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The evolution of the Portuguese health legislation and the new challenges for management from 2024 onwards

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Abstract *In the last 40 years, the National Health Service (SNS) has generated health gains that have placed Portugal at the top regarding quality of life for millions of citizens and reduced many of the inequalities in Portuguese society. We revisit the establishment of the Portuguese National Health Service and all the profound legislative changes introduced after the publication of the new Health Basic Law, the definition of the strategic axes of the SNS human resources policy and the establishment of the respective operationalization mechanisms, the approval of the new SNS Statute and the approval of the Organic and Statutes of the Executive Board of the SNS and the creation of Local Health Units (ULS) as public business entities. These legislative changes could be a fundamental step towards strengthening the construction of a fairer and more inclusive SNS, which better responds to the population's needs through the necessary structural reforms.*

Key words *National Health Service, Health, Legislation, Local Health Units*

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Creation of the National Health Service

On July 20, 1978, the Minister of Social Affairs of the Second Constitutional Government, António Arnaut, issued a Ministerial Order[1], which guaranteed citizens' rights to healthcare. This diploma was linked to Article 64 of the 1976 Constitution of the Republic, which safeguarded citizens' right to healthcare by establishing a universal, general, and free National Service. In 1979, the conditions were created for the creation of the SNS[2], where the State would be responsible for ensuring that all citizens, regardless of their social and economic status, have access to free and universal healthcare, with the system being financed by taxes and enjoying financial and administrative autonomy. The principles set out in the law structured a centralized SNS with decentralized management, concentrating on public healthcare services and services provided by the Social Security system. The decentralized management included central, regional, and local bodies, providing primary healthcare services and hospital and rehabilitation healthcare in an articulated pyramidal structure.

The 1989 constitutional review eliminated total free services, allowing for a "tendentially free" SNS, and the Health Basic Law (LBS) was reformulated in 1990 to accommodate the establishment of a private health market, which would progressively transform the health system in Portugal.

The 1990s were a time of Portuguese Public Administration reform, following the trend sweeping many European countries. In this context, three significant changes also occurred in the SNS. In 1990, the LBS was approved, establishing new principles for the organization and functioning of the health system and, in 1993, the Organic Law of the Ministry of Health, which included the new Statute of the SNS (ESNS) (Decree-Law No. 11/1993 of January 15), publishing the ESNS in order to apply the changes introduced by the Basic Law and, thus, overcome the duality between primary health care and hospital care, through integrated units. This attempt to overcome the structural hospital centrism established in Portuguese society aimed to coordinate groups of health centers and hospitals, tending towards more effective management of resources for the recipients. In 1999, the Local Health Systems regime was defined[3]. These would be sets of coordinated resources (hospitals and hospital centers and groups of health centers in the same region) based on complementarity and organized according to geographic-population criteria designed to promote and rationalize the use of resources.

A profound reform of primary health care occurred within the public administration reforms, which led to the creation of the Family Health Units[4] (USF), set up on the initiative of teams of professionals, which gradually reinforced the role of family medicine and health teams since 2005 (when this reform was first implemented), and which allowed the SNS model to build on the British concept of a gateway to the system, where the family doctor was responsible for diagnosing and referring patients, which triggered the successive intervention of different professionals, throughout the citizens' health continuum. It is also worth noting the new 2002 hospital management regime[5] (Law No. 27/2002 of November 8), which introduced substantial changes to the LBS, incorporating most hospitals/hospital centers into the State business sector.

Over the past 40 years, the SNS has generated health improvements that have placed Portugal at the forefront of the quality of life of millions of citizens and reduced many of the inequalities in Portuguese society. Over these four decades, Portugal has remained among the OECD countries with the lowest hospitalization rates for primary care-sensitive health problems and a reduction in permanent disability. We have seen an increase in healthy life expectancy at birth for both men and women, a decrease in the percentage of people who consider their health needs unmet, and an increase in the percentage of Portuguese people who classify their health as good or excellent.

The 2019 Health Basic Law

Following the reformist drive of the 1990s, which accompanied the organization and provision of healthcare in Portugal until late 2023, the national healthcare system has a mixed or semi-private nature, with a strong presence of the public system, but with more than a fifth of the population relying mainly on the private and social system. Three healthcare systems thus coexist in Portugal[6]: the universal SNS; special health insurance schemes for specific sectors/professions (civil servants, employees in the banking sector, and insurance companies, for example), known as health subsystems; and private voluntary health insurance.

The LBS is a legal instrument that establishes a legal framework for protecting and promoting the health of individuals, households, and com-

munities. The new Health Basic Law[7] was approved in 2019, revoking Law No. 48/1990 and Decree-Law No. 185/2002.

The 2019 LBS was born from a government decision that caused considerable controversy. Having created a working group expressly appointed to study the changes to be introduced in a document that should be open to a rapidly changing future, the Government chose to submit a substantially different proposal to Parliament.

