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Health policies in Southern Europe and deregulation of labour relations: a glimpse of Portugal

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Abstract *Under the Troika Memorandum (2011-2015), health policies in Portugal know a political agenda, business and organizational schedule guided by the principles of privatisation, deregulation and underfinancing of public services by the State. In this article, the authors provide a review of the literature on health systems in the countries of the Southern European countries, highlighting the Portuguese situation regarding reform processes and major health inequalities before and during the economic crisis. Complementarily, the testimonies of different professionals of the health sector (doctor, nurse, therapeutics technician, unions and heads of care units) are summoned. Based on an exploratory study, it is our purpose to discuss political-organisational transformations and their consequences in the deregulation and precariousness of labour relations in the health sector. Wage reductions, career freeze, contractual instability, professional demotivation, intensification of the work pace and disqualification of services are some of the most visible signs of a management agenda that conflicts with the missions of a universal National Health System (NHS) at the service of Portuguese society.*

Key words *Portugal, European Union, Health inequalities, Health policy, Health personnel*

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Introduction

The health sector is a unique economic activity within the productive and reproductive domain. Throughout the 1980s and 90s, it underwent reforms fuelled by the decentralisation, deregulation, privatisation and commodification trends guided by the principles of "economy, efficacy and efficiency"[1-3] . The change process has frequently been called reform policy designed to improve the well-being and social development, which are characteristic features of a Welfare State. However, the latter paradoxically faces increasingly complex and demanding challenges in the capacity to respond to problems, such as ageing and prevalence of multi-pathologies of the population, expansion and diversification of forms and types of healthcare, upsurge of social and territorial inequalities of access and healthcare provision.

With the escalation of the global and structural crisis from 2008 to the present day, many of the reforms pursued in the Southern European countries tend to uphold models of social protection and development of health policies that deepen trends of: i) privatisation and under-budgeting by the State; ii) dissemination of private management contracts driven by productivity requirements and outsourcing of services; iii) introduction of *software* and online platforms that integrate professional practice in the different strands (from management to the interaction with users and civil society); iv) career freeze and contractual instability of health providers; vi) intensification of work time patterns, salary devaluation, and social protection; and v) large migration flows of qualified professional from the healthcare sector[4,5].

The purpose of this paper is to analyse the political-organisational transformations in the healthcare agenda and their consequences in the growing deregulation and instability of the labour relations of health providers in Southern European countries, with a special focus on Portugal. We will begin by addressing the changes which are common to Portugal, Spain, Italy and Greece, and the reasons that allow us to justify the similarities to a *Welfare State* "corporative" model, distancing them from the models pursued by North and Central Europe, during the last decades, and especially during the crisis under the Troika Memorandum (2011 and 2015). This memorandum contains the agreed terms of the financial help granted to Portugal, as well as to other countries of the European Union, like Greece, Spain and Ireland, whenever the country does not comply with the limits of the discipline imposed on the member states, that is, whenever it has a budgetary *deficit* that is higher than the 3% of the GDP (Gross Domestic Product). In order to be granted financial help, the chosen country will have to comply with a structural adjustment programme, whose outlines are defined by the Troika institutions, and which consists of a consortium of creditors constituted by the European Commission (EC), the European Central Bank (ECB), the International Monetary Fund (IMF). As a rule of thumb, this structural adjustment programme takes on austerity outlines, by imposing reduction measures of the State's expenditure, with economic and social impact on public policies.

In the presentation of results, the discussion favours the suppositions and principles that support the ideology of the implementation of the *New Public Management*[6], providing support to the central argument of a "devaluation" of the workforce. This is a debate with growing interest in national and international literature, that has highlighted the different dimensions of deregulation and precariousness of the health professionals' (trans)national labour market visible in their professional trajectories and experiences in the last years.

