



Corporate Social Responsibility in Health Care

*Rute Abreu
Fátima David*

Escola Superior de Tecnologia e Gestão da Guarda, Portugal



Nota Introdutória

A Escola Superior de Tecnologia e Gestão (ESTG) do Instituto Politécnico da Guarda (IPG) congratula-se pelo facto do Professor Doutor *David Crowther*, da *London Metropolitan University*, Reino Unido ter aceite o convite para realizar uma visita de trabalho e investigação científica a decorrer entre os dias 9 a 15 de Novembro de 2002. Temos a certeza que com esta visita será possível desenvolver um debate privilegiado entre toda a comunidade Docente e Discente.

É igualmente um enorme privilégio dar início à série *Estudos e Documentos de Trabalho* com seis *papers* da autoria do Professor David Crowther. Esperemos que este seja o estímulo e o incentivo que falta para que, em particular a comunidade académica da ESTG, apresente trabalhos científicos que estimulem a discussão científica.

Não se poderá deixar de agradecer à Fundação para a Ciência e Tecnologia que, através do Fundo de Apoio à Comunidade Científica, generosamente aceitou a nossa candidatura, bem como todos aqueles que directa e indirectamente contribuíram para a sua concretização.

Constantino Rei

Professor Doutor do Departamento de Gestão
Director da Escola Superior de Tecnologia e Gestão do IPG

Corporate Social Responsibility in Health Care

por

Rute Abreu

Escola Superior de Tecnologia e Gestão do Instituto Politécnico da Guarda, Portugal

Fátima David

Escola Superior de Tecnologia e Gestão do Instituto Politécnico da Guarda, Portugal

Série **ESTUDOS E DOCUMENTOS DE TRABALHO** da

Escola Superior de Tecnologia e Gestão, Portugal

EDT – 02 / 2005

Setembro de 2005

ISSN 1645-6920



Copyright © 2005. All rights reserved. No part of this publication may be reproduced in any form or by any means, without the prior written consent of authors.

CORPORATE SOCIAL RESPONSIBILITY IN HEALTH CARE

ABREU, Rute (ra_hotmail@ipg.pt)

DAVID, Fátima (maria.david.2@netvisao.pt)

Escola Superior de Tecnologia e Gestão da Guarda

Av. Dr. Francisco Sá Carneiro, 50 - ESTG - Gab. 50, 6300-559 Guarda, Portugal

Abstract

The health care is an essential need of the society and it is an integral part thereof. In this sense, everybody is entitled to medical services to provide health and well-being that improves lifestyle. Policymakers and researchers focus substantial attention on hospitals and public spending of financial resources, because they recognise the political power and the general collective obligation of preserving a health care for the present and future generations.

The empirical analysis used a sample based in the 31 corporate hospitals that belong to the Portuguese health care system as a National Health Service in the period 2002-2003. The disclosure of information allows comparability and identifies similarities between the hospitals in the sample. Relevant organizational variables were managed statistically through the multivariate analysis. The geographical analysis shows inequalities of the distribution of hospitals facilities in Portugal, with marked concentration in the urban coastal areas, affected by the number of persons that live there. The financial analysis is supported in the Portuguese Official Accounting Plan that follows the same accounting trend of corporations. So, the disclosure and the accountability system are not opened up to a new field for accounting in health care based in the Health Official Accounting Plan. The research shows implications at the operational level, the efficiency and the effectiveness of the health care strategy with differences between hospitals. The authors believe that, as complex organizations, hospitals must based their disclosure police in transparency to allow patients to identify their own orientations that should be driven mainly by corporate social responsibility as a public service and not by the economic perspective of a business.

This research confirms that as a global strategy for the health care system, corporate social responsibility is urgently needed. As a finite resource, the health should demand a permanent attention from society, as well as the Government in accomplishment prevention and monitoring systems, with a view to the defence of a sustainable health care system. More than merely investing efforts in fighting for political changes, without any advantage for society it is crucial to invest in prevention of the quality of life as a basic requirement to honour the corporate social responsibility in hospitals. Especially needed are health care improvements and infrastructures. In summary, the health care system exists as a fundamental element that assures life and high standards of living, so it should be available to everybody and for everybody...

Key Word: CSR, Health care, Hospitals, Portugal.

Acknowledgements: Ideas expressed in the article are those of the authors and should not be attributed to any organization. Please, do not quote in any publication without prior written consent of authors.

Introduction

In a previous research, David and Abreu (2004) analysed if social responsibility is a reality or an illusion. In this context, the human life is the beginning and the ending of everything and the analysis of the corporate social responsibility (CSR) in the health care system presents its maximum exponent.

This system has a significant role to play in the development of CSR and in the study of the relationship between Government, Health Care and Society. To support this point of view, the authors previously analyzed the social responsibility based in the report elaborated by the Portuguese Government of the Health Operational Programme (HOP).

Since 1998 starts a health care reform that change public hospitals to corporations. Contract-programmes with each corporate hospital was established setting objectives, quantitative targets, priorities and modalities for the provision of services, quality standards, monitoring and evaluation systems. For all these reasons, the authors aimed to explore the CSR in health care system based in the corporate hospitals.

The increasing concerned of corporate social responsibility in all areas should develop the improvement of the Human life. For example, the health care is a formal system by which health care is provided to a patient in a specific place. Policymakers and researchers of this system tend to use the terms of universal care. This questions seems to be connect with protection of citizens against health threats, leads to a healthier way of life, contributes to reduce the incidence of major diseases, improves effectiveness and efficiency in health systems (see EU, 2005a) and reduces the individual financing process wholly or in majority part with public spending.

Several institutions¹ around the world have focus in the health strategy, such as the World Health Organization (WHO) that promotes health care and well being. In 1978, the Declaration of Alma-Ata specifies that:

Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community (WHO, 1978: 1).

In 1997, the Jakarta Declaration on Leading Health Promotion into the 21st Century promotes:

...emerging threats to health, new forms of action are needed. The challenge for the coming years will be to unlock the potential for health promotion inherent in many sectors of society, among local communities, and within families (WHO, 1997: 4).

Recently, in 2005, the fifty-eighth World Health Organization Assembly approved the revision of the International Health Regulations:

to build, strengthen and maintain the capacities required under the International Health Regulations (2005), to mobilize the resources necessary for that purpose...as to ensure their effective implementation (WHO, 2005: 3).

¹ For example, the EU Agencies includes: European Medicines Agency, European Food Safety Authority, European Monitoring Centre for Drugs and Drug Addiction, European Centre for Disease Prevention and Control and European Agency for Health and Safety at Work.

In the treaty that establishes a Constitution for Europe, the article II-95 says that:

A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities (EC, 2004: 49).

The new European Union (EU) Health strategy promotes by the European Commissioner for health and consumer protection defends that:

...good health is a state of physical and mental well-being necessary to live a meaningful, pleasant and productive life. Achieving good health for all means not just reacting to ill-health, but proactively promoting health, preventing diseases, helping people make healthy choices and is a shared responsibility that requires co-operation between the EU, its Member States and its citizens (Byrne, 2004: 1).

One of the principles of CSR is transparency that is not followed despite of being used in promotion information in the health care system. For example, the disclosure of health information does not include the available choices made by the citizen and usually promote disinformation to the society, especially based in the political objectives.

Patients are particularly affected by asymmetric information, in several situations, they do not themselves freely choose what health services and treatment want to receive (see EU, 2005b). In several medical facilities, patients are merely a commercial commodity, but they are not ordinary consumers, they are special clients and in a vulnerable position.

Problems in this complex system also rises due to the lack of understandable and factually accurate information and disclosure should be in time and constantly up-to-date to provide relevant decision to the society and not excessive controlled by the centralized state. For example, patients are obliged by physicians to signed non-prosecution documents before surgeries services.

More and more, in the perspective of the society, the health care system should have well behaviour of Government and human resources and at the same time present a sustainable development that could increase the CSR in the system. These challenges are related with demographic indicators including resident population, ageing-related conditions, birth and fertility rate that promotes high levels of lifestyle and enables health to each citizen. Table 1 publishes the demographic indicators in fifteen countries of the EU in the year 2002.

Table 1 - Demographic indicators in EU-15 in 2002

Country	Resident population					Birth rate (%)	Total fertility rate
	Total (1000)*	0-14 years (%)	15-64 years (%)	≥ 65 years			
				≥ 80 years (%)	≥ 80 years (%)		
Portugal	10368	15,80	67,50	16,70	3,50	11,03	1,47
Austria	82489	15,20	67,50	17,30	4,00	9,74	1,39
Belgium	8053	16,60	67,90	15,50	3,80	11,44 (2000)	1,53
Denmark	10333	17,50	65,60	17,00	3,90	12,57 (2000)	1,70
Finland	5376	18,80	66,40	14,80	4,00	10,68	1,70
France	41874	14,50	68,60	16,90	4,10	12,76	1,88
Germany	5201	17,90	66,90	15,20	3,60	8,77	1,31
Greece	59486	18,70	65,00	16,30	4,10	6,74	1,30
Ireland	10604	14,60	67,30	18,10	3,80	14,24 (2001)	1,98
Italy	16149	18,60	67,70	13,70	3,30	9,42	1,20 (2001)
Luxembourg	3932	21,10	67,80	11,10	2,60	11,98	1,63
Netherlands	57994	14,40	67,00	18,60	4,40	12,51	1,73
Spain	446	18,80	67,30	13,90	3,10	10,49	1,24 (2001)
Sweden	59232	18,60	65,50	15,90	4,30	10,28 (2001)	1,60
United Kingdom	8925	18,10	64,70	17,20	5,20	11,27	1,64

Note: * Mid-year population

Source: DGS (2005: 40)

Till 1986, before join the European Community, Portugal displayed very unfavourable socio-economic and health indicators especially when compared with other countries of the European context. But, in 2002, the demographic indicators presented in table 1 shows Portugal in an average position in relation with other countries of the EU-15. As the PCG (2005: 36) states:

...increased life expectancy has come in the wake of advances in medicine and a marked improvement in the socio-economic conditions of the Portuguese population, especially as regards health care.