While the Minister of Health had considered[8] (August 16, 2019) that the LBS enactment by the President of the Republic was "a victory for citizens" because it will allow for a "better design of the health system" and that it is a Basic Law for the 21st century, centered on people, reinforces the State's role, and improves the distribution of functions between the public, private, and social sectors, many critical voices are still heard on divisive issues[9].

The first issue concerns the system's financing. Healthcare underfunding is a recurring issue in public debates on health. When the SNS was created, Portugal was enduring a severe social crisis, associated with the return of many citizens in the context of the decolonization process and at a time when the world was undergoing the so-called first oil crisis, associated with a global financial crisis that Portugal was slow to address, with enormous social and economic losses. Furthermore, a tax-based financing model for the SNS was approved during social, economic, and financial crises. Since then, Portugal has experienced similar crises that have influenced political decisions on healthcare structuring and financing. During crises of this nature, governments tend to opt for underfunding the social and cultural sectors, focusing on the economy and finance, especially when there is a sharp increase in public spending.

In this new LBS, the SNS would normally have adequate funding to effectively ensure the right to health for all citizens, at least equaling the mean per capita health expenditure recorded in other European countries. Also, this financial reinforcement would impact health promotion, disease prevention, equipment modernization, health technologies, and information and communication systems. Since this issue has yet to be adequately incorporated, although essential reference has been made to multi-annual investment planning, healthcare financing depends on economic crises and each Government's economic and financial decisions. Without an established investment strategy and guidance being proposed for a path to be followed by legislators and governments, healthcare is still not seen as an investment and a decisive factor in creating national wealth.

Health system management

The Ministry of Health considered that the new LBS was "clear about its preferences regarding the health system's organization, based mainly on the SNS and the State's role and regarding how the public, private and social sectors should guarantee the right to the provision of and access to health".

Health politicization is unavoidable since the State is responsible for ensuring access to healthcare. Equal access, freedom of choice, and other issues of this nature are exclusive to the Government. A Basic Law should be non-partisan and accommodate different ideological orientations and government programs. Otherwise, it will be considered a mere political text.

The strong constraints on health systems imposed by the aging population, the prevalence of chronic diseases, and the Fourth Industrial Revolution, which is changing how it is understood, transforming diagnostic and treatment methods, management processes, and the relationship between professionals and citizens, the State and investors in the health market, are evident. The Government formed after the March 2024 elections will inherit an SNS in crisis. The length of waiting lists for appointments and surgeries is well known, as are the waiting times for emergency care, besides the lack of medical professionals in some specialties.

The SNS is not in crisis alone. Many citizens seeking healthcare address problems related to employment, housing, income, food choices, and access to other public services. COVID-19 followed the economic crisis and the Memorandum of Understanding, and austerity was added to the isolation and difficulties in providing healthcare, which have hit the most disadvantaged people hardest, to the point that mean life expectancy at birth (2020 and 2021) has fallen and stagnated at 81 years[10] for men and women, which affected retirement age.

The health system continues to follow a Beveridgean approach that cannot be distorted due to the commitments made and the Republic's Constitution and because this model has never been put up for public or parliamentary debate. The SNS financing based on taxes and univer-

sal, general, and generally free access continues to guarantee an improved democracy and social cohesion, which will need to be modernized regarding healthcare organization and innovation. However, the SNS is not an end in itself. It asserts itself as a useful instrument at the service of citizens without being imprisoned by its stakeholders, assuming a central and leading role in technical and scientific training, promoting equity and social cohesion, which may coordinate, under the terms of the law, with the sectors of the social economy and the private sector in an integrated, harmonious, regulated, and transparent system.

A strong, modern, and people-centered SNS

In defense of the new LBS, the Minister of Health highlighted that the law states that "relationships between the public, social, and private sectors are structured not by competition but by cooperation and coordination in a logic of transparency and prevention of conflicts of interest, eliminating State support for the development of the private sector in competition with the public sector". To safeguard the same rights for citizens who use services financed by the SNS but provided by entities from other sectors, it would be relevant to safeguard the duties of acting under the SNS principles, the monitoring of care quality standards, respect for the technical guidelines issued by the Ministry of Health, the duty to provide accounts under the negotiated annual calendars, and the monitoring of contracts, conventions, or agreements, following the experience acquired with the management of contracts and programs of hospitals with public-private partnerships.

We know that health system financing models are an ongoing challenge and vary over time and in mode, and the State is the primary funding source. In 2021, public spending accounted for around 66% of current health expenditure.

The political and financial choices of the State Budget determine the share that citizens will have to pay. These decisions hugely impact the lives of individuals and households, as they affect the equity of access to care and the amount of individual and collective health expenditure. Whenever a public service is unavailable to citizens, it leads to a search for alternative responses, with a direct financial impact on households.

