

Authors

Maria Asensio (ISCTE - University Institute of Lisbon) and Tamara Popic (European University Institute)

Title

Portuguese Healthcare Reforms in the Context of Crisis: External Pressure or Domestic Choice?

Abstract

As a result of the recent economic crisis, in 2011 Portugal signed a Memorandum of Understanding with the European Central Bank, the European Commission and the International Monetary Fund (the 'Troika'). In exchange for Troika's financial assistance, the Memorandum required the implementation of a specific set of reforms targeted at the healthcare sector. The literature on policy reforms in the context of crisis and conditionality argues that governments have restricted room to maneuver in responding to external pressure. We challenge this view, finding that even in cases of conditionality and strong external pressures, crisis can be used as a window of opportunity for reforms substantially shaped by domestic policy choices. In the case of Portuguese health reforms, these choices were based on pre-existing reform plans aimed on resolving country-specific deficiencies of the healthcare system and were enabled by the two main political parties' strategies of tacit cooperation and blame avoidance. The article emphasizes the need for more fine-grained analysis of welfare reforms in the crisis that pays equal attention to the institutional characteristics and the political context of the affected countries.

Keywords

Crisis, policy change, healthcare, Portugal.

Introduction

In Portugal, as in other Southern European countries, healthcare reforms were recently introduced as part of large-scale reforms of the public sector in the context of a sovereign debt crisis (see Guillén and Pavolini 2015). Portugal stands out, along with Greece, as a country in which the healthcare reforms were characterized not only by deep austerity but also by strong external pressure and conditionality. With the signing of the Memorandum of Understanding on Specific Economic Policy Conditionality (MoU) by the so-called 'Troika' (International Monetary Fund, European Central Bank and European Commission) and the Portuguese government in 2011, in exchange for financial assistance, the country's leaders agreed to accept, among other things, more than 30 austerity measures targeting the healthcare sector.

This article investigates the ways the sovereign debt crisis affected healthcare reform in Portugal. It challenges the view prominent in the literature that policy change in the context of crisis should be seen as shaped largely by external pressure and conditionality. We argue that while both can trigger change, the interplay between these external and domestic factors – the institutional and political context of policy change - actually shapes the process of policy transformation. As we show, external pressure triggered the 2011 Portuguese healthcare reforms, and the Troika's financial assistance was conditional on the implementation of healthcare reforms. However, the reforms did not simply follow the dictates of the Troika. Instead, Portuguese policymakers used the crisis and Troika pressure as window of opportunity to introduce already existing plans for large-scale health reforms. The crisis offered an opportunity to resolve some of the problems generated by the specific institutional setup of the Portuguese healthcare system and the two main political parties took advantage of this, introducing the reforms through strategy of tacit cooperation and blame avoidance. Looking at the interplay of external pressure and domestic policy choices in the Portuguese case, we emphasize that welfare reforms in crisis have to be analyzed in a more fine-grained way

that pays attention to institutional characteristics and political context of the affected countries.

The article contributes to a better understanding of welfare state change in the context of economic crisis. The literature on policy change in Portugal in the recent economic crisis mainly analyzes the broader set of austerity measures introduced by the agreement with the Troika (Moury and Freire 2013; Moury and Standring 2017). In contrast, we look more closely at the dynamics of reform in one area, the healthcare sector, one of the country's largest welfare sectors and subject to the harshest austerity under the MoU.¹ Theoretically, we rely on the existing argument that the crisis was used as a window of opportunity for reform (Moury and Standring 2017; see also Hopkin and Dubin 2013; Dukelow 2015). However, we extend this argument by explaining how not only political factors - elites' strategies of tacit cooperation and blame avoidance - but also institutional structures - fragmented character of the country's healthcare system that generated system-specific deficiencies - shaped the Portuguese healthcare reforms. In comparison to the existing studies that put forward the argument on external pressures as window of opportunity for Portuguese reforms (see Moury and Standring 2017), the article provides more specific empirical support for this argument relying on interviews with policy makers and official policy documents related to healthcare reform.

The article uses both primary and secondary sources. Primary sources include official policy documents on healthcare reforms, as well as 10 semi-structured interviews with public officials and healthcare policy experts conducted in Portugal in spring and summer 2016. The interview questions focused on healthcare policy and

¹ For healthcare, the MoU envisaged savings of EUR 550 million, while savings for pensions and unemployment insurance were projected at EUR 445 million and EUR 150 million, respectively (European Commission 2011: 3).

reforms both before and during the global economic crisis. Secondary sources include newspaper articles, electoral results and statistical data.

