

The Impact of Austerity on the Portuguese National Health Service, Citizens' Well-Being, and Health Inequalities

O impacto da austeridade no Serviço Nacional de Saúde português, o bem-estar dos cidadãos e as desigualdades na saúde

Pedro Hespanha



Electronic version

URL: <http://journals.openedition.org/eces/4187>

DOI: 10.4000/eces.4187

ISSN: 1647-0737

Publisher

Centro de Estudos Sociais da Universidade de Coimbra

Electronic reference

Pedro Hespanha, « The Impact of Austerity on the Portuguese National Health Service, Citizens' Well-Being, and Health Inequalities », *e-cadernos CES* [Online], 31 | 2019, Online since 15 June 2019, connection on 12 December 2019. URL : <http://journals.openedition.org/eces/4187> ; DOI : 10.4000/eces.4187



PEDRO HESPANHA

THE IMPACT OF AUSTERITY ON THE PORTUGUESE NATIONAL HEALTH SERVICE, CITIZENS' WELL-BEING, AND HEALTH INEQUALITIES

Abstract: This article discusses the main lines of the anti-crisis policy in Portugal, its consequences on the citizens' well-being and health inequalities and the impasses in health reforms planned both to ensure the financial sustainability of the health system and to improve equity. Different studies reveal that health inequalities in Portugal have been consistently higher than those observed in other European countries in the last decade and continue to be closely associated with geography, income, and health literacy. In the absence of a well-structured reform program, the blind cuts on expenses prevailed, showing no consideration to their impact in very sensitive areas of medical care. The manner in which slowness, insufficiency or downgrading of services affects citizens differs according to their social condition and the way they deal with the situation. The article is illustrated with examples of how citizens, families, and civil society organizations have sought to circumvent the lack of response from public health services.

Keywords: austerity, crisis, health inequalities, health reforms, National Health System.

O IMPACTO DA AUSTERIDADE NO SERVIÇO NACIONAL DE SAÚDE PORTUGUÊS, O BEM-ESTAR DOS CIDADÃOS E AS DESIGUALDADES NA SAÚDE

Resumo: Este artigo discute as principais linhas da política anti-crise em Portugal, as suas consequências sobre o bem-estar dos cidadãos e sobre as desigualdades em saúde, bem como os impasses nas reformas em saúde planeadas para garantir a sustentabilidade financeira do sistema de saúde e melhorar a sua equidade. Diferentes estudos revelam que as desigualdades na saúde em Portugal têm sido consistentemente mais altas do que as observadas em outros países europeus na última década e continuam intimamente associadas à geografia, ao rendimento e à literacia em saúde. Na ausência de um programa de reforma bem estruturado, prevaleceram os cortes cegos nas despesas públicas, sem levar em consideração o impacto que esses cortes produziram em áreas muito sensíveis dos cuidados médicos. A maneira pela qual a lentidão, a insuficiência ou a desqualificação dos serviços afeta os cidadãos difere de acordo com a respetiva condição social e com a maneira como lidam com a situação. O artigo é ilustrado com exemplos de como cidadãos, famílias e organizações da sociedade civil tentaram contornar a falta de respostas dos serviços públicos de saúde.

Palavras-chave: austeridade, crise, desigualdade em saúde, reformas na saúde, Serviço Nacional de Saúde.

1. WELFARE STATE, CRISIS AND REFORMS IN PORTUGAL

In the last 15 years, social protection systems have been undermined in many countries due to the convergence of neoliberal ideas and the increasing financial and political restrictions resulting from the state's financial crisis originated in the second half of the 1970s, deepened during the 1990s, and turned acute as from 2008 – initially only financial and soon after economic, social and political crises. Neoliberalization, which implies public provision remarketing, reversion of policies' universalism, and shared governance of social protection, has been putting at risk the fundamentals of both welfare state and welfare society.

Neoliberal trend reforms did not follow the same path all over the world (Jessop, 2013). Most European countries did not experience regime changes, but only adjustments in their policies to safeguard central achievements of the welfare state. Nevertheless, there is the risk that these adjustments accumulate until the point of creating a definitely neoliberal institutional framework of social welfare.

The emerging hypothesis regarding the nature of neoliberalization of the more radical structural adjustment processes, such as those occurring in Southern European countries like Portugal, is that one may be observing not only a mere neoliberal adjustment, but rather a change of regime in the social protection system, as has already happened in other parts of the world that are subjected to structural adjustment programs imposed by the International Monetary Fund (IMF) and the World Bank.

The historical alliance between market economy, welfare state, and democracy, which founded the modern nation-state project, appears to be breaking up at the present age of global capitalism. Nevertheless, the welfare state still has strong public support and one cannot affirm that a totally 'privatist' and 'individualistic' ideology has penetrated the values and expectations of Europeans. Actually, the state continues to be an arena of tensions between the ideas of social services privatization and the ideas that defend the public welfare provision for all citizens (Bourdieu, 1999, 2014; Wacquant, 2009).

If these characteristics are verifiable in all developed welfare states, they are even more so in the Southern European welfare states that emerged in the context of the international crisis of the second half of the 1970s and where the social pacts enabled the achievement of reforms in policies of social protection, employment, and income until the emergence of the 2008 economic and financial crisis. This crisis increasingly reduced the margin of flexibility of governments that were strongly subjected to the supervision of international institutions, thus forced to limit social dialogue regarding their main characteristics: decision-making autonomy of players and valorization of contributions from each part to the negotiation (Begega and Balbona, 2015), and, later, the impositions of adjustment programs following the sovereign debt rescue.

Focusing on Portugal, I will start by mentioning the factors that triggered the financial crisis and the problems that led Portugal to be submitted to a readjustment program. These factors consisted in the accumulation, during the first decade of the current century, of high external debts concerning the state, the families, and the firms. The growing demand for external financing of public debt and for banking investment provoked a strong interest rate increase in the financial markets along with a rating degradation of the Portuguese sovereign debt and bank solvency.

The adjustment program started in May 2011 and lasted until mid-2015. There are two aspects to be highlighted in the Portuguese case for the assessment of the anti-crisis policy: first, since 2009, before the subscription of the program, the government had started a set of measures to combat the crisis – Stability and Growth Programs I, II and III – basically consisting of public expenditure reduction; second, after the right-wing coalition government (2011), which had the responsibility to implement the adjustment program negotiated with the Troika.¹ Using the opportunity to impose its own agenda, clearly of neoliberal profile, this government moved further than the settled goals by reinforcing austerity measures.

The Memorandum of Understanding (MoU) subscribed by the Portuguese government comprised a set of measures specifically directed to the health sector, along with other transversal to different sectors aiming to reduce public expenditure (União Europeia *et al.*, 2011). The analysis will focus on these measures and their negative and somehow unforeseen consequences.

The immediacy and urgency imposed by the bail-out program very much centered on the control of public expenditure, fully conditioned the design and results of the adjustments and reforms. In a short period of time, a large number of measures were implemented along with a strict schedule monitored by the Troika every three months, which required from the government something that it couldn't afford in those circumstances – time and negotiation ability (Sakellarides *et al.*, 2014).²

2. THE BLIND CUTS AND THE RISK OF SERVICES DOWNGRADING

The tight regime of austerity chosen to control public expenditure basically meant cuts in public expenditure. Using an accessible language that all people would accept, the government formulated this objective in terms of “cutting off on the state's fat”. However, distinguishing between ‘fat’ and ‘clean flesh’ revealed to be a difficult task when

¹ A consortium of creditors constituted by the European Commission (EC), the European Central Bank (ECB) and the International Monetary Fund (IMF).

