Health care reform in Portugal: an evaluation of the NHS experience

Mónica Duarte Oliveira and Carlos Gouveia Pinto

Abstract

Since 1979, the Portuguese health care system has been based on a National Health Service structure that is expected to promote equity, efficiency, quality, accountability and the devolution of power. In this article, we analyse the content and impact of policies designed to reform the system between 1979 and 2002. This article differs from previous studies in that it uses a stage-based framework to evaluate the policy-making process and the impact of health care reform throughout different political cycles. We show that the NHS model has never been fully implemented and that many policies have diverted the system from its original objectives. Different governments have adopted a progressive split between financing and provision and the institution of ’new public management’ rules in public providers. We conclude that most policies put forward by Social Democratic governments have aimed at influencing demand, while Socialist governments have targeted the supply side. These policies have led to increases in health expenditure that have been comparatively more cost-shared by the State under Socialist governments. We show some overriding trends, namely as follows: despite huge improvements in health outcomes, the system is nonetheless lacking in meeting its goals, particularly in terms of the equity of access and utilisation; accountability problems, inadequacies in the use of operational reforming tools (such as resource allocation mechanisms) and a lack of mechanisms to promote efficient behaviour, are all associated with cost containment problems. Structural reforms have been undertaken since 2002 and these have offered some potential for improving accountability and efficiency. Nonetheless, the success of these reforms calls for certain conditions that do not seem to have been fulfilled. Copyright © 2005 John Wiley & Sons, Ltd.

Keywords health care reform; impact analysis; NHS evaluation; Portugal

Introduction

Since 1979, the Portuguese health care system has been based on a National Health Service (NHS) structure with public insurance, universal coverage, almost free access at the point of use and general taxation financing. The NHS law of 1979 created the NHS in accordance with the 1976 Constitution, which committed the State to providing health protection for the whole population and consequently attributed most importance to equity objectives. This was reinforced by successive legislation [1], which also attributed to the Portuguese health care system the objectives of promoting efficiency, quality, accountability and the devolution of power (with cost containment as an intermediate objective) [1,2].

However, in reality, the Portuguese NHS has never conformed to the general characteristics of the Beveridge model, mainly because of an incomplete transition from the previous fragmented social insurance system. Although universality...
was assured, most of the occupation-based insurance schemes that existed in 1979 were not integrated into the NHS. Instead, they benefited from additional public funding and allowed families to enjoy multiple coverage, thus contributing to inequalities in access. These insurance schemes have been named subsystems. Implementation of the ‘actual’ NHS eroded the equity principles on which the system was, in theory, based. For example, the care provided by the NHS has never been free at the point of use and the system has never provided the promised generality of benefits (e.g., coverage for all health care services). In addition, a large private sector has co-existed with the NHS and has not been exposed to strict regulation. Previous studies have shown that the Portuguese system is not achieving its political objectives, particularly with respect to financial and geographic equity of access [1,3,4].

The purpose of this article is to evaluate the impact of health care reform policies in the 1979-2002 period. Due to limitations of space, the Portuguese health care system is not described in detail here. Comprehensive accounts of the system can be found elsewhere: [3,5–9]; while the political context and underlying forces for health care reform are described in [10] (which provides evidence in support of the nondecision-making hypothesis) and [11] (which provides evidence on the ideological continuity of policies). This article differs from previous studies in that a stage-based framework is adopted to evaluate the policymaking process, attempting to link policy cycles with available evidence on impacts. We show that different governments have endorsed ‘new public management’ rules in public institutions, but that there have been differences in the type of policies adopted by Socialists and Social Democrats.

The article is structured as follows. Firstly, a brief description is provided of the Portuguese health care system and its evolution over the last 20 years. Secondly, resource allocation, incentives and the appropriateness of care mechanisms are analysed. Thirdly, the impact of policies on both access and outcomes is assessed, and, finally, the future prospects for the system are outlined.

The Portuguese health care system

According to the Constitution, the Portuguese health care system is based on centralised control and decentralised management, although in practice it has maintained a centralised structure dominated by the public provision of most primary and hospital care.

Figure 1 depicts key institutions and financial/service relationships between the stakeholders in the Portuguese health care sector. Most powers are still exercised at the central government level. Regional Health Authorities (RHAs) have been restricted to the management of primary care, despite their expected wider responsibilities, which include planning the primary and hospital care systems and assessing the performance of health care units. The Institute for Information and Financial Management (IGIF) is an agency of the Ministry of Health responsible for information on and management of NHS financial resources (in practice, it mainly manages the hospital sector).

Primary care gatekeepers refer patients to secondary care provided by medical specialists. Patients are expected to choose their NHS general practitioner (GP) from a list published by the Ministry of Health [1]. However, the gatekeeping system operates imperfectly, since access to emergency services has been mainly unrestricted, some population groups have benefited from direct access to public hospitals (mainly via occupational health insurance), and the local supply of GPs has imposed constraints on the patients’ choice of GP.

The private sector has always been present in the Portuguese health system and its role was explicitly recognised in the 1990 NHS law that instituted a mixed health care system with both the public and private sectors being involved in the delivery of health care [2]. The large private sector is responsible for the most profitable areas of health care (such as specialist visits and elective surgery), while patients choose the public sector for consultations with GPs, non-elective inpatient care and maternity care [12]. In 1996, the private hospital sector was responsible for 23% of hospital beds [1]. This ‘productive specialisation’ has been facilitated by the working status of doctors since they are allowed to practise in both public and private units.

Subsystems and private health insurance cover around 25% of the population [13] and provide coverage that is additional to the one provided by the NHS. This overlapping coverage is a legacy from the past and exacerbates inequities in access, as those groups that enjoy subsystem protection tend, on average, to be better off. In 1990, 80% of subsystem beneficiaries worked in the public sector.
and, in 1999, the civil servants’ subsystem covered 13% of the population [14]. This clearly illustrates the reluctance shown by successive governments to integrate subsystems into the NHS. People enrolled in most subsystems and in private health insurance are free to purchase services wherever they choose. Voluntary health insurance (VHI) covered around 8% of the population in 1995 and has been increasing, although it still remains relatively uncommon. Most VHI is built up through employment schemes [9] and the possibility for opting-out was legislated for in 1993.

