National Health Plan 2012 – 2016

3.2. Strategic Axis - Equity and Access to Healthcare

(January 2012)

National Health Plan
2012–2016

3.2. EQUITY AND ACCESS TO HEALTHCARE

Equity and proper access to healthcare result in health gains, ensure cohesion and social justice, and promote a country's development.

3.2.1. CONCEPTS

WHAT IS UNDERSTOOD BY EQUITY AND BY ACCESS?

.1. **Equity in health** is understood as the absence of avoidable and unfair differences, likely to change the health status of population groups from different social, geographic or demographic contexts (Marmot M *et al.*, 2008; Marmot M, 2007; WHO, 2010b). It is expressed as the equal opportunity every citizen has of achieving their health potential.

.2. The **access** to healthcare is an equity dimension and it is defined as the capacity to obtain of necessary and convenient quality care, at the proper place and time. (Ministerio de Sanidad y Política Social, 2010).

BOX 3.2.1 - HEALTH INEQUALITIES:

- They are strongly connected to social determinants (WHO, 2010a; Marmot M, 2007): socioeconomic and educational level, lifestyles, and access to healthcare. There is a **social gradient** in health status, in which the lower the individuals' position in the social hierarchy, the lower the probability of achieving their full individual health potential;
- They particularly affect **vulnerable groups**: for socioeconomic situation (for example, the poor, homeless, long-term unemployed, immigrants), individual constraints (for example, disability or rare disease) or age group (for example, children and the elderly);
- They affect the socioeconomic development (Johnson S *et al.*, 2008). Health is associated with each country's wealth, also generating development.
- They can be evaluated through indicators of average life expectancy, mortality and morbidity, outcomes in maternal and child health, stratified by socioeconomic characteristics;
- Their reduction generally involves multi- and inter-sectorial actions, from other institutions and from the community, at a regional and local level.

.3. The **inequalities in health** are related to the existing differences in the health status and in the corresponding determinants among different population groups. Some are inevitable, and it is impossible to change the conditions that determine them. Others, however, seem unnecessary and avoidable, representing relative injustices, socially generated and maintained, which translate into real **health inequities**; it is therefore mandatory, on an ethical level, to take measures to overcome them.

ACCESS PERSPECTIVES

ADEQUATE ACCESS

.4. **Adequate access** is one of the health determinants which enhance the reduction of inequalities.

REFER TO THE GLOSSARY:

Accessibility, adequate access, health determinants, social determinants of health, health inequality, health needs

- The use of healthcare is mediated by **predisposing** and **empowerment** factors (Andersen R, 1995; Furtado C, Pereira J, 2010).
  - *The predisposing factors include the educational and cultural level, occupation, ethnic group, and social and family networks. These, in turn, influence the convictions in health - values and attitudes towards health and healthcare -, and can condition the subsequent perception of risk and need to use health services. That is to say that they determine the individual's capacity to take responsibility for the adequate use of the available healthcare.*
  - *The empowerment factors relate to the necessary means for the individual to effectively access health services and use them, such as the possibility to bear the transportation costs.*
- It depends on the services offered and on the use by citizens. For an adequate health services provision, these must be organised in a proportional, necessary and sufficient way, according to the citizens' health needs.
- The health systems oriented towards Primary Healthcare as holistic, community-based, long-term and cross-sectional care services, show better performance, better outcomes, more equity and accessibility, better cost-benefit relation and greater citizen satisfaction (Atun R, 2004).
- The expenditure on services and treatment can be a barrier to access to healthcare. Disease situations, the subsequent costs and having to choose between health and essential goods can be **precipitating factors for poverty**, especially for chronic patients, unemployed people and the elderly. These are the groups in greatest need of healthcare, and who are therefore doubly weakened (Furtado C, Pereira J, 2010; WHO, 2008).
- At times of social and economic crisis, the health services become more relevant, because the worsening social conditions lead to an increasing demand for care (Furtado C, Pereira J, 2010; WHO, 2008).

THE ROLE OF THE PUBLIC SECTOR

.5. The **public sector** faces several challenges in the promotion of health equity[1]:

- Definition of essential services, i.e. those to which the possibility of access to all citizens should be explicit and guaranteed (Schreyögg J *et al*., 2005).
- Determining the degree to which it is possible to approach and personalise the care according to the needs of individuals, families and communities.
- Determining how the benefits of healthcare provision are being distributed to individuals from different socioeconomic classes (for example, through the degree of healthcare co-payment regressiveness).

[1] This topic is further developed in the chapter "Goals for the Health System - Strengthening Economic and Social Support in Health and Disease".

.6. Within the options of social policy, there is the positioning of the state role on reducing the differences between social classes ("socialising state") or on promoting the minimum guarantees of real access to healthcare ("social state"), for all citizens. Necessarily, states adopt mixed policies or privilege more one or the other option according to their values, philosophies and political priorities.