² For a better understanding of the sovereign debt crisis in Portugal and of the economic adjustment programs for the health sector imposed by the troika memorandum of understanding, see Hespanha (2017).

immediate results were expected. In the beginning, “fats” were identified with current expenses (not with personnel expenses), but soon it was clear that much outsourcing labor was also affected because in state accounting the “acquisition of services” is considered as a current expense.

Current expenses include activities that are instrumental to the services’ operation and therefore necessary for their achievement – such as expenses with transportation and ‘other specialized services’ (reduced by 25%), ‘purchase of services’ (reduced by 40%), ‘payment of overtime, subsidies for night shifts, communications, legal services and technical assistance’ (reduced by 20%) and, very significant due to its high expression, expenses with outsourcing, i.e., staff with no employment relationship with the state, which from the viewpoint of public accounting was financed from the same budget as xerox copies. The drastic reduction of outsourced staff led to a ‘massive dismissal’ of workers or, in some services, the paralysis of work (Hespanha *et al.*, 2014: 210).

The economic crisis impacted directly in health expenditure. Between 2010 and 2013 the Gross domestic product (GDP) was reduced by 5.4% and the total health expenditure by 12.4% (INE, 2016). When we analyze public expenses in health since 2010 the two most striking findings are the reduction of personnel expenses (between 2010 and 2012 they were reduced by 27%) and the reduction of capital expenses (between 2010 and 2014 they were reduced by 81%) (Table 1).³

Government expenditure on health fell more than in other public sectors, as the share of health to general government spending came down from 13.8% in 2009 to 12.3% in 2015. The public share of health expenditure fell more rapidly since 2011 and in 2017 accounts for 66% of total health financing, below the EU average of 79%. The share of out-of-pocket payments is the second largest source of revenue for health care spending (28%), well above the EU average (15%). Private VHI has been growing over the years, but still only accounts for 5% of health financing, converging with the EU average. (OECD and European Observatory, 2017: 6)

³ The data of the European Observatory on Health Systems and Policies are collected from the National Budgets (Orçamento Geral do Estado, in Portuguese) and, therefore, the numbers are a little higher (between +6,9% in 2012 and +2,5% in 2014).

TABLE I – Public Expenses in Health (Portugal, 2010-2017), in Million Euros

	CGE* 2010	CGE 2011	CGE 2012	CGE 2013	CGE 2014	CGE 2015	CGE 2016	CGE 2017
Current expenses	9 389,0	8 731,1	9 740,6	8 826,0	8 457,1	9 229,7	9 557,5	9 813,7
Personnel expenses	1 253,7	1 121,1	913,6	1 005,1	1 010,1	3 556,2	3 762,6	3 970,4
Pers. exp. / Total exp. (%)	13,2	12,7	9,3	12,4	11,8	37,7	38,7	39,9
Purchase of goods and services	8 036,6	7 533,1	8,767.0	7 749,2	7 365,2	5 563,5	5 695,9	5 755,4
Current transfers	81,5	70,9	45,7	242,1	56,8	69,9	62,3	58,5
Other current expenses	15,2	6,0	14,4	16,5	22,8	33,2	26,7	23,5
Capital expenses	134,2	125,7	97,5	51,0	24,3	192,5	159,2	145,5
Purchase of capital goods	94,0	99,9	78,3	21,6	20,4	163,4	116,6	110,6
Capital transfers	40,2	25,8	19,3	5,5	3,9	2,4	0,7	5,9
Total expenses	9 523,3	8 856,8	9 838,1	8 877,0	8 481,5	9 422,2	9 716,6	9 959,2

* CGE – Conta Geral do Estado, i.e. General State Account.

Source: Direção-Geral do Orçamento, *Conta Geral do Estado – 2010/2017*, disponível em <http://www.dgo.pt/politicaorcament/Paginas/Conta-Geral-do-Estado.aspx?Ano=2018>.

In the absence of a structured reform program based on a hierarchy of necessities, at large it prevailed a blind application of cuts on expenses, with no attention to the impact that these cuts would produce in very sensitive areas of health care. Also, the measures for efficiency improvement were implemented without taking into account the capacities of health administration to achieve them, which resulted in many of them not reaching the expected objectives (Sakellarides *et al.*, 2014).

The great criticism to be made about the implementation of the MoU is that it did not actually lead to the implementation of any of the reforms that were necessary and expected. During the four years under the Troika's rule, the government limited itself to presenting a draft for the state reform that was not even discussed (Governo de Portugal, 2013).

The announced reforms of hospital care and primary health care may serve as an example of what should have been done and has not been. Representing 60% of the expenses of the National Health Service – NHS (Serviço Nacional de Saúde, in Portuguese), public hospitals were considered the reforms' priority target. There should

have been a reorganization of the national hospital network, which was accused of suffering from significant inefficiencies, such as the duplication of services provided in certain areas, as urgencies, maternities, oncology, and transplant services. However, a report of the Troika (EC, 2014) recognizes that, although a lot had been done, the reform of the hospital network was far from being achieved and identifies a number of causes for this: resistance in the reclassification of hospitals and reallocation or sharing of medical equipment, low staff mobility and centralization of decisions that should be made at regional level. Regarding the latter, it is obvious that the strong resistance of services and the unpopularity of the reform is, above all, an effect of the absence of participation of the institutions and their officials and professionals in the reform design and implementation processes. Moreover, the fact that professionals were experiencing an overload of work did not contribute to a favorable atmosphere. This overload resulted from the dismissal of staff with no replacement or replaced by “insufficient quantity of young unexperienced physicians who, regardless of their specialty, must work 18 hours shifts at the emergency service, instead of the previous 12 hours”, as denounced by the President of the Portuguese Medical Association (Silva, 2015; translation by the author).

Similarly, the reinforcement of primary health care stipulated in the MoU was not implemented, despite the recognition of its potential contribution to the cost-efficiency of the hospital and emergency care. An important component of this type of care is provided by general practitioners or family doctors of the NHS, which are at the risk of increasing the numbers of citizens without medical assistant if new professionals are not recruited to substitute those who have retired. Despite some positive changes – such as the approval of the professional profile of the family nurse, the creation of vacancies for general and family medicine internship, and the creation of some Family Health Units (Unidade de Saúde Familiar, in Portuguese) –, there are hindrances in the daily work of professionals of Primary Health Care, which greatly hamper their tasks – from a deficient information system to the lack of human resources or the fragility of some operational unities (OPSS, 2014: 109).

The Portuguese Medical Association also reports some difficulties in staff recruitment. First, the freezing of public examinations for entry of family doctors led, on the one hand, to the emigration of many unemployed young physicians and, on the other hand, to hiring physicians in retirement situation as an alternative and cheaper option. Second, the incentives to keep doctors in the interior of the country turned out to be unacceptable due to the small amount of the mobility incentive and to the imposed mobility restrictions (five years of a mandatory period). Together with other causes, this explains the maintenance of one million Portuguese inhabitants (one and a half in every ten) without a family doctor, despite the availability of human resources in the market

and the increase in the number of patients per family doctor, making it impossible to manage the lists of patients waiting for consultation (Silva, 2015).

3. THE STAFF REDUCTION PRIORITY

Staff reduction in public services became a government obsession, despite the awareness that the blind reduction of the number of employees would have serious social consequences in the crisis context. These reductions were achieved, to a large extent, at the expense of worsening working conditions.

The reduction of health professional wages, the loss of holidays and Christmas subsidies (two extra month salaries) in 2012, the non-payment of overtime, the freezing of career promotions, and the no offer of public examinations for the recruitment of physicians and nurses led to the emigration of many unemployed professionals,⁴ the anticipated retirement of professionals with long careers and a considerable number of professionals moving to the private sector. In the case of physicians, there was severe criticism to the decision of not hiring young professionals, whose education lasted many years and to a large extent was financed by public resources, thus representing a serious waste of resources.

