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ARTICLE

Nursing in Portugal in the National Health Service at 40

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Abstract *We describe the development of nursing in Portugal since the creation of the National Health Service (SNS) in 1979, focusing on staff numbers, education, work conditions, career, and professional organization. We used the literature on the evolution of the Portuguese health sector and statistical data from the Nursing Council and the SNS. The number of nurses grew by 233% in the last 40 years, but the nurse/physician ratio only increased from 1.15 to 1.4. Most work in hospitals, despite repeated political commitments to expand primary health care. In the SNS, 55% are public servants, and the others are employed through private law contracts. The basic nursing course is currently offered in 20 public and 16 private institutions. In 2019, the career structure was revised and now comprises three categories: nurse, specialist nurse, nurse manager. Nurses remain moderately satisfied despite complaints about working conditions, remuneration, and lack of career progress. Nurses' role barely changed over the years, and the Medical Association is resisting to its expansion.*

Key words *Nursing, Portugal, Evolution of the profession, Education, Working conditions*

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Introduction

The Portuguese health system has evolved profoundly since the creation of the National Health Service (SNS) in 1979, through which the State has ensured the constitutional right to protect the health of Portuguese citizens[1]. The SNS has not fully complied with this initial project over the past forty years. Currently, the Portuguese health system is characterized by the coexistence and overlap of three systems: the SNS, health subsystems (insurance plans for specific occupational groups, such as public servants), and private health insurance[2]. However, the health gains achieved by Portugal[3] are mainly attributed to the SNS, which contributed to the health status of the Portuguese being at the level of the best in Europe[4].

This paper starts by briefly summarizing the evolution of the health sector over the last four decades, while simultaneously portraying the evolution of nursing – focusing successively on staff numbers, their composition and distribution, training, professional organization, career and working conditions, tasks, and relationships with the state. Finally, we discuss the biggest current challenges and some future perspectives.

Methods

We performed a narrative review of the literature. We searched in the *Diário da República Digital* database for diplomas published since 15 September 1979, the date of establishment of the Portuguese SNS to identify and describe the main policies related to both the health system and the nursing profession. We also used published and gray literature on the evolution of nursing in Portugal, searching the websites of nursing institutions (Nurse Council) and official websites of the Portuguese Government (e.g., the Ministry of Health and its institutions, Ministry of Science, Technology and Higher Education). Statistical data were obtained from official sources that are referenced in the text.

Results

From the establishment of the SNS to the present: evolution of the Portuguese health system

In 1976, the Constitution of the Portuguese Republic enshrined health as a universal right[5], which was made effective in 1979 with the establishment of the universal and free SNS, through which the State guarantees access to integrated health care, i.e., health promotion and surveillance, disease prevention, diagnosis and treatment and medical and social rehabilitation[1] to all citizens, regardless of their economic condition At the same time, the Health Regionalization in both Autonomous Regions of Portugal and the establishment of Regional Health Services took place. The SNS charter stipulated that the human resources policy for the SNS would be centralized, and, in 1982, it gained administrative and financial autonomy with its own budget[6]. In 1983 and 1984, the SNS expansion began through the consolidation of primary health care[7,8]. In the 1985-1994 period, the health sector experienced a predominance of market ideology through the encouragement of competition between public and private providers for expected efficiency gains. This period witnessed a withdrawal of the provider state through the implementation of service prioritization policies[9]. The first Health Basics Law was published in 1990; it reflects the characteristics of this period, namely regionalization of the administration of services, privatization of the care providing sectors and care financing, and integration of care between health facilities[10].

At the same time, in terms of human resources policy, if, during the establishment of the SNS, the exclusive dedication of its professionals was considered necessary, this period showed a progressive abandonment of exclusivity, namely of doctors, in order to stimulate the attractiveness of work in the public sector. This evolution culminated in the publication of the Health Basics Law, which allowed SNS professionals to engage in private activity, without adding any burden on the SNS[11]. Also, during this period, the need to find new ways of dividing labor into broader, more comprehensive, and less closed universes was confirmed.

