



Facing austerity: the decline in health access and quality of care for patients with cancer in Portugal

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Abstract

In April 2011, Portugal called on the European Union for a financial bailout due to its debt crisis, and counterbalanced this rescue with various austerity measures. Within the Portuguese public health system (Serviço Nacional de Saúde, SNS) these measures were swiftly applied on a large scale, and in turn led to increasing difficulties among the health professionals within the SNS with regard to the use of diagnostics, treatments, and medications for patients, as well as growing obstacles to regular clinical consultations. Through media analysis of Portuguese health policy related to cancer and statements from professionals in the SNS, this article expresses the concerns of these health providers and explores how this situation is negatively impacting the lives of those who deal with this disease every day.

Keywords: austerity; cancer; health professionals; Serviço Nacional de Saúde; political economy of health.

Cancer is a disease with rates of incidence and mortality, which will continue to increase on the global level (Boyle, Levin, 2008; WHO, 2014). The main causes are environmental and genetic factors, or combinations of the two (Cantor, 2007; Nunes, Costa, 2002; Sonnenschein, Soto, 2004; Proctor, 1995, 2012; Davies, 2007). Personal narratives describing experiences with this illness, public health policies, and biomedical and clinical research generate a kaleidoscope of dimensions from cancer, making it a rich area of research for social studies in health and medicine (SSHM) and generating a series of fundamental works.¹

The field of SSHM analyzes practices related to cancer (such as research, diagnosis, and treatment) framed within biomedical platforms (Keating, Cambrosio, 2003), accounts of experiences with illness (Stacey, 1997, 2002; Löwy, 1996), public policies and causative agents (Proctor, 1995, 2012; Löwy, 2010; Davies, 2007), and prevention (Bury, 2001). It is a diverse and conflicting history, particularly between private economic interests and the public sector, causing the “cancer wars” (Proctor, 1995). A vast group of practices and actors revolve around cancer as an object, in an arena where the scientific and the political intersect (Nunes, 1999). This centrality is highlighted by the multiplicity of networks, scales, discourses, and sociabilities (Biehl, 2007) through which it is assimilated, interpreted, and utilized by patients, health professionals, the pharmaceutical industry, formulators of public policies, and other actors. Within the context of a “biotechnical embrace” (Good, 2010), based on the biosciences and biotechnologies which lead research on cancer and its treatment,² it is essential to evaluate the perspectives of all the actors who have any type of involvement with this disease.

Because of the aging population, increased incidence and prevalence of chronic and degenerative diseases (Lock, Nguyen, 2010, p.80), and the biomedicalization of health (Clarke et al., 2010), the European Union (EU) is an extremely interesting market for private health interests. Cancer is the second most common cause of death in the EU; numerous initiatives and specific public policies at the national and supranational levels have been implemented to fight this disease.

Within the EU, Portugal is no exception, since it also bears the “cancer burden” (Boyle, Levin, 2008), dedicating significant public resources to prevention and treatment. This serious problem has been one of the main vectors of public health policies in the country. In recent times there has been a growing tendency to charge individuals with responsibility for their own health, and a clear push towards the gradual liberalization of health services (Lock, Nguyen, 2010). In the contemporary economic panorama, public health policies face tight budgetary constraints resulting from the economic crisis, with considerable pressure to ration human, material, and financial resources. One representation of this pressure is the presence of the *Troika*³ and structural adjustment programs in Europe (Santos, 2001), which show the voracity of the financial system and the neoliberal model⁴ that ensures its legitimacy through the governments that embrace this paradigm.

As a result of the Economic and Financial Assistance Program (2011–2014) implemented in Portugal, the resources intended for the Portuguese National Health Service (Serviço Nacional de Saúde, SNS) are being reduced. Consequently, health professionals in the area of oncology are facing major changes in their work related to pressure from public hospital administrations to manage resources according to advantageous cost/benefit ratios, as well as

from scientific and technological changes in the detection, diagnosis, and treatment of cancer. This brings with it serious consequences for disease prevention policies, due to “financial requirements to cut or dismantle public health services, along with their privatization and liberalization”⁵ (Nunes, 2006, p.25).

This article presents an account of how the austerity measures associated with financial recovery are changing the economics of health policy and health governance in Portugal, limiting citizens’ access to high-quality public health services and generating strong concerns among professionals in this area. This initially comprises an analysis of cancer policies and their repercussions in the Portuguese media, and is followed by statements from health professionals who work directly with cancer.

