

THE NATIONAL HEALTH SYSTEM IN PORTUGAL: FROM EXPANSION TO CRISIS BETWEEN 1970

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Abstract

Purpose: The purpose of this article is to discuss the idea that governments should not take policy measures for the development and growth of National Health System (NHS) without taking into account their financial sustainability

Design/methodology/approach: This article is based on a review of existing theories, documents and statistics.

Findings: This article analyses the major developments in public health policy in Portugal between 1970 and 2012. It presents the measures that established the National Health Service (NHS) in 1976, signalling the start of an expansionary health policy that led to quality health care provision, but at the cost of very high spending. From 1990, governments have focussed on reducing public expenditure on health, due to growth-rates in this area outstripping increases in GDP. Paradoxically, despite this position, in practice, all the governments have increased the amount of infrastructure supporting the NHS, which in turn has been funded

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through public debt. This debt was extended in all areas of public administration and became unsustainable, obliging the Portuguese government to ask the European Commission for financial assistance in 2011. Due to the austerity measures imposed by lenders, for the first time since the creation of the NHS, there was a real reduction of public expenditure on health in 2011 and 2012.

Originality/value: This article shows Portugal as a case study of wrong policies and practices in the health public sector

Key words: National Health Service, public expenditure on health, economic and financial crisis, Public sector reforms, Portugal

Paper type: Research paper

1. Introduction

Over the past four decades, Portugal has seen major reforms that have led to a considerable improvement of health indicators. For instance, the infant mortality rate saw a change from 53.7 infant deaths per thousand live births in 1970 (Baganha *et al.*, 2002) to 3.6 deaths in 2009, a figure that was lower than the OECD average of 4.4 for that year (OECD, 2011). The life expectancy at birth boasted a figure of 66.7 years in 1970 (Ministry of Health, 2010) increasing to 79.2 years for the period 2008-2010 (INE, 2011). These two indicators are not entirely explainable by NHS. Indeed, they also result from a better public health (ex., water supply, housing) from a better education and from a diet improvement. However these indicators should be analysed in connection with some health infrastructure indicators, as those on Table I.

Table I: Health infrastructure indicators (adapted from National Statistical Institute and Por-data, 2014)

INDICATORS	1970	1980	1990	2000	2010
Number of health centers	-	265	382	393	376
Number of care consultations per head of population	13.948	21.577	24.621	26.597	27.097
Number of hospital beds	54.514	51.524	39.690	38.165	35.646
Number of hospital admissions per head of population	35	31	349	906	907
Number of emergencies per head of population	906	4.758	5.387	5.943	6.450
Number of pharmacies per head of population	2,1	2,3	2,5	2,5	2,7
Number of doctors per head of population	8,1	19,3	28,0	32,40	41,40
Number of nurses per head of population	13,7	22,1	28,1	38,0	62,4

This table shows that there was a marked improvement in all indicators except in the number of hospital beds. However, when this indicator is analyzed together with the number of hospital admissions and emergencies, that have had very large increases, it becomes clear that this was a matter of efficiency of resources and not a problem of effectiveness of services. So these indicators show that there was a significant effort to create and develop a top-national health service.

Although the great improvement and excellence of health care in Portugal is undeniable, it was achieved while ignoring the economic sustainability of the NHS itself. This contributed to successive State budget deficits and continues to pose huge challenges to public health policies in Portugal.

In this article we present the foundation and development of the NHS from a chronological perspective; from its inception to the present day. We also highlight the important events for NHS growth, as well as government concerns that this growth has had on its sustainability. Reference will also be made to public spending on health in comparison with growth in GDP at different stages of the NHS, in order to understand better the policy measures of different governments that led to the serious crisis of sustainability. Finally we examine the measures put in place by the Troika as a rescue package after the Portuguese financial crisis and how this has affected health spending and health policy.

2. Origins of the National Health Service

The Portuguese health system is the result of a series of political decisions initiated in the early 20th century, with the “first public health era.” The main aim of these measures was to combat infectious and parasitic diseases, illness caused by poor diet and work-related health problems. Years later, a number of regional and sub-regional hospitals were built, which were managed by the Misericórdia charity institutions [Simões, 2004; Barros *et al.*, 2011], in order to provide health care for the poorer sections of Portuguese society [Simões, 2004].

After 1945, the so-called “second era of public health” occurred, which aimed to restructure health and welfare services to deal with the

difficult health conditions in Portugal. Because of this situation, institutes devoted to specific public health problems, such as tuberculosis and maternal health, were created.

