CHAPTER 8 - THE STATE AND MEDICINE IN THE GOVERNANCE OF HEALTHCARE IN PORTUGAL

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INTRODUCTION

According to Newman (2005), the way the state, public and private stakeholders, the health professions and the market connect with each other determines the structure of governance in healthcare in each particular country. This concept stresses a more complex and diversified set of regulatory mechanisms and practices than those provided by the broad typologies that divide Western healthcare systems into national health services (the Beveridge model); social security systems (the Bismarck model) and private health insurance systems (the market model) (see van der Zee & Kroneman 2007 for a synthesis). Countries sharing the same typology may actually reflect different governance arrangements, depending on the threefold articulation between the state, the professions and the market. In some cases, network-based governance has pride of place (the Netherlands or Norway); in others that key position is taken either by the state (the United Kingdom) or health professionals (in which case medicine may stand alone (Germany) or be obliged to negotiate with other health professions (Denmark)) (Burau & Vrangbæk 2008).

As regards Portugal, the place of medicine and its relationship with the state is still poorly understood, in particular in comparison with countries sharing the Beveridge model. In those, it

is well known that tighter regulation of accountability and performance has become the main strategy to reform the governance of healthcare (Kuhlmann & Saks 2008). These policies must be rooted in broader processes and not exclusively in the health sector – an issue that is highlighted by other contributions to this book. One such process is connected with the knowledge society but in a way that affects well-established professions. Like medicine in its professionalization (Freidson 1970), health management and other health professions nowadays make use of the status of their scientific knowledge to claim authority over new professional jurisdictions or compete for established jurisdictions in healthcare. Another of those processes is linked to the disengagement of the welfare state from areas traditionally under its protection, e.g. the health sector, as competition and marketization increase within the public administration in most European countries (Burau & Vrangbæk 2008). The latter process is what is commonly known as the New Public Management (NPM), which originated in public-choice theory and managerialism (Gruening 2001).

Of particular relevance for Portugal is the key position the medical profession continues to play in healthcare as against other stakeholders, including the state and other health professions (see Lopes 2006; Carvalho 2012, 2014). Moreover, according to a recent enquiry, the Portuguese continue to rely more on physicians than any other health professionals or patients' associations (Espanha et al. 2013). In sum, the place and role of medicine in Portugal apparently fails to confirm the evidence pointing towards increasing criticism of medical authority, the sharing of power with other health professions and the lack of trust in medical autonomy by better-informed citizens. While these transformations are taking place and are also expected to expand in the future in Portugal, our standpoint here is that processes of change should be perceived as cumulative rather than a break with the past. National dynamics profoundly affect how broader

trends such as those described above turn out in each country. In relation to Portugal, after the dictatorship fell in 1974 and the transition of the Social Security System to the National Health Service was legally accomplished in 1979, neither health professionals and the population in general nor the politicians and regulators were really more detached institutionally from previous ways of working, in particular in the place given to physicians as the centerpiece in the governance of the healthcare system (Carapinheiro 2006).

With this background in mind, this chapter brings together the evidence of three pieces of medical sociology research in Portugal, conducted 20 years apart (Carapinheiro 1993; Serra 2008; Correia 2012a). Each of these followed qualitative, in-depth methods focusing on specific features of the medical profession. Here, they are joined together and reinterpreted from a specific angle: the capacity of physicians to influence the way health policies are applied at the workplace level in public hospitals. The dimensions on which this examination is based are as follows: (I) the aim and scope of NPM; (II) the colonization of management tools by medical professionals, and (III) the medical control of technologies in health care.

FROM THE PAST TO THE PRESENT IN HEALTH POLICY

In most countries, NPM has led the state to tighten its control over the national regulatory frameworks for healthcare in order to achieve greater predictability and a reduction in the waste of resources. However, there are three ideas about health policy that are often mistaken. These are, firstly, that health policies resulted from the regulation of medicine; secondly, that ethical/moral issues underpinned the emergence of health policies; thirdly, that health policies were established after the Second World War.