Austerity cancer

Since the 1980s, the EU has made significant financial efforts to combat cancer, particularly through the “Europe against cancer” program.⁶ The institutional framework of health policy in Portugal is partly influenced by EU directives and recommendations, which partially shape the SNS. This is often described as one of the most valuable achievements of the Portuguese democratic regime that was established in 1974, along with the right to free education and social security (Nunes, 2012). According to the World Health Report 2000 (WHO, 2000) “Health systems: improving performance” – and despite criticism of the criteria used to evaluate the national health systems (Musgrove, 2003; Murray, Evans, 2003) – the Portuguese SNS ranked twelfth globally.

After the request for financial rescue in 2011, new elections were won by a coalition between the liberal PSD and conservative CDS-PP parties. Paulo de Macedo was appointed Minister of Health; he had been the CEO of Médis, one of the largest private health corporations in Portugal, and a close partner of the Portuguese private financial system.

Although health cuts had already attracted media attention in 2010, with the *Diário de Notícias* newspaper stating “Cuts in health put cancer treatment at risk” (Mendes, 26 maio 2010), it was when the CDS-PP took office that a new cycle of public health truly began in Portugal. One of the new government’s first pronouncements addressed the need for broad cuts in the SNS budget. This led to the largest doctor strike in Portugal’s history, which took place in July 2012 with an estimated 95% of physicians participating. During the strike, one doctor told a newspaper: “I saw the SNS grow, and now I see it sick and withering away” (Freitas, 12 jul. 2012). The strike had two main objectives: (1) to defend the dignity of the medical profession and career progression, and (2) to oppose the dismantling of the SNS, which was already underway. Mário Jorge Santos, a member of the Association of Public Health Physicians (Associação de Médicos de Saúde Pública), described how beautiful it was to “see all physicians united by public health” (Freitas, 12 jul. 2012).⁷ In terms of health professionals, some of the impacts of this rationing of the health care budget and its privatization are clearly visible in the present, while others will only be seen in the future. The “‘brain drain’ of health workers from public systems” (Pfeiffer, Nichter, 2008, p.411), whether to the private system or to foreign countries, is one of the most threatening effects of this process. Some prefer to stay in the public system, but deteriorating working conditions and a lack of investment (p.411)

combined with no prospects for future improvement or increased employment in the public sector lead many health professionals to migrate to the country's private sector, or to other countries such as the United Kingdom and Germany. According to the *Público* newspaper, "the crisis in Europe is affecting patients with cancer" (Gomes, 2 jul. 2012), such as in Portugal, but also in Greece, "[where] patients do not have [access to] drugs because of government debt" and Italy, where there is a "shortage of doctors."

Despite recommendations from the Portuguese Observatory on Health Systems (Observatório Português dos Sistemas de Saúde, OPSS) (OPSS, 2011, 2012) that the crisis should be seen as an opportunity to implement important and long-overdue positive reforms within the SNS to simultaneously ensure its characteristics as a universal and public system, these have been steadily ignored in recent years. Nevertheless, the role of public health professionals in the fight against the effects of austerity remains central and noteworthy (Stuckler, McKee, 2012).

A report by the Organization for Economic Cooperation and Development (Morgan, Astolfi, 2013) showed that CDS-PP government cut health care by more than twice the amount requested by the *Troika* when the austerity measures were negotiated. The same report mentioned the unpredictability of the long-term impacts of these measures on health. According to OPSS director Constantino Sakellarides (2012), the *Troika's* demands were "abusive" and placed the health and well-being of the Portuguese population at risk. This seems to confirm the statement that "those opposed to the welfare state never waste a good crisis" (Klein, 2008).

Access to public health services and the quality of these services are consequently threatened, with negative consequences for the overall health of the Portuguese population (OPSS, 2015). This reality is imposed by "agencies and institutions that work within a restricted neoliberal logic that favors cost control and promotes the privatization of health care" (Nunes, 2006, p.16). In this sense, cancer survival rates are similarly jeopardized because of the difficulty faced by the SNS in cost-sharing to guarantee access to first-line drugs (OPSS, 2015). The expected short-term success in the apparent containment of costs is generating other more lasting and negative effects for the general health of the population over the long term, after the Structural Deficit Adjustment Program. One of the ultimate goals of these interventions is to create a space for the privatization of health, which is essential for the global neoliberal economy of health (Nguyen, Peschard, 2003, p.447).