Table 2 – Standardized Mortality Rate in EU-15 in 2002

Country	Standardized mortality rate (all ages)										
	1	2	3	4	5	6	7	8	9	10	11
Portugal	728,88	161,62	23	21,95	261,77	63,67	122,22	26,41	17,27	14,07	19,03
Austria	649,64	170,82	33,43	25,95	289,12	130,82	62,34	16,82	20,89	17,69	10,14
Finland	675,87	145,92	26,86	21,04	274,96	165,17	62,06	7,51	15,27	13,18	7,48
Luxembourg	664,94	171,17	35,25	26,45	245,89	77,22	69,55	9,57	25,82	17,08	13,36
Netherlands	678,36	193,87	47	33,26	220,13	75,32	54,65	18,88	28,5	4,53	5,79
United Kingdom	676,52	189,71	41,96	30,07	250,39	128,37	66,75	7,79	31,28	10,42	5,3
Belgium (1997)	719,98	206,64	52,39	35,02	246,37	82,05	59,94	11,14	10,29	11,83	13,62
Denmark (2000)	751,75	222,44	51,69	36,64	248,08	111,15	59,54	18,81	48,12	13,98	8,43
France (2000)	613,61	186,68	35,38	27,01	167,36	49,4	39,03	11,86	9,91	13,36	11,99
Germany (2001)	657,62	176,57	34,39	27,51	286,05	122,92	56,3	16,23	18,23	16,99	7,86
Greece (2001)	639,71	162,12	39,04	22,72	302,77	84,68	105,3	4,33	0,43	5,03	17,19
Ireland (2001)	750,48	198,64	38,85	34,32	289,74	151,99	61,37	9,62	5,94	5,78	9,37
Italy (2001)	576,31	178,08	37,39	25,49	221,53	70,92	59,38	17,38	14,86	13,64	11,81
Spain (2001)	596,51	171,35	35,02	21,15	191,04	62,68	54,49	14,49	22,32	10,47	13,24
Sweden (2001)	599,5	157,85	25,37	22,06	248,66	120,67	55,97	11,6	16,15	5,35	5,87

Note: 1-all causes; 2-malignant tumour; 3-trachea bronchus and lung malignant tumour; 4-breast malignant tumour; 5-blood system diseases; 6-heart diseases; 7-cerebrovascular diseases; 8-diabetes mellitus; 9-bronchitis, emphysema and arrhythmia; 10-chronic fever and cirrhosis; 11-motor vehicle accidents.

Source: DGS (2005: 43)

Table 2 shows the standardized mortality rate in 2002, in six countries of the EU-15. The representativeness of several countries was not properly considered because the different year's data, such as Belgium in 1997, Denmark and France in 2000, and Germany, Greece, Ireland, Italy, Spain and Sweden in 2001. This could make problems in the study of similarities between the countries.

It is important to notice that the three more relevant causes of mortality rate in Portugal are the cerebrovascular diseases, the diabetes mellitus and the motor vehicle accident. The first two causes involve very high rate of mortality that generate progressively and permanently health damage of citizens. So, the health policy should be based in long-term investment in prevention and then their will be saving money on future treatment costs.

The international comparison of Portugal in this subject allows in the first cause – cerebrovascular diseases (code 7) – to register a maximum value of 122 in Portugal and a minimum value of 55 in Netherlands. The same happens with the second cause – diabetes mellitus (code 8) – with a maximum of 26 in Portugal and a minimum of 8 in Finland. And, finally, the third cause – motor vehicle accident (code 11) – has a maximum value of 19 in Portugal and a minimum of 5 in United Kingdom.

Another problem that table 2 shows is that European Union countries increasingly suffer from lifestyle related diseases especially due to an unbalanced diet, a physical inactivity and tobacco, drugs or alcohol abuse. The health and welfare policies were remain largely absent from the NHCS (see Santana, 2000). In fact, the Governments and European Union

should promote health care policy based in the (good and bad) effects of lifestyle on health and enable citizens to make the right choices.

As was developed in David and Abreu (2004), this research presents dual theoretical frameworks for the analysis of CSR in health care. The first theoretical framework is based in organisational and sociological theory (see Rahaman *et al.*, 2004) and the second framework, as is original in social accounting and disclosure information, provide explanations for CSR decisions (see Gray *et al.*, 1994; Tilt, 1994).

The Portuguese Health Care System

The Portuguese health care system is complex as a result of constant reforms. The system has succeeded in drastically improving the health status of the population and bringing it close to the European average in many health indicators in the last 30 years (see Guichard, 2004). As EOHCS (1999: 16) specifies, in Portugal:

the public health services only begin in 1901 with the creation of a network of medical officers responsible for public services. Before that, in the eighteenth century, health care was provided only for the poor by hospitals called *Misericórdias*.

During a large period of time, the Portuguese health care system was based in the network of the *Misericórdias Hospitals*. These religious institutions are independent charitable that concentrate their efforts in the health and social care systems to poor people in Portugal.

Before 1970, the Portuguese health care had few large state hospitals, some social security medical ambulatories, some public health services with "well baby clinics", some tuberculosis and mental health dispensaries, and the medical services were particularly based in ambulatory sector (see OPSS, 2003). By that time, the financial resources for the health sector were very small and human resources had to adapt to this social and economic situation.

In 1971, the health care centers were created as integrated in the primary health care. This was the main advantage of the modern health care system, because is distributed all over Portugal being more accessible and near the citizens. The Portuguese health system is characterized by three coexisting systems: the National Health Care Service (NHCS), health subsystems for certain professions and voluntary private health insurance. Providers to the NHCS are organised into three networks: the primary health care centers, the hospitals and the long-term care units. Primary health care services are provided by physicians and other health personnel who first contact with a patient seeking medical care.

In 1974 with the democratic revolution and with the Portuguese Constitution (see AR, 1976), Portugal changed deeply, because new social policies emerged. The new constitutional law established the right of all to health protection and required the creation of a universal, comprehensive and free NHCS with a hospitals network approved in the *Decreto-Lei* n° 129/77 (see MAS, 1977). It also referred to a sustainable economic, social, cultural development in order to ensure and promote health. The *Lei* n° 56/79 (see AR, 1979) institutionally creates the NHCS that changed after by the *Lei* n° 48/1990 (see AR, 1990). This system should be socially responsible as a condition of each entity jointly promote productivity, universally and generality. The established of the NHCS was seen as the most appropriate response to the society needs for a more extensive and equitable health service coverage.

The NHCS based in centralized in the control made by the Ministry of Health. Through the Ministry, the Government holds the legal responsibility for the regulation, organization and direction of the health care system as a whole. At the same time is a decentralized management developed by five strong regional structure of health administration approved by the *Decreto-Lei* n° 335/93 (see MS, 1993d). These five regional agencies are called North, Centre, *Lisboa* and *Tejo* valley, *Alentejo* and *Algarve*. One of the main aspects of these entities are to be near the citizens and to assurance equity in health assistance that everybody as full right.

In 1993, the *Decreto-Lei* n° 10/93 (see MS, 1993a) establishes the organic law of the Health Ministry and the *Decreto-Lei* n° 11/93 (see MS, 1993b) reorganized the national health care system. This legislation also aimed at stimulating the Portuguese private sector in the health arena; including the private management of NHS facilities (see OPSS, 2003).

The Portuguese Ministry of Health has a dual role, as the statutory agency responsible for health strategy and as the major provider of health services. The *Direcção Geral de Saúde* approved in the *Decreto-Lei* n° 122/97 (see MS, 1997) promotes the application in the system of the health care strategy. These were meant to promote better integration of primary, secondary, and tertiary care. Despite of that objective, in reality, health care resources are concentrated in coastal areas of Portugal.

In 1999, the *Decreto-Lei* n° 286/99 establishes regional centers of public health trying to promote the health and social integration that were considered to be priority areas in the intervention of the social sector (see MS, 1999). Strategies decided upon included the enlargement and renewal of hospitals and health centers as well as an improvement in the management of the NHCS. But, poor accessibility to health services is the most serious barrier (see Santana, 2000).

Recent developments in the Portuguese health system offer a context to study several and fundamental social responsibility aspects that allows the right of all citizens to have health care system that provides well-being and good quality of life. And differentiate health policies are adopted to promote to citizens basic principles of universality, accessibility, continuity, quality, and affordability in the health care system (see MF, 1999).

