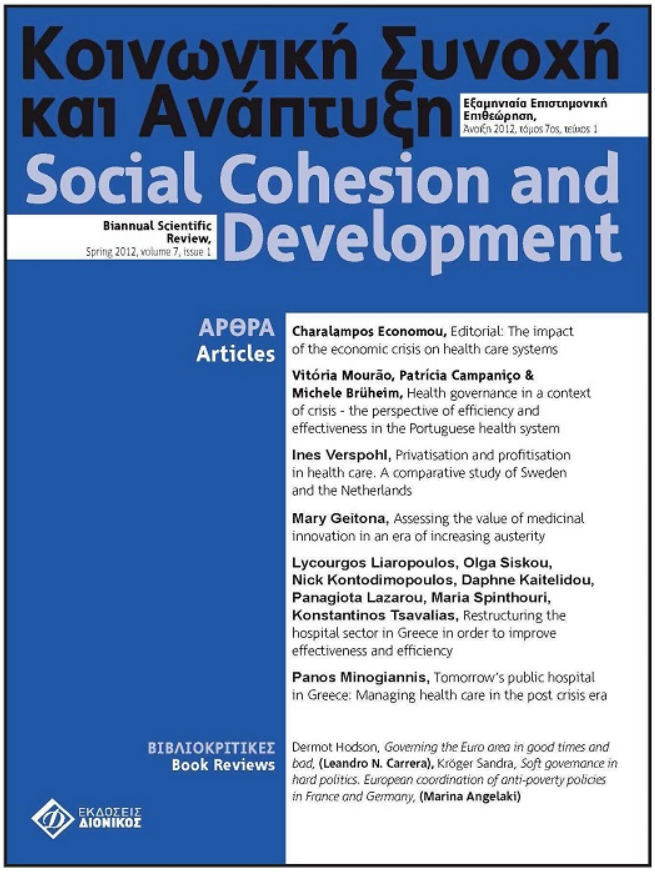
Social Cohesion and Development

Vol 7, No 1 (2012)



Health governance in a context of crisis - the perspective of efficiency and effectiveness in the Portuguese health system

Vitória Mourão, Patricia Campanico, Michele Bruheim

doi: 10.12681/scad.8986

To cite this article:

Mourão, V., Campanico, P., & Bruheim, M. (2016). Health governance in a context of crisis - the perspective of efficiency and effectiveness in the Portuguese health system. *Social Cohesion and Development*, *7*(1), 11–23. https://doi.org/10.12681/scad.8986

Κοινωνική Συνοχή και Ανάπτυξη 2012 7 (1), 11-23
Social Cohesion and Development 2012 7 (1), 11-23

Health governance in a context of crisis - the perspective of efficiency and effectiveness in the Portuguese health system

Vitória Mourão, Patrícia Campaniço & Michele Brüheim, *Technical University of Lisbon (UTL)*

Η διακυβέρνηση της υγείας στο πλαίσιο της κρίσης - η προοπτική της αποδοτικότητας και της αποτελεσματικότητας στο Πορτογαλικό σύστημα υγείας

Vitória Mourão, Patrícia Campaniço & Michele Brüheim, *Technical University of Lisbon (UTL)*

ABSTRACT

The financial and economic crisis from 2008 has a great impact in welfare states, notably in one of their fundamental pillars – health. In Portugal, the total spending on health reached 10.1% of GDP in 2008 and will increase in view of the current panorama. The objective of this study is to analyze the health policies and the Portuguese health system, in a context of economic, financial and social crisis, in the light of the speeches of policy-makers and experts about the processes of governance and contingency measures, considering dimensions of analysis efficiency and effectiveness. In the dimension of effectiveness, measures have been pointed out for protecting the most vulnerable, for the empowerment of citizens, for reduction of inequalities and for the protection and promotion of health. Finally, in the dimension of efficiency, there are important measures to cut off expenditure, of mobilization of financial resources, in the rationalization of resources and services and in professional and organizational development. In theoretical domains of risk and uncertainty, we see through the speeches of policy-makers and experts, that these are domains for the exercise of policies on critical governance processes, determined by identified sources of insecurity, processes of public debate and in terms of policy dispute.