The expenditure cuts imposed by the *Troika* and the "the predations of structural adjustment" (Lewis, 2012, p.102) which have already been tried in other regions and countries around the world, such as Africa (Sama, Nguyen, 2008) and Latin America (Nunes, 2012), are well known. What is new here is that several highly developed European countries are almost simultaneously the object of interventions on this scale. The neoliberal rhetoric disseminated by the institutions involved in financial recovery states that cuts are necessary to guarantee the existence of financially sustainable public services. This rhetoric is based on terms such as "intelligent selectivity, where the principle of universal access to health care" is abandoned (Nunes, 2012, p.80). It is the "assault on universalism," a fundamental characteristic of the welfare state (McKee, Stuckler, 2011).

Even so, the resources applied to rescue the Portuguese financial system were more than sufficient to ensure regular maintenance of the health, education, and social security systems for three to five years (Caldas, 17 dez. 2014). And yet the government claims that lack of funds is the main reason why it cannot keep public services running completely. The central argument in the political rhetoric supporting the austerity agenda was that Portugal could not afford to have public services it could not sustain, as if it were a “rich” country, and that the financial crisis was the fault of those who had lived beyond their means. Furthermore, public officials were seen as responsible for the situation, supposedly due to their “excessive” numbers, their low productivity, and the “privileges” within their employment contracts such as a level of social protection. On the other hand, high-risk financial products or public-private partnerships, which were also responsible for the high public deficit and had disastrous consequences for the state, were kept out of the public debate for quite some time. It is therefore necessary to “interrogate scarcity” (Schrecker, 2013) which was propagated and question why “some settings are resource-scarce and others are not” (p.1). Consequently, it is reasonable to believe that there is a socialization for scarcity, so that “thus, we set our sights and our aspirations lower” (Farmer, 12 dez. 2013).

Some authors state that “austerity has been not only an economic failure, but also a health failure, with increasing numbers of suicides and, where cuts in health budgets are being imposed, increasing numbers of people being unable to access care” (McKee et al., 2012, p.346). In this way, on behalf of the “market,” swift and harsh measures with great impact on the health of the citizens are taken to achieve sustainability and rationing, and we can conclude that “the markets are bad for health” (Nunes, 2011, 2012). This is unsurprising, since as João Arriscado Nunes (2012, p.128) states:

New markets and new (private) ways of organizing health service provision have transformed health into a highly profitable business, and pressures toward privatization or private management of public health services are a familiar theme for citizens of European countries, where the national public health services which can be accessed by all citizens for decades had been considered a part of democracy and democratic citizenship.

The austerity policies are producing negative effects and increasing obstacles to access high-quality public health through: (1) closure of SNS branches in areas with low population density; (2) providing smaller quantities of medications for shorter periods through public hospitals for patients who are receiving treatment at home; (3) providing generic versions of medications rather than drugs from recognized laboratories, with health professionals reporting that some of these generics are less effective and pose a significant number of side effects; and (4) introducing health co-payment measures, which in some cases involve fees for consultations in public health institutions, which have nearly doubled since the austerity measures were implemented (Barros, 2012). For example, the real prices of hospital consultations rose from €4.60 in 2011 to €7.75 in 2013, and consultations at Primary Health Units rose from €2.25 in 2011 to €5 in 2013. Similarly, emergency hospital treatment now costs €20.60, while in 2011 patients paid €9.60; emergency treatment in Primary Health Units cost €3.80 in 2011 and increased to €10.30 in 2013 (OPSS, 2013, p.40-41). Finally, the highest rates of unemployment in several decades have led to lower patient attendance at routine visits.

The consequences are that “differences in medical care lead to differential morbidity and mortality rates for the same disease in different social groups” (Nguyen, Peschard, 2003, p.460). In other words, we are talking about not only issues directly related to health, but also what has been described as structural violence (Farmer, 2003, 2004; Farmer et al., 2006; Galtung, 1969; Scheper- Hughes, 2004).

In spite of everything: Portugal and cancer

Cancer is the second leading cause of death in Portugal (Ministério da Saúde, 2011), with breast, colorectal, and prostate cancer the most common manifestations (16%, 14%, and 8% of total cases, respectively). The costs of cancer are among the highest in the Portuguese SNS, immediately after cardiovascular diseases (Araújo et al., 2009). There is, however, permanent underfunding of activities related to cancer (Araújo et al., 2009) when compared to the EU average (Wilking, Jönsson, 2007).