The Portuguese health care system is mainly financed through the State budget. Over the past two decades, total health expenditure has increased steadily and Portugal is at present a high
health care spender in the EU in terms of the percentage of GDP that it spends (in comparison with other countries that have NHS-based systems), but it still has the second lowest level of per capita expenditure (in PPP, 2002) [15]. Private financing was responsible for 29% of total expenditure in 2002 [15]. This is justified by out-of-pocket contributions, although there is little information available on the structure of private expenditure [3]. The main drivers of the level of out-of-pocket expenditure seem to relate directly to the benefit package, where there is implicit rationing in that the public provision of some services is insufficient (e.g. dental care, physiotherapy), waiting lists and times are long, and the purchase of pharmaceuticals is quite costly for low-income families [16]. Existing evidence on the tax system (described in detail below) points to health care financing being regressive and to inequality having increased during the 1980s, due especially to (uncapped) tax deductions allowed on private expenditure on health care and increasing levels of out-of-pocket expenditure [17].

Since the inception of the NHS, four main health policy cycles have been observed. The period 1979–1985 was characterised by political instability and the primacy of economic stabilisation policies; between 1985 and 1995, the Social Democratic Party was in government, with an absolute majority from 1987 onwards; 1995–2002 was marked by Socialist Party Governments, with relative majorities; and in 2002–2004 there was a centre-right coalition government. The 2002–2004 period will not be evaluated in depth since it is too early to evaluate recent policies. However, the basic essence of the recent changes are outlined in order to debate future reforms in the final section.

The policies put forward in each cycle are summarised using a stage-based framework to evaluate the policy-making process. In fact, Tables 1 and 2 provide an analysis of the actual impact of the policies and divide the policy-making process into the policy option (policy timing, explicit objectives, classification of policy on either the demand or supply side, and whether the policy changed micro-incentives); the context of the policy option (intended changes); the extent of implementation; and the degree of effectiveness vis-à-vis equity, efficiency, accountability and cost containment.

In the 1979–1985 period, most changes were directed at the transition to a NHS-based system, namely a shift to tax financing, the re-organisation of services and substantial investments in health care provision (mainly in infrastructure). Sharp improvements in health status occurred (particularly decreases in infant mortality) due to improvements in living conditions and the increased availability of and access to health care [18].

Between 1985 and 1995, the Social Democrats changed the regulatory framework of the system and formulated policies that altered the financing structure, mainly through demand policies (see Table 1), whilst following a market-oriented framework. Policies were adopted in the belief that there was a need to increase health care expenditures and diversify financing sources, namely by increasing private out-of-pocket payments [3]. The new NHS law implemented in 1990 [3] regulated the whole health care system and shifted the focus to the development of the private sector. Although the new role of the private sector was not clear, the creation of incentives to encourage the utilisation of private services apparently aimed at indirectly improving efficiency. Some of these incentives were:

- In private financing, the full deduction of health expenditures from taxable income was introduced in 1989, the formal allowance for the use of co-payments was established in 1993, and the equal treatment of public and private prescriptions in the reimbursement of pharmaceuticals was established in 1995.
- In private provision, doctors were allowed to work both in the public and private sectors in 1993 (although this was already common practice), and new laws introduced in 1990 and 1993 allowed for the private management of public providers.
- In terms of private coverage, a policy enabling opting-out agreements that transferred the responsibility for health care coverage out of the NHS was instituted in 1993 and targeted the development of the private insurance market as a substitute for the NHS. Nevertheless, the legal framework necessary to celebrate opting-out agreements was incomplete, and only after a 1998 law (that defined the nature of institutional agreements and the role of the MoH in establishing the mechanism for negotiation and the system of prices) opting-out was applied to small numbers of people belonging to some subsytems [1].
Table 1. Social Democrats 1985–1995 – policy evaluation