Methodology

The scarcity of studies on this topic enables us to propose a research design that presents the outlines of an exploratory study. It begins with a literature review and documentary research about the health systems of the Southern countries, focusing on the situation in Portugal, regarding the reform processes and the main health inequalities before and during the economic crisis. We use more relevant macro-economic indicators which are more illustrative of the dimensions under analysis, taken from the *OECD Health Statistics 2017* and guiding documents of the main macro-institutional reforms (e.g. *Health 2020 Framework for Action*, *Global strategy on human resources for health: Workforce 2030*). For the Portuguese case, the National Health Plan [*Plano Nacional de Saúde* (PNS- 2012-2016)] was analysed, which has been reviewed and extended until 2020. This Plan constitutes a basic element of the health policies in Portugal and is structured around four axes: i) Citizenship in Health, ii) Equity and Adequate Access to Healthcare services, iii) Quality in Health and iv) Healthy Policies. It

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outlines as fundamental target plans, the 30% increase of the healthy life expectancy at the age of 65 and also the reduction of risk factors related with non-communicable diseases, namely the consumption and exposure to cigarette smoke, and child obesity. In addition to this document, guiding documents of the reforms were consulted, such as the five last *Reports of the Portuguese Observatory of the National Health Systems* [*Observatório Português dos Sistemas de Saúde Nacional de Saúde* – OPSS] and the *Report of the Calouste Gulbenkian Foundation – A Future for Health: we all have a role to play* [Um Futuro para a Saúde: todos temos um papel a desempenhar].

Concurrently, we conducted nine semi-structured interviews intentionally applied to health sector agents from two hospitals in the Northern part of Portugal. In the first hospital, with Public-Private Partnership management statute, the following agents were interviewed: Eh1-doctor (40 years-old), Eh2-nurse (44 years-old), diagnose and therapeutics technician-Eh3 (50 years-old), union delegate nurse-Eh4 (40 years old) and managing nurse of a care unit-Eh5 (42 years old). In the second hospital, with Enterprise status, we interviewed the following agents: Eh6-doctor (50 years old), Eh7-doctor (50 years old), Eh8-higher technician (34years old), Eh9- Advanced health technician (40 years old).

The procedure for the interviews complied with consensual norms for the preservation of human dignity and integrity defence, i.e., after obtaining the participants' authorisations, it was explained to them - and they were fully conscious - that the data obtained could be disclosed within the academic community, respecting the confidential character of the identities.

The questions were systematised in a pre-designed script by the researchers, with topics targeting the experiences, perceptions and expectations that the different professionals in the health sector (individual and collective) attribute to the events related with their life path and professional experience in the last decade, and the same questionnaire was used with flexibility and adapted to the profile of the candidate. Two topics from the script were developed: i) access to the profession/job; ii) profession and the changes in the framework of Portuguese politics, and how they see the future of their current profession. These topics enabled the researchers to analyse the changes in the agenda of the national health policy, its consequences in the labour market and the professional paths of the health sector professionals (related with the health sector).

Data collection with the participants in this study took place between December 2017 and January 2018.

Mediterranean social well-being and health inequalities

The health sector is displayed as a significant activity of economy at the European Union level and it is intensive in terms of creation of employment. The pressure for privatisation, liberalisation, deregulation and sub-funding of the public services by the State has characterised the health policies in Portugal, as well as in other countries like Greece, Spain and Italy. Commonly associated to a Mediterranean well-being regime, these countries tend to be subjugated to the uncertain and increasingly volatile restructuring cycles of the globalised economy and of a neoliberal ideology.

As Ferrera[7] reminds us, understanding the problems associated to the reform and modernisation of the Social State is seen as more pertinent in view of the structural crisis that affects the social States of Southern Europe more severely, although the other countries also are also experiencing increasing difficulties in financing their health systems[8-10]. Even so, it is important to flag the significant advances in the improvement of life expectancy and child obesity in these countries. Nonetheless, due to the persistence of health imbalances as a function of material, educational resources, social *status* and territorial registration this topic is a privileged area of intervention for political decision-makers.

Regarding the Southern European countries, in particular, Spain, Greece, Italy and Portugal, the reforms of the national health systems in the 1980s and 90s did not manage to eliminate the territorial imbalances and the disparities of the universalisation of health care capacity. This major vulnerability in the consolidation of the social State by comparison with the other northern European countries is explained, on the one hand, by political and institutional reasons and, on the other hand, by the intensification of the economic crisis within the framework of the austerity policies imposed by the Troika since 2010-2011.