In this regard, under the terms of the legislation in force[11], besides moderating unnecessary use, there is an implicit purpose of financing through payment by those who need the service, despite the tax benefits and the reduced weight in the revenues of the SNS public entities. The moderation fees paid by households in SNS institutions and the co-payments for medicines prescribed in the SNS correspond to the expenditure paid by households[12], resulting from previous government decisions on SNS coverage. These two categories increase households' direct expenditure by around 4%. Thus, besides the public expenditure incurred, the public decision implies a further 70% of the financing of the health system.

Besides public funding, the healthcare system is also financed by private expenditure associated with healthcare subsystems and private insurance, which complement or overlap with State-provided mechanisms. Each time a citizen or household uses non-public sectors by their decision, they relieve the State of this expense, which falls entirely on the family budget. In 2021, private healthcare subsystems and insurance represented around 7.5% of healthcare expenditure in Portugal.

Direct household payments for healthcare make Portugal stand out among all European countries as one with the highest figure. According to Eurostat, in 2022, direct household expenditure amounted to 28.6% in Portugal (Figure 1), followed by Hungary with 27.65% and Estonia with 23.16%.

Portugal ranks 22nd in the 2022 World of Healthcare Innovation[13] ranking after being 17th in 2021 and 21st in 2020. This ranking includes 32 health systems from different countries and assesses dimensions such as citizens' choice of health services, quality, science and technology, and fiscal sustainability.

In this ranking, compared to most European countries (Figure 2), Portugal is described as having a healthcare system where the private sector is growing, and insurers enjoy less regulatory intervention when compared to the American system. Among the 32 countries, the best results are found in Switzerland, Ireland, the Netherlands, and Germany. The last ranked countries are Hungary (29th), Italy (30th), Saudi Arabia (31st), and Poland (32nd). Portugal best ranked in quality, where patient-centered care ranked 13th, better than Spain (19th). This ranking justifies the investments made over the years, especially since medical infrastructure ranked third.

Portugal's overall ranking was strongly influenced by its result in the "freedom of choice" dimension, which fell to 25th place, compared to 11th place obtained in 2021. In this dimension, one of

the most damaging aspects was the high cost of health insurance, which relegated the country to 31st place, despite the results obtained in access to new medical technologies (14th) and patients' ability to choose health services (10th). Portugal ranked 26th in science and technology due to a low rate of healthcare digitalization (29th), considerably below its European counterparts. Spain ranked fifteenth. Portuguese contributions to medical innovation ranked 20th and scientific innovation 24th, considerably lower than expected.

The last metric used was "financial sustainability"; in this regard, Portugal ranked 21st. The debt-to-GDP ratio strongly influenced this ranking, in which Portugal ranked a modest 29th. Despite this, the country ranked very well (6th) in terms of health expenditure as a percentage of GDP, which proves that government spending on health is increasingly low and that measures should be taken to bring it to the European median values.

This ranking, with the limitations of all others of its kind, points to essential directions: firstly, that we are on the right track in terms of quality of healthcare[14] and that the investment made to date is internationally recognized, as is what has been done in terms of healthcare infrastructure; secondly, the need to regulate the healthcare market. Thirty-four hospitals in Portugal are equipped with acute care structures, of which 68% are private for-profit establishments[15]. This reality cannot be ignored; the State is responsible for regulation. The Regulatory Authority also points out that around 20% of the population of mainland Portugal lives in 133 municipalities associated with "high concentration" levels of private, for-profit supply. In 88 municipalities, some operators work with a potentially dominant position. These results encompass 11% of the resident population, which occurs when household health expenditure increases by around 29%. According to the Ministry of Health, the new LBS "clearly refers to the role of the health system as a protector of people against the financial risks of illness". The State should establish mechanisms to guarantee equitable access to healthcare and establish sanctions for adverse selection and undue induction of expenditure.

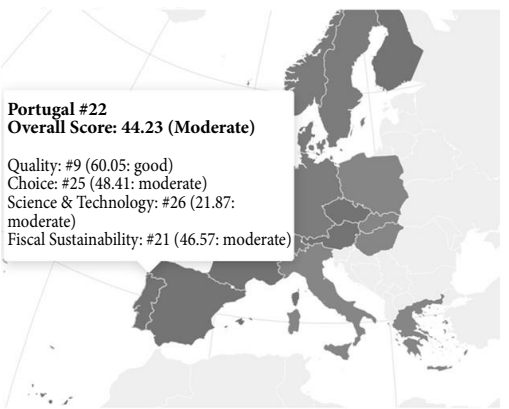

Figure 2. Interactive map comparing European countries integrated into the project.

Source: 2022 FREOPP World Index of Healthcare Innovation. Available on: Portugal: #22 in the 2022 World Index of Healthcare Innovation | by Grant Rigney | FREOPP.org. Cited 2023 dez 31.