The *Lei* n° 27/2002 (see AR, 2002) approves the new legal regimen of hospital administration. This law establish four different legal status for each hospital that co-exist, such as the official hospitals divided in the public hospitals and the public-private partnerships, the corporate hospitals with public equity, and finally the private hospitals.

The official hospitals called *hospitals SPA (Sector Público Administrativo)* approved in the *Decreto-Lei* n° 188/2003 (see MS, 2003b) have an administrative and financial autonomy. Public hospitals are under public management, must oblige the public sector administrative law and national accounting. Despite the special task forces that have been created and trained within the five regional structure of health administration to monitor these hospitals, as Guichard (2004: 27) comments:

Preliminary estimates for hospital SPA show that, in 2003, production increased but also costs, and debt continued to rise, by about 60 per cent.

The public-private partnerships (PPP) have an administrative, financial and asset management autonomy. These hospitals are under contracted private management, must

oblige the public sector administrative law and the official accounting plan. The general rules are ten-year contract for the medical services and thirty-year contract for the infrastructure will be granted after competitive bidding, with technical competence and economic terms offered being the most relevant criteria. The only previous experience of a PPP hospital in the Portuguese health care system started in 1995 with *Amadora Sintra Hospital* as a pilot experience.

Health care reform starts with the transformation of 34 public hospitals into 31 corporate hospitals called *Hospitals SA*. In this case, there is only one shareholder that is represented by the Portuguese State with public equity. It has launched through thirty one similar *Decreto-Lei*², which one highlight reforms in legal structure and in accountability systems of each corporate hospitals. These hospitals remain under the supervision of the regional structure of health administration and their development and performance have been monitored closely by a special task force called *Unidade de Missão Hospitais SA* directly attached to the Minister of Health.

During the last years, the private hospitals and medical centers have benefited from a lack of legal and financial detailed of the public-private mix. There were still financed by public funds. At the same time, the private sector operates inside public facilities without being adequately paying for the use of these facilities, equipments and human resources.

The level of reforms is so high that the *Decreto-Lei* n° 60/2003 (see MS, 2003a), related with primary health care network, was been postponed until after the Health Regulatory Agency starts its activity. This decree-law provides a general framework making new forms of management and financing of the primary health care system, for example new financing arrangements of the health care centers based on a weighted per capita basis and the possibility for centers to be managed by private sector.

The Health Regulatory Agency, called *Entidade Reguladora da Saúde*, was approved in the *Decreto-Lei* n° 309/2003 (see MS, 2003d). The new independent regulatory body is public with financial and administrative autonomy and is designed to ensure that productivity gains are not detrimental to quality and equity is an important step in the reform process. The new public, private and non-profit mix of health care providers to the NHCS for hospitals, health care centers and continuous care and the need to separate the state's tasks of provider and financing from its regulation role.

In 2003, another approach to promote quality in the health care system was designed and implemented. This includes a national network of long care medical services supported in the *Decreto-Lei* n° 281/2003 (see MS, 2003c).

The Portuguese Government increasingly influences the NHCS in a different perspective. The XVII Portuguese Government decided to change the health care strategy followed for the XVI Portuguese Government, for example in the *Decreto-Lei* n° 93/2005 is said:

As referred in the Programme of the XVII Portuguese Constitutional Government, now is necessary to transform the corporate hospitals in public entities (MS, 2005a: 3636).

² Each hospital has one specific *Decreto-Lei* that has been published in 2002 in the *Diário da República*, 284, I Série-A, December 9; *Diário da República*, 285, I Série-A, December 10; *Diário da República*, 286, I Série-A, December 11.

The Portuguese public hospitals (87) that belong to the Portuguese health care system as a National Health Service structure have been classified in three levels through the *Portaria* n° 281/2005 (see MS, 2005b). The first level is the central hospitals and involves thirty three hospitals; the second level is the district hospitals and includes thirty five hospitals and the third level is the first level hospitals and aggregate nineteen hospitals.

Although, the society expected that each modification to be followed by detailed examination of the outcomes of these changes. However, not always this information was disclosure and public available, especially the quantum and quality of analyses of effects. For example, the Government in the health sector intends to review the pay scheme for physicians on emergency hospital and health center medical services, the new set-up being similar to the one set out in *Decreto- Lei* n°117/98 of 5 May (see PCG, 2005).

The Portuguese Health Care system is characterised to have each single aspect of the health care system subject to laws, regulations and other legal documents as other develop countries in European Union (see Mougeot and Naegelen, 2005). This aspect increases the social organization and the delay in execution programmes. The authors agree with the commentary made by Santana (2002: 42), that:

...some of the Portuguese NHCS weaknesses are due to the poor planning, organisation and management; to the lack of a clear vision of the national health market; and to the fact that health policies are susceptible to political pressure and electoral requirements.

From the Portuguese Health Care System to understanding the Sample

The health care system shows a complexity and chain of entities and organizations spread all over Portugal. Table 3 presents the physical resources in Portugal, in 2002.

Table 3 – Physical resources in the Portuguese Health Care System in 2002

NUTS II	Health centers		Official hospitals				Private Hospitals		Medical Centers (2001) (3)		Pharmacies	Pharmaceutical departs	
			General and specialized						Official	Private			
	N	Hospitalization units	Public (1)		Others (2)		N	Beds	N	N	N	N	
Portugal	391	76	1,217	108	27,649	11	1,100	94	8,960	205	291	2,567	331
Mainland	362	60	886	104	26,213	11	1,100	82	7,256	190	281	2,478	301
North	124	21	400	33	8,204	2	152	27	2,423	40	97	757	55
Center	109	14	181	33	7,248	2	111	19	1,063	23	42	655	126
Lisboa and Tejo valley	54	2	14	27	8,424	6	722	29	3,503	105	118	718	13
Alentejo	59	16	167	7	1,510	1	115	3	194	19	13	244	99
Algarve	16	7	124	4	827			4	73	3	11	104	8
Açores	17	13	279	3	685			5	748	10	6	46	19
Madeira	12	3	52	1	751			7	956	5	4	43	11

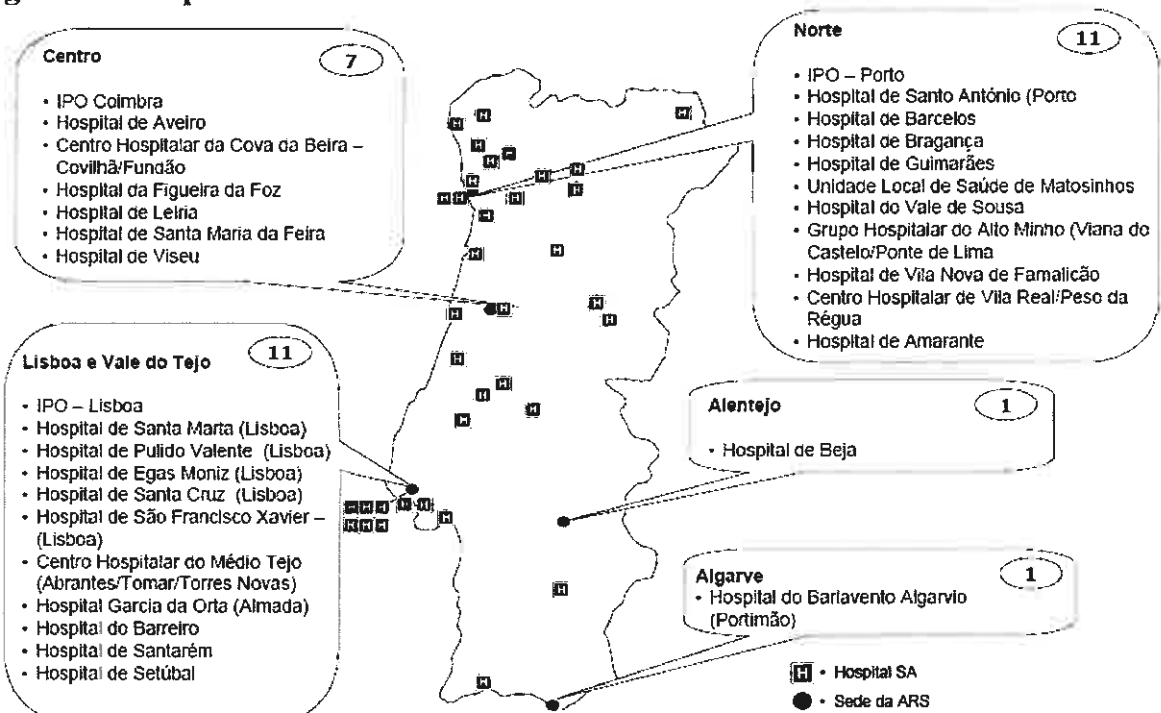
Source: DGS (2005: 11)

The physical resources in 2002 are 391 health centers, 213 official and private hospitals, 496 medical centers, 2,567 pharmacies and 331 pharmaceutical departments. The total of beds in the system is 38,926. When these data were comparing with data from 1999, the authors observed the decrease of official and private hospitals, medical centers and pharmaceutical departments. In other perspective, the authors observed the increase of health centers and pharmacies. The geographical distribution of physical resources shows differences between the administrative regions of Portugal. Social inequalities and inequities in Portuguese health care system are also larger and they are more concentrate in the mainland, particularly in the north of Portugal and *Lisboa* and *Tejo* valley.