KEY WORDS: Health system, crisis, governmentalization, risk, effectiveness, efficiency, Portugal

ΠΕΡΙΛΗΨΗ

Ο στόχος της παρούσας εργασίας είναι να αναλύσει τις πολιτικές για την υγεία και το σύστημα υγείας της Πορτογαλίας, στο πλαίσιο της οικονομικής, χρηματοπιστωτικής και κοινωνικής κρίσης, θέτοντας ως βάση τον λόγο των ίδιων των διαμορφωτών πολιτικής και των εμπειρογνωμόνων, σχετικά με τις μεθόδους διακυβέρνησης και τα μέτρα έκτακτης ανάγκης, λαμβάνοντας υπόψη ως διαστάσεις της ανάλυσης την αποδοτικότητα και την αποτελεσματικότητα. Ως προς τη διάσταση της αποτελεσματικότητας, επισημαίνονται μέτρα για την προστασία των πλέον ευάλωτων ομάδων, για την ενδυνάμωση των πολιτών, για τη μείωση των ανισοτήτων και για την προστασία και την προαγωγή της υγείας. Τέλος, στο πλαίσιο της διάστασης της αποδοτικότητας, επισημαίνονται σημαντικά μέτρα για την περικοπή των δαπανών, την κινητοποίηση των οικονομικών πόρων, τον εξορθολογισμό των πόρων και των υπηρεσιών και την επαγγελματική και οργανωτική ανάπτυξη. Αναφορικά με τις έννοιες του κινδύνου και της αβεβαιότητας, διαπιστώνεται, μέσα από τους λόγους των υπευθύνων χάραξης πολιτικής και των εμπειρογνωμόνων, ότι αυτοί είναι τομείς που συνδέονται με την άσκηση πολιτικών αναφορικά με κρίσιμες διαδικασίες διακυβέρνησης, που προσδιορίζονται από καθορισμένες πηγές ανασφάλειας, διαδικασίες δημόσιας συζήτησης και σε όρους πολιτικής διαφωνίας.

ΛΕΞΕΙΣ-ΚΛΕΙΔΙΑ: Σύστημα υγείας, κρίση, διακυβερνητισμός, κίνδυνος, αποτελεσματικότητα, αποδοτικότητα, Πορτογαλία

1. Introduction

One of the impacts of the worldwide and national financial and economic crisis that erupted in 2008 is the reduction of the social protection by the welfare state, mediated as a process of risk privatization, namely in one of its basic pillars - Health.

The Portuguese National Health Service (NHS), created in 1979, materializes the right of access to Health, described in the Portuguese Constitution as universal and tending to be free. Since then, Health services have developed bringing benefit for all citizens that access to it, however with some difficulty in corresponding to the critical challenges of its qualification.

The total expense with Health, in Portugal, was 10,1% of the GDP in 2009 and tends to increase with the aging population, increase of chronically ill people and medical technological innovation. In a crisis panorama, it is important to have a strategy of financing and improving administration and coordination of the NHS, developed in the optic of efficiency and effectiveness that assures the welfare of the citizens and in a context of GDP reduction, as in economic recession.

2. Economic, financial and social crisis: Impacts in health governance

The world is going through one of the major economic and financial crises since the Great Depression of 1930. The valuable growth of the world annual production decreased from 4%, in 2006-2007 to 1,6% in 2008 and to -2% in 2009 (United Nations, 2011).

Social impacts of the crisis are diverse: (i) reduction of families' purchasing power; (ii) growing unemployment rate with material and psychosocial consequences; (iii) and a limited ability from State to reply by the social protection nets (OPSS, 2011).

Europe, in particular, experiences a great economic contraction with devastating impact in people's lives. Labour flexibility and unemployment are the main consequences. Unemployment rate evolved from 7,1% in 2007, to 9,3% in 2010 (Ebner, 2010; United Nations, 2011). In Portugal, unemployment rate evolved from 8,9% in 2007 to 12,9% in 2011 and to 14,8% (Eurostat, 2012).

The Global Social Crisis. Report in the Social World Situation underlines social trends in the European Union in the context of global crisis: (i) social factor with a greater impact will be unemployment ; (ii) slow recovery of the crisis will increase long-term unemployment and cuts in social supports; (iii) cuts resulted from the weakness of social protection structures; (iv) devaluation of the housing sector will lie heavier in the financial affairs; (v) and the wellbeing of families will suffer with a reduction of the purchase power (European Commission, 2010).

With welfare state crisis and the development of different response strategies to this crisis in the main economies of the world, there is a reduction of the social protection supplied by the State, which becomes weak when confronted with the necessities and the normal indicators in the European social model. Reduction in the supply of some services by the welfare state disclosures the dismantling of the public social politics and the growing participation of the enterprise sector and the non-lucrative sector in the social rendering of services raising a functional trend and a strategy of reduction of costs on the part of states.

