

Decentralization and privatization in Portuguese health reforms

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The Portuguese National Health Service (SNS), a universal, centralized and public owned health care system, exhibits an extraordinary record of equalization in the access to health care and health gains in the late thirty years. However, the most recent history of the Portuguese health reform is pervaded by the influence of decentralization and privatization. Decentralization has been present in the system design since the 1976 Constitution, at least in theory. Private ownership of health care suppliers and out-of-pocket expenditures, on the financing side, both have a long tradition of relevance in the NHS mix of services. The initial aim of this study was to demonstrate expected parallelism between health reforms and public administration reforms, where a common pattern of joint decentralization and privatization was observed in many countries. Observers would be tempted to consider these two movements as common signs of new public management (NPM) developments. They have common objectives, are established around the core concepts of gains in effectiveness, efficiency, equity and quality of public services, through improved accountability. However, in practice, in Portugal, each movement was developed in a totally separated way. Besides those rooted in the NPM theory, there are few visible signs of association between decentralization and pri-

vatization. Decentralization, in the Portuguese SNS, was never intended to be followed by a privatization movement; it was seen merely as a public administration tool. Private management of health services, as stated in the most recent SNS legislation, was never intended to have decentralization as a condition or as a consequence. Paradoxically, in the Portuguese context, it has led invariably to centralized control. While presented as separate instruments for a common purpose, the association between decentralization and privatization still lacks a convincing demonstration. Many common health care management stereotypes remain to be checked out if we want to look for eventual associations between these two organizational tools.

Introduction

The Portuguese National Health Service (SNS), a universal, centralized and public owned health care system, exhibits an extraordinary record of equalization in the access to health care and health gains in the late thirty years (Campos and Ramos, 2004). However, the most recent history of the Portuguese health reform is pervaded by the influence of decentralization and privatization. Decentralization has been present in the system design since the 1976 Constitution, at least in theory (Portugal, 1990). Private ownership of health care suppliers and out-of-pocket expenditures, on the financing side, both have a long tradition of relevance in the NHS mix of services (Ramos *et al.*, 1987).



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Decentralization has a record, in Portugal, of a never implemented model: the 1976 Constitution imposed an «administrative» regionalization; the 8th November 1998 referendum rejected it and several laws recommended at least a reinforcement of municipal functions (Decreto-Lei n.º 558/99). Moreover, the Portuguese public administration tried, at different moments and through diverse models, to de-concentrate central state functions to regionally based units of public administration in different sectors, such as agriculture, education, environment, urban planning and obviously health. Being activated by different motivations and using diverse geographical and population basis, hardly can we consider de-concentration as a useful substitute of regionalization (Portugal. Ministério do Planeamento, do Equipamento e da Administração do Território, 1997).

On the other side, the growing signs of state inefficiencies in the management of health care services, and more recently, the losses in equity of access due to shortage of supply to respond to a growing demand (Pereira *et al.*, 1993), recommended for the adoption of new public management (NPM) instruments (Osborne and Gaebler, 1992), within the health sector, increasing accountability¹ in the public sector and substituting hierarchy by contracts or quasi-contracts in the relations between public services (Araújo, 2000). The most common examples were: the corporatization of public hospitals, either under the format of autonomous public institutions (*hospitais SPA*)², or as private hospitals under public property (*hospitais SA*); the enlargement of contracting-out arrangements; management contracts of public hospitals with private groups; and public-private partnerships (*PPP*) for the construction, financing and operation of public hospitals, among others (Campos, 2003).

This study is intended to look at the separate trajectory of decentralization and privatization in the Por-

tuguese health care system. While presented as separate instruments for a common purpose, the association between decentralization and privatization still lacks a convincing demonstration. Many common health care management stereotypes remain to be checked out if we want to look for eventual associations between these two organization instruments.

Constitution and law

Decentralization

Decentralization in general, and in the health sector as well, is a common organizational reform that shifts decision-making control and often revenue rights and responsibilities from central to lower-level government agencies (Harding and Preker, 2001). Since 1976, the Portuguese Constitution established a system of administrative regionalization as an objective of the state organization. Azores and Madeira islands, due to their geographical isolation, accessed to the condition of autonomous regions since the late 70's. In historical terms, in continental Portugal, decentralization was neither a prevalent, nor a popular orientation in a country whose united geographical regions and external frontiers date from the thirteen century. The access to European Union (EU), in 1986, implied a partial administrative reform in order to comply with the subsidiarity model prevalent in the EU doctrine (Bafoil and Hibou, 2003). Many EU supported projects in many sectors, including health, are expected to be implemented on a regional basis. This constraint became critical in the present 2000-2006 EU framework program with the explicit objective of phasing-out EU subventions to the Lisbon and Tagus Valley Region, under the assumption that, in the internal benchmarking, no further external support was needed to this region. A previous attempt to approve a regional roadmap for the mid level administration in the mainland, formatting Portugal according to the EU politically correct model of regional administration, failed totally in the November 1998 referendum. However, a partial compliance was reached: the National Health Service (SNS) was commissioned since the early 90's, to follow the health specific constitutional recommendation for its own management structure to be set up in a «decentralized and participative way» (Portugal, 1990. 148). The 1990 health system reform (assuming the concept of «system» larger than the NHS one, including the private and the not-for-profit sectors) proclaimed a regionalized structure for the NHS (Lei n.º 48/90). More detailed legislation was passed three years later, reducing 18 district health administrations

