The Portuguese universal health system

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> "Human anatomy and physiology are the same worldwide, but the organization and delivery of health care reflect individual cultures."
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> In Annas, J. G. et al. (1990), Preface — p. xxxi.

I. General data

Considering the last available data (2005) Portugal health expenditure in relation to GDP is currently 10.2%[1]. Portugal has been increasing the amount of gross domestic product (GDP)** spent on health, which has grown 24.4% percent in the period 1995-2001[2]. In 2005 the spending on health level was just right below the OECD average considering the health expenditure per capita notwithstanding spending almost 2000 euro per capita. In terms of GDP and income inequality Portugal GDP per capita is 20,030 USD PPP[3].

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** A list of the abbreviations used is presented in the end of this chapter.

Health care in Portugal is mainly financed by public funds (direct and indirect taxes). However, private expenditure (essentially out of pocket payments and private health insurance) in health has been around a quarter of the total expenditure on health (2.8% in a total of 10.0% of GDP spent on health care in 2004)[4].

Other relevant information may derive from the analysis of the OECD data on "health expenditure by functions of health care". At this level, in 2005, Portugal spent: 61% in curative and rehabilitation medicine; 1% in long-term care (OECD average is 11%); 25% in medical goods; 10% in ancillary services and 3% in public health and administration[5].

In Portugal the public health and prevention policies were never considered as a main priority by the State. Consequently, in 2005, and despite the fact that average OECD countries spend 3.1% of their public share in health expenditure, Portugal is only spending 1.4%. Pharmaceutical expenditure is a major health budget problem considering the most needed health sustainability. In the same year, Portugal spent 436 USD PPP in pharmaceuticals 60% of this value being assumed by the public sector. If we consider the period between 1995 and 2005 it is possible to determine the annual growth in pharmaceutical spending, which in Portugal is increasing in an annual average growth rate of 3.7%[5].

Also according to the last available data, in 2001 the employment rate in the health sector was 3.4 percent of the active population[6]. By the year 2004, there are 377 Health Centres in the country, with a further 1,940 extensions and 1,102 beds (primary health care), 75 general hospitals with a total of 22,634 beds and 95 psychiatric, alcoholics and drug abusers institutions with a capacity of 2,809 beds. In these institutions were working 24,697 physicians, 39,429 nurses and 7,475 paramedical professionals. Approximately 35,751 medical doctors, 4691 dentists, 9,395 pharmacists and 45,906 nurses were listed as members of their respective professional associations.[7]

In 2005 the main health indicators were: 4.6 nurses per 1,000 inhabitants; 3.4 physicians per 1000 inhabitants (1.7 general practitioners and 1.7 specialists per 1000 population[8]); 0.3 pharmacies per 1,000 inhabitants; 116.5 hospital admissions per 1000 inhabitants; 1,938.8 large or medium surgical procedures per day and 3.9 medical consultations per inhabitant.[9]

There are strong regional asymmetries in what concerns the health condition of the population showing that poverty is still associated with less quality of life and health care access.[10]

Portugal has 10,6 million of total population and has a population average annual growth rate of 0.5%.The mortality average age is getting higher every year. Life expectancy at birth in Portugal in 2006 was 75.2 years for men and 80.4 for women. This evolution brought the country from 7.7% of the population aged over 65 in 1960 to 17.0% in 2005 (over the OECD average)[11].

A dramatic and well known change in Portuguese health indicators can be found in the infant mortality rate which has decreased over the past 30 years from the concerning 10.9 per 1,000 in 1990 to 3.9 per 1000 in 2004. This positive evolution is due to the good policies and strategies that where set over the years[12].

A negative indicator is the AIDS incidence rate which puts Portugal in second place in the list of new cases year per million (79.5%). The USA is currently number one with 137 new cases; the OECD average is 18.8%.

A very concerning indicator is the mortality from road accidents putting Portugal in second place of all OECD countries with 17.4 dead per 100,000 population[13]. In 2005, the main causes of death for the Portuguese are cardiovascular diseases (211.7/ 100,000 individuals) and malignant tumors (156.1/100,000 individuals) of a total standardized mortality rate of 676.9/ 100,000 individuals[14].

The perceived health status gives us some concerning information because only 39% of the population aged 15 and over reported to be in good health. The OECD average is 69%[15].

II. The Portuguese health care system

Historical note on medical care[16]

Health services in Portugal have an historical Christian background, based in the charity spirit of helping the poor, the sick and the handicapped[17]. The embryo of the schools of medicine in Portugal may be found in an ancient (around the XII century) type of hostelry, built near pilgrims' roads that gave shelter to people in need. The existence and maintenance of these places were mainly due to the first Portuguese Queens, since Kings and other noble men were engaged in the war against the moors and other neighbour kingdoms. Those hostelries that started as regular shelter facilities were at a point divided into two different areas, in which one was only for the sick lodgers. These areas where the sick were treated by people with some kind of experience in the art of healing (normally monks), correspond to the first "hospitals"[18] in the country and hence to the very first schools of medicine.

Medicine was first taught in Portugal in a XII century monastery *(Mosteiro de Santa Cruz)* where it was part of a non systematized curricula among other subjects such as theology, mathematics and grammar. A man named Mendo Dias is the first person who is known to have studied medicine in Paris and to teach what he had learned back in Portugal in that monastery at that time. Frei Gil de Santarém (1185-1265) from whom there are numerous medical writings in the Évora Library and Pedro Hispano (1216-1276) who became Pope John XXI, where two of the first famous Portuguese who studied medicine in Paris[19].

The first University in the country was founded in Lisbon (General Study of Lisbon), in 1290 by the King D. Dinis. Since the very start it had medicine in its curricula but this subject was considered inferior to other courses, like law, letters or art. Medicine was taught by only one professor until 1493 when it begun to be taught by two professors. In 1537 the University moved to Coimbra.

In 1503-1504 under the King D. Manuel, the first reform of the medical course was made with the objective of improving education and efficiency amongst its students. The course begin to have the duration of five years and in the end of this one the graduated had to pass an examination done by the *físico-mor* ("major physician"), in order to get the "habilitation letter", prior condition to the practice of medicine.

The organization of the medical profession in Portugal dates from 1898, when the Association of the Portuguese Physicians was created. This Association changed its name to *Ordem dos Medicos* (Order of Physicians) in 1938.