In the 1995-2001 period, the state moved away from the health sector. A performance-based remuneration scheme was created specifically for primary care physicians[12]. In 1997, contracting agencies were set up at the level of the Regional Health Administrations to separate the state's roles of provider and payer.

The 2002-2010 period witnessed significant reforms at the hospital and primary care levels. A new management model was defined for hospitals, in which these adopted private law rules in human resources management and in the procu-

rement of goods and services, while their status and management remained public[9]. This led to the possibility of concluding individual employment contracts with health professionals, thus making labor relationships more flexible. If, on the one hand, this measure has allowed increasing competitiveness among SNS institutions or to retain more professionals, on the other hand, it has introduced entropy into the workforce as a whole, with "different pay for equal work". Also, the first public-private partnerships emerged during this period for hospitals, of which four still exist. To this day, there is no ideological consensus on this arrangement, which has proved to be the main point of contention between political parties in the recent discussion about a new Health Basics Law, recently enacted[13]. The establishment of Family Health Units in 2007, as a way of organizing and providing primary care, was a radical innovation that significantly changed access to primary care in a traditionally centralized context (Chart 1).

The ensuing period (2011-2014) was dominated by the financial crisis and the adoption of thirty-four measures to contain health expenditure, included in the Memorandum of Understanding signed between Portugal and the three financial institutions responsible for the country's financial rescue plan. These measures resulted, among other effects, in lower salaries of health workers, increasing the weekly workload for the vast majority by about 14% and freezing career plans. Also, at the recruitment level, a significant decrease was observed[14]. The health workforce decreased from 122,580 to 116,884 individuals[15].

In primary care, the list of clients per family doctor jumped from 1,500 to 1,900, contributing to a higher workload for doctors and nurses.

This period was one of increased emigration of health professionals, particularly nurses. In the latter case, while by 2010, it is estimated that around 500 had emigrated, by 2011, the number has doubled to 1,000, and in 2012, 2013 and 2014, to 2,000, dropping back to approximately 1,000 over the next four years. During this period, nurses emigrated mainly to England, which registered 781 and 1,211 Portuguese nurses in 2012 and 2013, respectively. Finding work, better career prospects, professional valorization, and remuneration were the main reasons that led to the emigration of these professionals[16].

In 2015, the beginning of a new legislative cycle marked a radical change in the country's socioeconomic orientation, aided by the slight economic growth of the large European countries. A new era of optimism contributed to a slow reversal of austerity in health care: public spending on health has increased since 2015, including

Chart 1. Family Health Units (USF): An Innovative Way of Accessing Primary Care.

In 2005, a reform broke with the traditional way of providing primary care by setting up Family Health Units (USF) in the SNS. New organizational modalities were promoted, such as teamwork, community orientation, autonomy, and administrative flexibility and performance evaluation. Typically, USFs comprise of an average of 20 professionals and technicians, forming a volunteer team of doctors and nurses, supported by 2-3 administrative secretaries. There is an average nurse/doctor ratio of 1.06, but there are low-ratio USFs with twice as many doctors as nurses. Each team is responsible for providing services to a population of 1,500 people per doctor (1,900 after the 2011 austerity measures), geographically defined. The USF signs a quality and service coverage objectives contract with its local Health Center Group (ACES), which is then approved by the Regional Health Administration (ARS) and finally by the Central Health System Administration (ACSS). Once the contract is approved, the USF receives resources such as infrastructure, equipment, and a budget. ACES also enables access to other professionals such as nutritionists, specialist nurses, or physical therapists.

Two USF models are in place: the new ones start as model A and then can become model B, with more demanding clinical objectives. Model B gives access to more resources and offers a pay-for-performance component. The first USFs began operations in 2007. In May 2019, there were 281 Model A, 254 Model B, and 52 active applications for A and 75 for B. Management is participatory, and all decisions are taken collectively, all team members being considered as equals. USFs operate with greater administrative autonomy in a less bureaucratic way.

In the USFs, nurses work more collegially with doctors, participating in decisions and, in the case of Model B, benefiting from performance-related incentives. Nurses have more opportunities for professional development through continuing education activities, such as individual apprenticeship plans, reading groups, participation in conferences, and meetings to review performance indicators.