The universe of this research represents all the public official hospitals which are a total of 108. The sample of this study manages 28.7% of the total of public official hospitals and focus in the 31 corporate hospitals that belong to the network called *Hospitais SA*. In this sense, these corporate hospitals follow a public limited company as a legal structure model and were given 100.0% public equity capital, inherited assets and liabilities of former public units.

Figure 1 presents 31 corporate hospitals that will be object of study in this research. Each hospital was distributed by one of the five regional structure of health administration that are: Centre with seven hospitals, North with eleven hospitals, *Lisboa* and *Tejo* valley with eleven hospitals, *Alentejo* with one hospital and *Algarve* with one hospital.

Figure 1 – Sample of the research



Source: UMH (2004c: 8)

Actually, the Portuguese Government changes again the legal structure of the 31 corporate hospitals to public entities. The authors could justify this political decision as a tendency against the privatization of health care system, so the enforcement was the *Decreto-Lei* nº 93/2005 (see MS, 2005a) that specifies new rules to these hospitals. This position is in favour of Wykle (1992: 50) that defends:

Today decisions concerning public interests such as health, safety, environment, and the type of technology with which we live are increasingly concentrated in the private hands of a few corporate managers.

All these happen because there has been a lack of truly reform initiatives that will have influence in citizen's life. Such instability in the NHCS often lead to the generation of unnecessary and undesirable variety of organisational structures and the principal consequence is an increase in complexity for the hospitality operations manager and for the National Health Care Policy.

From the Sample to the Financial Performance

Before understand the financial performance of the health care system, it is important to clarify two main aspects. Firstly, as Ginzberg (1998: 31) defends to United States:

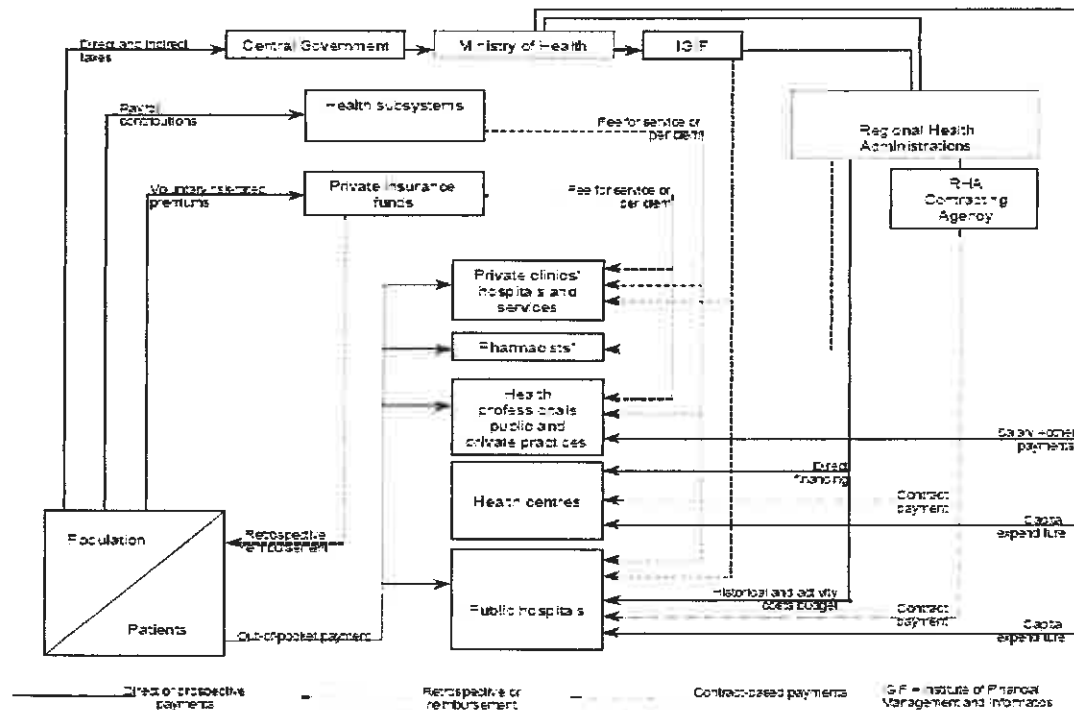
Health care sector cannot be meaningfully analyzed in terms of competitive market theory.

And secondly, as Byrne (2004: 4) promotes:

Health expenditure is, however, too often viewed as a short-term cost, not as a long-term investment, and is only now starting to gain recognition as a key driver of economic growth.

Figure 2 presents the financing flow chart of the Portuguese Health Care System.

Figure 2 – Financing flow chart of the Portuguese Health Care System



Source: EOHCS (1999: 81).

The NHCS is mainly financing by the State Budget through direct and indirect taxes pay by each citizen. Since 1990, the Portuguese Government introduced the payment of fees or charges for each service that a patient need, with same exemptions for poor and high risk groups in society. In the past years, successive Ministry of Health have formally introduced the application of charges in the health care system, but these charges were mainly identified with private for-profit health care. Each health euro better spent could make a net saving both for individual well-being and for Portuguese economic competitiveness (see Byrne, 2004). As Arnold (1991: 122) states:

The choice of accounting methods used to measure costs, thus had direct economic consequences since accounting calculations determined the amount of Medicare's cash payments, and the distribution of public monies to the private sector.

Thus, accountability is another principle of CSR, knowing that the financial flow of health care system managed different entities. The new field for accounting in health care based in the Health Ministry Official Accounting Plan is not possible, because each entity in the

figure 2 was subject to a different accounting system produced by a different accounting plan, such as: Official Accounting Plan, Public Official Accounting Plan and Health Ministry Official Accounting Plan. For example, the financial analysis of 31 corporate hospitals is supported in the Official Accounting Plan that follows the same accounting trend of corporations. Comprehensive review of this literature can be found in Zeller *et al.* (1996) that examine the different financial characteristics of hospital performance.

The authors analysed the sustainability of the health care based in their resources, in 2002, in fifteen countries of the EU, but the results confirm the words of Crowther and Rayman-Bacchus (2004: 239) that sustainability:

is concerned with the effect which action taken in the present has upon the options available in the future. If resources are utilised in the present then they are no longer available for use in the future, and this is of particular concern if the resources are finite in quantity.

Table 4 presents the human resources separated by physicians and nurses that provide health care and the expenditures on health divided by the total and the public expenditures and as Santana (2000: 1025) argues:

...examining the distribution of the health services resources is an important way to understand the inequities of access to health and to health care.

Table 4 – Human and Financial health resources in EU-15 in 2002

Country	Human resources (1000 inhabitants)		Expenditures on health					
			Total expenditures		Public expenditures		Private expenditures	
	Physicians	Nurses	% of GDP	per capita (1)	% of GDP	per capita (1)	% of GDP	per capita (1)
Portugal	3,2	4,0	9,1	1.673	6,4	1.201	2,7	472
Austria	3,3	9,3	7,3	2.096	5,3	1.551	2,0	545
Belgium	3,9	5,6	8,7	2.407	6,4	1.790	2,3	617
Denmark	3,3	9,7	8,6	2.516	7,1	2.142	1,5	374
Finland	3,1	9,0	7,0	1.875	5,3	1.470	1,7	405
France	3,3	7,2	9,5	2.671	7,2	2.080	2,3	591
Germany	3,3	9,9	10,6	2.738	8,3	2.212	2,3	526
Ireland	2,4	15,3	6,5	2.104	5,1	1.779	1,4	325
Italy	4,4	5,4	8,0	2.053	6,2	1.639	1,8	414
Luxembourg	2,6	10,8	6,2	3.062	5,3	2.618	0,9	444
Spain	2,9	7,1	7,4	1.593	5,2	1.176	2,2	417
Sweden	3,0 (2000)	8,8 (2000)	8,8	2.402	7,6	2.148	1,2	254
Greece	4,5 (2000)	4,0 (2000)	9,0	1.722	4,9	960	4,1	762
Netherlands	3,4	12,8 (2001)	8,7	2.520	8,1 (1997)	1.313 (1997)	0,6	1.207
United Kingdom	2,1	9,2	7,5 (2001)	2.012 (2001)	6,2 (2001)	1.801	1,3	211

Note: 1. In US dollars purchasing power parity.

Source: DGS (2005: 44)

In the EU-15, the human health resources have an average of 3.2 physicians and of 8.5 nurses per 1,000 inhabitants (see DGS, 2005). Portugal has the lowest number of nurses with four per 1,000 inhabitants and Ireland the biggest number of nurses with 15.3 per 1,000 inhabitants. It will be important to notice that the Portuguese Government should invest more in High Level Schools that will promote new degrees in Medicine and Nursing, by that way will increase the number of experts and new jobs in that area. Portugal has a similar average of physician in the EU-15.

In relation with human resources is important to specify that there are incentives for health care agents such as physicians, who receive salaries in the public sector but who also work simultaneously on a fee-for-service basis in the private sector. Table 5 presents the distribution of the Human Resources of the sample.

