

# National Health Plan 2012-2016

## Summarised Version

(May 2013)



**National Health Plan  
2012-2016**

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USF Conde Lousã / ACES II Amadora  
USF Faria Guimarães - ACES Porto Oriental / Nuno Filipe Inácio  
USF Marginal / Vítor Ramos  
USF Monte da Caparica / Américo Varela  
USF Santo André do Canidelo / Fernando Ferreira  
USF Uarcos / Sofia Azevedo  
USP - ACES Baixo Mondego I / Arlindo Santos

Alberto Melo	Ester Moutinho Freitas	Lina Borges
Ana Marçal	Fátima Contreiras	Luísa Mascarenhas / Family Doctor
Ana Marques	Pedro Coelho	Manuel Abecassis
Andreia Sara Rocha	Rita de Barros e Vasconcelos	Manuel Sá Moreira
Augusto Kutter Magalhães	Rosa Maria Ferreira	Manuela Castro
Carmo Carnot	Rosália Marques	Margarida Sizenando / Rehabilitation Health Teacher
Celeste Long	Rui Cordeiro	Maria Cabral / Citizen of the Autonomous Region of the Azores
Célia Pedras	João Dias	Maria Lourenço Nunes
César Nunes / Graduated Naturopath	João Guerra	Maria Manuela Castro
Cláudia Sequeira	João Santos	Rui Pedro Ângelo
Cristina Correia / Nurse	José Loureiro dos Santos / Retired Army General	Sara Nobre
Cristina da Cunha	José Castro	Torcatto Santos
Cristina Melo	José Galrinho	Vasco Calisto Duarte
Dália Isabel / Sociologist	Leonor Fernandes	

## ABBREVIATIONS AND ACRONYMS

ACES – Agrupamento de Centros de Saúde / Groups of Primary Care Centres

ACIDI – Alto Comissariado para a Imigração e o Diálogo Intercultural / High Commissioner for Immigration and Intercultural Dialogue

ACS – Alto Comissariado da Saúde / Office of the High Commissioner for Health

ACSS - Administração Central do Sistema de Saúde / Central Administration of the Health System

ADSE – Assistência na Doença aos Servidores do Estado / Civil Servants Health Subsystem

IDA – International Development Association

APD – Ajuda Pública ao Desenvolvimento / Public Development Aid

APAV – Associação Portuguesa de Apoio à Vítima / Portuguese Association for Victim Support

AQSA – Sanitary Quality Agency of Andalucía

ARS – Administração Regional de Saúde / Regional Health Administration

AVC – Acidente Vascular Cerebral / Cerebrovascular Diseases

PYLL - Potential Years of Life Lost

EBRD - European Bank for Reconstruction and Development

BSc – Balanced Scorecard

DAC - Development Assistance Committee (OECD)

CCI – Cuidados Continuados Integrados / Long-Term Integrated Care

EC – European Commission

CECSP – Coordenação Estratégica para os Cuidados de Saúde Primários / Primary Health Care Strategic Coordination

CH – Cuidados Hospitalares / Hospital Care

CH<sub>4</sub> - Methane

CIC - Comissão Interministerial para a Cooperação / Interministerial Committee for Cooperation

ICF - International Classification of Functioning, Disability and Health

CIHI - Canadian Institute for Health Information

CNPD – Comissão Nacional de Proteção de Dados / Portuguese Data Protection Authority

CNP - Centro Nacional de Pensões / National Pensions Centre

CNRSE – Comissão Nacional para o Registo de Saúde Eletrónico / National Commission for the Electronic Health Record

CNECV – Conselho Nacional de Ética para as Ciências da Vida / National Ethics Council for the Life Sciences

CNSIDA – Coordenação Nacional para a Infecção VIH/SIDA / National Coordination for HIV/AIDS

UNCRPD - United Nations Convention on the Rights of Persons with Disabilities

CMSMCA - Comissão Nacional de Saúde Materna, da Criança e do Adolescente / National Commission for Maternal, Child and Adolescent Health

CO<sub>2</sub> - Carbon dioxide

CODU - Centro de Orientação de Doentes Urgentes / Urgent Patients Dispatch Centre

COREPER - Permanent Representatives Committee of the Council of the European Union

CPLP - Comunidade dos Países de Língua Portuguesa / Community of Portuguese-speaking Countries

CS - Centros de Saúde / Primary Care Centres

CSP - Cuidados de Saúde Primários / Primary Healthcare

CTH - Consulta a Tempo e horas / On-Time Specialist Appointments

DeFTV – Doente em Fase Terminal de Vida / End-of-Life Patient

DDD - Defined Daily Dose

DGS - Direção-Geral da Saúde / Directorate-General of Health

IHD - Ischaemic Heart Disease

DL – Decree-Law

COPD - Chronic Obstructive Pulmonary Disease

AMI - Acute Myocardial Infarction

ECCI - Equipa Domiciliária de Cuidados Continuados Integrados / Domiciliary Long-Term Integrated Care Teams

ECDC – European Centre for Disease Prevention and Control

ECOSOC – United Nations Economic and Social Council

ELSA - Estratégias Locais de Saúde / Local Health Strategies

MS - Member State(s)

ENDEF - Estratégia Nacional para a Deficiência 2011-2013 / National Strategy for Disability 2011-2013

EMA – European Medicines Agency

ENQS – Estratégia Nacional para a Qualidade na Saúde / National Strategy for Quality in Health

ENRP - Estratégias Nacionais de Redução da Pobreza / National Strategy for Poverty Reduction

ENSP - Escola Nacional de Saúde Pública / National School of Public Health

EPE – Entidade Pública Empresarial / Public Business Entity

EPSCO – Employment, Social Policy, Health and



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Consumer Affairs Council	Institute for Rehabilitation
ERA – Equipas Regionais de Apoio / Regional Support Teams	INSA - Instituto Nacional de Saúde Doutor Ricardo Jorge / Dr. Ricardo Jorge National Health Institute
ERS – Entidade Reguladora da Saúde / Health Regulatory Agency	INS - Inquérito Nacional de Saúde / National Health Interview Survey
EUROMED – Euro-Mediterranean Partnership	IOM – International Organization for Migration
EUROSTAT - Statistical Office of the European Union	IP – Instituto Público / Public Institute
FAO – Food and Agriculture Organization of the United Nations	IPAD – Instituto Português de Apoio ao Desenvolvimento / Portuguese Institute for Development Support
FCG – Calouste Gulbenkian Foundation	IPJ - Instituto Português da Juventude / Portuguese Youth Institute
IMF – International Monetary Fund	IPO – Instituto Português de Oncologia / Portuguese Institute of Oncology
FML - Faculty of Medicine of Lisbon	IPOFGL – Instituto Português de Oncologia, Francisco Gentil / Portuguese Institute of Oncology of Lisbon, Francisco Gentil
UNFPA - United Nations Population Fund	IPS - Instituto Português do Sangue / Portuguese Blood Institute
GAIN – Global Alliance for Improved Nutrition	IPSS – Instituições Particulares de Solidariedade Social / Private Institutions of Social Solidarity
GAVI – Global Alliance for Vaccines and Immunisation	LBS - Lei de Bases da Saúde / Basic Law on Health
DRG - Diagnosis-Related Groups	LIC - Lista de Inscritos para Cirurgia / Surgery Waiting List
GHG - Greenhouse Gases	LVT – Lisboa e Vale do Tejo / Lisbon and Tagus Valley
GeS - Ganhos em Saúde / Health Gains	M€ – Million euros
GFATM – Global Fund to Fight AIDS, Tuberculosis and Malaria	MAI – Ministério da Administração Interna / Ministry of Internal Administration
GHTA – Global Health Workforce Alliance	MCSP - Missão dos Cuidados de Saúde Primários / Mission of Primary Healthcare
GOARN – Global Outbreak Alert and Response Network	MCTES – Ministério da Ciência, Tecnologia e Ensino Superior / Ministry of Science, Technology and Higher Education
GPEARI – Gabinete de Planeamento Estratégico, Avaliação e Relações Internacionais / Strategic Planning, Evaluation and International Relations Office	MIGA – Multilateral Investment Guarantee Agency
GPS - Ganhos Potenciais em Saúde / Potential Health Gains	MNE – Ministério dos Negócios Estrangeiros / Ministry of Foreign Affairs
RDI- Healthcare Research, Development and Innovation	MS – Ministério da Saúde / Ministry of Health
EU-SILC - European Union Statistics on Income and Living Conditions	MTSS – Ministério do Trabalho e da Solidariedade Social / Ministry of Labour and Social Solidarity
IDT – Instituto da Droga e da Toxicodpendência / Institute on Drugs and Drug Addiction	NOC – Normas de Orientação Clínica / Clinical Orientation Guidelines
IEFP – Instituto do Emprego e Formação Profissional / Employment and Vocational Training Institute	UN – United Nations
IHMT – Instituto de Higiene e Medicina Tropical / Institute of Hygiene and Tropical Medicine	OECD - Organisation for Economic Cooperation and Development
IHP – International Health Partnership	MDGs - United Nations Millennium Development Goals
II – Institute of Informatics	OECD – Organization for Economic Cooperation and Development
BMI - Body Mass Index	ILO - International Labour Organization
INML - Instituto Nacional de Medicina Legal / National Legal Medicine Institute	WTO - World Trade Organization
IMVF – Instituto Marquês de Valle Flôr / Marquês de Valle Flôr Institute	WHO - World Health Organization
INE - Instituto Nacional de Estatística / Statistics Portugal	OND - Observatório Nacional da Diabetes / National Diabetes Observatory
INEM – Instituto Nacional de Emergência Médica / National Institute for Medical Emergencies	NGO - Non-Governmental Organization
INFARMED – Autoridade Nacional do Medicamento e Produtos de Saúde, I.P. / National Authority of Medicines and Health Products	
INR - Instituto Nacional de Reabilitação, I.P. / National	

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NGDO – Non-Governmental Development Organization  
UN – United Nations  
PALOP – Países Africanos de Língua Oficial Portuguesa / Portuguese-speaking African Countries  
PECS/CPLP – Plano Estratégico de Cooperação em Saúde da CPLP / Strategic Plan in Health Cooperation of the CPLP  
PIC - Programas Integrados de Cooperação / Integrated Cooperation Programmes  
GDP - Gross Domestic Product  
PIO - Programa de Intervenção em Oftalmologia / Intervention Programme in Ophthalmology  
LDC - Least Developed Countries  
MAP - Medically Assisted Procreation  
SME - Small and Medium-Sized Enterprises  
PNPSO – Programa Nacional de Promoção de Saúde Oral / National Oral Health Programme  
NHP - National Health Plan  
UNDP – United Nations Development Programme  
PNV – Programa Nacional de Vacinação / National Vaccination Programme  
PPP - Public Private Partnership  
PT - Portugal  
PTCO - Programa de Tratamento Cirúrgico da Obesidade / Programme for Surgical Treatment of Obesity  
QUAR - Quadro de Avaliação e de Responsabilidade / Evaluation and Accountability Framework  
QeS – Qualidade em Saúde / Quality in Health  
RAR – Rede de Articulação e Referenciação / Articulation and Referral Network  
HR – Human Resources  
RNCCI – Rede Nacional de Cuidados Continuados Integrados / National Long-Term Care Network  
RRH – Rede de Referenciação Hospitalar / Hospital Referral Network  
RSE – Registo de Saúde Eletrónico / Electronic Health Record  
SAP – Serviço de Atendimento Permanente / Permanent Attendance Service  
SARS – Severe Acute Respiratory Syndrome  
HS - Health System(s)  
SEF – Serviço de Estrangeiros e Fronteiras / Immigration and Borders Service  
SIADAP - Sistema Integrado de Gestão e Avaliação do Desempenho na Administração Pública / Integrated System of Management and Performance Assessment in the Public Administration  
SICAD - Serviço de Intervenção nos Comportamentos

Aditivos e nas Dependências / Service for Intervention on Addictive Behaviours and Dependencies  
SIGIC - Sistema de Informação de Gestão de Inscritos para Cirurgia / System for the Management of Patients Waiting for Surgery  
SISO – Sistema de Informação para a Saúde Oral / Oral Health Information System  
NHS - National Health Service  
SPA – Sector Público Administrativo / Public Administrative Sector  
SE – Serviços de Urgência / Emergency Service  
SUB – Serviços de Urgência Básica / Basic Emergency Service  
SUMC – Serviços de Urgência Médico-Cirúrgica / Medical/Surgical Emergency Service  
SUP – Serviços de Urgência Polivalente / Multipurpose Emergency Service  
TE - Tempo de Espera / Waiting Time  
TMRG – Tempos Máximos de Resposta Garantidos / Maximum Response Time Guaranteed  
SMR - Standardised Mortality Rate  
t CO<sub>2</sub>eq - Ton of Carbon Dioxide-Equivalent  
CCU – Community Care Unit  
UCF – Unidade Coordenadora Funcional / Functional Coordinating Unit  
UCSP - Unidade de Cuidados de Saúde Personalizados / Personalised Healthcare Unit  
EU – European Union  
ULS – Unidade Local de Saúde / Local Health Unit  
UMCCI - Unidade de Missão para os Cuidados Continuados Integrados / Mission for Long-Term Integrated Care  
UNAIDS – United Nations Programme on HIV/AIDS  
UNDP – United Nations Development Programme  
UNESCO – United Nations Educational, Scientific and Cultural Organization  
UNICEF – United Nations Children's Fund  
UNL – Universidade Nova de Lisboa / New University of Lisbon  
URAP – Unidade de Recursos Assistenciais Partilhados / Shared Assistance Resources Unit  
USF - Unidade de Saúde Familiar / Family Healthcare Unit  
USP – Unidade de Saúde Pública / Public Health Unit  
HIV/AIDS - Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome  
WFP – World Food Programme  
WHO – World Health Organization

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## EXPLANATORY NOTE

This version is an extended summary of the document "National Health Plan 2012-2016", available at [www.dgs.pt](http://www.dgs.pt).

This document sought to keep the spirit of the original document, maintaining the basic structure of each chapter: Concepts, Guidelines and Evidence, and Vision for 2016. The Threats and Opportunities regarding each of the Strategic Axes and Objectives for the Health System were included as an annex.

This extended summary does not preclude the reading of the full document.

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## PREFACE BY THE MINISTRY OF HEALTH

The National Health Plan (NHP) is the Health Planning instrument and resource which creates a framework for the goals, plans and strategies of all of those whose mission is to maintain, improve or recover the health of individuals or populations in Portugal.

Portugal has followed a significant path towards the development of Health Planning macro-instruments. The level of stringency set by the National Health Plan 2004-2010, with the establishment of indicators and targets, priority programs, an interministerial monitoring committee and structures dedicated to its operationalisation and development, motivated Portugal to become one of the first European countries to carry out an external and independent evaluation of its NHP and Health System.

The current challenges of demographic transition, economic and environmental sustainability and globalisation require that the Health Systems of developed countries revisit and recast their goals and the object of their social contract.

This NHP proposes itself as a foundation for the Health System of the 21st century:

- It involves and addresses the Health System, collecting and framing the contribution of all, starting with the citizens and civil society, to achieve health gains;
- Its mission is to strengthen the ability of all health stakeholders;
- It creates a collective vision towards the development of the Health System;
- It recognises and promotes knowledge innovation and management, gradually extending and cyclically upgrading itself, with a continuous search for the best medium and long-term solutions for the Health System.

The NHP has a very clear vision:

*“To maximise health gains through the alignment and integration of sustained efforts of all sectors of society and the use of strategies based on citizenship, equity and access, quality and healthy policies”.*

This vision is a direction with which all are invited to identify themselves.

Specific health questions demand specific health responses. Local needs, health plans targeted at specific problems, or the reform of parts of the Health System can be found at this level. The NHP's mission is to provide a meaning and a larger framework, ensuring that the Health System responds to the needs, has the plans and resources it needs and optimises the impact of its reforms. Hence its strategic value.

Given its nature, the NHS proposes strategic actions. These are not all the necessary actions, nor all the priority actions. These are the actions, both strategic and structural, which will lead to a Health System more capable of achieving health gains for all. After the achievement of these levels, new actions will be necessary and relevant for the following steps on the development of the Health System. An active and dynamic NHP will ensure that its mission, value and contribution for the Health System will always be invaluable.

To all those who have directly or indirectly contributed to this NHP, a new invitation follows the acknowledgement and gratitude: may you help the NHP to fulfil its mission, by involving more stakeholders and individuals, continuing to bring stringency and contributions, as well as by being privileged stakeholders in its operationalisation.

Notwithstanding the monitoring, supervision and continuous assessment, this NHP will be technically and socially evaluated at the end of its validity. New lessons will be learnt, and Portugal will be able to start a new, even more enriched cycle. We will be able to look back and ascertain the opportunities we have enjoyed, those we have created and those we were not able to respond to. May this NHP be a useful and essential guide, a common purpose and a convergent vision so that, together, we can do more and better.

For the Health of All.

Lisbon, 31 January 2011

Paulo José Ribeiro Moita de Macedo  
Minister of Health

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## MESSAGE FROM THE DIRECTOR-GENERAL OF HEALTH

We all recognise, today, the opportunity to harmonise programmes, projects, actions and initiatives within the framework of a strategic direction for health which promotes the articulation of the products resulting from the work developed in the pursuit of more health gains.

This document translates that main concern while establishing the guidelines to achieve the targets set.

The National Health Plan (NHP) 2012-2016 stands on a matrix that is transversal to the Health System and that has collected vast contributions and broad national consensus. This matrix is structured into 4 axes (Citizenship in Health; Equity and Adequate Access to Healthcare; Quality in Health; Healthy Policies) and 4 goals for the Health System (Obtaining Health Gains; Promoting Supportive Environments for Health Over the Life Cycle; Strengthening Economic and Social Support in Health and Disease; Strengthening Portugal's Participation in Global Health).

The NHP 2012-2016, like all plans, takes on the mission to be a guide of great usefulness for policy makers, institutions and care providers, but it should be especially interesting for the common citizen.

It is based on the promotion of equity and adequate access to healthcare, dictating the development of urgent measures to improve the health of citizens and reduce gaps.