Actually, the spread of health policies in Western countries registered differences both in speed and in motives. As Foucault (1979) describes, the first type of modern health policy was originally pursued in Germany in the early 18th century, as part of the state strategy to manage demography in the context of ongoing wars. Medical training and practice became partially subject to state regulation, which gave rise to national-level health plans and the creation of medical policies aimed at supervising and controlling populations. The second type was visible in late-18th century France. In this case, the concerns of the increasingly influential urban bourgeoisie were behind the rise of health policies. These were centered, in particular, on the collectivization of urban spaces such as cemeteries, sewers or basements, which were perceived as threatening public health. Sanitary policies, including quarantine against the plague, emerged at that time. In this case, medicine did not serve as the means for the state to control the population, as in Germany, but rather to identify, group, delimit and oversee outbreaks of disease ("sanitary medicine"). A third type of health policy was particularly visible in England in the second half of the 19th century when diseases became statistically correlated with poverty and unemployment in the industrial era. State healthcare policies sought to provide social assistance for the poor through the control of vaccination, the specification of housing conditions and clinical registration.

In short, these three points in European history reveal differences in health policy: this was implemented according to specific political and economic demands that in turn created differences in the interplay between the state and medicine. On the other hand, regardless of such differences, the interdependence between these two players became common in Western countries. The more medical knowledge was regarded as the sole basis to define and defeat diseases, the more medical and state regulation overlapped. Scientifically tested allopathic

medicine became one of the expert systems that states most needed to expand their administrative rationale. This eventually boosted the autonomy and authority of medicine throughout the various countries, producing the so-called 'golden era of medicine' (Turner 2006).

In sum, with reference to health policies in Western societies, the following should be considered: (i) the processes through which the body, health and illness became collective issues, and thus a matter of public concern and surveillance; (ii) the different aims encompassed by medical knowledge, involving both dependence on and independence from the state (that is, the aim of assistance for the poor and the control and protection of workers, the sanitary aim for the population at large, and the liberal aim for the richer, according to the rules of the market) (Herzlich & Pierret 1987).

At present, further changes in the interplay between the state and medicine are re-igniting the discussion. Not only have different players emerged, such as pharmacologists, biotechnologists (Clarke et al. 2010) and private investors in increasingly liberalized markets (Mirowski & Plehwe 2009), but financial constraints have also led the states to increase their control over medical procedures. Today's public policies are shaped by the NPM rationale and thus aim to introduce the 3Es into public organizations: economics, effectiveness and efficiency (Rhodes 1994). Generally speaking, the public sector is run and funded, like private corporations (Ferlie et al. 1996; du Gay 2000), through the strengthening of bureaucratic procedures. It is expected that greater objectivity and predictability will be achieved in dealing with uncertainty and the lack of transparency by the discretionary use of scientific knowledge (Gabe 2004; Slater 2001; Chamberlain 2009). This issue has been addressed in particular with regard to medical autonomy and authority. Cross-country analyses converge in showing the states involved as generally

pursuing strategies that enhance their position in the governance of healthcare systems. However, the consequences for medicine seem contradictory, given that the results vary between continued autonomy and greater accountability (Davies 2004).

SOCIOLOGICAL PERSPECTIVES OF THE GOVERNANCE OF HEALTHCARE IN PORTUGAL

The Portuguese healthcare system has undergone comprehensive reforms, just alike its Western counterparts. Although the underlying reasons are similar, the outcomes diverge, notably in the influence of medical professionals on the shaping regulatory mechanisms and practices. In other words, despite the strengthening of the hierarchical control over professional autonomy, which has made medical professionals more accountable and has led to evaluation of their procedures and performance, a number of studies in Portugal have noted the strategies of medical professionals within the organizations that protect occupational professionalism (e.g. values based on trust, competence, identity and cooperation. See Evetts, 2005). It is therefore important to shed light on how medical professionals maintain self-regulation over procedures and performance almost intact, by either bypassing tighter state regulation or bringing it within its own jurisdiction.