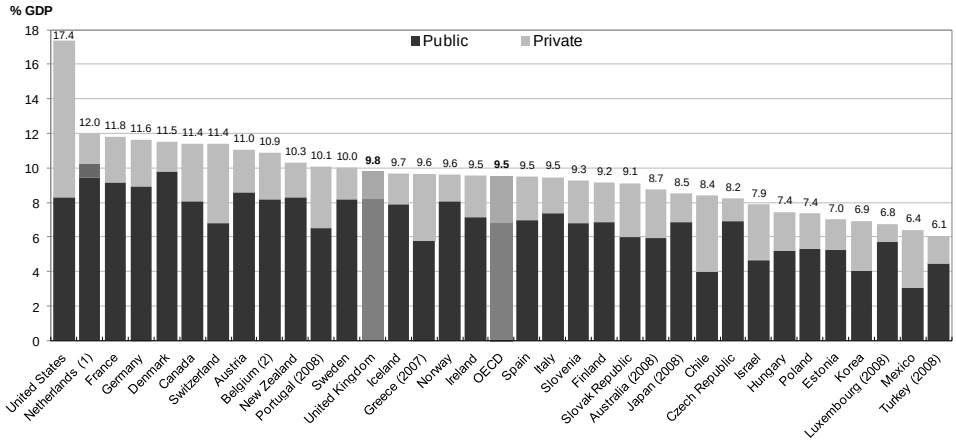
In the conjuncture of social changes caused by the crisis, the global concern with health stands out as one of the main pillars of the welfare system. To assure sustainability and equity, health systems are submitted to revaluation and readjustment to the crisis period.

With demographic aging and life expectancy growth, population health needs increase as well as responsibility of providing efficient health care for all. Reduction of funds to invest in health is an essential question imposing political measures that allow reduction of costs associated to the delivering of health cares without affecting quality.

Portuguese health expenditure rose, in the last decade, compared with the majority of the countries of the OECD, growing from 7,5% of the GDP in 1993 to 9,9% in 2006, (OECD, 2010). However, the pressure of current conjuncture has consequences in public expenses in health that tends to diminish, through cuts in the state budget invested. Public expenditure in Health decreased from 7,1% of the GDP in 2006 to 6,3% in 2009.

The total of Portuguese health expenditure reached 10.1% of the GDP in 2009, in Figure 1 (OECD, 2011), and will tend to increase due to the extension of health care, the growing weight of chronic diseases and technological innovation, along with the rise of average life expectancy and population aging. However, when analysing per capita expenditure, the country spends only EUR 1.700 while the average of the OECD is EUR 2.200 (OECD, 2011).

Figure 1: Health expenditure as a share of GDP - OECD countries, 2009 (source: OECD, 2011)



Since 1979, the Portuguese Health System is composed by the NHS, the voluntary and private health insurances, the health subsystems of health and by private health renders of the non-lucrative sector. The NHS is financed by taxes on incomes and less for the moderating fees in the moment of the health care delivery.

In 2012, payments in the act have raised from EUR 2.15 in a primary care appointment to EUR 5 an increase of 133% from 2007 to 2012, and EUR 9.2 in urgency hospital appointment to EUR 20 as a minimal charge that can go up to EUR 50 including complementary diagnostic methods, an increase of 117% and 443%.

The financing of the Portuguese National Health System, as previously referred, is a combination of public and private resources, as happens in the majority of the countries of the European Union. According to *OECD Health Data 2010* (2010), in 2006, 71.7% of total financing of the health expenditure, came from the State and remaining 28.3% resulted from co-payments and private health insurances, among others. In health sector, public expenditure is the more affected and the private sector has a complementary role.

Deloitte Report (2011) states the main problems in Portuguese health sector as being the financial unsustainability of the system, the lack of strategic planning and the elevated levels of inefficiency. The challenge in a time of crisis is making necessary structural reforms such as: (i) reorganization and regulation of health system regarding elimination of duplications; (ii) reorganization of care delivery in three essential questions: a biggest allocation of financial resources for prevention and primary care, accountability of health institutions managers and revision of their financing model; (iii) a good strategic planning based diagnosis of population health needs.

To answer the challenges and improve the performance of the Portuguese health system, World Health Organization (WHO, 2010) recommends: (i) promotion of health policies leading to healthy life styles, reduction of health inequalities and improvement of citizens health literacy; (ii) increase of the investment in Health, prioritizing primary care, public health and the efficiency of delivered services; (iii) assuring participation of citizens in health policy decisions, that should answer the needs and expectations of population; (iv) clarifying the role of private sector, providing this partner with legal and political framing; (v) a better articulation between public system and subsystems, where these will have a supplementary role; (vi) decentralization in health services delivery; (vii) reduction of economic barriers in the access to health, especially in case of populations with lesser incomes; (viii) develop of human resources strategies to correct the actual shortage in some geographical areas and of some specialists and clarify the role of health professionals and their organizations; (ix) and improvement of health governance quality, promoting investigation on the services and systems of health and evaluation of the impact of technological programs while assuring transparency and responsibility.

In a context of budgetary restriction and austerity as that of the European and national crisis, it becomes necessary to adopt strong measures, in the diverse related areas that contribute for effectiveness and sustenance of the NHS and for more efficient management of the existing resources.