¹ According to Christopher Hood, the new public management (NPM) involves a different concept of public accountability, with different patterns of trust and distrust and then a different style of accountitization, reversing the two cardinal doctrines of progressive public administration (PPA); that is lessening or removing differences between the public and the private sector and shifting the emphasis from process accountability towards results. Accounting, in this new conception of accountability, reflects high trust in the market and private business methods and low trust in public servants and professionals, whose activity needs to be more closely costed and evaluated by accounting techniques (Hood, 1995).

² The first step to increase hospital autonomy, transforming autonomous public institutions in public enterprises (*hospitais EPE*), was enable by the general legislation issued in 1999 (Portugal, 1999b) and recommended to be used in the health sector in 2002 (Resolução do Conselho de Ministros n.º 41/2002).

(ADSS) into 5 regional health administrations (ARS) (Decreto-Lei n.º 11/93).

Eleven years passed, results are gloomy: the SNS was, in fact, decentralized to five health regions, whose management teams are appointed by the minister of Health; however, all public hospitals and health centers still belong to the central administration, its financial resources coming dominantly from the state budget; staff allocation, investment decisions, technical orientation and organizational rules are centrally decided. Bafoil and Hibou (2003), commenting on the overall Portuguese decentralization process, calls this a false decentralization: due to the complexity of financial circuits to manage EU programs, the weak capacity of the regional organization, the historical leverage of central institutions, the new structure ends up reinforcing central level administrations.

Central command does not forcefully imply effective authority. Frequently the central capacity is more apparent than real. It became frequently weakened by the share of power at central level. Stakeholders and pressure groups are centrally organized: unions, doctors', nurses' and paramedical associations, private pharmacists, the pharmaceutical industry, the private health insurance companies, the civil servants' subsystem, the recently created health business groups, all of them are firmly established at central level, in order to exert pressure over the central government, a highly vulnerable health department (Campos, 2002b).

Privatization

The Portuguese health system has a strong historic component of «in-born» privatization, since its universality dates from the early 70's. «Acquired» or modern privatization came in the late nineties, as the state recognized growing inefficiency losses in the management of health services and assumed that corporatization, as well as private management of public hospitals and health centers, could be an useful tool to gain technical efficiency as a first objective, expected to be followed by allocative efficiency, later on.

During the pre-revolution authoritarian regime, all district hospitals belong to charities, even if they relied heavily (95%) on the state and municipal budgets, or on social security payments for services. Medical ambulatory services were provided by social security posts operated by salaried doctors and nurses. Diagnostic image tests, including those pushed by new medical technology, tended to be privately provided on a conventional fix-price basis.

Pharmacies have been private since ever. Public ownership was limited to central and specialized hospitals, and to dispensaries and sanatoria for social diseases. The then created (1971) primary health care centers (PHC centers), oriented to disease prevention, health promotion and mother and child care were all public owned. After the revolution, charity hospitals became public, social security posts were integrated in health centers for both individual and collective health care delivery, the state became the single financial public source for health care and all providers were granted civil servant status. Due to shortage of human resources and low salaries, doctors and nurses were allowed to complementary private practice. In short, in provision grounds, the system became dominantly public and heavily centralized. However, a non negligible private sector stayed untouched: psychiatric charity hospitals, private clinics, polyclinics and surgeries, diagnostic labs and treatment facilities operated by doctors, nurses and technicians in their tolerated private practice, as well as community based pharmacies (Campos *et al.*, 1987). This relatively strong private sector provision has been currently financed, 67% by out-of-pocket expenditures and 33% by public funds, accounting for 54% of the total health care provision (Portugal. INA, 1999).

More recently, in the mid 90' an important discussion on the reintroduction of competition in the health sector also attained Portugal. It started with the split between purchaser and provider, recommending the separation between the regulatory role, and the financing one, from one side and the provision of services, from the other side. The creation of an internal market within publicly owned services was clearly postulated by many authors (Campos, 1994; Portugal. Ministério da Saúde, 1995; Portugal. CRES, 1997), together with recommendations for the increasing outsourcing of services in health care institutions. By the end of 1995, the management of a large public hospital in the outskirts of Lisbon was contracted out, under a public bid, to a private firm. Later on, in 2002, public hospitals and health centers were transformed into autonomous public institutions or private firms publicly own, an advanced form of «corporatization». The design, building, finance and operating of new public facilities, by private entrepreneurs, known as public-private partnerships (PPP), seen as a reasonable way of spreading or avoiding the risk of new and inefficient investments, was allowed by law, in 2003 (Decreto-Lei n.º 309/2003). Finally, the selling out of public assets of hospitals and clinics to private operators (privatization) is also under consideration. As argued by Bafoil and Hibou (2003), these phenomena of delegation or

state privatization can not be seen as a way of balancing excessive centralization. By the contrary, it represents a peculiar way of using hybrid institutions, either public or private, either centrally dependent or with larger autonomy, to recover efficiency. The effect of reinforcing state control over the public administration shall be seen as a byproduct.