Readers who are not familiar with the Portuguese situation should be aware of the gap commonly identified in southern European countries between how institutional policies are presented and how they are implemented (Gough 1996). This issue reveals the contrast between the analyses by medical sociologists and those of health economists and policy analysts. Whereas the latter draw their conclusions from institutional features, the former pay attention to the

processes taking place within organizational spaces. Fundamentally, the conclusions sociologists have managed to reach remain invisible to the eyes of other disciplines in Portugal.

By following qualitative and intensive data collection techniques, Portuguese medical sociologists have sought to provide a comprehensive explanation of precisely how the legal transformations in the health care system impact on the micro-level relationships that exist in health organizations. This includes the study of internal differences in the medical profession, as well as the interplay of physicians with other health professionals, and with managers and patients. The evidence presented in this chapter draws on the conclusions of three of these studies (Carapinheiro 1993; Serra 2008; Correia 2012a), which related, in particular, to the relationship between the state and medicine within public hospitals. We intend here to provide a schematic and longitudinal reading of the interplay between state regulation and professional self-regulation in Portugal regarding the medical professionals' strategies to bypass, react to and in some cases control the constraints externally imposed by hospital administrators. It is important to mention that, despite the internal hierarchies in the medical profession, which are important to an understanding of the strategies medical professionals can or cannot employ, they are not analyzed in this discussion. They involve a more comprehensive reading of the medical profession in Portugal, which remains to be conducted. For the moment, the intention is to shed light on certain conditions that help us to understand how medical professionals succeed in resisting pressures introduced externally by the state within the framework of NPM. The market also remained outside the analysis, given that its implications for the medical profession have only recently started to be grasped in greater detail.

The aim and scope of NPM in the Portuguese NHS

In classical studies, terms such as advisory bureaucracy (Goss 1963) and professional bureaucracy (Bucher & Stelling 1969) are used to describe the organizational structure of hospitals, given the effects of the authority exerted by medical professionals. Essentially, this reflects the role of expertise in defining bureaucratic procedures.

In publicly funded and managed hospitals in particular, the state hierarchy necessarily encounters medical self-regulation. On one hand, the NHS model presumes a single voice of command in the provision of and access to health care. Historically, on the other hand, the development of hospitals has overlapped with the professionalization of medicine (Coe 1984).

According to recent studies, the maintenance of self-regulated medical spaces in hospitals has no general pattern in Western countries, in view of the differences in the roles of nurses, management and users in the arrangements for hospital governance (see examples in Kuhlmann et al. 2013). The evidence relating to Portugal demonstrates that the medical professionals have always played a key position in governing hospitals, by either unsettling or replacing managerial authority. Not only do the independent interests of those in charge of a ward usually prevail over those of the hospital's board of directors, but also medical rationale outweighs administrative logic in arranging organizational spaces:

To a certain extent, the wards are not organized to offer the assistance, teaching and research (…) that the country needs. They are molded much more in line with the personal interests of the medical directors who run them and work in them. (…) In a teaching hospital like this, which still has an almost medieval tradition, in some ways this is felt much more strongly. (Physician, 1988)

The hospital administrators might have the support of a clinical director and a nursing director… but they aren't physicians (…) In practice, have they altered the way I work? No, they haven't. Despite all the changes that have taken place more recently [in the direction of the NPM rationale], the physicians still have muscle. Even the administrators who dare to pressure us directly and threaten us are afraid of the consequences. A physician can say before a judge, "That patient died because of the administrator's decision." That is hell and can end up in a court case. So the physicians are very strong. They have a lot of power and they sometimes forget this. And so that's another reason why I say that I am not afraid of anything or anyone in my daily professional life (…). (Physician, 2010)

Even though these two statements were made over 20 years apart, they point towards the same issue: the medical professional's authority underpinned by the use of "discretion". Apparently, this has not been limited over time, either formally, by the regulators, or informally, by increasingly demanding users. In fact, discretion has consistently been the medical professionals' main strategy to fight back external pressures, even in the context of managerialism, e.g. where non-clinical administrators are formally accountable for running hospital organizations.