The official Portuguese health policy agency that deals specifically with oncological diseases is the National Oncological Plan (Plano Nacional Oncológico, PNO), which was created in 1990. However, it has only really begun to function in the last decade, covering topics such as the training and education of professionals in the area of oncology and organizing tracking at the institutional and individual levels. Despite several improvements, it has been recognized that “as in other EU member countries, its implementation was less than desired” (Ministério da Saúde, 2007, p.5). One of the reasons given for this state was the great “disparity between regions as well as institutions” (p.5). A continual increase in cancer deaths was seen prior to 2005, indicating that unlike in other EU countries or the USA, prevention and tracking programs were not carried out correctly. These are characterized by considerable heterogeneity, because they are established regionally. These data, which were collected at the first National Conference on Cancer Prevention, organized by the Portuguese League Against Cancer (Liga Portuguesa Contra o Câncer) in 2012, focused on the need to “homogenize cancer prevention programs at the national level, paying particular attention to the ‘effects of the crisis’ and ‘poorer groups’”. In April of that year, the Directorate General for Health had admitted that “cancer patients are not all treated the same way, and cancer examinations do not work the same way everywhere throughout the country” (Lusa, 2 abr. 2012). More than 20 years after the PNO was created, although some advances can be seen, the trajectory in the fight against cancer has come up against a variety of obstacles imposed by the harsh austerity policies, which are already producing negative effects.

Several studies have been directed toward the reduction in the total cost of the SNS, and more particularly in medications and staff, with a focus on oncology. One example of this is the report by the National Committee for Ethics in the Life Sciences (Comitê Nacional de Ética nas Ciências da Vida, CNECV) (CNECV, set. 2012), which described the financing of medications by the SNS. The report concluded that explicit rationing of drugs should replace the previous unofficial rationing, and that cuts in more expensive medications (such as those used to treat cancer) should be discussed. The Health Services Users Movement (Movimento de Utentes do Serviço de Saúde) immediately described the report as “a clear attitude of dehumanization” which seemed to defend a distinction between first- and second-class

citizens of Portugal. José Manuel Silva, head of the Order of Physicians (Ordem dos Médicos) said the report was “inhumane and unacceptable,” and that such rationing would never be ethical. This aspect is much more important when one considers that the reduction in the SNS's budget was largely counterbalanced by aid to the financial sector and a variety of public-private partnerships, which devastated public coffers (Caldas, 17 dez. 2014).

On the same day, the media released a report stating that the Ministry of Health was investigating further cuts to anti-cancer drugs. Nevertheless, the president of the CNECV reaffirmed that several hospitals were already rationing these medications through informal contacts between hospital boards and medical staff which encouraged them to stop prescribing certain medications due to cost. Other public hospitals decided to send letters to their physicians showing their overall performance translated into monthly costs to the health service.

Some of the most illustrative cases involving medications and the impact of austerity measures are abiraterone acetate and cabazitaxel. Abiraterone acetate is often used as a first-line treatment for metastatic prostate cancer, with proven effects on overall patient survival and pain management without disease progression. But over the last four years, the majority of hospital administrations have progressively refused oncologists' requests for pharmaceutical laboratories to provide this drug to hospitals based solely on economic criteria, and this drug has essentially been abandoned. The existence of a monthly spending limit created a logic in which this treatment would only be available for patients who are hospitalized before this monetary threshold is reached. Regorafenib, a medication used to treat metastatic colorectal cancer, was not even authorized by the administration of some hospitals because of its high cost and the fact that global survival is 1.7 months. The medical professionals in the area of oncology we interviewed demonstrated their aversion to this type of approach, particularly indicating the lack of medical criteria supporting such decisions.

Smaller hospitals had even more limited access to medication for political reasons, given their lower visibility and prominence on the national level, while larger hospitals had access to some drugs that smaller hospitals were barred from purchasing. Different hospitals had different time limits for medication use, most likely based on differentiated management of resources. Today, no hospital can acquire these medications. Doctors and patients (through patient organizations) continue to express their dissatisfaction with the recent changes in the SNS, and are monitoring them closely.

Field work carried out between October 2011 and October 2013 in a public oncology unit in Portugal allowed us to explore how these changes were perceived by health professionals. Because of the diversity of interviewees, we hoped to obtain a good range of views on this issue, because as Julie Livingston (2012, p.25) has stated: “Ethnographers recognize that the hospital is an intensive space where critical, moral, political and social questions arise regularly and with great urgency, and where broader political, social, and moral forces in society can be witnessed in a condensed fashion.”

Despite quantitative scientific production on the consequences of the financial crisis for access to health care, innovative and qualitative approaches are needed which clearly identify the impacts and strategies of individuals who are in the orbit of cancer: “In our traditional roles as culture brokers, we are often better positioned, as both health workers and observers,

than other public health professionals to document and contextualize the effectiveness of health services as they impact the people's lives" (Pfeiffer, Nichter, 2008, p.412).