<table>
<thead>
<tr>
<th>Policy, timing</th>
<th>Explicit objectives</th>
<th>Demand, Supply? Micro change in incentives?</th>
<th>Intended changes</th>
<th>Implementation?</th>
<th>Equity</th>
<th>Efficiency and accountability</th>
<th>Cost containment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full tax deductions (uncapped), 1989</td>
<td>Increase of private expenditure</td>
<td>Demand and micro</td>
<td>Development of private sector in provision, Diversification of funding sources</td>
<td>High</td>
<td>(−) Increase in regressivity in the financing system</td>
<td>(＋) High increase in private spending, highly co-funded by families</td>
<td></td>
</tr>
<tr>
<td>Co-payments allowed, 1993</td>
<td>Efficiency (rationalisation of use) and raising revenue</td>
<td>Demand and micro</td>
<td>Institutionalised current practice</td>
<td>Low</td>
<td>(?) No evidence of more rational use of health care services</td>
<td>(?) Negligible impact on revenue</td>
<td></td>
</tr>
<tr>
<td>Dual employment status for doctors allowed, 1993</td>
<td>Efficiency (flexibility for management)</td>
<td>Supply and micro</td>
<td>Institutionalised current practice</td>
<td>High</td>
<td>(－) Low number of doctors chose to work full-time for the public sector. No control for public, private activity. Low motivation for doctors' work in the public sector</td>
<td>(－) Insufficient incentives to attract private insurers</td>
<td></td>
</tr>
<tr>
<td>Opting-out legislated, 1993</td>
<td>Transfer finance and coverage to the private</td>
<td>Demand and micro</td>
<td>Development of private insurance market as a substitute to the NHS, Diversification of funding sources</td>
<td>Low</td>
<td>(?) Insufficient incentives to attract private insurers</td>
<td>(－) Hospital system continued to operate in a centralised fashion</td>
<td></td>
</tr>
<tr>
<td>Creation of 5 RHAs (decentralisation), 1993</td>
<td>Improve accountability</td>
<td>Supply and micro</td>
<td>Cost containment</td>
<td>Low</td>
<td>(－) Hospital system continued to operate in a centralised fashion</td>
<td>(－) High increases in public expenditure with pharmaceuticals</td>
<td></td>
</tr>
<tr>
<td>Cost sharing of prescriptions, 1995</td>
<td>Equity of access</td>
<td>Demand and micro</td>
<td>Put the private sector on an equal footing with the NHS</td>
<td>High</td>
<td>(－) Lack of evidence. Expected benefits to private</td>
<td>(－) High increases in public expenditure with pharmaceuticals</td>
<td></td>
</tr>
<tr>
<td>Policy, timing</td>
<td>Explicit objectives</td>
<td>Demand Supply?</td>
<td>Intended changes</td>
<td>Implementation?</td>
<td>Equity</td>
<td>Efficiency and accountability</td>
<td>Cost containment</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------</td>
<td>----------------</td>
<td>------------------</td>
<td>-----------------</td>
<td>-------</td>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Development of data card technologies, 1995</td>
<td>Efficiency</td>
<td>Supply</td>
<td>Revenue generation by charging subsystem and private users</td>
<td>Low</td>
<td></td>
<td>(? ) Slow pace of implementation</td>
<td></td>
</tr>
<tr>
<td>Agreement with the pharmaceutical industry to cap pharmaceutical expenditure 1997</td>
<td>Cost containment</td>
<td>Demand</td>
<td></td>
<td>High</td>
<td></td>
<td>(- ) Ineffective tool for controlling pharmaceutical expenditure</td>
<td></td>
</tr>
<tr>
<td>Internal market, 1997</td>
<td>Efficiency (re-organisation, rationalisation, accountability and responsiveness)</td>
<td>Supply</td>
<td>Re-organisation of relationship between public finance and public and private provision</td>
<td>Low</td>
<td></td>
<td>(- ) Negligible implementation</td>
<td></td>
</tr>
<tr>
<td>Definition of the conventional sector, 1998</td>
<td>Efficiency (clarifying relationship with private sector)</td>
<td>Supply</td>
<td></td>
<td>High</td>
<td></td>
<td>(+ ) Easier entry of private providers and public procurement of private provision</td>
<td></td>
</tr>
<tr>
<td>Policy/Metric</td>
<td>Type</td>
<td>Evaluation</td>
<td>Notes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>----------</td>
<td>------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experimental systems for GP payments, 1999</td>
<td>Efficiency</td>
<td>Supply and micro</td>
<td>Low</td>
<td>(?) Unknown evaluation and very limited scope of application</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cap on tax deduction for private health expenditure and creation of allowance for private health insurance, 1999</td>
<td>Cost containment, development of the private health insurance market as complementary to the NHS, and equity of access</td>
<td>Demand and micro</td>
<td>High</td>
<td>(?) Expected (marginal) improvement in equity in finance. Clear deduction of expenditure for individual private insurance might benefit the well-off</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local health units and local health systems, 1999</td>
<td>Efficiency (decentralisation and re-organisation; closer links with primary and other health providers)</td>
<td>Supply</td>
<td>Low</td>
<td>(?) Expected marginal improvements</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial and non-financial incentives to improve mobility for civil servants, 1999</td>
<td>Equity of access and efficiency</td>
<td>Supply</td>
<td>Incentives to move low human resources to areas in need</td>
<td>Low</td>
<td>(?) Limited adherence of doctors and nurses to those incentives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting lists programme, since 1999</td>
<td>Efficiency (use of spare capacity in public hospitals) and equity of access</td>
<td>Supply</td>
<td>Short-term solution for a sustainable system and patient satisfaction</td>
<td>Medium</td>
<td>(+) Doctors responded positively to financial incentives of the programme</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social Democratic policies introduced deviations from the NHS model. Key effects were an even less clear separation of the public and private sectors (as it was made easier for doctors to have a dual employment status) and a sharp increase in regressivity in the system due to the increase in the out-of-pocket contributions that were fully deductible from taxable income (detailed information on this aspect is presented below). Expected improvements in efficiency were undermined, as specific policies, such as the dual employment status, did not achieve the intended effects (see Table 1). The period was also marked by very high investments in infrastructure, mainly in the public sector, co-funded by the EU.

Reforms under the Socialist Governments (1995–2002) were aimed at restructuring the NHS, moving the health system away from the command and control system. Most reforming initiatives dealt with multiple organisational changes and institutional arrangements, targeting the delivery side (see Table 2). The Socialists emphasised the complementary role of the private to the public sector but introduced only minor changes to the system, explicitly targeting efficiency and cost containment in particular.

Table 2 shows that Socialist policies were aimed at improving efficiency and cost containment, but faced huge problems with regard to their implementation when their objective was to re-organise the system. Almost no policies targeted improvements in equity (see the second and fourth columns of Table 2) and there was a lack of policies targeting changes in incentives to providers, which were crucial for improving efficiency (and accountability). The Socialists were mainly concerned with social consensus [19], which differentiated their style of government from that of the Social Democrats. The key policies of the Socialist governments were in line with market mechanisms (although this influence was relatively weaker than under the Social Democrats) and they passively accepted the legacy inherited from previous governments. The Socialists failed in their attempts to honour their electoral promises, such as changing the prescription system of pharmaceuticals to one of prescribing by generic name, and their attempts at improving resource allocation were restricted by the lack of accountability of health care managers in relation to budget deficits. However, the investment effort was kept going, motivated by co-funding from EU investment programmes.

Key policies throughout this period included:

- The introduction of the purchaser–provider split in 1997, with the NHS assuming the role of main provider. In practice, the internal market favoured an ‘institutional’ re-organisation of the relationship between public financing and public and private provision with the creation of contracting agencies parallel to the RHAs. However, this was barely implemented;
- A shift from the deduction of out-of-pocket expenditures from taxable income to their deduction from income tax in 1999, with the aim of decreasing inequity. Moreover, tax incentives were created for individuals to purchase private health insurance, such as the creation of a specific tax allowance for VHI.
- The launch of a special programme to reduce waiting lists in 1999 through contracts signed with public and private institutions (analysed below);
- Stricter regulation of the pharmaceutical market since 1999, such as the acceptance of economic evaluation as one of the criteria for deciding on reimbursement; the de-listing of reimbursed pharmaceuticals with unproven efficacy; and a review of the pricing system of generics [20];
- Quality and health outcomes received some attention with the creation of the Institute for Quality in Health in 1999 and the publication of the first official document on shifting the focus of policies from health care to health, by way of defined health targets [21].