The article is structured as follows. The first section outlines the theoretical framework of the article and specifies its core hypotheses. The second section briefly describes the historical development of the Portuguese healthcare system, showing how crisis and external pressure presented an opportunity to introduce large-scale reforms targeting some of the healthcare system's core deficiencies. The third section shows that the reforms were the results of the interplay between external pressure and domestic political choices, characterized by tacit inter-party cooperation and mutual blame avoidance. The last section summarizes the findings and provides some concluding reflections.

Social Policy Reforms in the Context of Crisis

In the context of the recent economic crisis, some of Europe's most economically vulnerable countries were pressured to accept external conditionality, whereby specific reforms were requested in exchange for financial assistance. As exposure to external conditionality was often associated with a high degree of social policy change, some scholars explain the crisis-related reforms in these countries as caused by external pressures (e.g. Stepan and Anderson 2014; Theodoropolou 2014; Helderman 2015; Baeten and Vanhercke 2017). This view assumes domestic factors, such as institutional or political context of reforms, play a minor role, or no role at all, in policy transformation. Rather than adjusting the crisis-driven measures to the existing institutions and policies, or having policymakers follow their political aims and strategies, in this view, social policy change is a response to the demands of external actors. The view also implies that crisis constrains domestic policy choice. As events over which policymakers have very little or no control, crisis and external pressure

constrain their room to maneuver, so the freedom of policy choice becomes severely, if not completely, restricted.

Following this view of social policy change, Stepan and Anderson (2014) analyze pension reforms in Greece and Hungary, two countries hard hit by the crisis. They claim the crisis provided international actors, notably the EU and the International Monetary Fund (IMF), a new framework to influence national governments, which involved making loans dependent on the fulfillment of specific criteria. The two countries introduced very specific pension reforms that would be unthinkable in the absence of external incentives and conditions set by the Troika had 'substantial influence' on both the direction and scope of their respective pension reforms (*ibid.* p. 329-30; see also Anderson and Kaeding 2013). Focusing on Greece and Portugal, Theodoropolou (2014) similarly argues that the crisis and the accompanying MoUs changed the EU's potential to intrude into the reform of national social and labor market policy, with an 'unprecedentedly strong enforcement dimension' (*ibid.* p. 10). She finds the Troika measures had a high level of interference with objectives of national welfare policies, with the greater level of intrusiveness characteristic for more political or technical difficult reforms. Focusing specifically on healthcare in countries that signed a MoU with the Troika, Baeten and Vanhercke (2017) also argue that health reforms conditioned by financial assistance led to the EU's interference in national health systems and the emergence of a new EU role in healthcare (see also Helderma 2015; Vollaard and Martinsen 2017).

However, other literature on policy change in the context of crisis suggests the view of external factors as key determinants of change might not explain the variety of changes taking place or account for the domestic factors that continue to play a crucial role in policy transformation (e.g. Frisina-Doetter and Götze 2011; Pavolini and Guillén 2013). Even in economically harsh times, when countries are vulnerable and face external pressure to reform, domestic realities, such as country and policy-specific

institutional and political context, can have a substantial influence on the scope, nature, and direction of policy change. The importance of existing institutional setups and political dynamics for crisis-driven social policy changes suggests policy-making is 'path-dependent' and embedded in a specific context. This implies that even in times of crisis and external pressure, there is space for domestic policy choice as courses of action will be profoundly shaped by the country's institutional and political setting.

The research more specifically focused on healthcare policy change shows previous developments of healthcare system's institutions and policies can be crucial in shaping the content and scope of reforms even in the context of crisis (see Frisina-Doetter and Götze 2011; Mladovsky *et al.* 2012; Pavolini *et al.* 2013; Stamati and Baeten 2015). In their analysis of healthcare reforms in Italy and the United Kingdom, Frisina-Doetter and Götze (2011) focus on particular characteristics of the National Health Service (NHS) systems in two countries, looking at their 'system-specific deficits' (see also Schmid *et al.* 2010).² They find policy changes introduced during the crisis were essentially responses to systemic deficits typical for the NHS type healthcare systems, which included long waiting lists, insufficient investment in healthcare facilities and poor responsiveness. Similarly, Mladovsky and colleagues (2012) explain the diversity of crisis responses in the European healthcare sectors by showing that healthcare systems in some countries due to the previous policy choices were better prepared for the crisis than in others. Those having a more stable financial situation, i.e. less debt, were able to respond to the crisis by introducing smaller range of reforms than those with accumulated financial reserves.