The role of anthropology, particularly of medical anthropology criticism, is decisive. The work of authors such as Paul Farmer, Vinh-Kim Nguyen, Nancy Scheper-Hughes, Arthur Kleinman, Merrill Singer, Michael Fischer, Veena Das, and Julie Livingston offers significant contributions to a better understanding of how to act on global health and how to improve its scope and results. In this article, we follow Craig Janes and Kitty Corbett (2009, p.169), who refer to anthropology, which can help by reducing global health inequalities and developing "salutogenic sociocultural, political, and economic systems." Ignoring the experience of all those who relate to cancer in different ways, or "not to look, not to touch, ... can be the hostile act; an act of indifference and of turning away" (Scheper-Hughes, 1995, p.418).

In the first phase, the interviews were conducted with representatives of different medical specialties involved in breast cancer and participants in weekly group meetings in this unit, such as oncologists, surgeons, pathologists, nurses, and psychologists. The researcher was present at these meetings for a period of 6 months. During this first phase, only the health professionals in the oncology unit were interviewed (three nurses, three surgeons, and four oncologists). Subsequently, two heads of oncology units provided a comprehensive overview of the impact of the crisis on the availability of financial resources, care provided, and the physician-patient relationship. A set of three complementary interviews was conducted with oncologists at another public oncology hospital in central Portugal, and later with the director of the National Oncological Plan.

In these meetings, the effects of economic scarcity and mandatory cost control often emerged as important issues, either as causes for change in medical practice or as a factor which deteriorated the trust relationship established between health professionals and patients (a decisive dimension of the welfare state). In particular, we verified the difficulty of finding generic medications with the same (or similar) effectiveness as brand-name drugs, the imposition of more stringent and demanding conditions for hospital administrators to approve diagnostic tests (such as positron emission tomography [PET] and computed axial tomography [CAT]), the migration of patients from the private health sector to the public health sector, saturating it even more, the effect of material restrictions associated with the crisis (Borja-Santos, 8 jun. 2015), and the deterioration of the trust relationship between doctors and patients.

The reason for interviewing health professionals was inquire about the negative impacts on their professional practices from austerity measures, which had already been aired during at the meetings.

On "spending"

In this climate of economic constraint, some attempts were made by the Ministry of Health to mitigate the effects of the crisis on the population. These included providing cheaper medications and expanding the categories of people exempt from paying moderating fees in hospitals and other public health institutions. These measures were positive to the extent that they exempted nearly 50% of the Portuguese population from any form of

co-payment (more specifically, 5,588,016 individuals) (OPSS, 2013, p.38). Even so, the health professionals expressed growing anxiety about the future, namely a change in the patterns of accessing public health care and how the current situation affects their commitment to patient care and well-being.

The increase in clinical criteria for approval of diagnostic methods is becoming a way of deterring and discouraging medical staff from requesting them, a trend which is likely to continue:

Ah, yes! It is much more difficult now, of course, to schedule a CAT scan, a mammogram, a PET scan, or to ask for a new medication. You have to justify much more and there is the possibility it will not be approved. [Justification is based] on the criteria of patient need. It is part of the protocols that already exist. But even with the need documented at this time, any characteristic that prevents this approval is taken into account. And before it was easier... for example, to get an 80-year-old patient to have the right to treatment, than it is now – according to age, for example, or to general condition. Whereas before it was a selection criterion (Physician 1).

Yes, small things where you can perceive resistance... With PET scans this happens a bit, although we have never been denied, but we have to ask... There is this bureaucracy that in some form is meant to limit requests, but things keep functioning (Physician 2).

The nurses also noticed differences, such as the change in quality of treatments available for recovery after surgery, and how these differences affect recovery in the medium and long term:

It affects everything! We have had patients who did not do chemotherapy or radiation treatments, because when they healed [from surgery] the doctor said: 'Now it isn't worth doing because all the timing [has been lost]. Indeed, it goes far beyond the timing.' This is because there has been a complete change!... We used to have a range of products to treat wounds, I think that we were at a marvelous level nationally. With the cuts that have come... they were replaced by a range that does not replace everything – in fact, not even the same thing, one product replaced three or four, that didn't have the same characteristics as the previous [products], let alone the indications (Nurse 1).

Patient also came for fewer routine consultations and hospital emergencies. The increase in the moderating co-pay fees and removal of free transportation are the main reasons, although these do not apply in the case of continued treatments. This information is corroborated by both medical and nursing staff:

As for our patients, I take note of who has missed the most appointments, and sometimes they don't comply with a medication we prescribe because they don't have the money. And they don't come, because they have to pay for transportation. Even though they are exempt from the moderating co-pay fees (Physician 3).