BOX 3.2.2 - THE ADEQUATE ACCESS RESULTS FROM SEVERAL INTERRELATED DIMENSIONS:

- **Adequate demand for services,** a consequence of the perception of health and service as the most advantageous response;
- **Availability**, referring to the adequate care provision to the population needs;
- **Proximity,** reflected by the services' geographic dispersion;
- **Direct costs**, such as service procurement;
- **Indirect costs**, such as absence from work and transportation;
- **Quality**, regarding the service organisation and the technical dimension and humanisation;
- **Acceptance**, resulting from the citizens' expectations, attitudes and behaviours.

Source: Furtado C, Pereira J, 2010.

THE ROLE OF THE PRIVATE SECTOR

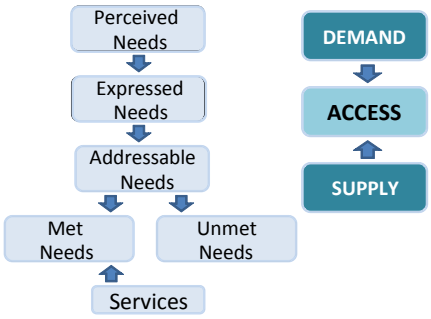
.7. In view of the responsibility assumed by the State, **the Private Sector** takes on three functions:

- It enables the complementarity of public services, increasing the technical and response capacity, in a convention relation.
- It expands the freedom of choice and the diversity of models and service provision, based on free enterprise, in the respect for the necessary guarantees of certification, quality, information and articulation.
- Together with the public sector, it takes on the responsibility for health services provision, ensuring the infrastructures, the management, and other aspects of care provision.

ASSESSMENT OF HEALTH NEEDS

.8. The accessibility planning is based on the assessement of needs, the services quality criteria and the principle of resource management. Therefore, the adequacy of care responds to local needs.

FIGURE 3.2.1 - Health needs, demand and supply of services



Source: Adapted from Wright J, Williams R, Wilkinson JR, 1998.

- It distinguishes between perceived, expressed and addressable needs, and between demand and response from the health service.
- It allows to identify unmet needs that require intervention of other sectors.
- It facilitates proactive healthcare, the definition of priorities and the separation between responsibility for funding and care provision.

WHICH STRATEGIES AND RESOURCES FOR ACCESS PROMOTION?

.9. They are identified as strategies and resources for the promotion of access:

BOX 3.2.3 - ACCESS PROMOTION STRATEGIES AND RESOURCES:

- Information and access monitoring systems;
- Specific projects
- Territorial organisation of healthcare
- Articulation strategies
  - Between care levels
  - In each level
  - Intra-institutional
  - Between sectors
- Empowerment strategies

- **The use of access information and monitoring systems** which include indicators about social determinants, in order to understand the problem and allow an effective intervention.
- **The implementation of specific projects** (temporary, vertical or integrated) aimed at additional health gains through the reduction of health inequalities, in a cross-sectional manner or focused on vulnerable groups. They will be more relevant the more they empower the system, improve their effectiveness and if they are disseminated as best practices.

HEALTHCARE ORGANISATION

- Territorial healthcare organisation which consists of:
  - ***The Primary Healthcare network*** *as a structure of proximity, continuity and privileged access, focused on the citizen, family and community;*
  - ***Pre-Hospital Healthcare****, namely medical emergency;*
  - ***The hospital network*** *(number of hospitals, location and type) is understood as an integrated system of highly specialised, urgent and emergent healthcare provision, coherently organised and based on rationality and efficiency principles;*
  - ***The National Long-term Care Network.***

ARTICULATION BETWEEN LEVELS

- **Articulation in each care level** , between levels and between sectors, in order to ensure:
  - *The sharing of information through: platforms of integrated disease management, information systems and clinical files, referral protocols, consultancy, management of the pathway between care levels (case management) (Dias A, Queirós A, 2010);*
  - *The good activity by inter-institutional organisations, responsible for defining, implementing, monitoring and assessing the articulation between Primary and Hospital Healthcare, according to clinical areas, such as the Functional Coordinating Units for maternal and new-born, child and adolescent health;*
  - *The strategic management and the common operationalisation among the service provision units of different levels, of which the Local Health Units are an example;*
  - *The Hospital Referral Networks (RRH) as access organisation instruments which allow care in complementarity and technical support between hospital institutions, based on an integrated system of inter-institutional information (Ministry of Health, 2007). The RRH are based on medical specialties, which can make this integration more difficult, whether due to the dispersion of professionals, or to the fact that patients may be*

carriers of multiple pathologies;

- *The strategic management and operationalisation common to several service provision units capable of achieving intermediate planning and coordinating complementary resources (e.g. ACES);*
- *The articulation between the National Long-term Care Network (Order No. 7968/2011) and the hospital, for the management of a more efficient hospital discharge, a greater involvement of the family and/or informal caregivers, lower risk of complications and morbidity, as well as less expenses;*

INSTITUTIONAL

- *The integrated management of intra-hospital resources and discharge management, processes for the promotion of equity and accessibility that include: the transfer of general care to Primary Care and to the community, common management of beds for acute situations, the reinforcement of day hospital services and outpatient surgery, hospital discharge planning at the earliest possible stage;*
- *A strategy of inter-sectoral articulation, facilitated through the case manager, whose mission includes mobilising the necessary social resources to each situation, through the several interveners (Health, Social Security and Municipalities) (Dias A, Queirós A, 2010;Lopes et al., 2010);*