Within the context of political-institutional reasons, "geo-evolutionist" arguments are convened[7] to support the relative delay in developing the social State in the Southern European countries and in dealing with more problematic socio-economic means. This has conditioned, since the beginning of their implementation,

systems of social protection more permeable to "permanent" austerity and institutional "under-development", rooted in a "two-tier" social protection system. This duality of the social protection system is based on a regime of very generous instalments for the main categories of the labour market (civil servants and employees of the major industries) and modest protection schemes for the peripheral categories (precarious, self-employed workers and employees in small companies). Thus, problems related with the irregularity of the public services regarding their distribution on the territory, and the availability of financial and human resources to face the different categories of social problems (e.g. unemployment, the risk of ageing and of poverty, social housing) tend to persist. That assumes particular visibility in the field of healthcare services, with the implementation of a national healthcare service which, associating healthcare services to universal citizenship has combined institutions with non-public social actors, and thus the public-private articulation takes on particular importance. In turn, in these countries and particularly in Portugal, the existence of a "welfare society"[11] reinforced the role of the family, of the neighbourhood networks, and of the local communities. These support ties of inter-knowledge and mutual help which enable the exchange of goods and services on a non-commercial basis, operating as "cushion" in the deprivation or insufficiency of institutional help (support services, namely home support).

In this construction of the social State, consolidated over the expansion of the Keynesian capitalism, Esping-Andersen identified three *Welfare regimes*[12], specifically: the social-democratic regime of the Scandinavian countries; the conservative-corporate regime, of continental Europe; and the liberal regime of the Anglo-Saxon countries. Integrating the Southern European countries in one of the variants of the "conservative-corporative" model, this typology of social State models was criticised by various authors[6,13-16] who enhanced the importance of configuring a "fourth model", designated as "corporative". This last model is based on historical, socio-political facts, but also on the existence of authoritarian governments, on the influence of the Catholic church, and on the high party-political competition[17]. Furthermore, it is important to consider the professionalisation strategies by the doctors, when compared to other professional categories, with undeniable power to monopolise the labour market and avoiding the encroachment of their professional field and autonomy of the "medical act". The prevalence of a hospital-centred model of the health systems, in which the medical specialities are assumed as the central organisation of the healthcare system, strengthens the "corporative" character of these Southern European countries. In this social division of work in the health sector, the doctors have managed to maintain part of their professional prerogatives, resisting the erosion of their autonomy and *expertise* that can happen with the introduction of the new public management principles, moving away from an underlying trend which is more pronounced in the Scandinavian countries, and in the countries of Continental Europe[18,19]. Therefore, beyond sociopolitical and historical reasons, the legal political and ideological reasons are recalled as common denominator of those countries of Southern Europe.

Agenda of the healthcare policies and their reformist goals in Portugal

The political project of the National Health Service in Portugal, created in 1979, has gone through several reforms in order to promote an accessible, high quality and economically sustainable health service for everyone. There are several landmarks that outlined the development of health policies, still with great intermittence and volatility according to the party-political frameworks of the governmental action, such as: the implementation of the Basic Law on Health in 1990 (under revision in the current constitutional government), the creation of the National Health Service Statute in, and the first National Health Plan 2004-2010, following the recommendations of the European Union. Nonetheless, ever since these first stages we notice the sub-financing and the pooling of resources in the hospital sector, the scarce coordination between primary and secondary care services, the strong presence of the private sector guided by neoliberal principles that condition unequal opportunities in healthcare access by population groups that are economically more vulnerable.

In the first decade of the twentieth-first century, the Portuguese government put forward a set of reforms, many of which are still ongoing, that aim at a profound restructuring of the management and organisation systems of the healthcare in the hospital setting and in primary health. A significant part of the public hospitals was first turned into Limited Companies (Ltd.) and soon after, into Public Enterpreneurial Entities [Enti-

dades Públicas Empresariais (E.P.E.)], embodying the tendency for corporatisation, including the privatisation, the pressure towards the fulfilment of quality pattern requirements and the outsourcing of services through private-public partnerships[20]. Moreover, a national hospital network is created through the concentration of the diverse hospitals in Hospital Centres, enabling a more rational and efficient management of the type of care that is provided to the populations. Thus, a first step is taken in the reform regarding the separation between funding and care provision, stemming from the contractualisation between State and public hospitals together with the enforcement of a type of management by objectives, and also of the progressive transference of public services to the private sector. Simultaneously, the establishment of an internal market due to the competition between public and private hospitals occurs, spreading management instruments rooted in remuneration systems and distinct labour contracts and tax incentives.