Table 5 – Distribution of human resources of the sample

Variables	Average	Median	Std. Deviation	Minimum	Maximum	Total
Human resources	1.360	1.262	558	431	3.151	42.157
physicians	239	217	139	52	732	7.400
nurses	421	424	190	152	1.019	13.061
medical technicians	88	82	44	19	200	2.728
other personnel	612	601	236	201	1.200	18.968
Board of hospital						
general assembly members	2	2	1	0	3	58
executive members	4	4	1	1	5	126
non-executive members	1	0	1	0	3	23

The authors decide to analyse³ the human resources and board members of the sample. As Ibrahim *et al.* (2000: 91) defend:

...in health care, the issue of board member's corporate social responsibility is likely to gain increased attention because of societal demands on hospitals and growing concern regarding the ethical and economic dimensions of decision making.

As Table 5 presents, the total of human resources in the 31 corporate hospitals are 42.157 persons divided by 45.0% of other personnel, 31.0 % of nurses, 17.5% of physicians and 6.5% of medical technicians. There are a higher proportion of executive members (126) in the board of the hospital and less proportion of non-executive members (23). But, on the average, the board of each hospital has a similar distribution of members, such as four executive and one non-executive. As Ritchie (2002: 122) defends, clinical governance in the national health service in United Kingdom will improve patient's health, psychological welfare and quality of life but:

... requires that managers within the health service to monitor current performance and develop service delivery to predetermined standards.

The Organization for Economic Cooperation and Development (OECD) promotes a study between the members related with the public expenditure on the health care. This study shows inequalities between the members countries of OECD in terms of the percentage of gross domestic product (GDP) spent on health care. It is important to notice the change in Portugal from 3.6% of the trend of 1980 GDP to 6.4% of the trend of 2000 GDP (see OECD, 2004). In the Stability and Growth Programme 2005-2009, the financing requirements of several public Ministries had been grossly underestimated, among them the National Health Service revised upwards by €1,513 million (see PCG, 2005). Similar results, in table 6, were presented by Germany, Australia and Japan that change the trend of 2000 GDP.

³ It was not possible to analyse the background of each member, but usually are physicians and nurses that tend to be concerned with issues related with patient well being.

Table 6 – Evolution of the Public expenditure on health care (% of trend GDP)

Country	1980	1990	2000	Δ 1980-1990	Δ 1990-2000
Australia	4.6	4.9	6.3	0.2	1.5
Austria	5.2	5.2	5.4	-0.0	0.2
Canada	5.3	6.6	6.2	1.3	-0.4
Denmark	8.0	7.0	6.9	-1.0	-0.1
Finland	5.0	6.3	5.0	1.3	-1.3
France	5.7	6.6	7.1	0.8	0.5
Germany	6.8	6.5	8.3	-0.3	1.9
Greece	3.7	4.0	5.2	0.3	1.3
Iceland	5.5	6.9	7.7	1.4	0.8
Ireland	6.8	4.4	4.7	-2.4	0.3
Japan	4.6	4.6	6.1	0.0	1.5
New Zealand	5.4	5.7	6.2	0.3	0.5
Norway	5.9	6.4	6.5	0.5	0.1
Portugal	3.6	4.1	6.4	0.5	2.3
Spain	4.3	5.3	5.3	0.9	0.1
Sweden	8.4	7.5	7.2	-0.9	-0.4
United Kingdom	5.0	5.0	5.9	-0.0	0.9
United States	3.6	4.7	5.8	1.1	1.1
OECD ¹	5.2	5.1	5.7	-0.1	0.6
EU ¹	5.6	5.7	6.0	0.0	0.4

Note: 1. Unweighted average; includes all available countries at the relevant point of time.

Source: OECD (2004).

Table 6 distinguishes between the tax-financed systems of Portugal, UK and Denmark; the social insurance systems of France, Spain and Netherlands; and the predominantly private systems of the United States and Switzerland (see Wagstaff and van Doorslae, 1992).

This question rises to the important aspect of the free-payment for everybody. But, the change happens in 1989. The Portuguese Parliament's approved the tendency of leaving free-payment considering the economic and social conditions of citizens. Nowadays, it is increasingly understood that user fees cannot become the preferred health care financing alternative and a new target population for the extension of coverage is the very large number of migrant workers. But as Ron (1998: 20) argues:

“free” care is an inaccurate term. Health services funded through general taxation revenues are indeed paid for by the economically active members of society, and then provided free of charge to those who use it. In this era of structural adjustment and economic liberalization, public expenditure and direct public responsibility for the provision as well as financing of social services, including health care, are likely to decline rather than grow and to be limited to the most needy and noneconomically active individuals.

Despite of the importance of this question, the authors will not consider these impacts of health care system expenditure in this research, because the data is not available and allows to explain that the decreasing importance of the social welfare State in the Portuguese healthcare system should give place to the increase of the social responsibility and cooperation among the private sector, improving quality and welfare competitiveness between the civil society.

The health care human resources, generally, consider and protect the interests of the patients. As EU (2005a: 9) promotes:

health providers have great responsibility when they deliver services. Any “after sales” claims for poor quality service are unlike to compensate for permanent health damage or loss of life.

In relationship with the health care, the corporate social responsibility can work where regulations and laws are necessary but cannot work itself (see Mintzberg, 1983). Around the world, health care system face funding problems, especially related with new innovations in health care that are expensive. And there is a growing percentage of population that is elderly and needs more health care, while the percentage of working population and thus tax-paying decreases. These questions affected the State Budget and the financing of the system. As was defended by Chuan and Preston (1994), there is also evidence that substantial capital sums have been invested on legal changes, information disclosure and accounting systems in corporate hospitals. But, more than concerned about money spending, the health care system should play a more important role in the overall welfare of society.

From the Sample to the Operational Performance

The authors used the same research design by Llewellyn and Northcott (2005). Several sources and types of documents were employed. First, statistics⁴ related with Health care system obtained through the Ministry of Health and *Hospitals SA* that allow authors to collect the data. Second, Government documents and European Union papers and official statements were analysed. Third, academic papers were used to conceptually frame the issues under discussion.

The authors want to understand the operational performance of each 31 corporate hospitals of the sample and to provide explanations for corporate social responsibility decisions in the health care system. The operational performance of this system will contribute to development the society, as Becker and Potter (2002: 46) argue:

Instead of assuming that both efficiency and social responsibility can be or should be maximized, we may want to consider what a change in one is likely to do to the other.

This research allows that accountability and medical practices came face to face and increase the acceptance that accounting cannot be understood as an autonomous sphere of activity, but needs to be recognized as part of a complex series of political, economic, and organization contexts in which it operates (see Lawrence *et al.*, 1997). But, the authors had difficulties in obtaining recent data with the same degree of detail that would allow for data comparison.

After preliminary analysis, fifteen original variables are presented in the table 7 and were retained to produce an exploratory model. The variables have one financial data that is equity of each corporate hospital and fourteen nonfinancial data captures aspects of hospital performance that financial data may not totally translate and perhaps has informational value that makes manager take financial decisions (see Watkins, 2000). The explanatory power⁵ of the factorial analysis that produced the exploratory model will be summarized by the Kaiser-Meyer-Olkin, Bartlett's test of sphericity and the proportion of the total variance explained in the factor analysis by each factor.

⁴ See DGS (2002; 2003; 2004); UMH (2004a; 2004b).

⁵ In the factor analysis, the main objective is used to data reduction and to identify a three factors or components, which explain most of the variance observed in the fifteen original variables and with the authors best knowledge it will be represent conceptually what the component means. In this case with some original variables in the health care the interpretation of factors is much more difficult, but one of the most interesting works that is the analysis and understanding of them.

Table 7 – Variables of the sample

Code	Definition	Definição
X ₁	inpatient discharge	<i>Altas de internamento</i>
X ₂	surgery services	<i>Cirurgias</i>
X ₃	external consultation	<i>Consultas externas</i>
X ₄	emergency medical services	<i>Episódios de urgência</i>
X ₅	day hospital session	<i>Sessões de hospitais de dia</i>
X ₆	patient-standard	<i>Doente padrão</i>
X ₇	total expenses	<i>Custos totais</i>
X ₈	unit expenses	<i>Custos unitários</i>
X ₉	adjusted average delay	<i>Demora média ajustada</i>
X ₁₀	medical personnel per 10 beds	<i>Pessoal clínico por 10 camas</i>
X ₁₁	charges of ambulatory surgery	<i>Taxas de cirurgia do ambulatorio</i>
X ₁₂	personnel	<i>Pessoal</i>
X ₁₃	patient/personnel	<i>Doente por pessoal</i>
X ₁₄	inpatient occupancy rate	<i>Taxa de ocupação de camas</i>
X ₁₅	equity	<i>Capital social</i>

In producing a definition of health care operational performance, there is an implication that performance can be objectively measured. This hypothesis confirms that modern hospitals are complex multi-product organizations (see Smet, 2002). This model based some findings in similar results of the Ozcan *et al.* (1997: 184) study.

The operational level of the health care in hospitals is result of their activity level and capability to provide to citizens reliable health care programmes and user friendly information about how hospitals develop their activity usually centred in main services as surgeries, external consultations and day hospital sessions. All these services are available to patients in hospitals.