Another important domestic factor in the explanation of social policy change is the political process. While a crisis can hit a country's economy hard, causing its

² According to Schmid and colleagues (2010), healthcare systems have a tendency to feature deficiencies that are related to their institutional type. These deficiencies cannot be solved by routine mechanism but through implementation of innovative policies (ibid. p. 456).

international economic position to deteriorate and exposing it to external pressure to reform, policymaking in crisis is still strongly driven by internal political motivations and struggles. While the specific characteristics of the political dynamics will vary across countries, the literature on the politics of welfare reforms in the context of crisis suggests some cross-country patterns. One is the tendency of political elites to use a crisis as window of opportunity for reform, which can be particularly useful in healthcare, a sector characterized by pressure to introduce reforms that are both sensitive and unpopular (Frisina-Doetter and Götze 2011; Roubal 2012; Pavolini and Guillén 2013). A related strategy is blame avoidance, wherein political elites avoid responsibility for unpopular reforms by blaming others for them (Weaver 1986; Bonoli and Natali 2012). Political parties use blame avoidance to gain an advantage over other parties, but blame avoidance can also be used in the context of pressure for unpopular reforms coming from external actors, for example, international or supranational organizations. Domestic actors shift the blame to these actors and use them as scapegoats to further their own political agenda (Graziano *et al.* 2011). Generally speaking, then, domestic politics plays a crucial role even in the case of reforms and social policy changes introduced in the context of intense external pressure.

Based on the literature on the role of domestic factors in policy change during periods of crisis, we hypothesize that even in the context of conditionality marked by intense external pressure for reform, policy choice will be profoundly shaped by the country-specific institutional and political context. Focusing on Portuguese healthcare reforms, we formulate two specific arguments. The first is that the external pressure to reform the healthcare sector in exchange for financial assistance was used by policymakers as a window of opportunity to introduce previously politically unfeasible reforms aimed at problems caused by the fragmented structure of the Portuguese health sector. The second argument is that the capacity of policymakers to use external pressure as an opportunity for reform, i.e. the possibility of domestic choice, depended

on country-specific political dynamics, in this case, political elites' tacit inter-party cooperation and blame avoidance.

External Pressures as Opportunity for Health Reforms

In this section, we place the Portuguese healthcare reforms enacted under the Memorandum of Understanding (MoU) in the broader context of the country's healthcare system development. As we show, the MoU reforms were continuous with previous reform trends and represented gradual rather than radical change. In fact, the reforms were based on pre-crisis policy proposals targeting very particular system deficits caused by the fragmented structure of the Portuguese healthcare system. This provides support for our first argument: while crisis and external pressure triggered healthcare reform, these reforms were crafted domestically as policymakers used the crisis as an opportunity to introduce planned reforms aimed at solving system-specific problems.

Evolution of the Portuguese Healthcare System

The establishment of the National Health Service (NHS) marked the first phase (1979-1989) in the evolution of the modern-day healthcare system in Portugal. The shift toward the NHS in 1979 introduced universal system of healthcare, ensuring access to healthcare as a social right. It also entailed dramatic changes in healthcare provision, mainly in terms of the ownership of healthcare facilities, most of which became public. In financing, changes were less radical because even though the NHS introduced universal coverage, some pre-existing social health insurance (SHI) schemes for specific occupational groups ('healthcare subsystems') were left untouched. In addition, voluntary private insurance was introduced during the 1980s (Barros *et al.* 2011). As a consequence, the transition to the NHS was incomplete (see Guillen 1999), resulting in a fragmented system combining NHS, SHI and private insurance elements.

The second phase (1989-2001) was marked by a new policy paradigm based on the ideas of privatization and managed competition, aimed at achieving greater efficiency. In healthcare financing, private spending increased with the implementation of several new policies, including introduction of user fees (*taxas moderadoras*), tax allowance for private healthcare insurance spending, and an opt-out clause allowing individuals above a certain income level to pull out of NHS and opt for a private coverage. Far from improvement, the introduction of the private elements into the system magnified its already fragmented structure and threatened equality in healthcare access (Dixon and Mossialos 2000; Bentes *et al.* 2004; Oliveira and Pinto 2005).

Efforts to integrate the public and private sector marked the third phase (2001-2008). This phase reinforced a paradigm openly unfavorable to the expansion of public spending and the strong role of the state (see Kanacos & McKee 1998). The reforms, focused on policies of cost-containment and adjustment of the public healthcare management according to a private management model, was expected to leverage efficiency gains and improve responsiveness to patient needs (Diogo 2004). Important changes during this phase were the introduction of contracting with the private sector and the emergence of hospitals based on public-private partnerships.