With respect to the reconfiguration of networks of primary and long-term care networks, the Family Health Unit [Unidade de Saúde Familiar (USF)] features the main change and takes on the "political flagship of the reform's success"[21]. The latter is registered in a system of programme-contract in which the type and quantity of services and care to be provided to the population are defined, the funding being indexed to the fulfilment of a set of indicators and to the standardisation of the practice of the "clinical act". Concurrently, the medicine policy of the based on the promotion of the generic market and on the system of reference prices comes as a response to the growing pressure in the contention of expenses with the medicines, which are common to the majority of the European Union countries. The increase of expenses with the over-prescription or inadequate prescription practices have revealed limits to this policy regarding its potential in the reduction of the growth of the public and private expense with the medium and long-term medicines. In addition, the practices of decrease of the co-funding in medicines, the increase of the user-charges, the limitation of the use of complementary means of diagnosis, among others, are maintained.

Intensification of the crisis in the Southern European countries

Generally, the greatest health coverage and promotion of equity and social justice in the European countries has been accompanied by an increase of the healthcare expenses which in 2016 represented around 9% of the GDP on average[22]. The Southern European countries are ranked below that average in the comparison extended to 35 countries and much lower than when we consider the public investment in the Scandinavian and Continental Europe countries. Given the larger public co-funding, the governments have come to advocate interventions of health promotion which are more profitable and enable the decrease of the health inequalities (Table 1).

It is well-known that the economic slowdown and the globalisation of diseases and economies, with growing demands for chronic care that are partially linked to the ageing of populations, they have been demanding increasing attention for the funding of healthcare systems.

Likewise, in spite of the recognition of the universal and complimentary access to health for all citizens, we notice a progressive increase of the individual/family contribution in the overall expenses with health (Table 2): 23% in Italy, 24% in Spain, 28% in Portugal and 35% in Greece[23]. Besides testing the expansion of the privatisation of the healthcare services, this tendency mainly reinforces the reduction of the public financial responsibility, currently transferred to families and individuals, either via the proliferation of the health insurance funds, or by the increase of the direct family expenses. One of the most immediate consequences is the escalation of the inequalities of access by segments of the population with inferior socioeconomic conditions.

In contrast to the other countries of the European Union, Portugal, Spain, Italy and Greece implemented large-scale cuts in the public employment in general, through the non-replacement of retired workers, the freeze of new admissions and/or dismissal of permanent employees, like in Greece. The contraction in the health sector varied between career freezing to severe cuts, with more impact on those two first countries. Thus, we can see that the values are not only inferior to the OECD average of 35 countries, but also to the Scandinavian and Northern European countries, their growth in 15 years being clearly residual (Table 3).

In view of this underfunding pressure and privatisation of the health sector, the signs of reinforcement of the public policies at the level of the political-normative axes of a neoliberal nature.

Table 1. Health expenditure as a share of GDP, 2016 (or nearest year).

Country	Total	Government/Compulsory	Voluntary/Out-of-pocket
Germany	11,3	9,5	1,7
Sweden	11,0	9,2	1,8
France	11,0	8,7	2,3
Netherlands	10,5	8,5	2,0
Norway	10,5	8,9	1,5
Belgium	10,4	8,0	2,4
Denmark	10,4	8,7	1,7
Austria	10,4	7,8	2,5
United Kingdom	9,7	7,7	2,0
Finland	9,3	7,0	2,4
OECD35	9,0	6,5	2,5
Spain	9,0	6,3	2,6
Portugal	8,9	5,9	3,0
Italy	8,9	6,7	2,2
Slovenia	8,6	6,1	2,4
Greece	8,3	4,8	3,5

Source: OECD Health Statistics 2017, WHO Global Health Expenditure Database (adaptation by us).

Table 2. Health expenditure by type of financing, 2015 (or nearest year).

Country	Government schemes	Compulsory health insurance	Out-of-pocket	Voluntary health insurance
Norway	74	11	14	0
Germany	7	78	13	1
Denmark	84	0	14	2
Sweden	84	0	15	1
Luxembourg	9	73	11	6
Iceland	52	29	17	0
Netherlands	9	71	12	6
Slovak Republic	4	75	18	0
United Kingdom	80	0	15	3
France [1]	4	75	7	14
Belgium	18	59	18	5
Estonia	11	65	23	0
Austria	31	45	18	5
Italy	75	0	23	2
Finland	61	13	20	3
OECD35	36	36	20	6
Slovenia	3	69	13	15
Spain	66	5	24	4
Portugal	65	1	28	5
Greece	30	29	35	4

Source: OECD Health Statistics 2017 (adaptation by us).