The Order of Physicians was established by the decree-law 29 172 dated November 24th, of 1938 and succeeded the Association of the Portuguese Physicians. At the time it embraced only the physicians who practiced medicine as a liberal profession. This legal instrument was replaced by decree-law 40 651 dated June 21st, of 1956 and later amended three times by respectively, decree-law 48 587 of September 23rd, 1968, decree-law 48 879 of February 22nd, of 1969 and decree-law 333/70 of July 14th. With the democratic revolution the need for new rules increased.

In 1977, Decree-Law 282/77 of July 5th approved the present Statute of the Order of Physicians. The preamble of the statute recognizes disciplinary competence to the Order of Physicians and determines its jurisdiction over all the physicians.

The Order of Physicians is a public law professional association, consisted of all the physicians as single persons. As a

public law association it expresses the constitutional desideratum for the participation of the citizens in the general government. It allows an articulation between the public interest, concerning the manner in which certain activities — as the medical activity — should be exercised, and the private interests of its professionals.

The professional orders find, since 1982, a constitutional legitimation in article 267/4 of the Portuguese Constitution (before, their existence, and particularly the restricted access to the profession, were highly discussed and controversial). According to article 267/4 of the Portuguese Constitution, public associations can only be created to perform specific functions (principle of specification) and necessarily different from the ones of the Unions (non-competition principle). Additionally they must have an internal organisation based upon democratic principles and on the respect for its member's rights. As a public law association, the Order of Physicians was created by a legislative act (in the case, by Decree-law 282/77, of July 5th). The extent and scope of its powers is determined by this legislative act.

Its primary object is the representation of the interests of its members — physicians. Simultaneously they must regulate the profession and stipulate its disciplinary rules. In order to accomplish these last nominated functions, and because it is a public association, the Order of Physicians has received, by law, administrative powers and the necessary instruments from the state to exercise a truly public administration function, even if restricted to its members.

As it happens in general with other professional public associations, the Order of Physicians is based upon the principles of the obligation of inscription and quotas system. That also means that the organization of the physicians obeys the principle of the control of the access to the profession (as already stated above). Moreover the Order involves a whole particular deontological system and its inherent sanctions panel.

As part of the so-called "autonomic public administration", the Order of Physicians is granted a major degree of autonomy from the state. Despite this autonomy the Order is subjected to the State's guardianship in terms of the control of legality as any other public law entity.

The NHS — the National Health Service

Presently, the Portuguese Health Care System is based in the existence of a National Health Service (NHS)[20] composed of the healthcare institutions and units (hospitals and health centres) that belong to the Public sector, under the control of the Ministry of Health[21]. The NHS[22] is considered by Article 64 of the Portuguese Constitution as the main element to attain the fulfilment of the *right to health care protection*: "Everyone has the right to health protection and the duty to defend and promote it", and according to the same constitutional disposition, is oriented by the principles of universal access (accessible to all citizens), comprehensive health care services (offering all kinds of healthcare needed), pending to gratuity, "participated" (managed with the collaboration of all health care actors) and decentralized (organized with proximity to the populations served)[23].

The NHS is composed of the health care units that are under the supervision of the Ministry of Health, including two main entities: hospitals and health centres (Bases XXII/2 and XXXVI of Health Bases Law — Law 48/90, August 24th). It is important to note at this point that the current concept of hospitals had their legal existence recognized long ago, in the year 1946 (Law 2011), while the Health Centres model was only conceived after the health reform of 1971[24] (DL 413/71, of September 27th). In numbers from the National Health Plan, in 2001, 363 health centres equipped the Portuguese territory, with 1797 extensions,

employing 6,961 physicians, 6,850 nurses and 875 paramedics. A reform of the primary health care sector is currently under development.

Nevertheless, Portugal has a considerable private healthcare sector[25] the majority of which contracts with the State to provide health care services to NHS beneficiaries.

A very intensive trait of the Portuguese Health System legal history has been the constant changing of this reality in each different government or even sometimes during the same government. In fact, Portugal passed through different health policies phases that had a strong effect in the structure of the health care system and in the way that its components are conceived and managed. These phases were more clear in the past, depending on the ideology of the political party in power, but nowadays the scenario is more fuzzy, and the type of reforms do not correspond to any of the ideologies originally connected to a political party. Traditional leftist political parties can at present show liberal reforms and vice-versa. The constant changes, however, are a very strong characteristic of the health legislation field. Going back and forth in some of the reforms has happened very often as we will see in the description below.

The first phase, from 1976 to 1990, based in the original version of Article 64 of the CRP, was a post-revolutionary period where the prevalent idea was to subordinate the private sector to a *social medicine* concept[26], to make the NHS the only healthcare provider in the country. This was expressed in a paragraph of the original version of Article 64, where it was said that the State should "orient its actions to the socialization of medicine" (this principle was substituted *grosso modo* in the constitutional amendment of 1989 by the sentence "socialization of costs" which has prevailed up to the present days). In 1986, Portugal became member of the European Economic Community (now European Union) and became

eligible for European funding for social and economic infrastructure development which included the health sector. Since then the Portuguese NHS facilities were able to expand in better and more sustained way as the country's increasing wealth significantly benefited the health sector.

A second phase may be identified from 1990 to 2002. In 1990[27], with a liberal politics party in power, the Health Bases Law (Law 48/90, of August 24th) was enacted, giving to the health sector an entrepreneurial orientation legal framework for the first time. This legal reform had two crucial points:

i) *The integration of the NHS in a "Health System's" context*
The 1979 NHS legislation ignored the existence of an important private and social sector in the health framework. The above-mentioned 1990 Health Bases Law, created for the first time in Portuguese Health Law the concept of "Health System", inserting in this one, besides Ministry of Health dependent public hospitals and health centers, *i.e.* the NHS, also the private health care institutions, which had contracts with the latter (see Base XII, *ibid.*).

ii) *The birth of private management in the public health sector*
The 1990 new law aimed at stimulating the Portuguese private health sector and mainly the private management of NHS facilities. The starting point was the *Hospital Fernando da Fonseca*[28], a new 600 bed public hospital near Lisbon built by the State and opened in 1995, under a management contract with a private consortium. This modality is still unique but other forms of private management within the NHS started at this point. Besides the *Fernando da Fonseca Hospital*, and other few isolated experiences of private management in public hospitals, there were no more consequences of the 1990 law in what concerns the NHS main structure and organisation.