It emphasises quality, in the sense that continuous improvement is the duty of Public Administration, as, in practice, citizens are the ones who finance, almost entirely, the services they receive.

Another commitment, which is connected to the previous one, dictates the improvement of governance, either by promoting the leadership process or facilitating wide participation, open to all stakeholders and, of course, to the representatives of civil society.

The NHP proposes guidelines for investments in Public Health, based on the surveillance of the health and well-being of citizens; the monitoring and response to risks and emergencies; the protection of health in its various aspects (environmental, occupational and food-related, within a logic of Health in All Policies); the addressing of social determinants of health and promotion of equity; the prevention of diseases, including early detection and diagnosis; the promotion of awareness, communication and social mobilisation; and the analysis of information/production of knowledge in health.

This Plan addresses the challenges posed by demographic transition and changing of the epidemiological profile in Portugal. Complementarily, 9 national priority programmes were created, as a response to the main health problems.

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This nation-wide document, which guides health policies, focuses on all citizens, families and communities by promoting their resilience, i.e. their ability to withstand adversity. In short, it seeks to promote healthy communities through health literacy and information, communication platforms, support and cooperation networks, and the empowerment of patients and citizens, with the consequent empowerment of Portuguese families.

Lisbon, May 2013

Francisco George

Director-General of Health

# 1. FRAMEWORK OF THE NATIONAL HEALTH PLAN

## 1.1. FOREWORD

.1. The National Health Plan (NHP) is a set of guidelines, recommendations and concrete actions, of a strategic nature, designed to enable and promote the empowerment of the Health System to fulfil its potential. We believe that the ability to maintain and promote the health potential is the responsibility of citizens, families, communities, organisations of civil society and the private and social sectors. It also lies at the level of national strategic planning. The NHP proposes recommendations and involves these stakeholders, seeking to demonstrate how critical their efforts are for the social mission and for the achievement of a common vision for the Health System.

.2. The process of preparing the NHP encompassed broad participation by all stakeholders in healthcare and in other areas of public administration, including national and international experts, comprising an exceptional capital of involvement and knowledge. The NHP benefited from broad consensus as to its mission and vision, which were widely discussed in the III National Health Forum, held in March 2010.

### GOALS OF THE NATIONAL HEALTH PLAN

.3. The NHP aims to strengthen the operational and planning capacity of the Health System. To this end, it intends to answer four questions:

- *As a stakeholder of the Health System, how can I contribute to maximise health gains?*
- *As a Health System, towards which goals should we converge?*
- *Which are the cross-sectional policies supporting everyone's mission in the accomplishment of the Health System's Goals, including the provision of healthcare?*
- *What operational support is required to accomplish the NHP?*

.4. The NHP also provides a rationale for the identification of health gains, definition of targets and indicators, as well as a framework for priority health programmes, at a regional and sectoral level, while facilitating the integration and articulation of efforts and the creation of synergies.

## 1.2. VISION OF THE NHP

*To maximise health gains through the alignment around common goals, the integration of sustained efforts of all sectors of society, and the use of strategies based on citizenship, equity and access, quality and healthy policies.*

### .1. The NHP intends to:

Maximise health gains while recognising that these are always relative, through additional health outcomes for the population, in general terms and by age group, gender, region, socioeconomic level and vulnerability factors;

Strengthen the Health System as a strategic option with highest health, social and economic return, considering the national and international context (WHO, 2008), while promoting the conditions for all stakeholders to better perform their mission.

## 1.3. MISSION OF THE NHP

### .1. The mission of the National Health Plan is to:

*State the values and principles that support the identity of the Health System and strengthen the coherence of the system around those;*

*Clarify and consolidate common understandings that facilitate the integration of efforts and valorisation of stakeholders in achieving gains and value in health;*

*Frame and articulate the different levels of strategic and operational decision-making around the Health System goals;*

*Create and sustain an expectation of development of the Health System, through guidelines and action proposals;*

*Be a reference and enable the monitoring and evaluation of the adequacy, performance and development of the Health System.*



## 1.4. CONSTRUCTION PROCESS OF THE NHP

.1. The construction of the NHP had as starting points: i) The reflection on gains and shortcomings arising from the preparation and implementation of the previous NHP (2004-2010) which included its evaluation by an external entity (WHO, 2010); ii) A proposal for a conceptual model; iii) Sector expert reviews, evidence and critical analyses, recommendations, identifying gains and required resources; iv) The collection, integration and discussion of institutional and intersectoral plans and instruments; v) The identification of convergences, opportunities for strengthening, collaboration and alignment; vi) The interaction, engagement and consultation of citizens, health professionals, public, private and social sector institutions.

### Box 1 – WHO Evaluation of the NHP 2004-2010

#### POSITIVE ASPECTS:

- ✓ Extended participation;
- ✓ Consensus on priorities;
- ✓ Political commitment.

#### TO IMPROVE:

- ✓ Support to sustainability;
- ✓ Hierarchy of indicators and targets: Greater focus on social determinants and health outcomes;
- ✓ Method for assigning gains.

.2. This NHP follows the **NHP 2004-2010**, the Health System document for strategic, policy, technical and financial guidance.

.3. **Evaluation of NHP 2004-2010 and of the performance of the Health System by WHO (WHO – Euro, 2010)**, conducted in 2009 and 2010, whose results are summarised in Box 1.

.4. It was recommended that the next NHP should enhance the performance of the Health System: i) as a platform for communicating goals and organising them into priorities, actions, indicators and targets; ii) with a focus on health impact assessment; iii) considering the threats to sustainability; iv) supporting the attainment of health gains through intermediate objectives, such as the improvement of the indicators of mortality, morbidity, disability and self-perceived health status.

.5. Sector expert reviews – Twenty specialised analyses to support the development of the NHP were conducted by national experts with international consultation and public discussion.

.6. Engagement and public consultation – Different work groups were put into motion, as well as several instruments of active participation (NHP microsite, social media, the "Pensar Saúde" (Think Health) News Bulletin, Newsletters, national and regional Forums, among others), the focal points of several Ministries, Professional Associations and other bodies were heard, and an Advisory Board was created.

## 1.5. VALUES AND PRINCIPLES OF THE NHP

.1. The NHP takes on the fundamental values of the European health systems (Box 2) (EU Council, 2006).

.2. Of the principles of the NHP, the following stand out:

- Transparency and accountability, which enable the development of trust and appreciation of the stakeholders;
- The involvement and participation of all stakeholders in the health creation processes;
- The reduction of health inequities, as a basis for the promotion of equity and social justice;
- The integration and continuity of care;
- Sustainability, in order to preserve these values for the future.

### Box3 – Values and principles of the NHP

#### VALUES OF THE NHP

- ✓ Universality;
- ✓ Access to quality care;
- ✓ Equity;
- ✓ Solidarity;
- ✓ Social Justice;
- ✓ Citizen empowerment;
- ✓ Provision of person-centred healthcare;
- ✓ Respect;
- ✓ Solicitude;
- ✓ Decision supported by scientific evidence.

.3. The NHP abides by these values and principles:

- Promoting them in its own building process;
- Proposing guidelines, indicators, actions and recommendations towards their achievement;
- Creating benchmarks for accountability and assessment of the way the Health System promotes its values and principles.

### Box 4 – Dimensions of the Conceptual Model

#### Intrinsic

- ✓ Strategic strengthening of the Health System;
- ✓ Definition, evidence and implementation of strategic guidelines.

#### Extrinsic

- ✓ Strategic Axes;
- ✓ Goals for the Health System;
- ✓ Cross-sectional Policies;
- ✓ Operationalisation Processes and Tools.

## 1.6. CONCEPTUAL MODEL AND STRUCTURE

.1. To fulfil its vision and mission, the NHP takes on two dimensions: INTRINSIC AND EXTRINSIC (Box 3).

.2. STRATEGIC ALIGNMENT - Seeks to ensure that stakeholders follow common directions for achieving goals with greater health value.

.3. STRATEGIC INTEGRATION - Seeks to ensure the best performance and adequacy of care which

maximise the use of resources, quality, equity and access.

.4. The Health System finds balances between the proximity of care and the rational management of limited resources; between redundancy and complementarity of the services offered by the public, private and social sectors; between the comprehensive response and the specialised response to health requirements.

.5. SUSTAINED EFFORTS - The definition of Health is useful as a horizon for prioritising actions. From this standpoint, all societies determine what portion of resources and investment they allocate to the Health System (Figure 1).

.6. The investment of social resources in the Health System is performed in competition with the other social systems. This competition reduces with the ability of the sectors to integrate efforts and resources, with gains for all.

**Figure 1 – Definition of Health**

*"Health is a dynamic state of well-being characterized by a physical, mental and social potential which satisfies the demands of life commensurate with age, culture, and personal responsibility" (Bircher, 2005).*

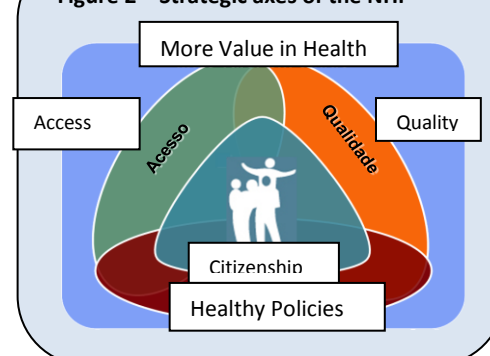
.7. Creating and conveying value that promotes and justifies the investment is the responsibility of the Health System, which continuously establishes compromises between available resources and those to be developed, the services provided and the results obtained. This is the concept of Health Value (Porter ME & Teisberg EO, 2006), i.e., obtaining gains proportional to the investment made.

.8. The NHP assumes that health gains will result from the best fit between health needs and services, and from the best relationship between resources and outcomes, i.e., the best performance.

.9. The lines of definition, evidence and implementation of the guidelines allow explaining the rationale behind the proposed guidelines, actions and recommendations. The process is based on: Concepts; Framework; Guidelines and Evidence; Vision for 2016; it is complemented with Bibliographic References and a Glossary.

.10. STRATEGIC AXES - These are perspectives on the scope, responsibility and competence of each stakeholder in the Health System (citizen, health professional, manager and administrator, representative of interest groups, entrepreneur, policy-maker), whose improvement requires recognising their interdependence, while reinforcing the perspective of the Health System. These generate returns, improve performance and strengthen the alignment, integration and sustainability of the Health System, as well as its ability to develop as a whole.

**Figure 2 – Strategic axes of the NHP**



.11. Four Strategic Axes are considered (Figure 2):

- **Citizenship in Health;**
- **Equity and Adequate Access to Healthcare;**
- **Quality in Health;**
- **Healthy Policies.**

.12. GOALS FOR THE HEALTH SYSTEM - These ensure that:

- The values and principles are implemented in an objective and assessable manner;
- The Health System is geared towards achieving results in an integrated, aligned and open way, having adequate tools and processes for that purpose;
- The Health System promotes the expected guarantees of responsiveness, effectiveness, protection, solidarity and innovation and is valued for its capacity.

.13. The NHP clarifies and defines the framework for four Health System Goals (HSG):

- **HSG 1 - Obtaining Health Gains-** The development of the Health System should be reflected in measurable gains in the health of populations and subgroups, by identifying priorities and allocating resources at the different levels, considering cost-effective interventions with greater impact.
- **HSG 2 - Promoting Supportive Environments for Health Throughout the Life Cycle-** Fostering healthy environments throughout the life cycle involves the promotion, protection and maintenance of health; prevention, treatment and rehabilitation from disease, allowing an integrated view of the needs and opportunities for context-specific intervention in a continuous manner (WHO, 2002). It enables overlapping visions of articulation and integration of efforts between contexts.
- **HSG 3 - Strengthening Economic and Social Support in Health and Disease -** Health is an individual and social asset, and the solidarity and protection mechanisms in case of disease are crucial for social cohesion, justice and safety. The Health System's capacity to promote economic and social support in health and disease involves clarifying the role of the different stakeholders in the system, strengthening its mechanisms and maintaining the sustainability of the System.
- **HSG 4 - Strengthening Portugal's Participation in Global Health -** Health Systems should be open, interdependent, of fast development and capable of rapidly responding to new threats. The Health System should share innovation, articulate itself internationally, contribute towards the strengthening and supportive development of other systems, and incorporate international developments.

.14. CROSS-SECTIONAL POLICIES, OPERATIONALISATION PROCESSES AND TOOLS - (Box 4) are guidelines for the Health System (levels of care, processes, tools and mechanisms) to develop its capacity to implement the strategies of the NHP. They propose guidelines for the planning, operationalisation, participation and influencing, monitoring and evaluation of the NHP and of the associated decision-making processes.

**Box 5 –Cross-sectional policies and healthcare provision  
for the strategic implementation of the NHP**

- ✓ Governance
- ✓ Participation and Influence
- ✓ Monitoring
- ✓ Assessment
- ✓ Healthcare
  - Public health
  - Primary
  - Hospital
  - Long-term integrated care
- ✓ Articulation and continuity of care
- ✓ Spatial planning and local health strategies
- ✓ Healthcare human resources
- ✓ Information and communication technologies
- ✓ Medicines, medical devices and technology assessment
- ✓ Research, development and innovation
- ✓ Sustainability of the Health System

## 2. PORTUGUESE HEALTH PROFILE

The intention is to characterise the health status of the Portuguese population<sup>1</sup>, highlighting the significant health gains that Portugal has achieved in recent years, measured and evaluated by a set of indicators that have come to be near the best figures registered in European Union (EU) countries. In fact, the health status of the population has improved consistently and sustainably, which may have been the result of a positive development of the several health determinants and the ability to invest in this domain.

### 2.1. HEALTH STATUS OF THE POPULATION

#### 2.1.1. HEALTH DETERMINANTS

.1. Among the health determinants associated to lifestyle, tobacco use and alcohol consumption stand out. The data collected during the 4th National Health Interview Survey (INS) (between February 2005 and February 2006) allow the characterisation of these consumptions, in population aged 15 years and older.

.2. In 2006, 20.8% of the population residing in Mainland Portugal was smoking. Among smokers, approximately 10.6% smoked only occasionally and 89.4% smoked daily. The proportion of current smokers was higher in the male population: 30.5%, versus 11.8% of women. In both genders, the highest value was in the group of 35 to 44 years of age: 44.6% and 21.2%, respectively, for men and women.

.3. According to data collected in the 4th INS, 40.5% of residents in Mainland Portugal reported having consumed at least one alcoholic beverage in the week preceding the interview. This proportion increased to 54.8% in the total male population, twice what was observed for women: 27.0%.

.4. In 2006, 15.2% of the Portuguese adult population (18 and older) was obese<sup>2</sup>. The prevalence of obesity in women (15.9%) was slightly higher than in men (14.4%). Regardless of gender, the proportion of individuals with obesity was highest in age groups between 45 and 74 years, with ratios above 20%.

.5. Other determinants associated with risk behaviours show an improvement, there being a decrease in the proportion of hospital admissions exclusively attributable to alcohol, as well as in the

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<sup>1</sup> The figures shown throughout the chapter concern Mainland Portugal, except where such figures are unavailable. In such cases, the figures provided pertain to Portugal, including the Autonomous Regions.

<sup>2</sup> The condition of obesity was calculated based on the Body Mass Index (BMI). According to this indicator, people are considered to be obese when their result is 30 kg/m<sup>2</sup> or higher.

proportion of motor accident casualties with blood alcohol level of 0.5 g/l or higher. Mortality due to motor vehicle accidents and work-related accidents has also shown a generally decreasing trend.

.6. Premature mortality due to alcohol-related diseases and suicide showed an increasing trend in the last few years. In 2009, the mortality rate due to alcohol-related diseases under the age of 65 reached 12.9 deaths per 100,000 inhabitants and the male rate was about 6 times higher than the female rate, indicating this is a problem which essentially conditions men's health. In 2009, the standardised mortality rate due to suicide under the age of 65 was of 5.9 deaths per 100,000 inhabitants, the male rate being 4 times higher than the female rate. In the European context, Portugal remains among the countries with the least premature mortality due to suicide.

.7. In a global analysis of the data presented for health determinants related to lifestyles, there are remarkable differences between genders. Those are mostly related to alcohol and tobacco consumption, in all age groups studied, and to mortality due to work-related and motor accidents, alcohol-related diseases and suicide, the higher values corresponding to the male gender.

.8. The National Vaccination Programme (PNV), universal and free, operational since 1965, surpassed the coverage of 95% of all population.

.9. The number of beds contracted for long-term integrated healthcare has increased, having reached 5,948 (2012): 906 for "convalescence", 1808 for "medium-term and rehabilitation", 3041 for "long-term and maintenance" and 193 for "palliative care", with occupancy rates between 94% and 100% in the various health regions.

.10. In the last decade, there have been increases in the average number of medical appointments per capita, as well as in the percentage of first appointments in the total of outpatient appointments. In National Health Service (NHS) hospital units, there was a slight decrease in more recent years both in the number of patients discharged as in the number of patients seen in the emergency services (since 2005 in the first case and 2007 in the second). However, this temporal analysis should take into account the emergence of new private hospital facilities, which may lead to substantial variations of the results.

.11. In 2010, each inhabitant of Mainland Portugal went, on average, 4.2 times to the doctor<sup>3</sup>. In 2010, from the total of outpatient appointments in NHS hospital units, 28.7% were first appointments. Concerning access to surgical care, according to the Summarized Report on Elective Surgical Activity (ACSS, 2012), the demand for surgical care tends to grow continuously ever since a systematic measurement was introduced. Growth, versus the first half of 2006, is of 41.5%.

.12. The waiting list for surgery (LIC), which represents the cumulative episodes awaiting surgery, had

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<sup>3</sup> To calculate the average figure for medical appointments, we considered external consultations at hospitals (every specialty) and appointments at Primary Care Centres (following specialities: General and Family Medicine/General Practice – Adult Health, Gynaecology/Obstetrics, Family planning, New-born, child and adolescent health, Maternal health).

been declining steadily since the introduction of the system for management of patients waiting for surgery (SIGIC) and reversed the trend for the first time December 2011, presenting an increase of 11.2% when compared to the same period of the previous year. The behaviour of the median waiting time (TE) of users who are waiting for surgery is similar to that of the LIC. In the first half of 2006 it presented a value of nearly 7 months and since then it had been steadily decreasing, presenting in the first half of 2011 a value of 3.13 months. This trend was reversed in the second half of 2011, which presented a value of 3.33 months.