The Memorandum of understanding on specific economic policy conditionality (European Union, 2011) approved by Portuguese government, sets a goal of reduction in health budget of 550ME, through measures of efficiency and effectiveness: (i) Review and increase overall NHS moderating fees; (ii) Cut substantially tax allowances for healthcare and health care subsystems; (iii) Pricing and reimbursement of pharmaceuticals; (iv) Monitoring of prescription; (v) Implement the existing legislation regulating pharmacies; (vi) Centralized purchasing and procurement; (vii) reinforcement of primary care services; (viii) Reduction of EUR 200 million in the operational costs of hospitals in 2012 ; (ix) Finalise the set-up of a system of patient electronic medical records.; (x) Reduce costs for patient transportation by one third.

3. Methodological and theoretical options

This study intends to analyse health policies and the Portuguese health system, in a context of economic, financial and social crisis, bearing in mind the speeches of policy-makers and experts about the processes of governance and contingency measures, considering as dimensions of analysis, efficiency and effectiveness.

Assuming a constructivist perspective of risk and governmentalization, it deals with the perspective of agents, which allows discussion of discursive and praxiological dimensions of risk (Marinker, 2006). The central theoretical approach of this study applied to health policies,

makes visible forms of governmentalization in health area, as well as various procedures used in construction of new political agendas.

The work of Foucault is in evidence among studies on the concept of governmentalization. The author defined governmentality through three key elements: (i) combination of institutions, practices and knowledge that exert a certain power on population by security mechanisms and economic policies; (ii) tendency for the prominence of state power; (iii) and governmentalization of administrative state, in combination with the effects of this governmentalization with the interactions of society, State and individuals. (Foucault, 2000). Rose, O'Malley and Valverde (2006), from the perspective of governmentality, refer that the command-control model of power is replaced by a more subtle form involving citizen's empowerment to act and power training and exercise through control technologies of the individuals.

Governmentality emphasizes a multiplicity of power relations and the diversity of their origin and effects. Governmentalization is the practice of governmentality. In health area, techniques of governance have been based on the existence of risks. (O'Malley, 2007). The discourse of key actors in health policies emerges possible ways of governance, being a form of power, according to the theory of governmentality.

The methodology of the study was based on two processes: (i) analysis of documents, official and statistical sources and bibliography searches on topics related with the subject; (ii) and analysis of discourse of involved actors in designing and implementing public health policies.

For empirical support, 20 in-depth interviews were applied between January and October 2011, to privileged actors in health area, chosen through a snowball sample, allowing the saturation of information and collect and analyse political plans and respondents proposals that could be the basis of health governance.

The types of actors interviewed were the following: (i) 6 policy-makers (Ministers, State Secretaries, congressmen and members of political parties, experts in the field of health; (ii) 14 scientific and technical experts (researchers and professors, hospital administrators, doctors, nurses, representatives of professional orders, consultants in the area of health quality).

Analysis of information obtained through interviews was made by analysis content procedure, through four distinct phases (Bardin, 2008), supported by the software MAXQDA: (i) full transcript of interviews; (ii) careful reading of interviews and identification of categories of analysis; (iii) construction of interviews synopses and of analysis of MAXQDA matrix; (iv) descriptive categorical analysis of interviews.

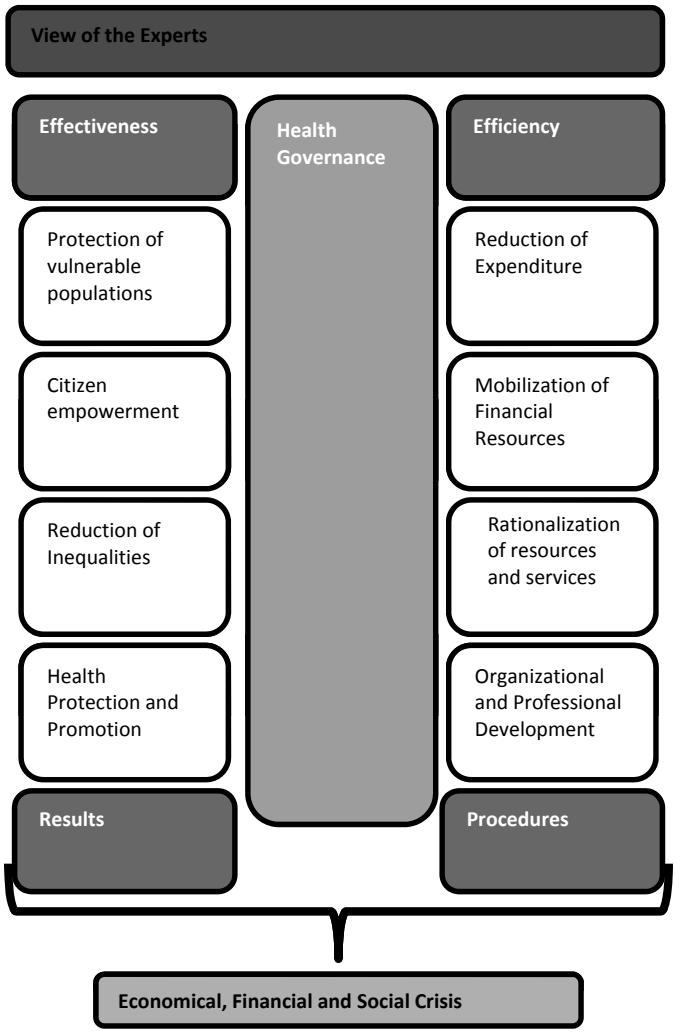
The present study analyses health policies through the discourse of interviewed actors, considering the dimensions of efficiency and effectiveness, in the definition of programs and measures for a better organization and coordination of health services.