The beginning of a third phase is marked by the first and only amendment to the Health Bases Law in 2002 (Law 27/2002, of November 8th) and is still going on. In fact, the mentioned amendment allowed the transformation of 33 public hospitals in SA companies (*Sociedades Anónimas* — Joint Stock Companies), switching these institutions from the state administrative sector (public statute and management) to the state entrepreneurial sector (private statute and management). From January 1, 2003, approximately 30% of Portuguese public hospitals (corresponding to close to 50% of the public sector bed capacity) were managed under a private legal framework.

Nevertheless, the changing of Government in 2005 led to a new switch in the legal nature of hospitals. The DL 233/2005 of December 29th transformed the hospitals SA into hospitals "EPEs", *i.e.,* "Entrepreneurial Public Entities", meaning that the management of these hospitals was again integrated in the public sector rules.

This period, although punctuated by health policy divergences between the two main political parties, has been marked by a solidification of an entrepreneurial management scheme in public health units. This assertion may be seen in hospitals by the PPPs initiative and in health centers with the creation of the *USFs,* as described in the two following points:

i) *The PPPs*
Ten new public funded and owned hospitals are expected to be constructed over the next few years within a "PPPs — private investment, public financing and private management"[29] framework[30]. The PPPs are defined by Article 2/1 of DL 86/2003, of April 26th as a Union of Contracts under which private entities (named as "private partners") oblige themselves before a "public partner", to a lasting performance of a collective need. The financing,

investment and management of the specific developed activity belong, altogether or partly, to the "private partner". In the Health sector, the PPP's object is a lasting association of "private partners" to the provision of health care.

These partnerships consist of one or more of the following activities: conception, construction, financing, conservation and management of the health units. The main principles and tools of the Heath PPP's are defined by DL 185/2002, of August 20th, amended by DL 141/2006, of July 27th, while DR 14/2003, of June 30th has approved a standard specification contract. The development and implementation of the PPP's in the health sector is an assignment of an *"ad hoc" Mission Unit* nominated "Parcerias. Saúde", created by *Resolução do Conselho de Ministros* 1627/2001, of November 16th.

ii) *The USFs*

The *Unidades de Saúde Familiar* (Family General Practicioner's Units) or *USFs* constitute the main innovation of the ongoing national reform of the management of primary health care units[31], by using a range of market mechanisms within the public sector. Having a strong and close relation with the local Health Centers *(Centros de Saúde),* although they are technically and functionally autonomous, the *USFs* are primary health care units that use mainly contract based management tools to set a basic series of health services[32] that ought to be accessible by the populations.

Although the Health Bases Law[33] sets primary health care as a priority, the Portuguese Healthcare System has been up to now too Hospital centered. The *USFs* represent some of the new implemented policies with the aim of reducing Hospital over-utilization, rationing the use of resources and create incentives for people to have a *family doctor,* offering a range of basic health care services in close proximity to the patients.

The performance contracts celebrated by the *USFs* brought stronger incentives[34], which had repercussions in the implementation of the first *USFs,* as in just a few years the number of these units in the country has grown dramatically[35].

The *USFs* management model is considered a breakthrough[36] in the primary care public sector strategies, mainly because it introduces a new dynamic in the system by reinforcing the shared responsibility between different health care professionals, to comply with the performance agreements. This reality is different from traditional health centers which are mainly focused on the physicians' responsibility and which management is not based on performance levels.

USFs may assume three different models/forms. Each model (A, B or C) offers different levels of autonomy and goals. A team/group of health care professionals (led by a physician) must apply[37] to constitute an *USF*, providing the fulfillment of all legal requirements.

To conclude, it is pertinent to note that although the Primary Health Care sector is still undergoing the development of the still recent introduction of the *USFs*, a new reform has already been set. This occurred based on the norms approved by DL 28/2008, of February 22nd, which created the *Agrupamentos de Centros de Saúde* or *ACES* (Health Centers' Clusters).

Article 2/1 of this statute defines the *ACES* as "health services with administrative autonomy constituted by several functional units belonging to one or more health centers" (author's translation).

It is still early to conclude if the *USFs* are going to continue to be the basic model of a new management paradigm in Portuguese primary health care units or if they are going to be

diluted in the latest forms of health centers' organization prescribed in the 2008 *ACES* mentioned statute.

III. The National Health Plan

The Ministry of Health, by the auspices of the Portuguese Directorate-General for Health, has published a National Health Plan for the period 2004-2010[38], based on the fundamental values and principles of human dignity, solidarity, social justice, citizens' empowerment, equity, sustainability and continuity of care setting the necessary interventions and recommended strategies.

This Plan points out the strategic guidelines for the minimum range of activities that the institutions of the Ministry of Health should assure within the context of an agenda to improve health gains and efficiency. The Plan presents a state of the art in several areas of the health sector, both in a global view and in a healthcare system perspective. It aims to comprise all the fundamental health issues along the life cycle, mentioning in particular areas such as transmissible diseases, cancer, cardio-vascular diseases, chronic-degenerative diseases, mental health and psychiatric diseases, pain and traumatic lesions. Every section of the plan analyses the current figures on each issue, the existing regional interventions and national programs. The Regional Office of WHO supervised and assessed the conception and contents of the document.

IV. Main administrative structure of the Ministry of Health

A) Organic statute of the Ministry of Health

In 2006, the structure of the Ministry of Health (MH) central services and dependent bodies was the object of an important

administrative reform by a new statute (DL 212/2006, of October 27th, approving the Ministry of Health Organic Statute). This Ministry is the governmental department that has the responsibility to define and promote national health policies[39], using its normative functions while having the obligation to provide the assessment of its policies outcomes (Article 1, *ibid.*).

To achieve the aforementioned goals the MH must regulate all health care activities (public and private) as well as to plan, to audit, to inspect and to assess all the NHS related issues (Article 2 of the mentioned Organic Statute). This body is also responsible for the financing of the NHS (*ibid.*)

According to the Health Bases Law, the MH and the Regional Health Administration Departments (*ARSs*) may contract with private institutions in order to assure NHS beneficiaries the proper health care services, provided that the institutions demonstrate the economic benefit and the adequate quality-cost relation between the health care provided and its cost and assure equity in the access to care[40].

The organic structure of the Portuguese MH comprises a very complex and heavy system, which relies on the interaction of different juridical kinds of entities[41] (central services and departments; public agencies; enterprises and consulting bodies; healthcare units) with diverse functions, *e.g.* bureaucratic, management or healthcare delivery, towards which the MH exercise diverse types of powers[42].