.13. The public/agreed specialised structures network for the treatment of addictions associated with alcohol and drug abuse has increased nationwide, facilitating integration into rehabilitation programs. In 2010, the public network for the treatment of drug addiction (outpatients) integrated 37,983 users, of which 8444 were new users (first appointments).

.14. Investment was made in basic and advanced life support equipment, whose ratio per 100,000 inhabitants more than doubled in recent years. During the year 2011, 56% of cases (at national level) were screened by the Urgent Patients Dispatch Centre (CODU) by sending emergency resources to the site of occurrence, and there has been an increase of 3% compared to the year 2010.

.15. The *per capita* consumption of medicines, in the total market, increased from 288 Euros in 2002 to 327 Euros in 2009.

### 2.1.2. HEALTH STATUS

.16. Life expectancy at birth in Mainland Portugal for the 2008/2010 triennium reached 79.38 years, with women living, on average, 6 more years than men. There is also a difference of about 2.4 years between the life expectancy at birth in Mainland Portugal and the average value of this indicator in the five EU countries where people live the longest. This difference is clearer for men (3.1 years) than for women (1.8 years). However, when analysing life expectancy without disability in Portugal, for the year 2010, it is seen that men live on average 59.3 years with no limitations to their activity, while for women the life expectancy without disability is 56.6 years.



.17. In the last decade (2001-2011), infant mortality decreased from 4.8 to 3.1 deaths and the risk of dying before the age of 5 from 6.2 to 3.9 deaths of children under 5 years of age (per 1000 live births). The number of live births to adolescent women (under 20 years of age) decreased from 5.9 to 3.6; the number of preterm live births increased from 5.7 to 7.5 and the number of live births with low birth weight from 7.2 to 8.4 (per 100 live births). The number of caesarean section deliveries increased from 29.7 to 36.1 (per 100 live births) between 2001 and 2010.

.18. Mortality at young ages (10 to 24) is reduced, compared to that observed at later ages, but still has decreased steadily over the past two decades. Mortality rates are higher for females than for males. However, the difference has been progressively decreasing. The main causes for hospital admission of children and young people under 18 are respiratory (22.8%) and digestive (13.9%) system diseases. In the adult population, diseases of the circulatory system and malignant neoplasms represent, respectively, 10.1% and 7.9% of all hospital admissions.

.19. In hospital admissions considered avoidable through primary prevention, including hospital admissions for trachea, bronchus and lung cancer (0-74 years), liver cirrhosis (0-74 years) and motor vehicle accidents (all ages)<sup>4</sup>, the admissions due to motor vehicle accidents stand out with greater expression (43.5%). Considering hospital admissions avoidable through ambulatory care<sup>5</sup>, those related to diabetes stand out (18.9%).

.20. Morbidity and mortality due to infectious diseases have suffered a significant and sustained decrease since the implementation of the National Vaccination Programme (PNV), in 1965. However, despite the significant improvements recorded, the incidence of tuberculosis and HIV infection in Portugal is still very high when compared with the average of the five EU countries with the lowest incidence rates. Between 2000 and 2010, the incidence rate of tuberculosis decreased from 41.3 to 23.4 and HIV decreased from 27.6 to 9.0 (per 100,000 inhabitants).

.21. Circulatory diseases (32%), malignant tumours (23%) and respiratory diseases (11.1%) are, for both genders, the leading causes of mortality. The fourth leading cause includes accidents, poisoning and violence, for males, and diabetes mellitus, for females.

.22. Premature mortality from all causes of death, as measured by the PYLL (Potential Years of Life Lost) rate, is higher for males than for females (twice as high). The PYLL rate evolved positively in the last decade. From 2002 to 2010, there was a substantial reduction: from 5280 to 3906 years of life lost per 100,000 inhabitants. This evolution is more pronounced in males, for which the problem of early death is more important. In recent years, there seems to be some tendency towards convergence in these rates. However, although it is clear that in the values concerning males there is a considerable margin for positive progression (to reach the level of PYLL observed in females, for

<sup>4</sup> Ellen Nolte Methodology (Nolte and McKee, 2004) for mortality avoidable through primary prevention.

<sup>5</sup> Hospital admissions considered: Epilepsy Grand Mal, COPD, Asthma, Diabetes, Heart failure and pulmonary oedema, Hypertension and Angina pectoris (ages 0-74). Methodology of the *Canadian Institute for Health Information* (CIHI, 2012).

example), the female gender appears to have reached the nadir point which presents serious challenges as to the policies to follow in order to obtain gains in this indicator.

.23. The leading causes of premature mortality, as measured through the PYLL rate, include malignant tumours (31.7%), external causes (16.3%) and circulatory diseases (11.5%), and it should be pointed out that undetermined causes come in 3rd (13.0%).

.24. The leading causes of PYLL for both genders are fully in line with the pattern observed in males, which is understandable, since premature mortality is particularly associated with males.

.25. The distribution of the leading causes of PYLL in females shows a different pattern. Causes such as malignant tumours of the respiratory system and of the intra-thoracic organs, alcohol-related diseases, transport accidents and some infectious and parasitic diseases are leading causes of premature mortality in males but not in females. By contrast, conditions gaining importance as causes of premature mortality in females include specific malignant tumours (bones, skin and breast or in genital-urinary organs, for instance).

.26. PYLL due to causes regarded as avoidable through primary prevention and healthcare<sup>6</sup> amount to 36% of overall PYLL (12% and 24%, respectively). In terms of causes of PYLL which are avoidable through primary prevention, in 2002 and 2010, the leading causes included motor vehicle accidents and malignant neoplasm of the trachea, bronchus and lung. Despite the improvements achieved, between 2002 and 2010, cerebrovascular diseases and ischemic heart diseases remained the most significant causes of PYLL avoidable through healthcare.

.27. Ageing and less healthy lifestyles result in higher prevalence of chronic diseases, namely cardio-cerebrovascular diseases, hypertension and diabetes. Not only are hypertension and diabetes chronic diseases, but they are also major risk factors for other illnesses. From 1999 to 2006, the percentage of population reporting to suffer from hypertension rose by 34%, with a 38% increase for diabetes. It is estimated that the prevalence of hypertension is 46%, with diabetes at approximately 12.3%.

.28. Some of the available indicators regarding smoking-related diseases show favourable progress. The standardised mortality rate from chronic obstructive pulmonary disease (COPD) has dropped consistently since 1980, having reached its lowest levels during the first decade of the 2000's; the standardised mortality rate from ischemic heart disease (IHD) has decreased since the early 1990's, and in 2009, it achieved the lowest level of the three previous decades; the standardised mortality rate from malignant neoplasm of the lung appears to have peaked in the late 1990's. In terms of morbidity, the rates of patients discharged from public hospitals due to asthma, COPD and IHD also showed positive aspects. The rate due to IHD increased until 2008, with a decrease in 2009; the rate of COPD also dropped substantially in 2009, and the rate for asthma has continued its downward

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<sup>6</sup> Causes of death selected on the basis of the Ellen Nolte Methodology (Nolte and McKee, 2004)

trend since the mid-1990s.

.29. The average number of working days lost due to illness<sup>7</sup> has been decreasing, though in the last year there has been an opposite trend, reaching 7.3 days. The number of disability pensioners has also been decreasing.

.30. The self-perceived health status is an important predictive indicator of mortality and morbidity, as well as the use of healthcare services. From 1999 to 2006, the proportion of individuals with a favourable (good or very good) assessment of their health status rose from 47% to 53%. In every age group, females show a less positive self-perception of their health status.

## 2.2. ORGANISATION OF RESOURCES, PROVISION OF HEALTHCARE AND FUNDING

### 2.2.1. STRUCTURE

.1. The provision of healthcare in Portugal is characterised by the coexistence of a National Health Service (NHS), public and private subsystems specific for certain professional categories and voluntary private insurance. The NHS is the main healthcare providing structure, integrating all aspects of healthcare, from promotion and surveillance to disease prevention, diagnosis and treatment, as well as medical and social rehabilitation.

.2. The last decade was marked by a set of reforms, with particular incidence on the hospital network and emergency services, on primary healthcare (CSP) and on long-term care (CCI). The hospital network in Mainland Portugal comprises 212 hospitals, 91 of which are privately-owned. The 363 Primary Care Centres were organised into 74 Groups of Primary Care Centres (ACES). In 2012, 342 Family Healthcare Units and 186 Community Care Units were in operation. The number of available contracted beds as of 31 December 2011 in the National Long-Term Care Network was 5595. These beds were distributed according to the following types: 906 for convalescence, 1747 for medium-term and rehabilitation use, 2752 for long-term and maintenance use, and 190 for palliative care.

.3. This restructuring process and the creation of new healthcare services were accompanied by a positive evolution in the number of healthcare professionals. The ratio of physicians per 1000 inhabitants rose from 3.3 to 4.0 from 2001 to 2010, although there are specialties that now have or expect to have a shortage of doctors, such as General and Family Medicine, Paediatrics, Anaesthesiology and Internal Medicine, among others. Likewise, the ratio of nurses per 1000 inhabitants has increased: from 3.8 to 6.0 between 2001 and 2011. The geographical distribution of healthcare services and human resources shows asymmetries, resulting in a greater supply along the coast compared to the interior.

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<sup>7</sup> Ratio of Days of Absence due to Illness/Natural Persons with at least one income and/or contribution during the year (MTSS/GEP, 2010).

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## 2.2.2. FUNDING AND EXPENDITURE

.4. The Portuguese Health System simultaneously includes public and private funding. The NHS is mostly (90%) funded with taxes, with subsystems funded by workers and employees, while private healthcare funds come from co-payments and direct payments from patients, as well as from health insurance premiums.

.5. The population's increased longevity and the growing use of medication and technology have brought about increased healthcare expenditures, resulting in an ever-growing portion of Portugal's Gross Domestic Product (GDP). Curative care and rehabilitation services and medical devices made available to outpatients make up for the most significant expenditures, for both private and public healthcare providers.

.6. In 2010, current costs with healthcare rose by 1.6% compared to 2009, amounting to 10.2% of the GDP and a *per capita* expenditure of 1648.41 Euros. Preliminary results show that in 2011 there was a decrease of around 4.6% in the current healthcare costs. In that year, expenditure dropped to 16,727.7 billion Euros, thus accounting for 9.8% of the GDP. In 2010 and 2011, the relative weight of current expenditure borne by public funding bodies<sup>8</sup> decreased, particularly in the last year (65.5% in 2011, 1.8% less than in 2010, the lowest figure since 2000).

.7. With regard to private funding bodies<sup>9</sup>, in 2010 and 2011, current expenditure rose slightly (2.5% and 0.6%, respectively). From 2006 to 2011, in cumulative terms, private current healthcare expenditure jumped 12.1% higher than public current expenditure. On average, the former achieved an annual growth rate of 3.6%, while the latter rose by 1.4%.

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<sup>8</sup> Public funding bodies encompass public administration bodies, such as those included in the NHS, public healthcare subsystems and social security funds.

<sup>9</sup> Private funding bodies encompass private insurances (private healthcare subsystems and other private insurances), families, non-profit institutions serving families and other companies.

.8. Medication expenditures in Portugal account for 21.8% of overall health costs, which corresponds to 2.1% of the GDP (2006 data). However, public funding of this expenditure is only 55.9%, one of the lowest percentages within the European context. At NHS hospitals, there is a sustained growth trend in the medicines market; in nominal terms, the figure for medication expenditures more than doubled from 2002 to 2009, thus achieving an average annual growth over 10%. At such institutions, cancer therapy, anti-retrovirals and biological medication account for 70% of medication expenditures. Anxiolytics, hypnotic drugs, sedatives and antidepressants are those which have contributed most towards such an increase, within the scope of outpatient care. The use of antibiotics, namely quinolones and cephalosporins, used as a quality indicator, has been decreasing.

.9. The use of anxiolytics, hypnotic drugs, sedatives and antidepressants on the overall NHS market (DDD/1000 inhabitants/day) recorded a relative increase exceeding 40% from 2002 to 2009 (2002: 115.6; 2009: 162.3). The use of antibiotics decreased from 65,279,709 to 63,635,373 (Daily Defined Dose - DDD) from 2006 to 2009 and the percentage of cephalosporins and quinolones on the total of antibiotics dropped, from 2002 to 2009, respectively, from 12.6% to 9.2% and from 14.9% to 12.6%.

### 3. STRATEGIC AXES

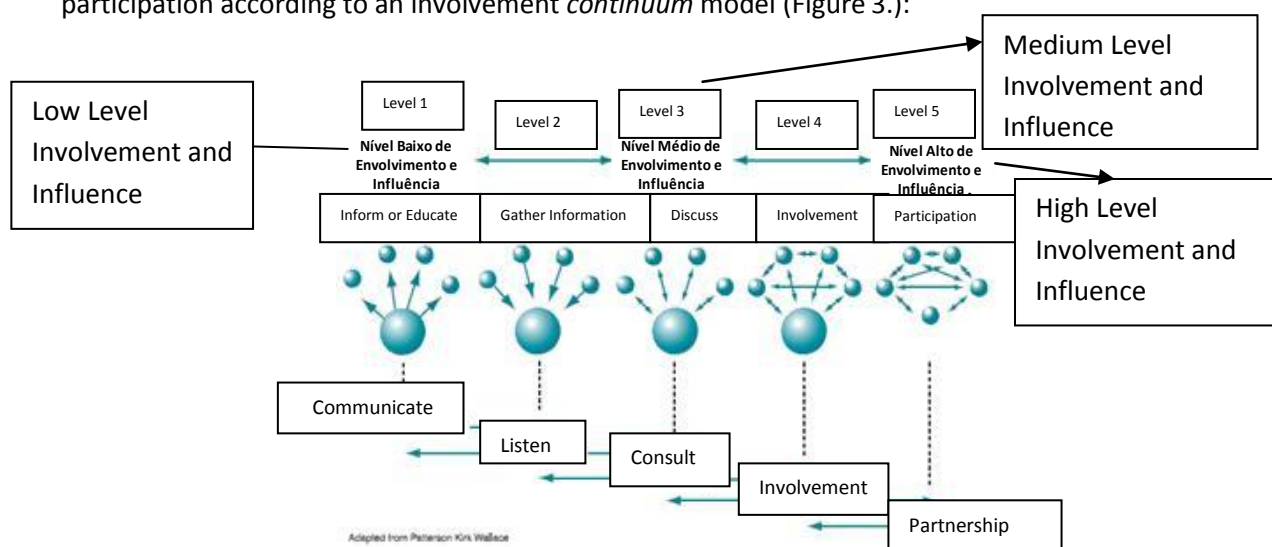
#### 3.1. CITIZENSHIP IN HEALTH

##### 3.1.1. CONCEPTS

.1. Citizenship designates membership in a political community (local, national, supranational) on which there is a relationship of responsibility, legitimised by each person assuming a set of rights and duties (Gaventa J et al., 2002).

- Active citizenship assumes that individuals and organisations take responsibility for developing society, through actions such as public and political participation, associations, volunteering and philanthropy.
- The organisations shall be responsible for their overall impact, their performance, and responsiveness to needs and expectations, while promoting the engagement of the citizen and civil society, its continued development and creation of social value (services, products, quality and safety standards).

.2. Citizens and/or organisations representing citizens and social interests can frame their participation according to an involvement *continuum* model (Figure 3.):



**Figure 3 – Health Canada's Public Involvement Continuum, departmental policy, 2000**  
(Adapted)

.3. Citizenship in Health emerges in 1978 from the Declaration of Alma-Ata as the people's "right and duty to participate individually and collectively in the planning and implementation of their health care" (Alma-Ata, 1978). In this Context, citizens are responsible for their own health and that of the

society they are part of, having the obligation to defend and promote it, in respect for the common good, for the benefit of their interests and recognised freedom of choice (Basic Law on Health, 1990), through individual actions and/or by associating themselves and forming institutions.

.4. The Citizen is the centre of the Health System. According to Coulter (2002), the patient is a decision-maker, care manager and co-producer of health, an evaluator, a potential change agent, a taxpayer and an active citizen whose voice must be heard by decision-makers (Ottawa Charter, 1986).

.5. As part of the strategic perspectives for the development of Citizenship in Health, an investment is made in strengthening the citizens' power and responsibility to contribute to the improvement of individual and collective health; it is reinforced through the promotion of a continuous development dynamic that integrates the production and sharing of information and knowledge (health literacy), within a culture of pro-activeness, commitment and self-control of the citizen (capacity-building/active participation), for maximum responsibility, and individual and collective autonomy (empowerment).).

.6. There is a set of resources and tools for strengthening Citizenship in Health, such as representation and participation of the citizen and community in governance structures; and public information of a political, institutional or professional nature.

.7. The opportunities and threats for to the exercise of citizenship in Health can be analysed in more detail in the Annex.

### **3.1.2. GUIDELINES AND EVIDENCE**

#### **AT THE POLITICAL LEVEL, ONE SHOULD:**

.8. Promote a culture of citizenship, based on the development of initiatives targeted at the community or population groups, aimed at improving literacy, capacity-building, empowerment and participation, based on axes such as the dissemination of information, the development of skills, and the engagement and participation in individual, institutional and political decisions, while creating conditions for citizens to become more autonomous and responsible regarding their health and the health of those who depend on them, as well as promoting a positive view on health.

.9. Ratify and disseminate the charter of citizens' rights and duties in the field of health.

.10. Develop the planning, interventions, monitoring and evaluation in the area of Citizenship in Health: information and monitoring systems, preparation of evidence and recommendations, assessment and identification of best practices, promotion of an agenda for research and innovation.