First hypothesis: the operational level of the health care will be represented by surgery services (x₂), external consultation (x₃), day hospital session (x₅), total expenses (x₇), medical personnel per 10 beds (x₁₀), charges of ambulatory surgery (x₁₁), personnel (x₁₂) and equity (x₁₅) in each hospital of the sample.

The efficiency of the health care in hospitals are affected by options made in the service offer to the patient, especially in emergency medical services, because everybody wants and expects access to the latest and best treatment, in a small period of time. Related with these are two other variables by patient that are the unit expenses and the personnel. The inpatient discharge tries to reduce the longer periods and at higher cost that medical care in hospitals require.

Second hypothesis: the efficiency of the health care will be represented by inpatient discharge (x₁), emergency medical services (x₄), patient-standard (x₆), unit expenses (x₈) and patient/personnel (x₁₃) in each hospital of the sample.

The effectiveness of the health care in hospitals presents the relation between the occupancy rate in the hospital and average delay in the medical treatment or the time spend to be in good health. But, improving effectiveness of the health care must become an economic priority with corporate social responsibility, because health care and social costs will continue to rise and the economy of Portugal will suffer.

Third hypothesis: the effectiveness of the health care will be represented by adjusted average delay (x_9) and inpatient occupancy rate (x_{14}) in each hospital of the sample.

All these factors are extremely difficult to quantify, not only because they have medical uncertainty, but because they are intangible variables. Santana (2000: 1035) defends that:

...research studies carried out in many countries on the effects of the various factors in the healthcare usage clarify the effects of individual variables. Nevertheless, the difficulty to achieve their precise role deals with the interrelationship between the variables and the specificity of each country concerning health policy and the cultural structure of the population.

The multivariate technique used was principal component analysis with varimax rotational approach. This technique can achieve their purposes from an exploratory perspective whose primary purpose is to analyse the structure of the interrelationships among a large number of original variables by defining a set of common underlying dimensions (see Hair *et al.*, 2004). This issue is addressed through an analysis of the sources of variability of original variables and a consideration of potential techniques to reduce or eliminate the incidence of this instability as a means to reduce complexity and enhance performance. The statistics of the exploratory model for the period 2002-2003 are showed in table 8.

Table 8 – Statistics of the exploratory model

Statistics		2002		2003	
		1 st test with equity (x_{15})	2 nd test without equity (x_{15})	1 st test with equity (x_{15})	2 nd test without equity (x_{15})
Kaiser-Meyer-Olkin (measure of sampling adequacy)		0,71	0,68	0,67	0,62
Bartlett's Test of Sphericity	Approx. Chi-Square	580,38	521,21	609,42	551,89
	df	105,00	91,00	105,00	91,00
	Sig.	0,00	0,00	0,00	0,00
Total variance explained		79,41	78,81	78,83	78,08

Table 9 presents two tests of the exploratory model for the period 2002-2003. The first test includes all the variables, so nonfinancial variables are added to the equity to create a combined model. The explanatory ability of the second test, with decrease of variables taken into account, is then compared to that of the model utilizing financial variables.

Table 9 – Exploratory model

Factor	Year	Variables
1st test with equity (x_{15})		
operational level	2003	$0.95 x_{15} + 0.94 x_7 + 0.89 x_3 + 0.89 x_{12} + 0.76 x_2 + 0.78 x_{10} + 0.61 x_5 + 0.57 x_{11}$
	2002	$0.93 x_{15} + 0.93 x_7 + 0.92 x_3 + 0.94 x_{12} + 0.81 x_2 + 0.63 x_{10} + 0.63 x_5 + 0.56 x_{11}$
efficiency	2003	$0.94 x_4 - 0.76 x_8 + 0.87 x_6 + 0.88 x_1 + 0.75 x_{13}$
	2002	$0.90 x_4 - 0.84 x_8 + 0.78 x_6 + 0.82 x_{13} + 0.78 x_1$
effectiveness	2003	$+ 0.74 x_9 + 0.65 x_{14}$
	2002	$- 0.80 x_9 + 0.68 x_{14}$
2nd test without equity (x_{15})		
operational level	2003	$0.93 x_7 + 0.88 x_{12} + 0.87 x_3 + 0.81 x_{10} + 0.74 x_2 + 0.62 x_5 + 0.59 x_{11}$
	2002	$0.95 x_7 + 0.92 x_3 + 0.93 x_{12} + 0.79 x_2 + 0.65 x_{10} + 0.64 x_5 + 0.59 x_{11}$
efficiency	2003	$0.94 x_4 + 0.89 x_6 + 0.89 x_1 + 0.73 x_{13} - 0.74 x_8$
	2002	$0.91 x_4 + 0.81 x_6 + 0.80 x_{13} + 0.80 x_1 - 0.83 x_8$
effectiveness	2003	$+ 0.76 x_9 + 0.61 x_{14}$
	2002	$- 0.80 x_9 + 0.68 x_{14}$

The first test of the exploratory model uses both financial and nonfinancial data and it demonstrates greater explanatory ability than the second test of the same model. Then, this provides some empirical evidence that financial data conveys incremental information beyond that provided by nonfinancial variables. Additionally, these show that nonfinancial data may be relevant in assessing the performance of hospitals (see appendix 1).

The exploratory model proposed in Table 9 shows the complexity and different scale in the 31 corporate hospitals. The operational performance is concentrated in the operational level of the activity combined with efficiency and effectiveness of each hospital. The model shows the intensifying competition between all the hospitals as a result of unstable and rapidly changing strategic and operational environment for each hospital.

Effectiveness of the health care in hospitals presents a lower level due to the lack of appropriate public infrastructure for long-term care, so elderly tend to use hospitals to seek assistance, blocking beds that would be otherwise used for acute care. Oliveira and Bevan (2003) show evidence those older age groups in Portugal increase the high hospital spending. But probably will change these results in relation with the creation of a Long-Term Care National Network approved in 2002 that provide norms related to the quality, financing and general management of long-term care units. The goal is to create a strong network, mainly built with private entities, in particular the *misericórdias*. This network will include units for long-term hospitalisation, home care and day care, well integrated with primary health care and hospitals.

Hospitals are diverse in medical services, located in different cities of Portugal and comparing hospitals involves its classification in categories. Through the empirical investigation, the research shows differences in the distribution of factors: operational level, efficiency and effectiveness by hospital. Figure 3 e 4 provides these distribution differentiated by tests (1st and 2nd) and years (2002 and 2003) (see appendix 2).

Figure 3 – Distribution of 31 corporate hospitals of the exploratory model (1st test)

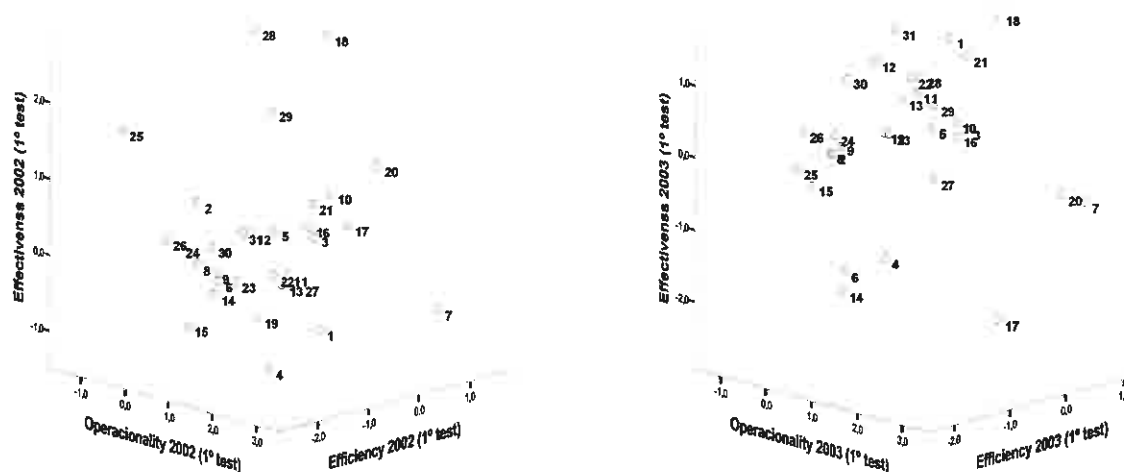
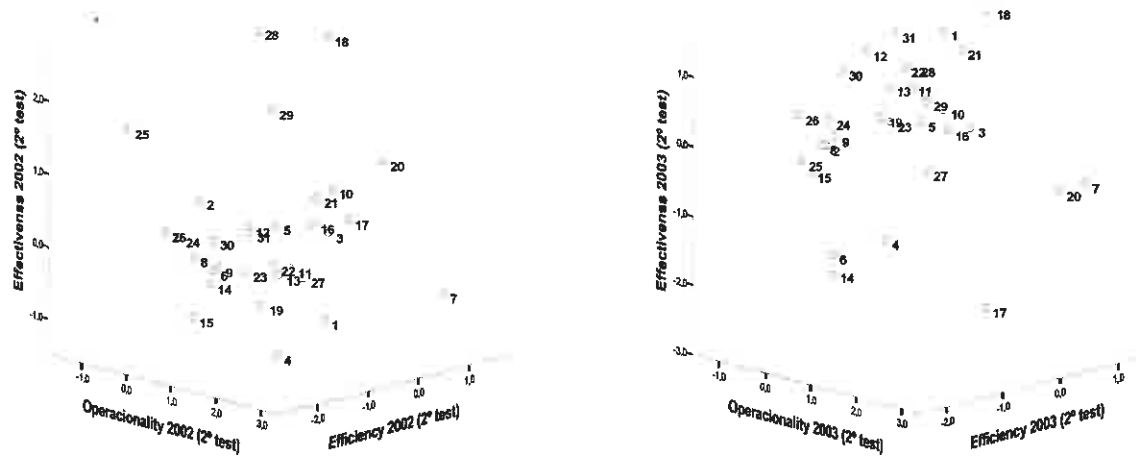