This situation led to a strike of physicians in July 2012, when the Ministry of Health and the unions negotiated an agreement that included revision of wages, reduction of heavy overloads, hiring new professionals, opportunities for career progression, extending users' lists of family doctors (from 1500 to 1900) and increased mobility of doctors within the NHS (Sakellarides *et al.*, 2014).

In spite of this, the effects of the staff reduction policy on the quality of health care services associated with other austerity policies are a matter of great concern. The same with increasing levels of burnout syndrome among health professionals, associated with the perception of poor working conditions and reduced professional experience (WHO *et al.*, 2018: 18; Marques and Macedo, 2018).

There are many examples of services that are going through processes of degradation as a consequence of the austerity cuts and discipline (Paoletti and Carvalho, 2012; Eurofound, 2012; Oxfam, 2013; Hauban *et al.*, 2012). In some cases, the aim of costs reductions is concealed under the argument of greater rationalization of services or compliance with international standards, as in the cases of closing urgencies and

⁴ It is estimated that, since 2009, 14,780 nurses have applied for emigration documents (Rita and Saramago, 2016). According to the President of the Medical Association, "hundreds of physicians are emigrating every year and if we don't do what is necessary to retain them it will be a great loss, in terms of investment and scientific knowledge. We are exporting brains" (Observatório da Emigração, 2015; translation by the author). Furthermore, the dynamics of medical school graduates and the retirement of medical doctors are likely to generate a surplus that may not be absorbed by the healthcare system until 2025 (Santana *et al.*, 2014).

maternities, prescription of medicines in public hospitals, and ‘implicit rationalization’ of public health services.⁵

The services quality degradation resulting from the reduction or freezing of human and material resources’ expenses, is one of the greatest threats to the public health system. It undermines citizens’ confidence and increases their dissatisfaction. A report from OECD reveals critical aspects in the operation of hospital services: e.g. high fatality rates within 30 days after admission for ischemic stroke cases – 10.5% against 8.5% in OECD member countries average (OECD, 2015: 29). Portugal also presented the worst performance regarding waiting time for surgeries and the rate of infections associated with care in hospitalization (approximately 11% of hospitalized patients in 2012, well above the average of 6% in the EU) (*ibidem*).

In the same direction, another report on Portugal concludes that “in comparative terms, the universal healthcare system produces good results, although the expenses cuts have undermined inclusiveness and quality” (SGI, 2015). Yet, a study carried out by an independent Swedish organization placed the Portuguese National Health System four positions below the one occupied in 2009, mainly due to excessively long waiting time, reduction on co-payment of medicines, difficulty in the access to innovative pharmaceutical products, and a huge stagnation of the system (Björnberg, 2016).

It is worthy to recall the remark made by Ramesh Mishra, a long time ago, regarding the strategy of residualization of public services followed by Margaret Thatcher’s government: “cost containment and the decline of quality of public services may be expected to lead to more private alternatives especially in times of increasing private prosperity. In other words, universality may be weakened by attrition rather than by assault” (Mishra, 1990: 37). Or, as stated by Boaventura de Sousa Santos in 2002:

many of these services that are currently “public services” have almost endless business potentialities. In order to make this happen without much social disturbance, it is necessary that the idea of public service is gradually demoralized. The most efficient strategy consists in starting from false generalizations, taking blind measures, and justifying them with populist arguments (against the “misspending of taxpayers’ money”). (Santos, 2002; translation by the author)

⁵ A broad description of the signs of health services downgrading and progressive inaccessibility to patients is available in the 2012 issue of Portuguese Observatory of the Health Systems (OPSS, in the Portuguese acronym).

4. GOVERNMENTS' LIMITED ROOM FOR MANEUVER

This crisis increasingly reduced the room for maneuver of governments that were strongly subjected to the supervision of international institutions, thus forced to limit social dialogue regarding their main characteristics: decision-making autonomy of players and valorization of contributions from each part to the negotiation (Begega and Balbona, 2015), and, later, the impositions of adjustment programs following the sovereign debt rescue.

In order to better control the implementation of the MoU, the government was forced to reverse the ongoing decentralization process of the public health system. This centralist return, not being an expressed option, was manifested by means of a set of mechanisms that limited the participation of organizations and public health services in policies' decision-making and concentrated them at the top of the Ministry of Finances (OPSS, 2014: 23).

One of these mechanisms is the "law of commitments", in force since the beginning of 2012 to "reduce the deficit of Public Administration" and restrain "expenditure growth". It institutes that those responsible for the accountancy in public services may not assume commitments that exceed the available funds in the short-term. The assumption of multiannual commitments, including new investment projects, reprogramming of old ones or hiring contracts, among others, must be subjected to previous authorization of the Ministry of Finances (Assembleia da República, 2012).

The OPSS considers that this law had very negative effects, in particular, on the motivation and accountability of the heads of health services, already disturbed by the excessive and unnecessary bureaucratization of the process of personnel hiring and purchase of goods and services.

The short term bureaucratic barriers and the environment of uncertainty regarding the availability of resources for health care services hinder strategic planning, multiannual contracting, and, ultimately, organizations' sustainability [...]. Transforming regional and local structures in mere driving belts for decisions taken centrally removes the efficacy, critical mass, experience, and innovation capacity to find adequate solutions. (OPSS, 2014: 34; translation by the author)

Other mechanisms promoted as well the centralist return, by centralizing the recruiting of staff for the public administration into an inter-ministerial commission (Comissão de Recrutamento e Seleção para a Administração Pública, in Portuguese); by making more difficult the celebration or the renewal of job contracts by state-owned enterprises; by grouping the Health Centers for management purposes in regional

entities (Agrupamentos de Centros de Saúde, in Portuguese); by concentrating the dissemination of information in a centralized department of the Ministry for Health (Direção-Geral da Saúde, in Portuguese); and by creating limitations and constraints concerning decision-making within organizations, both in the administrative public sector and the state-owned enterprises (OPSS, 2014).

In an inverse movement to that of centralizing decision-making, the government entrusts more and more the private sector, for-profit or non-profit, with the responsibility of managing health units under the argument of public expenses reduction, without any clear evidence of its truth. For José Manuel Silva, the President of the Portuguese Medical Association, there was a high increase in contracting services with the private sector and the non-profit sector. At the same time, the Ministry of Health promoted the move of physicians and other health professionals to the private sector. According to Silva (2015), the government has been promoting the destruction of the small private medicine of proximity in order to favor the large health oligopolies, by imposing on them small rules that even the state does not comply with.

A particularly serious situation results from the fact that apparently positive measures meant to reduce expenditure and improve the well-being of users of the national health system are producing unexpected effects that have worsened the previous situation. It is the case of the policy of reducing the price of drugs recommended by the Troika and thoroughly followed by the Portuguese government. This policy has several addressees: starting with the pharmaceutical industry and then the drugstore sector.

The government established several agreements with the pharmaceutical industry in order to lower the prices of medicines and, in this way, to reduce public expenditure and to fix a new tax on the sales of pharmaceutical products in the modality of withholding tax. The price reduction was well-succeeded but generated an unexpected problem: some drugs became internationally competitive and the wholesalers preferred to export them instead of supplying the national market as it was supposed. According to the Executive Director of Health Cluster Portugal, “these results have been produced by the ability of firms that, due to the prices being internally pressed down, searched for new markets” (Alves, 2016; translation by the author).

Regarding drugstores, it was verified that the reduction of the market margin of medicines also reduced their capacity to maintain stocks of the usual ones, resulting in supply shortage and, therefore, a decrease in patients’ access to them (OPSS, 2015; Vogler *et al.*, 2011). According to OPSS, 1,756 drugstores had suspended their supply in 2014, in at least one wholesaler (i.e., over 60% of the totality of drugstores in Portugal and with a growing tendency). In the same period, the global amount of the drugstores’ litigious debt with wholesalers reached 303 million euros, to which is added the amount

of 27 million euros for delayed payment, in pre-litigious phase (OPSS, 2015: 74). A study carried out in 2012 concluded that approximately 88% of the drugstores reduced the minimum stock of most medicines, 86.5% reduced the average amount of purchased packages, and 92% reported almost daily difficulties to obtain medicines from wholesalers (OPSS, 2013: 63).