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- .11. Promote the active participation of organisations representing the interests of the citizen (e.g., Patient or Consumer Associations, Private Institutions of Social Solidarity - IPSS, "Misericórdias", etc.).
  - .12. Ensure the development of citizenship-promoting skills by health professionals, both at pre-and post-graduate level, and monitor and assess the practices adopted.
  - .13. Promote, at institutional level, continuous improvement processes of the exercise of citizenship (e.g. regular assessments on the needs of citizens, interventions promoting participation and literacy).

**AT AN ORGANISATIONAL LEVEL, INSTITUTIONS SHOULD:**

- .14. Improve the citizens' knowledge of rights and duties, as well as promote the conditions for the exercise thereof.
- .15. Improve the citizens' confidence in the institutions and the conditions for its enhancement, through regular consultation of the users' needs, expectations, satisfaction and experiences.
- .16. Disseminate institutional information in a transparent way, by publishing performance progress indicators and results of the health services and professionals.
- .17. Promote, monitor and assess the exercise of citizenship in the process of decision-making, strategic development and assessment of institutions, implementing mechanisms for surveying the satisfaction levels.
- .18. Develop programmes in the area of health education and self-management of disease.
- .19. Promote voluntary service for a more active citizenship.

**IN THEIR PRACTICE, HEALTHCARE PROFESSIONALS SHOULD:**

- .20. Increase the provision of individualised and personalised care, with the participation of the patient in the therapy decision-making process.
- .21. Consider and assess the socioeconomic and cultural context, and tailor healthcare to the reality of the citizens, their family and community.



#### AT INDIVIDUAL LEVEL, CITIZENS SHOULD:

- .23. Proactively improve their knowledge and ability to exercise their responsibilities and rights, as well as to fulfil their duties in health.
- .24. Assume responsibility for the promotion of health and healthy lifestyles and actively participate in decisions regarding personal, family and community health.
- .25. Establish therapeutic alliances with healthcare professionals, forming partnerships in disease management.
- .26. Promote the rational and appropriate use of health services.

### 3.1.3. VISION FOR 2016

.27. There are **strategies for the empowerment of citizens and the increase in health literacy**, at national, regional, local and institutional level, which are intersectoral and involve both the private and social sector. They identify goals, instruments and assess their impact. These may involve public figures, sports institutions, educational programmes, and the media, among others. There is a social agreement on the messages, which is everyone's responsibility, as regards health gains, the adequate use of services and values underlying the Health System. The citizens perceive health priorities at national, regional and local level. Institutions and citizens share common views and expectations about development.

*Communication strategies assessed for achieving social agreements on priorities and expectations.*

.28. **Citizens should have electronic access to their personal health records**, which gather information from various care providers, complementary tests, a schedule for health monitoring and disease prevention, chronic disease management, as well as their own notes. This *file* is fed by clinical records, through formatted information (e.g. summary of the consultation or hospital discharge letter, lab results) and/or personalised information (e.g. notes written by the health professional). It is a privileged platform for issuing recommendations, personalised information, and support for the self-management of chronic diseases, which must be based on partnerships with scientific, professional and academic societies, and patient organisations, among others.

*Access to the electronic health record.*

.29. Regional health authorities, local authorities, primary, hospital and long-term care institutions, and health professionals have standardised and specific indicators for healthcare satisfaction and level of literacy, which enable them to monitor performance, identify best practices and implement processes of continuous improvement and accreditation. The indicators are stratified by

*Monitoring, assessment and enhancement of the promotion of citizenship at local and institutional level.*

sociodemographic characteristics and allow monitoring vulnerable groups. The planning instruments (national, regional, local and institutional plans; activity plans) include the review of this information and interventions aimed at improving citizens' satisfaction and experience. The evolution of the institutions' performance in these areas is part of the contract and assessment goals, in addition to the management of complaints and qualitative aspects related to the consultation and user experience. The institutions favour the **participation of citizens and their representatives** in the discussion of strategies and policies through public discussions, studies, consultancy, assessment and decision-making, among others. The institutions and professionals are valued for this engagement.

.30. The **Health Portal** has evolved into a privileged instrument of health information and access to services. It gives access to performance indicators of public, private or social institutions providing care. There is a private access area, with personalised information on the status of the citizen, as for benefits, registration in Primary Healthcare and specialty consultations, subsystems, insurance, waiting lists, and different clinical records, among others. It offers information, through messages or other means, on the access to and operation of health services. It is articulated with other services such as the Linha Saúde 24 hotline, for counselling and personalised guidance in real time.

*Online health information and support to the Health System.*

.31. Health institutions and public and private organisations of the civil society have developed brand and identity images, mission statements and charters of rights and duties that reflect their social responsibility, including responsibility for the health status of the community of which they are part, of the professionals and users, and processes of public participation and involvement (e.g. volunteer work). The **Community Councils** reinforce the existence of networks and partnerships, projects and development of health strategies at local level, informing the public and media on the resources and local social capital (e.g. support groups, community services), projects and ongoing activities and results, monitoring indicators of health status and satisfaction, adding social value to their work.

*Development of the local health system, through networks and partnerships.*

.32. The curriculum of **health professionals** includes curricular units on the assessment of personal and social communication, the humanisation of care, the relationship with the patient, as well as education and promotion of health. Professional associations and bodies promote the skills and the social role of professionals in these areas, valuing them.

*Competent professionals in communication, relationship and education.*

## 3.2. EQUITY AND ACCESS TO HEALTHCARE

### 3.2.1. CONCEPTS

.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 necessary and convenient quality care, at the proper place and time (Ministerio de Sanidad y Política Social, 2010).

.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 (Box 5).

.4. Adequate access is one of the health determinants with the potential to minimise inequalities, taking into consideration, among others, proximity services and the socioeconomic situation of the population (Box 6).

.5. Assessment of Health Needs - The accessibility planning is based on the assessment of needs, the quality criteria of the services, the principles of resource management and a proper distribution of the healthcare offer in the public, private and social sectors (Figure 4).

#### Box 6 – Health inequalities

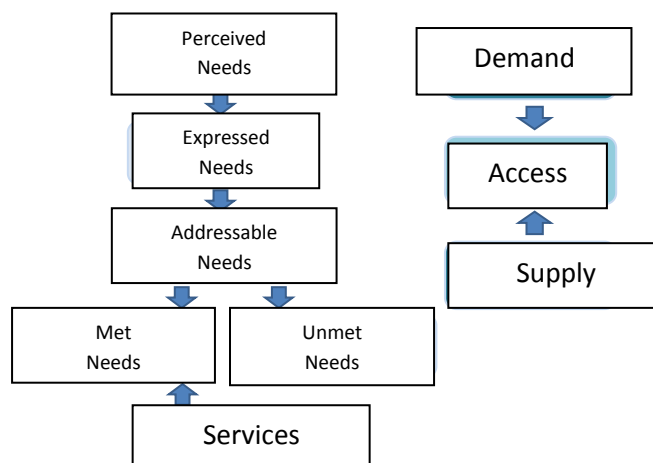
- They are strongly connected to social determinants (WHO, 2010a; Marmot M, 2007): socioeconomic and educational level, lifestyles, and access to healthcare. There is a social gradient in health status, in which the lower the individuals' position in the social hierarchy, the lower the probability of achieving their full individual health potential;
- They particularly affect vulnerable groups: due to their economic situation, individual constraints or age group.
- They affect the socioeconomic development of each country (Johnson S et al., 2008).
- 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 usually involves multi- and intersectoral actions.

#### Box 7 – Adequate access results from several interrelated dimensions

- Adequate demand for services; Availability; Proximity; Direct costs; Indirect costs; Quality; Acceptance.

Source: Furtado C, Pereira J, 2010.

Figure 4 – Health needs, demand and supply of services



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

.6. The following are identified as strategies and resources for the promotion of equity in the access to health:

- The use of information and monitoring systems.
- The implementation of specific projects aimed at obtaining additional health gains through the reduction of inequalities.
- The territorial organisation of healthcare services includes the Primary Healthcare Network, Pre-hospital Care, the Hospital Network and the National Long-Term Care Network.
- Articulation at each level of care, across levels and sectors, and among institutions.
- Citizen *empowerment* strategies.

.7. The opportunities and threats relating to Equity and Access to Healthcare can be analysed in more detail in the Annex.

### 3.2.2. GUIDELINES AND EVIDENCE

#### AT THE POLITICAL LEVEL, ONE SHOULD:

.8. Equip health information and monitoring systems as to enable them to include, in a comprehensive and coordinated way, the perspective of equity and access, allowing for care integration and support for decision-making at various levels, and provide the necessary information to consider the needs, resources, adequacy and performance of health services and outcomes.

- 
- .9. Establish, in an integrated way, benchmarks for the improvement of access to health services and the promotion of equity.
  - .10. Systematically evaluate the impact of institutional policies and practices in Health and other policies from other ministries and sectors in access and equity - Impact assessment.
  - .11. Prioritise resources in improving access, adequacy and performance of Primary Healthcare and Long-Term Integrated Care.
  - .12. Reinforce the articulation of health services, clarify the coverage and responsibilities of services and evaluate the adequacy and efficiency of the network response.

**AT AN ORGANISATIONAL LEVEL, INSTITUTIONS SHOULD:**

- .13. Publicise the evolution of equity and access indicators, as well as the commitments made for their improvement and the institution's response to the special needs of vulnerable groups.
- .14. Develop and monitor indicators and assess the equity, accessibility and adequacy of services.
- .15. Strengthen the contribution of health services, at a local level, for the reduction of the impact of social determinants, considering access as a key factor for the minimisation of inequalities;
- .16. Work in partnership with other sectors to develop integrated and proactive responses to the health needs of vulnerable groups.

**IN THEIR PRACTICE, HEALTHCARE PROFESSIONALS SHOULD:**

- .17. Develop and establish protocols for the articulation of care and invest proactively in effective communication between providers, both within and among institutions and services.
- .18. Act on the determinants associated to access as the key-factor for health inequities, promoting strategies to improve access, tailoring their services, providing a more flexible response, diversifying their practices, exchanging experiences and assessing their performance.
- .19. Promote the citizens' trust in their family doctor and nurse in a relationship that promotes proximity and continuity of personalised 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:

.20. Use access mechanisms in a way that is adequate to their health needs, understanding the advantages of resorting to fast and urgent guidance and to personalised long-term care, instead of making an improper use of hospital emergency services.

### 3.2.3. VISION FOR 2016

.21. In 2016, there are **accessibility and equity 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 maximise 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 health services. Institutions compete, establish networks and partnerships, and are evaluated by their response capacity, including access. The citizens realise that access, together with quality and their active participation, are domains in which health services search for continuous development.

*The institutions undertake public commitments of providing access conditions which are adequate to the needs.*

.22. Health professionals consider the patient's context and history, adapting and guiding their pathway in healthcare in a fast and effective way, and the responsibility of the case manager is very clear. Care providers communicate with each other and share information through the **integrated electronic** process and through other channels, ensuring an optimal, personalised and holistic response. There is a risk management system that foresees the scenarios of new medical care needs and facilitates the adequate access to healthcare 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.*

.23. Local, regional and national administrations, civil society organisations, such as patient associations and scientific societies, among others, **actively promote equity and the improvement of adequate access**. They participate in the information and empowerment of patients/citizens 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

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

in the identification of health needs and best practices. They promote the introduction and sustained dissemination of cost-effective technology and adequate access.

.24. 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

*Citizens have confidence in the response of the Health System.*

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.

.25. 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

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

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.

### 3.3. QUALITY IN HEALTH

#### 3.3.1. CONCEPTS

.1. Quality in Health can be defined as the provision of affordable and equitable healthcare, with an excellent professional level, taking into account the available resources, while achieving the citizen's adhesion and satisfaction (Saturno P *et al.*, 1990). It also implies the adequacy of healthcare to the needs and expectations of citizens and the best possible performance.

- Quality in Health depends on the interventions on: i) the healthcare structures; ii) the processes arising therefrom; iii) the outcomes, (UK Integrated Governance Handbook, 2006).

.2. Perspectives for the promotion of Quality in Health:

- The Law on the Fundamental Principles of Health (Law No. 48/90, as amended by Law No. 27/2002) grants special importance to the adequacy of resources and the performance of the Health System, aimed at the promotion of health and prevention of diseases. Such fact implies a holistic conception of health and imposes on healthcare providers the challenge of incorporating, within a framework of continuous quality improvement, the actions of health promotion and disease prevention the same way that they incorporate the provision of curative, rehabilitative or palliative care.

- Fostering a culture of continuous quality improvement implies equating prospects for its further development and implementation.

- The perspectives for the promotion of Quality in Health involve the promotion of the healthcare value chain (Box 7), understood as the processes that lead to greater achievement of gains, considering the investment made (Porter M, Teisberg EO, 2006).

**Box 8 - The promotion of quality in Health involves**

- Promotion of the healthcare value chain;
- Cycles of continuous quality improvement and professional and institutional development;
- Monitoring, *benchmarking* and evaluation (internal and

- Cycles of continuous quality improvement, through the systematic identification of problems and opportunities. These processes must be multidisciplinary, non-punitive, of the professionals' own initiative and associated with institutional professional development plans.

- Monitoring, benchmarking and evaluation (internal and external), including processes of accreditation, evaluation and identification of best practices, among others. These should occur at the levels of the professional, work team, service, institution and political decision-making.

.3. Strategies and resources for the enhancement of quality in health - Quality in Health depends on



the programmed intervention in certain areas:

- **Integrated Governance:** It encompasses clinical, corporate, financial, informational governance and risk management (UK NHS in East Essex, 2010). Clinical Governance is a reference for areas such as professional performance and technical competence, the efficient use of resources, risk management and patient satisfaction (UK Integrated Governance Handbook, 2006). Corporate Governance applied to healthcare is understood as a set of systems and processes by which health services lead, direct and control their functions in order to meet their organisational goals and through which they relate to their partners and to the community (UK Corporate Governance Framework Manual for Strategic Health Authorities, 2003). Information Systems are tools for quality improvement and cost reduction. Safety is a major dimension of Quality, and Risk Management represents a tool for its assurance.
- **Influence mechanisms,** such as: Clinical and Organisational Orientation Guidelines (NOCs); Structural aspects, such as architecture and environment; Funding models and care payment system; Human Resources Planning; Culture of quality assessment and development.
- **Integrated Care Processes:** These processes place citizens, with their needs and expectations, in the heart of the system and include, in a logic of continuous process, all the actions of health professionals. The approach by integrated assistance processes allows sorting and optimising the different workflows, integrating the different components involved in the provision of care, harmonising actions and focusing on outcomes.
- **Participation and empowerment of patients, families and informal caregivers,** including aspects of chronic disease management.

.4. The opportunities and threats relating to Quality in Health can be analysed in more detail in the Annex.

### 3.3.2. GUIDELINES AND EVIDENCE

**AT THE POLITICAL LEVEL, ONE SHOULD:**

.5. Enhance responsibility for integrated governance, including clinical governance at all levels and in all sectors of the Health System, in line with the National Strategy for Quality in Health.

- 
- .7. Assess the quality policy, by appointing external independent bodies, responsible for monitoring, preparing recommendations and regularly publishing the outcomes.
  - .8. Develop standardisation tools (*standards*) for the promotion of quality in clinical procedures, information, quality indicators, monitoring and assessment, training and management of services and institutions.
  - .9. Promote the accreditation of the healthcare-providing services.
  - .10. Strengthen the responsibility of general medical specialties, such as family and general medicine, internal medicine and paediatrics in the overall management of the case/person/family/caregiver and in the responsibility for the clinical pathway.
  - .11. Institutionalise the assessment of healthcare technologies as a prerequisite for the paced and careful introduction of innovation, including medicines, medical devices, information technologies, and organisation of care.
  - .12. Promote the adoption of actions with better cost-effectiveness and avoid waste.
  - .13. Develop mechanisms to promote benchmarking, the identification of best practices and the improvement of the value chain.

**AT AN ORGANISATIONAL LEVEL, INSTITUTIONS SHOULD:**

- .14. Establish quality policies at an institutional level, including strategies and processes to promote quality, monitoring, safety, identification and correction of errors.
- .15. Establish quality policies at an institutional level to ensure the quality of care and the safety of patients/users and professionals.
- .16. Monitor the satisfaction levels of citizens and professionals.
- .17. Promote training sessions on Quality in Health in healthcare organisations, focusing on the use of standards and guidelines according to the most recent scientific evidence.
- .18. Assess and disseminate the quality and cost-effectiveness of institutional practices, in a rigorous and transparent way.

**IN THEIR PRACTICE, HEALTHCARE PROFESSIONALS SHOULD:**

- .19. Ensure the constant search for a vision for Quality in Health, understanding the healthcare value chain of which they are a part of and promoting and employing practices and skills of continuous improvement.

.20. Have a specific view on patient safety and risk management in their individual and personalised actions, as well as in aspects of overall quality.

.21. Strengthening the responsibility of health professionals in the promotion of health, prevention of disease and, where appropriate, management of the disease.

#### AT INDIVIDUAL LEVEL, CITIZENS SHOULD:

.22. Contribute to the improvement of Quality in Health.

.23. Increase their knowledge and skills associated with their individual responsibilities, becoming an active partner of a quality Health System.

### 3.3.3. VISION FOR 2016

.24. Institutions compete to demonstrate the **quality of their services and professionals**. Professionals and patients/users can verify the progress in technical and human aspects of healthcare, in the management and articulation between institutions, driven by the accreditation process. The process for institutional monitoring of

*Institutions take on continuous quality improvement as their culture.*

quality and access indicators is consistent with the areas of epidemiological and clinical relevance, management, quality and patient safety, taking on a strategic character in the development of the institution and its professionals, while closely associated with training and research. Professionals feel rewarded for their commitment to continuous improvement, whether of a financial nature, or in the conditions for innovation and for developing their own projects, or in the recognition both by citizens and the institution. Continuous improvement and compliance with standards of excellence and reference are part of the identity and mission of the institutions.