The Minister of Health is the vertex of the administrative pyramid of the Portuguese Health System. Immediately underneath the Minister, there are five central bodies (Article 4 of the MH Organic Statute) all with special and diverse powers including regulation and evaluation powers. These entities, which are especially regulated by the mentioned organic statute are the following: the High Commissioner for Health (Article 11, *ibid.*), the IGAS — General-Inspectorate for Health Activities (Article

12, *ibid.*), the Authority for Blood and Transplantation Services (Article 15, *ibid.*), the DGS-Directorate-general for Health (Article 14, *ibid.*) and the General Secretariat of the Ministry of Health (Article 13, *ibid.*).

Working under the supervision of the Minister of Health, belonging as such to the "indirect" administration, there are several public agencies, which execute the objectives of the MH. These entities, according to Article 5/1 and 2 of the MH Organic Statute, are the following:

— The ACSS — Central Administration for the Health System (Article 16, *ibid.*);
— The INFARMED — National Authority of Medicine and Health Products (Article 17, *ibid.*);
— The INEM-National Medical Emergency Institute (Article 18, *ibid.*);
— The Portuguese Blood Institute (Article 19, *ibid.*);
— The IDT- Institute for Drugs and Drug-Addiction (Article 20, *ibid.*);
— The INSA-National Health Institute Ricardo Jorge (Article 21, *ibid.*), and
— The *ARSs* — Regional Health Departments[43] (Article 22, *ibid.*).

B) The General-Directorate for Health

In Chapter III, Section I, Article 14 of the DL 212/2006, of October 27th we find the basic structure and responsibilities of the Portuguese General-Directorate for Health. This body inherited the competences and attributions of the entity first established in 1899 with the controversial name *Direcção-Geral de Saúde e Beneficência Pública* (General-Directorate of Health and Public Beneficence)[44].

In 1911, the General-Directorate of Health and Public Beneficence was transformed into the General-Directorate of Health (DGS), splitting from the public beneficence services, which were then integrated in a different public institution. In the same year Ricardo Jorge, a distinguished physician who had a crucial role in the spread and promotion of the Public Health science and teaching in Portugal was nominated the first Portuguese General Surgeon (Director-General for Health).

According to the mentioned DL 212/2006, of October 27th and also in DR 66/2007, of May 29th (DGS Organic Statute) the DGS must regulate, orient and coordinate all the health promotion related issues, especially regarding disease prevention[45]. The definition of the desirable technical conditions for the health care services is also a crucial DGS responsibility. The DGS is directed by the General Surgeon *(Director-Geral de Saúde),* who is obligatorily a physician, being also the national Health Authority[46]. The General Surgeon may nominate up to three sub-directors to his office (Article 14/3 DL 212/2006, of October 27th).

The DGS has the responsibility to develop Public Health programs[47], as well as setting orientations for health programs in order to make them more efficient and with a higher quality standard (Article 14/2, of the MH Organic Statute). The national epidemiologic surveillance, health statistics[48] and technical health care related studies are all in the sphere of responsibility of the DGS.

Especially considering the quality promotion of all health care services the DGS shall determine and disseminate guidelines for the development of excellence at all levels of care (Article 2/2/c) of The DGS Organic Statute). In this last legal reform the DGS has also assumed the mission, the responsibilities and the powers of the extinguished Institute for Health Quality (Article 10, *ibid.*). In the same direction, the DGS has today the responsibility to define the standards of the best practices, having

the power to the licensing of healthcare units in articulation with the ACSS — Central Administration for the Health System (Article 2/2 d) *ibid.*).

To achieve all the goals mentioned above, the DGS may rely on the collaboration and support of all the Ministry of Health services and related institutes, as well as the cooperation of all healthcare providers (integrated or not in the NHS[49]).

C) Regional Health Departments (ARS, I.P.)

The already mentioned *ARS, I.P.* are mentioned in Chapter III, Section II, Article 22 of the DL 212/2006, of October 27th. Here we found the legal description of the *ARS's* main structure and powers. The *ARS's* are public agencies regulated by Public Law, integrated in the "indirect" administration, being a legal entity with administrative and financial autonomy (Article 1/1 of the *ARSs* Organic Statute — DL 222/2007, of May 29th).

The *ARSs* mission, if summarized in a basic and clear goal, would be to assure the access to health care services to all the population in their specific region. To achieve this goal the *ARSs* must guarantee a level of services adequate to their population needs, accomplishing along the way the objectives of the National Health Plan for their region (Article 22/1, of DL 212/2006, of October 27th). The organic statute of the *ARSs* determines that these bodies should be composed of three different organs: a Directive Board, a Supervising Official (*Fiscal Único*) and a Consultant Board (Article 22/3 and 4, *ibid.*). The Directive Board has a different structure design depending on the area of the specific *ARS*. In the more populated regions of the Lisbon and Tagus Valley *ARS* and the North *ARS* the Directive Boards are composed of one president, one vice-president and three other members; in the *Alentejo, Algarve* and *Center ARSs* the same board

is composed by a president, one vice-president but only two more members.

Within their specific regions, the *ARSs* must coordinate, evaluate and execute the health policies, accordingly with the global and sectorial policies with the main objective of using the resources adequately. In this sense the *ARSs* shall participate in the definition of the coordination measures in intersectorial grounds (see Article 22/2/a)/b) and c), *ibid.*).

The *ARSs* must also assure the human and material resources planning, including the execution of necessary investment projects for the healthcare units under its supervision. These units, technically supported by the *ARSs*, also have the crucial responsibility of evaluating the healthcare unit's performance, providing the national policies and technical demands. The *ARSs* are also the competent bodies to provide a technical opinion regarding the future licensing of new private health care institutions (Article 22/2/d)/e) and f), *ibid.*).

The aforementioned description of the *ARSs* structure and functions in the Ministry of Health Organic Statute is repeated and developed in the *ARSs* own organic statute, the DL 222/2007 of May 29th. In fact, accordingly to Article 3/2 of the latter, *ARSs* must assure the subsequent actions:

— To coordinate and execute the Ministry of Health policies in their own geographic area (*ibid.*/a) and b));
— To cooperate in the elaboration of the National Health Plan, as well as in the monitoring of its application (*ibid.*/c));
— To develop and enhance public health activities to promote their population's health (*ibid.*/d));
— To assure the adequate network contracts between health care providers (*ibid.*/e));
— To plan, coordinate and monitor the human resources management within their own area of influence (*ibid.*/i)).

— To give advice on the creation, modification and integration of health care services (*ibid.*/m));
— To license private health care units (*ibid.*/p)).