The direct effect of the reduction of margins⁶ in combination with the indirect effect of successive reductions of prices of medicines,⁷ and the main remuneration source of drugstores (Martins and Queirós, 2015) resulted in a negative impact, especially to drugstores and wholesalers particularly affected by the double reduction in their remuneration. Between 2011 and 2014, the market margin of medicines was reduced in approximately 322.8 million euros, far above the 50 million euros established by Troika's MoU. In this period, many drugstores were closed (Infarmed, 2015) and the sector registered an increase of 177% in the number of drugstores with insolvency processes and 79.4% in the number of drugstores with pledges.

5. INCREASING INEQUALITIES IN THE ACCESS TO NHS

In the European context, Portugal appears as one of the countries in which the institutionalization of social rights and the responses of the state with the adequate means for coherent social policy occurred later and were more problematic. This fact is related to historical circumstances that influenced the evolution of Portuguese society throughout the 20th century, mainly in its second half. First, the persistence of a dictatorial regime until the beginning of the 1970s, which delayed the modernization of the administrative apparatus and the establishment of citizenship rights. Second, a clear delay in the processes of industrialization, urbanization, and expansion of service sector compared to what occurred in the northern European countries.

The so-called Estado Novo, ruled for nearly half a century by Salazar, adopted a model of social regulation hostile to the development of consistent social policies. It staked itself, rather, on a conservative ideology supported by the rural condition of large part of the population, which permitted the maintenance of social support based on family and community solidarity and on weak expectations in relation to consumption and quality of life.

It was only after the establishment of the democratic regime in 1974 that the first systematic programs, aiming at the construction of a welfare state were developed. This was reflected in the growth of public expenses on welfare. However, this takeoff occurred

⁶ Decreto-Lei no. 112/2011, from 29/11, altered by Decreto-Lei no. 19/2014, from 05/02.

⁷ The reduction of expenses per capita with medicines was of 5.9% in 2010 and 2011 (OECD, 2015).

during an international economic crisis, exactly when the more developed welfare states had begun to face the need of adopting more restrictive postures. As a consequence, the expansionism felt since the change of regime was followed by a phase of budget restraint after 1982, which prevented Portugal from approaching the model of state producing welfare which characterized many other European countries. However, the frailties of the Portuguese “semi-welfare-state” (Santos, 1993) have been partially compensated for by the action of a civil society rich in community ties. This ‘welfare society’ operates on a parallel with the systems of the state and of the market, and constitutes one of the singular elements of the welfare model dominant in the Portuguese society (Hespanha *et al.*, 1997: 173).

Anyway, Portugal created its NHS in 1979, based on universalism, generality, and free of charge (fully funded by taxes). Since its beginning the NHS faced many obstacles and limitations: right-wing parties, the Portuguese Medical Association and the biggest health industry corporations joined together to constrain its development; the weakness of public resources for investment, including some areas of specialized doctors, forced governments to make agreements with private health clinics, laboratories, and diagnostic units in order to ensure universalism. Later on, new hospitals were created under public-private partnerships and private hospitals were committed to assisting patients included in long waiting lists of NHS hospitals. Instead of growing and gaining autonomy in the provision of services, as expected, the Portuguese NHS has become increasingly dependent on private provision (Carapinheiro, 2006; Campos, 2011, 2014; Carapinheiro *et al.*, 2013).

The austerity policies imposed by the financial assistance program of the Troika since May 2011 and embraced by the right-wing governments between June 2011 and November 2015 have greatly aggravated this picture as discussed previously.

This austerity rule has not well defined outlines which may lead to quite different interpretations. To simplify, it can be said that it refers to a set of economic and social policy options by which governments aim to halt or reduce public expenditure, and that these options allow “altering the state’s redistributive policy and the expenditure related to the functioning of the economy and social reproduction” (Ferreira, 2014: 117; translation by the author).

The MoU signed in May 2011 by the Portuguese Government consisted of a shock therapy for the recovering of the fiscal crisis that included a large array of measures with a potential negative impact on social equity. First, to ensure a fiscal consolidation over the medium term by containing expenditure growth, reducing transfers from the state to public bodies and other entities; second, to decrease the staff numbers of central, regional and local administration, reducing the wages of civil servants, freezing new

admissions as well as constraining their promotions; and to promote flexibility, adaptability and mobility of human resources across the administration; third, to reduce social benefits, pensions and subsidies; fourth, to cut on expenses of public bodies and state-owned enterprises and to reduce capital expenditure; fifth, to reduce *corporate* tax deductions and special regimes, to reduce the *personal income tax* benefits and deductions; sixth, to increase VAT revenues and some special taxes; seventh, to reduce the degree of subsidization of public enterprises; eighth, to privatize, total or partially, the biggest public enterprises. In the particular field of health policies, the Memorandum includes the following measures: first, the strict control of costs in health sector with substantial reduction in operational costs, in spending on overtime compensation, and in costs for patient transportation; second, the increase of overall NHS user charges or moderating fees (*taxas moderadoras*)⁸ in parallel to a stricter design of means-testing criteria for exempting taxes; third, the substantial cut in tax allowances for healthcare, including private insurance (by two thirds overall); fourth, the reduction of the budgetary cost of health-benefits schemes for civil servants; fifth, the reduction of the reimbursement of medicines for patients.

The governmental coalition that ruled during the Troika period used austerity to enforce a project of state political reform of a neoliberal imprint, which under the argument that there is no alternative to austerity as a response to the crisis, restrained expenditure, privatized state-owned enterprises and used labour cost as an adjustment variable of the deficit. In result, political institutions became weak, inefficient and unqualified, citizens became dependent, poor, and deprived, and exceptional rights that do not respect the most basic principles of the rule of law and of democracy (Ferreira, 2014: 438).

Damages caused by austerity to the Portuguese economy and society manifested in many ways. From the beginning, deep recession occurred with serious implications for the future, not only due to investment halt and sovereign debt increase but mainly through social consequences: employment destruction and unemployment increase; precariousness, especially, of the younger segments of the economically active population; large emigration flow of qualified workers; and worsening of poverty, social exclusion and income inequalities (Silva *et al.*, 2013; Costa and Caldas, 2014: 119). A Caritas report on the impact of the crisis and austerity on people shows that the anti-crisis policies primarily based on austerity caused vulnerability on the weaker members of society and therefore it could not be successful (Caritas Europa, 2013: 51).

⁸ Before this increase, moderating fees represented 0.74% of the NHS total revenue in 2010 and 0.95% in 2011. In 2012, they accounted for 1.7% and in 2015 about 2.0% (WHO, 2018: 27).

The social impact of austerity felt unequally on families and individuals. According to a study published by the European Commission (Avram *et al.*, 2013), among the nine EU countries with larger budgetary deficits after the financial crisis at the end of the first half of the 2000s and the subsequent economic recession (Estonia, Greece, Spain, Italy, Latvia, Lithuania, Portugal, Romania and United Kingdom), Portugal, Lithuania and Estonia are the only countries where austerity measures imposed heavier financial burden on the poor than on the rich. In the period from 2009 to June 2012, Portugal underwent a regressive distribution, resulting mainly from the freezing of means-tested benefits,⁹ in a country that was already one of the most unequal in the EU. In a synthesis,

the financial crisis reduced the availability of public financial resources for health services coverage and investments. This has led to some reduction of services, the higher financial burden to households and lower incomes of health services staff. The reductions have directly affected patterns of health and services utilization of the Portuguese population. (WHO *et al.*, 2018: 32)

In order to analyze the consequences of crisis and austerity on inequalities, we may consider different dimensions: access to health care, increase in families' out-of-pocket health spending, reduction in public healthcare investment (Serapioni, 2017).