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Table 3. Employment in health and social work as a share of total employment, 2000 and 2015 (or nearest year).

Country	2000	2015	
Norway	17,8	20,4	2014
Denmark	17,3	17,9	
Sweden	16,7	16,7	
Netherlands	12,3	15,7	
Finland	13,2	15,6	
France	12,2	14,3	
Belgium	9,8	12,9	
Germany	10,4	12,8	
United Kingdom	10,1	12,4	
Ireland	7,8	12,2	
Iceland		11,4	
Austria	8,2	10,4	
Luxembourg	6,7	10,2	
OECD 35	**8,5**	**10,1**	
Portugal	5,6	7,9	2013
Italy	6,5	7,6	
Spain	5,3	7,0	2011
Greece	4,2	5,4	

Source: OECD National Accounts (SNA); Annual Labour Force Statistics (adaptation by us).

New public management and instability of work relations

The generalisation of the market and consumerism principles, of a managerial and controlling discourse explicit in the logic of results, quality and assessment frame the *New Public Management*[1,6]. This strategy has been accompanied by a growing instability of the work relations, with individual and flexible contracts and the escalation of structural unemployment[24-27].

This transposition or *mimicry* of the rationale of private entrepreneurial management to the "public affairs", related with the healthcare provision, however, brings important consequences to the constitution of the workforce, Despite having a highly qualified population as far as qualifications are concerned, the workers are currently subject to a dualisation and significant segmentation regarding the processes of employment relations and organisational contexts in which they perform their activities. Some remain in public careers, even if they are still subjected to the policies of the last years of contention in taking on personnel and in career progression freeze; many others, especially the younger ones, endure a subcontracting regime and/or work in private units of healthcare provision with general rules of individual labour contracts. Thus, we see a tendency towards increasing employment of the different professional groups in uncertain, underpaid jobs, with no social protection and no prospects regarding the development of qualifications and professional careers, and under more intense and demanding working conditions from the point of view of the professional exercise.

The consequences that this entails challenge us to a discussion of the "new directions" of professionalism and the dilemmas of regulation in the (trans) national labour markets, with special impact for the health professionals, until then with tariff-setting powers of their jurisdictions and strategies to monopolise the labour market[19,28].

Well, there were a lot of implications of the reforms introduced in the health sector, mainly seen as incomplete and introducing different levels of performance by the Government, and of complexity in view of the difficulties and challenges it faces[29]. By analysing the last five reports of the Portuguese Observatory of Health System [Observatório Português dos Sistemas de Saúde (OPSS)] the escalation of the crisis in the health sector, and especially, the escalation of inequalities becomes obvious: "Two faces of health – Spring Report" (2003) ["Duas faces da saúde - Relatório de Primavera" (2013)], "Denial Syndrome – Spring Report" (2014) ["Síndrome da]negação - Relatório de Primavera" (2014)]; "Access to health care – an endangered risk? – Spring Report" (2015) ["Acesso aos cuidados de saúde. Um direito em risco? – Relatório Primavera" (2015)]; "Health: In search of new routes – Spring Report" (2016) [Saúde: Procuram-se novos caminhos – Relatório Primavera" (2016)]; "Living in uncertain times: Sustainability and Equity in Health" – Spring Report (2017) [Viver em tempos incertos Sustentabilidade e equidade na saúde – Relatório Primavera" (2017)] (available at http://www.opss.pt/).

The report of the Calouste Gulbenkian Foundation, namely "A Future for Health: we all have a role to play" ("Um Futuro para a Saúde: todos temos um papel a desempenhar") also outlines the main challenges or difficulties of this sector. Among its contents, common concerns arise regarding the signs of a health agenda which tends to be "non-universal", imported with the impact on the funding of the National Health service [Serviço Nacional de Saúde (SNS)] on the country's GDP, in the absence of clear guidelines for

the investment on health and on the organisational health of the SNS, and the demotivation of the health professionals; there is a tendency for "talent waste" and the dissatisfaction of the most vulnerable segment of the population with the response of the SNS. About this particular issue, please note the following excerpt:

[…] *the civil servants, including the health professionals of the SNS, suffered a reduction of about 15% in their salaries, and saw a decrease in the value of their reforms in the future. The number of professionals was reduced and, simultaneously, the demand for healthcare services increased. There are unemployed nurses, many of them quite young, as well as some more elderly ones who are leaving the country and looking for better opportunities elsewhere*[27].