EMPOWERMENT

- *Empowerment strategies for citizens and informal caregivers, and promotion of volunteering (see chapter on Citizenship in Health), which are relevant to improve literacy, enable self-care, minimise the need for access and reduce the inadequate demand for health services (Lopes et al., 2010). The community services for the elderly also facilitate the reduction of hospitalisation, the improvement of life quality and the costs reduction (Lopes et al., 2010; Fassbender K, 2009 cit in Escoval A, Fernandes AC, 2010).*

BOX 3.2.4 - OPPORTUNITIES RESULTING FROM THE PROMOTION OF EQUITY AND ACCESS TO HEALTHCARE:

FOR CITIZENS:

i) Valorisation of continuity, holistic, community-based and personalised care services, as an essential condition for the promotion of healthy lifestyles, promotion of health and disease prevention, in a positive vision of health;

ii) Morbidity and incapacity improvement resulting from early screening and diagnosis, intervention in key pathologies, fast resolution of health problems and early rehabilitation;

iii) Adequate and fast clinical pathway among and inside institutions, with integrated care, shorter periods of hospital admission, recovery and long-term care in the community or in the nearby units;

iv) Increase of literacy and empowerment of citizens and informal caregivers, aimed at self-care and adequate access to health services;

FOR HEALTHCARE PROFESSIONALS:

v) Better communication among health professionals, with quality improvement and less likelihood of error;

vi) Reinforced multidisciplinary, multi-professional and inter-institutional work, focusing on the needs of the person, family or community.

FOR HEALTHCARE INSTITUTIONS:

vii) Empowerment of the institutions as organisations responsible for the health status of communities and populations, through the reinforcement of needs assessment and response capability in the planning of its services;

viii) Integrated social support through the planned and proactive mobilisation of social resources, customised to the individual and familiar needs, such as admission to homes, phased work integration, social supports;

ix) Expenditure reduction and release of resulting resources;

FOR POLICY-MAKERS:

x) Access equity for vulnerable groups or people with special needs, like drug addicts, HIV-AIDS and other sexually transmitted diseases, mental illness or situations associated with poverty and social exclusion;

xi) Increasing of the Health System's social value, as an accessible, community-based and personalised resource, of unconditional and continuous support in situations of economic and social difficulties, and of disease and suffering.

BOX 3.2.5 – POTENTIAL THREATS AGAINST THE PROMOTION OF EQUITY AND ACCESS TO HEALTHCARE:

FOR CITIZENS:

i) Poor literacy and autonomy of citizens/patients in view of impersonal health services, based on technology and focused on service provision (versus care);

ii) Healthcare being understood as mere commercial goods, transactionable in a market logic, with no respect for the ethical principles necessary to create therapeutic trust and alliance;

FOR HEALTHCARE PROFESSIONALS:

iii) Lack of communication and articulation between providers and care, with low responsibility of the providers for case management and for leading the patient's clinical pathway through the health service;

FOR HEALTHCARE INSTITUTIONS:

iv) Access difficulties caused by the scattering and fragmentation of care in Hospital Centres united by geographic institutions distant from each other.

v) Low planning and organisation capability from the institutions, including the collection and analysis of information for defining health needs; definition of interventions for continuous improvement; implementation and sustainability of measures; monitoring and assessment of health outcomes. Low capability for service organisation and proactive responses.

FOR POLICY-MAKERS:

vi) Low health services orientation for obtaining health outcomes, keeping focused on the opportunistic provision instead on the proactive reaction to disease, as well as low investment on risk management;

vii) Insufficient perception of the impact of social determinants of health in the access and incapacity, morbidity, and mortality amenable to health care;

viii) Health services fragmentation, with low accountability for the evolution of a population's health status.

3.2.2. FRAMEWORK

LEGAL, LEGISLATIVE, REGULATORY AND STRATEGIC FRAMEWORK

.1. According to the Portuguese Constitution, "no one may be privileged, favoured, prejudiced, deprived of any right or exempted from any duty for reasons of ancestry, sex, race, language, territory of origin, religion, political or ideological beliefs, education, economic situation, social circumstances or sexual orientation" (article 13(2)). Still according to the Constitution, "everyone has the right to the protection of health and the duty to defend and promote health" (article 64(1)).

.2. Equity and universal access to healthcare are assured in Portugal by the **National Health Service** and by the **Basic Law on Health** (Law No. 56/79; Law No.48/90)**.**

- The **General Principles of the Basic Law on Health** (BLH) emphasize that "health protection is an individual and community right which is accomplished through the joint responsibility of citizens, society and the State, with freedom of care demand and provision, pursuant to the Constitution and the law" (General Principle 1) and that "the State promotes and guarantees the access of all

citizens to healthcare within the limits of human, technical and financial resources available" (General Principle 2).