This period was marked by the changing social role of the state, influenced by national context (demographic and economic changes) and international context (changes in the concept of the state of social welfare and social rights in Europe) (Pereirinha and Carolo, 2006). The basic foundations of the welfare state were laid in this decade with the creation of the Federação das Caixas de Previdência in 1946, which aimed to cover risks, such as those related to work and illness, via mandatory social insurance (Ferreira, 1989). Employees and independent health institutions (overseen by the State) entered into contracts with those bodies (Caixas de Seguros) responsible for health care provision (Ferreira, 1989). In this case, funding for the insurance-illness system came from contributions from employers and workers to the respective funds, with no financial contribution from the State (Decree-Law no. 23048, 23rd September, 1933). Only the poorest benefited from the care provided by charitable institutions, which were the responsibility of Previdência Social (social welfare) (Barros and Simões, 2007; Ferreira, 1990).

3. Creation of the National Health Service

Until 1970, total health expenditure in Portugal represented 2% of GDP, which was lower than other European countries (4.6%) (OECD, 2008), and public spending on health was around 1.7% of GDP, which was below the European average (approx. 2.7%) (Silva, 2010). From that time, we have seen a sharp increase in public spending on health, often outstripping the growth rate of GDP and creating serious imbalances between the slow-down in the economy and the increases in public spending on health.

In 1971, the state took responsibility for health policy (Ferreira, 1990; Simões and Dias, 2010; Barros *et al.*, 2011), creating “first generation” health centres that focussed on immunisation, health monitoring and school and environmental health (Ferreira, 1990). At the time,

there was a mixed health system, given that there were two types of health care providers, which were not mutually integrated: the “first generation” health centres and the Caixas de Previdência (health insurance funds) (Branco and Ramos, 2001).

The democratic revolution of 1974, which put an end to the dictatorial regime, led to a new Constitution of the Republic that enshrined the right to health protection via the creation of an NHS that was general and free (Constitutional Law no. 86/76, 10th April). Although the NHS had been defined in the Constitution of the Republic, it was only the “Arnaut Law” of 1979 (Law no. 56/79, 15th September) that saw its implementation (Sakellarides, 2010; Barros and Simões, 2007). The foundations of the current NHS are based on the principles established at that time.

The creation of the NHS marked a change from the *Bismarck* model (set up in Germany in the late-19th century) to the *Beveridge* model (created in the United Kingdom from 1948). As such, funding for the NHS began being taken from the General State Budget (Sakellarides, 2010; Barros *et al.*, 2011) and became the responsibility of the Ministry of Health (Decree-Law no. 488/75, 4th September). These changes led to the nationalisation of hospitals belonging to the Misericórdia institutions and their subsequent public management (Sakellarides *et al.*, 2005).

In 1980, there was an increase in total health expenditure resulting from the rapid increase in public spending, which more than doubled the amount spent in comparison to 1970. Namely, it was 1.29% in 1970 and 3.30% in 1980 (OCDE, 2012). This shows an average increase of 134.9%, demonstrating an average increase of 13.49% per year during this decade. In terms of changes in GDP in the period 1970-1980, the average annual growth was 5.3% (Pordata database - GDP behaviour). As such, for the first time in Portugal, growth in public spending on health was much greater than the wealth generated by the country.

4. Expansion of the National Health Service

In the early 1980s, “second generation” health centres were created (DGS, 2002; Silva, 2010), paving the way for NHS expansion and

access to primary integrated health care for the entire population (Decree Law no. 97/83, 22nd April), putting an end to Caixas de Previdência. This signalled a break with the past and a new move to expand the NHS, due to the creation of the Directorate-General of Primary Health Care (Decree-Law no. 74-C/84, 2nd March) and various health centres.

From 1986 onwards, there was another steep increase in health expenditure due to Portugal's entry into the European Economic Community, which led to the need for greater investment in health care, to raise life quality to European standards.

In 1990, the Health Act was passed, which reflected the first governmental concerns regarding the control of health expenditure. This Act sought to encourage the separation between the health care provider and funder, as well as competition among health care providers (Campos, 2007). The payment of health services via user payments was considered (Novais, 2010), attempting to rationalise excessive use of health care (Barros and Gomes, 2002; Novais, 2010). People were also encouraged to opt for private health insurance (Campos, 2007; Sakellarides *et al.*, 2005; Oliveira, 2010), which has led to an increase in the number of private hospitals (Tountas *et al.*, 2005; Doyle and Bull, 2000).