Finally, showing how broad the functions of the *ARSs* are in the management and administration of the Portuguese health system, these public agencies have also important responsibilities concerning the laboratory studies and tests for transplantation purposes. In fact, the *ARSs*, have the obligation of maintenance of the National Center of Bone Marrow, Stem Cells and Umbilical Cord Blood Donors[50] (CEDACE), and of the computerized waiting list for transplantation (*ibid.*/h)).

V. Legal Framework of the Private Health Sector

According to Article 64 of the CRP, the State must provide adequate conditions to assure the citizen's right to access quality health care services. In order to achieve this goal, the State may act at different levels in the health care chain (financing, contracting, or providing services itself), working alongside private institutions. Article 64/3/d) of the CRP, constitutionally defines the desirable interaction between the State and the private health care units. It determines as State priorities the supervision and the control of the entrepreneurial and private forms of the medical practice, which should operate in conjunction with the NHS, in order to assure, in public and private health care units, a high and adequate level of quality and efficiency.

The Health Bases Law (Law 48/90, of August 24th) also sheds some light on this matter. In Chapter IV, Base XXXVII, it especially mentions the State's duty of supporting the private health sector development. In this sense, one of the measures

prescribed by this law is the facilitation for NHS human resources (working in the public sector), to work in the private sector as well (Base XXXVII/2, *ibid.*). Additionally, the *ARSs* may celebrate contracts with private health care units to provide specific services to the NHS beneficiaries (*ibid.,* Base XXVII/3/e).

Moreover, private health care institutions have to meet the State's licensing requirements, and to cooperate with the State's supervising and surveillance in all the quality related issues to operate legally. In particular, private hospitalization must act in conjunction with the NHS (*ibid.,* Base XXXIX/1 and 2).

The legal definition of private healthcare units is found in Article 1/2 of DL 13/93, of January 15th which states that these units are not integrated into the NHS, even though they provide medical, nursing, inpatient or recovery services.

DL 13/93, of January 15th is the legal framework statute of the private health care units, comprising the major principles and requirements applicable to these units. According to this statute, private institutions need a Health Minister's Order authorizing the licensing of the private unit (Article 4/1, *ibid.*). The types of services provided and the specialties that the private institution may offer should all be stated in the *License Order,* as well as the maximum number of users/patients permitted (*ibid.*/2).

Two principles must be also assured: the adequacy[6] of the requiring entity and the quality of the services provided (*ibid.,* Articles 7 and 8).

A final requirement, public control, comprises the responsibility of two different bodies, the DGS and the IGAS. The first has to perform an audit/evaluation prior to the Minister's authorization, and the latter may collaborate (when requested) with the DGS in the supervising and control activities.

DR 63/94, of November 2nd prescribes the requirements for the installation, organization and functioning of private health

care units and sets the standards throughout its 46 articles and 11 annexes, as follows:

— Quality promotion system (amongst other norms, see Article 43, *ibid.*);
— Location (Section I, Articles 4 and 6, *ibid.*);
— The terrain (Section II, Articles 6 and 7, *ibid.*);
— The building (Section III, Articles 8 to 19, *ibid.*);
— The technical facilities and equipments (Article 35, *ibid.*);
— Confidentiality issues (Article 41, *ibid.*);
— Safety issues (amongst other norms, see Article 42, *ibid.*).

The licensing, functioning and supervision of several private medical activities have specific legal regulations. This is the case of drug abuse treatment clinics (regulated by DL 16/99, of January 25th), physical rehabilitation clinics (regulated by DL 500/99, of November 19th [52]), private dental care clinics (regulated by DL 233/2001, of August 25th [53]), social support private entities (by DL 64/2007, of March 14th).

VI. The National Health System and patient rights

During the Portuguese dictatorship that lasted 48 years (1926-1974) the country was politically ruled by authoritarian and "anti-liberal" policies based on a Constitution that deliberately excluded fundamental rights of the citizens. This dictatorial repression explains why the legislator was so reluctant to use the "language of rights", even in the health legislation, and the term "rights" never appeared during that period. An example of this is the Hospital Statutory Law of 1968 (Decree-Law 48,357, dated 27th of April 1968), in which we find, in Articles 80 to 82, some of the main patients rights of today (privacy, informed consent,

refusal of treatment, religious assistance) without ever using expressions such as "rights" or "patients rights".

The situation changed after the entering into force of the first democratic Constitution, in April 1976. In this new Constitution of the Portuguese Republic, the importance of the fundamental rights increased considerably compared with all former Portuguese constitutions. The chapters on rights, liberties and guaranties of the citizens are now wide and protected from any subsequent constitutional revisions by article 288/d) of the Constitution.

The demystification of the use of the word "right" after the revolution had immediate consequences in the first National Health Service Law (1979) where some "rights" are already given to the user of the system. Surprisingly, the Portuguese citizen had to wait until the Health Bases Law of 1990 (Law 48/90, dated 24th of August) to have a real legal statute of rights in the health sector.

In the Base XIV of this law, there are nine rights attributed to the users of the health system: a) the right to choose the deliverer of care within some restrictions; b) the right to decide to take or to refuse health care, unless exceptions exist in the law; c) the right to be treated by adequate means, with humanity, promptness, technical accuracy, privacy and respect; d) the right to confidentiality of the personal data disclosed; e) the right to be informed about their situation, the possible alternatives of treatment and the probable evolution of their condition; f) the right to receive, if desired, religious assistance; g) the right to complain and to sue regarding the way they were treated and, if it is the case, to receive compensation for damage; h) the right to constitute representative organisations that would defend their interests; i) the right to constitute organisations that will collaborate with the health system, like associations for the promotion and defence of health or health units friends groups.

Base XIV/2 continues with the list of the duties of the health system where we find among others, the duty to respect the rights of the other patients and the duty to collaborate with the health professionals in relation to their own health.

Patient's rights in the Portuguese legal framework also include the "Oviedo Convention" (Council of Europe Convention for the Protection of Human Rights and Biomedicine). This convention is now part of the internal juridical order after a Presidential Decree of the 3rd January 2001.

All the rights inscribed in the Health Bases Law and in the Oviedo Convention are fundamental rights and are the patrimony of any citizen in the position of being a user of a public or private Portuguese health care unit.

Although the laws and declarations exist, doubts persist whether patients' rights are truly observed in hospitals and other health care units of the country.

There are various reasons for the lack of implementation of the law, the first being the difficulties that come from the deficiencies of the Portuguese health law. As we saw above, the Law gives important rights to the citizens as users of the health services. Nevertheless, these norms are too vague and general to be of practical use. There are no specific regulations to guide the health provider on the detailed contents of the declared rights of a patient.