- The **Basic Law on Health** (Law No. 48/90) provides, in Base 1, Principle 1, that "the State promotes and assures the access of all citizens to healthcare" and that the **National Health Service** should "ensure access equity, in order to reduce the effects of economic, geographic and any other inequalities in the access to healthcare" (Base XXIV). Furthermore, the Basic Law on Health states that the Health System is based on Primary Healthcare, and should be located near the communities, with intense articulation between the several levels of healthcare (Base X); also according to the law, the National Health Service (NHS) is characterised by ensuring the equity of access to users, aiming at reducing the effects of economic, geographic and any other inequalities in the access to healthcare. (Base XX).
- The **Charter of Access Rights** (Law No. 41/2007) establishes the provision of healthcare in a clinically acceptable period of time and the right to information.
- The **National Health Plan 2004-2010 (**http://www.dgsaude.min-saude.pt/pns/index.html) establishes the priority for the poor and the need to reduce health inequalities through actions aimed at vulnerable groups. The strategies adopted are based on an approach based on *settings,* with a significant impact in the improvement of access to health services by underprivileged and territorially concentrated populations.

BOX 3.2.6 - LEGISLATION AND INTER-SECTORAL STRATEGIES AIMED AT VULNERABLE GROUPS:

- **Immigrants**: Order from the Ministry of Health regarding access to the NHS (Order No. 25360/2001; Resolution of the Council of Ministers No. 6 3-A/2007)[2] and the Plan for the Integration of Immigrants 2010-2013, under the responsibility of the ACIDI (Order No. 25360/2001).
- **Children and Young People:** Model Programme of Action for the Health of Children and Young People (National Programme for the Health of Children and Young People 2006-2010) (Order No. 12045/2006); Action for the Health of Children and Young People at Risk (Order No. 31292/2008); CUIDA-TE (TAKE CARE OF YOURSELF) Programme (Ordinance No. 655/2008); National Early Intervention System - SNIPI (Decree-Law No. 281/2009);
- **The Elderly**: National Programme for the Health of the Elderly 2004-2010 (DGS-PNSPI, 2006);
- **People with Disabilities**: National Strategy for Disability 2011-2013 (Resolution of the Council of Ministers No. 97/2010);
- National Programme for **Rare Diseases** 2010-2015 (Approved by the Minister of Health on November 2nd 2008; DGS-PNDR 2007).
- **Women and Men:** IV National Plan for Equality, Gender, Citizenship and Non-Discrimination 2011-2013 (Resolution of the Council of Ministers No. 5/2011); II National Plan against Trafficking in Human Beings (Resolution of the Council of Ministers No. 94/2010); IV National Plan against Domestic Violence (Resolution of the Council of Ministers No. 100/2010);

[2] In Portugal, legislation facilitates integration and adequate access to healthcare for immigrants and their families as long as they have been residents for more than 90 days.

STUDIES AND SOURCES OF KNOWLEDGE ABOUT ACCESS AND HEALTH INEQUALITIES

.3. Inequalities in health are described in the chapter "Portugal's Health Profile".

BOX 3.2.7 - REFERENCE DOCUMENTS ABOUT THE ACCESS TO HEALTH IN PORTUGAL:

- Ministry of Health. Annual Report on Access to Healthcare in the NHS. 2010.
- Pereira J, Furtado C. Equity and Access to Healthcare. Office of the High Commissioner for Health 2010

- On a **gender** perspective, women present a **higher life expectancy** at birth and half of the potential years of life lost (WHO, 2010), lower early mortality rate from ischemic heart disease and cerebrovascular disease, but a **worse healthy life expectancy** (Eurostat, 2010); in relation to **avoidable causes**, men present a higher mortality related to work accidents, motor vehicle accidents, alcohol-related diseases (Santana P, 2009), and suicide. As far as **risk factors** are concerned, obesity is more prevalent among women and smoking among men.

- **Regional inequalities**, which can be marked, show a lower **life expectancy** at young ages and in less populated and rural regions from Alentejo and Algarve, regions with **specific early mortality rates** which are higher for suicide, ischemic heart disease and traffic accidents. **Hospital admissions** due to diabetes are more frequent in the Algarve; hospital admissions due to alcohol-related causes are more frequent in the North and less frequent in Alentejo. Low birth weight and infant mortality rate are higher in Alentejo and lower in the Centre. In relation to access, the municipalities from the countryside and the south are the ones which have older populations and, simultaneously, with **places of residence more distant from health services**, especially from specialty services.

- **Socioeconomic inequalities**, with an impact on access, with the groups of higher socioeconomic levels and with higher schooling having better access to specialist appointments, namely dentistry and cardiology (National Programme for the Health of the Elderly, 2006).

- **Inequalities in vulnerable groups**, with immigrant families having worse health indicators due to multiple barriers, namely of a structural, organisational, economic, cultural and linguistic nature. There is also evidence of discrimination, gender inequalities (Dias SF, Severo M, Barros H, 2008) and higher perinatal and infant mortality among immigrant children, as well as more maternal pathology during pregnancy (Machado MC *et al*., 2007).