The principle of the separation between the provider and funder of health care was consolidated with the setting up of Health Services Contracts Agencies in 1999 (Sakellarides, 2010; Ferreira *et al.*, 2010; Escoval 2010), which exist until today. These agencies were established with the mission of developing a negotiation process for the distribution of financial resources from the State Budget to units providing health care (Sakellarides, 2010).

This new health care funding process involved a contract between healthcare providers and funders (Escoval, 2003). In the contracting model, financial resources became allocated via programme-contracts (Escoval, 2010; ACS, 2010), in which production-line objectives and payment were based on activity via a base-price per hospital group, allowing providers to focus on efficient production of services determined by the buyer (ACS, 2010).

Hospital funding thus became determined by the systemic grouping of Homogeneous Diagnostic Groups (HDG) (Bentes, 1996; Escovai, 2010). The HDG system is one of patient classification that groups hospitalised patients with similar conditions in terms of resource consumption and the number of outpatients (Bentes, 1996). This system also involves the calculation of case-mix index adjusted hospital budgets, which reflect the range of different cases treated at each hospital, expressing the hospital's type of production via the proportion of the various types of patients treated (Barros and Gomes, 2002).

In the 1990s, "third generation health centres" were created to increase primary care for the entire population (DGS, 2002). To finance these services, the Ministry of Health distributed funds to the Regional Health Administrations (RHA), which redistributed these to the new health centres (Barros and Simões, 2007).

In 1990, the proportion of total health expenditure in terms of GDP came to 5.6% (OECD, 2012), which was lower than the European average of 7.8% (Silva, 2010). The same figure for 1980 was 5.3%, demonstrating an overall increase of 14.2% between 1980 and 1990. In 1990, the proportion of public expenditure on health in terms of GDP was 3.63% (below the European average of 5.6%) (ODCE, 2012), representing an overall increase of 10.3% in relation to 1980. Between 1980 and 1990, average annual growth in GDP was 3.8% (Base Pordata - GDP behaviour), outstripping growth in health expenditure. This positive trend was not repeated in subsequent decades.

The total spending on health represented 8.6% of GDP in 2000 and 5.59% in 1990 (ODCE, 2012). This difference boasts an overall increase of 53.8%. The public expenditure on health was 3.63% and 5.97% respectively in 1990 and 2000. This indicates an overall average increase of 64.4% (ODCE, 2012). During the same period, the average growth of GDP was 3.09%, which meant that it did not keep pace with growth in health expenditure.

5. Concerns/growth of the National Health Service

As the NHS is based on the Beveridge model, governments had to

borrow to fund the building of the infrastructure (e.g., second and third generation health centres) that led to the structural expansion of the NHS. Such a political strategy by governments also increased political clientelism, because while it grew, the NHS increased the number of civil servants employed and the two political parties that governed the country attracted votes as a result.

From 2000 onwards, the new political agenda gave priority to the private management of public hospitals (via public-private partnerships) and the growth of the private sector funded by the state, which was foreseen in the Health Act (Sakellarides *et al.*, 2005). However, at that time, alarm bells began to ring, as spending on health appeared to escalate, while the country's wealth diminished and public debt became unbridled.

In 2002, the new legal framework for hospital management was approved and the Health Act was amended (Decree Law no. 27/2002, 8th November), with hospitals changing from public institutes that were part of the public administration sector (PAS) to typical business concerns - Hospitals S.A. (Simões, 2005; Silva, 2010). This change of status was encouraged by the approval of the new hospital management model in 2002, which was called "New Public Management" (NPM).

Despite concerns about expenditure control, in 2003 the Network of Primary Health Care was set up (Decree-Law no. 60/2003, 1st April and Silva, 2010). This network is regarded as the institutional basis of Primary Health Care (PHC) and aimed to provide universal coverage and access to a single health centre (Decree-Law no. 60/2003, 1st April). This network took on an important role in permanently coordinating hospital care and continued integrated care, being core to the promotion of health and the prevention of illness (Decree-Law no. 60/2003, 1st April).

In 2005, the government approved the transition of 31 S.A. hospitals to the status of Public Business Bodies (PBB) (Decree-Law no. 93/2005, 7th June; Silva, 2010). However, despite the hospitals being autonomous, they continued to be dependent on the state as they were funded by it.

In 2005, Hospital Centres were also created, which were structured like PBBs (Decree-Law no. 93/2005, 7th June). Created in various parts of the country, these centres were the result of the merger of a number of hospitals in the continuing process of corporatisation (Deloitte, 2011). The creation of these centres was one of the most controversial health initiatives, provoking many demonstrations because they effectively reduced the population's accessibility to health care in hospitals.