Another factor that creates obstacles to patient's rights protection is the dilution of responsibility in the present setting of healthcare units. The number of health professionals that deal with one single patient continues to increase. Consider the classical example of the medical secret that is no longer a "medical" but a "shared" secret among numerous different health professionals. How is it possible to protect the right to confidentiality in these circumstances?

Patient's rights are also affected by the crisis of the Portuguese justice system, which being particularly slow and

expensive, makes the citizen reluctant to bring to court actions to remedy violations of their rights law or even seek the advice of a lawyer. Civil liability regarding damage caused by health care malpractice in Portugal is still governed under the "Napoleonic" rule of the *culpa* (fault) that demands going to court in order to get compensation. The judicial difficulties together with this system, leads Portuguese patients to be very hesitant to bring attention to violation of their rights made by health professionals or health care institutions.

All the mentioned obstacles to a real implementation of patients' rights in Portuguese health care units lead to the conclusion that the patient is still the weakest link in the health care process. Even if the law undoubtedly declares his rights, the Portuguese patient is normally a fearful individual, unaware of his legal status and with no direct representative organizations in the civil society.

Several factors seem to point to a higher standard of protection of patients' rights in the future, as these rights become better known, discussed and respected by health professionals.

VII. Patients' duties in Portugal

A) The inheritance of European fundamental duties theory

The subject of "patients' duties" subject cannot be understood without being linked to the broader issue of "fundamental rights and duties" because these two issues share some basic conceptual problems. As we will explain more in detail, "patients' duties" have inherited some of the main juridical features of fundamental duties in European countries constitutional law and this fact can partially help to explain some

of the problems European laws have to define the concept of "patient duty" and its scope.

In fundamental rights and duties theory, there is no consensus on whether to consider fundamental duties as "autonomous counterparts" to fundamental rights or as a mere "manifestation of inherent limits" of the latter[54]. There is little express recognition of the existence of fundamental duties in the majority of European constitutions and where it does happen, the mentioned duties are seen as limits upon fundamental rights and freedoms or as a natural part of the "socially integrated individual", rather than as independent existing and enforceable duties[55].

One of the main reasons for the reluctance of European democratic constitutions to recognize and to mention fundamental duties may be historical, as citizens' duties lists are still a symbol of dictatorial political regimes, being a feature of communist constitutions or reminders of the dark effects of the "national duty" so cherished by the Third Reich[56].

Therefore, it seems that the absence of "patients' duties" in European health laws follows the general tendency of avoiding a written recognition of citizens' duties. Not even the crucial citizens' duties of paying taxes or to attend obligatory school have expression in most of European Constitutions. Fundamental duties are mainly considered as an implicit corollary of a unwritten rule of responsibility that all citizens should have regarding the use of their rights and freedoms. European case law treats fundamental duties as "constitutional values", used for a proper systematic interpretation of the constitutional principles rather than as an independent source of particular obligations of the individual[57].

In what concerns the European Union Law, we cannot find any fundamental duties nor in the Treaties or in the derivate law. These duties which are considered to be historically seen as

"republican obligations imposed on each citizen for the common well-being"[58] are deeply linked to the concept of citizenship which is it self not developed in the Community Law". Stefan Kadelbach, in his work on fundamental duties in the perspective of the European Court of Justice, concludes that these duties in Community Law "do not form autonomous counterparts to fundamental rights"[59].

Nevertheless, despite their rather "subsidiary" nature to rights and freedoms, citizens' fundamental duties cannot be considered as mere moral obligations. We may find some evidence of this assertion in some countries case law, *e.g.* Finland, where two 1997 judgments referred to the constitutional duty to defend the country regarding criminal guilt and sentencing[60] and also in the German constitutional parental duties which are enforceable by the law, being considered not as mere limits to parental rights but rather as one of the elements that defines parental law[61]. We also find European countries (*e.g.* Portugal) that have included a fundamental duty to defend and promote health in the Constitution (Art. 64/1), duty that is repeated in health ordinary laws, showing that this fundamental duty towards health is not seen as a mere moral obligation.

The importance of a balance between patients' duties and health professionals' rights and duties is not very often mentioned as a tool to the implementation of patients' rights, but it was the main concern of the European Forum of Medical Associations Statement on the "Declaration of Amsterdam" (Declaration on the Promotion of Patients' Rights in Europe)[62], issued during a meeting with WHO, held in Stockholm in February 1996. This statement, as we will show, is evidence that the medical professionals feel the gap between all the weight given to patients' rights and the lack of any importance given to correspondent patients' responsibilities, mainly in what concerns their duty to collaborate with health professionals.

In the mentioned document, the Forum "recalls" that "an essential element in the fulfillment of patients' rights to health care is mutual confidence between the health care professional and the patient (implying mutual recognition of the rights and obligations of both parties) and that the relationship between professional and patient should be one of partnership, with the object of achieving an appropriate improvement in the health of the patient" (§6 of the mentioned document). The Forum Statement also cherishes that the Declaration of Amsterdam, in the part entitled "purpose of the document" draws attention "in particular to patients' responsibilities both to themselves (for their own self care) and also to health professionals (for providing them with all necessary information for diagnosis and treatment, as well as for recognizing that they are entitled to the same rights as other citizens)" (*ibid.,* §8).

B) The duties of Portuguese patients

The already mentioned Portuguese Health Bases Law (Law 84/90, of the 24th of August) gives a general responsibility to the individuals in the accomplishment of the right to health protection (Bases I/1 and IV/3 of the Law), but it also attributes concrete duties to the patients. In Base XIV/2, the same Law has a list where we find that the users of the health system have the following duties:

1) To respect the rights of the other users;
2) To observe the rules of organisation and functioning of the services and institutions;
3) To collaborate with the health professionals in relation to their own health;

4) To use the services in accordance with the established rules;
5) To pay the charges that derived from healthcare deliverance when due.

Being unusual in contemporary European Health Law, we may find a reason for the list of Portuguese patients' duties if we consider that these duties where adapted from the Hospital Statute (Decree Law 48,357, of the 27th April, art. 81) that dates from 1968, when Portugal was still not a democracy. This gives force to the fundamental duties theory that these duties are connoted as juridical features of dictatorial regimes. The 1990 adaptation deleted the article of the 1968 law that mentioned as a legal obligation of the patients the duty to comply with the medical prescriptions and therapeutics prescribed to them. However the 1968 Law was never explicitly derogated, and this duty nowadays seems to be against the self-determination principle and informed consent rules.

