay out a guarantee that SNS users should receive a defined set of outpatient services (e.g. home visits, diagnostic tests, and planned surgery) within a clinically acceptable time and should have information about what those times are. The Ministry of Health was to publish a detailed list of services and expected times on an annual basis. Additional measures included extending the SIGIC program launched in 2004 under the previous government to include private entities contracted by the SNS (Ministerial Order 45/2008) and starting the "On-time Appointments" project (Ministerial Order 615/2008) to better link health centers and SNS hospitals to improve response times, especially for those seeking specialist consultations. The latter order also allowed seeking healthcare outside one's area of residence (but within the SNS network) if the waiting time was too long. At the same time, however, in 2007, co-payments were increased and new ones introduced for ambulatory and hospital admissions, in order to react to the budget situation (Dispatch 395-A/2007).

Financial crisis and health system restructuring, 2011–15<B>

These reform steps had been taken in the run-up to the financial and economic crisis experienced by Portugal from 2009 to 2014, which had profound social, political, and policy consequences in healthcare and many other fields. At the same time, there was a heavy burden on democratic politics and governance because external pressures made it difficult for governments to deliver on their campaign promises. These

[8] Later in 2010, legislation was introduced to allow retired doctors to continue to practice medicine.

pressures had swift and powerful effects on electoral politics: elections held during this period were characterized by high level of voter volatility and frequent alternations in government as voters punished government parties that implemented austerity policies.

Already in the September 2009 general election results, widespread discontent with the Socialist government, especially its austerity measures, was evident. On election day, the Socialist Party won a leading 97 seats, but remained well short of a majority in the 230-seat legislature. Voters were not much happier with the Social Democrats either: for the first time since 1985, the Socialists and Social Democrats together won less than 70% of votes cast. Lacking a suitable coalition partner, the Socialists led by José Sócrates formed a minority government in October in the midst of recession and financial crisis. In December 2009, the EU and IMF warned the government of the need to reduce a record deficit of more than 9% of GDP.

In March 2010, credit agencies downgraded Portugal's bond rating because of the deficit and national debt. The same month Parliament enacted a four-year austerity program that included a wage freeze for government employees, cuts to the military and public services, and tax increases, which prompted strikes on the part of civil servants. Portugal's credit rating was further downgraded in December 2010. In February 2011 the ECB intervened to purchase Portuguese bonds as concerns mounted that the country would be forced to seek a bailout similar to those negotiated by Greece and Ireland with the IMF and EU. The Sócrates government developed a new austerity package to satisfy EU requirements for financial aid, but the opposition voted against the economic program in March. Sócrates resigned, and new elections were called for June. The Social Democrats won a plurality of 108 seats in the legislature, and party leader Pedro Passos Coelho formed a coalition government with the CDS-PP on 21 June.

Between 2011 and 2015 Portugal implemented an austerity program designed to reestablish control over fiscal policy in order to meet the requirements established by the Troika (European Commission, IMF, and ECB) as conditions for receiving financial assistance. In May 2011, already before the June elections, the Portuguese government had negotiated a Memorandum of Understanding (MoU) with the Troika that included tough cuts to public spending and reforms that would ensure future fiscal discipline and enhance public service efficiency. This included the healthcare sector, with most measures related to healthcare delivery and pharmaceutical policy (Asensio and Popic 2019; Nunes and Ferreira 2018; Barros 2012; Correia de Campos, 2008).

2011 Decree-Law on Moderating Fees, Exemptions, and Payments<C>

One of the key objectives of the part of the MoU relating to the health system was to induce more rational use of services and control of expenditures, thereby bolstering the financial sustainability of the SNS. This was to be achieved by, among other measures, increasing moderating fees, tightening means-testing for exemptions, and tying future fee increases to the rate of inflation. The 2011 Decree-Law on Moderating Fees, Exemptions, and Payments (113/2011) did just that. Moderating fees were fixed and raised for ambulatory care, including consultations, emergency visits, home visits, diagnostic testing, and therapeutic procedures. The new fee schedule, first published in Ministerial Order 306-A/2011, to be updated annually, was biased to incentivize use of primary care services rather than specialist or emergency services. The fees were to be paid upon receipt of health services, unless the user was unable to pay because of health condition or lack of financial resources. A subsequent ministerial order (311-D/2011) laid out the tighter criteria for verification of a user's claim to fee exemption based on economic difficulty. As the economic crisis deepened, a first

amendment to the 2011 decree-law (Decree-Law 128/2012) was required to exempt the involuntarily unemployed from moderating fees and to cover transportation costs for certain patients. Furthermore, the amount of tax deduction allowed for healthcare expenditures, including those for private provision and insurance, was reduced.