.25. Institutions and services/departments have a **vision of development based on the improvement of quality integrated into a network of shared responsibility**, with emphasis on the complementarity between proximity, versatility and specialised services. They consider the area of influence, the optimal relationship between concentration of resources (services, technology, specialised human resources) and

*The development plans of the institutions/services are articulated and contracted.*

accessibility (within a geographic network of resource allocation). Contractualisation reinforces this view, as well as the responsibility of each unit within the network in which it operates and the articulation with all others. It is based on the negotiation of goals and responsibilities, in a logic of coherent and continuous development, which complies with the plans articulated at the different levels (national, regional, local and institutional), of various natures (type of services and distribution of technology, human resources, training, referral networks), and strengthening strategic development programmes (e.g. integrated management of disease, quality or research, among

others).

.26. There is an **Electronic Health Record (RSE)**, with adequate access and security levels to ensure the privacy of the data. It is shared by public and private care providers and provides information to citizens on their medical condition, including emergency episodes. The duly authorised health professional has access to the medical history, diagnostic tests and therapies, for a well-informed clinical decision, lower risk, information sharing between providers and a better therapy balance. The RSE is also associated with clinical guidance protocols for prevention (e.g. scheduling of vaccination and screenings) and chronic disease surveillance, through notices, thus reducing missed opportunities in the contact with the different care providers. It also warns about drug interactions and predefined safety situations, while respecting the autonomy of healthcare professionals. This record features an interface for the citizen, thus being an instrument of communication, literacy, and support to self-management and empowerment. It also allows the creation of statistical indicators on the quality of the clinical pathway, the integration of care and adherence to NOCs. Professionals feel the need to maintain their records properly documented and valid, as they are shared and informative for the citizens themselves, for adequacy and professional and institutional performance statistics, and also support clinical research.

*The Health Data Platform promotes quality and continuity of care.*

.27. The **training of professionals** includes: i) prospects and determinants of structure, process and outcome that influence the quality of the acts; ii) patient safety and risk management; iii) skills for continuous quality improvement; iv) aspects of multidisciplinary teamwork, communication and health education. It also includes skills for a critical approach to scientific evidence, for engagement and decision sharing with the patient, for auditing and preparing clinical essays/assessments, for participation in research. Professionals are assessed for suitability and performance of services, including knowledge, skills, clinical attitudes and management of their activity, teamwork and relationship with the citizens.

*The training and assessment of professionals focus on continuous quality improvement.*

.28. Health professionals have access to updated **Clinical Orientation Guidelines** that incorporate scientific evidence and respond to the most common and relevant situations. The NOCs adequately assume the context of the practice of care, multidisciplinary care, multiple pathologies, use of multiple medications, risk management and clinical pathway perspective, enabling case management and teamwork. The NOCs promote the best service efficiency and establish comparative quality standards, including indicators of access, adequacy and performance, with more cost-effective actions. Professionals adopt and implement NOCs within their teams, disseminating the health institution as a benchmark to citizens/users/patients. Institutions have explicit policies for the adoption, implementation and assessment of compliance and impact of

*There are national references on quality standards of care, supporting clinical decision, integration and coordination of care, and interdisciplinary work.*

the NOCs and participate in their creation and review. Academia, scientific societies, patient organisations and the industry (pharmaceuticals, medical devices and information technologies) are the driving force behind the creation of NOCs, whose quality, certification and assessment are conducted by an independent body.

.29. The assessment of policies, institutions and professionals is regarded as an essential step in the process of continuous improvement, credibility and valorisation of all stakeholders and is also considered a learning process for organisations, which is vital to their dynamics. The State takes on a positive regulatory role by ensuring high quality resources and tools for the systematic evaluation

*Promoting an assessment culture, at all levels.*

of policies, institutions and professionals. These resources include (*corporate governance*), clinical governance, systems to support decision-making (at the political, managerial and clinical level), monitoring, identification of best practices and assessment. Institutions, services and departments promote **internal processes for the continuous improvement of quality**, accreditation processes and participate in external evaluations as highly enriching processes in which similar institutions within the public, private and social sectors, professional bodies and associations, scientific societies and patient associations are also involved.

## 3.4. HEALTHY POLICIES

### 3.4.1. CONCEPTS

.1. Healthy Policies are policies established by the government, municipalities and other sectors, which define parameters and priorities for action: i) in response to health needs; ii) in the distribution of health resources; iii) in optimising positive health impacts, mitigating negative impacts, and in response to other political priorities (Glossary, WHO 1998).

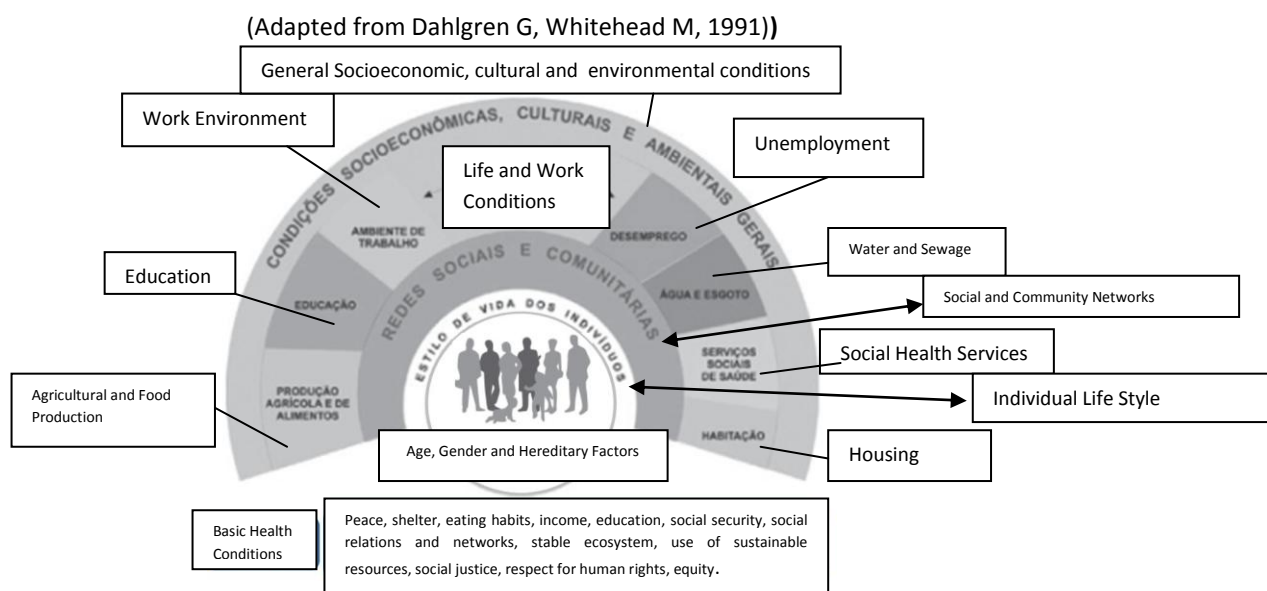
.2. They are materialised in legal, regulatory, normative, administrative or other measures, aimed at creating favourable environmental, social, economic and cultural conditions for the individual and collective health. These measures should contribute to making healthy choices easier for citizens, making them more accessible to all (WHO Adelaide Statement, 1988).

.3. It is a comprehensive concept, which holds not only the health sector accountable, but all others, including the private and the third sector, which should contribute to the creation of physical and social environments that promote well-being and health of populations, ensuring that every citizen has equal opportunity to make healthy choices (WHO Health Report, 2010).

.4. Health and well-being are the result of basic conditions (WHO Jakarta Declaration, 1997) and of the complex interplay of multiple biological, behavioural, ecological and social factors (Figure 5) (Dahlgren G, Whitehead M, 1991), and therefore the responsibility for the promotion of health

involves all sectors.

**Figure 5 – Model of Health Determinants**



.5. The concept of Healthy Policies encompasses the dual perspective of Public Health Policies and Health in All Policies:

- Public Health Policies are efforts primarily organised and aimed at benefiting the health status of a population, emphasising the protection and promotion of health and the prevention of disease, in addition to the provision of healthcare. They can be Global or Specific to the health system:
  - Global - the health sector can take up positions of leadership, support, partnership and/or advocacy for the development of intersectoral action (Ferrinho P, Rego I, 2010).
  - Specific to the Health System - geared towards the coordination, regulation, production or distribution of health goods and services. For example, healthcare access.
- Health in All Policies is an explicit strategy of intersectoral approach, based on the evidence that actions and policies taken under the initiative of sectors outside the health sector have positive or negative impacts on health and equity (Kickbusch E, 2007; Svensson PG, 1988). It aims at achieving gains in health and quality of life, through interventions targeting social determinants of health.

.6. Healthy Policies can be viewed from multiple scales of design and implementation, involving policy-makers, local authorities and/or other institutions, as well as civil society organisations, communities and families.

.7. In this sense, Public Health Policies should:

- Be based on the identification of health priorities.
- Prioritise interventions resulting in greater impact on the achievement of sustainable health gains.
- Establish trade-offs between opportunities, resources and priorities at local, regional and national level, in order to maximise health gains at each level of intervention.
- Promote access, quality, citizenship, and reduce inequalities.

.8. Health promotion is a participatory, holistic, intersectoral, equitable and sustainable process, based on combinations of multiple strategies (WHO Evaluation in Health Promotion, 2001).

.9. Strategic planning defines the priorities for Public Health interventions and enables the evaluation of plans, strategies and actions, at various levels, according to the following sequence: i) assessment of health needs; ii) identification of target-determinants and of potential gains; iii) identification of the most effective interventions; iv) prioritisation. The aforementioned evidence of impacts, interventions based on models and the involvement of agents and recipients are essential for the identification of health gains.

.10. Healthy Policies are based on strategies and resources, such as: regulatory measures; institutions, agencies and departments; platforms and intersectoral partnership networks; planning and governance of Health Programs; knowledge management and evidence-building system; sanitary and epidemiological surveillance systems; organisation of health care; medium- and long-term media and social *marketing* strategies; preparedness and response to Health threats; health impact assessments.

.11. The opportunities and threats relating to Healthy Policies can be analysed in more detail in the Annex.

### 3.4.2. GUIDELINES AND EVIDENCE

#### AT THE POLITICAL LEVEL, ONE SHOULD:

.12. Systematically maximise existing opportunities and create new opportunities, developing leadership and incorporating Health in All Policies.

.13. Develop and provide evidence bases on the effectiveness and cost-benefit of interventions and policies within Healthy Policies.

.14. In a critical manner, use a broad reference framework in the evaluation of health needs, identification of health determinants, prioritising of interventions and monitoring/evaluation of the impacts of policies at various levels and in various sectors.

.15. Integrate and provide longitudinal and geo-referenced information on the sociodemographic monitoring of health, with indicators, services and resources at all levels and from all sectors, including interventions that are the responsibility of various levels and agents, as well as their expected impact on health (targets).

.16. Promote and test different models for planning, financing, joint management and intersectoral assessment of initiatives and services with an impact on health, in order to help institutions integrate multiple intersectoral strategies.

.17. Foster the systematic evaluation of national, regional and local opportunities for the development of Healthy Policies.

#### AT AN ORGANISATIONAL LEVEL, INSTITUTIONS SHOULD:

.18. Ensure intersectoral preparedness and responses to Public Health threats.

.19. Promote dialogue, networks and partnerships of intersectoral and multidisciplinary interventions within and between institutions, in planning, provision of services and evaluation processes.

.20. Promote opportunities for intervention, training and multidisciplinary and intersectoral research, in order to strengthen the awareness and skills of health professionals.

.21. Resort to common benchmarks for information, prioritisation, resource allocation, monitoring and assessment procedures.

.22. Strengthen Local Health Strategies (ELSA).

#### IN THEIR PRACTICE, HEALTHCARE PROFESSIONALS SHOULD:

.23. Raise awareness among health professionals about the relevance of an intersectoral approach and intervention in health and of the development of skills that allow making the most of working together with professionals from other sectors.

.24. Promote regular training in the area of Public Health, including the definition of policies, planning, implementation, monitoring and evaluation, and the engagement of all stakeholders, including the recipients of healthcare.

#### AT INDIVIDUAL LEVEL, CITIZENS SHOULD:



.25. Be aware of the need to comply with the measures for the protection and promotion of health. The same is true for civil society.

.26. Actively participate in the promotion and protection of health, both individual and collective.

### 3.4.3. VISION FOR 2016

.27. Healthy Policies should promote a **positive view of health**, as a resource that allows citizens, families and communities to realise their full potential. With the increase in the levels of health literacy, active ageing and prevalence of chronic diseases, globalisation and social interculturality, the strengthening of social networks and the focus on economic and environmental sustainability, an isolated, fragmented and purely technical response by the Health System in the prevention and control of diseases will be increasingly insufficient. Healthy Policies should promote, in all contexts and activities, a culture of health as a social value, focusing on quality of life, equity, reduction of social inequalities, and individual and social skills.

*The culture of health is a highly valued social capital.*

.28. The various sectors work together through a network of strategic offices. They analyse the legislative agenda of measures which will potentially have an impact on health, they optimise the positive character of that impact, they conduct preparatory studies and impact analyses and they create opportunities for reinforcing intersectoral work. This work has a strong technical support from health institutions and organisations outside the sphere of health (public and private), from academia, scientific societies and patient associations, allowing their influence, input and involvement in the planning, implementation, monitoring and evaluation of Healthy Policies. There is a similar model **of an intersectoral network, at the regional and local level**, which reinforces the opportunities for a synergistic articulation between levels.

*Health in All Policies is a pillar of central and local governance that systematically seeks opportunities for creating and making the most of Healthy Policies, with the involvement of several sectors.*

.29. Institutions, within and outside the health sector (e.g. schools, social care homes, prisons), local authorities, ACES, ARSs and other levels of planning have the capacity and the responsibility to **monitor the health status of the population** they serve and to incorporate improvement actions into their strategic plans. The monitoring system creates reports with common health profile models, which enable longitudinal analysis, comparison of performance between levels, calculation and projection of indicators, detection of local specificities and support to informed decision-making on potential gains, priorities and impact of the interventions. There is a temporal and geographic

*Institutions, local authorities, groups of Primary Care centres and local health strategies, with innovative and specific responses, articulated between themselves and at the national level.*

mapping and a follow up of interventions relevant for Public Health, which include local health strategies. The health status and performance indicators of the Health System make it possible to cross-reference socioeconomic, environmental, social resource, local services and policies data and provide information on health inequalities and on the contribution made by organisations to their reduction.

.30. There is a **social agreement and a medium to long-term view of health needs, potential gains and priorities at national, regional and local levels** that make it possible to plan, implement and evaluate Healthy Policies on a stable basis. The institutions are aware of their capacity

*A medium to long-term vision of health gains allows the development of Healthy Policies, institutions and professionals.*

and responsibility for obtaining gains and are valued by their adequacy and performance. Governance strengthens the Health System through cross-sectional regulation, strategies and instruments, which increase the capacity, autonomy and empowerment of institutions, health professionals and citizens. Feedback on the performance of institutions and professionals is provided, as a way to encourage continuous development, multidisciplinary work, the engagement of citizens and professional satisfaction. There is an evident interdependence between professionals, institutions and sectors in order to obtain health gains.

.31. Healthy Policies are constructed and analysed based on solid scientific evidence, giving priority to interventions for which there is a proven cost-benefit ratio. Both the impact of Public Health interventions and programmes and the impact on health of other sectors' policies are **systematically evaluated**. This culture exists at a central, regional, local and institutional level, and leads to an intensive exchange of experiences and knowledge, to discussions on Public Health and general health recommendations and decisions in all policies, thus strengthening the influence of Public Health. These processes of monitoring, of evaluation of opportunities and of influence over health policies and management of health resources, in an articulated and integrated manner, increase the social and the Health System's response capacity to the needs and threats posed to health.

*Healthy Policies are strengthened by scientific evidence and by the evaluation of cost-effectiveness and impact.*

.32. Health is a fundamental value for social well-being, identity and development. It is recognised that Health contributes to economic and social development and is dependent on other sectors, such as education, economy, social security, environment, spatial planning, research and innovation, etc. As such, gains result more or less directly from these sectors and also have an influence on their objectives. This understanding has a political and social nature and therefore the importance and the social **discourse on health transcend the individual, economic, health access and quality of services perspective**.

*Health is a fundamental value for social fulfillment, identity and development.*

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## 4. GOALS FOR THE HEALTH SYSTEM

### 4.1. OBTAINING HEALTH GAINS

#### 4.1.1. CONCEPTS

- .1. Improving the level of health of all citizens is one of the main objectives of a Health System.
- .2. The complexity of Health determines that it is necessary to regularly define the areas in which a programmed intervention will result in better health for the population. The NHP has that responsibility: to identify the gains to be obtained, in order to guide the Health System to make the most appropriate use of available resources.
- .3. Health Gains are understood as positive outcomes in health indicators, and include references about their evolution.
  - These express the improvement in outcomes (Nutbeam D, 1998) and translate as gains in years of life, reduction of disease episodes or shortening of their duration, reduction of temporary or permanent disability situations, increase of physical and psycho-social functionality and also reduction of avoidable suffering and improvement of health-related or health-conditioned quality of life.
- .4. Potential Health Gains are those resulting from the ability to intervene over avoidable, controllable or quickly solvable causes. These are calculated considering the time evolution at national, regional or local level, in an inequality reduction logic.
  - In the health planning process, there is, at all levels, a responsibility to identify health needs, Potential Health Gains and priority interventions capable of achieving those gains with the resources available.
- .5. The estimation of Potential Health Gains is included in the monitoring strategy of the NHP, with the following aims:
  - To identify the areas and, subsequently, the interventions with higher potential for obtaining health gains, including the perspective of inequality reduction;
  - To establish the relationship between the health needs and the response of the Health System (adequacy) and between the latter and the use of resources (performance);
  - To define responsibilities, objectives, targets and interventions by the Health System stakeholders through determinant models;

- To be based on existing information, but part of an updatable and evolving process.

.6. Potential Health Gains present a multidimensional perspective, including mortality, morbidity, disability, satisfaction, Health System response and sustainability.