The Report of European Commission "Health inequalities in the EU" published in 2013 (EC, 2013) distinguishes "health inequalities" (i.e. in life expectancy, in mortality), from "social inequalities" (i.e. in the conditions of daily life, based on power, money and resources) and outlines the different causes of inequalities and the policy responses. It compares data from 2009 to 2013 and concludes that the financial, economic and social crisis "is threatening to undermine existing policies, and may negatively affect health inequalities" (*ibidem*: ix); and adverts to the fact that "inequalities in health cannot be reduced by the health sector alone – they require action on all the social determinants of health" (*ibidem*). Thus, "most policies with explicit aims to reduce health inequalities focus on 'vulnerable groups' such as immigrants, ethnic minorities, early school leavers, people from lower socio-economic groups or unemployed or homeless people" (*ibidem*).

We take these general traces common to the member states of the EU to inspire our analysis of the Portuguese case. The annual reports of the OPSS created in 2000 by a network of researchers and academic institutions are a good source of information for

⁹ The estimates of the austerity weight on the distribution model largely depends on the analytical choices and assumptions: for example, whether or not to include cuts on in equipment, such as wheelchairs, articulated beds, food; or the effects of increases on Value-Added Tax (VAT) on families. This explains the discrepancies in these estimates (Laparra and Pérez Eransus, 2012). Spain is considered the most regressive among the five countries – Germany, Denmark, Spain, France, and United Kingdom.

analyzing the course of health inequalities in Portugal, but there are other recent studies using other data and methodologies that also shed light on the same subject, as we will see later.

The OPSS Report for 2015 (OPSS, 2015), the first year after the end of the external intervention, used the access to health care as its central theme. Health care accessibility is guaranteed to every citizen, “regardless of their economic condition”, by the Portuguese Republic Constitution (art. 64, no. 3, al. a). According to the OPSS report for 2015 the crisis has interfered with access to health care, whether considered the dimensions associated with supply (human resources in health, access to emergency services, access to consultations, and availability of beds in hospitals) or those associated with demand (socioeconomic conditions of citizens, out-of-pocket health expenses, and unmet health needs).

The OPSS report for 2016 (OPSS, 2016) devotes a whole chapter to the theme of social inequalities in health. It began by stating three reasons why health inequalities related to social and economic factors are a cause for concern: first, inequalities in health are a matter of social justice; second, they represent an economic cost to society; and third, they seem to have persisted, and even increased in some cases, over the last few years. The report concludes that the analysis carried out on social inequalities in health has revealed that health inequalities in Portugal have been consistently higher than those observed in other European countries in the last decade and continue to be closely associated with socioeconomic factors (income, education, gender, age – children and elderly).¹⁰

Taking the level of education as an independent variable, it can be observed that, between 2005/2006 and 2014, people with lower levels of education has experienced disadvantages regarding three health indicators (poor or very poor self-reported health, the presence of at least one chronic disease, and the presence of functional limitations). In particular, inequality is very high in reported ill-health, and in 2014 uneducated people have a risk of being six times poorer than those with more education (secondary education or more). For the same indicator, inequality seems to have increased within 10 years, as for chronic disease. The increase in the risk of self-reported ill-health for uneducated people in 2008 and 2011 is understood as resulting from the onset of the crisis and the implementation of austerity measures, respectively.

The OPSS report for 2017, the first after the governmental change that reversed austerity policies since 2016, focused on equity in health care, assuming that equity

¹⁰ Main statistical sources used: The National Health Surveys (Inquérito Nacional de Saúde, in Portuguese) of 2005/2006 and 2014, the European Health, Aging and Retirement Survey (SHARE), and the EU Statistics on Income and Living Conditions (SILC).

means that care is distributed according to the needs and not to the ability to pay or to the socioeconomic condition (OPSS, 2017: 73).

The assessment of equity in the access to health care has been measured by: i) the probability of having unmet needs for four dimensions of care (medical appointments or treatments, dental care, purchase of prescribed drugs, and mental health appointments or treatments); ii) the income category (in quintiles). There is a strong probability of reporting unmet needs in all income categories, but this probability is quite unequally distributed in the cases of dental appointments (from 9% in the richest to 53% in the poorest) and mental health treatments (from 9% in the richest to 48% in the poorest). Even for medical appointments or treatments in general, access barriers range from 4% to 19%. Regarding waiting times, people in the highest income quintile have a significantly lower probability of waiting for a consultation, as compared to people in the lowest income (*ibidem*: 77).¹¹

A recent academic study (Campos-Matos *et al.*, 2017) followed the same objective using EU-SILC database to analyze inequalities regarding three particular health limitations – daily activities due to health problems, self-reported health, and chronic conditions – in Portugal between 2004 and 2014. Demographic and socioeconomic variables – age, sex, income, education, occupation, activity, and savings – were used as explanatory variables. The proportion of individuals who had limitations was calculated for each year in the overall sample, within each income tercile, and stratified by age groups. A complex model of analysis allowed to observe that the proportion of individuals with limitations (mostly in daily activities), was stable at around 30% until 2011, when it increased to 43%, and then increased again in 2014 to 47% (*ibidem*: 2); however, health inequalities seem to have decreased over the same period driven by an increase in limitations in active people due to mechanisms such as migration trends (based on the ‘healthy migrant effect’) and socio-economic groups’ different ability to adapt to changing circumstances (*ibidem*: 5). Recognizing that these findings may be limited by the database design, the authors advocate “a more detailed exploration of these changes in the determinants of health, perhaps using longitudinal data, in order to capture trajectories rather than compositional changes within socioeconomic groups” (*ibidem*).

¹¹ According to the Eurofound *European Quality of Life Survey 2016* a delay in getting an appointment was reported as being ‘very difficult’ for 18% of respondents in 2016 in Portugal (Eurofound, 2017: 53).

6. CITIZENS' RESISTANCE STRATEGIES TOWARDS CRISIS AND AUSTERITY

The manner in which insufficiency, downgrading or decreasing of services affect citizens differs extensively according to a large array of variables, the same way as dealing with this situation differs. Systematic and comprehensive research on citizens' behavior is needed, which is hindered by the policy of public services opacity, on the one hand, and by the very unequal and irregular quality of data collection, on the other hand.

It is important to stress that the effects of the reforms introduced in various domains of the health system should have been previously evaluated not only regarding their benefits for public management but also the disadvantages that they could bring to users, as has already been mentioned.

For those citizens who saw the reduction of income and social support to which they had access, and also the aggravation of their living expenses, a common attitude is the reduction of health care demand such as consultations, exams, medicines, etc. Official data confirm the decrease of the number of consultations since 2011 and particularly the high absenteeism to mental health consultations because patients cannot afford to pay for transport costs (OPSS, 2015: 140). Regarding the purchase of prescribed medicines, there is evidence that many patients do not buy on a regular basis medicines associated to certain diseases: chronicle diseases, high blood pressure and hypercholesterolemia, depression, etc. (Sakellarides *et al.*, 2014).