In addition to adjusting moderating fees, the government also tried to get expenditures on pharmaceuticals under control. Drug prices were reduced via an agreement negotiated between the government and the pharmaceutical industry (2011). Further, a decree-law (112/2011) published on the same day as the one on moderating fees introduced a revised system for establishing pharmaceutical prices paid by the SNS, including a more realistic reference pricing mechanism. These and other decrees and orders such as those promoting the use of generics were intended to help reduce costs to the SNS.

Other cost-containment measures adopted between 2012 and 2015 included a general cut to the health budget, wage cuts and reduction of overtime payment for health professionals, and restrictions on new hires and on external service contracting. The MoU commitment to make the health subsystems of civil servants such as ADSE self-financing and less a drain on public sector budgets resulted in a series of decree-laws and other measures that cut their costs, adjusted the scope of health benefits, and reduced the government's (i.e. the employer's) contributions (Law 30/2014).

On top of austerity, the MoU outlined organizational reforms that should lead to the SNS's longer term efficiency and sustainability. These included continuation of the process of concentration and rationalization of public hospitals and health centers, improvements in purchasing and procurement practices, installation of information systems, and introduction of electronic prescription procedures. Another important measure (Law 8/2012) was the setting of a timetable to clear all debts and introduce

standardized control procedures for all health (and other public) entities to prevent the re-emergence of debts.

Many of the austerity measures enacted between 2011 and 2015 had an immediate impact, whereas structural reforms were sometimes slow to take hold. For example, pharmaceuticals expenditure for outpatient care was reduced by approximately 12% between 2011 and 2014 (Simões et al. 2017: 124). The measures aimed at containing costs have disproportionately affected vulnerable groups because of increasing user fees and higher costs for transportation. The volume of appointments in primary care declined. Plans to assign all residents a family doctor were not achieved, and progress in creating family health units stalled. Cost containment in the hospital sector has hampered access. New hospital construction was postponed, and there were attempts to shut down healthcare facilities, including maternity wards. In the pharmaceutical sector, increased access to generic drugs improved things somewhat, but the effect of the crisis on pharmacies meant that not all patients saw these benefits. Finally, healthcare professionals experienced wage cuts, many emigrated, and there remained a shortage of GPs within the SNS system (OPSS 2016).

Moving Beyond Austerity<B>

The October 2015 legislative elections represented evidence of the resilience of Portugal's political party system (De Giorgi & Santana-Pereira, 2016). These elections were expected to be an opportunity for citizens to protest and appeal for change. Despite several years of austerity under the Social Democratic governments, the Socialist Party won only 32.3% of the vote, noticeably less than the right-wing CDS-PP (38.6%). Nevertheless, at the end of the day the Socialists agreed with several left-wing parties

(Bloco de Esquerda, Left Bloc, and an electoral alliance between the Communist Party and the Greens , PCP-PEV) to form a government under António Costa with a parliamentary majority named *geringonça* or "contraption" (*Negócios*, 31 May 2017). The Socialists had campaigned on a platform of moving beyond austerity. The shared goal of kicking the right-wing parties out of power and ending austerity provided the motivations for the left-wing parties to negotiate the agreement (De Giorgi & Santana-Pereira 2016). These election results represented a shift to the left in Portugal.

The main health reforms proposed by the Socialist "contraption" government in the post-austerity recovery period sought to improve access and restore the people's trust in the SNS by reducing co-payments (Ministerial Order 64-C/2016), increasing exemptions from the payment of user fees for specific groups (2016), and restoring free transportation for some patients, including those in palliative care (Ministerial Order 83/2016). Other reforms were designed to promote increased proximity for GPs in their appointment systems, reduce the volume of emergency cases that end up in hospitals, and improve monitoring by GPs (2016). Several measures were introduced in primary care to improve the range of services provided (2016). Measures were also adopted to improve the working conditions for medical professionals (2016). Taken together, these reforms have improved access to healthcare in terms of consultations, surgical procedures, and other treatments. Waiting lists have been reduced, and patients now have more control over the management of their primary healthcare (Nunes and Ferreira 2016).