One of the interviewees highlights the degradation of the National Health Service concerning the economic and assistance level:

be concerned about the impact the SNS funding can have on the country's GDP. There are no concerns regarding the costs with Private-Public partnerships, both in the Health sector and in others. These costs do not seem to matter as long as they are not directly included in the State Budget. The latter will have to be submitted to the European Union and may go under scrutiny by the Social Partners, bringing along difficulties to the country. (E4- Trade Union delegate nurse, 40 years old).

From scientific literature review, we would also like to register the repercussions of the reforms introduced in this sector, particularly concerning the doctor, a central category of the health system in terms of power, autonomy and prestige[28]. In turn, the testimonies collected, allow us to reinforce the repercussions of budgetary instability translated in the successive and significant cuts in the State budget, as well as in the salaries of its professionals, having significantly affected the life of the institutions, in their numerous areas of activity.

At the level of corporatisation of the hospitals, the contractual relationships have changed and started to abide by the individual labour contract, their holders being penalised in terms of working conditions, with consequences for the "organisational climate", as becomes evident in the following interview excerpts:

[…] *I believe that the employment path has brought more instability, under a behind a veil of flexibility. Very trendy jargons like 'productivity' and 'competitiveness' unbalanced the work relationship to the detriment of the worker and often, ironically, with his consent* (E1-Doctor, 40 years old).

[…] *within the framework of Portuguese politics, in spite of the great investment in training, there is a clear disinvestment in the career of these professionals, which have been stagnated for more than 18 years. This disinvestment is also noticed in recruitment, despite the ever more significant shortage of these professionals in the National Health Service* (E3-Technicians of Diagnose and Therapeutics, 50 years old).

As far as the nursing profession are concerned, even more alterations resulting from the career revision were registered. We should refer, for example, the fact that the different categories were eliminated (graduate, specialist and manager) and only two were created (head nurse and nurses). The second never even occurred:

[…] *over the last the years, the nurses didn't have any progression in their careers and had to deal with massive uncertainty… the fact that the manager nurses nowadays are nominated by the head nurse, in my opinion, also takes away the necessary independence for the daily protection in the creation of the safety conditions and quality in the care provided* (E5 – Leader of a care unit, 42 years old).

[…] *the focus was placed on the career freeze, there was no evolution according to the expectations created, making the team elements today much more demotivated and unhappy. This fact also contributes to this dissatisfaction and the investment made academically is not reflected in their career…With no career progressions, no competitions will open… etc. Besides, in the health sector in public service, the weekly workload also rose to 40 hours, which means that the rotation schedules were greatly influenced* (E5 – Manager Nurse, 42 years old).

The neoliberal rationalisation was translated by neo-taylorian organisational changes (the rationalisation of the clients' paths, the centralisation of information, the standardisation of the care protocols, the intensification of work, care timing, sectorisation and planning of the activities of the different care providers), and by changes of the participatory type which aimed to show a rationale that was compatible with the activity of the services, of the profitable pathologies defined from a strategic negotiation on which the medical service and nursing project and of therapeutic management technicians lies. The care framework it considered crucial nowadays for the operationalisation and rationalisation of the services. In addition, the investment of the health professionals in managerial support areas seems to be significant, when compared to the invest-

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ment in resources of the technical areas of health. We also observe the creation of *ranking* awards at the national level, among the institutions. That enhances the pressure to increase the satisfaction levels of the patients and professionals. Often, the professionals are urged by the senior managers to provide an effective care supervision. According to our next interviewee, "Management has swallowed Health":

[…] *occasionally … marketing operations* […] *I usually say that Management has swallowed Health. The decisions and the options are made by individuals who are not health professionals. The latter are only consulting elements, and that makes all the difference* (E5 – Managing Nurse, 42 years old).