The public-private financing mix

Since the revolution, the mix of health care financing became increasingly public, fluctuating between a weaker and a stronger public contribution, according to the political and ideological characteristics of each government majority (*Table I*).

Left or center-left governments tend to deter privatization and to shift the trend to a larger public funding. Right or center-right governments tend to do the reverse. The most visible effect was noticed during Cavaco Silva long consulate (1985-1995), where a

clear regression from 66% to 61% of public financing was observed. By the contrary, during the six years of António Guterres government, the public share in total health spending went up from 61% to 71% (OECD, 2002).

State failures on health

The stronger the importance of public funding, the higher became the visibility of state or bureaucratic failures in the health care sector (Portugal. Ministério da Saúde, 1995). Several major state failure risks can be identified in the Portuguese health sector (*Table II*).

Inefficiencies in plant

New hospitals and new health centers tend to be larger and bigger than the dimension planned according to needs. Incentives to have a larger than needed

Table I
Public-private financing mix according to political majorities

Period	Political orientation	Year	Health in GDP (%)	% private	% public
1974-1980	Left	1975	5.6	43.1	58.9
1980-1983	Center-right	1982	5.8	37.7	62.3
1983-1985	Center	1985	6.2	33.9	66.1
1985-1995	Center-right	1995	8.3	38.6	61.4
1995-2002	Center-left	2000	8.2	29.3	70.7
2002-...	Right	2002	8.6	29.1	70.9

OECD, Health Data, 2002.

Table II
State failures in health

State failures risk	Hospitals	Health centers	Pharmaceuticals	Diagnostic tests
Inefficiencies in plant	High	High	n. a.	Low
Low staff productivity	High	High	n. a.	Low
Soft budgeting	High	High	High	High
Technological gap	Medium	High	Low	None
Quality gap	Low	Medium	Low	High
Accessibility gap	Medium	High	Low	Low
Fraud and corruption	Low	Low	Medium	High

n. a.: not applicable.

plant are a common motivation for many stakeholders: hospital and health center staff, architects, engineers, building and equipment firms, unions, local politicians. They all agree on building a facility bigger than needed, since the sole financial responsible for the investment will be the central health department, lacking risk transfer mechanisms (Portugal. CESO, 1997).

Low staff productivity

Doctors, nurses, paramedical and clerical staff working in hospitals and health centers all of them are civil servants. When attempts have been made to apply private sector methods of recruitment and compensation policies, to public hospital systems, civil service constraints tend to block or undermined them. A critical barrier to apply these principles in the public sector is the lack of control that public sector managers have over production factors (Harding and Preker, 2001). Performance related payments seldom apply to this labor force. Job stability, low flexibility, unclear hierarchical links, no stated objectives and targets to perform and reduced accountability to patients or local administrators are common characteristics of their practice. Moreover, doctors working in a 35 hours per week schedule are allowed to perform their own practice outside the hospitals, often generating interests conflicting with their public duties (OECD, 1998).

Soft budgeting

Cost-control insensitivity is a common feature in health services, such as hospitals, where a combination of demand pressure and meager initial budgets generates a gap in budget responsibility. Due to the long process of capital investment decisions, hospital managers tend to rely on current budgets and deficits to finance refurbishments and to purchase new equipment. As a consequence, the hospital budget sores. An implicit acceptance of these practices by the Department of Health destroys any attempt to improve financial accountability. The fact that budget managers stay in the center and usually ignore the hospital idiosyncrasy made this practice a routine in public hospitals (Campos and Ramos, 2004). Primary health care managers feel low pressure to over-draft their budgets, except on pharmaceuticals and diagnostic tests and treatments, where provider induced demand hardly feels any restriction through administrative decisions. Moreover, these budget items are not locally managed, information being

collected at regional level and price and spending decisions made at central level.

Technological gap

This gap applies to health centers, not to public hospitals. Due to the historical separation between hospitals and specialized care, health centers were forced to rely mostly on private providers to perform lab and imaging tests, examinations and ambulatory treatments. This technological gap offered a clear incentive to the private sector to enter an open and unrestricted market, where prices were conventional, not market based. For example, 63% of digital angiography capacity is in the hands of private clinics. For computerized tomography, lithotriptors and MRI the percentages are even higher, respectively 69, 75 and 86 per cent (Portugal. CESO, 1997; Pereira *et al.*, 1993).

Quality gap

Quality is considered to be higher in public, than in private hospitals, though patients tend to perceive private sector amenities as a signal of quality, what is not necessarily true. Pharmaceutical prescriptions, distribution and consumption grades usually high in safety and quality, due to a traditionally good regulation by the central pharmaceutical agency. The same does not apply to contracted-out services such as laboratorial, imaging, physiotherapy, where quality problems rose in the recent past, due to the absence of control mechanisms, in a sector where provider induced demand tends to be common among health care providers.