- The use of the **private sector services** shows gender inequalities (more frequent in women), regional inequalities (greater offer in Lisbon and Tagus Valley), and socioeconomic inequalities (more active citizens, with higher schooling and socioeconomic status) (Villaverde Cabral M, Silva PA, 2009).

ACCESS TO HEALTH SERVICES

.4. From the access analysis to health services:

- In respect to **Primary Healthcare**, in 2009, better access, more appointments and greater rationalisation of care use were noted, a factor suggested by the improvement of the average usage indicator (Ministry of Health, 2010); just 0.03% of the population live more than 30 minutes away (using own vehicle) from a primary care centre or extension (ERS, 2009); from all the people registered in primary care centres, 85.2% have a family doctor (ACSS, 2010).

- The current (2009) **hospital network** allows 88% of the population to live less than 30 minutes away using their own vehicle and only 1% of the population to live more than 60 minutes away from an hospital (Ordinance No. 615/2008), being the distances higher in countryside municipalities. There is inequality in the concentration of **medical specialists,** which is higher in the Lisbon and Tagus Valley region and lower in Alentejo and Algarve (Pereira J, Furtado C, 2010).

- With regard to **the use of subsystems and private services**, in Portugal there are over 250000

inhabitants with health subsystems or insurances (2010) and a variety of healthcare providers. 81.1% of the population use the NHS, 10.1% have access to the ADSE (INSA-INE, 2005-2006), 1.3% do not use any health subsystem, and 7.5% use other subsystems (INSA-INE, 2005-2006). 10.5% of the population have private health insurances (INSA-INE, 2005-2006), and the number has grown between 2001 and 2008 to the detriment of company insurance (from 57.3% to 80.0%) Between 2001 and 2008, there was a decrease in the number of citizens that access to the NHS through health subsystems.

CITIZENS INFORMATION SYSTEMS

.5. Several systems, actions and programmes are developed as instruments and mechanisms for monitoring and promoting equity and access to health services, such as (see also Chapter 2.1 - Citizenship in Health):

- Linha Saúde 24;
- National Medical Emergency Telephone Number;
- Health Portal;
- DGS website.

INFORMATION SYSTEMS RELEVANT TO MONITOR ACCESS

.6. Other information systems for monitoring and promoting access:

- The **National Patient Registry** of the NHS, which provides knowledge about the coverage and use of the NHS services, still under development.
- **Nascer Cidadão**, a partnership with the Ministry of Justice and the Ministry of Labour and Social Solidarity which allows the registry of new-borns in public and private maternities, simultaneously with various purposes, including the articulation of healthcare to the new-born.
- **SIM-Cidadão**, a System for the Management of Suggestions and Complaints from Users of the National Health System which enables to monitor the perceptions healthcare users have when they contact different healthcare-providing entities.
- **e-Health** services which enable greater autonomy and a direct access to information and health services. Example of that are **e-SIGIC**, to follow the position on the surgery waiting list; **e-Agenda**, that allows to schedule primary healthcare appointments online; **e-Prescrição**; **e-vacina** and the **Health Data Platform** (in the process of implementation).

INSTRUMENTS AND MECHANISMS TO PROMOTE ACCESS TO HEALTH SERVICES:

GOVERNANCE

- In 2005, the **Reform of Primary Healthcare** was started (Ministry of Health, Reform of Primary Healthcare. Strategic Plan 2010-2011; Decree-Law No. 88/2005; Resolution of the Council of Ministers No. 157/2005), and it includes goals related to the improvement of access to close and adequate care, reorganising PHC into 74 Groups of Primary Care Centres (ACES) (Decree-Law No. 28/2008) responsible for the community's access to healthcare, contractualisation of access and production indicators, as well as incentives to Family Healthcare Units (315 in February 2012); creation of Community Care Units (155 in February 2012) (www.mcsp.min-saude.pt).
- The implementation of the **National Long-term Care Network** (RNCCI) began in 2007, based on partnerships between public, private, and social sector institutions. It comprises Convalescence, Mid-term and Rehabilitation, Long-term and Maintenance, Palliative Care, Day Care and Autonomy Promotion Units, and Home Care Teams. Since its creation, it has received over 61,401 users, with an increase of 20% in the first semester of 2010 (10.251 more) when compared to 2009. In July 2010, it had 4,120 beds (a growth above 5%, compared to 2009) and 3,733 home care teams, most of which in the Centre and Lisbon and Tagus Valley regions. It has its own information system which allows access monitoring (Decree-Law No. 101/2006).

- In 2007, the criteria, access conditions and the proposal for emergency network points have been widely discussed, in the sequence of the work of the Technical Commission for Support to the Requalification Process of the General Emergency Network, created under Order No. 17736/2006 (2nd series), dated August 31, having the requalification and geographic redistribution of emergency points been held, with the new emergency network defined and classified under Order No. 5414/2008 (2nd series), dated February 28. This network provides for the existence of 89 emergency units, in three levels of differentiation: 14 multi-purpose units (SUP), 30 medical-surgical units (SUMC) and 45 basic units (SUB). The network implementation is currently being reassessed, after the work carried out by the Commission for the Revaluation of the National Emergency Network, created by the Order No. 13377/2011 (2nd series), dated October 6.