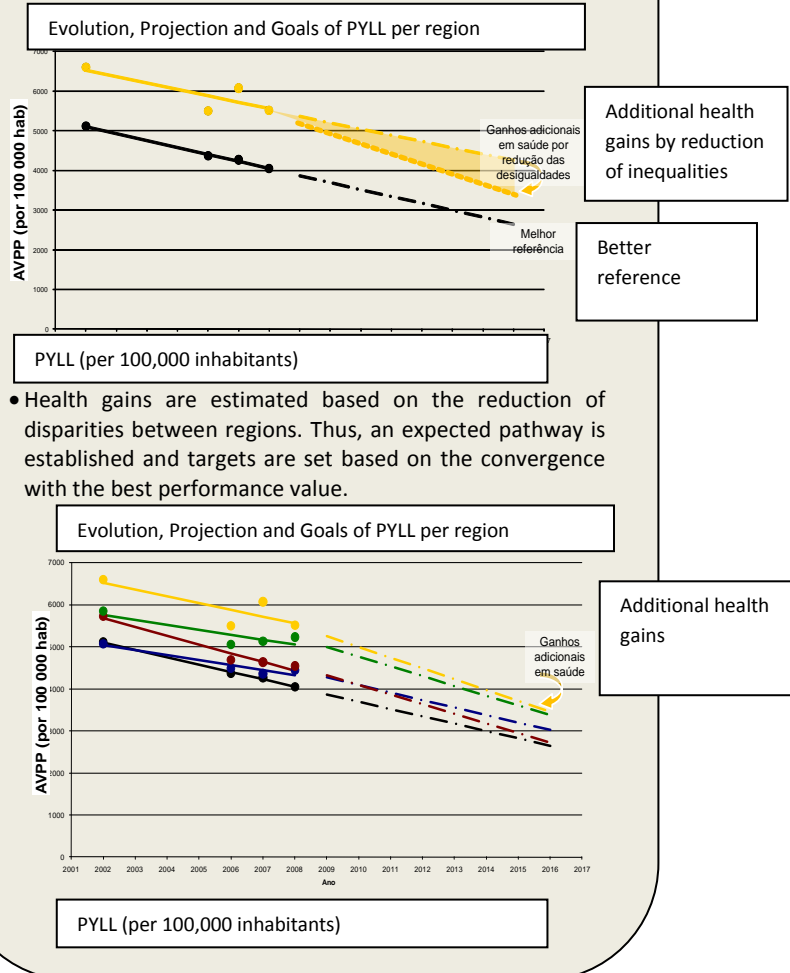
.7. The NHP proposes, as the base for the identification of Potential Health Gains, the consideration of areas with the greatest inequalities among levels. Thus:

- National Priority Areas are identified as those where Portugal has a wider difference (gap), *when compared* with other countries with better levels;
- Regional Priority Areas are those where a region finds itself with a wider difference when compared to other with better values;
- The same process is applied to the definition of local priority areas and priority areas for the institutions themselves, using as reference the comparable unit of the same level with better values.

.8. Targets are defined as expectations in terms of pathway and values to attain. The target definition process must follow rules that are common to the several levels, so as to maintain the coherence and the value creation chain between levels. The method to calculate Potential Health Gains and the definition of targets may be applied to the several health indicators with regular measurements, considering social and demographic stratifications.

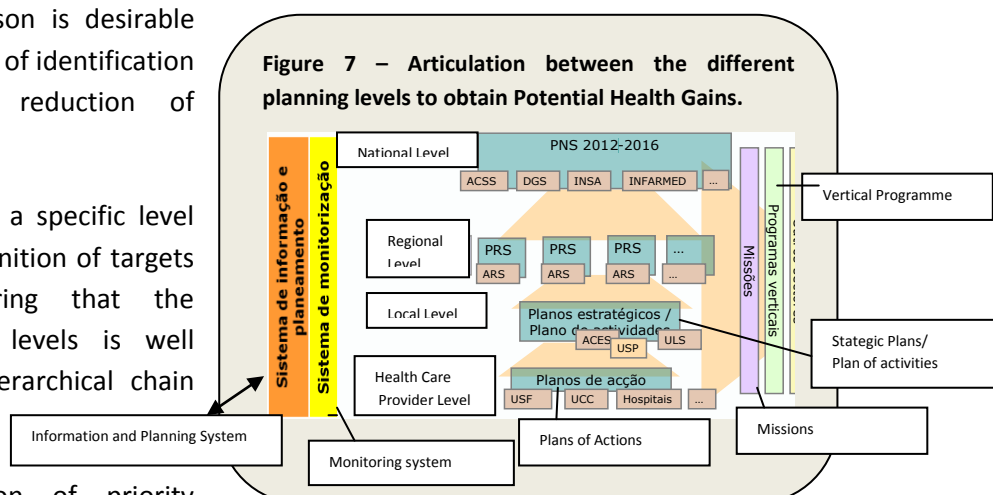
**Figure 6 - Target definition process (illustration)**

- Evolution of the Potential Years of Life Lost (PYLL) indicator by Health region.
- In the first figure, the performance projection of a health region is compared to the region showing the best performance (in this case, the lowest value).



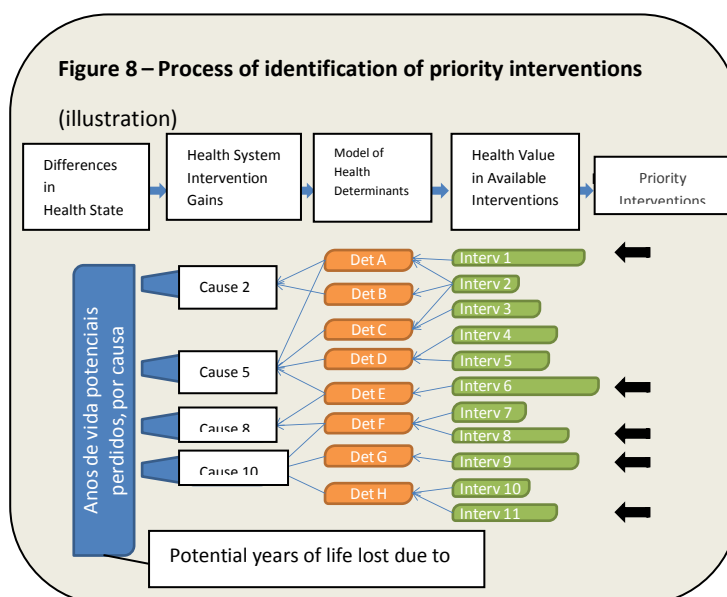
- The setting of targets shapes the tendency of indicators, allowing creating an expectation of their evolution, assuming that the conditions are maintained, as well as identifying the units with the best performances to be used as a reference (Figure 6.). For units with similar structure and responsibility, this comparison is desirable and reinforces the processes of identification of best practices and reduction of inequalities.

.9. The definition of targets at a specific level should be reflected on the definition of targets at subsidiary levels, ensuring that the contribution of the several levels is well identified and valued in a hierarchical chain (Figure 7).



.10. The process of selection of priority interventions may be represented as follows (Figure 8.):

- Ranking of health status gaps between units of a certain level (e.g. ACES);
- Identification of causes suitable for intervention, namely those sensitive to healthcare and primary prevention;
- For each cause, the most important determinants for which there are interventions are identified. One determinant may be associated with one or more causes or constitute itself as a set of determinants;



- An intervention may have as its object one or more determinants and it may be a set of strategies (e.g., a set of clinical orientation guidelines);
- Analysis of interventions with the highest and most cost-effective predicted return in health gains, which will depend on the nature of the intervention, but also on whether it is capable of affecting various determinants which, in turn, operate on several relevant causes;

- The available resources should be distributed by the interventions with higher return per cost. Such interventions are considered a priority.

#### 4.1.2. GUIDELINES AND EVIDENCE

##### AT THE POLITICAL LEVEL, ONE SHOULD:

.11. Identify the areas with higher potential health gains, which should be subject to determinant model analyses and to an identification of interventions with a cost-benefit ratio that may allow allocating resources and investment in order to obtain those gains.

- This process should have national benchmarks and, whenever appropriate, regional and/or local adaptations;
- The interventions should preferably be integrated in institutions, making use of their resources, and not form vertical structures.
- These interventions should be very well defined in their scope, governance and engagement model, duration, information, monitoring and impact assessment process, as well as concerning the expected gains on the national, regional or local level.

.12. Establish targets and goals for regions and institutions, which include performance, planning instruments and the expectation of obtaining health gains, so as to value those aspects in the contractualisation and distribution of resources, and as to align and articulate institutions and professionals in order to obtain the identified health gains.

.13. Create the conditions so that the several information systems allow interoperability, monitoring and assessment.

.14. Systematically improve the quality of information, through system architecture and training of professionals.

.15. Align Local and Regional Health Plans with the NHP, taking into account that the implementation of the strategies must follow the guidance for areas considered a priority nationwide.

##### AT AN ORGANISATIONAL LEVEL, INSTITUTIONS SHOULD:

.16. Be prepared to understand their ability to contribute for health gains at the level of their mandate and at higher levels (local, regional and national), as a way to promote their value and the value of their professionals.

.17. Adopt and maximise the effect of recommendations, guidelines and policies aimed at achieving health gains, whether in the scope of their mandate or cooperating with other institutions, within and outside the health sector.

.18. Promote the allocation of internal resources towards obtaining health gains in priority areas, based on interventions with proven cost-benefit ratio or intervention research that is considered promising.

#### IN THEIR PRACTICE, HEALTHCARE PROFESSIONALS SHOULD:

.19. Ensure high quality records, understanding their value, not only for direct, long-term and multidisciplinary care of the citizens, but also for the information, organisation and performance of the Health System.

.20. Promote continuous improvement of performance in the areas and interventions considered priorities.

.21. Develop, research, assess and disseminate innovative strategies for specific situations and contexts in the scope of the areas considered priorities.

#### AT INDIVIDUAL LEVEL, CITIZENS SHOULD:

.22. Mobilise, at several levels, around the areas where there are increased delays and health losses, as a result of social conditioning, many of which are signs or results from socioeconomic, educational or family and social support inequalities.

### 4.1.3. VISION FOR 2016

.23. The **areas of potential health gains** are a motive of focus and alignment at all levels. There is an articulated strategy between the health sector and the remaining sectors. Indicators related to structure, process, intermediate and final results show those efforts, rewarding the Health System's ability to converge its actions towards economic development and social welfare.

*Portugal is coming close to the best European values in the areas identified as having potential health gains.*

.24. There are comprehensive and concrete conceptual models in the identified areas and their determinants. The possible cost-effective interventions were implemented, based on national strategic recommendations that embody both national and international evidence. Their impact, interventions and necessary resources, monitoring and assessment are well defined. They have a **perspective of integration, alignment and empowerment of the Health System**, avoiding one-off, unsustainable or non-integrated interventions. They acknowledge the sharing of determinants and intervention strategies. There is a mapping of national, regional and local policies and strategies, of indicators and of impact assessments in a continuous work to assist in decision-making, contractualisation and

*There are national recommendations that define the cost-effective strategies for the areas identified as having potential gains.*

local health strategies at all levels.

- .25. **Regional Health Plans**, as well as **Local Plans**, are in line with the national strategy and contribute in an articulated manner, for the attainment of national targets. The regions have also developed specific strategies in the areas identified as having potential regional gains and have defined their impact, interventions and necessary resources, monitoring and assessment. There is a mapping of regional and local policies and strategies, of indicators and of impact assessments.

*The regions develop specific strategies in the areas identified as having potential regional gains and define their impact, interventions and necessary resources, monitoring and assessment.*

- .26. Each institution identifies **opportunities for intervention and improvement of access, quality and citizen engagement**. This is the basis of the services and interventions proposal in contractualisation, considering also the perspective of sustainability. The institutions promote and are part of networks, partnerships and local health strategies, as a way of capitalising interinstitutional and intersectoral gains and synergies. They monitor the impact of their actions, being valued for the contribution they provide. High impact interventions are proposed as best practices and their model is disseminated. Citizens and professionals feel the value of institutions in the attainment of such gains.

*The institutions articulate efforts, monitor interventions and assess the impact of their activity.*

- .27. There is a **perspective of integration and development of information systems**, in order to empower the several levels of decision-making so as to identify potential health gains, priority interventions and monitor activity and performance. This perspective is based on an information systems development plan, reviewed annually, resulting from the engagement of the different interested parties. The reliability of information systems enables the reformulation of policies and priorities and the improvement of the Health System's quality in terms of decision, performance and monitoring. A better understanding and capacity to mobilise society and institutions around objectives and determinants is progressively built, because it becomes clear that they have an influence on citizens' health, economy and potential well-being.

*Integrated information systems enable planning, decision-making and monitoring of the Health System's performance.*

## 4.2. PROMOTING SUPPORTIVE ENVIRONMENTS FOR HEALTH OVER THE LIFE CYCLE

### 4.2.1. CONCEPTS



.1. The Health System assumes the responsibility for promoting, enhancing and preserving health, recognising individual potential, over the life cycle, at every moment and in each environment.

.2. Health does not accumulate but results from a history of health promotion and prevention of disease and its complications, from the adoption of healthy behaviours and life in healthy environments.

.3. The individual health journey is not constant; it has specific needs and particularly important moments - Critical Periods - which, due to the way they occur, directly influence, positively or negatively, the next stages of life (Health Promoting Health Systems. WHO, 2009). The intervention in these moments - Windows of Opportunity - promotes and protects health and may have great relevance in the medium- and long-term (Social determinants of health and the role of evaluation. WHO, 2010).

.4. The perspective of the life cycle approach:

- Highlights the opportunity of early intervention on risk factors.

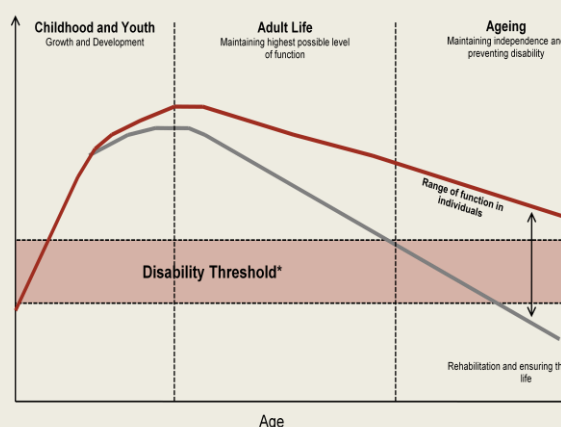
- Returns gains in health and sustainability, by strengthening a chain of maximisation of the positive effects or mitigation of the negative effects of risk factors and determinants.

- Cumulative health losses determine the early onset of disability and chronic and degenerative diseases (Figure 9).

- Health promoting contexts are synergistic in creating opportunities among themselves and with the health services. Contexts with various levels may be considered, according to health determinants. These are associated with life stages, those of greatest vulnerability, but can also be transversal to the entire life cycle (e.g., family).

.5. Each profession or activity, in its context, has an impact on the health and well-being of individuals and the community. Professionals must cultivate a holistic and salutogenic perspective of health and value their work also by its impact on health and well-being. Health shall result from a multidisciplinary work, in which each profession contributes with its knowledge and responsibility.

**Figure 9 – Loss of Health Capital Over the Individual Journey**



Source: Active Ageing: A Policy Framework WHO, 2002.

.6. The life cycle approach allows to maintain continuity with the intervention strategy of the NHP 2004-2010, according to **Box 8**. Death is also addressed in Dying with Dignity.

.7. The following are identified as strategies and resources to promote supportive environments for health:

- Strategic management and sharing of operationalisation between different sectors;
- Orientation guidelines for the assessment of health needs according to life cycle stage;
- Guidelines and protocols for cooperation and articulation between institutions and sectors; Multi-sectoral programmes;
- Management of multi-sectoral/interdisciplinary knowledge;
- Systems for information, monitoring and assessment of the health status and impact on health which allow: Monitoring the influence of each context;
- Identifying characteristics that promote and protect health;
- Integration of actions across sectors communication, intersectoral training and empowerment of citizens and informal caregivers on health.

**Box 9 – Stages of the Life Cycle:**

- **Be Born Healthy**, pregnancy and neonatal period;
- **Growing Safely**, post-neonatal up to 9 years;
- **Young People Seeking a Healthy Future**, 10 to 24 years;
- **A Productive Adult Life**, 25 to 64 years;
- **An Active Ageing**, over 65 years.
- **Dying with Dignity**.

.8. The opportunities and threats relating to Promoting Supportive Environments for Health Over the Life Cycle can be analysed in more detail in the Annex.

## 4.2.2. GUIDELINES AND EVIDENCE

### AT THE POLITICAL LEVEL, ONE SHOULD:

.9. Develop benchmarks and guidelines that encourage opportunities for promotion and protection of health and prevention of diseases and their complications throughout the life cycle (critical periods and windows of opportunity), according to contexts, physiological conditions and special needs.

.10. Include recommendations, mechanisms and tools in programmes and clinical guidelines that may facilitate the identification and understanding of health needs sensitive to the influence of context and encourage the integrated action of other professionals.

- 
- .11. Include guidelines and tools that facilitate the identification and understanding of health needs which are sensitive to the influence of context and promote social responsibility in programmes, recommendations and quality/accreditation criteria of practices and institutions within and outside the health sector.
  - .12. Develop benchmarks and guidelines to identify critical periods and windows of opportunity where the potential for health promotion and disease prevention is high, for signalling and articulation with healthcare.
  - .13. Enhance information and health monitoring systems, so that, in a comprehensive and integrated manner, it may be possible to: know the health and risk potential associated with each context; measure the results of activities and interventions with impact on health; review health indicators from a life cycle standpoint.
  - .14. Assess the impact on health of policies and practices of other contexts with greatest potential for improvement and/or health risk.
  - .15. Promote in society a culture of valuation of health that recognises contributions from individuals, health services and from institutions outside the health sector.
  - .16. Strengthen the articulated contribution of health services and local stakeholders in improving the population's health, taking into account the determinants and an approach centred on the promotion and protection of health, and on the prevention and treatment of disease.