At the institutional level, the reforms introduced over several decades resulted in a fragmented system divided into three tiers. The first tier was the NHS, universally available, financed and operated by the public sector; the second was the SHI with schemes for specific occupations, and the third was a voluntary private health insurance, financed by individuals or third parties and subsidized by the state. This three-tier structure contributed to the system deficiencies as it created inequalities in healthcare access across population groups (Jamieson *et al.* 1990). In addition to universal coverage provided by the NHS, around 25 per cent of the population enjoyed coverage through the various occupational SHI schemes and private insurance plans (Barros *et al.* 2011: 29), which offered easier access and greater choice of providers than the NHS

coverage. This specific structure of the Portuguese healthcare system was coupled with other deficiencies, including long waiting lists, major increases in expenditure, difficulties with cost-control, increased healthcare demands from vulnerable groups and dissatisfaction of both users and healthcare professionals (Bentes *et al.* 2004: 13).

Concern about the healthcare system led to new reform efforts after the 2005 elections, when the left-wing government of the Socialist Party (*Partido Socialista - PS*) led by José Sócrates came into power (see table 1 in Appendix for government changes and healthcare reforms). In 2006, the Ministry of Health appointed a special Governmental Commission composed of healthcare experts and asked it to come up with reform proposals that would ensure the sustainability and efficiency of the healthcare system (Interview #2, #3). In June the following year, the Ministry of Health published Commission's report that pointed out the key problems of the healthcare system and indicated ten scenarios of system development with a list of reform recommendations (Ministry of Health 2007). These recommendations clearly targeted the system deficiencies, most of them focusing on reducing the cost of healthcare provision and inequalities in healthcare access, including measures such as revision of user fees, decrease in tax allowance for private healthcare spending and dismantling of the SHI schemes, the so-called 'subsystems' (*ibid.*).

However, it quickly became apparent that the government's reform proposal lacked political support. Even though the *PS* had managed to form a one-party majority government, the party itself was rife with internal conflict. One party stream was strongly leftist and opposed the reforms proposed by the Commission, while another was in favor. The main source of discord was the revision of user fees, as it re-opened debate on their constitutionality.³ At the same time, the reform lacked support from the

³ Revision of the Portuguese Constitution in 1989 changed the description of health services from “free of charge” to “approximately free of charge”. While this resulted in a prolonged discussion about the exact

stakeholders. The unions representing civil servants, insured through one of the SHI schemes, strongly opposed the idea of their dismantling (Interview #3, #4). Healthcare professionals also opposed the reforms, seeing them as a threat to their existing status allowing them to combine work in both the public and the private sector. As the political environment became more hostile to the reforms, the government began to see them as a problem. With elections approaching, it decided to shelve the Commission's proposal and leave it for the next politically opportune moment (Interview #4).

Healthcare Reforms in the Context of Crisis

At the outset of the financial crisis, the Portuguese healthcare sector was relatively unaffected, with anti-crisis measures focusing more broadly on the public sector workers. The more comprehensive healthcare reforms were introduced after the signing of the MoU between the Portuguese government and the Troika, on 17 May 2011. These reforms were strongly marked by austerity, as the MoU demanded cost control to achieve savings of €550 million (European Commission 2011: 3). The list of the measures expected to result in savings covered eight healthcare subsectors and contained more than 30 specific measures (*ibid.* pp. 17-20).

The MoU measures were focused mainly on cost-containment and on three main aspects of healthcare provision: changes in the system of financing, reorganization of primary care and hospital network, and changes in medicine pricing. A closer look on these measures reveals a number of striking similarities with the reforms proposed by the Governmental Commission in 2007 (see table 2 in the Appendix). One similarity is that both documents recommended revision and update of the existing system of user fees, stressing the need for changes in the eligibility criteria for fee exemptions (see

meaning of the new term, the intention was to make clear that the Constitution did not preclude the existence of user fees in the NHS (see Barros *et al.* 2011).

Barros 2012a). Another similarity was a provision to reduce the tax allowances for private healthcare spending. The MoU specified a reduction of 30 to 10 per cent of total personal private health spending and envisaged the termination of the allowances for those in upper income brackets. Furthermore, like the Commission, the MoU envisaged changes in the 'subsystems'. Measures focused on the financial stabilization and autonomy of the largest SHI fund, for civil servants (*Direcção Geral de Protecção Social aos Funcionários e Agentes da Administração Pública - ADSE*), and other two funds covering police and military personnel (*Assistência na Doença da Polícia de Segurança Pública - SAD, Assistência na Doença aos Militares - ADM*). The plan was to reduce the costs of the funds by lowering the employer's, i.e. the state's contribution rate, and adjusting the scope of benefits (Sakellarides *et al.* 2015: 295).