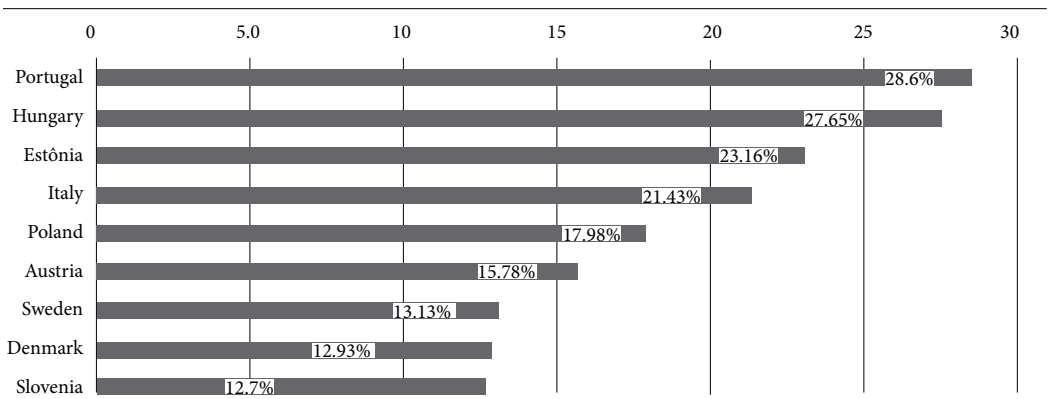

Figure 1. Household out-of-pocket health expenditures. Annual, 2002.

Source: Eurostat. Access code online: tepsr_sp310. Available on: Statistics | Eurostat (europa.eu). Cited 2023 dez 31.

Strategic axes of the National Health Service's human resources policy

Decision No. 6,417/2022 of May 20, 2022[16], defines the strategic axes of the SNS human resources policy and creates the respective operationalization mechanisms.

Health institutions must be prepared to adjust their approach and implement their management strategy to ensure a rapid and flexible response capacity, identifying needs and finding appropriate solutions, often innovative and increasingly collaborative.

The COVID-19 pandemic has reinforced the importance of maintaining a solid healthcare system, with people at its center and the public health service as its essential pillar.

People management is one of the priority areas, as healthcare professionals who are decisive for the efficiency of organizations — complex in their mission and structure and marked by the high level of autonomy, multidisciplinarity, and degree of technical-scientific specialization of their teams — are systematically faced with new challenges, which implies the need for their participation in defining new solutions.

For this reason, the Government reiterates, in its program, the objective of strengthening the SNS human resources policy, recognizing that health professionals have always been the guarantor of the quality of health care provision, having assumed a decisive role in the country's response to the pandemic in the last two years.

In this context, given that the attraction, retention, and motivation of professionals are critical, it is essential to continue the policy of strengthening the SNS human resources, aligned with the main challenges facing the management of health services, namely strengthening the anticipatory capacity and timeliness in responding and valuing work environments that support the career and life projects of its professionals, also managing the quality of relationships and the work context.

Only this broad approach, based on three strategic axes — consolidating a system of health professions, promoting the development of the skills of SNS professionals, and improving work environments and well-being — can attract and retain talent, foster creativity and flexibility, solve complex problems to ensure a response to increasingly informed citizens and promote the inclusion of all. This strategic and integrated vision for managing human resources in health underpins the new SNS Statute. It is aligned with the investments and reforms provided for in the Recovery and Resilience Plan (RRP).

Approval of the National Health Service Statute

The new 2019 Health Basic Law assumed the purpose of clarifying the role and relationship between the several stakeholders in the health system, reaffirming SNS centrality, guided by the principles of universality, generality, a tendency towards free provision, and endowed with its status. It is, therefore, now vital to approve a new ESNS and revoke Decree-Law No. 11/1993 of January 15, in its current wording, which approved the SNS Statute, not only because the new Health Basic Law lacks densification in specific aspects, but also because almost 30 years have elapsed since the publication of the previous ESNS in 1993. Many changes have occurred in the SNS, which have led to several of its provisions being subject to scattered changes in the meantime, which hinders achieving a desirable overall view.

In developing the new LBS, the SNS Statute provides for the SNS human resources and its multi-annual planning. The central aspect of this section is defining the complete dedication regime[17], an instrument for individual contracting and performance enhancement, which aims to improve user access and the retention and motivation of SNS healthcare professionals. This regime of progressive implementation begins with SNS medical workers voluntarily, except for new service or department directors, and healthcare commitment. The issue of SNS human resources is not over until the SNS Statute also defines an exceptional regime for recruiting, conducting additional work, and mobility in the SNS, instruments for more flexible management in a sector heavily dependent on a differentiated workforce intended to be organized into careers. On the one hand, the highest management bodies of the SNS establishments and services reinforce their autonomy to hire workers, regardless of the type of contract, within their respective management instruments. Moreover, these establishments and services now have an overtime regime that includes their work in an entity other than that to which the worker is linked and wants their remuneration increased when the annual limit set is exceeded.