These dimensions are essential for a good evaluation on the performance of organizations and programs. According to Bilhim (2008) measuring effectiveness and efficiency is an obligation created by the need to know if organization is actively seeking to achieve its objectives. Effectiveness can be defined as a normative measure of achievement of organization global results, while efficiency is considered a measure of the means, procedures and methods used which need to be planned and organized for the optimization of available resources.

Since this study is about governance measures implemented in the health system, the use of these dimensions allowed, through the speech of respondents, establishing of decision-making criteria that seal any shortcomings of orientation and system failures and direct investments and actions for the pursuit of the NHS objectives.

Figure 2 presents the analysis model, putting in each dimension the corresponding categories.

Figure 2: Model analysis based on the criteria of efficiency and effectiveness in health governance



In the dimension of effectiveness were established the following categories: (i) protection to the most vulnerable (regards access to healthcare, protection and prevention actions and promoting specific health actions); (ii) citizens empowerment (literacy promotion and active participation and informed choice of citizens) (iii) inequality reduction (access and financing of health care); (iv) protection and promotion of health (public health strategies and plans).

Finally, in the dimension of efficiency, the categories were: (i) reduction of expenditure; (ii) mobilization of financial resources (mobilization through taxes, co-payments or supplementary

insurance); (iii) rationalization of resources and services (fighting inefficiency in supply, demand and use of services); and (iv) professional and organizational development (human resources management, professional satisfaction and clinical governance).

4. A look of the experts on the national health system: Measures of governance

The analysis of dimensions of effectiveness and efficiency on measures proposed by the interviewees in the quest for good health governance and activation and modification of existing policies induced by risk in the current panorama, allows to evaluate decision-making criteria that point to the control of conditions and desired results, for structuring of the objectives and for deficiencies resolution in health system in this context of crisis, from the perspective of the actors.

In short, starting from readings and analysis of in-depth interviews conducted, answers it were searched to optimize expenses and investments in health and to increase effectiveness of the NHS, in an environment of economic, financial and social crisis, where the sustainability of protective systems, in particular the health system, is a point of weakness of governance in Portugal.

4.1 Effectiveness – promotion of equity and universality of health care

As already stated above, in the dimension of effectiveness the following categories were established: (i) protection of the most vulnerable; (ii) reducing inequalities (iii) empowerment of citizens; and (iv) health protection and promotion.

In the category "protecting the most vulnerable", respondents pointed out a set of measures which enable a better financial protection and facilitate access to general and specific health care.

Choices made in terms of public and private for profit and non-profit funding, can determine the level of degree of health care coverage. Respondents pointed out a moment of medium/long term uncertainty about the nature of needs of the most vulnerable citizens, and therefore better financial management will keep the public funding of access. Guarantee of access to health care for all citizens, no matter their age or socio economic statute, must be a priority in the health system, being this a basic right, that State should assure in a tending to be free system (Int1; Int6; Int8; Int12).

Investment in primary health care and in proximity care is another measure widely defended (Int2, Int3, Int5, Int15 and Int17) that allows a better management and mediation of health process for users. The vision centred in the hospital will have to be substituted by one more centred in primary health care, strengthening the relation of the user with the family health unit and his family doctor, leaving for the hospital more acute cases and preventing the surcharge of services with less urgent cases.

In this sense, interviewees underlined importance of the central role of general practitioners, as privileged informers, on methods of tracing, risk behaviours and healthy life choices. Investment in prevention, promotion and education for health, assumed by several professionals and organizations must be strengthened (Int4, Int.5, Int6, Int7, Int9, Int13).

Non-lucrative sector has an important role in the intervention among populations in bigger risk of exclusion to health access (Int11, Int13, Int16, Int17, Int18, Int19).

Another access related aspect referred by the interviewees is the management of waiting lists for consultations and surgeries. The following measures were suggested for the reduction of

waiting time within the stated periods foreseen in the law: (i) spreading of the Letter of Rights of Access of the NHS users; (ii) publishing of maximum stated periods for consultations and surgeries; (iii) diagnostic, following and evaluation of waiting lists; (iv) redefinition of health professionals role; (v) better planning and management of human and material resources; and (vi) reinforcement of primary cares (Int1, Int3, Int4, Int5, Int8, Int9).