Also echoing the Commission's recommendations, the MoU measures targeted pharmaceutical spending, including such changes as the promotion of the use of generic medicines, redefinition of the pricing methodology, stricter regulation and monitoring of prescriptions, centralization of purchasing and procurement system and increase in competition among private providers (Barros 2012b: 34).

Finally, both envisaged similar changes in healthcare delivery. While the Commission focused on investment in primary care, improvement of gatekeeping and changes in hospital networks, the MoU planned an increase in the number of family health units, reorganization of hospital networks, settlement of hospital arrears, and establishment of a benchmarking system for hospital performance (Table 2, see also Sakellarides *et al.* 2015).

External Pressures and Political Strategies

The striking similarity between the 2007 Commission's proposal for health reforms and the 2011 MoU measures suggests that the Troika's pressure represented an opportunity to introduce an already existing reform plan that aimed on resolving specific

deficiencies of the Portuguese healthcare system. But, why were Portuguese healthcare reforms possible in 2011 but not in 2007? In this section, we provide support for our second argument showing that the reforms were enabled by two consciously chosen political strategies of the Portuguese political elites: one was tacit cooperation between the country's two main political parties and another was their use of blame avoidance.

Portugal's External Pressures

At the beginning of the crisis, the Portuguese government led by Socialist Prime Minister José Sócrates (*PS*) responded to some of the first crisis effects with an expansionary social policy. However, as these led to spending increases, the policy shifted to austerity (Zartaloudis 2014), with three specific austerity packages applied across the public sector. The first two packages, introduced in Spring 2010, targeted social benefits of public sector workers, including a replacement of obligatory with voluntary membership in the largest social insurance fund, for civil servants (*ADSE*). The third package, which was tied to the 2011 budget, affected public sector workers and therefore also the NHS staff. It implied freezes and cut in public sector salaries, and reductions in spending on pensions and social benefits. At the same time, however, the package also included some expansionary elements, for example, an increase in tax allowance for private healthcare insurance spending (Table 1; see also Afonso *et al.* 2015).

The austerity packages were used to demonstrate the willingness of the country's leaders to stay on the austerity path and were the government's attempt to avoid international financial support. However, at the beginning of 2011, a set of new reports reinforced the market sentiment that international financial assistance was unavoidable (see Lourtie 2011). Under mounting pressure, in April 2011, Sócrates announced that the country was facing bankruptcy and would request financial assistance from the Troika. This led to the signing of the MoU in May.

Political Strategies: Inter-Party Cooperation and Blame Avoidance

Reforms introduced under the MoU, including the healthcare reforms, were triggered by external pressure but shaped by Portugal's domestic politics. Political management of the crisis was characterized by two country-specific factors. The first was the tacit cooperation between the two main political parties, the left-wing Socialist Party (*Partido Socialista - PS*) and the right-wing Social Democratic Party (*Partido Social Democrata - PSD*) and the second was their use of blame avoidance.

As aforementioned, the *PS* initiated austerity measures from 2005 to 2008, under a majority government headed by Sócrates. During its 2009 election campaign, the *PS* seemed to be back on its ideological track and was campaigning for a stimulus approach. However, in the September elections neither the *PS* nor the *PSD* won a majority, with 97 and 81 out of 230 parliamentary seats respectively, but the *PS* managed to form a minority government (Table 1).

The *PS*'s minority government introduced a set of expansionary policies, but then quickly shifted back to austerity with the three austerity packages mentioned above. It had broken its pre-election promises, but it justified the move as an attempt to save the country by calming the international markets and resisting external financial assistance. While the 'salvation' plans introduced under the *PS* government were radical, the government's minority status meant that they could be instated only with the informal support of the *PS*'s strongest political opponent, the *PSD*. This was not an entirely new phenomenon. Tacit cooperation between the *PS* and the *PSD* had started in 2009, when the *PSD*, together with the other opposition party, Christian Democratic Party - People's Party (*Partido do Centro Democrático Social – Partido Popular - CDS-PP*), offered passive support for the austerity measures during the parliamentary debates over the 2010 budget. More specifically, the *PSD* promised to let the budget pass by abstaining from the vote in exchange for concessions in the timing of fiscal

consolidation. The cooperation continued during the introduction of the three austerity packages. The first package, in March 2010, was negotiated with the *PSD*, and the *PSD* enabled its passage by again abstaining from the vote. The second package, adopted a month later, was also jointly agreed upon by Sócrates and the new *PSD* leader, Pedro Passos Coelho. The third austerity plan, which was tied to the 2011 budget, was reluctantly supported by the *PSD* and was passed in Parliament despite a lack of support from other opposition parties (Afonso *et al.* 2015: 323-4).