At a time when the demands in the health organisations are increasing, the human resources didn't always keep up their pace, either due to their number, or because of their training. Some examples are provided, namely at the level of work methodologies, computer records, management and supervision processes, production and cost control, among others. Some transcripts of the interviewees reveal these changes:

I witnessed the change of Nursing records from paper to complex computer-based systems. Instead of rendering better healthcare to the population, in my opinion, the exact same care is worse nowadays than when I started working. Twelve years after I started my duties, the debate in the changing of shifts is amorphous and not very inclined toward care improvement. In comparison with the period when I began my duties, as a team we debated what was best for those we targeted in care provision, an initiative which is quite different from what is common practice nowadays) (E2-Nurse, 44 years old).

In my team, the number of elements per shift was reduced and constituted by 60 Nurses, myself and two more people lodged a complaint with the Order of Nurses due to what would be the reduction of hours devoted to the provision of care to patients, who were once users and are now called 'customers' of the institution. Notwithstanding the fact that the service suffered a reduction of its elements, we were also moved from our workplace for being cheeky (E4- Union Deputy Nurse, 40 years old).

There were quite a few changes – on the one hand, the introduction of the Public-Private Partnerships and, on the other hand, the career freeze in Public Office. […] *the focus was on the management processes, production control, cost control, creation and monitoring of multiple indicators, which brought a new reality to our hospitals* (E5 – Managing Nurse, 42 years old).

Over the last thirty years, the totality of these agents has seen their missions, functional contents and work methods transformed. These professionals, also designated as Board partners and are determinant for the evolution of the work organisation. Their mission is to keep away transversal projects (in terms of equipment and therapeutic guidance), and provide solutions depending on the external constraints (competition with other organisations), envisioning the evolution of work organisation. Some strategies are accomplished, like meetings, project groups, management training courses planned by the Training Centres that progressively contribute to modify the practices and discourses of these new Board partners[30].

The job of the relational professionals is currently confronted with demands for change. Their managers urge them to pursue different directions (training, blame, complaints from "customers" or taxpayers) as a means of waiving the small-scale reference as their professions were usually thought of, to move on to an administrative professionalism. As far as the political discourse is concerned, we intend to concurrently gather efforts from different areas, which are capable of generating a new and homogeneous "framework culture" and other organisational forms.

Conclusions

The repercussions of the financial crisis and of the austerity policies are inscribed in a long tendency for underfunding and privatisation, common to Southern European countries, as mentioned before. To foresee the recent changes in the health sector in Portugal and within the context of the countries from Southern Europe does not pursue a comparative purpose, although it is still relevant to take into account the protagonists and the transnational agendas in this domain. The weight of the institutions, norms and values that shape the public policies sends us in the direction of the specificities of each of the historical-societal configurations of the Nation-State. In spite of the preliminary results of the current study, the health sector in Portugal faces tensions and challenges common to the member-States, which go through: 1) financial constraints and significant cuts in the State budgets, especially more severe in over-indebted countries like Portugal, under the Troika memorandum; 2) the ageing of the current health professionals and insufficient/

difficulties in recruiting new professionals; 3) problems in setting the health professionals due to the work conditions and low salaries offered in some occupations, leading partly to the "brain drain" phenomenon/migration in a global market; 4) the emergence of new healthcare patterns in view of the chronic conditions of ageing of the population; 5) the importance of the new health technologies (e.g. e-health, telemedicine, collaborative platforms) that demand other/ new competences (*skill mix*) and future professions.

The health professionals try to fight this "deviation", simultaneously reiterating the missions of an organisation with a public nature, open to the nearest population, such as: offering the first-line care required by a hospitalisation, for economic, psychological, social or medical reasons; to evaluate the severity of the treated cases and redirect them to a more adapted service. In this regard, the criticism formulated towards achieving a scientific, high-productivity and elitist medicine may be halted, but they cannot prevent the regrouping of the services imposed by hegemonic factions inside the health organisations, that originate the inequalities – regional disparities, equipment and care actions). The recent audiences concerning health do not seem to bring anything admirable in their conclusions, but they display data which, at times, are alarming, about certain factions of the population and bluntly conjure up the lack of efficiency of the health policy.

Collaborations

This article was written with the contributions of two authors: APP Marques in the document research and literature review, and APMC Macedo in the accomplishment of the exploratory interviews.

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