In the category "reduction of inequalities", the access and financing to health care and information and actions on inequalities in health are discussed. In this scope, beyond some measures analysed in previous dimension, interviewee referred the need of revision of co-payment of medication according with needs of chronically ill, with population incomes and with strategies of national health plan, promoting the equity of access to therapeutic (Int2).

The category "Empowerment of the citizens", relates to active citizenship, information and literacy in health and to participation of the citizen as subscriber of the health contract, is constant in the answers of the interviewees, given its preponderant role in persecution of health system goals.

As the main subscriber of social contract, citizens emerge in the interviews as a central element in the planning and implementation of health public politics that must have in account the needs and public discussion of health budget. Int20 referred as a diagnostic methodology and information focus groups to listen to all sectors of population about evaluation of health services and proposals for improvements in the sector.

Citizens must be conscious of their rights and duties, of their contributions and expenses in the NHS, moderating the consumption and adapting their expectations to possibilities of the State, for the full exercise of a responsible and informed citizenship. (Int3, Int10, Int12, Int13, Int17, Int18, Int20). The role of citizen in management of health care process must be active, contributing for a culture of commitment, evaluation and accountability. (Int8, Int14, Int15, Int18).

Through interviews analysis, it became clear the relation between information and health literacy and an informed choice in the individual process of health with a bigger conscience of belonging to social contract (Int1, Int2, Int5, Int7, Int9, Int14). Debate on literacy concludes on the need to invest in health education and information and in a platform of information on behaviours and lifestyles and use of communication technologies, promoting an active evolvement of citizens.

In the perspective of "health promotion and protection", referring to public health, to the management of risks and to the cooperation between the health sector and other sectors, interviewees stated the need to bet in prevention and in tracing of illnesses, as main focus of the questions of public health (Int2, Int7, Int9).

The effective action in identifying territories of bigger fragility and in developing adequate programs to complexity of human being implies a good articulation between municipalities and ministries, such as the Ministry of Health and the Ministry of Solidarity and of Social Affairs, as well as the participation of the civil society associations (Int5, Int11, Int13, Int18, Int19).

4.2 Efficiency - Strategies, procedures and methods for the optimization of the National Health Service

Concerning the dimension of efficiency, the considered categories are: (i) reduction of public expense; (ii) mobilization of financial resources (iii) rationalization of resources and services; and (iv) organizational and professional development.

The category of "reduction of public expense" relates to a set of actions, pointed by interviewee, aiming control and containment of expenditure growth in health sector, in areas as medication and acquisition of goods and services for Ministry of Health.

The central question of public expense in health is defined as the mechanism of decision on the budget ratio of a certain state to be spent in health. The need to rethink and to promote a public debate on the health budget is then a key point that must consider not only the economic growth but also the welfare of citizens. (Int1, Int8).

The current expense in health is 10.1% of the GDP in 2009. However the Portuguese GDP is relatively low when compared with other countries and this expenditure tends to be effectively less, although occupying a bigger percentage. In this sense, interviewees advised to increase GDP, thus improving the percentage allocated to Health (Int10, Int11).

Aiming the reduction of the expenditure, Int10 defends less fiscal deductions of the health expenditures. Interviewees also remark the reduction of expenditure with medication, privileging the following measures: (i) preference for the generics use (Int2, Int6, Int7, Int9, Int11, Int17 and Int19) and setting of its price in a maximum of 60% of the price of original medication (Int18) (ii) importation of medication with reduced prices (Int5 and Int13) or (iii) centralization of purchases (Int2, Int5, Int6, Int12) and (iv) organization of public contracts for acquisitions (Int3, Int8, Int12, Int17); (v) instauration of guidelines for prescriptions, examinations and procedures (Int3, Int12, Int14, Int17); (vi) electronic prescription followed by the quality control (Int18); and (vii) prescription of medications by amounts and individual doses (Int9, Int17).

The resource to finance the access to quality health services is mobilized through taxes, co-payments and supplemental insurances. The continuity of the investment in health, in crisis times is emphasized by Int7, with the objective of guarantying to the population one of its basic and universal rights. The NHS financing must be assured by governmental budget, where the moderating taxes have only a symbolic role (Int6, Int10). The mobilization through taxes must have in account a bigger social justice as for example raised taxes for the bigger economic and financial groups (Int5, Int8, Int10) and the mobilization through co-payments, pointed by Int10 and Int19 that consider the ADSE reintegration (public subsystem) in the NHS.

Interviewees pointed a need for a better rationalization and efficiency of health resources on supply, demand and use of resources and health services. Strategic orientation for the gradual equilibrium of relative accounts in health, recommended by Int8, that must have in account the elimination of harmful management and frauds, among other topics. In the same view, Int1, 5, 9, 12, 16 and 17 enhance need of a better strategic planning for health and of a rigorous middle and top management that does not compromise the quality and the efficiency of the services.