Since April 2002, when a centre-right government came to power, a set of policies has been introduced challenging the current structure of the NHS and operating at both the normative and operational levels [7,22]. For example, new legislation stipulated the need for close cooperation between public and private facilities in primary, secondary and tertiary care; the creation of different mixes for the public–private management, financing and ownership of hospitals (e.g. segmentation of the NHS hospital network into groups of State-owned hospital enterprises and public administration hospitals); the introduction of individual (as opposed to collective) labour contracts; and the possibility of alternative models of primary care management based on
management by teams of doctors or other entities (as opposed to the previous model of public administration). Recent policies have also led to increased user charges and extended their application to almost all types of care; created an independent authority to regulate the activity of the private sector and monitor and supervise all healthcare providers; established a renewed emphasis on the waiting lists programme with a greater use of contracts with the private sector; and made substantial changes in pharmaceutical policy (such as the introduction of reference prices and a major effort to promote generics).

These policies can be seen as contributing to a 'big bang reform' of the current system as they may collectively bring about a profound change in the healthcare system. Specifically, the system seems to be moving towards offering a greater role to the private sector in terms of provision.

Analysis of aggregate expenditures between 1979 and 2002 (see Figure 2) shows an increase in total health expenditure over the years and confirms the sustained increase in health care spending as a percentage of GDP throughout the period. Under Social Democratic governments, there was a stabilisation of the ratio of public spending to total spending at two different levels (before and after 1990), and the increase in this ratio in 1990 seems to be explained by the effect of tax reforms in 1989, with an uncapped deduction of health expenditure from taxable income. Under Socialist governments, there was a gradual annual increase in the proportion of public spending. This seems to indicate that Social Democratic policies (mostly after 1990) were accompanied by increases in health spending paid for in similar amounts by the State and families, while Socialist policies led to increases in health expenditure with a higher relative contribution of public spending.

Increases (in absolute values) in the expenditure of families can in part be explained by increases in prices, as shown by variations in the health price index – increases of 105% between 1990 and 1995, 20% between 1995 and 1996 [15], and 6% and 5% in 1997 and 1998, respectively [23] – which were all well above the level of inflation. It seems that the demand-led policies of the Social Democrats (as compared to the supply oriented policies of the Socialists) had a comparatively higher impact on the contributions paid by families and put greater pressure on health care prices.

![Figure 2. Evolution of expenditure in health care. Source [15]](image-url)
Resource allocation, incentives and the appropriateness of care mechanisms

Until 2002, there was a low and effective use of resource allocation mechanisms, payment systems and regulation of the public and private sectors to enhance efficiency and cost containment. It seems that there were no marked differences between governments in using these tools and that the allocation of resources continued to be based mainly on retrospective reimbursement.

Budget allocation

The health care budget is decided through political negotiation during the formation of the State budget and is divided into several streams. Allocation between the streams is also based on political judgements made with the use of multiple resource allocation tools.

There has been a devolution of primary care budgets to the (geographically defined) RHAs and the (population-group defined) subsystems. Hospitals are directly funded by central government, despite the 1997 legislation relating to the purchaser–provider separation in the hospital sector, which stated that resources would be devolved to contracting agencies.

A capitation scheme (introduced by the Socialist government) has been used since 1998 to allocate primary care budgets to the RHAs, but the scheme has been heavily moderated by reference to historical expenditures. Capitation (taken as a proxy for need as it is weighted by age and sex, and approximated by primary care consultations) represented 8% of the total budget in 1998, whilst incremental budgeting, reflecting levels of past spending, was responsible for the remaining 92% [24]. These proportions were 50–50% in 2002 [7] and the formula was later altered to include the burden of disease, through an index based on chronic conditions.

While resource allocation methods for RHAs have had implicit equity objectives, efficiency has been the embedded objective in setting resource allocation methods for hospitals [1]. Hospital budgets have been based partly on reimbursement for activity (measured by DRGs) and partly on incremental budgeting (by applying a percentage increase to the previous year’s budget). DRGs were developed in the 1980s by the Social Democrats and used as a budget setting tool between 1990 and 1992, and after 1997 by the Socialists. Despite the use of these tools, financing has been more or less open-ended and has accommodated systematic expenditure overruns by hospitals and primary care centres [25]. Systematic overruns partly reflect the lack of accountability for health care managers, as well as the absence of expenditure caps.

The devolution of budgets to two small subsystems was based on a fixed capitation (€145 p.a./per user, applied in 1998 and 1999), the amount of which is determined politically. Public financing to subsystems lies outside the NHS budget as different ministries are responsible for these flows.

Pressure has been generated by the high increase in the expenditure of the civil servants’ scheme. Since 1979, evidence has shown that the percentage increase in the expenditure of this scheme has been much higher than the growth rate of total public health care expenditure and is disproportionate to the percentage change in the number of beneficiaries [23]. The expenditure of the civil servants’ subsystem represented 5.3% of the NHS budget in 1995 and increased by 56% in the 1979-1985 period, 51% between 1985 and 1990, 73% in 1990-1995 and 33% between 1995 and 1998 [23]. Thus, the dynamics of the expenditure of the subsystems has remained independent of the growth in the health care budget.

Until recently, the financing of services other than primary and hospital care (such as medical education) was mainly incremental, reflecting both inflation and the growth rate of the public sector budget. However, since 1999, health budgets have also earmarked centralised funds for specific programmes, namely those designed to reduce waiting lists, financed by a capitation formula (with allocations going to the RHAs) [24]. Although there has never been a specific budget for pharmaceuticals, public spending on ambulatory drugs has been regularly monitored and a policy for capping expenditure on pharmaceuticals was negotiated with the industry in 1997. The consequence was a decrease in the growth rate of pharmaceutical expenditure in 1997 and 1998 [26]. There are some (hidden) subsidies that affect resource allocation in the health sector. Examples of these are public units often not charging private users and members of subsystems for the utilisation of public services.
and tax benefits awarded to health care expenditure.

Payment to providers

Payment to doctors, dentists and pharmacists. There were no major changes in payment systems until 2002 as only some experimental schemes had been tested with a few providers. Until September 2002, NHS doctors were civil servants, paid on a salaried basis and with careers that were based on their years of service. However, since 1993, they have been able to work in both the public and the private sectors and are asked to choose from one of four work regimes in the public sector – part-time, full-time, extended full-time, or working exclusively for the NHS. In 1993, the vast majority of them chose either the full-time or extended full-time regimes [13]. This required them to spend 35 or 42 hours per week in public services, but also allowed for private practice if this was authorised by their superiors (which was generally agreed to). In 1993, the wages of medical staff in the public sector were less than half the EU average, while the services provided in the private sector were priced on average 30% higher than in the EU [13]. Providers contracted by subsystems and private insurers were paid on a fee-for-service basis, the fees being negotiated independently with doctors working in the private sector, in accordance with the minimum reference prices established by the Portuguese Medical Association.