Source: Biscaia & Heleno[17], Lapão & Pisco[18].

on worker remuneration, weekly working hours were reduced and career progression was made possible again. Also, during this legislature, the primary care reform was resumed through the creation of more USFs, the expansion of family doctor coverage, and new forms of contracting, namely, through service agreements. At hospital level, ten institutions selected based on efficiency indicators were allowed greater autonomy, including the management of human resources[9]. However, staff recruitment remains centralized at the Ministry of Health. Finally, in this last period, the nursing career was reviewed, and specialties valorized, albeit subject to quotas of available posts. The year 2019 was also marked by the discussion of a new Health Basics Law, enacted in August, which reintroduced the full-time exclusivity of health professionals. A common denominator to the different development stages of the SNS and the Portuguese health system in the last 40 years was the lack of a strategic vision guiding the development of the health workforce[12,19], in spite of strategic health planning exercises since 1998[20].

Portuguese nursing in numbers

The establishment of the SNS created a need for more health professionals. In 1980, there were 19,327 doctors in Portugal and 22,144 nurses. The Portuguese population grew 19.6% in the last forty years, the number of doctors by178% (53,657) and that of nurses by 233% (73,650).

In 1980, there were 505 and 441 inhabitants per doctor and per nurse, and in 2018, the ratio was 191 and 139, respectively. The nurse-to-doctor ratio has also risen from 1.15 to 1.4, although it remains below the mean for European Union countries. Currently, nurses represent about one-third of the total SNS workers, with 43,312 staff, mostly female and young[15].

About 70% of the SNS nurses are in the Lisbon and Tagus Valley Region (34%) and the Northern Region (35%); the vast majority (79%) works in hospitals, despite repeated political commitments in favor of expanded primary health care[15].

Information about the distribution of health professionals, particularly doctors and nurses, in the private sector is scarce. In general, private sector nurses' salaries are lower than in the public sector, as well as career prospects.

Education

The period of the creation and early expansion of the SNS, from 1974 to 1984, was marked by increasing demand for nursing education[21], which was now recognized as a short higher education program. During this phase, a single nursing career was created in the SNS with five categories (including specialist nurse) applicable to three practice areas – care delivery, administration and teaching, which was meant to ensure the provision of better nursing care, better use of existing human resources and efficiency of services and higher professional achievement and progress. This period witnessed the establishment of post-primary schools in the north, center, and south of the country to respond to the need for additional and specialized training of these professionals. The nursing program was the equivalent of a bachelor's degree. Nursing education was integrated into polytechnic education between 1984 and 1995, which prevented the creation of undergraduate nursing programs at universities, even in those where doctoral and master's degrees in nursing were already available.

In the late 1990s, nursing schools were submitted to the exclusive control of the Ministry of Education; the school network was reorganized, with integration into larger units (polytechnic institutes, polytechnic health institutes or universities), and the figure of the higher school of health was created. Two new higher schools of health were created to extend training provision to all regions of the country.

Since 1999, nurses have had a 4-year basic education that provides a degree equivalent to the first cycle of Bologna Licence-Masters- Doctorate structure. The shift from the traditional nursing course to an undergraduate degree allowed "direct" access to master's or doctorate degrees, without requiring a degree in another area of knowledge, as was the case before. In January 2019, the 240 ECTS undergraduate nursing program (8 academic semesters) was offered at 20 Higher Schools of Nursing or Higher Schools of Health of the public sector, and 16 of the private sector. The conditions of access are completion of the 12th grade and the fulfillment of prerequisites (e.g., national exams), which vary according to educational institution. The specialized nursing training is performed through the Postgraduate Nursing Program (CPLE), which does not grant an academic degree. In an attempt to overcome this constraint, some educational institutions have developed master's degree programs in nursing, some with a generic title, others with a title corresponding to specialty areas. Students enroll in both the master's pro-

gram and the CPLE. In the end, those who also complete the non-teaching component of the master's degree are qualified with the specialist title, conferred by the Association of Nurses, and with a Master, granted by the educational institution. The educational institutions establish the number of spaces for each specialty and the type of specialty offered.