**AT AN ORGANISATIONAL LEVEL, INSTITUTIONS SHOULD:**

- .17. Identify health problems and priority opportunities for health promotion within their context and level of performance and proactively seek the collaboration and contribution of institutions and resources outside the health sector in synergistic and articulated responses.
  - .18. Share information and analysis on health needs and potential interventions allowing institutions outside the sphere of health and communities to understand their own health profile, their specific needs and prioritise local or specific health strategies.
  - .19. Develop training, intervention and intersectoral cooperation activities at local, regional and national levels in order to create synergies, continuity of action and the connection of professionals and institutions to give proper response to health needs.
  - .20. Collect and share information and analysis on health, environment and health determinants data related to professionals, clients and/or groups of the population directly or indirectly influenced by the activity or responsibility of the institution, in order to understand the health needs and opportunities for intervention in these groups.
-

.21. Develop the social responsibility of institutions and their professionals for providing opportunities for health and healthy choices, promoting a salutogenic culture, and for the development of relations and interinstitutional and intersectoral initiatives aiming at the promotion of health and prevention of disease.

.22. Enhance, share and develop, within a network, the health projects and outcomes developed by institutions outside the health sector.

#### IN THEIR PRACTICE, HEALTHCARE PROFESSIONALS SHOULD:

.23. Incorporate aspects of health and well-being of citizens and populations in the mission of their career, from the standpoint of a Health System stakeholder, with capacity and responsibility of producing and/or protecting health.

#### AT INDIVIDUAL LEVEL, CITIZENS SHOULD:

.24. Create the expectation, value and cooperate with health institutions and those outside the health sector in their efforts to promote health and prevent disease, including the development of local, regional and national actions at the initiative of the citizens themselves.

.25. Understand their health potential, health determinants and specificities associated with their life cycle stage and context, and develop the knowledge, attitudes, skills and responsibility to promote health and prevent disease for themselves, their families, communities and the context in which they live.

### 4.2.3. VISION FOR 2016

.26. The institutions know the **health profile** of their professionals, clients or groups under their influence (e.g. municipalities, schools, universities, homes, workplaces, prisons, sports associations, etc.). That profile is developed in collaboration with other institutions, including health institutions (information and analysis), and aims to identify priorities in health which are sensitive to intervention within the context of the institution, whether it is a specific intervention of this institution or through interinstitutional and intersectoral collaborations. This analysis provides a health potential under the influence or the responsibility of the institution and identifies the resources that the institution has to promote health and prevent disease, including cooperation protocols, interventions with proven effectiveness, or other institutions' and/or community specific resources accessible to the institution. These profiles are typified and developed, on a regular basis, from the adequacy of models and with networked technical support, including from health professionals and institutions. Institutions, over

*In each context, the opportunities for health promotion and prevention of the disease, under the responsibility of institutions, are clearly identified, including those that make use of intersectoral*

time, understand the impact of their policies and actions in the health status of populations under their influence.

.27. There is a **holistic perspective adapted to the life cycle** and the notion of health potential worth promoting and preserving. In the different contexts, critical periods and windows of opportunity, as well as their criteria for successful stages, are clear. These include educational and behavioural aspects, of social support and signalling criteria, interprofessional, intersectoral and interinstitutional

*The institutions collaborate and develop intervention, signaling and articulation networks, with their own monitoring and*

articulation and referral. These criteria, and the respective networks, are well typified and established, and the development, performance monitoring and assessment are promoted by network collaboration models. Health institutions and professionals collaborate with these networks in aspects such as information sharing, empowerment, joint intervention, consultancy, research and impact assessment.

.28. Health institutions and professionals know the networks and interinstitutional resources, as well as the channels of collaboration with professionals from other institutions outside the sphere of health. The clinical guidelines include, where appropriate, specific aspects of the life cycle and the articulation with other contexts that potentiate

*Health institutions and professionals are proactive in engaging professionals and institutions outside the sphere of health in the intervention on individual and population health needs, as well as they respond to the needs of collaboration in contexts outside the sphere of*

the activities of the health services. Health institutions share information that allows the different contexts to draw their own health profiles, as well as **collaborate proactively in the development of joint interventions** with other sectors on priority issues. The response of health institutions to the cooperation needs of other sectors is known, assessed and valued as part of their social responsibility.

.29. As for major health problems for which gains are expected through the organisation of local or proximity responses, there are intersectoral local health strategies, whose leadership may belong to health institutions or fall outside the health sector, and involve local, regional and national resources. These strategies are known, assessed and appreciated, and should be geared towards specific situations in a logic of obtaining health gains.

*Local health strategies are developed as a means to articulate responses from several institutions and sectors regarding specific situations, as to obtain health gains.*

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## 4.3. STRENGTHENING ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE

### 4.3.1. CONCEPTS

.1. The Health System is not only concerned with improving the health status of individuals and populations, but also with protecting individuals and families from the social and financial burden of health and disease. For this purpose, and respecting social values and principles, the Health System has the responsibility of:

- Generating and managing resources capable of providing economic and social protection for citizens, families and informal caregivers;
- Developing its services and interventions on the basis of cost-benefit and sustainability criteria.

.2. Health is a priceless human and social capital, interdependent with other capitals, such as education and wealth. But, unlike these, health cannot be accumulated.

.3. Disease represents an added cost for most people, both in direct and indirect costs.

.4. Solidarity and social justice mean that the burden of the expenses is distributed fairly in accordance with the capacity to contribute, and that families should not become impoverished as a consequence of disease and of having to use health services (WHO. The Tallinn Charter, 2008).

.5. Universal social protection is a key means to achieve equity, improve health and reduce the risk of disease, which can lead to poverty (WHO. Primary Health Care, 2008).

.6. The cost of treatment can be a barrier to access, equity and health gains, as less privileged socioeconomic groups will be less able to access to healthcare if they have to pay for it at the time of their use.

.7. The impact of healthcare costs can be considered at two levels:

- In the protection of underprivileged socioeconomic groups, i.e. those that fall below a threshold that prevents access to healthcare. This group includes policies related to the exemption from direct costs with health and direct expenses with health.
- In reducing the impact of health costs in socioeconomically vulnerable citizens, preventing families from impoverishing due to situations of disease. This group includes the co-payment policies for health expenditures.

.8. The protection from the impact of healthcare costs can contribute to the achievement of health

gains.

.9. The sustainability of the Health System involves the search for a satisfactory balance between health needs, the ability to meet these needs, and the provision of necessary resources.

.10. Given the increasing ability to improve healthcare and health services and indeterminable health needs, all health systems attempt to allocate their resources to the fulfilment of their social expectations and the achievement of health gains, by setting limits, rules and policies.

.11. Times of crisis generate, in society and in institutions, openness to change but also increase social and economic vulnerabilities to disease and its impacts.

.12. In times of economic crisis, Health Systems should focus on protecting those with greater needs and greater social and economic vulnerabilities; they should concentrate on areas where they are most effective and where they return greater value in health; they should become intelligent economic stakeholders in terms of investment, expenses and employability.

.13. Although it is necessary to supplement social protection with funding, it is always necessary to:

- Identify vulnerable or excluded groups and develop specific social mechanisms;
- Address the social determinants of health inequalities through intersectoral policies (Health 2015 Public Health Programme. Finland, 2001).

.14. Health Systems need to find complex balances between interests that tend to be divergent, such as: generalisation versus specialisation and concentration of resources.

.15. The existence of these '*conflicts*' within the Health System is the reason why it cannot be understood only according to the perspective of a simple market logic, and why the performance and quality of institutions and professionals must be demonstrated, contributing to their accountability and social value.

.16. The following are identified as strategies and resources to strengthen Economic and Social Support:

- Reducing the economic and social impact of disease;
- Ensuring quality healthcare, provided in accordance with the health needs and the economic level of families;
- The complementarity and competition of Public and Private Services;

- Valuing health and the Health System from a social and economic perspective.

.17. Apart from its intrinsic value, health contributes to social welfare through its impact on economic development, competitiveness and productivity (WHO. The Tallinn Charter, 2008).

.18. The Health System must show the other sectors and society in general that accessible and high quality health services are an effective and efficient way of preventing and reducing poverty and social inequalities, and that smart investments in health, such as promoting equity, contribute towards economic development with social cohesion.

.19. The opportunities and threats relating to the Strengthening of Social and Economic Support can be analysed in more detail in the Annex.

#### 4.3.2. GUIDELINES AND EVIDENCE

##### AT THE POLITICAL LEVEL, ONE SHOULD:

.20. Strengthen the mechanisms of solidarity and social support in health promotion and in responding to temporary or permanent health requirements, focusing on those most in need.

.21. Prioritise access and quality response of Primary Healthcare, Long-Term Integrated Care, Community Care and Public Health as the basis for meeting first line proximity health needs and for freeing funds from Hospital Care.

.22. Specify the minimum and desirable services, in terms of types of service, distance and access times, to be provided by the NHS as a basis for defining the response of the National Health Service, convention policies and the need to articulate with non-public health services.

.23. Increase rationalisation in the allocation of health resources in order to achieve more cost-effective health gains.

.24. Organise public health policies, vertical health programs and the integration of technology in a logic of prioritisation through cost-effectiveness criteria, increased equity and impact on health gains.

.25. Implement information and monitoring systems for the social and economic determinants of health and for notifying/referring situations of social and economic disadvantage, abnormal expenditure on healthcare, and difficulties of access and continuity of care.

##### AT AN ORGANISATIONAL LEVEL, INSTITUTIONS SHOULD:

.26. Take up, as part of their social function, the objective of strengthening economic and social



support to the populations being served, translated into policy and institutional services, with a focus on accessibility, public and private expenditure, capacity-building, empowerment and equitable health outcomes.

.27. Develop and disseminate best practices for social inclusion, accessibility for vulnerable groups, capacity-building and empowerment, as well as solidarity support to citizens.

.28. Proactively collaborate in social and intersectoral national, regional and local groups, with the mission of promoting health and well-being of vulnerable populations.

.29. Strengthen articulation with social services and resources of the communities they serve, in order to identify and refer situations of social and economic need with an impact on health.

.30. Monitor and assess the impact of institutional policies on accessibility, equity, expenditure and health outcomes among the populations they serve, in general and according to their socioeconomic status.

.31. Inform citizens, both generally and individually, about the actual costs with healthcare, as a basis for promoting accountability in the proper use of resources and a consciousness of solidarity in health.

#### IN THEIR PRACTICE, HEALTHCARE PROFESSIONALS SHOULD:

.32. Increase awareness and consider social and economic issues in health decisions, from the point of view of the implications for the citizen.

.33. Consistently and appropriately include the assessment of the social and economic conditions in the holistic assessment of the health status and disease condition, either directly or associated with the implications of the care provided (e.g., existence of informal caregivers, compliance with the therapy, ability to maintain care), as well as promote the upgrade of information systems on these dimensions.

.34. Identify situations of risk or social and economic deprivation and refer to or provide advice on the available services and support resources.

#### AT INDIVIDUAL LEVEL, CITIZENS SHOULD:

.35. Know their rights and responsibilities regarding the resources of social and economic support in health and disease.

.36. Promote solidarity mechanisms and the responsiveness of the Health System by taking responsibility for one's own health, and the health of one's family and of one's community.

#### 4.3.3. VISION FOR 2016

.37. The ability and commitment of the Health System in terms of response, and in particular of the NHS, are quite clear for society. This is expressed in terms of guaranteed response times, estimated expenses and care by type of illness or pathological process, referral networks by levels, performance indicators of the Health System, among others. In the debate and decision on the social and political options at national, regional and local levels, there is good information on the responsiveness and performance, on the appropriateness of the use of health services, on the possibility to optimise the Health System and on the expected return from additional investments in the Health System. This information is not only based on average data, but includes the distribution according to socioeconomic and geographical characteristics, with inequality and inequity indicators, and, whenever relevant, an intergenerational perspective. The responsiveness and performance capacity, as well as the resources for economic and social support in health and disease are associated with macroeconomic indicators that reflect the economic and investment capacity of the country.

*Society is well informed about the capacity and commitment of the Health System in terms of response and ability to provide social and economic support, and how these are associated to the economic capacity of the country.*

.38. There is evidence of the economic, social, cultural or other barriers justifying health inequalities and inequities. Such evidence is based on resource monitoring and information cross-checking at various levels, associated to research on inequalities and socioeconomic determinants of health. Such monitoring makes it possible to assess the impact of policies and instruments of social and economic support at various levels (institutional, municipal, regional, national), and constitutes a basis for identifying and sharing best practices. Institutions take up the goal of being promoters of social inclusion and cohesion, measuring and disseminating the impact of their policies, services and interagency collaborations in reducing inequalities.

*There is a good understanding of the social and economic barriers, monitoring of inequalities in health, impact assessment and sharing best practices, so the economic and social health gains resulting from the reduction of inequities are well understood.*

.39. Health professionals are sensitive and assess the socioeconomic conditions, as well as socioeconomic implications of their decisions for citizens/patients, caregivers, institutions and society at large.

*Health professionals consider the socioeconomic conditions in the evaluation and decision, and are informed stakeholders, promoters of the empowerment of citizens and their families in these areas, within their scope of competence.*

As resource managers, health professionals understand their responsibilities in the distribution of resources and in the empowerment of citizens or of informal caregivers. Within their professional responsibilities, they are stakeholders and resources for information, referral and social and economic support. Health professionals receive information on the economic and social impact of their decisions, as well as participate in the development and evaluation of guidelines and best practices that consider health inequalities and the available resources for social and economic support.

## 4.4. STRENGTHENING PORTUGAL'S PARTICIPATION IN GLOBAL HEALTH

### 4.4.1. CONCEPTS

.1. Global Health is a comprehensive concept which includes health status, its determinants and interventions on world population that outweighs the countries' interests and individual perspectives.

.2. The liberalisation of international commerce, capital, technologies and information flows has progressively evolved into a network of social, political and economic interdependence. This phenomenon, known as globalisation, represents a new way of developing joint actions, organising transnational social movements and it is an opportunity for national intervention on the global agenda (Castells, 1996, Woodward 2001).

.3. International policies and events have an impact on national policies, which, in turn, have an influence on global health (Health is Global. A UK Government Strategy 2008-2013, UK, 2008).

.4. Health Systems are permeable to foreign threats and to sociodemographic and economic characteristics. They cooperate for training, technology, service provision, knowledge creation, international innovation and development.

.5. The responsibilities of Health Systems towards Global Health are the following:

- To create opportunities and influence the international agenda coherently with national needs and interests;
- To incorporate and demonstrate that they can fulfil international commitments, aligning their internal goals with these commitments, making use of synergies and opportunities;

- To incorporate knowledge, innovation, models and best international practices (Kickbusch, Silberschmidt & Buss, 2007);
- To value themselves, competing and using health capital for the cooperation between countries, providing services internationally and obtaining recognition;
- To acknowledge the influence of Global Health in an articulated way, in order to minimise international health threats (Oslo Ministerial Declaration, 2007).

.6. The following are considered as perspectives for the reinforcement of Portugal's position in Global Health:

- Health Diplomacy; migrations; global threats to health; health in all policies; investment and self-empowerment in areas such as quality, research and innovation; mobility of health professionals and of citizens for healthcare/health tourism.
- Health is a basic value and an asset in the dialogue and relationship between countries, in the establishment of common goals (Oslo Ministerial Declaration, 2007). The cooperation between countries benefits from a supranational framework, which ensures that increasingly scarce resources are used in a synergistic, enabling and *empowerment-promoting* way, and avoids the duplication of efforts from the cooperative countries [WHO, Health Strategy 2020, 2020 Jan Draft].

.7. The opportunities and threats relating to Strengthening Portugal's Participation in Global Health can be analysed in more detail in the Annex.

#### 4.4.2. GUIDELINES AND EVIDENCE

##### AT THE POLITICAL LEVEL, ONE SHOULD:

- .8. Ensure the continuity of participation in areas where Portugal has recently stood out, such as Health in All Policies and Impact Assessment of Policies of other sectors (in cooperation with the WHO, 2009-2011).
- .9. Lead, coherently and substantively, contributions of its own in strategic areas of national interest and in international governance space, leading, in particular, to the development of the Portuguese Health System and strategic development of international relations.
- .10. Invest and participate in research at the European level, contributing, for example, to address global health problems, develop effective interventions that translate into management decisions (Decision No 1982/2006/EC of the European Parliament and of the Council of 18 December 2006, European Union, 2006).

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- .11. Proactively and systematically identify opportunities for participation, dissemination and attraction of international resources (funding, partnerships, training, etc.) that may empower the Health System.
  - .12. Carry out the assignment, strategic and operational planning, accountability, monitoring and evaluation of international commitments, including, for example epidemiological surveillance, plans, programmes and projects.
  - .13. Develop and perform simulations of action plans for international health threat situations, either own plans or integrated in international action strategies.
  - .14. Analyse and monitor the impact of bidirectional mobility of people and patients: foreigners and migrants, regarding access, quality and impact on the sustainability of the Health System, as well as regarding the satisfaction of specific health needs.
  - .15. Organise and build strategic perspectives, and promote their discussion, at national and regional level, about goals, priorities and resources for the Portuguese cooperation in health, as well as evaluate and report on their impact.
  - .16. Promote the development and availability of postgraduate internships for foreigners in Portuguese universities and educational, research and healthcare institutions (e.g. specific programs in the English language).
  - .17. Train and empower resources in health diplomacy that allow the performance of a leadership, negotiation and well-informed influence function in the international agenda, as well as influence over national institutions.

#### AT AN ORGANISATIONAL LEVEL, INSTITUTIONS SHOULD:

- .18. Identify and incorporate international operational models in institutions, including concepts, best practices, processes and indicators.
- .19. Search for models, promote participation in international accreditation processes and develop training, in order to facilitate the recognition of excellence centres and attract training professionals from other countries.
- .20. Promote national and international strategic and operational discussions about the Portuguese participation on Global Health.

#### IN THEIR PRACTICE, HEALTHCARE PROFESSIONALS SHOULD:

- .21. Identify the best international references for professional practice and reinforce a perspective of individual and team development.

.22. Participate and contribute to the strategic and operational discussions at national and international level on the development views for professions from international recommendations, and their implications.