Also, in the chapter on organization and functioning, the SNS Statute introduces one of its main innovations by establishing an SNS Executive Board. This entity assumes the coordina-

tion of the healthcare response of the SNS healthcare units and units that are part of the National Network of Integrated Continuing Care (RNCCI) and the National Network of Palliative Care (RNCP), ensuring their functioning as a network. This role was vital in the fight against the COVID-19 pandemic and essential to strengthen. Furthermore, this entity assumes responsibilities previously assigned to other institutions, particularly managing access to healthcare, the RNCCI, and the RNCP. It is also responsible for proposing the appointment of members of the management bodies of the healthcare units.

The role of the SNS Executive Board is naturally distinct from that of the Ministry of Health, which is responsible for conducting national health policy and having specific responsibilities relating to the SNS, but not for the operational coordination of its responses.

The SNS Executive Board

Decree-Law No. 61/2022 of September 23 approved the organic structure of the SNS Executive Board[18], and Ordinance No. 306-A/2023 of October 12 approved the respective statutes[19]. The diversity of care it provides, the capillarity of its services, the high technical autonomy of its health professionals, the increasing healthcare costs, and expectations of a more informed and demanding society give the SNS an organizational and management complexity with challenging parallel in the Portuguese State and justify the mission of the DE-SNS, I. P.: to coordinate the care response of the SNS health units, ensuring their operation as a network, the continuous improvement of access to healthcare, the participation of users, and the alignment of clinical and health governance.

The entry into force of the new SNS Statute marked a profound organizational change in the SNS, strengthening its capacity to invest in promoting health and well-being, enabling it to offer more efficiency, greater accessibility, and better health care.

The established DE-SNS, I. P. brought a new dimension to the SNS management and operational structure. It is crucial to provide it with an adequate operational capacity, which enables it to implement policies and actions that will promote equal access, streamline the use of resources, and foster the continuous improvement of the quality of services provided in a SNS network concept.

From 2023 onwards, this new entity assumed central responsibility for managing the SNS in an innovative and dynamic approach that enables the coordination and cooperation of all the system's components, from the provision of healthcare to the efficient management of resources, including, naturally, health promotion, and disease prevention and recovery through integrated care.

Establishment of Local Health Units

Decree-Law No. 102/2023 of November 7[20] established the Local Health Units detailed in Chart 1 as public business entities.

The increase in the health and well-being needs of the population, associated with aging, the burden of disease, and their growing demands and expectations, requires that the SNS continue to increase access and efficiency in the provision of healthcare, fostering organizational models that promote the integrated management of PHC and hospital care, ensuring a focus on people[21,22].

The special coordination between these levels of care has always been a constant concern since the creation of the SNS, given the added value it can bring to the adequate provision of healthcare to its beneficiaries.

Aligned with the 2030 Agenda for Sustainable Development and based on its triple dimension — economic, social, and environmental, the promotion of "Proximal Health" through local proximity devices was one of the objectives of the Program of the XXIII Constitutional Government, thus contributing to achieving the Sustainable Development Goals[23] (SDGs), particularly, SDG 3 ("Quality Health").

In this sense, paragraph d) of No. 2 of Base 20 of the new LBS established that the SNS must ground its actions on integrated care[24]. The integration mentioned above aims, among other things, to ensure that SNS beneficiaries have access to the type of care that best suits their actual needs.

Article 5 of the new SNS Statute[25] also determined that SNS establishments and services must guide their operations based on provision proximity, integrated care, and coordinated responses.

Of the aforementioned organizational models, the ULS stand out as health establishments responsible for ensuring primary and hospital health care are integrated.

More than 20 years after the creation of the first ULS[26] through Decree-Law No. 207/1999 of June 9, which established an innovative experience in Matosinhos, integrating the several

services and institutions of the SNS existing in that municipality into a single public entity, with business management, and more than 10 years after the creation of the last ULS, we observe today a movement to reorganize the SNS, the ultimate goal of which is to organize people-based health responses.

The integration of the ACES[27], hospitals, and existing hospital centers into the ULS model qualifies the SNS response, simplifying processes, increasing coordination between teams of health professionals, focusing on experience and pathways between the different care levels, increasing management autonomy, improving the participation of citizens, communities, professionals, and local authorities in defining, monitoring, and evaluating health policies, maximizing SNS access and efficiency.

Additionally, with the integration mentioned above, greater efficiency is achieved in managing public resources, simultaneously with the guarantee and respect for the fundamental role of the participation of municipalities in the planning, organization, and management of the effective health response to the population of a given geographical area, enhancing proximity and network management[28].

We should underscore that the maturation of this organizational model allows the ULS to benefit from new management instruments, namely: i) risk stratification, which identifies the distribution of the disease burden in the population; ii) information systems that enhance care integration, such as the single electronic health record; iii) financial and non-financial performance incentives, focused on results and value creation; and iv) innovative care delivery models, based on teams that make commitments focused on responding to people, emphasizing family health and community care units within PHC, or for the hospital area, integrated responsibility centers.

Furthermore, the diversity and complexity of this new wave of ULS requires an adjustment regarding its management bodies, the change of which is also promoted through this decree-law.