Yes, they miss their appointments, because of the moderating fees. And also we have situations, for example, where they have to pay for a situation that is benign, or for what was referred here and they need to get a mammogram or an ultrasound: 'Can't I do just one?' – to pay only one moderating co-pay fee. But one complements the other, doesn't it?... [Missing an appointment] used to be rare (Nurse 1).

And some problems are simply too complex:

There was a young patient, 42 or 43 years old, who is about to start primary chemotherapy – she is unemployed and her husband is unemployed, only one daughter works and she has a disabled daughter. So the only daughter that works is who supports that household – plus the subsidies. In August she found a lump; because she had no money, she had to wait 15 days until the daughter received the approval to go to the family doctor, because they had no money for transportation to the Health Center or the moderating fee. When she had the money, she went there, the doctor palpated the lump and ordered an ultrasound and a mammogram. But because she had no money to pay for the exams and the mammogram, she had to do it in a clinic that was far away, and she had no money for transportation. So she came back and had to wait to do the exams, two months and some passed. So when she came here the tumor, the lump, had doubled, it was much larger, and already showed signs of inflammation, a much more advanced situation than it was in August. So there, I take notice: that the patients wait, because they don't have money to do the exams (Physician 3).

In addition to the direct consequences of the crisis and the effects of the *Troika* which are seen in these statements, the prevalence of structural violence is visible in informal conversations between patients and health professionals. Women with breast cancer mention their fears of missing a day of work because of doctor visits or treatment because of strong pressure from the labor market driven by high unemployment and fierce competition which could lead to them being fired, shedding even more light on the vulnerable position of women in the Portuguese labor market (Ferreira, 2010). Job (in)security, lower income, and even future unemployment caused by cancer, even in those cases that can be cured, has already been documented in other countries (De Boer et al., 2009).

Along with lower wages and unemployment comes the difficulty people who used to have access to private health services face in paying for these services now. Patients with breast cancer are now being transferred from the private health care sector to public health care, because even when health insurance pays for surgery, treatments like chemotherapy, radiation, and hormone therapy are very expensive and generally not covered. As a result, patients who cannot pay for treatment end up at the public health service, which represents a last resort in the search for successful treatment. Their reactions are somewhat surprising and reveal popular conceptions about how the SNS functions; they demonstrate a lack of knowledge on how health plans work as well as a misconception of the SNS.

Then there is another thing, whether the patient has the economic ability to do all the things [that is, the surgical procedure and subsequent treatment]. In the area of breast cancer, right now it is rare for patients to have only surgery. Normally they undergo several therapeutic modalities. Purely private-pay patients, who pay everything out of their pocket, are increasingly rare because of the crisis... Clearly [there is a decrease of people in the private system]. On the other hand, people who have a lot of money obviously are not worried about paying the doctor... and they show up with health insurance... Now, health insurance plans are calculated. The philosophy of health insurance is made for surgery. For routine visits... and for certain exams and then an operation. So the major great burden on multicare medical insurance is a potential surgery... It is something scheduled or something urgent... And there are radiation treatments, which cost more than the surgery. There are chemotherapy treatments that

cost more for each cycle than what is spent on surgery. Then there are patients who are convinced they have marvelous health insurance. They think that having a Médis card entitles them to VIP treatment. This is the same concept among the general population which thinks they have the right to use the SNS. And then they are disappointed because everything works well for surgery, but later there is no availability for radiotherapy or chemotherapy. And what happens to these people? They have to go find someone who knows how to deal with the SNS, right? (Physician 2).

Despite the general social and economic conditions in the country, strong incentives to move people from the public health system to private health insurance companies are underway, through marketing campaigns featuring a wide reach and strong pressure. According to Tiago Correia et al. (2015, p.2): “The results suggest a process of reconfiguring the private market in Portugal: the decrease in activity at the medical offices and in some clinics contrasts with the increased activity at private hospitals.”

Another problem is related to the trust relationship between doctors and patients. Confidence in the health system and in the doctor-patient relationship plays a fundamental role in the public health service, and may influence people’s statements about their own health conditions (Armstrong et al., 2006) and all the activities which comprise the physician-patient relationship. This is particularly important in oncology, where a patient’s confidence in his or her doctors is a “key phenomenon” (Hillen, De Haes, Smets, 2010) for evaluating proper adherence to treatment, the utilization of preventative services and behaviors, the choice between available medical treatments (which at times may be radical and offer limited success), management of care (Kazimierczak et al., 2012), and better results in terms of cure. Although different concepts of trust have been verified (Lock, Nguyen, 2010; Thom, Campbell, 1997; Mechanic, Meyer, 2000; Kleinman, abr. 1998), among patients with severe illnesses, trust can play a crucial role in “inform[ing] public policy deliberations and balance[ing] market forces that threaten the doctor-patient relationship” (Thom, Hall, Pawlson, 2004).