Note of the author

Portugal is under a constantly changing legal framework, mainly in the social sectors of Health, Labor and Education. Reforms come in rapid succession, sometimes without enough time to be understood or implemented before being replaced by a newer reform. An article on the legal framework of the national healthcare system has an inherent risk of being (at least partially) already outdated at the time it is published.

Health politics is in constant movement these days in Portugal. Hence, health legislation in our country is constantly changing the juridical shape of the Portuguese Health System. The author recommends that readers check for amendments of the legislation mentioned in this chapter before quoting it.

List of used abbreviations

ACES	*Agrupamentos de Centros de Saúde* (Health Centers' Clusters)
ARSs	*Administrações Regionais de Saúde I.P.* (Regional Health Departments, Public Agencies)
CRP	*Constituição da República Portuguesa* (Constitution of the Portuguese Republic — Constitutional — Law 1/ 2005, of August 12th)
D.R.	*Diário da República* (Portuguese Official Journal)
DGS	*Direcção-Geral da Saúde* (Directorate-General for Health)
DL	*Decreto-Lei* (Decree-Law)
DN	*Despacho Normativo* (Order Implementing the law)
DR	*Decreto-Regulamentar* (Decree Implementing the law)
e.g.	*exempli gratia*
EEC	European Economic Community
EPEs	*Entidades Públicas Empresariais* (Entrepreneurial Public Entities)
EU	European Union
GDP	Gross Domestic Product
i.e.	*id est*
Ibid.	*ibidem*
LO	*Lei Orgânica* (Organic Statute)
MH	Ministry of Health
NHS	*Serviço Nacional de Saúde* (Portuguese National Health Care Service)
OECD	Organization for Economic Co-operation and Development
OPSS	*Observatório Português dos Sistemas de Saúde* (Portuguese Health System Observatory)
PORT	*Portaria* (Implementing Order)
PPPs	*Parcerias Público-Privadas* (Public-Private Partnerships)

SA	*Sociedade Anónima* (Joint Stock Company)
UNESCO	United Nations Educational, Scientific and Cultural Organization
USD PPP	Purchasing Power Parity in US Dollar
USF	*Unidades de Saúde Familiar* (Family General Practicioner's Units)
WHO	World Health Organization

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[1] OECD, 2007. Health at a glance 2007: OECD Indicators [monograph on the Internet]. Paris : OECD. [accessed June 2008]. Available at: http://oberon.sourceoecd.org/vl=2288233/cl=22/nw=1/rpsv/health2007/index.htm.

[2] *Ibid.* See also Campos, A. C. & Ramos, F., 2005. Contas e ganhos na saúde em Portugal : dez anos de percurso. In *Desafios para Portugal:Seminários da Presidência da República*. Lisboa: Casa das Letras. p.159-223. These authors mention that between 1990 and 2002 health expenses increased from 6.2% to 8.6% of the GDP.

[3] OECD, *ibid.*

[4] Directorate-General of Health, 2006. Health in Portugal : basic indicators 2004 [monograph on the Internet]. Lisbon : Directorate-General of Health. [accessed June 2008]. Available at: http://www.dgs.pt/.

[5] OECD, *ibid.* Available at: http://titania.sourceoecd.org/vl=10682715/cl=13/nw=1/rpsv/health2007/g5-3-01.htm

[6] Directorate-General of Health, 2004 — National Health Plan 2004/2010 [monograph on the Internet]. Vol. I, English version, p. 6. Lisbon : Directorate-General of Health. [accessed June 2008]. Available at: http://www.dgsaude.pt/upload/membro.id/ficheiros/i006666.pdf.

[7] Directorate-General of Health, 2006.

[8] OECD, *ibid.*

[9] INE, 2006. Statistical Yearbook of Portugal [monograph on the Internet]. Lisbon: Instituto Nacional de Estatística. [accessed June 2008]. Available at: http://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_publicacoes&PUBLICACOESpub_boui=11796801&PUBLICACOESmodo=2.

[10] Observatório Português dos Sistemas de Saúde (OPSS), 2005. Novo serviço público da saúde : novos desafios : relatório de Primavera 2005. [monograph on the Internet]. Lisboa : OPSS. [accessed June 2008]. Available at: http://www.observaport.org/OPSS/Relatorios/.

[11] INE, *ibid.*

[12] Directorate-General of Health, 2006.

[13] OECD, *ibid.*

[14] Directorate-General of Health, 2007. Health in Portugal : 2007 [monograph on the Internet]. Lisbon : Directorate-General of Health. Ministry of Health. (Portugal 2007. Portuguese Presidency of the Council of the European Union). [accessed June 2008]. Available at: http://www.contratualizacao.min-saude.pt/Downloads_Contrat/Informa%C3%A7%C3%A3o%20T%C3%A9cnica%20Online/Health_in_Portugal.pdf.

[15] OECD, *ibid.*

[16] See for this section Ferreira, F. A. Gonçalves, 1990. História da saúde e dos serviços de saúde em Portugal. Lisboa : Fundação Calouste Gulbenkian, p. 62 and 63.

[17] *Ibid.*, p. 65.

[18] The English word *hospital,* which is the same in Portuguese, has its origin in the Italian term *sprital* or *spital* that means "hostelry". Until the Discoveries period, the current word for hospital was still *sprital* (*Ibid.,* p. 62 and 63*).*

[19] *Ibid.,* p. 75 and 76.

[20] The NHS enshrined in Article 64 of the CRP (fundamental right to health care protection) was first created and regulated by Law 56/79 of September 15th. This law may be considered implicitly revoked in 1990 by the Health Bases Law — Law 48/90, August 24th. In fact, it is preconized by the doctrine (see for all Ferrara, F. (1987) p. 191-195) that when the legislator approves a new global legal framework for a certain matter, this is equivalent to a renovative *mens legislatoris*, which should lead the interpreter to a conclusion in the sense of an abrogation of the ancient ruling system. [Ferrara, F., 1987. Interpretação e aplicação das Leis. 4th ed. *Colecção Studium* : temas filosóficos, jurídicos e sociais. Coimbra : Arménio Amado]. Additionally, the subsequent approval of a new statute of the NHS in 1993 (DL 11/93, of January 15th, which implemented the Health Bases Law) is also a clear sign of the legislator's intention of breaking in block with the past legal regime.

[21] See Base XII/2 of Health Bases Law (Law 48/90, of August 24th).