The main challenges for the new ULS

Considering that the SNS has grown and gained the trust of the Portuguese people over the last 40 years and is the guarantee of the fundamental right of all citizens to health protection, regardless of their social status, economic situation, or geographical location, the review of the legislation that supports it, namely its Statute, is a fundamental step towards strengthening the construction of a fairer and more inclusive SNS, which better responds to the needs of the population through the necessary structural reforms.

The shortage of health professionals is a deteriorating reality in inland regions or regions with lower population density and large urban centers, such as the Lisbon region. Recruitment and retention of health professionals will be one of the main challenges for the ULS, as safeguarding equitable access to health services is essential in the SNS.

The new ULS model is based on integrated care. However, one of the main concerns has been that the management of ULS tends to be hospital-centric, contradicting the intended assumption of shared responsibility in following up with people involving primary and hospital care to monopolize one of the care levels. Therefore, the ULS should guarantee a new model of healthcare centered on people, focusing on prevention and ensuring coordinated care.

The aging population and limited resources make financing a crucial aspect. A new financing model based on the clinical risk of users has been announced with the implementation of new tools. Healthcare underfunding in Portugal has been a recurring reality. Thus, these new tools should be adapted to the population's growing needs and consider developments in innovation and technology, which are hallmarks of the evolution and progress of medicine. In this sense, we highlight access to teleconsulting services and the implementation of a single electronic user record, with access to clinical information by the several doctors who provide care, safeguarding privacy and security to ensure quality care.

Aligned with the sustainable development goals (SDGs), the ULS will also have to implement environmental sustainability measures to reduce the environmental impact of their interventions.

Thus, we can easily conclude that responding to these challenges requires the availability of several strategies that include strategic investments, effective health policies, and professional involvement. All strategies must coexist over time, be agile in responding to changes in population needs, and be flexible per the current health outlook.

Multiple reforms have focused on structural issues since the SNS foundation. However, subsequent governments will have to address primarily non-health issues that have profound implications for the SNS, such as education, em-

Chart 1. Creation of 39 ULS as public business entities.

Local Health Units (ULS)	Health Units
Guarda	HNS Assunção, H Sousa Martins, CS Guarda, Mêda, Almeida.
Castelo Branco	H Amato Lusitano, ACES Beira Interior Sul and PIS.
Matosinhos	H Pedro Hispano, CS Leça da Palmeira, Matosinhos, Srª da Hora.
Alto Minho	CH Alto Minho. CS Arcos de Valdevez, Caminha, Melgaço, Monção, Paredes de Coura, Ponte da Barca, Ponte de Lima, Valença, Viana do Castelo and Vila Nova de Cerveira.
Baixo Alentejo	CH Baixo Alentejo, CS distrito de Beja, except for Odemira.
Litoral alentejano	H Litoral Alentejano, CS Alcácer do Sal, Grândola, Odemira, Santiago do Cacém, Sines.
Nordeste	CH Nordeste, ACES do Alto Trás-os-Montes I and ACES Nordeste.
Alto Ave	H da Senhora da Oliveira Guimarães, ACES Alto Ave - Guimarães/Vizela/Terras de Basto and CS de Celorico de Basto.
Barcelos/Esposende	H Santa Maria Maior - Barcelos, ACES Cávado III - Barcelos/Esposende.
Braga	H Braga, ACES Cávado I and II – Braga, Gerês/Cabreira.
Póvoa de Varzim/ Vila do Conde	CH Póvoa de Varzim/Vila do Conde, ACES Grande Porto IV - Póvoa de Varzim/Vila do Conde.
Médio Ave	CH Médio Ave, ACES Grande Porto I - Santo Tirso/Trofa and Ave -Famalicão.
Tâmega e Sousa	CH Tâmega e Sousa, ACES Tâmega I, II and III- Baixo Tâmega, except for CS de Celorico de Basto, Vale do Sousa Norte and Sousa Sul.
Gaia/Espinho	CH Vila Nova de Gaia/Espinho, ACES do Grande Porto VII and VIII – Gaia.
Trás-os-Montes e Alto Douro	CH Trás-os-Montes e Alto Douro, ACES Trás-os-Montes - Alto Tâmega e Barroso, do Douro I and II – Marão, Douro Norte and Douro Sul.
Entre Douro e Vouga	CH de Entre Douro and Vouga, ACES de Entre Douro e Vouga I and II – Feira, Arouca and Aveiro Norte.
São João	CHU São João, ACES Grande Porto III and IV - Maia/Valongo and Porto Oriental.
Santo António	CHU Santo António, ACES Grande Porto II and V – Gondomar and Porto Ocidental.
Baixo Mondego	HD da Figueira da Foz, CS da Figueira da Foz, Soure and Montemor -o -Velho.
Cova da Beira	CHU Cova da Beira, ACES Cova da Beira.
Viseu/Dão-Lafões	CH Tondela-Viseu, ACES Dão-Lafões.
Leiria	CH Leiria, ACES Pinhal Litoral, CS Ourém, Fátima, Alcobaça and Nazaré.
Coimbra	CHU Coimbra, H João Crisóstomo - Cantanhede, CMRRC – Rovisco Pais, do Agrupamento de Centros de Saúde do Pinhal Interior Norte and CS Cantanhede, Celas, Eiras, Fernão Magalhães, Norton de Matos, Santa Clara, São Martinho do Bispo, Condeixa-a-Nova, Mealhada, Mira, Mortágua, Penacova.
Aveiro	CH do Baixo Vouga, Hospital Dr. Francisco Zagalo, and ACES do Baixo Vouga.
Amadora/Sintra	Hospital Professor Doutor Fernando Fonseca, ACES Amadora and Sintra.
Almada-Seixal	Hospital Garcia de Orta, ACES Almada-Seixal.
Lezíria	Hospital Distrital de Santarém, ACES Lezíria.
Estuário do Tejo	Hospital de Vila Franca de Xira, ACES Estuário do Tejo.
Loures-Odivelas	Hospital de Loures, ACES Loures-Odivelas, except for CS de Sacavém.
Santa Maria	CHU Lisboa Norte, ACES Lisboa Norte and CS Mafra.
São José	CHU Lisboa Central, CH Psiquiátrico de Lisboa, Instituto de Oftalmologia Dr. Gama Pinto, ACES Lisboa Central and CS Sacavém.
Oeste	CH Oeste, ACES Oeste Sul, com exceção de Mafra, and CS do Bombarral, Caldas da Rainha, Óbidos and Peniche.
Médio Tejo	CH Médio Tejo, CS Abrantes, Alcanena, Constância, Entroncamento, Ferreira do Zêzere, Mação, Sardoal, Torres Novas, Tomar, Vila Nova da Barquinha and Vila Rei.
Arrábida	Centro Hospitalar Setúbal, ACES da Arrábida.
Lisboa Ocidental	Centro Hospitalar Lisboa Ocidental, ACES Lisboa Ocidental and Oeiras.
Arco Ribeirinho	Centro Hospitalar Barreiro-Montijo, ACES Arco Ribeirinho.
Alto Alentejo	ULS do Norte Alentejano, Laboratório de Saúde Pública do Alentejo.
Alentejo Central	Hospital do Espírito Santo de Évora, ACES Alentejo Central.
Algarve	CHU Algarve, ACES Central, Barlavento, Sotavento.