Shaping how healthcare is organized and delivered is one of the cornerstones of the NPM rationale in Portugal. Generally speaking, it means non-clinical administrators are given the authority to define the nature, content and form of the professionals' work organization. However, the changes in the way organizations function fall far below expectations:

Governments insist on hospitals having more and more rules and greater compliance with them by medical professionals (…) as they can't have everything their own way. However, it's very hard working with them. They go against us [administrators] and want no interference in their work. It is very difficult to change the way medical professionals organize their own and the nurses' work; information is not shared with administrators. Besides, it is virtually impossible to understand their minds from a rational point of view. (Administrator, 2010).

What this evidence shows is that medical professionalism continues to shape the hospital space and processes. The issue is to understand how medical professionals succeed in resisting the changes imposed by administrators if administrators are legally charged with controlling the hospitals' administrative processes and procedures. The explanation must be sought in the aim and scope of the policies implementing NPM in Portugal. Firstly, NPM should be understood as a normative conception that depends on each country's institutional features and right and left-wing parties' ideologies (Gruening 2001). In the UK, NPM has turned into national-level policies aiming at the structural control of medical knowledge (e.g. regulatory institutions providing standard specifications, inspection of performance and the reconfirmation of physicians' registration (see Harrison 2003)). In contrast, NPM in Portugal has restricted itself more to the financial control of organizations (Correia, 2012a). On this evidence, alongside the hospital-centered configuration of the Portuguese NHS, conclusions may be drawn as to medical professionals' ongoing power in relation to other health professions, hospital administrators and the state due to their control of medical knowledge (Carapinheiro & Page 2001; Correia 2012a). Decisions on what to do and when and how to do it remain under the medicine's jurisdiction.

The colonization of hospital management by medical professionals

The arguments set out above seem to show that medical professionals stand in opposition to administrators. Yet what the evidence really suggests is a hybrid position between them, as they may oppose as much as cooperate. More importantly, the data also suggests that some medical professionals have colonized the managerial instruments in hospital organizations. By colonization we mean the process by which professionals on a more individual basis or professions in more structural terms make use of other professions' tasks, knowledge and rationale in order to strengthen their own professionalism. In this case, we refer to surgeons selecting, appropriating and making use of administrative instruments as a means of protecting their own positions within hospitals. Although this process is not common among medical specialties, discussing it in the context of stricter managerial rules is meaningful. Against the background of recent debates on the interplay between managerialism and professionalism, this evidence suggests not only that professionals are willing to accept new organizational orders (Exworthy & Halford 1999) but that hybrid professionalisms are arising within professions (Noordegraaf 2007; Correia 2013). It also underlines the fact that professionals undertake individual strategies to strengthen their positions within bureaucracies (Faulconbridge & Muzio 2008).

In 2002, Law 27/2002 was passed, with the aim of redesigning hospital governance, in particular by turning public hospitals into public corporations. This transformation, usually referred as 'corporatization', is also seen in other NHS countries subject to the NPM rationale. Broadly speaking, it means aligning the rules for funding and human resources in the public administration with the rules prevailing in the private sector. For this reason, administrators are

given stronger powers to enhance efficiency and control over professional discretion (see Correia 2011 for a detail description).

That law, with other pieces of legislation that followed, intended to centralize hospital governance under the administrators' control. In particular, this involved financial matters (drawing up hospital and ward budgets and setting and controlling performance targets) and quality (controlling technological tools; auditing clinical procedures; setting quality targets and clinical guidelines; monitoring patient safety programs; evaluating malpractice; rewarding best practices; defining staff qualifications).