According to the interviews, confidence in physicians and in the SNS has never faced greater risk in democratic Portugal than it faces now. Most prominent among the reasons for this change are the recurring messages from the media about the huge cuts to the SNS, affecting the salaries of health professionals as well as therapies, principally medications:

So this is so ingrained that just the other day I was going to tell a patient that she was going to do radiation therapy, and she asked me: ‘Doctor, order it quickly, before they stop doing it because of the money.’ And I said: ‘But did someone tell you that they were going to stop doing radiation?’ (patient): ‘Ah, they say that now they’re not going to do anything.’ For the patient, and right now, until proven otherwise, the problem is to save money [there is broadening distrust] Entirely!

‘Why is it that I’m done and I can’t do any more?’ Because it is not indicated. ‘Is because there’s no money?’ No. It’s not indicated. [This question] is very frequent. Until proven otherwise, the hospital will not give a better treatment in order to save money. Similarly, until proven otherwise that anyone who comes to a hospital like this is treated poorly... a public hospital is where you do poorly. And then they say: ‘By chance, I got lucky. I don’t know what to say.’

The vast majority of people who say bad things are those who weren’t treated there. Because those who were treated there say better things than those that never went

there, who say that it's terrible!... Until proven otherwise, the public system is bad. And will treat them badly (Physician 3).

But the closing of branches of public health services in less populated areas has also become a serious problem. The medical profession is aware of this fact, and of the pressure on it to carry out its tasks as quickly as possible, in a profitable manner, which leads to a decrease in the quality of health care. However, Kenagy (cited in Friedenber, 2003, p.306) reports that this group "believes that pleasing the patient improves the outcome and clinical satisfaction and can be cost-efficient."

But within a neoliberal context, where the cost-efficiency imperative is fundamental, health care has become an extremely profitable business, maintaining and aggravating tensions. Is it possible to simultaneously be a good physician and a manager without damaging the trust relationship established with patients?

There is one thing that worries me very much, which is the loss of confidence in the doctor, in the system. I can be an excellent technician... But if I don't convey trust it's complicated... because the person [thinks], 'what does it matter if he is an excellent technician, if he doesn't talk to me'... Obviously there is a political aspect to disinvestment in the SNS. But, I think that the doctors are widely blamed... I had a director of services who, in a discussion on how long a pre-surgery consult should take, said that five minutes was enough. If a person has consultations every five minutes, that says it all! And sick people, they can't even come in! Not even sit down... I'm a fabulous technician. My consultations take a minute. Now the patient, what opinion of us will he take away?... This massification imposed by the system, by the politicians, the managers, the service directors... The pressure to always produce more... It is cheap, it's free, isn't it? And people want to consume, and this leads to that person who had the appointment... But who leaves frustrated (Physician 2).

The relationship between physician and patient is built on trust. In Portugal, this has been one of the pillars of the SNS. This trust was built through proximity with the populations, based on the principle and on the real, universal delivery of health care. But since its creation in 1978, the achievements of the SNS are now at risk because of the effects of the current financial, economic, and social crisis. The change in the patterns of medical assistance in recent decades has been associated with the weakening of a humanistic approach to patients in the name of cost-efficiency. The corporate interests of healthcare companies have actively promoted this change. In the final analysis, this can cause irreversible damage to the trust relationship the Portuguese population has in its public health system (OPSS, 2013).

Instead of looking for ways to maintain the strong points of the system, such as this trust which was built, and improving the negative points, the way is being prepared for private health care to colonize the area of public health. It is up to health professionals, managers, and citizens who are willing to preserve the SNS to continue working for the "democratization of health" based on a "renewed social contract" (Sakellarides, 2012).

Final considerations

The bailout requested by the Portuguese government in 2011 was not only a catalyst, but accelerated a neoliberal ideological stance on public goods and services. In the field of health, the SNS, which until recently was recognized as one of the best public health systems in the world, faces pressure from neoliberal forces through the government and the *Troika*, despite some positive reforms (OPSS, 2012). The objective is to dismantle the SNS by privatizing some health units, introducing managerial practices similar to those of the private sector into public health units, using public resources to increase the private provision of care, and creating space for private health companies to expand. Consequently, because of the structural adjustment program imposed by the *Troika*, the general state of health among the Portuguese population shows signs of deterioration, particularly in the increase of infectious, respiratory, and mental illnesses (OPSS, 2014).⁸ There are still other reasons for concern, such as the existence of “mechanisms that bar or limit health researchers’ access to SNS data, and therefore lead to less transparent and less participative governance” (OPSS, 2014).