Despite clear funding problems in the country, at the same time, a National Network of Continuous Integrated Care (NNCIC) was created. This network was created to deal with the progressive ageing of the population and increasing numbers of people with disabling chronic conditions (Decree-Law no. 101/2006, 6th June).

Later, the first Family Health Units (FHU) were set up in order to provide personalised primary health care (DGS, 2002 and Silva, 2010). To this end, a contracting model was formulated that was based on process and outcome indicators and not solely on activity undertaken (e.g. number of consultations) (Matos *et al.*, 2010).

In 2008, PBB-orientated Local Health Units (LHU) were created, which enabled the integration of primary care and special care in a single body, contributing to the improvement and efficiency of health systems (Deloitte, 2011).

During this period, it is worth highlighting the increase in Public-Private Partnerships (PPP), which have been used to circumvent the Stability and Growth Pact (EU requirement that imposed limits on the public deficit for fiscal stability) (Vaz, 2011) and were inspired by the British Private Finance Initiatives (PFI) (Vaz, 2011 and Barros, 2010). However, due to a number of irregularities in procedures and a lack of transparency, many of these hospitals were not built (Raposo and Harfouche, 2011).

In 2010, total health expenditure was 10.15% of GPD (OECD, 2012), which represents an overall increase of 18% in relation to 2000 (8.6%). In terms of public expenditure on health, this was 6.84% of GDP in 2010 and it was 5.59% in 2000 (OECD, 2012). The rate of GDP growth in 2010

was 1.9% (Pordata database - GDP behaviour), which reflects a significant decrease in comparison to 2000 (3.92%), which shows an overall decrease of 50%. The data shows that the growth rate in health spending doubled the wealth generated by the country, once again moving in the opposite direction of GDP.

It is worth mentioning that the growth rate of public spending on health has almost always exceeded budgetary limits, which meant the approval of supplementary budgets for many years (Barros *et al.*, 2011).

As such, although governments and other health professionals were concerned about controlling expenditure growth, the truth is that there has been a significant expansion of health infrastructure (e.g., primary health care network, national network of integrated continuous care, local health units). The entire range of NHS structures created for over 20 years was essentially supported by state public debt. Once again, this strategy by the two main parties of government meant they benefited at the ballot box.

6. The Troika programme

The combination of the growth in public spending over the last two decades and the progressively weaker levels of GDP growth led to a dire economic and financial crisis. In April 2011, the banks and the Portuguese government were unable to get sufficient finance from foreign markets, leading to the Portuguese government to negotiate an agreement with the Troika (the European Commission, European Central Bank and International Monetary Fund) in May 2011, which involved a loan of 78 billion euros to fund the Portuguese economy. In exchange for this support, a package of austerity measures aimed at controlling public spending and reducing budget deficits was introduced. Obviously, given that public spending on health represented 17.3% of total state spending, this sector is fundamental in terms of the state budget (Ministry of Finance and Public Administration, 2011).

In an attempt at ensuring the sustainability of the health system, the budget for spending on health fell, overall, by 12.8% in 2011, in comparison with the previous year, which meant a reduction of 1,255.8

million euros. Similarly, the NHS budget was reduced by around 6.4% (Ministry of Finance and Public Administration, 2011).

The government programme for 2012 decreed a reduction in health spending of around 9%, resulting in a saving of 757.8 million euros (Ministry of Finance and Public Administration, 2012). This year, the NHS budget was around 9.1% lower than in 2011 (Ministry of Finance and Public Administration, 2012).

Within this context, there was a review of medicines policy, as state contributions in this area were one of the most expensive in the health sector, representing approximately 2% of GDP. As such, a new system for calculating the price of medicines was adopted where the Retail Price (RP) of the first generic drug (marketed) must be equal to or below 50% of the RP of the reference medicine (Decree-Law no. 112/2011, 29th November, 2011).

The imperative to control public spending in the health sector led to the introduction of higher user fees for some services (Ministry of Finance, 2011). For example, the cost of an appointment at a health centre increased by 63% and the fee for an emergency appointment at a hospital increased by 104% (Order no. 1320/2010, 28th November 2010 and Order no. 306-A/2011, 20th December).

In terms of primary care, the Government continued their consolidation of these services, in order to reduce unnecessary visits to specialists and hospitals, in an effort to improve coordination of health care (Ministry of Finance, 2011).

The Government also sought to continue the reorganisation and rationalisation of the hospital network via the specialisation and concentration of hospital services and the joint operation of hospitals (Ministry of Finance, 2011).