Accessibility gap

Hospitals and health centers have been experiencing growing accessibility problems. In spite of their ever increasing performance, improved and newly generated demand, better patient information and modern technology, hospitals tend to keep crowded waiting lists for specialized outpatient consultations and elective surgery (Alves *et al.*, 1996; OPSS, 2003). Failures in accessibility in PHC centers reorient many patients to hospital emergency rooms, without needing specialized care. This is basically explained by the lack of physicians and nurses working in family practice and by the depletion of diagnostic technology in health centers, an option adopted since their inception, to avoid a sec-

ond rate specialized care in ambulatory settings. Accessibility to pharmaceuticals is usually high, even in excess, since every doctor working either in a hospital and health center, or in its own private practice, is entitled to prescribe drugs to be publicly reimbursed (OECD, 1998). The access to private diagnostic and treatment is relatively fair, also, since the whole country is already covered by a complex network of private services.

Fraud and corruption

Conditions for fraud and corruption have been relatively low in public hospitals and health centers. Multiplication of administrative controls and reduction of fraud incentives, together with repression have been quite effective. The same does not apply to pharmaceutical and lab tests prescription where several cases of collusion and corruption have been regularly reported in the media. Most common fraud practices have been falsified prescriptions and bills presented for payment to regional health treasuries.

Addressing state failure problems

According to Williamson (1975), hierarchy and market are alternative ways of coordinating and controlling public service activities. The hierarchy utilizes public organizations to directly coordinate and control service provision, the market uses contracts, through incentives, as an indirect way of addressing the same issue. To what extent, are state failures' problems better overcome or addressed by direct and centralized administration or by decentralization and privatization strategies is an interesting question. The proper answer must be found in transaction costs, the costs associated with structures needed to maintain the organization running (Araújo, 2000). Existing administrative controls in hierarchical organizations (supervision, career rewards and penalties, financial controls) usually are expected to increase organizational costs. Detailed information about local conditions to produce efficient allocative decisions may become too expensive to collect and treat and may arrive late to decision makers. Interest groups, contradicting the public service mission, tend to grow in hierarchical organizations. Managers tend to spend more efforts at lobbying, than on achieving efficient production. For the sake of this argument, both decentralization and privatization are expected to increase «incentive intensity» (Williamson, 1975). Four ways of ad-

ressing state failure problems were considered in the following analysis (Maeda, 2004):

- *Delegating decision and management authority closer to clients and constituencies:* to transfer decision and management authority closer to constituents and sources of information is expected to better meet their needs, to introduce greater transparency and accountability and to promote more active participation of the constituents in the decision making process. Partial efficiency gains may be derived from this type of decentralization reforms.
- *Introducing performance-based payment systems and internal markets:* the reform of the internal incentive system by introducing greater competition and performance-based payment is expected to align incentives with expected outcomes. It could be done through:
 - a) The creation of an internal market model with a gradual separation of provider and payer functions within the public system; this could be done by increasing hospital autonomy in a wide variety of arrangements in order for them to get control over labor, recruitment, salaries, staff mix, in some cases as a new form of government agency (Harding *et al.*, 2001)³;
 - b) The contracting-out of health care services from the private sector market; this model is based on the principal-agent relationship: as a principal, the government (payer) designs a contract inducing the contracted agent (provider) to behave according to the principal's plan;
 - c) The transformation of public hospitals, either into public enterprises (*hospitais EPE*), or the transformation of public hospitals into private firms under public property (*hospitais SA*);
 - d) The design, building, finance and long or short-term operating of new public facilities, by private entrepreneurs (public-private partnerships (*PPP*));
 - e) The selling out of public assets of hospitals and clinics to private operators (privatization).

³ According to the five critical factors that influence organizational behavior (decision rights, market exposure, residual claimant, accountability and social functions), Harding *et al.* (2001) identified the following organizational hospital reform modalities: budgetary organizations, autonomized organizations, corporatized organizations and privatized organizations.

- *Finding optimal economies of scale and scope for the decentralized health system:* the assumption here is that decentralization would break up large state owned health care systems into smaller, autonomous units. A question arises: up to what point does this fragmentation help or damage economies of scale and of scope? Hospitals, medical and nursing training centers and medical technology units may have an optimal scale for efficient production and service delivery (Maeda, 2004). On the scope side, hospitals are less and less isolated from PHC units and from nursing homes, calling for vertical integration for more comprehensive, effective, equitable and efficient provision of care. Recent research in the UK shows that primary care trusts, general practices and NHS trusts could improve care for people with chronic conditions, while improving efficiency. Competitive pressures between managed care organizations provide an incentive for innovation in management of chronic diseases. For example, reducing preventable admissions for people with chronic conditions, aligning goals of clinical and managerial staff more successfully, pilot risk stratification and case management programs, collect accurate information on each case and encourage clinicians to peer review their cases (Dixon *et al.*, 2004). To what point decentralization and privatization initiatives may contribute to improve service networking or even integration, for patient satisfaction and better care quality or, by the contrary, to generate isolation, strict technical efficiency objectives, fragmentation of patient treatment and adverse selection?
- *Regulating the health system and assuring quality:* decentralization, privatization and the correspondent risk of services fragmentation make more difficult to meet the expectations of consumers and decision makers (Maeda, 2004). Governance structures at regional and local level may be weaker than former central management control structures. Increased autonomy requires accountability mechanisms not tied to direct control. These controls, such as contracts, take considerable capacity to write and enforce, especially in the case of health services where outputs and outcomes are difficult to specify precisely (Harding *et al.*, 2001). Contract management became a highly sophisticated function for a new and unqualified buyer. The creation of new regulatory agencies mainly to protect patient constitutional rights, the collection of information across the different new components of the health system, and resources needed to improve institu-