Figure 4 – Distribution of 31 corporate hospitals of the exploratory model (2nd test)

Hospitals (facilities and high technology equipments) are concentrated in three main urban areas (Lisbon, Porto and *Coimbra*) leaving the mainland of Portugal under-served. It was possible to observe the individual effect of each factor in the corporate hospital. At the operational level, the three big hospitals with higher effect are H St António (Porto), H Garcia Orta (Almada) and IPO Lisboa and the two small hospitals with lower effect are H Sta Maria Maior (Barcelos) and H São Gonçalo (Amarante). In the efficiency, the higher effect is in H São Sebastião (Sta Maria Feira) and H. São Teótonio (Viseu) and the lower effect is in the H Sta Cruz (Lisboa), H St Maria (Lisboa) and IPO Lisboa. In the effectiveness, the higher effect is in H São Bernardo (Setúbal) and H São Teotónio (Viseu) and with lower effect in IPO Porto and H São Sebastião (Sta Maria Feira).

The exploratory model proposed in this research seems to confirm that the bigger corporate hospitals could provide medical responsive services at least with higher operational level, efficiency and effectiveness, but, probably, these hospitals are more vulnerable to economic, financial and social problems. The same happens in the research develop by Becker and Potter (2002: 46) as they say:

...there appears to be an inverse relationship between hospitals efficiency and social responsibility.

The factors in a specific hospital provide flexibility to adapt to the community needs. Programs to reduce outpatient clinic congestion, to improve links between hospitals and the community needs and to disclosure full information should receive special attention (see Andrulis *et al.*, 1996). All these aspects combined with the exploratory model proposed by the authors should retain the traditional public hospital mission that creates an alternative model of corporate governance surround by CSR.

Discussion

This research confirms that as a global strategy for the health care system, corporate social responsibility is urgently needed. As a finite resource, the health should demand a permanent attention from society, as well as the Government in accomplishment

prevention and monitoring systems, with a view to the defence of a sustainable health care system.

The challenge of the National Health Care system should be realist to local and regional needs of the Portuguese society. Resources should be available to all citizens according these needs and not concentrated in the coastal area of Portugal.

The health care professionals should be well co-ordinated and made all their important decisions about the welfare and treatment of each patient (see Lawrence *et al.*, 1997). In consequence of the scarcity of human resources, the government should establish a national recruitment of health personnel and distributed them for the each job in the each Portuguese hospital.

Different levels and types of resistance have introduced problems and difficulties in the implementation of the balanced scorecard in corporate hospitals. This was used in 2003 to measure and compare hospital performance, but several problems remain such as the appropriateness and usefulness of the balanced scorecard for promoting accountability and strategic management in the health care system (see Aidemark, 2001; Modell, 2004).

The disclosure and the accountability system are not opened up to a new field for accounting in health care based in the Health Official Accounting Plan. This disclosure and more accurate accountability systems must be developed for the health care system to be transparent and reliable to everybody.

As in other countries around the world, Portugal has special characteristics as hospitality, good weather conditions and with health care improvements in this system, in infrastructures, in human resources, in training and in research and development could be promoted the medical tourism as political decision, with important economic influences.

More than merely investing efforts in fighting for political changes, without any advantage for society it is crucial to invest in prevention of life as a basic requirement to honour the corporate social responsibility of hospitals.

In summary, the health care system exists as a fundamental element that assures life and quality of living, so it should be available to everybody and for everybody...

References

- Aidemark, L-G. (2001). The Meaning of Balanced Scorecards in the Health Care Organisation. *Financial Accountability & Management*, 17 (1): 23-40.
- Andrulis, D., Acuff, K., Weiss, K. and Anderson, R. (1996). Public hospitals and health care reform: choices and challenges. *American Journal of Public Health*, 86 (2): 162-165.
- Arnold, P. (1991). Accounting and the State: Consequences of Merger and Acquisition Accounting in the U.S. Hospital Industry. *Accounting, Organizations and Society*, 16 (2): 121-140.
- Assembleia da República (AR, 1976). Constituição da República Portuguesa. *Diário da República*, I Série-A, April 2.
- Assembleia da República (AR, 1979). Lei nº 56/1979. *Diário da República*, 214, I Série, September 15: 2357-2363.
- Assembleia da República (AR, 1990). Lei nº 48/1990. *Diário da República*, 195, I Série-A, August 24: 3452-3459.

- Assembleia da República (AR, 2002). Lei nº 27/2002. *Diário da República*, 258, I Série-A, November 8: 7150-7154.
- Becker, E. and Potter, S. (2002). Organizational rationality, performance, and social responsibility: results from the hospital industry. *Journal of Health Care Finance*, 29 (1): 23-48.
- Byrne, D. (2004). *Enabling good health for all. A reflection process for a new EU Health strategy*. Brussels: European Union Publications.
- Chuan, W. and Preston, A. (1994). Worrying about accounting in Health Care. *Accounting, Auditing & Accountability Journal*, 7 (3): 4-17.
- Crowther, D. and Rayman-Bacchus, L. (2004). 'The Future of Corporate Social Responsibility', in Crowther, D. and Rayman-Bacchus, L. (eds), *Perspectives on Corporate Social Responsibility*. Aldershot: Ashgate, 229-249.
- David, F. and Abreu, R. (2004). 'Social Responsibility: Reality or Illusion?', in D. Crowther & K. Tunca (eds), *Stakeholders and Social Responsibility*. Penang: Ansted Services Center: 225-242.
- Direcção Geral de Saúde (DGS, 2002). *Health in Portugal 1999*. Lisboa: DGS.
- Direcção Geral de Saúde (DGS, 2003). *Health in Portugal, Basic Indicators 2000*. Lisboa: DGS.
- Direcção Geral de Saúde (DGS, 2004). *Health in Portugal, Basic Indicators 2001*. Lisboa: DGS.
- Direcção Geral de Saúde (DGS, 2005). *Health in Portugal, Basic Indicators 2002*. Lisboa: DGS.
- Empresarialização*. II Curso de Gestão para Clínicos na Escola Nacional de Saúde Pública. Lisboa: Hospitais SA.
- European Community (EC, 2004). Treaty establishing a Constitution for Europe. *Official Journal of the European Communities*, C 310, December 16: 1-474.
- European Observatory on Health Care Systems (EOHCS, 1999). *Health Care Systems in transition*. Copenhagen: EOHCS.
- European Union (EU, 2005a). *Recommendations on Health Services and the Internal Market*. Health Policy Forum. Brussels: European Union Publications.
- European Union (EU, 2005b). *COM (2005) 115 final: Healthier, safer, more confident citizens: a health and consumer protection strategy*. Proposal for a Decision establishing a programme of Community action in the field of Health and Consumer Protection 2007-2013. Brussels: European Union Publications.
- Ginzberg, E. (1998). The noncompetitive health-care market. *Challenge*, 41 (4): 31-41.
- Gray, R., Kouhy, R. and Lavers, S. (1994). Constructing research database of social and environmental reporting by UK companies, *Accounting, Auditing & Accountability Journal*, 8 (2): 78-101.
- Guichard, S. (2004). *The reform of the health care system in Portugal*. Working paper of Economics Department, 405. OECD.
- Hair, J., Anderson, R., Tatham, R. and Black, W. (2004). *Multivariate Data Analysis*. New Jersey: Prentice Hall.
- Ibrahim, N., Angelidis, J. and Howard, D. (2000). The corporate social responsiveness orientation of Hospital directors: Does occupational background make a difference? *Health Care Management Review*, 25 (2): 85-92.
- Lawrence, S., Alam, M., Northcott, D. and Lowe, T. (1997). Accounting systems and systems of accountability in the New Zealand health sector. *Accounting, Auditing & Accountability Journal*, 10 (5): 665-683.
- Llewellyn, S. and Northcott, D. (2005). The average hospital. *Accounting, Organizations and Society*, 30: 555-583.
- Ministério da Saúde (MS, 1988). Decreto-Lei nº 19/88. *Diário da República*, 17, I Série-A, January 21: 20-23.
- Ministério da Saúde (MS, 1993a). Decreto-Lei nº 10/93. *Diário da República*, 12, I Série-A, January 15: 126-129.
- Ministério da Saúde (MS, 1993b). Decreto-Lei nº 11/93. *Diário da República*, 12, I Série-A, January 15: 129-134.
- Ministério da Saúde (MS, 1993c). Decreto-Lei nº 291/93. *Diário da República*, 198, I Série-A, August 24: 4491-4496.

Unidade de Missão dos Hospitais SA (UMH, 2004b). *Hospitais SA: Relatório de Actividade do Ano 2003. Errata*. Lisboa: Hospitais SA.