The offer of consultations, mainly of specialties, will have to be moderate because it increases the unnecessary demand (Int10 and Int11), being preferential the investment in primary care (Int18). Another measure for elimination of inefficiencies and wastefulness is to diminish useless prescription and the duplication of medications and exams (Int1, Int3, Int6, Int8, Int10, Int14, Int16, Int20). With this goal the improvement of information management and the informatization of health processes (Int2, Int3, Int14, Int15) and elaboration of a list of equipment and resources (Int2) allow the prevention of duplicate efforts and resources and a bigger control of supply and demand of services. Finally, evaluation processes and the following of cost practical efficiency for the technologies, politics and of management in the health sector (Int5, Int8).

The last category is "organizational and professional development" that includes the components of development of new instruments of management and clinical and organizational governance.

Effective middle and top governance in the health units is one of the questions more emphasized by interviewees. A governance independent of political interests, articulated with the activities of some organisms, public and private, as well as recruitment according with professional

profiles and skills, and nominations for positions by merit (Int3, Int4, Int6, Int9, Int12, Int20). Another objective is a good monitoring to guarantee the systematic evaluation of contratualization results (Int8), attributing responsibilities to hospital managers and their teams for the results of services they represent (Int14, Int16, Int20).

Management of human resources must have a strategy of optimization of existing resources, solving the scarcity of doctors and nurses in some geographic zones and specialties (Int4, Int7, Int11, Int12, Int15, Int16, Int17). It has also been referred the redefinition of health professional profiles, as for example, attributing more functions to nurses and specialized technicians (Int3, Int5, Int7, Int10 and Int13). Human resources planning imply the regulation of the professional abilities to basic and continued training (Int4, Int5 and Int7).

5. Risk and uncertainty in discourses of social actors as space of policies exercise in health

Over the years, Portuguese health system has undergone several reforms to improve and to monitor the needs of the population. Recently, there have been strict measures and expenditure retrenchment policies imposed by budget constraints with the aim of reducing the expense and system inefficiencies.

The impact of the crisis worsens or decreases with ability of governments to deal with and neutralize the effects of crisis. This ability depends on efficiency and strength of macroeconomic policy mechanisms of social protection systems, on legal frameworks and on the structures of governance and political stability (United Nations, 2011) to cope with social implications adjacent to the crisis.

The current and future challenge of Portuguese government is to find a balance between needs of providing quality health care to citizens and the increasing demand for health care, aging population and technological development that financially pressure the Portuguese health system (Paulo, 2010).

Public expenditure on health in Portugal has been increasing, which implies reforms geared towards the better use of resources and effectiveness of the system. This panorama of social risk and health issues emerge as a social arena and a field of study, where different constellations of power, management technologies and theoretical perspectives confronts, representing alternative visions of the world from different subjects and political agents (Sakellarides, 2006). Initially, policies arise from new scientific discoveries, epidemiological and demographic trends, needs, perceptions of risk threats, public dissatisfaction regarding the campaigns of specific interest groups, political parties and media agendas (Marques & Torgal, 2002). For the implementation of policies and measures, there must be a media discussion of the theme, which can occur when more international, national or local level (Marinker, 2006).

In this same theoretical reading, domains of risk and uncertainty become spaces for the exercise of policies determined by the identification of sources of insecurity and consequent areas of human interaction, in particular through the emergence of processes of debate and political contestation in relation to that same identification (Huysmans, 2006).

In the speech of the interviewees, their conceptions of risk and uncertainty are evident in the context of proposals for intervention in the sector, reflected in the objectives and needs of health and their own media, public and political agendas. This framework of crisis is also verified in the

international context of its proposals, which fit in forward-looking measures of other international actors engaged in analysis of health system performance, such as WHO, OECD, United Nations and also in the European Council Implementing Decision, providing policy makers and various social authors a set of recommendations aimed to improve health system performance.

The debate on need for improving effectiveness and efficiency of the healthcare system in Portugal is verified in the speeches of respondents, who suggest new forms of governance in this panorama of crisis and risk and with the goals they intend to achieve in health, through concrete actions that incorporate a tactical and strategic vision and with impact in the short and long term on health sector. Dominant discourse on health expresses the challenges and costs of change, in a risk context in which it arises as a scenario that validates certain governmental practices, namely the reduction of expenditure and the decrease of social protection in health by the State.

6. Final considerations

Briefly, this study allows to understand how contingencies of crisis situation and the risks that it entails, triggering the need for decisions and attempts to transform the unpredictable consequences of civil decisions into predictable and controllable and lead to the introduction of additional mechanisms of cost containment that have direct implications on the allocation of resources to health sector.

Situation of contingency – crisis - in Portugal enforces actions and decisions aiming a greater effectiveness and efficiency of the NHS that ensures the wellbeing of citizens, without forgetting the need for country's economic growth.