The reduction of the exemptions on moderating fees, the duplication of the amount of these fees,¹² and the extension of the moderating fees to other services,¹³ along with the increase of the delay to access healthcare due to the shortage of professionals, have further aggravated the situation, namely for those patients who cannot afford to use the private sector. However, there is evidence that those who can afford it shift to the private sector, subscribe to private health insurance (already covering 20% of the population in 2011), or press the public system to respond as expected. Some cases of this pressure were much publicized, as the reaction against the rationing of expensive medicaments. In February 2015 a hepatitis C patient protested at Parliament, face to face with the Minister of Health, against the decision to prevent the access to an innovative treatment (with a high cure rate) based on the high cost of the treatment. As a result, the

¹² This revision of the moderating fees regime raised several questions: a) inequity of the duplication of fees amount when a severe economic and social crisis was underway; b) an assistance logic and a stigmatization risk behind the limitation of access to moderating fees exemption only to those who prove not to have the required means; c) very high costs to implement a control system for requests of fees exemption; d) reduced impact on health budget from the rise of moderating fees; and e) the fact that the moderating fees fall on the delivery of health services not chosen by users, but rather those prescribed by the doctors (Sakellarides *et al.*, 2014).

¹³ Services of nursing, vaccination not included in the national vaccination plan, radiologic exams, and therapeutics in the scope of urgency services.

government was forced to liberate the access to that medication for all patients in the same situation.

But there are other alternatives. Citizens are not always isolated in the resolution of problems generated from or aggravated by austerity policies. This crisis also raises the emergence of answers within civil society, as for example mutual aid for the care of dependent persons, informal assistance to children, sharing of private transportation or housing, medication bank, etc. The origin of such responses is very diverse: spontaneous emergence in proximity contexts; insertion in a social and solidarity economy logic; philanthropic or social volunteering inspiration (Laville, 2005, 2011; Laville and Jané, 2009; Hespanha and Santos, 2016).

Therefore, it is important to identify where the responses originate from and learn the different aspects that allow us to evaluate their efficacy: the way in which the answers arise; their more or less formal and organized condition; the individualistic, particularistic or solidarity philosophy that inspires them; the type of solidarity that feeds them – to make it simple: paternalistic or democratic, vertical or horizontal –; its sphere of action more or less enlarged and integrated; the consistency and durability of these answers; their innovative and transformative character; and the institutional recognition of the answers.

7. IN DEFENSE OF THE PUBLIC HEALTH SERVICES

Several years of a strict policy of austerity, lack of investment and neglect of work conditions of the health professionals discredited and weakened the services and may have produced a strong negative impact on the people affected by the cuts and the shortage of services. The degradation of quality in health services resulting from the reduction or freezing of wages and capital investment is one of the great threats to the Portuguese NHS. It undermines citizens' confidence, increases their dissatisfaction¹⁴ and exacerbates the current inequalities in accessing health care. However, the damages caused by this policy will take some time to repair and this cannot be achieved without significant investment in human resources and infrastructure. Since 2016, a new government essayed a policy of reversing the main austerity measures by recovering the citizens' lost income and giving priority to the reversal of salaries, social benefits, and exemptions. But it lacks a steady policy of investment in human resources and infrastructure. "Although most of the wage cuts introduced in 2012 are currently being reversed, the payment to health care workers in the NHS, particularly physicians, is lower

¹⁴ More than half of the respondents in a study on the satisfaction of the users of the Portuguese health system feel that public health services need major changes/adjustments (38.2%) or to be completely restructured (15%) (DGS, 2015).

than in the private sector” (Simões *et al.*, 2017). The promise to create 100 new Family Health Units is already consummated and represents an important investment in order to expand and improve the Primary Health Care network and allow the allocation of family doctors to approximately more 500 thousand people (XXI Governo Constitucional, 2015: 97). An increase in hiring health professionals to compensate for staff outflows caused by austerity and the reduction of the working week from 40 to 35 hours, has been successfully accomplished. In contrast, the recovery of the pre-crisis levels of investment in hospitals has failed, despite the statement by the Minister of Health, Marta Temido, that hospitals of the NHS will benefit, in the next three years, of 500 million euros of equipment investment (*O Jornal Económico com Lusa*, 2018). However, the real challenge to the government consists in making the needed investment with public funding¹⁵ and at the same time maintaining financial sustainability, through increasing efficiency in NHS health units (Simões *et al.*, 2017: 171).

The combined analysis of the evolution and impact of the austerity on social policies with the way in which Portuguese society is suffering the impact of the crisis reveals a huge lack of legitimacy of the austerity measures, regarding the values and legitimate expectations of social welfare in a modern European society based on the principles of political and social citizenship. At the same time, these measures are contributing to the loss of social capital, generating the risk of destroying the society's fundamentals.

Whatever the circumstances are, it is important to sustain that the reform of NHS cannot abandon the essential objectives to minimize inequalities, protect the more vulnerable persons, and improve the well-being of all citizens. There are still many obstacles – possibly even more than in the past – for the improvement of public services, and one of them, very important, is the bureaucratic, authoritarian and clientelist nature of public administration, which the democratic political system intended to transform, but was not able or did not want to. Lately one observes the reinforcement of these tendencies and the increasing opacity of the criteria of public administration management, thus hampering the access to information on the austerity impacts.

¹⁵ There is a staunch debate in Portugal about the public nature of the NHS, since the creation, in 2002, of public-private partnerships (PPPs) for the management of public hospitals. Recent reports from the Court of Auditors have concluded, first, that “there is no evidence to confirm that the option for the PPP model generates added value compared to the traditional contracting model” (Tribunal de Contas, 2013: 16 and 2015: 8; translation by the author), and second, that “the production of hospital care agreed annually between the state and the private partner has not been subordinated to the needs of the population's health services, leading to increased lists and waiting times for consultations and surgeries” (Tribunal de Contas, 2016: 3; translation by the author). This debate rebound recently in the Parliament when the Government submitted a project to change the Health Framework Law of 1990 (*Lei de Bases da Saúde*, in Portuguese), which established the principle of parity between the public and the private sectors of health care and promoted the development of the private health sector in competition with the public sector (Base 2, al. f).

The NHS becomes essential in a context of crisis and the consequences of its degradation or suppression will be dramatic for the majority of the Portuguese citizens. Therefore, the defense of social welfare and the role of the state in health protection is made, largely, through requesting the ability of health services to adjust to the new realities, making good use of the responses that society has invented – such as proximity services, health in the community, informal care –, creating closer bonds with territories, and giving more attention to the needs of the community at each moment.

PEDRO HESPANHA

Faculdade de Economia da Universidade de Coimbra | Centro de Estudos Sociais da Universidade de Coimbra
Avenida Dr. Dias da Silva 165, 3004-512 Coimbra, Portugal
Contact: hespanha@fe.uc.pt

Received on 25.01.2019

Accepted for publication on 21.05.2019

REFERENCES

- Alves, Virginia (2016), “As exportações do sector da saúde cresceram 8% em 2012”, *Dinheiro Vivo*, June 2. Accessed on 30.10.2018, at <https://www.dinheirovivo.pt/economia/as-exportacoes-do-sector-da-saude-cresceram-8-em-2012/>.
- Avram, Silvia; Figari, Francesco; Leventi, Chrysa; Levy, Horacio; Navicke, Jekaterina; Matsaganis, Manos; Militaru, Eva; Paulus, Alari; Rastrigina, Olga; Holly Sutherland (2013), “The Distributional Effects of Fiscal Consolidation in Nine EU Countries”, *EUROMOD – Working Paper Series*, EM 2/13.
- Assembleia da República (2012), Lei n.º 8/2012 de 21 de fevereiro. *Diário da República*. Accessed on 12.09.2018, at http://www.pgdlisboa.pt/leis/lei_mostra_articulado.php?nid=2273&tabela=leis.
- Begega, Sergio; Balbona, David (2015), “Crisis económica y deterioro de los pactos sociales en el sur de Europa: Los casos de España y Portugal”, *Revista Internacional de Sociología*, 73(2). DOI: 10.3989/ris.2014.03.17
- Björnberg, Arne (2016), “Euro Health Consumer Index 2015: Report”, *Health Consumer Powerhouse*. Accessed on 30.10.2018, at <https://healthpowerhouse.com/media/EHCI-2015/EHCI-2015-report.pdf>.
- Bourdieu, Pierre (1999), “The Abdication of the State in the Weight of the World: Social Suffering in Contemporary Society”, in Pierre Bourdieu *et al.*, *The Weight of the World: Social Suffering in Contemporary Society*. Cambridge: Polity Press, 181-188. Translation by Priscilla Parkhurst *et al.* [orig. 1993].