In 2018-19, a total of 1,381 spaces, accessible to nurses with at least two years of professional experience, were available in the following specialties: rehabilitation (402), child and pediatric health (192), medical and surgical (195), community health (237), mental health and psychiatry (195), and maternal and obstetric health (160). The community health specialty also comprises two sub-specialization areas: public health nursing and family health nursing. The medical-surgical nursing specialty comprises four "sub-specialization" areas: intensive care, palliative care, perioperative care, and permanent status (Chart 2).

In 2017, the Nursing Council regulated areas of increased competency in nursing defined as *knowledge, skills, and attitudes that allow the professional to practice to a level of progressive complexity, in the various fields of intervention of nurses and the technical-scientific development of the profession*[22](p.23636). There are two types of enhanced skills – "differentiated" and advanced. The former skills are added to those of the general nurse and the specialist nurse, while the latter are only added to those of the specialist nurse. The Nursing Council recognizes the increased competencies; regardless of the type of enhanced competencies; certification is individual and mentioned on the professional identity card. Currently, four "differentiated" enhanced competencies are defined, namely, occupational nursing, clinical supervision, out-of-hospital emergency and stomatherapy, and four advanced enhanced ones: management, clinical supervision, stomatherapy, and psychotherapy.

Working conditions

Currently, in the SNS, nurses may be civil servants or hold an individual employment contract (under private law). Most (55%) are civil servants on an open-ended contract. The recruitment of nurses is centralized and is by public examination. In 2019, and after a long negotiation process, the nursing career was revised and became multi-categorical with three categories: nurse, specialist nurse, and nurse manager[23]. As regards compensation and benefits, a nurse's monthly basic salary is 1,201.48 euros before tax, rising to 1,407.45 euros in the specialist nurse category, and 2,334.30 euros in the nurse manager category. Career progression is subject to quotas and is based on a points award system.

In the private sector, nursing careers are structured differently, are more precarious, with wages generally lower than in the public sector at entry. On average, a private sector nurse would earn slightly more than 1,015 euros a month before tax (www.sep.org.pt/files/uploads/2019/08/sep_14082019_bte.pdf). In general, nurses' pay, as that of other SNS health professionals, is perceived as low and referred to as one of the reasons for seeking work abroad. In Model B USFs, besides the basic salary, nurses receive incentives that are indexed to the unit's performance.

It is challenging to characterize nurses' satisfaction levels. Data such as the number of strike days (known) and private and foreign departures (estimated) suggest low levels. Few scientific studies are available on the subject, except for some academic theses, and other works covering small samples of professionals. These studies tend to conclude that there are high levels of dissatisfac-

Chart 2. Recognition of the Family Health Nursing Specialty.

With the creation of USFs, the issue of the recognition of the specific character of nursing in primary care emerged. Several years of debate preceded the recognition of the figure of "family nurse" as a member of family health teams by Decree-Law N° 118/2014 of August 5. This decree provided for experimental inclusion of such nurses in 30 USFs. As early as 2010, the Nursing Council had proposed a definition of family nurse responsibilities and tasks, and some nursing schools began offering specialization programs. However, due to the lack of consensus between the Council, the unions and the Ministry of Health on the content of family nurse work, until 2017, these pilot projects had not started. The Council only recognized the family health nursing specialty as a sub-specialization area of community health in 2018.

Source: Simões et al.[2].

tion with work conditions, pay, and career progression. The replication in Portugal of the multi-country study RN4cast (http://www.rn4cast.eu/#) is the study that shows a more detailed and scientifically accurate picture, both by the size of the sample and the use of validated questionnaires. This is a quantitative, observational, cross-sectional, and analytical study in which, between November 2017 and May 2018, included 5,075 nurses from all regions and contexts of care in Portugal. The distribution of respondents corresponded to the profile of registered by the Nursing Council. Data was collected through the RN4Cast electronic questionnaire, with support, available at a link to this effect, disseminated through the organizational communication of the Nursing Council, the Catholic University of Portugal (UCP) and social networks. All nurses working in Portugal and devoting most of their time to direct care, regardless of the context, were invited to participate voluntarily and anonymously. The study used the versions already translated, validated and verified for Portugal of the scales of practice environment, burnout, and engagement, whose authors were part of the research team. Chart 3 shows the main results of this study.