tional development at lower levels, as well as new organisms for quality assurance, all these new developments may increase overall transaction costs in the system. Civil society organizations, such as patient and hospital associations, accreditation agencies, and professional bodies may not be in a development level sufficient to substitute former state control and may need public support and partial financing (Maeda, 2004).

Let us look into each one of these four analytical tools and see how they apply to the Portuguese health sector.

Decentralization and privatization in Portugal

Delegating decision and management authority

Many positive features under this heading, in the Portuguese health reform, were associated with the 1990's revision of the NHS law (Reis, 1995) and the adoption, in 1993, of the devolution to regional level of many central duties (Decreto-Lei n.º 11/93). This move can not be considered as administrative decentralization, since managerial authority was based on centrally appointed regional health administrators. However, the fact that these administrators live and operate in the head town of each one of five regions (Lisbon and Tagus Valley, North, Center, Alentejo and Algarve) and that their power is exerted over hospitals, health centers and other health care institutions in their region, represents an important change of many consequences: hospital and PHC managers are locally recruited and «suggested» for ministerial appointment, giving considerable power to the new regional boards. Resources start smoothly to be allocated on a service-contract basis, with DRG based payment slowly increasing its share in hospital financing.

As a less positive feature, health services regionalization was not accompanied by a general administrative regionalization. District general and sectorial authorities (those closely associated to health, such as education, social security, agriculture, housing, transportation and environment), as well as municipalities, didn't increase their relative powers. The health sector became once more a lonely runner. Moreover, many normal features of hospital and PHC organization and functioning, such as budgeting, staff management, facilities planning and control of contracts with private providers remain dependent on the central level of government.

By 1999, a parliamentary law granted new health functions to municipalities, such as the regular man-

agement of PHC centers, construction and maintenance (Lei n.º 159/99); unfortunately this piece of legislation was never implemented till now. Finally, the appointment of hospital and PHC boards became increasingly politicized, fluctuating at the pace of parliamentary majorities.

Performance-based payment systems and internal markets

The political platform advanced, back in 1995, by a center-left government had already shed most remnants of traditional social democracy and sought a new compromise between social concerns, economic liberalism and budgetary orthodoxy. Later on, in the first half of 2000, the Portuguese presidency of the European Council transposed for the first time to EU level many of the ideas «third way» leaders have been trying to implement in their respective countries (Costa-Lobo and Magalhães, 2001). This movement was continued, at least in the health sector, by the new right wing government, starting in April 2002. Many interesting and innovative features can be registered during this period: prospective budgeting was adopted for hospitals, in the mid 90's, with increased use of DRG data; by the end of 1995, one public hospital, Hospital Fernando da Fonseca, serving the municipalities of Amadora and Sintra in the outskirts of Lisbon, was conceded to private management, following a specific call for tenders; by end 90's, three recently built district hospitals (Santa Maria da Feira, Matosinhos and Barlavento Algarvio) were allowed to adopt a flexible public corporate structure, though remaining totally under public ownership; one of the three, Matosinhos, was jointly managed as a local health unit, with PHC centers in ascendant vertical integration; more recently, 31 district hospitals were transformed into private enterprises under public ownership and new boards were appointed, many of them chaired by non-health related managers.

On the other side, private management of public hospitals was kept limited to a single hospital (Fernando da Fonseca) what increased the experiment's political vulnerability. The impact of prospective payment was reduced by many exemptions, such as those pertaining to teaching and specialized hospitals. The fact that 31 corporate hospitals were reimbursed by diverse fee schedules, one for the whole SNS and others, more provider friendly, for subsystems and private insurance companies, may generate the risk of market segmentation and price discrimination, jeopardizing the system's universality. Finally, the other side of the managerial refreshment intro-

duced inside new hospital boards was its deep ideological and partisan dependency, weakening their authority and credibility.

Finding optimal economies of scale and scope

During the second half of the 90's, performance related payments were tried in several PHC centers on an experimental basis (Sousa *et al.*, 2003). These locally based experiments never became nationally relevant. Medical co-operatives start to be prepared according to the 1993 legislation, but none had yet leveled off. The Matosinhos Local Health Unit, integrating a district hospital with health centers in its catchment's area, was assessed in a benchmark of new experiments and seen as a positive tentative of vertical integration (Portugal. INA, 2002; Simões, 2004). It remained, however, an isolated experience. Potential vertical integration or at least coordination between acute and continued care, still need economic incentives and special legislation, since care for the elderly falls outside the health sector, referring to the department in charge of social security.