- Bourdieu, Pierre (2014), *Sobre o Estado*. São Paulo: Companhia das Letras.
- Campos, António Correia de; Simões, Jorge (2011), *O percurso da saúde: Portugal na Europa*. Coimbra: Edições Almedina.
- Campos, António Correia de; Simões, Jorge (eds.) (2014), *40 anos de Abril na saúde*. Coimbra: Edições Almedina.
- Campos-Matos, Inês; Russo, Giuliano; Gonçalves, Luzia (2017), “Shifting Determinants of Health Inequalities in Unstable Times: Portugal as a Case Study”, *European Journal of Public Health*, 28(1), 4-9.
- Carapinheiro, Graça (2006), “A saúde enquanto matéria política”, in Graça Carapinheiro (ed.), *Sociologia da saúde. Estudos e perspectivas*. Coimbra: Pé de Página, 137-164.
- Carapinheiro, Graça; Serra, Helena; Correia, Tiago (2013), “Estado, medicina e políticas em Portugal”, in Fátima Alves (ed.), *Saúde, medicina e sociedade – Uma visão sociológica*. Lisboa: Pactor, 49-74.
- Caritas Europa (2013), *The Impact of European Crisis: A Study of the Impact of the Crisis and Austerity on People, with a Special Focus on Greece, Ireland, Italy, Portugal and Spain*. Brussels: Caritas Europa.
- Costa, Ana; Caldas, José Castro (2014), “A União Europeia e Portugal entre os resgates bancários e a austeridade”, in José Reis (ed.), *A economia política do retrocesso: crise, causas e objetivos*. Coimbra: CES/Almedina, 87-126.
- DGS – Direção-Geral de Saúde (2015), *Estudo de satisfação dos utentes do sistema de saúde português*. Lisboa: Direção-Geral de Saúde. Accessed on 12.10.2018, at <https://www.dgs.pt/documentos-e-publicacoes/estudo-de-satisfacao-dos-utentes-do-sistema-de-saude-portugues-2015-pdf.aspx>.
- EC – European Commission (2013), *Health Inequalities in the EU — Final Report of a Consortium. Consortium Lead: Sir Michael Marmot*. Brussels: Directorate-General for Health and Consumers. Accessed on 10.09.2018, at https://ec.europa.eu/health/sites/health/files/social_determinants/docs/healthinequalitiesin_eu_2013_en.pdf.
- EC – European Commission (2014), “The Economic Adjustment Programme for Portugal, 2011-2014”, *Occasional Papers*, 202. Brussels: Directorate-General for Economic and Financial Affairs.
- Eurofound – European Foundation for the Improvement of Living and Working Conditions (2012), *Third European Quality of Life Survey: Quality of Life in Europe: Impacts of the Crisis*. Luxembourg: Publications Office of the European Union.
- Eurofound – European Foundation for the Improvement of Living and Working Conditions (2017), *European Quality of Life Survey 2016: Quality of Life, Quality of Public Services, and Quality of Society*. Luxembourg: Publications Office of the European Union.
- Ferreira, António Casimiro (2014), *Política e sociedade: teoria social em tempo de austeridade*. Porto: Vida Económica.

- Governo de Portugal (2013), “Um Estado melhor: proposta do Governo, aprovada no CM de 30 de outubro de 2013”. Lisboa: Presidência do Conselho de Ministros. Accessed on 12.09.2018, at <https://www.dn.pt/DNMultimedia/DOCS+PDFS/EstadoMelhor%2030%2010%20-%20um-estado-melhor7856bba1.pdf>.
- Hauban, Harald; Coucheir, Michael; Spooren, Jan; McAnaney, Donal; Delfosse, Claude (2012), *Assessing the Impact of European Governments’ Austerity Plans on the Rights of People with Disabilities. European Report*. European Foundation Centre. Accessed on 09.06.2018, at http://www.enil.eu/wp-content/uploads/2012/12/Austerity-European-Report_FINAL.pdf.
- Hespanha, Pedro (2017), “As reformas dos sistemas de saúde na Europa do Sul: crises e alternativas”, in Paulo Henrique Rodrigues; Isabela Santos (eds.), *Políticas e riscos sociais no Brasil e na Europa: convergências e divergências*. Rio de Janeiro: HUCITEC Editora, 81-110.
- Hespanha, Pedro; Ferreira, Claudino; Portugal, Sílvia (1997), “Welfare Society and Welfare State”, in Maurice Roche; Rik van Berkel (eds.), *European Citizenship and Social Exclusion*. Aldershot: Ashgate, 169-183.
- Hespanha, Pedro; Ferreira, Sílvia; Pacheco, Vanda (2014), “O Estado social, crise e reformas”, in José Reis (ed.), *A economia política do retrocesso: crise, causas e objetivos*. Coimbra: CES/Almedina, 189-281.
- Hespanha, Pedro; Santos, Luciane Lucas dos (2016), “O nome e a coisa. Sobre a invisibilidade e a ausência de reconhecimento institucional da Economia Solidária em Portugal”, *Revista de Economia Solidária*, 9, 22-68.
- INE – Instituto Nacional de Estatística (2016), *Statistics Portugal Database*. Available at https://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_main.
- Infarmed – Autoridade Nacional do Medicamento e Produtos de Saúde, I. P. (2015), *Estatística do medicamento 2013*. Lisboa: Ministério da Saúde. Accessed on 02.09.2018, at <http://www.infarmed.pt/documents/15786/1229727/Estat%C3%ADstica+do+Medicamento+2013/031fe3d4-8f86-45f7-adc9-55bc1ca2079e?version=1.1>.
- Jessop, Bob (2013), “Putting Neoliberalism in Its Time and Place: a Response to the Debate”, *Social Anthropology*, 21(1), 65-74.
- Laparra, Miguel; Pérez Eransus, Begoña (eds.) (2012), *Crisis y fractura social en Europa. Causas y efectos en España*, Colección Estudios Sociales, no. 35. Barcelona: Obra Social ‘La Caixa’.
- Laville, Jean-Louis (2005), *Sociologie des services: entre marché et solidarité*. Ramonville: Érés.
- Laville, Jean-Louis (2011), *Agir à gauche: L’économie sociale et solidaire*. Paris: Desclée de Brouwer.
- Laville, Jean-Louis; Jané, Jordi (2009), *Crisis capitalista y economía solidaria: una economía que emerge como alternativa real*. Barcelona: Icaria.