However, a fourth austerity package failed to pass in Parliament in March 2011. The *PSD* argued it was not negotiated with the opposition, and it withdrew its support. The other opposition parties followed suit. The government's failure to pass this austerity package resulted in Sócrates' resignation, and new elections were called in early June.

In the meantime, the external pressure on Portugal was growing with the realization that the country would not be able to meet its debt obligations. Accordingly, the country accepted the Troika's bailout package and signed the MoU. The MoU measures specifically targeting the healthcare sector were clearly based on the 2007 reform proposal and were readily agreed upon by the caretaker socialist government and the Troika experts, with the political support of the *PSD* (Interview #1, #3). The measures were proposed to a large extent by Portuguese officials and were characterized by an easily reached consensus between the two main parties. Consensus was easy because most of the measures had already been discussed in policymaking circles (Interview #2, #3, #6). The MoU was signed by the *PS* and the *PSD*, as well as by the *CDS-PP*, the third strongest party. The cooperation of the *PSD* was not seen as surprising because, at the time of the signing of the Memorandum, it looked like the most probable winner of the upcoming elections, implying that implementation of reform could not take place without its support (see Magalhães 2012). The *PSD* cooperation was even more obvious when, after winning the June election by a

convincing margin over the *PS*, it formed a government together with the *CDS-PP* and promptly started implementing the MoU measures (Interview #8).

The cooperation between the parties was initially justified by national interests. Shortly before signing the MoU, Sócrates stated: 'What the country certainly hopes is that this time the sense of responsibility will prevail, as well as the sense of higher national interest that we all must defend' (*Visão* 2011). Nevertheless, the discourse of cooperation quickly shifted to one of blame avoidance. Before the bailout, the *PS* assigned blame for the country's dire conditions to the global financial markets and international rating agencies. After signing the MoU, it shifted blame to the *PSD*, claiming that the acceptance of the MoU measures was unavoidable because the *PSD* had not supported the last austerity package (see Magalhães 2012; *Financial Times* 2014). Sócrates also sought to shift his party's responsibility for signing the MoU by stressing that the support of the opposition parties was crucial for the Troika measures to be accepted (*Jornal de Notícias* 2011a). During the election campaign and once the *PSD* formed a coalition government (with *CDS-PP*) after June 2011 elections and started implementing the measures, the finger pointing continued, with the *PS* accusing the *PSD* of destroying the NHS (*Jornal de Notícias* 2011b; Interview #5, #7) and arguing that harsh austerity measures in the healthcare sector were 'going beyond the Troika measures' (*Publico* 2014a; Interview #8).

The *PSD* was involved in blame avoidance as well. The *PSD-CDS-PP* government, led by *PSD*'s leader Pedro Passos Coelho, implemented the MoU measures but continued to accuse the previous, *PS* government of causing the country's problems, while emphasizing the limited room to maneuver in the context of the Troika measures (*Publico* 2011). The new Minister of Health, Paulo Macedo, also denied the *PS* accusation that the *PSD* government was going beyond the Troika measures and was simply applying 'blind cuts' in the healthcare sector (*Publico* 2014b).

Both the *PS* and the *PSD* were able to use the blame avoidance strategy because

the inter-party cooperation during the introduction of austerity packages and the signing of the MoU had blurred the issue of responsibility (see Magalhães 2012; Interview #9, #10). As the second Sócrates government was a minority government, it needed *PSD* help to pass its austerity plans, but the cooperation was never really open. The signing of the MoU by both parties and the change of power from the *PS* to the *PSD* immediately after the MoU further obscured the responsibility issue and enabled the two parties to easily shift the blame for the healthcare reforms to one another. The relative success of the parties' blame avoidance strategies was confirmed by the results of the June 2011 elections. Although the *PSD* won, the *PS* came second and kept about 30 per cent of the seats in the Parliament (Döring and Manow 2018).

Conclusion

This article analyzed Portugal's healthcare policy reforms in the context of the recent financial crisis. We argued that external pressure led to the signing of the Memorandum of Understanding with the Troika and triggered the reforms, but policymakers used the crisis as an opportunity to implement already planned structural reforms, targeting very specific deficiencies of the Portuguese healthcare system. The effective use of the crisis was also enabled by country-specific political factors. One was the tacit cooperation of the two main political parties, the *PS* and the *PSD*, and another was the use of a blame avoidance strategy that enabled each party to shift blame for the unpopular healthcare austerity measures to the other.