In the old private sector, organized on a general contract basis, nothing was done to catch market induced efficiency gains. Prices of outsourced lab tests and treatments remain out of market, set up by administrative decisions, strongly influenced by stakeholders and interest groups, which means that they can hardly improve efficiency and quality. In a new market environment, existing private providers in ambulatory care, including diagnostic tests, potentially face a double threat, as observed in the UK: the loss of traditional private practice as waiting lists are reduced and loss of clients in diagnostic centers if new centers join the market (Dash, 2004).

Another opportunity for private sector development was a recent and specially funded program created to absorb waiting lists for elective surgery, both in public and in private hospitals, and reimbursed on a fee-for-service basis. Each institution contractually agrees with the regional health administration on a certain number of interventions to be performed out of regular working hours. It could be seen as an atypical outsourcing activity.

Regulating the health system and ensuring quality

New corporate hospitals, medical co-operatives in PHC centers, integrated or merged health care units, the new system for hospital performance related financing, as well as the coming call for tenders for new PPP hospitals, much of this new activity

strongly calls for regulatory capacity in their new market environment.

A Health Regulatory Authority was created in the beginning of 2004 (Decreto-Lei n.º 309/2003), and settled down in Porto, the northern second town of Portugal. Its geographical location was seen as a symbolic feature of a health decentralized administration. The new authority is expected to care for quality, universal access to health services, regulate competition among private providers and between private and public providers, in order to achieve efficiency gains within the system.

These positive features may have several loopholes. The regulatory authority, though installed out of Lisbon, has no plans for its own decentralization, which implies a considerable bureaucratic burden, having in account the amount and diversity of stakeholders to be regulated. Moreover, the new authority mission needs clarification: it encompasses many duties attributed to existing agencies, such as the General Directorate for Health, the regional health administration boards and the General Inspectorate for Health.

Expected and observed failures in decentralization and in privatization

Decentralization problems and health service ownership

The recent history of health services organization and development in Portugal demonstrates that decentralization was by far more difficult to implement than privatization. The public sector remains highly centralized due to the failure of the administrative devolution. On the privatization trend, by the contrary, institutions tend to be created independently and to intervene in the market as individual partners.

This trend evolves frequently to market distortions. Cartelization, central coordination of private institutions and association of private providers tend to be a common market reaction to an excessively centralized health administration. The state centralization paradigm is transferred to the private sector organization. Matrix presented in *Table III* shows this effect applied to several institutions or stakeholders: hospitals, health centers, diagnostic laboratories, pharmacies and the management of surgical waiting lists. Hospitals and health centers are institutions where privatization may go together with decentralization: private hospitals and private clinics, once in cruise speed, seem to operate on their own, under state control exerted at regional level, with no visible dependency from the central administration. The limited amount of new private hospitals does not provide yet a clear information on their autonomy or dependency from their owners. The striking features presented in the table may be explained by the following reasons: PHC centers have a strong potential to be managed at municipal level; however they remain under the central administration authority, with visible inefficiencies and losses in accountability. Diagnostic and treatment laboratories, all of them private contractors, have gradually been horizontally integrated, either through mergers, or through associations set up for price and payment negotiations. Potential advantages of an atomistic supply market were overcome by monopolistic or at least cartelized practices, the most visible being the imposition of the same fee's schedule for the whole country, economies of scale being captured solely by the producer, never the purchaser. The same happens, in a larger scale, to private pharmacies. The big issue being here payment delays by regional health administration, the pharmacists association got a unique situation of an agency relationship for payment collection, representing almost the

Table III
Health services mix of provision. Association between privatization and decentralization

	Public ownership	Private ownership
Hospitals	No association	Highly associated
Ambulatory care PHC centers	Potential for health centers municipalization	Highly associated
Diagnostic laboratories	n. a.	Highly associated; trend to cartelization
Pharmacies	n. a.	Highly associated, strong cartelization in place
Elective surgery lists	Quasi-market behavior	Highly associated, risk of regional cartelization

n. a.: not applicable.

totality of providers, imposing to Government a shorter delay for payment and collecting from associates a 1.5% fee on gross invoicing, which builds up a self reproductive strong financial capability. This centralization through the market represents a capture of the main advantage of hierarchy: the management information flow remains a centralized system. It allows for an effective control of environment uncertainties, for the prevention of dumping practices, and finally to avoid some partners to gain a strategic advantage over the others (Araújo, 2000).

Market failures in privatized health services

The growing trend to privatization or to the development of quasi-market institutions raises the question of the well known market failures. We limit this analysis, in the Portuguese case, to five types of failures, familiar to the health economics and health administration literature: natural monopoly, asymmetric information, the disturbance in economic behavior introduced by a complex principal-agent relationship, the provider induced demand and adverse selection leading to losses in equity of access (Kay and Vickers, 1988). Five types of health care provision institutions were analyzed in the matrix presented on *Table IV*.