- Marques, Ana Paula; Macedo, Ana Paula (2018), “Políticas de Saúde do Sul da Europa e desregulação das relações de trabalho: um olhar sobre Portugal”, *Ciência & Saúde Coletiva*, 23(7), 2253-2263.
- Martins, Lurdes Castro; Queirós, Sónia (2015), “Competition among Pharmacies and the Typology of Services Delivered: The Portuguese Case”, *Health Policy*, 119(5), 640-647.
- Mishra, Ramesh (1990), *The Welfare State in Capitalist Society*. Hempstead: Harvester Wheatsheaf.
- O *Jornal Económico* com Lusa (2018) “Hospitais precisam de 500 milhões em equipamentos nos próximos três anos, diz ministra”, *O Jornal Económico*, December 14. Accessed on 14.12.2018, at <https://jornaleconomico.sapo.pt/noticias/hospitais-precisam-de-500-milhoes-em-equipamentos-nos-proximos-tres-anos-diz-ministra-389499>.
- Observatório da Emigração (2015), “Médicos estão a emigrar às centenas”, October 22. Accessed on 23.10.2018, at <http://observatorioemigracao.pt/np4/4623.html>.
- OECD (2015), *Reviews of Health Care Quality: Portugal*. Paris: OECD Publishing.
- OECD; European Observatory on Health Systems and Policies (2017), *State of Health in the EU – Portugal: Country Health Profile 2017*. Paris: OECD Publishing. Accessed on 10.09.2018, at <https://www.oecd-ilibrary.org/docserver/9789264283527-en.pdf?expires=1545399351&id=id&accname=guest&checksum=D125AE893B4628A0DB7AFA31CC69AEEF>.
- OPSS – Observatório Português dos Sistemas de Saúde (2013), *Duas faces da saúde: relatório de primavera 2013*, Observatório da Saúde Collection, no. 10. Coimbra: Mar da Palavra. Accessed on 13.10.2018, at http://www.uc.pt/org/ceisuc/Documentos/rp/rp_2013.pdf.
- OPSS – Observatório Português dos Sistemas de Saúde (2014), *Saúde síndrome de negação: relatório de primavera 2014*. Coimbra: OPSS. Accessed on 13.10.2018, at <https://justnews.pt/documentos/file/Relatorio%20Primavera%202014%20-%2028junho1.pdf>.
- OPSS – Observatório Português dos Sistemas de Saúde (2015), *Acesso aos cuidados de saúde. Um direito em risco? Relatório de primavera 2015*. Coimbra: OPSS. Accessed on 13.10.2018, at http://www.apdh.pt/sites/apdh.pt/files/Relatorio_Primavera_2015_VF.pdf.
- OPSS – Observatório Português dos Sistemas de Saúde (2016), *Saúde: procuram-se novos caminhos. Relatório de primavera 2016*. Coimbra: OPSS. Accessed on 13.10.2018, at http://opss.pt/wp-content/uploads/2018/06/Relatorio_Primavera_2016_1.pdf.
- OPSS – Observatório Português dos Sistemas de Saúde (2017), *Viver tempos incertos: sustentabilidade e equidade na saúde. Relatório de primavera 2017*. Coimbra: OPSS. Accessed on 13.10.2018, at http://opss.pt/wp-content/uploads/2018/06/Relatorio_Primavera_2017.pdf.
- OXFAM – Oxford Committee for Famine Relief (2013), “A Cautionary Tale: The True Cost of Austerity and Inequality in Europe”, *OXFAM Briefing Paper*, 174. Accessed on 06.06.2016, at https://www-cdn.oxfam.org/s3fs-public/file_attachments/bp174-cautionary-tale-austerity-inequality-europe-120913-en_1_1.pdf.

- Paoletti, Isabella; Carvalho, Maria Irene de (2012), “Ageing, Poverty and Social Services in Portugal: The Importance of Quality Services”, *Indian Journal of Gerontology*, 26(3), 396-413.
- Rita, Cristina; Saramago, João (2016), “14 mil enfermeiros saíram em 7 anos”, *Correio da Manhã*, January 31. Accessed on 06.06.2016, at https://www.cmjornal.pt/portugal/detalhe/14_mil_enfermeiros_sairam_em_7_anos.
- Sakellarides, Constantino; Castelo-Branco, Luis; Barbosa, Patrícia; Azevedo, Helda (2014), *The Impact of the Financial Crisis on the Health System and Health in Portugal*. Copenhagen: WHO Europe/European Observatory on Health Systems and Policies.
- Santana, Paula; Peixoto, Helena; Duarte, Nuno (2014), “Demografia médica em Portugal: análise prospectiva”, *Acta Médica Portuguesa*, 27(2), 246-251.
- Santos, Boaventura de Sousa (1993), “O Estado, as relações salariais e o bem-estar social na semi-periferia: o caso Português”, in Boaventura de Sousa Santos (ed.), *Portugal: um retrato singular*. Porto: Edições Afrontamento, 15-56.
- Santos, Boaventura de Sousa (2002), “A ideia do serviço público”, *Visão*, 29th May. Accessed on 30.10.2017, at <http://saladeimprensa.ces.uc.pt/index.php?col=opinioao&id=1708>.
- Serapioni, Mauro (2017), “Economic Crisis and Inequalities in Health Systems in the Countries of Southern Europe”, *Cadernos de Saúde Pública*, 33(9). DOI: 10.1590/0102-311x00170116
- SGI – Sustainable Governance Indicators (2015), “Portugal: Social Policies”. Accessed on 30.10.2017, at http://www.sgi-network.org/2015/Portugal/Social_Policies.
- Silva, José Manuel (2015), “O necessário e resumido balanço de quatro anos de Ministério da Saúde. Olhar o passado a pensar no futuro”, *Revista da Ordem dos Médicos*, 162, 5-11.
- Silva, Luisa; Augusto, Amélia; Backstrom, Barbara; Alves, Fátima (2013) “Desigualdades sociais e saúde”, in Fátima Alves (ed.), *Saúde, medicina e sociedade: uma visão sociológica*. Lisboa: Pactor, 25-45.
- Simões, Jorge de Almeida; Augusto, Gonçalo Figueiredo; Fronteira, Inês; Hernández-Quevedo, Cristina (2017), “Portugal: Health System Review”, *Health Systems in Transition*, 19(2).
- Tribunal de Contas (2013), “Encargos do Estado com PPP na Saúde.”, *Relatório n.º 18/2013 – 2.ª Secção*, volume I. Lisboa: Tribunal de Contas. Accessed on 10.09.2018, at https://www.tcontas.pt/pt/actos/rel_auditoria/2013/2s/audit-dgpc-rel018-2013-2s.pdf.
- Tribunal de Contas (2015), “Auditoria à execução do contrato de gestão do Hospital de Loures”, *Relatório n.º 19/2015 – 2.ª Secção*, volume I. Lisboa: Tribunal de Contas. Accessed on 10.09.2018, at http://www.tcontas.pt/pt/actos/rel_auditoria/2015/2s/audit-dgpc-rel019-2015-2s.PDF.
- Tribunal de Contas (2016), “Auditoria à execução do contrato de gestão do Hospital de Braga em parceria público-privada (PPP)”, *Relatório n.º 24/2016 – 2.ª Secção*, volume I. Lisboa: Tribunal de Contas. Accessed on 10.09.2018, at https://www.tcontas.pt/pt/actos/rel_auditoria/2016/2s/rel024-2016-2s.pdf.

- União Europeia; Fundo Monetário Internacional; Banco Central Europeu (2011), “Memorando de entendimento sobre as condicionalidades de política económica”. Lisboa: Ministério das Finanças.
- Vogler, Sabine; Zimmermann, Nina; Leopold, Christine; Joncheere, Kees de (2011), “Pharmaceutical Policies in European Countries in Response to the Global Financial Crisis”, *Southern Med Review*, 4(2), 69-79.
- Wacquant, Loïc (2009), *Punishing the Poor: The Neoliberal Government of Social Insecurity*. Durham: Duke University Press.
- WHO – World Health Organization; República Portuguesa; European Observatory on Health Systems and Policies (2018), *Health System Review: Portugal. Phase 1 Final Report*. Accessed on 23.10.2018, at https://www.sns.gov.pt/wp-content/uploads/2018/04/PortugalReviewReport_Printers_03April2018-2.pdf.
- XXI Governo Constitucional (2015), *Programa do XXI Governo Constitucional 2015-2019*. Accessed on 07.11.2018, at <https://www.portugal.gov.pt/ficheiros-geral/programa-do-governo-pdf.aspx>.