The empirical research conducted on the corporatization of public hospitals in Portugal (Correia 2012a) suggests that a managerial/bureaucratic hierarchy coexists with well-established medical power that is exerted from the bottom up by medical professionals in wards. Administrative changes on the top level of the hospitals have taken place although their influence is poorly established at the different levels of the organization. Accordingly, professionals have continued to control some of the tools that administrators were expected to secure more firmly after the reforms were put into practice. Forms of partnership between physicians and other health professionals such as nurses, and even patient involvement in hospital governance have also been poorly developed. Moreover, as a result of the fragmented and limited power that administrators were able to exert over the physicians' self-governance, managerial governance itself lacks transparency and, more importantly, the outcomes vary in different hospitals.

One of the cases that best illustrate the tensions and intersections between hospital administration and medical professionals in Portugal, specifically regarding the latters' colonization of managerial tools, relates to the Integrated Responsibility Centers (IRCs). These units were

created within public hospitals exclusively for medical specialties with a high level of technical specialization, technological dependence and patient turnover. They are fully independent with regard to their assets, finances and human resources (see Correia, 2014):

An IRC represents financial and administrative independence, which is ideal for us. It would allow us [surgeons] to hire in line with the head of ward's specific targets; we could invoice our work and then pay our salaries. Part of the profits we [surgeons] brought to the hospital would ultimately be distributed in the unit [IRC] for investment and staff. (Surgeon, 2010)

Transplants play a huge role in the hospital's financing as they increase its case mix index. We [administrators] have found a totally different structure there from other wards so we choose not to interfere. The surgeons are the ones who must take the decisions there! We generally know how they are organized and the way they distribute their own financial incentives, though without interfering in the process. We are not even worried about trying to implement other criteria there. (Administrator, 2010)

First, these excerpts demonstrate that professionalism and managerialism do not necessarily conflict. This argument has also found support in recent debates drawing attention to hybrid interests linking medicine and management (Noordegraaf 2007; Jespersen & Wrede 2009; Saltman, Dubois & Durán 2011; Goodall 2011; Reich 2012; Kuhlmann et al. 2013). In this case, medical and managerial values meet with regard to the standardization of procedures, greater efficiency and predictability, greater productivity, and economy in the use of resources. The more often procedures are performed, the more money comes into the hospital through the

surgeons. If we look back in time, similar trends were visible in physicians' concerns with being more profitable and productive 20 years ago (Carapinheiro 1993):

There are pros and cons to choosing to specialize. The advantage is that with the same resources we produce much more if more protocols and better structures are created. This is a huge advantage for patients, the hospital and the interns (…) I think that the move of this department towards specialization is a must. There are more advantages than disadvantages! (Physician, 1988)

Second, the excerpts point out the medical control of managerial tools in hiring professionals and staff, defining salaries, distributing profits, defining teams and so on. The very establishment of IRCs implied the need for professionals to make use of bureaucratic tools. Given that IRCs have been created by government decision in order to enhance the quality of highly specialized medical expertise within the NHS, medical colonization of managerial tools is ultimately strengthened by the state. As the most innovative managerial event in healthcare in Portugal, IRCs can only be run more effectively if new and strengthened managerial tools and procedures are defined and assessed on the basis of medical criteria. Otherwise, surgeons will not be interested in getting involved, nor will administrators know how to meet the professionals' needs.

Medical control over health technologies

The control of health technologies is the third example of the intersection between the state and medical regulation. As already noted, the setting of the quality of medical procedures in countries where healthcare is publicly funded creates a paradox: the need for public investment in technologies coexists with the inability to control them. That is to say, in the context of the knowledge society, expertise is not only secured by traditional professions such as medicine but the expertise itself is perceived as a threat to public security (Nowotny, Scott & Gibbons 2008) – and yet, the state continues to rely on the medicine's discretionary expertise for the selection and use of technical procedures in healthcare. Moreover, access to technology gives rise to competition among hospitals, medical specialties, wards and patients. Regarding hospitals and medical specialties more particularly, the control of technologies allows them to attract public and private investment as much as it boosts the professionals' self-regulation. The study by Serra (2008) shows that cutting-edge wards are defined as such not only for the technical expertise involved but also for allowing other hospital areas to develop, which, in turn, stimulates the development of the organization as a whole. The excerpt below provides evidence from a liver transplant unit (TU):