Market failures are considerably high in four health care services, the exception being health centers, where characteristics of a new managerial model still remain unclear. In corporate hospitals a natural monopoly situation is the general rule, whatever the nature, public or private. If hospitals can integrate themselves, either vertically with health centers and nursing homes, or horizontally avoiding overlapping of specialties, the notion of catchment's area and its universality basis would be in crisis.

In the prescription of co-paid pharmaceuticals, the high risk of asymmetric information and of provider induced demand exists since ever. The same happens in the provision of lab services by private providers. Asymmetric information decreases the consumer power making him vulnerable to induced demand. Provider induced demand may have a synergistic effect with adverse selection. If hospitals and health centers are expected to be paid by different fee schedules according to third payer, providers will be tempted to concentrate better and more care on those who pay higher fees, generating simultaneously, adverse selection and induced demand. On lab tests and medical examinations, the coincidence of private and public provider status in a single person and correspondent conflicts of interest usually induces public providers to refer clients to their private settings. The payment on a fix fee-for-service schedule increases moral hazard, reducing efficiency of price variation according to the production function, resulting in the consumption of unnecessary services.

Waiting lists for surgical procedures, if not well regulated by a regional authority, may induce unnecessary demand and may easily imply declining quality, due to strong asymmetric information and complex principal agent relationship (Campos, 2002a). Moreover, the trend to specialization in elective surgeries may create adverse selection situations, with those more in need of an intervention being delayed, due to the complexity of the care they need.

Decentralization and privatization. Common wisdom and practical realities

When we associate both movements, decentralization and privatization, and try to analyze their consequences in efficiency, equity and quality terms sev-

Table IV
Market failures in privatized health services

Mark failure risk	Corporate hospitals	Health centers	Pharmac. products	Lab tests & treatments	Waiting lists
Natural monopoly	High	Low	High	Low	Low
Asymmetric information	High	Low	High	High	High
Principal/agent relat.	High	Low	Low	High	High
Induced demand	High	None	High	High	High
Adverse selection	High	Low	Low	Low	High

eral ambiguities may become evident. There is no silver bullet in these trends, as we may see in *Table V*. The common wisdom tells us that the public sector is expected to overcome the private sector in equity, both at central and decentralized level, as well as in efficiency and in quality, at the decentralized level. The reality may not correspond to the stereotype: health care publicly provided in a decentralized way may loose simultaneously, quality and efficiency. Moreover, centralization of health care management has a good record of success in Portugal: the well known effect of the centralized SNS in the management of health services in Portugal was responsible, since the late 70's, for a rather quick distribution of general practitioners, health centers, district hospitals, lab tests and pharmaceuticals availability through the whole country, conducing to a deep decline of many communicable diseases and causes of death (Campos and Ramos, 2004). By common wisdom, the private sector is expected to have higher efficiency than the public one, both in central and in decentralized practices. However, a recent and carefully done assessment of three hospitals with diverse management' models, shows that Santa Maria da Feira Hospital, a public hospital managed as a public enterprise, was clearly more efficient than a public hospital under totally private management (Simões, 2004). In terms of equity, the private sector ranks usually low in central organizations and may occasionally rank high in decentralized practices. However, one of the major concerns of the pharmacist's national organization, by reasons of corporate prestige, is the guarantee of equal access to equal need and one shall

recognize that this association has been highly sensitive to public health campaigns, such as diabetic and hypertension prevention and treatment, as well as free access to syringes by HIV positive patients. Many private pharmacists may be poorly interested in these public health activities, but their central association warrants regular payment of state bills, encouraging them to act collectively. In quality grounds the private sector may not be ranked high, either in central or in decentralized structures, due to lack of accountability and high cost of quality services. However, many private surgeries, small clinics, laboratories, dental treatment clinics, private laboratories and the almost entirely private provision of renal dialysis services provide quality service and become highly regarded by the users. On the reverse side, according to this matrix, a decentralized and public owned care structure would provide services with higher efficiency, equity and quality than any other combination. And if decentralization is combined with public ownership results will become even better. However, PHC centers and hospital emergency units seldom rate high in the public perception of quality, patient satisfaction and staff morale (Cabral, 2002). As we demonstrate, the above mentioned assumptions are no more than stereotypes, critically in need of empirical evidence.

Conclusion

Decentralization has been a longtime waited state reorganization in Portugal. The need to increase client proximity, service accountability, better use of existing local resources, gains in efficiency and equity, the influence of the EU concept of subsidiarity, as well as the legitimate desire of local citizens to locally decide on their public services provision did push health care administration to tentatively delegate power to regional levels of central government. However this movement can not be considered as decentralization. In fact, in all public administration sectors, decision-making remains in the hands of central level of government, changing drastically when political majority changes, but always keeping the local users outside the decision making circuit. There are good reasons to consider health sector de-concentration in Portugal as a partial failure (Bafail and Hibou, 2003). Recent experiences in other countries are freezing common enthusiasm towards decentralization. The long lastly paradigm of hospital decentralized management, particularly prevalent in the Nordic countries, was contradicted by reforms during the late

Table V
Decentralization and privatization. Common wisdom

Ownership	Provision	
	Centralization	Decentralization
Public	- Efficiency	+ Efficiency
	+ Equity	+ Equity
	- Quality	+ Quality
	+ Efficiency	+ Efficiency
Private	- Equity	+ Equity
	- Quality	- Quality

+: gains; -: losses.