These payment systems provide no financial incentives for doctors to improve their performance in the public sector. Nor do they promote high standards of care or productivity improvements in the NHS (resulting in growing waiting lists and times). Instead, they encourage doctors to maximise their income by working overtime in both the public sector and the private sector, and also to transfer patients from the public to the private sector [3].

Although the ratio of physicians to the population is close to the European average [15], there is a shortage of doctors in some specialities and their geographical distribution very uneven, with there being an excessive concentration in Lisbon, Porto and Coimbra [1]. There has been no regulation of the distribution of doctors amongst regions. A law to promote the mobility of civil servants was published in 1999 (also applying to health personnel, see Table 2), allowing for the use of financial incentives to move personnel to areas where demand is high. The application of this incentive scheme depended upon the initiative of health units in opening vacancies, and there has been no evidence to show that this law has had an impact on the health sector. The ratio of nurses to the total population was well below the European average and remained constant between 1999 and 2002 [15] (see Table 3), a situation which has apparently contributed to allocative inefficiency (11), using 1999 data.

The profile of the health labour market led to a growth in personnel costs throughout the 1990s due to the increasing large number of people working in the health sector and the increases in overtime payments. In fact, the percentage of total public workers employed in the health sector grew from 14% in 1992 to 18% in 1996, whilst the share of personnel costs in total NHS expenditure increased from 49% in 1993 to 53% in 1998 [23], later falling to 48.5% in 2002 [27]. Overtime payments for hospitals increased from 14.4% of salaries in 1999 to 17.7% in 2002. The rigidity of the payment system by salary, together with the growth in personnel costs, put pressure on the total health care budget. Given the crucial problems in terms of accountability, the pressure for doctors to contain costs was almost nonexistent until 2002. For example, evidence points to doctors' prescription patterns being influenced by the pharmaceutical industry [6], whilst most doctors do not take into consideration the cost implications when prescribing drugs. A survey showed that the majority did not consider it ethical to restrict the adoption of technology or financing on the basis of costs [28].

Following the implementation of the hospital management law (dating from September 2002), individual labour contracts replaced collective contracts, so that hospitals are now allowed to hire personnel and use different payment systems. This is expected to increase the mobility of human resources, improve performance incentives and reduce inefficiencies in hospitals where the lack of doctors has acted as a constraint on the use of resources [1]. A first assessment of the use of a financial incentive scheme based on monthly productivity bonuses and annual research fellowships in one Portuguese hospital (applied at the end of the 1990s) shows that it produced such effects as a higher motivation of professionals, an alignment of individual incentives with
Table 3. Utilisation and supply indicators (variation in relation to previous year is shown in brackets)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS outpatient consultations (per 1000 inhabitants)</td>
<td>2599</td>
<td>2221</td>
<td>2883</td>
<td>3092</td>
<td>3166</td>
<td>3400**</td>
<td>3600**</td>
</tr>
<tr>
<td>NHS inpatient admissions (per 1000 inhabitants)</td>
<td>477</td>
<td>584</td>
<td>732</td>
<td>832</td>
<td>937</td>
<td>977</td>
<td>1077</td>
</tr>
<tr>
<td>NHS emergencies (per 1000 inhabitants)</td>
<td>4548</td>
<td>5771</td>
<td>8719</td>
<td>10205</td>
<td>11175</td>
<td>11856</td>
<td>12357</td>
</tr>
<tr>
<td>Outpatient consultations outside the NHS (per 1000 inhabitants)</td>
<td>2042</td>
<td>1412</td>
<td>1191</td>
<td>3118</td>
<td>4017</td>
<td>2939</td>
<td>3204</td>
</tr>
<tr>
<td>Inpatient admissions outside the NHS (per 1000 inhabitants)</td>
<td>402</td>
<td>249</td>
<td>328</td>
<td>292</td>
<td>234</td>
<td>20%</td>
<td>32%</td>
</tr>
<tr>
<td>Emergencies outside the NHS (per 1000 inhabitants)</td>
<td>211</td>
<td>602</td>
<td>552</td>
<td>1095</td>
<td>1084</td>
<td>3.1</td>
<td>3.2</td>
</tr>
<tr>
<td>Doctors (per 1000 inhabitants)</td>
<td>2.0</td>
<td>2.5</td>
<td>2.8</td>
<td>3.0</td>
<td>3.4</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>Nurses (per 1000 inhabitants)</td>
<td>2.3</td>
<td>2.4</td>
<td>2.8</td>
<td>3.9</td>
<td>3.4</td>
<td>3.8</td>
<td>3.8</td>
</tr>
<tr>
<td>LOS (days)</td>
<td>14.4</td>
<td>13.9</td>
<td>10.8</td>
<td>9.8</td>
<td>9.3</td>
<td>8.9</td>
<td>8.9</td>
</tr>
<tr>
<td>Inpatient care occupancy rate (% of available beds)</td>
<td>62.6</td>
<td>69.2</td>
<td>65.4</td>
<td>71</td>
<td>73.5</td>
<td>69.7</td>
<td>69.9</td>
</tr>
<tr>
<td>Growth in per capita health expenditure (1990 constant prices)</td>
<td>20%</td>
<td>40%</td>
<td>43%</td>
<td>7%</td>
<td>10%</td>
<td>23%</td>
<td></td>
</tr>
</tbody>
</table>

*Computed at 1995 constant prices.
**Data for consultations from the public and private sectors.

Source: [15,23].

Management goals and a higher quality of service, coupled with productivity increases in the public sector and lies outside the NHS benefit package. In 1996, only 8% of visits to dentists were covered by the public sector [16]. Dentists are paid on a fee-for-service basis, mostly by out-of-pocket payments which have impeded access to this type of care [16].