- With regard to the **Hospital Referral Networks**, 17 have been approved and published[3], and 10 more await approval.[4].

.7. Systems dedicated to the facilitation and definition of access priorities:

ACCESS PROMOTION SYSTEMS

- **Linha Saúde 24:** national telephone service, for triage, counselling and referring citizens in situations of disease, including urgencies and emergencies. It enables access to an universal service of high availability, with an effectiveness rate of 97% and a growth in usage when compared with the average rate in 2009 (data from the 1st quarter of 2010) (Ministry of Health, 2010).

- **The Manchester Triage System in the Emergency Service:** created June 2003, in the sequence of the protocol established with the Portuguese Triage Group, it uses a clinical protocol that conducts a fast identification of the patients who resort to the Emergency Service, allowing for the attending staff to see first the patients in more serious conditions, and not necessarily the ones who arrived first.

- **The Fast Tracks for Acute Myocardial Infarction and Stroke**: these constitute a strategic programme implemented in 2007 aiming at obtaining gains with regard to mortality and morbidity of those situations, through a partnership with the ARS, INEM, emergency network and hospital network, and the empowerment of citizens.

- The **Sepsis Fast Track** (DGS, 2010): organisation and establishment of protocols for mechanisms that allow its fast identification and timely administration of optimised therapy.

ACCESS PROMOTION PROGRAMMES

- **System for Management of Patients Waiting for Surgery (SIGIC)** (Resolution of the Council of Ministers No. 79/2004): it monitors the waiting times for elective surgery and allows to manage the waiting lists. From 2005 to 2009 there was a reduction of 39% in the average waiting time, with an increase of 4% in the number of operated patients, and an increase of 7.3% in the number of registered people, in 2008.

- **On-Time Specialist Appointment (CTH) (Ordinance No. 615/2008)**: it monitors the access to

[3]Maternal and Child, Neurology, Interventional Cardiology, Infectious Diseases, Oncology, Immuno-allergology, Physical and Rehabilitation Medicine, Rheumatology, Nephrology, Transplantation, Pathological Anatomy, Medical Genetics, Vascular Surgery, Psychiatry and Mental Health, Ophthalmology, Urology and Gastroenterology.

[4] Nuclear Medicine, Endocrinology, Internal Medicine, Pneumology, Dermatology, ENT, General Surgery, Orthopaedics, Anaesthesiology and Interventional Cardiology. Oncology is under review and Neurosurgery under preparation.

hospital specialties appointments by patients referred by the family doctor. CHT operationalizes the maximum response time guaranteed (TMRG) (Ordinance No. 1529/2008), defined by the Charter of Access Rights. In 2011, 70% of the requested appointments took place within the recommended time frame for the corresponding priority level. There is greater difficulty in hospital response in Ophthalmology, Orthopaedics, ENT, and Dermato-venereology; there is a lower number of appointments outside the TMRG for appointments of head, neck, maxillofacial and paediatric surgery.

- **Platform for the Integrated Management of Disease** (http://gid.min-saude.pt/publicacoes/index.php): implemented in 2007 with the management of renal failure patients, it evolved to include obesity, chronic obstructive pulmonary disease, diabetic retinopathy and multiple sclerosis, and it is expected to expand to include provision of care to diabetic patients; it enables information sharing between several caregivers and it is supported by a convention model for the provision of care between the public and private sector.

- **National Oral Health Programme (PNPSO)** (Ordinance No. 301/2009): developed in private services in articulation with the programmes for school health, child and youth health, and maternal health, and with the Information System for Oral Health (SISO) (https://www.saudeoral.min-saude.pt/siso/welcome/welcomeUser.action) which allows to manage the programme nationally, regionally and locally. The access to care is done through a dentist cheque allocated to pregnant women, elderly people who benefit from the pension supplement, children and young people under 16. In 2011, 543,619 dentist cheques were issued and 409,998 were used (75% usage rate) in a total of 321,166 users, of which: 38,882 were pregnant women, 5,496 were elderly people and 276,566 were children. (DGS. SISO, 2012).

- **Incentive Programme for Medically Assisted Procreation** (Law No. 32/2006): it allows access to infertility appointments and medically assisted procreation (MAP) techniques, under strict inclusion and permanence criteria. On the other hand, there was an increase in the co-payment rate of associated medicines, a referral network was established, training was provided to general practitioners and family doctors, investments in infrastructures and equipment were carried out and the creation of an articulated IT platform - FERTIS - was initiated.

- **Action for the Health of Children and Young People at Risk** (Order No. 31292/2008): it creates a structured response from the National Health Service to the phenomenon of Abuse, through the development of the "National Network of Support Groups for Children and Young People at Risk" established at the level of ACES, ULS and hospitals with paediatric assistance *(electronic application being designed*).