This also has occurred in other countries where similar programs were implemented. The growth in unemployment and poverty, successive reductions in middle-class income and employment including salaries and pensions, and the introduction of higher charges for access to public health care impede improvements in health care in the near future. This in turn affects Portuguese society’s ability to emerge from the crisis, since it is well known that when the health of a country’s population is more fragile, there are greater negative effects on the country’s wealth (Coburn, Coburn, 2007). Dominant neoliberal doctrines therefore lead to “increased social and income inequalities and lowered social cohesion, which are themselves related, through various avenues, to health inequalities” (Coburn, Coburn, 2007, p.32).

In the field of oncology, the pressure toward rationing and cost-effectiveness are transforming the daily practices of health professionals and health units’ capacity to respond to the needs of their patients. Medical and nursing staff are expressing growing anxiety about the quality of care they can offer, emphasizing how the practice of oncology is limited by public policies, both directly and indirectly as well as through structural determinations such as gender inequality. Financial cuts in the area of health care have real effects on real patients, and place the focus on the structural violence to which these patients are subjected. They provide visibility for the terms and concepts which are constantly at risk of being dehumanized by the daily rhetoric employed by the media. Studies monitoring the real effects of this crisis on the health of Portuguese citizens are still lacking (OPSS, 2012; Arreigoso, 27 maio 2015). Trust also appears as an important issue which will consume significant attention, since it is essential for the recognition and public support of public health services and the work of professionals in this area (Callahan, 2000).

Although they may partially agree with some of the health reforms they considered necessary, the professionals we spoke to in the area of oncology clearly opposed the majority of the austerity measures, which have serious consequences for oncology. Commitment to patients was recognized as an indisputable principle.

Our prolonged presence in the field, using the resources of critical medical anthropology, allowed to provide visibility for these issues. It also allowed us to identify the hopes, struggles, and conflicts associated with the difficulties that arise from the process of structural adjustment and its effects on the public distribution of health care. Qualitative methodologies, specifically a fine-layered ethnography (Marcus, 1998), together with a critical and integrated perspective (Campbell, 2010), have provided effective tools for original investigations on present and future social inequalities in health and produced effective responses to these inequalities.

The experience of patients with chronic conditions requiring long-term care, such as some forms of cancer, is central to understanding the strengths and weaknesses of the current state of SNS in health care provision. This in turn raises the question of whether and how this “country that suffers” (OPSS, 2012) will be able to reach innovative responses to these processes, so that the principle of universal access to health care (which is one of the greatest achievements of Portuguese democracy) may persist.

NOTES

¹ See Byron Good, 1994; Mary-Jo Good, 1998, 2010; Fujimura, 1997; Löwy, 1996, 2010; Sontag, 2001; Stacey, 1997, 2002; Proctor, 1995; Keating, Cambrosio, 2003, 2012; Livingston, 2012; Gibbon, 2007.

² Our goal here is to call attention to an approach that places greater emphasis on curing cancer through highly specialized and scientific medicine, with all the economic costs that this involves, rather than formulating public policies which ban hundreds of products containing carcinogenic agents consumed daily, for example.

³ In Portugal, the *Troika* is the designation for the triad composed of the European Commission, the European Central Bank, and the International Monetary Fund, which was responsible for Economic and Financial Assistance Program (2011-2014).

⁴ In a public statement in 2007, a candidate for a post in the Portuguese Ministry of Health, Isabel Vaz, who at the time (April 18, 2007) headed the Espírito Santo Saúde economic group, told the main Portuguese public television channel, RTP1: “Health is perhaps one of the largest business areas on a global level. I would say the only business better than health is the arms industry.”

⁵ In this and other quotes from texts published in non-English languages, a free translation has been provided.

⁶ The program summary and report on the second phase of implementation can be found at: <http://aei.pitt.edu/5009/1/5009.pdf>.

⁷ Similar protests occurred in Spain and were described as a *marea blanca* (white tide) uniting all health professionals. In Spain, turnout was so high that it led to a civic movement to defend public health and the welfare state.

⁸ For example, deaths from pneumonia, a disease closely linked to unemployment, poor living conditions, and poverty, increased 25% between 2011 and 2013.

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