It doesn't just involve the whole hospital; in fact, a hospital that has a transplant unit has to be one with excellent services, it has to have a blood service… our blood service is exceptional in transplants and I think it is one of the best I have ever seen. So it really draws the best out of what there is. Some wards were started because of the transplants, the liver transplants. This kind of surgery is really a driving force for every area of a hospital. (Surgeon, 2002)

Actually, this technical rationale reveals more than the interdependence of wards. It indicates the key position of cutting-edge wards in a hierarchy of priorities and funding, making them the driving force of the hospital. Given the scarcity of resources in public administration and the highly differentiated knowledge applied in these units, professionals working there enjoy economic and strategic advantages over other wards, even in the same hospital. Serra (2008) also noted that, to some extent, these wards are immune to unfavorable opinions from the hospital board of directors. One of the surgeon states:

In comparison to other wards, my impression is that the board of directors gives us preference. For instance, the previous board was 100% for us and we are grateful to them. With other wards things get stuck, work any which way (…) compared to the other wards, we seem to be given preference. Even if there was ill feeling towards the TU, administrators would not be able to openly undermine us. The procedures we perform here are what make this hospital stand out from other hospitals. Therefore, administrators can't say anything against the transplant unit. There has never been any open hostility, never. So, all the boards that have run the hospital have supported us. We are a kind of flagship for the hospital, and administrators do everything in their power to ensure the ward works as well as possible. (Surgeon, 2002)

Other opinions in the hospital regarding the ward are ambiguous. Physicians and nurses often use expressions like 'it's an elitist ward' or 'they are seen with a certain exoticism' (field notes); whatever the standpoint, other professionals' comments testify to the exceptional nature of the

cutting-edge ward and the hierarchies it causes within medicine. Though the ward is seen as bringing prestige to the hospital, the other wards consider that they are disadvantaged in favor of this one. On the side of the hospital board of directors, the dominance given to cutting-edge wards over other hospital wards is also confirmed. Transplant surgeons have priority over all other surgeons in access to operating theaters. In sum, everything is made available by the administrators to allow the transplant surgeons to do their work as well and as quickly as possible. According to one of the administrators:

The outcome for the hospital is positive, very positive... I mean, look at the situations the patients find themselves in – they are almost dying when they are admitted, but they leave alive and well – that makes the work "enjoyable". It's highly gratifying for health professionals to see the fruits of their labor, isn't it? On the other hand, the infrastructure has recently been renewed and well equipped. All this attracts people, particularly the best. The kind of patients admitted there also makes the professionals treat them very carefully; they are very vulnerable and that makes us take great care. (Administrator, 2002)

These findings are enlightening, particularly if we go back 20 years in time. At that time, Carapinheiro (1993) found the very beginning of the strengthening of bureaucratic/managerial procedures inside hospitals that, years later, gave rise to the corporatization process previously described. According to those initial findings, the formal hierarchical rules continued to be informally bent by medical professionals up to the point of affecting the bureaucratic functioning of the medical specialties and activities performed in different wards:

There are early signs that something is growing there [reference to the doctors' attempt to create new wards in the hospital]. We have to be very careful to understand whether it fits in with the rationale of the hospital or if it's just in one man's interest (Administrator, 1988).

Despite the new principles linked to the 3Es – economy, effectiveness and efficiency (Rhodes 1994) – that are reshaping the governance of hospitals nowadays, the capacity of medical professionals to control organizations scientifically and technologically has remained almost unchanged, a fact that, consequently, determines the financial control. Professionals still have autonomy to decide what technologies are used, when they are used and for whom. The dependence on technology is defined as 'technocracy' (Serra 2010, 2011), which means that medical procedures converge with the managerial rationale insofar as this boosts professional power. To a certain extent, NPM allows medical technocracy to grow stronger. Medical procedures using technologies are viewed as being "more scientific" than other medical knowledge, besides creating order and certainty in chaos and uncertainty. Technology justifies itself as safe, neutral and objective knowledge. Moreover, according to Nettleton (1995), medicine mobilizes public opinion and the state as long as it controls the use and application of technology.