Unidade de Missão dos Hospitais SA (UMH, 2004c). *Hospitais SA: Balanço do Primeiro Ano de Wagstaff, A. and van Doorslae, E. (1992). Equity in the finance of health care: Some international comparisons. Journal of Health Economics, 11 (4): 361-387.*

Watkins, A. (2000). Hospital financial ratio classification patterns revisited: Upon considering nonfinancial information. *Journal of Accounting and Public Policy, 19: 73-95.*

World Health Organization (WHO, 1978). *Declaration of Alma-Ata*. International Conference on Primary Health Care. September 6 a 12. Alma-Ata: WHO.

World Health Organization (WHO, 1997). *The Jakarta Declaration on Leading Health Promotion into the 21st Century*. Geneva: WHO.

World Health Organization (WHO, 2005). *International Health Regulations 2005*. Fifty-Eight World Health Organization Assembly. May 23. Geneva: WHO.

Wykle, L. (1992). Social Responsibilities of Corporate Managers in an International Context. *Journal of Management Development, 11 (4): 49-56.*

Zeller, T., Stanko, B. and Cleverley, W. (1996). A revised classification pattern of hospital financial ratios. *Journal of Accounting and Public Policy, 15 (2): 161-182.*

Appendix 1 – Distribution of the exploratory model by factor of each hospital

Factor	Test	Code	6	8	2	9	14	12	30	5	26	29	13	15	24	11	25	28	31	22	17	10	18	16	21	27	1	19	3	4	20	23	7
Operational level	1st test	F1 02	6	8	2	9	14	12	30	5	26	29	13	15	24	11	25	28	31	22	17	10	18	16	21	27	1	19	3	4	20	23	7
		F1 03	8	6	9	2	12	30	5	14	13	11	10	26	15	31	22	24	16	1	29	28	21	18	27	17	25	19	3	4	23	20	7
	2nd test	F4 02	6	8	2	14	9	12	30	5	26	13	29	24	11	15	28	25	17	10	22	31	18	16	21	27	1	19	3	4	20	23	7
		F4 03	8	6	9	2	12	30	5	13	14	10	11	26	22	15	24	16	1	31	29	28	18	21	27	17	25	19	3	4	23	20	7
Efficacy	1st test	F2 02	25	23	26	24	15	4	19	30	31	2	14	8	9	28	3	22	12	27	6	29	7	13	1	5	11	16	21	20	18	10	17
		F2 03	25	26	23	15	4	24	19	14	30	2	9	8	31	6	12	22	28	3	27	13	7	11	29	1	16	21	5	10	20	17	18
	2nd test	F5 02	25	23	26	24	15	4	19	30	2	31	14	8	9	28	3	22	12	6	27	29	13	7	5	1	11	16	21	20	18	10	17
		F5 03	25	26	23	15	4	24	19	14	30	2	9	8	6	31	12	22	3	28	27	13	11	29	7	1	16	5	21	10	17	20	18
Effectiveness	1st test	F3 02	4	1	15	6	14	13	19	11	27	9	8	22	7	30	17	12	5	16	23	31	24	26	3	2	21	10	20	29	25	18	28
		F3 03	17	14	6	4	20	27	7	8	15	2	9	5	16	10	25	3	24	29	13	26	19	11	23	22	28	30	12	21	1	18	31
	2nd test	F6 02	4	1	15	6	14	13	19	27	11	9	8	22	7	17	30	12	5	16	31	23	24	3	26	2	10	21	20	29	25	18	28
		F6 03	17	14	6	4	20	27	8	15	7	2	16	9	5	10	25	3	29	24	13	11	26	19	23	22	30	28	12	21	1	31	18

Appendix 2 – Distribution of the 31 corporate hospitals

Code	Name	Local
1	CH Alto Minho	Viana Castelo/Ponte Lima
2	H Distrital Bragança	Bragança
3	Unidade Local Saúde Matosinhos	Matosinhos
4	IPO Porto	Porto
5	H Padre Americo	Vale do Sousa
6	H Santa Maria Maior	Barcelos
7	H Santo António	Porto
8	H São Gonçalo	Amarante
9	H São João Deus	Famalicão
10	H Senhora Oliveira	Guimarães
11	CH Vila Real /Peso Regua	Vila Real /Peso Regua
12	CH Cova Beira	Covilhã/Fundão
13	H Infante Dom Pedro	Aveiro
14	H Distrital Figueira Foz	Figueira da Foz
15	IPO Coimbra	Coimbra
16	H Santo André	Leiria
17	H São Sebastião	St Maria Feira
18	H São Teotónio	Viseu
19	H Egas Moniz	Lisboa
20	H Garcia Orta	Almada
21	CH Médio Tejo	Abrantes/Torres Novas/Tomar
22	H Nossa Senhora Rosário	Barreiro
23	IPO Lisboa	Lisboa
24	H Pulido Valente	Lisboa
25	H Santa Cruz	Lisboa
26	H Santa Marta	Lisboa
27	H Distrital Santarém	Santarém
28	H São Bernardo	Setúbal
29	H São Francisco Xavier	Lisboa
30	H José Joaquim Fernandes	Beja
31	H Barvalento Algarvio	Portimão

Guidelines

Content: *Estudos e Documentos de Trabalho da ESTG* or *Studies and Working Papers of ESTG* publish papers that promote the dissemination of knowledge developed by researchers in the ESTG and in other higher education institutions. Also, EDT Series provide a means of pre-publishing paper that is being or will be submitted as one or more journal articles and to publish detailed material and reports that have intrinsic merit but, at this moment, it is in progress. The Editorial Board of *Estudos e Documentos de Trabalho da ESTG* strive to promote critical discussion and consideration of fields of inquiry that are pertinent to our professional, intellectual and contemporary global concerns.

Submission Process: Authors must send the manuscript to director.estg@ipg.pt and then we will start the review process of *Estudos e Documentos de Trabalho da ESTG*. The manuscript sent for publication should not exceed, in general, 15.000 words, and the abstract must include 250-300 words.

Format: All articles must follow the Harvard style and carefully checked for completeness, accuracy and consistency. Please consult these and review the paper carefully prior to submission. All citations must be fully listed as references at the end of the paper, and all references listed must be cited in the text.

Review Process: *Estudos e Documentos de Trabalho da ESTG* uses a blind editorial process, which means that all papers are read anonymously by the Editorial Board and Scientific Committees of different entities. The Editorial Board is responsible for suggesting, reviewing and approving contributions for the EDT Series. The overall responsibility for the development of the *Estudos e Documentos de Trabalho da ESTG* lies with the ESTG Board. Depending on their recommendations, one of the following will happen:

1. we will reach a decision to publish the piece as is,
2. we will reach a decision to publish the piece on the condition that the author make the necessary changes as described by our readers,
3. we will decide not to publish your paper.

Regardless of our decision, and provided your paper meets our minimum requirements, we will send you **extensive feedback** that will provide you with constructive comments from your colleagues. They will write an assessment of the sophistication of the language of the paper, the embeddedness and relevance of your argument, the articulation of your thesis statement, additional secondary sources you may want to review, and include other thoughtful suggestions and critiques for you to take into account as you revise your work. It is vital that authors be prepared to revise their papers according to the comments made by our readers in a timely fashion. We make every effort to provide our readers and authors with sufficient time to conduct evaluations and revisions. For the editorial process to function well, we require that our researchers comply with our deadlines. We will not accept submissions that do not meet these requirements.

Escola Superior de Tecnologia e Gestão da Guarda

Série

ESTUDOS E DOCUMENTOS DE TRABALHO

Número	Autor	Título
Ano 2002		
01/02	David Crowther	No accounting for fashion: the flawed quest for shareholder value
02/02	David Crowther	The poetics of corporate reporting: evidence from the UK water industry
03/02	David Crowther	Three bites of the cherry? Performance measurement in the UK electricity industry and the effects of industry structure
04/02	David Crowther	A semiology of corporate reporting
05/02	David Crowther	The importance of Corporate Social Responsibility
06/02	David Crowther	The theology of managerial superordinancy
Ano 2003		
01/03	David, Fátima Abreu, Rute Marques, Pedro	Income Tax: an overview of the Portuguese situation
02/03	Abreu, Rute David, Fátima	The Corporate Social Responsibility: Exploration inside the Experiences and Practices in EU Level
03/03	Rei, Constantino	Causal evidence on the "Productivity Paradox": Portugal, 1980-2000
Ano 2004		
01/04	David, Fátima Abreu, Rute	Responsabilidade Social: Seu Impacto na Competitividade das Organizações
02/04	Abreu, Rute David, Fátima	Empirical Evidence of Corporate Social Responsibility in Portugal
03/04	David, Fátima Abreu, Rute	Social Responsibility: Reality and Illusion?
Ano 2005		
01/05	Crowther, David Abreu, Rute David, Fátima	The Myth of Corporate Social Responsibility
02/05	Abreu, Rute David, Fátima	Corporate Social Responsibility in Health Care

Escola Superior de Tecnologia e Gestão da Guarda

Av. Dr. Francisco Sá Carneiro, 50

6300-559 Guarda

Tel. 271 220 120 | Fax 271 220 150

www.estg.ipg.pt