Source: Decree-Law No.102/2023 of November 7.

ployment, income, housing, and, in short, the determinants of health. It is necessary to ensure long-term investment that profoundly changes the health needs of populations, inequalities, and access to health care. It is not about removing or adding services; on the contrary, it is about identifying redundancies, correcting this waste, and investing in everything upstream of the disease.

Currently, health systems are dealing with the consequences of COVID-19, but the causes of the current crisis predate 2019 by a long way, such as underfunded health services and staff shortages. In an uncertain future, investing in changing the population's health needs is necessary. Otherwise, health organizations will continue to deteriorate, increasing labor conflicts, uncertainty, and the reluctance of new professionals toward public services.

The future challenges will, therefore, involve increasing accessibility, particularly in acute illness, focusing on prevention and early intervention to improve the management of chronic diseases, supporting the integration and provision of multidisciplinary care, selecting the available evidence for the adequate provision of quality care, and using technology to support good practices. ULS' future will be linked to the success or failure in addressing education and research. It will depend on whether we win or lose the battle for information and communication systems, efficiency, management, clinical governance, quality, and good practices. The future will increasingly depend on whether we win or lose in our chosen strategy with people, teamwork, a culture of health, organization, community intervention, and creating working conditions and spaces, authentic places of service to the population, with motivated professionals who enjoy their work and dealing with others.

Collaborations

LAC Pisco, VP Silva and BR Monteiro worked on the conception and final draft.