Not even the rise in Portugal of new health professions related with the use of technological procedures has threatened medical dominance (Lopes 2006). In fact, the strategies of professionalization, supported by legal recognition through the academic training carried out by professions such as cardiopneumology and radiology, have not changed the medical domination

of the social division of hospital work. What happens is the mismatch between the skills taught in these new health professions and those that medical professionals allow their members to perform in health organizations. For this reason, the professional independence of these professions is far from being achieved. In contrast to the established form of medicine, the knowledge in these professions means standardization and is controlled from the outside by another profession, thus limiting their recognition in the eyes of the state and users.

THE STATE AND MEDICAL REGULATION IN PORTUGAL: THE EBBS AND FLOWS OF POWER

The more health turned into an issue of a public right, the more difficult it became to clearly define state and medical regulation in the governance of healthcare. Though related, these forms of regulation should remain distinct. In the light of the three studies, we will now discuss the ebb and flow of power between the state and medicine in the governance of healthcare in Portugal.

The thread linking these studies is that, both formally and informally, medical professionals have managed to employ strategies in workplace contexts that bypass policies imposed externally by the state – thus protecting specific, profession-related interests. These two parties should not be viewed as separate players standing against each other as countervailing forces. Rather, the situation indicates the complex nature of this interplay. The state is as dependent on medical discretion as medicine is on state policies to boost occupational professionalism – hence what we term the ebb and flow of power. This interdependence has arisen from three features encountered in the Portuguese NHS: the aim and scope of NPM, the NHS's strengthened managerial tools and its technological investment. In particular, the medical professionals' control of managerial

tools reveals changes in medical knowledge. More importantly, possession of the control of knowledge is the best strategy for a profession to protect its occupational professionalism. This is precisely what has happened with medicine in Portugal in relation to the strengthening of NPM. Additionally, we have been able to show the extent to which policies formally controlled by the state hierarchy are filtered and reshaped in workplace contexts by those responsible for undertaking them in their daily practice. The issue is that hospital reform has had little impact on the structure of the governance of public hospitals. To help the reader grasp the argument more easily, we may summarize the salient features as follows:

(i) The definition of public policies: by legislative or executive bodies that may or may not listen to the regulatory bodies of the medical profession (the National Association, unions or advisory panels).

(ii) The implementation of public policies: in a fragmented manner due to the medical professionals' possession of control within organizational spaces. The governance structure of hospitals has remained almost intact, as the legally-required changes at the workplace level have not been fully implemented.

(iii) The monitoring and assessment of public policies at the workplace level: ineffective plans for monitoring and evaluating malpractice, poor performance or non-compliance with the state's regulations.

Previously, we mentioned the contrast between the analyses by medical sociologists and those of health economists and policy analysts. While the latter tend to analyze the ebb of power from the state to the medical profession, with the focus more on institutional processes (point i), the

former includes in the analysis the flow of power from the medical profession to the state, with the focus on processes taking place within organizations (points ii and iii). By this we mean that one should not disregard that the mechanisms set out by the state to define an organization's funding and quality are continuously shaped by professionals in ways that allow them to boost their professional power inside organizations. Two of the strategies identified were the colonization of professional jurisdictions and the control of instruments (e.g., technologies) that are key to the success or failure of public policies. As a result, medical professionals protect their autonomy and authority inside organizations by: i) setting professional jurisdictions; ii) influencing organizational models in the NHS (the definition of hospital versus nonhospital care); iii) defining how care is provided and evaluated (the control of financial and clinical instruments).

We also argue that the strengthened position of medical professionals within organizations is somehow transposed to macro-level dynamics. If physicians and surgeons control and define how national policies on specialization, research and education are applied at the workplace level, then the structural legitimacy of medicine in society is reinforced even in the context of NPM.