[22] As a sociological note, we may cite here Barreto, A. , 2003. Social change in Portugal : 1960-2000. In Pinto, A. C., ed. 2003. Contemporary Portugal : politics, society and culture. New York : Columbia University Press. (Social Sciences Monographs). 159-182, stressing how the NHS represents an important milestone regarding the evolution of health care services in Portugal. The author states that "(...) after a slow evolution, already visible during the 1960s, the health system underwent a rapid expansion, covering all the territory, and is apparently within the reach of whole population regardless of region, locality, profession or social condition. In the late 1970s when the National Health Service was created, around two-thirds of the population were already covered by some other system of sickness support. The reduction in infant mortality, and death from contagious disease (including tuberculosis), as well as the increase in life expectancy,

attest the positive effects of the expansion of public health services". See *ibid*., p. 171.

[23] See Article 64/2/a), of the CRP. See for all Canotilho, J. J. G. & Moreira, V., 2007. Constituição da República Portuguesa Anotada. 4th ed. Vol. 1. Coimbra : Coimbra Editora, on the annotation to Article 64.

[24] For a description of the early history of health centers in Portugal see Sakellarides, C., 2005. De Alma a Harry : crónica da democratização da saúde. Coimbra : Almedina. p.65-75.

[25] Private Health expenditure is currently 2.8% of the GDP. Source UNDP (United Nations Development Programme), 2007. Human Development Reports 2007/2008 (Portugal) [monograph on the Internet]. [accessed June 2008]. Available at: http://hdrstats.undp.org/countries/data_sheets/cty_ds_PRT.html.

[26] See Canotilho, J. J. G. & Moreira, V., 1978. Constituição da República Portuguesa : anotada. Coimbra : Coimbra Editora, in annotation to the original version of Article 64/3/c) of the CRP.

[27] Based on data provided by the *Portuguese Observatory of Health Systems,* although there are small divergences in the interpretation and description of the legal reform of 1990.

[28] In 2008, a new Minister of Health (of the same Government) announced the end of the private management contracts in this Hospital. A new legal status reverting the management of *Fernando da Fonseca* Hospital to the Public sector has been announced, although not yet approved.

[29] For an insight on the historical evolution of the private intervention in the public provision of health care services, especially regarding PPPs, see Reis, V., 2004. A intervenção privada na prestação pública : da expansão do Estado às parcerias público-privadas. *Revista Portuguesa de Saúde Pública*. Volume temático : 4 (2004) 121-135.

[30] It is necessary to mention that the Minister of Health recently announced some changes to be applied to the PPPs in

the health sector. However, a legal expression of this intention was not yet approved.

[31] See DL 298/2007 of August 20, which created the legal framework of these units. It is though important to mention that the concept of the *USFs* has more than 10 years, since it was already previewed in DL 157/99 of May 10th.

[32] *PORT* 1368/2007, of October 18th establishes the basic level of services required.

[33] Law 48/90, of August 24th (Base XIII) determines primary healthcare care as the top priority of the Health Care System; however, this legal prescription does not reflect the real situation.

[34] *E,g.* pay-for-performance financing schemes; more autonomy in terms of management throughout an explicit agreement between the government and the professionals.

[35] Numbers available point to the existence of 105 *USFs* by January 2008, spread throughout the country. Available at: http://www.mcsp.min-saude.pt.

[36] Base XXXVI of Law 48/90, of August 24th, focus on the need of using and implementing some new management tools in the public health care management.

[37] DN 9/2006, of February 16th. This piece of legislation has the set of rules that health professionals must observe when applying for the constitution and management of an *USF*.

[38] Available at: http://www.dgs.pt and http://www.euro.who.int/observatory .

[39] The Health Ministry is specifically responsible to achieve the goals set by the Health Bases Law (see Base VI of Law 48/90, of August 24th).

[40] Base XII of the Law 48/90, of August 24th.

[41] See Article 3 of the Organic Statute.

[42] These powers belong to two categories: "direction" powers, which concern central services or other bodies that are directly

dependent from the Minister and "supervision" powers, concerning public agencies (organizations to which government has devolved power). The "supervision" powers (*tutela*) have a more or less intervention level, depending on the degree of autonomy given by statute to those "quasi" — independent public bodies (see Article 199/d) of the CRP, on the different administrative powers of the Government).

[43] The *ARSs* are five the North Regional Health Department; the Lisboa and Tagus Valley Regional Health Department; the Centre Regional Health Department; the Alentejo Regional Health Department and the Algarve Regional Health Department (see Article 5/2, *ibid.*).

[44] This body statute, published in 1901 was a long and exhaustive document with 374 Articles, each one with several paragraphs creating a difficult structure with too many entities with overlapping competences and powers.

[45] See Article 2 of DR 66/2007, of May 29th.

[46] According to DL 336/99 of September 29th and by the Article 4/1 of DL 212/2006, of October 27th.

[47] Article 2/3/c) *ibid.* determines that the DGS is responsible for the coordination of all necessary interventions in the Public Health ambit, especially considering the Public Health emergencies.

[48] The DR 66/2007, of May 29th in its Article 2/2/f) goes further on this responsibility, demanding form the DGS a "continuous enhancement of the health statistics provided by this Institution".

[49] See (Article 2/5 *ibid.*).

[50] More information about this Center is available at: http://www.chsul.pt/relatorio_cedace.htm.

[51] *Ibid.,* Base XXXIX/1 and 2.

[52] Article 8 of this statute was revoked by DL 222/2007, of May 29th

[53] Article 9 of this statute was revoked by DL 222/2007, of May 29th

[54] See Weber, A., ed., 2001, Fundamental rights in Europe and North America. Part A. The Hague : Kluwer Law International. p. 8.

[55] It seems to be the general opinion of the authors of 11 European countries that contributed to the chapter on fundamental duties *in* Weber, A., *op.cit.* See pages 95-96 in particular.

[56] Holznager, B., 2001, *in* Weber, A., *op. cit.,* p. 95.

[57] Garlick, L. & Wyrzikovski, M., 2001, *in* Weber, A., *op.cit.,* PL60.

[58] Kadelbach, S., 2001, *in* Weber, A., *op. cit.*, p. EC 81

[59] *Ibid.,* p. EC 82.

[60] Scheinin, M., 2001, *in* Weber, A., *op.cit.*, p. 69.

[61] Holznagel, B., *ibid.*, p.

[62] See "Declaration on the Promotion of Patients Rights in Europe", 1996. *International Digest of Health Legislation.* 47(3), p. 410-411.

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