.8. Other Programmes to promote access, through conventions on medical interventions:

- **Intervention Programme in Ophthalmology (PIO)** (Ordinance No. 1306/2008): aims at the reduction of ophthalmology surgery waiting lists. During the validity of the PIO, between July 2008 and June 2009, there was an increase of 30 thousand surgeries and 75 thousand first appointments.

- **Programme for Surgical Treatment of Obesity** (PTCO) (Ordinance No. 1454/2009): it is in its implementation phase, and 2,500 surgeries have been contracted in the NHS for the treatment of obesity in 2010.

ASSESSMENT OF HEALTHCARE

- In 2010, the Ministry of Health published the **Annual Report on Healthcare Access in the NHS** (Annual Report on Healthcare Access, 2010), which analyses the actions for the improvement of healthcare access and the response at the several care levels.

ACCESS:

- The **Technical Commission to Support the Process of Emergency Requalification** evaluated the existing emergency services and identified an offer which is inadequate to the needs, a kind of assistance that is not in accordance with the patients' and families' expectations, disorganized or non-existent means of internal and external communication, unrealised potential in the improvement of communication and patient service, difficult patient drainage, non-existence of uniform systems of clinical data record and lack of population information campaigns about the correct usage of the services (The Emergency Network. Recommendations for the organisation of urgent and emergency care, Technical Commission to Support the Process of Emergency Requalification, 2007).

INNOVATION PROJECTS AND FUTURE PROSPECTS

- The strategic policies and actions for the reduction of inequity are a priority in the European Union Health Strategy (2008-2013) (EU, 2008); the WHO establishes the target to reduce the differences in health levels, focused on vulnerable groups, 25% by 2020.

3.2.3. GUIDELINES AND EVIDENCE

AT THE POLITICAL LEVEL, ONE SHOULD

- **Empower the health information and monitoring systems to consider the access perspective in a comprehensive and integrated way**, enabling the integration of care and the support to decision-making at several levels, through their integration/interoperability, inclusion of information associated to social determinants of health, and information necessary to the consideration of needs, resources, adequacy and service performance, and health outcomes.
- **Establish, in an integrated way, benchmarks for the improvement of access to health services and the promotion of equity** that have into account health needs, inequalities, service response quality, and that are associated with resource allocation and performance assessment processes.
- **Systematically evaluate the impact of institutional policies and practices in health and other policies from other ministries and sectors in access and equity**, prior to the implementation or posterior, through health impact assessment processes.
- **Prioritise resources in improving access, adequacy and performance of Primary Healthcare and Long-term Integrated Care**, to the extent that the reinforcement of these levels diminishes hospital emergency service use and releases resources for the improvement of access and performance of hospital care, and of the whole system.
    - *The community services for the elderly enable the reduction of hospital admissions and costs, and to improve quality of life (Lopes et al., 2010; Fassbender K, 2009).*
- **Reinforce the articulation of health services (public, private and from the third sector), systematising and reorganising Pre-hospital Care, Emergency Services, Primary Healthcare, Hospital Care, Long-term Integrated Care, agreed services, and private and social resources**, allowing for an integrated vision of clinical pathways in every situation, clarify the technical and service coverage and responsibility, the articulation between these, and evaluate the adequacy and efficiency of the network response.
    - *The requalification of the emergency services has a dynamic character and is adaptable to*

the demands of local and regional development (Parliament Resolution No. 48/2010).

- *Hospital care should develop a high degree of **flexibility** that will allow them to immediately adapt to changes in the citizen's needs and expectations (Rechel B et al., 2010).*
- *Hospital **quality and efficiency** should be promoted, which necessarily includes avoiding the substitution of primary care, ensuring appropriate access levels and close cooperation with other Primary Care, Long-term Integrated Care and local services (Escoval A, Fernandes AC, 2010; Dia A, Queirós A, 2010).*
- *The **hospital network** should be an integrated system for the provision of highly specialised care, coherently organised, based on principles of rationality, cooperation and efficiency (Ministry of Health, 2010), from which the integrated management of intra-hospital resources (Dias A, Queirós A, 2010) and discharge management are the instruments to use (Ministry of Health, 2010).*
- *Further cooperation among hospital specialists and Primary Healthcare, in the form of technical consultancy, empowering primary healthcare, and preventing some patients from having to resort to the hospital.*

AT THE LEVEL OF INSTITUTIONS, ONE SHOULD:

- **Publicise the evolution of access indicators and the assumed commitments for the improvement of access** and the institution's response to the special needs of vulnerable groups regarding access (for example, young people, citizens with disabilities, the elderly, homeless, immigrants).
- **Develop, monitor indicators and evaluate the accessibility and adequacy of services** including partnership and integration of care in several levels of health services and community resources, the **satisfaction of health needs** and service demand, intra and inter-institutional **referral channels** and the **response** from the institution itself to referrals.
- **Strengthen the contribution of health services, at local level, to the reduction of the impact of social determinants** considering health access and inequities as key-factors for the reduction of inequalities and working with other sectors in integrated and proactive responses to the health needs of vulnerable groups.