Our findings are in line with existing research showing that even in the context of intense external pressure for reform, as in the recent economic crisis, policy change is shaped by the domestic context, and that agency remains an important aspect of policy change (Dukelow 2015; Fonseca and Ferreira 2015; Moury and Standing 2017). As the Portuguese case illustrates, the policymakers signed the MoU specifying that in return for a financial bailout, they would make reforms, but they turned this conditionality into

an opportunity to enact previously proposed reforms that were politically unfeasible. This shift from conditionality to opportunity, as we show, was enabled by the strategies of the main political parties - tacit cooperation and blame avoidance.

We believe these findings can stimulate further research. Our findings are in line with the literature that points to the role of institutions (Frisina-Doetter and Götze 2011; Pavolini *et al.* 2013; Stamati and Baeten 2015) as it shows that the fragmented [institutional character](#) of the Portuguese healthcare system explains the incentives of domestic actors to agree on policy change. Nevertheless, they also point to the need for research on how other types of institutions, e.g. political institutions, in the context of crisis and external pressure for policy change interact with policymakers, creating politically opportune moments for implementation of difficult welfare reforms.

The findings from the Portuguese case also reveal that certain pre-conditions, such as existence of Government's reform plan, need to be in place in order for policymakers to use the crisis as window of opportunity. They also point to the need for the agreement of policy goals between the external and domestic policy actors. Further research on the relationship between external and domestic policy goals that compares Portugal with other countries, especially those in which crisis was not coupled with policy change, could shed more light on the conditions under which crisis can be used as an opportunity for change.

In addition, our findings on tacit cooperation are in line with the research showing that policymaking during the Portuguese crisis involved collaboration between main political actors (see Afonso *et al.* 2015; Giorgi *et al.* 2015), but further research on policy preferences in the context of crisis would yield valuable insights into what makes this collaboration possible. The recent work by Giger and Nelson (2011) on the electoral consequences of retrenchment politics and work by Jensen (2014) on the similarity of parties' policy preferences in specific welfare sectors such as healthcare could be particularly useful in this respect.

Lastly, our findings on the use of blame avoidance in the context of externally conditioned reforms back up previous literature on the use of Europe as a scapegoat in welfare state change linked to social, political and economic costs (see Graziano *et al.* 2011; Zartaloudis 2013). However, further research is needed to clarify when and why specific strategies on the use of Europe become attractive in the domestic context of political competition. Recent work by Magalhães and colleagues (2016) points to the gap between the Portuguese elites' opinion of Europe and the general public's opinion, with the public becoming less pro-European than the elites. This interesting finding indicates the need for further research on this topic.

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Appendix

List of interviewees

#1 Senior public official, Ministry of Health, 7 June 2016

#2 Healthcare policy expert, Nova School of Business and Economics, 9 June 2016

#3 Healthcare policy expert, Institute of Hygiene and Tropical Medicine, 9 June 2016

#4 Minister of Health, 8 June 2016

#5 Minister of Health, 9 June 2016

#6 Advisor to the Minister, Ministry of Health, 6 June 2016

#7 Advisor of the Minister, Minister of Health, 10 June 2016

#8 Senior public official, Ministry of Health, 10 June 2016

#9 Advisor to the Minister, Ministry of Health, 13 June 2016

#10 Advisor to the Minister, Minister of Health, 13 June 2016

Table 1. Healthcare reforms and governments in Portugal 2007-2015.

| Reform measure or proposal | Law number and date passed in the Parliament | Reform implementation date | Parties in the Government (surname of Prime Minister) | Government's type | Government's ideological orientation |
|---|---|-----------------------------------|--|--------------------------|---|
| Commission Report | 22.06.2007 (published) | n/a | PS (Sócrates) | Majority | Centre-Left |
| Enrolment in ADSE (social health insurance for civil servants) becomes optional. | Law n.º 3-B/2010, 28.04.2010 | 29.04.2010 | PS (Sócrates) | Minority | Centre-Left |
| Salary freezes and reductions for NHS staff and freezes in the pay-for-performance payments. | Law n.º 55-A/2010, 31.12.2010 | 01.01.2011 | PS (Sócrates) | Minority | Centre-Left |
| Introduction of 30% tax deduction for private healthcare insurance spending. | Law n.º 55-A/2010, 31.12.2010 | 01.01.2011 | PS (Sócrates) | Minority | Centre-Left |
| MoU – Memorandum of Understanding | 17.05.2011 (signed) | n/a | PS (Sócrates) | Minority | Centre-Left |
| Revision of the pricing system for pharmaceuticals and promotion of the use of generic medicines. | Decree-Law n.º 112/2011, 29.11.2011 | 01.01.2012 | PSD, CSD-PP (Passos Coelho) | Majority | Centre-Right |
| Increase in user fees and revision of the existing rules for fees exemptions. | Decree-Law n.º 113/ 2011, 29.11.2011 | 01.01.2012 | PSD, CSD-PP (Passos Coelho) | Majority | Centre-Right |
| Elimination of tax deductions for private healthcare spending for the top two income brackets. | Law n.º 64-B/2011, 30.12.2011 | 01.01.2012 | PSD, CSD-PP (Passos Coelho) | Majority | Centre-Right |
| Reduction of tax deductions for private healthcare insurance spending from 30% to 10%. | | | | | |
| Exemption of the unemployed from the user fees. | Decree-Law n.º 128/2012, 30.12.2011 | 22.06.2012 | PSD, CSD-PP (Passos Coelho) | Majority | Centre-Right |