The pharmacy sector is extensively regulated, but regulation rather than enhanced competition has preserved the pharmacies' monopoly over the distribution of drugs. There are barriers to entry into the pharmacists' profession and to the establishment of community pharmacies. The pharmacy margins of prescribed drugs to wholesalers and pharmacies are fixed (the wholesalers' gross margin is 8%) and the retail margin is 20% of the market price. Pharmacists are paid by doctors who prescribe and doctors have contributed to a sharp increase in pharmacaceutical expenditure [20]. For example, per capita pharmaceutical expenditure at PFP grew 33% between 1990 and 1995, 42% between 1995 and 1999, and 18% between 1999 and 2002 [15].

Payment to hospitals. Since the 1980s, Portugal has attempted to move from incremental and historical funding to the establishment and development of DRCs, a new financing system that was developed in 1984, since when DRGs have been introduced. This new system was a crucial role as a management tool for hospitals, which were able to set budgets based on hospital activities spent on the basis of actual cost and make DRGs for hospital production indicators. The remaining on incremental budgeting, which was replaced by the data on DRG production indicators, and the DRGs were first used to set budgets between 1999 and 2001, the DRG-based financing system, while the DRGs have continued to be used by hospitals, were revealed problems in the field of DRCs [17].

Between 1999 and 2001, the DRG-based financing system was gradually abandoned [3], mainly for reasons of complexity and difficulty of implementation. The system was gradually replaced by other financing systems, such as the diagnosis-related groups (DRGs) system, which was based on the diagnosis-related groups (DRGs) system [18].
because a move was favoured towards an internal market with payments being fixed by block contracts (negotiated at the central level) and, after 2002, based on health care acts. Combined payments by DRGs and incremental budgeting do not offer ways of inducing cost containment (nor of allocating resources in accordance with need) and, since overspending remained unpunished, NHS deficits increased between 1999 and 2002 [27].

Several studies using data referring to the 1990s point to persistently high levels of allocative and technical inefficiency in the hospital system, with high inefficiency scores and wide variations reported in hospital costs [1]. Allocative inefficiency is mainly explained by factors such as rigidity in the management tools and a lack of human resources in rural areas. The most likely explanations for technical inefficiencies are the incentives created by doctors working in both public and private units, with little stimulus to increase productivity in the former, and agency problems between hospital administrators and doctors. Two studies based on 1999 and 2001 data report that 20% of hospital spending is avoidable [1,30]. However, there is very little quantitative information available on changes in efficiency levels over time.

The 1980–2001 period was marked by large increases in provision, but an analysis of crude indicators shows that (overall) hospital production levels increased at a lower rate than hospital expenditure, as shown in Table 3. For most of the periods, real per capita current expenditure grew at a faster rate than most indicators of hospital production and hospital inputs (for example, doctors), whilst length of stay (LOS) decreased and occupancy rates did not improve. The fact that expenditure grew at a faster rate than production and/or inputs may be interpreted as an indicator for the lack of any efficiency gains.

It has been difficult to reduce the ‘weight’ of the hospital sector in the system. In fact, the share of expenditure on primary care increased between 1998 and 2000 (from 42 to 46%) and decreased again until 2002 (to 42%) [27], reflecting difficulties in shifting the balance towards primary care (for example, replacing the use of emergency services with consultations in primary care centres). Within public hospitals, payments to personnel and high levels of outsourcing to and procurement from the private sector have been key causes of increased costs [1].

**Appropriateness of care.** Labour and education have been highly regulated. The creation of new posts for doctors and nurses within the NHS required the approval of the government and supply controls have been in force since 1977, with the adoption of a _numerus clausus_ for the admission of medical students to university (strongly influenced by the Portuguese Medical Association). This restriction was inadequately planned as it led to a shortage of doctors in some areas. Only after 2001 were new courses in medicine created outside the main urban centres and more recently there have been increases in the numbers of students admitted to the main teaching universities.

Many problems in terms of accountability and information systems have made it difficult to supervise hospitals, both financially and in terms of the appropriateness of the care they provide (for example, information on the amount of hospitals’ debts has been unreliable) [31]. Similarly, very few utilisation reviews (which could potentially provide guidelines on utilisation and managers) were carried out in the past.

Guidelines on prescribing behaviour are issued to doctors by the National Pharmacy and Medicines Institute (the pharmaceutical agency within the MoH), and directors of health centres are encouraged to develop local formulares [32]. However, these guidelines are not mandatory, and there is evidence suggesting that the Portuguese pharmaceutical industry has used sophisticated procedures to promote pharmaceutical usage [6] and to encourage a persistent overconsumption and inappropriate use of pharmaceuticals [20].

There has been no monitoring of variations in outcomes at the level of health care providers. Only one academic study has compared the distribution of health outcomes for two hospitals with different types of management and found a better health outcome distribution for the hospital under private management (1997 values) [29]. Within the NHS, there has been no monitoring of medical errors, although the Portuguese Medical Association has investigated a number of complaints. Despite this, an increasing number of patients claiming compensation for clinical errors have brought their cases to court ( _O Público_ , 08.09.2003). At the national level, there has been a lack of assessment as to whether policies have narrowed the gap between the distribution of resources and actual needs. However, the evidence shown below points to the continuation of huge
inequalities. The waiting list programme sought to improve access, but the size of the programme was small.

In conclusion, successive governments have been unable to control costs and there have been several factors that might help us to understand this phenomenon. For example, there were expenditure pressures due to the cost of human resources, rigidities making it difficult to shift funding away from the hospital sector, a growth in subsystem expenditure funded by the government, increases in the pharmaceutical budget, and the non-accountability of providers and managers. Incentives designed to alter providers' behaviour were limited in both their scope and coverage. There have been only minor improvements in efficiency, due to institutional inertia and the lack of incentives for altering stakeholders' behaviour (providers and consumers) [10].

**Access and outcomes**

Analysis of access and outcomes shows that no policies have tackled the two-tiered structure, since unequal access continues along the urban/rural, double/single coverage and high/low socio-economic divides. It also shows that Portugal performs very badly in the EU and OECD contexts in relation to both equity of utilisation and the financial equity of access. It seems that in the last decade there has been increasing awareness amongst the general population of the problems existing in the health care system.

**General issues**

Universal coverage after the creation of the NHS improved equity of access. Nonetheless, the allowance of multiple coverage has created a two-tiered structure and implies inequalities in access and outcomes [14,33]. In addition, although its impact is small, VHI implies an element of unequal access due to cream-skimming by health insurers [4].