2016 Patient Choice Dispatch

One of the priorities of the "contraption" government was to reduce inequalities in access to healthcare services. Both access and efficiency were to be improved by

reducing waiting lists for appointments and surgical procedures via a new Integrated System for Access Management (Sistema Integrado de Gestão do Acesso, SIGA). The new system would enable doctors and patients to have sufficient information to decide where treatment would be available. With the 2016 Patient Choice Dispatch (6170-A/2016), the Ministry of Health allows the family doctor, in consultation with the patient, to refer the patient for a first hospital consultation to any SNS hospital offering the needed specialty. The choice is conditional on there being shorter waiting times for the relevant procedure or outpatient consultation than in their local area. As part of this effort, the SNS set up a website with information on relevant waiting times (Simões et al. 2017).

2019 Basic Law on Healthcare<C>

In September 2019, just a month before the next legislative elections were to take place, a new Basic Law on Healthcare was enacted, replacing the older law from 2002, as well as a number of other decree-laws. The basic law served as an updated framework for the many changes that had occurred within the Portuguese health system. The law incorporated the provisions allowing for private providers but specified that competition from private providers could not be injurious to the SNS, which remains at the center of the health system. In line with the provisions of the 1989 constitutional revision, is the responsibility of individuals for their own health and the responsibility of the health system to provide health education, but the new law also updated its provisions on information for the digital era. Notably the law lifted co-payments for primary care. This was concretized by the 2019 Law Lifting Moderating Taxes for Primary Care, which removed co-payments for primary care visits and for other health services that have been ordered via referral. The idea is to strengthen the gatekeeping

system by incentivizing patients to consult their family doctors first and seek a referral before going to specialists.

V. Conclusion <A>

Since 1989, the Portuguese SNS has moved decisively in the direction of New Public Management in an effort to improve the quality and efficiency of its healthcare services. At the same time, the fiscal sustainability of the health system has been a reoccurring concern. Since the creation of the SNS in 1979, Portugal has recorded significant improvements in health outcomes. Certainly, many external factors have positively contributed to these advances, including new technologies, economic growth that increased (most) citizens' purchasing power, European Union membership, and lifestyle changes. Still, policy reforms such as those enhancing articulation between the public and private sectors and others that have been described here have also been instrumental. Despite the various health policy measures implemented since 1979 that sought ever greater efficiency in the system, it was only during the period of austerity (2011–15) that the level of public health expenditure diminished. In all other periods of democracy, public health expenditure increased constantly, and health outcomes improved overall.

While inclusion of private providers and the adoption of private management principles into the more traditionally governed SNS have indeed helped to expand provision and improve the quality of services, the promise of savings from better management and increased individual responsibility for one's health have not panned out. At the same time, there remains a cleavage in provision between the urban coast and rural inland, as well as between those with access to special health subsystems and

those outside this system, as well as based on income differences, as the amount of OPP payment remains considerable.

Healthcare Solidarity<B>

Since a return to Socialist-led governments in 2015 and 2019, the balance between health universalism, privatization and austerity has been re-calibrated. While long-held far-reaching plans for eliminating the special subsystems and reducing tax incentives for stepping outside of the NHS have not been resuscitated, the elimination of co-payments for primary care and the large reduction in tax benefits has closed or at least reduced some of the holes in the health safety net. The new Basic law in Healthcare indicates that the SNS is the dominant provider and indicates a determination to ensure that private provision of services does not erode the constitutional commitment to universal and equal coverage. To be sure, some of these changes were introduced during the austerity period, and the efforts to introduce voluntary health insurance as well as to better control the fiscal consequences of opting out provisions were addressed by Democratic Socialist governments, as well. Nevertheless, following the COVID-19 crisis, the commitment so health solidarity is sure to become even more pronounced.

Impact of Europeanization, Globalization, and Migration<B>

The entry of Portugal into the EU was a watershed, transforming the country and its health system. The European integration process led to a renewal of the National Health System after decades of dictatorship and a very instable political transition to

democracy (Bentes et al 2004). In the last decades, the pressures of monetary union and fiscal crisis have emanating from the EU have however also put the healthcare system under severe austerity pressures which are difficult to reconcile with the universal aims of the SNS (Petmesidou and Glatzer 2015). Nevertheless, the Portuguese legislative process has shown itself capable of decisively introducing unpopular measures, even under divided government. The Portuguese route stands out as a laboratory for NPM strategies as the policy changes have had both positive and negative results, and it is clear that policymakers are committed to building a data base to aid the study of internal markets and managed competition, as indicated by the 1990 Basic Law. The commitment to the universal right to health care—not only to Portuguese citizens but to foreign nationals and asylum seekers—has been re-asserted very clearly.

Health State Futures<B>

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