90's in Sweden and more recently in Norway. In Sweden, following the early 90's economic depression, many central and district hospitals became centrally managed. In Norway, the recent transference to the central government of responsibility for all Norwegian hospitals represents a radical break with a tradition going back over more than 30 years, where hospitals were owned and managed by the 19 county councils. In the year 2000, Norwegian parliament approved a proposal to initiate a state takeover of all publicly owned hospitals, which were then defined as state health enterprises. A recent hospital reform divided the country into five health regions. Each region was responsible for its own regional health enterprise, which in turn owned the hospitals in that region. However, while the hospitals may be state owned, they actually remain de-centralized and self governing (Slattebrekk and Aarseth, 2003). Even in «model» countries, such as the Nordic ones, the decentralization paradigm is suffering.

Privatization, either in service ownership or in management duties, is a tool introduced by NPM doctrines, to increase competition through enlarged accountability among public service deliverers. However it may create quality problems. Quality of care, when the private competes with the public sector, due to efficiency pressure, will have to be measured in more sophisticated ways than we use at present. Information about quality, a critical issue to improve competition, will need to be made available to users to enable them to make appropriate decisions about access to health care (Dash, 2004). Efficiency, alone, with poor quality loses utility.

Privatization, in Portugal, hardly can be seen as accomplishing decentralization objectives. By the contrary, in a centralized state, privatization ends up in more centralization. Privatization core concept is efficiency. As a secondary objective it may encompass prevention of equity losses, growing prevalently in public provided health care services, where the purchaser-provider split was not implemented. Privatization of health services, in Portugal as elsewhere, is growing and becoming more popular, theoretically. In practice, the evidence of its merits to reach intended efficiency objectives is still lacking, due to the novelty of the move.

This study was intended to demonstrate expected parallelism between health reforms and public administration reforms. Many observers would be tempted to consider these two movements, decentralization and privatization, as common signs of NPM developments (Simões, 2004). They have common objectives, are established around the core concepts of gains in effectiveness, efficiency, equity and quality of public services, through improved account-

ability. However, in practice, in Portugal, each movement was developed in a totally separated way.

Besides those rooted in NPM theory, there are few visible signs of association between decentralization and privatization. Decentralization, in the Portuguese NHS, was never intended to be followed by a privatization movement it was seen merely as a public administration tool. Private management of health services, as stated in the most recent NHS legislation (Lei n.º 27/2002; Decreto-Lei n.º 185/2002) was never intended to have decentralization as a condition or as a consequence. Paradoxically, in the Portuguese context, it has led invariably to centralized control.

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□ Resumo

DESCENTRALIZAÇÃO E PRIVATIZAÇÃO NAS REFORMAS DO SISTEMA DE SAÚDE PORTUGUÊS

O Serviço Nacional de Saúde português (SNS), sistema de prestação de cuidados de saúde universal, centralizado e público, detém um notável registo de equalização no acesso aos cuidados de saúde e a ganhos em saúde nos últimos trinta anos. Contudo, a história mais recente da reforma da saúde em Portugal tem vindo a ser influenciada pela descentralização e pela privatização. A descentralização tem estado sempre presente no SNS desde a Constituição de 1976, pelo menos em teoria. A propriedade privada da prestação e os gastos privados das famílias, do lado do financiamento, têm tido sempre enorme relevo no debate sobre a combinação público-privada do SNS. O objectivo inicial deste estudo consistia em demonstrar o esperado paralelismo entre as reformas na saúde e as reformas na Administração Pública, onde se tem observado, em diversos países, um padrão comum de descentralização e privatização. Alguns observadores serão tentados a considerar estes dois movimentos como sinais comuns de desenvolvimentos da moderna gestão pública (MGP). Partilham objectivos comuns, estão estabelecidos em torno de conceitos de ganhos de efectividade, eficiência, equidade e qualidade do serviço público. Contudo, em Portugal, cada um destes movimentos desenvolveu-se de forma inteiramente separada. Para além dos que mergulham as suas raízes na MGP, há poucos sinais adicionais visíveis de associação entre a descentralização e a privatização. A descentralização, no SNS português, nunca foi idealizada para ser seguida por uma tendência privatizadora; foi sempre vista como um instrumento de administração apenas. A gestão privada de serviços de saúde, tal como aparece na mais recente legislação do SNS, nunca foi pensada para ter a descentralização como condição, ou como consequência. Em termos paradoxais, no contexto português, a privatização levou sempre a mais centralização. Embora apresentadas como instrumentos separados com vista a um fim comum de mais eficiência, a eventual associação entre descentralização e privatização continua a carecer de demonstração. Muitos estereótipos de administração de saúde têm de ser reconsiderados se pretendermos encontrar qualquer associação entre estes dois instrumentos organizacionais.