Effectiveness of the system or fulfilment of the goal of universality of access implies the protection of the most vulnerable and the reduction of inequalities in access, in particular through the maintenance of public funding of the NHS, through State budget.

Investment in primary care and proximity care, with strengthening of the role of the family doctor and the biggest concern with the prevention, health promotion and health education, supporting the efforts of the non-profit sector with vulnerable populations is important. To solve the problem of waiting lists for consultations and surgery is proposed the publication of the rights of users and the wait timeouts, redefinition of professional profiles and better planning of human and material resources in addition to the already mentioned strengthening of primary care.

Citizen empowerment implies the strengthening of existing social contract and to involve citizens, well informed, on their choices and in the management of their own health process, adapting their expectations to the possibilities of state, with the support of information and communication technologies.

To promote the efficiency of NHS, the categories relate to a better utilization and mobilization of human and material resources and with the professional and organizational development. Mobilization of resources through taxation must be maintained, however as a measure of greater social justice, higher taxes for large economic and financial groups are pointed out. The public debate in the percentage of tax spending on health would also be important.

With a view to possible reduction of health spending, medicine policy is one of the priorities. The decrease of costs allocated to inefficiencies and waste also involves better information management policies and negotiations with suppliers of the Ministry of Health, centralized, with longer term and involving public contracts.

Better use of human resources can be done through measures such as adequacy of professional skills to basic and continuous training, redefinition of health professionals roles and appointment of senior management and administration according with principles of competence and professional profiles.

In conclusion, the debate on improving the effectiveness and efficiency of healthcare system in Portugal generates new forms of governance that take into account how the problems are thought, what solutions are idealized, what are the objectives to achieve and how, through which concrete actions that incorporate a tactical and strategic vision. The dominant discourse on health expresses the challenges and costs of change, in a context where risk arises as a social construction that legitimizes certain government practices.

Bibliographical references

Bardin L., (2008), *Análise de Conteúdo,* Lisboa: Edições 70.

Bilhim J.A.F., (2008), *Teoria Organizacional. Estruturas e Pessoas*, Lisboa: ISCSP.

Deloitte, (2011), *Saúde em Análise: uma visão para o futuro*, Lisboa: Deloitte.

Ebner Y., (2010), *The impact of Economic Crisis on Health inequalities*. An AER Background paper for AER Conference on health inequalities, October 2010: Assemblée des Regions d'Europe.

European Commission, (2010), *The Social Situation in the European Union 2009*. Eurostat, Luxemburg: European Union.

Foucault M., (2000), *Microfísica do Poder*, Rio de Janeiro: Graal.

Huysmans J., (2006), *The Politics of Insecurity. Fear, Migration and Asylum in the EU,* UK: Routledge.

Marinker M., (2006), "Health Policy and the constructive conversionalist", in: Marinker M. (ed.), *Constructive Conversations on Health. Policy and Values*, London: Radcliff.

Marques F. & Torgal J., (2002), "Contributo para a Definição de uma estratégia da cooperação portuguesa para o desenvolvimento no sector da saúde", in: *Revista Portuguesa de Saúde Pública*, 20(1): 21-26.

O'Malley P., (2008), "Governmentality and risk", in: Zinn Jens (ed.), (2008 a), *Social theories of risk and uncertainty – an introduction*, Oxford: Blackwell Publishing: 52-75.

OECD, (2009), *Health at a Glance OECD Indicators*, Paris: OECD.

OECD, (2010), *OECD Health Data 2010: Statistics and Indicators,* Paris: OECD.

OPSS, (2011), *Relatório de Primavera 2011. Da depressão à crise: Para a governação prospectiva da saúde,* Lisboa: Observatório Português dos Sistemas de Saúde.

Paulo A., (2010), SNS: Caracterização e Desafios, Artigo 09/2010. Lisboa: GPEARI-Ministério das Finanças e da Administração Pública: January 2012,

www.gpeari.min-financas.pt/analise-economica/publicacoes/ficheiros-do-bmep/dezembro-de-2010/artigos/artigo-9-sns-caracterizacao-e-desafios.

Rose N., O'Malley P. & Valverde M., (2006), "Governmentality", in: *Annual Review of Law and Social Sciences*, 2, 83-104.

United Nations, (2011), *The Global Social Crisis. Report in the World Social Situation,* Department of Economic and Social Affairs. New York: United Nations.

WHO, (2010), *Portugal Health System Performance Assessment,* Genebra: WHO.

Websites

Eurostat, (2012), Unemployment rate, annual average, by sex and age groups (%) *http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=une_rt_a&lang=en (13/03/2012)*.

European Union, (2011), Memorandum of understanding on specific economic policy conditionality *http://aventadores.files.wordpress.com/2011/05/2011-05-18-mou-portugal_en.pdf (13/03/2012)*.