Organization of the profession

Anyone wishing to practice as a nurse in Portugal must register with the Nursing Council, which verifies the qualifications required to have access to the labor market, namely, successful training in a recognized institution. The Council was established in 1998 as a Public Law Association to which the State began to delegate the powers of regulation and oversight of professional practice. By nature, the Council is the

Chart 3. Results of the RN4cast Portugal Study, 2017-18.

While very exhausted, nurses remain moderately satisfied, trust the care they provide, rank the care quality and safety as "good", remain very engaged, and want to stay in the profession. However, less positive aspects persist, namely:

• Unfavorable Work Environments (PES-NWI – Mean: 2.39 (Standard Deviation 0.41), especially regarding strands Participation of Nurses in the Organization's Governance – 2.11 (0.50); Adequacy of Human and Material Resources – 2.13 (0.60); and in Management, Leadership and Nursing Support – 2.13 (0.62), all below the cut-off point 2.50;

• Low Organizational Culture regarding safety. Respondents agree or are neutral regarding the following: "that their mistakes are used against them" (70.5%), "there is a low level of freedom to question the decisions or actions of their superiors" (68.7% disagree or take a neutral stance). They disagreeing or remain neutral with respect to "hospital/organization management interventions show that patient safety is a top priority" (63.2%);

• Perception of high workloads – 38.5% of participants (16 times higher) respond that they totally disagree, versus 2.3% who say otherwise when asked if there are enough nurses to provide quality care to patients;

• High levels of burnout, particularly in the Emotional Exhaustion (at least 55.3%) and Turnover (Intention to Leave Workplace) realms – 52%, but low rates of lack of personal accomplishment and depersonalization;

• Job dissatisfaction, especially regarding Salary (over 90%) and Career Opportunities (86.3%);

• High number of patients assigned to each nurse, taking into account the functional content, responsibility and staff mix in Portugal (on average, more than eight patients per nurse);

• High prevalence of some incidents (with clients and nurses), care left undone due to lack of time, and performing non-nursing "tasks" (e.g. answering phone calls, bureaucratic tasks).

In conclusion:

- Some favorable aspects regarding the perception of the quality and safety of care, despite the unfavorable practice environments;
- Incipient participation in the governance of organizations, adequacy of human and material resources and management, leadership and nursing support;
- Considerable regional and organizational variability in many of the indicators studied;
- Poorer rates in hospitalization contexts, in general, and when compared with previous results (2013/14), in the same type of services (medical-surgical);
- Lack of relationship or existence of unfavorable negative association in some of the studied indicators (e.g., adequacy of human and material resources, burnout, engagement…) with the reference of whether or not the organization is "Accredited for Quality";
- Nurses who, although exhausted, remain moderately satisfied (43.7%), very engaged with work (80.8%), and wish to remain in the profession (65.5%) against those who claim they wish to change organization (52.0%).

Source: Jesus[24].

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organization with the most significant number of members. There are also unions (Portuguese Nurses Association, Portuguese Nurses Union, the largest, with 16,000 members, Democratic Nurses Union of Portugal, Independent Nursing Professionals Union, Madeira Nurses Union), and Scientific Purpose Associations (Portuguese Association Nurse managers and Leadership). The membership of unions, whose exact percentage is unknown, is very fragmented among the different ones, which generates rivalries. The Trade Union Law does not include rules for the creation a union, in terms of a threshold of representativeness, and in 2018 alone, two new unions emerged, with stronger claims than those of more traditional unions. There is a high level of conflict with the government, exacerbated by an underdeveloped labor regulatory framework.

Discussion and agenda for the future

The number of trained nurses has quadrupled over the past forty years, which at first glance is substantial progress. However, this was not enough to significantly increase the nurse-doctor ratio of 1.4, compared to the mean ratio of 2.8 of the 35 OECD countries, and three times lower than in countries such as Finland and Denmark[25]. Besides the reduced availability of nurses, it shows a lower efficiency in the production of health services, particularly in USFs, where the number of doctors and nurses is practically similar. The division of labor between doctors and nurses has changed little over the years, despite the efforts of the Council and professional associations in spite of their efforts in favour of the recognition of areas of specialty, as some of the care provided by doctors could be provided by nurses, with a positive impact on team productivity[2]. The activities formally performed by general care nurses have hardly changed over the years, although nurses, especially specialists or enhanced competences certification holders, have knowledge and skills that allow them to perform more complex tasks independently, such as managing stable chronic patients, normal pregnancies, prescribing technical aids, some medicines, analyses, and tests without any risk to the user.