References

1. Portugal. Diário da República nº 173 – II série de 29 de julho de 1978. *Despacho Ministerial de 20 de julho de 1978***.** (Despacho Arnault).
2. Portugal. Diário da República n.º 214, de 15 de setembro de 1979. Na sequência do Despacho Arnaut, é aprovada a Lei n.º 56/1979, de 15 de setembro (Lei de Bases da Saúde), que cria o Serviço Nacional de Saúde. *Diário da República*; 1979.
3. Portugal. Decreto-Lei nº 156, de 10 de maio de 1999. Sistemas Locais de Saúde. Estabelece o regime dos sistemas locais de saúde. *Diário da República*; 1999.
4. Portugal. Regime Jurídico das USF. 1.ª série – Nº 161 – DL nº 298/2007, de 22 de agosto de 2007. *Diário da República*; 2007
5. Portugal. Lei n.º 27, de 8 de novembro de 2002. Novo regime jurídico de gestão hospitalar de 2002. *Diário da República* n.º 258; 2002.
6. Simões J, Augusto GF, Fronteira I, Hernández-Quevedo C. Portugal: Health system review. *Health Systems Transition* 2017; 19(2):1-184.
7. Portugal. Lei n.º 95/2019, de 4 de setembro de 2019. Aprova a Lei de Bases da Saúde e revoga a Lei n.º 48/1990, de 24 de agosto, e o Decreto-Lei n.º 185/2002, de 20 de agosto. *Diário da República*; 2019.
8. Ministra da Saúde Marta Temido. *Declarações à Agência Lusa na apresentação da nova Lei de Bases da Saúde*. Lisboa; 2018 dez 13.
9. Pereira AGD. Uma Lei de Bases da Saúde para os anos 2020. *Rev Eletr Direito Publico* 2019; 6(1):1-14.
10. Pordata. *Esperança de vida à nascença: total e por sexo (base triénio a partir de 2001)* [Internet]. [acessado 2023 jan 15]. Disponível em: https://www.pordata.pt/pt/estatisticas/populacao/esperanca-de-vida-e-obitos/esperanca-de-vida-nascenca-por-sexo.
11. Antunes AP. *As taxas moderadoras e a lei de bases da saúde* [Internet]. Semana da Bioética; 2019 [acessado 2023 jan 15]. Disponível em: https://www.cidp.pt/revistas/rjlb/2020/1/2020_01_0327_0362.pdf.
12. Barros PP, Costa E. *Despesas diretas das famílias no sistema de saúde português-Julho de 2023. Observatório da Despesa em Saúde/03* [Internet]. [acessado 2023 jan 15]. Disponível em: https://www.novasbe.unl.pt/Portals/0/Files/Social%20Equity%20Initiative/03_Observatorio_despesa_saude.pdf.
13. Rigney G. Portugal: #22 in the 2022 World Index of Healthcare Innovation. Disponível em: Portugal: #22 in the 2022 World Index of Healthcare Innovation | Grant Rigney | FREOPP.org.
14. World Health Organization (WHO). *Quality of care: a process for making strategic choices in health systems*. Geneva: WHO; 2006.
15. Entidade Reguladora da Saúde. *Estudo sobre concorrência no setor hospitalar não público* [Internet]. [acessado 2024 jan 2]. Disponível em: https://www.ers.pt/pt/comunicacao/destaques/lista-de-destaques/estudo-sobre-a-concorrencia-no-setor-hospitalar-nao-publico/.
16. Portugal. Despacho n.º 6417, de 20 de maio de 2022. Define os eixos estratégicos da política de recursos humanos do Serviço Nacional de Saúde e cria os respetivos mecanismos de operacionalização. *Diário da República*; 2022.

17. Portugal. Decreto-Lei n.º 103, de 7 de novembro de 2023. Aprova o regime jurídico de dedicação plena no Serviço Nacional de Saúde e da organização e do funcionamento das unidades de saúde familiar. *Diário da República*; 2023.
18. Portugal. Decreto-Lei n.º 61, de 23 de setembro de 2022. Aprova a orgânica da Direção Executiva do Serviço Nacional de Saúde. *Diário da República*; 2022.
19. Portugal. Portaria n.º 306-A, de 12 de outubro de 2023. Aprova os Estatutos da Direção Executiva do Serviço Nacional de Saúde, I. P. *Diário da República*; 2023.
20. Portugal. Decreto-Lei n.º 102, de 7 de novembro de 2023. Procede à criação, com natureza de entidades públicas empresariais, de unidades locais de saúde. *Diário da República*; 2023.
21. World Health Organization (WHO). *What are integrated people-centred health services?* [Internet]. [cited 2023 dez 30]. Available from: http://www.who.int/servicedeliverysafety/areas/people-centred-care/ipchs-what/en/.
22. Ramsay A, Fulop N. *The evidence base for integrated care*. *Department of Health.* Kings College London: NIHR King's Patient Safety and Service Quality Research Centre; 2008.
23. United Nations. *Transforming our world: the 2030 Agenda for Sustainable Development* [Internet]. New York: United Nations; 2015 [cited 2023 dez 30]. Available from: https://sustainabledevelopment.un.org/post2015/transformingourworld.
24. World Health Organization (WHO). *Integrated health services – what and why? Technical Brief No. 1*. Geneva: WHO; 2008.
25. Portugal. Decreto-Lei n.º 52, de 4 de agosto de 2022. Aprova o Estatuto do Serviço Nacional de Saúde. *Diário da República*; 2022.
26. Portugal. Decreto-Lei n.º 207, de 9 de junho de 1999. Criação da ULS de Matosinhos. *Diário da República*; 1999.
27. Portugal. Decreto-Lei n.º 28, de 22 de fevereiro de 2008. Regime Jurídico dos ACES. *Diário da República*; 2008.
28. Portugal. Lei n.º 50, de 16 de agosto de 2018. Lei-quadro da transferência de competências as autarquias locais e para as entidades intermunicipais. *Diário da República*; 2018.

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