AT THE LEVEL OF PROFESSIONALS, ONE SHOULD::

- **Develop and establish protocols for the articulation of care, invest proactively in the communication between providers within and among institutions and services**, ensuring the articulation of care and guiding the patients efficiently, and allow monitoring and assessment.
- **Act on the determinants associated to access as the key-factor for health inequities**, promoting strategies to improve access to the care they provide, adapting their services (for example, fast response at first appointment for triage or referral), making their response flexible, diversifying their practices (telephone access, email), exchanging experiences and evaluating their performance.
- **Actively stimulate education for health, self-care, the image of the informal caregiver, volunteer and the social sector** as relevant factors for the provision of care and as partners in healthcare, as they minimise the need for access and reduce the inadequate demand for health services.
- **Promote the citizens' trust in their family doctor and nurse in a relationship that promotes proximity and continuity of personalized care**, as the main managers of their health situation,

and as people responsible for the mobility among the several health services.

AT INDIVIDUAL LEVEL, CITIZENS SHOULD:

- Use **access mechanisms in a way that is adequate to their health needs**, understanding the advantages of resorting to fast and urgent guidance (Linha Saúde 24, National Medical Emergency Telephone Number) and to personalised long-term care (family doctor's appointment), to the detriment of an inadequate use of hospital emergency.

3.2.4. VISION FOR 2016

*In 2016 there are **accessibility indicators** for every primary, long-term integrated, hospital, emergency and urgency healthcare services, taken on as **public response commitments** of the Health System. There are **strong organisational models** of care that maximize access, respect local specificities and contexts, built by processes of innovation, continuous development and incorporation of best practices, and that allow the stability of resources, including human resources, in health services. There is a vision and an **information system that integrates the public, private, and third sectors and community resources**, which enables **monitoring actual conditions of access, use and mobility in the health services**. Institutions compete, establish networks and partnerships, and are evaluated by their response capacity, including access. The citizens realize that access, together with quality and their active participation, are domains in which health services search for continuous development.*

The institutions are valued by the response capacity, improvement of health status and reduction of inequalities of the populations they serve

*Health professionals consider the patient context and history, adapting and guiding their pathway in healthcare in a fast and effective way, being the empowerment an explicit **responsibility of the case manager**. Care providers **communicate with each other and share information** through the integrated electronic process and other channels, ensuring an optimal, personalised and holistic response. There is a **risk management** that foresees the scenarios of new medical care needs, and facilitates the adequate access to care in such situations. **Professionals empower citizens/patients and informal caregivers on the self-management** of the disease and adequate access to health services, whether in an opportunistic way, or in a proactive and organised way.*

Citizens trust the support of the case and risk manager, and actively participate in the adequate use of health services.

Local, regional and national administrations, civil society organisations, such as patient associations and scientific societies, among others, ***actively promote the improvement of adequate access****. They participate in the information and patient/citizen empowerment for the adequate use of health services. They inform and influence the negotiation of* ***intervention and resource allocation models with an impact on accessibility****, for example, through the establishment of contracts. They take part in the monitoring and assessment of the Health System's response, and in the identification of health needs and best practices. They promote the introduction and sustained dissemination of cost-effective technology and adequate access.*

The organisations inform and influence citizens and institutions providing care, in order to promote adequate access.

Citizens have confidence in the response of the Health System

Citizens have ***confidence in the response of the Health System****. That confidence results from: the* ***personalised relationship of proximity and continuity*** *with their family doctor and primary healthcare team, that extends beyond the Primary Care Centre/USF, involving the community resources and citizen/patient pathway in the remaining levels of care; the* ***diversity and effectiveness*** *of adequate responses to the various health needs (emergency, acute disease, chronic disease, etc.); the* ***visibility of the organisational investment in accessible care provision****, capable of understanding the actual and expressed health needs of each individual, and of giving an adequate, empowering and sustainable response. The Health System presents* ***extensive services and friendly interfaces*** *for the access to information, counselling and administration, including online and telephone services. The citizens' confidence is measured and assessed, it guides the service organisation, and is part of the* ***social value*** *given to health services and their identity.*

The institutions are valued by the response capacity, improvement of health status and reduction of inequalities of the populations they serve

The institutions understand their contribution and responsibility for the health of populations and/or specific groups, ***basing the organisation of the care they provide on the monitoring and assessment of the health needs*** *of the groups they serve, on access and on quality. And they extend their response capacity to the health needs through the* ***support and partnerships with other sectors****, private and civil society organisations, focusing on community resources. There is flexibility in the response, allowing close and accessible care to vulnerable groups and to groups with special needs. The institutions are* ***assessed and valued by the response capacity, performance and contribution to the improvement of health status and reduction of inequities*** *of the populations they serve.*

The access to health services is socially understood as a determinant factor for obtaining additional health gains. Social policies, whether national or local, enhance access in a diversified and synergistic way (education, spatial planning, labour legislation, etc.), and the impact of new policies in other sectors is evaluated in terms of the way they influence health, including the access to health services. The other ministries and municipalities count on the Health System as a partner in initiatives for the design, implementation and assessment of policies that promote adequate access.

The access to health services is socially understood as a determinant factor for obtaining additional health gains