In a large number of OECD countries, nurses have been assuming care traditionally provided by medical professionals, playing new and additional roles. Training programs aimed at gaining new competencies are available and adapted regulatory and new legal frameworks frame the advanced exercise of nursing[26]. In Portugal, there is an opening for the expanded nurse's role at the level of professionals in the field, but resistance from the Medical Council and weak advocacy capacity of the profession due to some internal divisions around this issue[27,28] are obstacles to change.

Increasing the number of general and specialist nurses, and at the same time expanding their role, are very demanding and permanent challenges. First, more candidates must be attracted to nursing, which several European countries have done with relative success through strategies such as promoting the profession in secondary schools or offering scholarships[29]. Then, staff needs to be retained, by providing more positive practice environments, ensuring opportunities for professional development, improving pay and offering more flexible working hours to nurses with young children or older/dependent adults, and by preventing early departures by providing older nurses with less demanding work conditions. Such measures would help correct the adverse effects of working conditions revealed by the RN4cast study. The adoption of policies to improve working conditions and recognize the role of nurses can help to limit emigration, whose costs are high given the investment made in training those who leave. Training more nurses implies strengthening the capacity of training institutions, in particular by recruiting qualified trainers; it also requires the expansion of the network of clinical training sites. Finally, it also requires a commitment by major employers, including the public sector, to hire more staff.

The redefinition of the role of nurses is a political rather than technical challenge, that can only be met if the profession itself shows a consensual front and achieves the social and political support needed to revise the relevant legislation. However, it is necessary to define which nursing model Portugal should adopt, whether more generalist or more specialized, and, in the latter case, what would be the balance between specialists and advanced practitioners. This clarification is of paramount importance as the competencies of each other, as well as their scope of practice, are quite different, thereby requiring different planning and combination of competences.

The exclusivity of undergraduate nursing education in polytechnics is perhaps one of the crucial impediments to the scientific development of the profession, as one cannot develop doctoral programs in these institutions (only masters only), where it is there that most of the reserve of empirical knowledge exists. Addressing

this issue also requires a firm political commitment to increase the availability, accessibility, and efficiency of health services and to mobilize the necessary political and financial resources.

In Portugal, working conditions in the public sector are characterized by low wages, heavy workloads, and few possibilities for professional advancement, and have barely changed since the creation of the SNS. The situation of other health professionals is comparable to that of nurses. A comprehensive human resources for health policy is still missing, a problem that has long been identified[14]. There is no explicit vision of the future of the SNS and of the health sector in general, nor is there a systematic human resources planning process. An integrated, reliable, up-to-date, and easily accessible information system would characterize the private sector workforce, monitor mobility between the SNS and the private sector, departures from the country and from the health sector, and provide material for the production of valid data and knowledge about the health workforce. As regards nursing, an investment in research is urgent to inform the definition of policies that can contribute to the more rational use of nurses' knowledge and skills.

Conclusion

In parallel to the creation and consolidation of the SNS, nursing has seen unprecedented technical and scientific development during these last forty years. Nursing is currently a highly qualified and relevant profession for the provision of health care. Forty years into the creation of the SNS, it is essential not only to think about a new development and consolidation strategy for the coming decades, keeping the commitment made with the citizens to deliver a service capable of responding to the changing demographic, social and epidemiological demands, but also rethink nursing so that it continues to address the health needs of citizens and the growing complexity of health care. The consolidation, reengineering, and strategic development of the SNS cannot be disconnected from the analysis of health human resources development policies, where nursing workforce development is framed.

Collaborations

G Dussault conceived the initial structure of the manuscript; I Fronteira and EH Jesus have agreed and contributed to all stages of manuscript production.

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