| | | | | | |
|--|--|------------|--------------------------------|----------|--------------|
| salary. | 19.05.2014 | | Coelho) | | |
| Salary freezes and reductions for NHS staff. | Law n.º 82-B/2014, 31.12.2014 | 01.01.2015 | PSD, CSD-PP (Passos Coelho) | Majority | Centre-Right |
| Increase in the number of family health units. | Decree-Law n.º 223/2015, 08.10.2015 | 9.10.2015 | PSD, CSD-PP (Passos Coelho) | Majority | Centre-Right |

Source: own and Döring and Manow 2018.

Table 2. Comparison of selected recommendations by the Commission Report and measures by the Memorandum of Understanding.

| Policy Aspect/Document | 2007 Commission Report | 2011 Memorandum of Understanding |
|------------------------|---|---|
| Cost-control | Achieve greater efficiency in the provision of healthcare, implemented either through a lower expenditure, or by a lower growth rate of public expenditure on health. | Control costs in health sector on the basis of detailed measures listed below under 'Health-care system', achieving savings worth EUR 550 million. |
| User fees | Update user fees (<i>taxas moderadoras</i>) as a discipline measure for excessive use of the NHS. Revision of | Review and increase user fees (<i>taxas moderadoras</i>) through: i) substantial revision of existing exemption categories, including stricter means-testing; ii) increase of fees in certain services; |

| | | |
|-----------------|---|--|
| | the current regime of exemptions from user fees, with a redefinition of the exemptions based on two criteria: capacity to pay and the need for continuing healthcare. | iii) legislate automatic indexation of fees to inflation. |
| Tax allowances | Reduce the tax benefits associated with the health expenditure, approaching the practice observed in most OECD countries. | Cut allowances from a maximum of 30 % to 10 % of private healthcare spending. Cancellation of tax allowances for upper income categories. |
| Subsystems | Remove the budget space of the public subsystems, considering possible evolution of their elimination or financial self-sustainability. | Reduce budgetary costs of the healthcare subsystems (ADSE, ADM and SAD) by lowering the employer's contribution and adjusting the scope of healthcare benefits, by 20 % in 2012 and further 20 % in 2013. |
| Pharmaceuticals | Control of the rising costs of pharmaceuticals, including changes in reimbursement system of drugs, extending the list of medicines without prescription, introduction of lists of reference prices, encouraging the use of generics, positive lists of medicines for reimbursement, and extension of list of drugs subject to authorization consumption. | Set the maximum price of the first generic introduced in the market to 60% of the branded product with similar active substance. Revise the existing reference-pricing system. Make electronic prescription covered by public reimbursement compulsory in both the public and private sector. Improve the monitoring system of prescription of medicines. Induce both private and public physicians to prescribe generic medicines. Establish clear rules for the prescription. Remove all effective entry barriers for generic medicines. |
| Primary care | Aspects that should be reinforced are investments in primary care services and its gate-keeping function. | Reinforce primary care services so as to further reduce unnecessary visits to specialists and emergencies and to improve care coordination through: i) increasing the number of USF (<i>Unidades de Saúde Familiares</i>) units contracting with regional authorities (ARSs); ii) setting-up a mechanism to guarantee the presence of family doctors in needed areas to induce a more even distribution. |
| Hospitals | Revise the hospital network. | Set out timetable to clear all arrears. Reduce hospital operation costs for €200 million by 2012, thorough management concentration and hospital mergers. Reorganize and rationalize the hospital network through specialization and concentration of hospital and emergency services and joint management. Establish a system for comparison of hospital performance (benchmarking) on the basis of a comprehensive set of indicators. |

Sources: Ministry of Health (2007) and European Commission (2010: 17-20).