In sum, organizational change should be perceived as more complex than the application of policies set out at a national level. Rather, those who control knowledge are the key players in determining how institutional reforms in the healthcare sector turn out. It is important to mention that medical teaching and training is still restricted to public universities and mostly defined and assessed by the medical profession itself. This gives it the capacity to gate-keep bureaucratic processes such as the division of labor and access to technologies.

As a consequence, the non-linearity between the regulatory and normative elements of institutions becomes visible (Burau & Vrangbæk 2008). The governance of institutions is as dependent on hierarchy-based regulation as on values not necessarily aligned with those regulatory institutions. This is precisely the space enjoyed by medicine. The increasing control imposed externally by public opinion and the state may be true. However, certain features may favor partial, self-regulated norms and values in order to continue blocking those pressures. Burau (2005) suggests the notion of 'actor-centered governance' as a step forward in conceptualizing governance as comprising both institutional and normative dimensions that may or may not overlap. Similarly, our standpoint is that the effectiveness of reforms results less in institutional change itself and should include symbolic dimensions. Otherwise it will be difficult to grasp: (i) how the medical profession continues to control organizational procedures under the jurisdiction of non-clinical administrators, (ii) why regulation by the state is not effectively assessed at the workplace level, and (iii) why the state is ambiguous in strengthening public accountability while allowing medical professionals effective control over the funding and quality of organizations.

These arguments should not underrate the increasing role of the state in the governance of healthcare in Portugal too. More than ever, these procedures allow the monitoring of performance more accurately; skilled non-clinical managers have been hired for hospitals; information flows have been computerized, and so on. Nevertheless, healthcare reform has been more effective on the issue of accountability in relation to users and other health professionals than doctors. In the case of users, Correia (2012b) discusses the growing individualization of access to healthcare in Portugal. The author means the process by which the state shifts a growing proportion of NHS funding onto the citizens, in addition to the taxes and contributions

already paid. According to OECD data for 2011, Portugal was one of the countries where the percentage of co-payments has risen most sharply over the last decade. Portuguese families are now funding twice as much of their access to the NHS, which coexists in some cases with third party funding for voluntary private health insurance. In the case of other health professions, studies have shown not only the dominance the medical profession over these professions but also the growing and effective control by the state through the use of the managerial tools that the medical side has succeed in controlling or bypassing (Serra 2008; Carvalho 2014). Nursing and other health professions are now under far more external constraints than before.

FINAL NOTES

Current analyses of the binomial relationship state/medicine in the governance of healthcare systems highlight different experiences not only between Europe and North America but also among European countries. These differences allow us to formulate two ideas: firstly, that comparative analyses of health policies must take contextual variables into account in order to ensure a detailed understanding of the arrangements linking the state, medicine and other health professions within organizations; secondly, that the mechanisms in the regulation of health care are not necessarily the same, despite shared financial constraints and pressures regarding NPM. This explains our concern to make the Portuguese case more visible within the debate. Despite the introduction of measures seeking the rationalization of public resources, as in many other countries, public regulation has struggled to change the dominant position of medical professionals within health organizations, particularly in the light of the empirical evidence from the early 1990s. More importantly, now, 20 years later, studies show complex dynamics taking

place, in particular with what we termed here the medical colonization of management tools and the medical control of health technologies. Both cases suggest the strengthening of medical professionalism, even though extensive evidence is still required for the different medical specialties.

Studies in sociology often stand out from those in health economics and policy analysis. Our emphasis is that any discussion about health policies cannot underestimate informal, workplace dynamics in favor of biased institutional analyses. The state has been able to introduce normative changes at the macro-level although the consequences are not similarly transposed into organizations. To better grasp the reasons for this gap, we need to pay attention to the interplay between medicine, the state, management, other health professions and the citizens.

In sum, the governance of healthcare in Portugal indicates interdependence rather than conflict between the state and the medical profession. Accordingly, we refer to the ebbs and flows of power: whereas the power of medicine builds on public policies by the state, the state depends on medicine to ensure the protection of health as a public right.

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