According to Fernandes and Barros (2012), a year after the onset of the Troika Programme, spending was reduced, due in the main to measures in the areas of medicines and user fees. A later analysis carried out by the OECD (2013) states that, between 2011 and 2012, the Portuguese government significantly increased user fees, reduced the cost of medicines, reduced health benefits for civil servants, reduced

the number of managers and rationalised hospitals and public health centres. These changes led to a reduction of around 11% in total state spending on health. In conclusion, for the first time, there was an effective reduction in public expenditure on health in Portugal.

7. Conclusions

Until 1970, health care was disorganised, poorly coordinated and funded by workers and companies that paid contributions to the *Caixas de Seguros*, which provided healthcare services. The poorest sections of society were given free help by religious, independent and not-for-profit institutions.

Between 1970 and 1979, the Portuguese NHS was set up, with the state taking on a leading role in health, seeking to provide citizens with access to healthcare, regardless of their economic and financial situation. A universal health policy was established and health care began being funded from the state budget through employee and employer tax.

From 1980, the NHS expanded considerably and healthcare was extended to the entire population. However, between 1990 and 1999, governments began showing concern for controlling expenditure on health, especially because GDP growth had slowed. Paradoxically, the amount of health infrastructure supported by public debt increased.

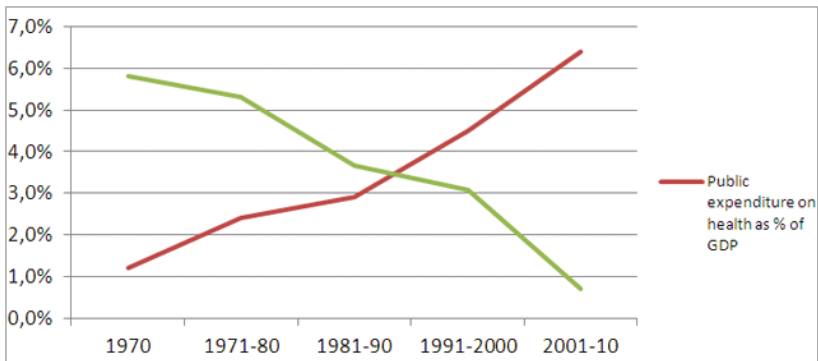
At the turn of the new century, spending on health continued to grow faster than the wealth of the country, leading to controversial measures to reduce expenditure and the creation of hospital centres. However, the Government continued to be committed to huge investment projects based on public debt, such as, for example, the creation of new Public-Private Partnerships hospitals and the national network of continued integrated care.

In 2011, the financial and economic crisis in the country led to a Troika bailout. In return, a package of austerity measures was implemented which aimed to restore economic and financial balance. Given that the health sector represents a large part of public spending, the budget for health was reduced. As such, between 2011 and 2012, there were successes with measures regarding medicines, user fees,

public administration health benefits, reducing the number of hospital managers and the rationalization of hospitals and public health centres. For the first time in the history of the NHS, public spending on health was reduced.

In order to understand this development in the NHS better, it is worth focussing on the relationship between public expenditure on health and GDP. So Figure I shows the public expenditure on health in 1970 and also the decade average of public expenditure on health. As it can be seen between 1970 and 2010 there was an average rise in the public spending on health from 1.2% in 1970 to an average of 6.4% in 2000-2010. Analysing the behaviour of GDP during the same period, we can see that GDP growth decreased between 1970 and 2010, while there was a sharp increase in public expenditure on health. Furthermore, since 1990, GDP growth has fallen sharply, and in contrast the public expenditure average has increased and the behaviour of the lines became opposite.

Figure I: Total and public expenditure on health as a percentage of GDP and GDP growth (adapted from National Statistical Institute)



These differences between the wealth created in the country and public spending on health underline the serious problem that Portugal faces, given that the NHS is based on the *Beveridge* model, where funding for the health system is based on the country's wealth. In this model, if GDP growth falls, then public spending on health should follow suit. In reality, the exact opposite has happened. As previously mentioned, since 1990, successive governments have expressed the necessity of reducing public expenditure on health. However, if political discourse has indicated one thing, in practice what has been done is very different, with increases in infrastructure based on public debt and the acceptance of overall growth in expenditure.

In conclusion, it seems clear that electioneering policies in the field of Portuguese health have prevailed for 40 years in the NHS, going against what is asked of governments, which is defining a strategy for the NHS that strikes a balance between growth/development and economic sustainability, in order to improve and maintain the population's health over generations. We hope that the history of the NHS serves as a lesson, so that the same measures are not be implemented again after public expenditure on health in Portugal has stabilised.

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