In terms of health outcomes, the evidence points to the persistence of great inequalities across socio-economic groups [12,34]. Subsystem users have a much higher level of education, income and self-assessed health [33]; and income is a significant variable in explaining utilisation of the private sector [14]. Recent EU studies have also pointed to wide variations in health care utilisation (both primary care and outpatient consultations) across socio-economic groups with a high pro-rich gradient in the utilisation of services, with Portugal being the EU country with the highest level of inequalities in health care utilisation [18,35,36]. Similarly, (in the EU context) Portugal was shown to have one of the most regressive systems of health care financing (1990 data) [37] and the second worst level of inequality in terms of income distribution in the EU (1994 data) [38].

There have also been – and still are – serious geographical inequalities in the provision of health care services, with supply (both public and private) being concentrated in urban and coastal areas [1,39]. Investment in rural areas has been constrained by the unwillingness of doctors to move to these areas due to a lack of incentives and by the shortage of doctors in some specialties. Although the total supply of doctors is currently satisfactory (as described above), the number of doctors per capita varies widely between regions, with an excessive concentration in urban areas, especially in the Lisbon and Coimbra districts (the number of doctors in the Coimbra district is 161% above the relative need, as computed by the capitation formula), and there is a wide range of travelling times to the nearest doctor [1]. These inequalities in access affect the most disadvantaged groups in particular [39].

**User charges**

The deployment of user charges in 1993 represented an attempt to rationalise the use of emergency services (given the high rate of false emergencies [4]) and increase revenue. User charges were introduced at a fixed rate (i.e. regardless of people's ability to pay) and exemptions were allowed for certain income and disease groups. Available evidence indicates that implementation was hampered by information problems (namely with regard to the identification of those exempted) and by administrative difficulties in charging; and user charges were largely ineffective in either rationalising the use of resources or increasing revenue [3]. User charges were updated (by small amounts) after 1993, but these increases do not seem to have produced any significant changes in the previous situation [16]. Pharmaceutical co-payments have been a significant
component of out-of-pocket expenditure and evidence shows that they have strongly contributed to the regressivity of the financing system [20].

Waiting lists

A waiting lists programme – the Programme for the Promotion of Access – was implemented in 1999 in an attempt to tackle inequalities in access by using spare capacity in public hospitals. The programme has had some success in improving access for the poorest patients (because the better-off tend to make use of private services to escape waiting lists), but has not helped to correct the perverse incentives in the system.

RHAs have had to contract public, private for-profit and not-for-profit providers, but until 2002 priority was given to public hospitals. Each year, the NHS ‘auctions’ lists of patients waiting for surgery to the public and private providers, and payments are made on a fee-for-service basis that has equal rates for all institutions [16]. The waiting list programme has been limited in scope and has affected only a small number of specialities (13 in total) with unacceptable clinical waiting times. It has been restricted to inpatient care, and the proportion of the public health care budget allocated to it has been small (1% in 2000 [1]).

However, the programme has not tackled the structural inefficiencies of the system. For example, although hospital workers receive variable income for their overtime work, they are paid for their ‘normal’ hours on a salary basis, which means that they have weak ‘productivity’ incentives to work in their normal working hours, and which has translated into a persistent underutilisation of operating theatres [40]. Table 3 shows that there were no improvements in occupancy rates after 1997.

Preliminary analysis of the results of the programme shows that initially doctors responded positively to the financial incentives since they generated extra income [41], but there is a critical lack of data on production levels per hospital and other information (such as waiting times and types of patients) needed to evaluate the programme [16]. Performance, as measured by the ratio of executed to contracted surgeries, has been higher for hospitals in the public sector [16], although the private sector has been increasing its share. However, large regional variations have continued to exist in the programme [16]. For the RHA of the centre region, and for 1999, preliminary evaluation of the programme shows the following situations [29]: there was a greater activity of the public sector and a significant participation of the private sector (this being, for example, responsible for 65% of hip replacements in the centre region in 1999); prices put forward by the public sector were lower – but not much lower than prices in the private sector (considering that the private hospitals pay for all their costs, while public ones can charge at marginal prices) [29].

Outcomes

Over the last 20 years there have been huge improvements in health outcomes. Available data rely heavily on mortality statistics (as there is no information available on morbidity or quality of life) and on perceived health status. Infant mortality rates have decreased sharply over the last two decades (falling from 17 deaths in 1985 to 5 deaths per 1000 live births in 2002 [15]), and were the most important cause of the sustainable increase in life expectancy. Similarly, particularly during the 1990s, the pattern of specific mortality rates has changed, indicating a convergence towards the patterns of more developed countries [23]. However, health status as measured by potential years of life lost continues to be low when compared to other countries, taking into account the amount of resources invested in the health care system [18].

Evidence shows that the improvements occurring in health in recent decades were helped by increases in health care provision (in particular, improvements in child preventive care), the use of new technologies, changes in nutritional habits (such as a substantial increase in the per capita intake of calories between 1979 and 2001 [15]), and changes in lifestyle induced by increases in income and economic development [18]. Nonetheless, no study has attempted to disentangle the impact of each of these factors on health outcomes from health policies themselves.

Information is scarce about changes over time in perceptions of health status, in particular by type of coverage or socio-economic group. However, health survey data indicate that self-assessed health improved slightly in the second half of the 1990s [42,43]; and individuals with higher incomes
report better states of health (information from the 1995/1996 National Health Survey) [12].

Evidence about patient satisfaction is mixed. Most studies indicate that patients in the health care system have been dissatisfied [10], whilst some studies point towards mixed evidence about patients' satisfaction with the health care system, with lower socio-economic groups being comparatively more satisfied (in 2001) [44]. Patients do seem to be more satisfied with private services than public services (for 1998/1999 in [43], and for 2001 in [44]). The level of responsiveness of the system regarding non-health matters is low, as reported by the World Health Organisation (1997 information) [45]. Nonetheless, the relative concern with the health care sector as a priority sector for State intervention increased sharply between 1991 and 2001, among all socio-economic groups [44].

The future

This article has assessed the evolution and impact of Portuguese health care policies between 1979 and 2002 and has shown that different governments endorsed a progressive split between financing and provision and the institution of 'new public management' rules in public providers. Despite differences in the type of policies put forward by Social Democratic and Socialist governments, these have led to the formation of some overriding trends, such as increases in health expenditure and improvements in health outcomes. Nevertheless, in 2002, the health care system was failing to meet its goals (in particular in equity of access and utilisation) and was facing critical problems, such as a lack of cost containment on the part of health care providers, an inadequate supply of doctors and nurses, an inadequate balance between the hospital and other health care sectors and growing waiting lists. The main challenges for reform were concerned with correcting incentives, improving implementation, creating regulatory capabilities, and balancing a NHS with a co-existing private sector in a context in which doctors with dual employment status and multiple coverage possibilities persist (in order to pay more attention to existing inequalities).

For most 'political' actors, there has been a consensus that the system should be based on contracts, regulation and supervision through a greater specialisation of regulating functions in an independent regulatory authority (e.g. public/private mix, surveillance of health outcomes, evaluation of hospital performance and the enforcement of penalties, and specification of the information to be published about providers) [46]; and there is also a need to move away from the public administration model currently followed in most public hospitals by introducing new forms of management (for example, the use of mixed payments to stimulate greater productivity of the labour force). There is a general consensus that the level of expenditure is adequate, but there are serious doubts as to the appropriateness of the current allocation criteria [347]. Nonetheless, evidence suggests that some countries have endorsed this type of policy and have had difficulties in achieving the expected benefits (e.g. the UK).

The disagreements between the two major political parties about reforming policies mainly relate to: the role of the private sector (seen as competing with the public sector for the Social Democrats, complementary for the Socialists), the type of contracting (centralised contracting for the Social Democrats, decentralised contracting for the Socialists), and the pace of reform (fast for the Social Democrats, slow and with negotiation among stakeholders for the Socialists).

Recent developments since 2002 have introduced somewhat irreversible changes and raised questions about the continuity of the NHS – for example, with the increase in hospital debts and the need to contain the public deficit, it might prove to be impossible for governments to keep hospital enterprises totally owned by the State: and the government is now proposing to apply the user-payer principle to user charges in health care, with levels of charges being linked to information on real costs.

The reforms implemented since 2002 appear to have some potential for improving accountability and efficiency. In particular, the introduction of private management by converting one-third of public hospitals into state-owned hospital enterprises allowed for the transfer of the financial risk to providers. Nevertheless, we believe that several necessary conditions are required if current reforms are to achieve their objectives (in terms of both efficiency and equity) and if future reforms are to target current problems in the system.

First of all, it is vital for new policies to be formulated to tackle inequalities. Policies to
promote equity need to look at the structure of tax
deductions and user charges, the mechanisms
influencing the level of supply, the distribution of
doctors and nurses, and the factors that have
contributed to unequal financial and geographical
access by disadvantaged populations. Furthermore,
given that it is unlikely that the subsystems
will be integrated into the NHS, it may be
important to use appropriate payment systems
and resource allocation tools, such as risk-related
premiums for insurance systems and risk-related
capitation for NHS purchasers and providers, in
order to improve the horizontal and vertical equity
of access within the system.

Secondly, changes are needed in the system of
incentives and in managerial and organisational
structures (if properly designed) in order to
improve accountability and facilitate implementa-
tion, thereby contributing to efficiency. For example,
performance-related payment systems
for doctors may prove beneficial for improving
incentives in their work in the public sector [18,29].

Thirdly, potential gains in accountability and
efficiency are highly dependent on the development
of capabilities for the regulation of the system.
Regulation is needed to clarify the relationships
between the public and private sectors, to super-
vise providers and to make sure that information is
published about the providers' activity. Without
regulation, there will be less incentives for provid-
ers to be more efficient and more incentives for
risk-skimming. Adequate cost and outcome data
are required to guide decision-makers and to
guarantee outcome levels, whilst risk-adjusted
outcomes indicators are needed to link information
and control systems.

Fourthly, governments need to look at imple-
mentation (to avoid repeating problems from the past),
as well as to be aware of the evidence that
points to the probable failure of these types of 'big bang'
reforms [48].

Finally, recent reforms create risks for the
fragmentation of the health care system [8] that
may lead providers (hospital enterprises vs public
administration hospitals) to concentrate on their
individual performance ratios (at the expense of
other units, which affects efficiency) and to neglect
equity of access (through cream-skimming). Even
a strong regulator might face difficulties in super-
vising a fragmented system. Thus, policies are
urgently required to promote integration of the
activity of providers and to shift the balance
towards more primary and preventive care [18].

Acknowledgements

This research was funded by a research grant from the
European Commission. We wish to thank George
France, Adam Oliver, Aris Sissouras, the participants
in the IMPACT project and two anonymous reviewers
for their useful comments. All errors, omissions and
opinions are the sole responsibility of the authors.

References

1. Oliveira MDCD. Achieving geographic equity in the
Portuguese hospital financing system. Ph.D. Thesis,
Operational Research Department, London School
of Economics, University of London, London,
2003.
2. Assembleia da República. Lei 48/90: Lei de bases da
3. Pereira J et al. Health care reform and cost
containment in Portugal. In Health Care and Cost
Containment in the European Union, Mossialos E, Le
4. Dixon A, Mossialos E. Has the Portuguese NHS
achieved its objectives of equity and efficiency? Int
5. OPSS, Conhecer os Caminhos da Saúde - Relatório
6. OPSS. O Estado da Saúde e o Estado do Estudo -
Relatório Primavera 2002. OPSS, ENSP: Lisboa,
2002.
7. OPSS. Relatório de Primavera de 2003 - Saúde: Que
8. OPSS. Relatório de Primavera de 2004 – Incertezas:
Gestão da Mudança na Saúde. OPSS, ENSP: Lisboa,
2004.
Portugal, Health Care Systems in Transition.
EOHCS (ed.). EOHCS. Copenhagen, 2004: 120.
10. Oliveira MD, Magone J, Pereira JA. Nondecision-
making and inertia in Portuguese health policy.
11. Simões J. Reitro Político da Saúde-Dependência do
Percursos e Inovação em Saúde: De Ideologia no
12. Barros PP. As políticas de saúde em Portugal nos
últimos 25 anos. Evolução da prestação na década
2004].
14. Lourenço O. Os utentes dos subsistemas de saúde
vs. os utentes do SNS: a utilização de cuidados de
saúde privados e especializados. Communication 8th
Meeting of Portuguese Association of Health
[October 2004].