#### 4.4.3. VISION FOR 2016

.23. The **responsibility of participating in Global Health is assumed by all** and is incorporated in planning, monitoring and evaluation processes, in incentives and in the

*Portugal has a solid perspective of participation in Global Health, supported by a multisectoral dynamic and engagement of the Health System.*

identification of best practices. The Health System shares a common vision, with identification of priorities and alignment of contributions from experts, institutions and public and private organisations, as well as other sectors. There is a historical and analysis directory of international health interest areas that stimulates multidisciplinary and intersectoral discussion and integrates the critical reflection of the Portuguese representatives in international institutions. The opportunities for political intervention are identified and anticipated. International commitments, political and institutional operationalisation, monitoring and evaluation are performed in a proactive and transparent way, contributing for the creation of political capital in health.

.24. The Portuguese Health System internationally identifies, values and promotes **best practices** in its policies, organisations and professions.

Best practices result from planning, monitoring, evaluation, intersectoral and multidisciplinary work, research and innovation. Foreign representations know and follow them, promoting them as national capital and as opportunities for cooperation, valorisation and development.

*The best political practices from institutions and professions are systematically identified and valued in*

.25. The activities of the institutions, their plans and evaluations fit into excellence models recognised internationally, promoting their comparability. The institutions identify and promote innovation and best practices, either individually, or in networks and partnerships. Scientific societies, professionals or patients' associations position their activities, define their value and contribute for the international development of visions.

*The institutions and associations base their mandate and activities on international excellence standards, ensuring comparability, incorporating and disseminating best practices, innovation and a*

.26. Portugal understands the value of health in foreign policy and the diplomatic corps contains trained professionals with experience in Health, allowing a qualified foreign participation and

*Diplomacy skills are reinforced and understood as an essential process for the development of institutions and professionals, as well as for international participation.*

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informed decision-making. International representatives are supported by experts and institutions with experience and perspectives built to respond to, contribute to and influence the international agenda. There are training models in Health Diplomacy, Global Health and International Health that create opportunities of participation, development and valorisation in international context.

## 5. HEALTHCARE INDICATORS AND TARGETS

### 5.1. CONCEPTS

.1. Although the National Health Plan monitoring process proposes to be dynamic and evolving, it is necessary to establish a set of health indicators that makes the Health System commit to health gains and to the monitoring of outcomes and performance.

.2. Multiple factors influence the health of a population. The health status depends on each citizen's genetic heritage, and on his/her social, cultural and physical environment (Quigley et al, 2006), but also on the performance of the Health System.

Health Indicators are summary measurement instruments, which directly or indirectly reflect relevant information on different attributes and dimensions of health and the factors that determine it (Dias C et al, cit., 2007) (Nutbeam D, 1998).

.3. In general, four major groups of Health Indicators can be considered:

- Group I: Health Status Indicators - allow to determine how healthy a population is, through variables such as mortality, morbidity, disability, and well-being;
- Group II: Health Determinants Indicators - provide knowledge on factors for which there is scientific evidence regarding their influence on the health status and healthcare utilisation (behaviours, living and working conditions, personal and environmental resources);
- Group III: Health System Performance Indicators - in their multiple dimensions of acceptability, access, quality, capacity-building, care integration, effectiveness, efficiency and safety, they help analysing the quality of the Health System;
- Group IV: Context Indicators - contain measures of characterisation, which, although not being health status indicators, individual determinants or indicators of Health System performance, provide important contextual information and allow, by adjustment, a comparison between different populations.

.4. These groups are further subdivided into several areas, ensuring that the various dimensions of information on Health are duly considered (Table 1).



**Table 1 – Groups of health indicators and respective areas**

(adapted from CIHI, 2005 e CIHI, 1999)

Group I: Health Status Indicators			
Mortality	Morbidity	Disability	Well-being
By age groups (e.g. infants); by specific cause; derivatives (e.g. life expectancy, PYLL)	Interferes with daily activity and with demand for health services.	Includes impairment (of function or body structure), activity limitation (difficulty in executing a task or action)	Physical, mental and social. The self-perceived health status is an example.
Group II: Health Determinants Indicators			
Behaviours	Living and working conditions	Personal Resources	Environmental
That influence the health status.	Socioeconomic profile and working conditions.	Prevalence of factors such as social support and stress-producing life events related to health.	That influence the health status.
Group III: Health System Performance Indicators			
Acceptability	Access	Quality	Citizens' empowerment
Meets the expectations of citizens, communities, providers and payers.	Suited to needs.	Adequate and based on established standards.	The citizen's knowledge is suited to the healthcare provided
Healthcare integration	Effectiveness	Efficiency	Safety
Ability to provide care in a continuous and coordinated way, through programmes, professionals between healthcare levels, over time.	The proposed results are achieved, in terms of technical level and satisfaction of providers and users.	The results are maximised (quantitatively and qualitatively) with minimum expended time and resources.	Potential risks of a procedure or of the very environment of healthcare services
Group IV: Context Indicators			
These are not indicators of health status or of Health System performance, but they provide important contextual information and allow the comparison of populations over time.			

.5. It is considered that indicators of Health Status (outcome) and of Health System performance (process) are not completely indistinct because, along with genetic heritage and individual behaviours, they both influence the health of a population. Similarly, various indicators of Health Determinants can be considered indicators of Health Status, as is the case with risk factors for various diseases.

.6. Health Indicators can be used to improve knowledge on health determinants and identify gaps in the health status of specific populations but they are also useful to inform planning and health policies and manage the Health System (CIHI, 2005).

.7. The NHP indicators are those selected from among the Health Indicators, for the areas in which the NHP proposes to intervene.

.8. The NHP monitoring strategy defines three major sets of Indicators: 1) of Health Gains; 2) of the Health Status and Health System Performance.

- Health Gain Indicators, within the scope of the NHP, are health indicators whose behaviour is significantly attributable to the action of the Health System. This set of Health Gain Indicators, planned and to be developed, includes indicators from Group I (Health Status Indicators) and Group III (Health System Performance Indicators). The process of selection, target definition and calculation of health gains is described in chapter Obtaining Health Gains.

- The Health Status and Health System Performance Indicators describe the health status of the Portuguese population and the Health System's capacity to achieve the proposed goals. They are combined into one single set because they influence each other. This set of Health Status and Health System Performance Indicators, planned and to be developed, includes indicators from all the groups previously defined (I to IV).

.9. NHP indicators include some already monitored in the NHP 2004-2010, which are considered relevant in the life cycle and approach, also used in this Plan, because they measure important health problems and the performance of the system and also for advantages in the continuity of monitoring. In addition, new indicators selected to calculate Health Gains, and other deemed relevant, are also included.

.10. The indicators considered in the NHP may be supplemented by other indicators, such as those specific to Regions, plans, programmes, projects, actions or interventions of a national interest and which contribute to the NHP's mission.

.11. The criteria for calculating targets are described in chapter Obtaining Health Gains and are based on a progressive reduction, of up to 50%, of differences in 2016, according to projections, between each unit and the unit with the best indicator performance. The achievement of the targets is, therefore, necessarily the result of significant improvements, articulated locally, regionally and nationally.

## 5.2. INDICATORS OF THE NATIONAL HEALTH PLAN 2012-2016

### 5.2.1. PROPOSED INDICATORS

#### Health Gain Indicators

**Table 2 – List of Health Gain indicators and associated values for Mainland Portugal**

(Observed, projected, targets and accumulated gains)

INDICATOR		VALUES				
N	Name	2001 (a)	2009 (a)	Projection 2016	TARGET 2016	Accumulated gains
<b>AREA: MORTALITY</b>						
1	PYLL due to land transport accidents (/100000 pop. under 70 years)	515.2	248.6	124.3	100.1	620.5
2	PYLL due to Chronic liver disease (/100000 pop. under 70 years)	162.6	128.5	106.6	93.6	612.7
3	PYLL due to certain conditions originating in the perinatal period (/100000 pop. under 70 years)	224.2	236.3	199.4	174.3	560.8
4	PYLL due to malignant neoplasm of the trachea, bronchus and lung (/100000 pop. under 70 years)	122.3	144.4	164.6	131.7	532.4
5	PYLL due to malignant neoplasm of cervix uteri (/100000 female pop. under 70 years)	52.4	40.3	27.0	18.9	111.4
6	PYLL due to malignant neoplasm of the female breast (/100000 female pop. under 70 years)	190.8	159.7	134.7	118.3	291.6
7	PYLL due to HIV Infection/AIDS (/100000 pop. under 70 years)	297.6	128.5	63.1	45.0	241.5
8	PYLL due to malignant neoplasm of colon, rectum and anus (/100000 pop. under 70 years)	91.6	86.6	82.1	77.1	232.8
9	PYLL due to pneumonia (/100000 pop. under 70 years)	76.5	58.5	38.2	31.0	191.1
10	PYLL due to diabetes (/100000 pop. under 70 years)	56.9	40.0	26.6	18.7	177.9
11	PYLL due to cerebrovascular diseases (/100000 pop. under 70 years)	219.4	119.9	63.9	59.1	93.5
<b>AREA: MORBIDITY</b>						
12	Hospital admissions due to diabetes (/100000 pop. under 70 years)	35.2	30.0	29.4	25.5	236.9
13	Hospital admissions due to asthma (/100000 pop. under 70 years)	39.9	29.5	22.1	20.1	123.8
14	Hospital admissions due to Chronic Obstructive Pulmonary Disease (/100000 pop. under 70 years)	35.2	29.4	24.8	17.9	95.9
15	Hospital admissions due to grand mal status and other epileptic convulsions (/100000 pop. under 70 years)	29.7	28.3	28.8	25.2	131.3
16	Hospital admissions due to heart failure	28.5	27.9	28.8	25.3	72.9

INDICATOR		VALUES				
N	Name	2001 (a)	2009 (a)	Projection 2016	TARGET 2016	Accumulated gains
	(/100000 pop. under 70 years)					
17	Hospital admissions due to angina pectoris (/100000 pop. under 70 years)	37.2	23.2	18.4	16.4	206.8
18	Hospital admissions due to arterial hypertension (/100000 pop. under 70 years)	20.6	11.3	7.9	6.4	51.4
<b>AREA: DISABILITY</b>						
19	Disability pensioners (/1000 pop. 18-64 years)	55.8	42.3	34.4	30.2	82.6

(a) Or nearest year. (b) Due to a large growth trend of the 2001-2009 series in Alentejo region, the projection was based on different mathematical model from the one used in the projections for other indicators.

**Targets for 2016:** Regional targets are based on progressive reduction, of up to 50%, of differences between each Region and the Region with the best indicator performance, according to projections for 2016. The target for Mainland Portugal is a weighted average of the regional targets, using each Region's population (final results of Census 2011) as weight factors.

## Health Status and Health System Performance Indicators

**Table 3 – List of Health Status and Health System Performance indicators for Mainland Portugal**

(Observed and projected values and targets)

INDICATOR		VALUES			
N	Name	2001 (a)	2009 (a)	Projection 2016	TARGET 2016
<b>AREA: MORTALITY</b>					
20	Life expectancy at birth (years)	76.6	79.2	81.7	81.8
21	Life expectancy at age 65 (years)	17.0	18.4	19.8	20.0
<b>AREA: MORBIDITY</b>					
22	Pre-term births (/100 live births)	5.9	8.8	13.5	11.2
23	Low birth weight infants (/100 live births)	7.1	8.2	8.8	8.5
<b>AREA: QUALITY</b>					
24	Caesarean sections (/100 live births)	28.0	36.4	45.7	40.4
<b>AREA: EFFECTIVENESS</b>					
25	Live births from adolescent mothers (/100 live births)	6.0	4.2	3.0	2.6
<b>AREA: MORTALITY</b>					
26	Perinatal mortality (/1000 births)	6.2	4.5	3.0	2.5
27	Infant mortality (/1000 live births)	5.3	3.6	2.1	1.9
28	Mortality below the age of 5 (/1000 live births)	6.8	4.5	2.6	2.3
29	Mortality from 5 to 14 years (/100000 pop.)	22.1	11.5	7.2	6.1
30	Mortality from 15 to 24 years (/100000 pop.)	81.9	41.4	23.3	21.8
31	Mortality from 25 to 64 years (/100000 pop.)	354.1	292.5	242.8	237.6
32	Mortality from 65 to 74 years (/100000 pop.)	2182.5	1649.5	1325.4	1301.4
33	Mortality due to malignant neoplasm of female breast under 65 years (/100000 female pop.)	13.8	12.6	9.1	9.0
34	Mortality due to malignant neoplasm of cervix uteri under 65 years (/100000 female pop.)	2.6	2.7	2.1	2.0
35	Mortality due to malignant neoplasm of colon and rectum under 65 years (/100000 pop.)	7.1	7.3	7.1	6.8

INDICATOR		VALUES			
N	Name	2001 (a)	2009 (a)	Projection 2016	TARGET 2016
36	Mortality due to ischemic heart disease under 65 years (/100000 pop.)	14.8	9.2	6.0	4.4
37	Mortality due to cerebrovascular diseases under 65 years (/100000 pop.)	17.8	9.5	5.2	5.0
38	Mortality due to AIDS under 65 years (/100000 pop.)	9.9	6.2	4.2	3.1
39	Mortality due to suicide under 65 years (/100000 pop.)	3.0	5.9	7.3	6.4
40	Mortality due to alcohol-related diseases under 65 years (/100000 pop.)	11.9	12.9	12.3	10.7
41	Mortality due to motor vehicle traffic accidents under 65 years (/100000 pop.)	11.5	7.6	4.2	4.0
42	Mortality due to work-related accidents (/100000 pop.)	2.7	1.8	0.9	0.8
<b>AREA: ACCESS</b>					
43	Coverage of health status monitoring of 6 year-old students (%)	76	70	56	75
44	Coverage of health status monitoring of 13 year-old students (%)	35	36	41	58
<b>AREA: EFFICIENCY</b>					
45	Medical doctors (/100000 pop.)	323.7	383.7	431.5	451.5
46	Nurses (/100000 pop.)	359.0	551.3	764.7	801.1
47	Nurses in Primary Healthcare (/100000 pop.)	68.8	75.2	81.4	106.5
48	Family Medicine appointments (/pop./year)	2.7	2.7	3.0	3.4
49	Hospital medical appointments (/pop./year)	0.8	1.4	2.3	2.4
50	Hospital emergency admissions (/1000 pop./year)	647.7	708.2	754.3	720.1
51	Ratio between hospital emergencies and outpatient appointments	0.77	0.50	0.33	0.31
52	Expenditure on medicines in the total health expenditure (%) (b)	22.8	18.5	14.2	NA
53	Generic drugs in the total market of medicines (%)	14.9	28.8	89.5	94.3
<b>AREA: QUALITY</b>					
54	Analgesic and antipyretic drugs consumption in the NHS, in outpatient treatments (DDD/1000 pop./day)	4.9	5.0	5.1	4.3
55	Anxiolytic, hypnotic and sedative drugs consumption in the NHS, in outpatient treatments (DDD/1000 pop./day)	67.0	73.7	86.9	72.5
56	Antidepressants consumption in the NHS, in outpatient treatments (DDD/1000 pop./day)	38.1	58.1	122.0	103.3
57	Antibacterial drugs consumption in the NHS, in outpatient treatments (DDD/1000 pop./day)	18.9	17.2	14.4	14.2

(a) Or nearest year. (B) Because this indicator is not broken down by region, the respective target for 2016 was not defined, as the method used for its calculation is not applicable in this situation.

**Targets for 2016:** Regional targets are based on progressive reduction, of up to 50%, of differences between each Region and the Region with the best indicator performance, according to projections for 2016. The target for Mainland Portugal is a weighted average of the regional targets, using each Region's population (final results of Census 2011) as weight factors.

## 5.2.2. INDICATORS TO BE DEVELOPED

This list is a provisional and evolving work list.

## Health Gain Indicators

Table 4 - List of Health Gain Indicators to be developed

INDICATOR	
N	NAME
<b>AREA: DISABILITY</b>	
58	Healthy life years at birth (years)
59	Healthy life years at age 65 (years)
<b>AREA: MORTALITY</b>	
60	Mortality due to alcohol-related motor accidents (/100000 pop.)
<b>AREA: QUALITY</b>	
61	Breast cancer five-year relative survival (%)
62	Cervix uteri cancer five-year relative survival (%)
63	Colon and rectum cancer five-year relative survival (%)
<b>AREA: MORBIDITY</b>	
64	Hospital admissions due to alcohol-related diseases (/100000 pop. under 70 years)
65	Hospital admissions due to ambulatory care-sensitive conditions (/100000 pop. under 70 years)
<b>AREA: QUALITY</b>	
66	Incidence of diabetic foot amputations (/10000 pop.)
<b>AREA: DISABILITY</b>	
67	Years of work lost due to disability (years)
68	Absenteeism from work due to illness (days)
<b>AREA: ACCESS</b>	
69	Patients without a family doctor (%)
70	Pregnancy appointments in the first trimester (%)
71	Patients with first hospital specialty appointments made within the reference time (%)
72	Surgical patients with waiting time under the maximum response time guaranteed (%)
73	Long-term care referral times (days)
<b>AREA: QUALITY</b>	
74	Patients who are very satisfied/satisfied with the healthcare services (%)

## Health Status and Health System Performance Indicators

Table 5 – List of Health Status and Health System Performance indicators to be developed

INDICATOR	
N	NAME
<b>AREA: MORBIDITY</b>	
75	Population with diabetes (%)
76	Population with asthma (%)
77	Population with arterial hypertension (%)
78	Population suffering from chronic pain (%)
79	Population suffering from depression (%)
<b>AREA: BEHAVIOURS</b>	
80	Population who consumes tobacco daily (%)
81	Population who consumes alcohol (%)
82	Overweight population (%)
83	Obese population (%)
<b>AREA: WELL-BEING</b>	

INDICATOR	
N	NAME
84	Population who evaluates positively their Health Status (%)
AREA: BEHAVIOURS	
85	Physical Activity (minutes/day)
AREA: MORBIDITY	
86	DMFT Index (decayed, missing, and filled teeth in permanent teeth) at the age of 12
AREA: EFFICIENCY	
87	General practitioners and family doctors (/100000 pop.)
AREA: CONTEXT	
88	Health expenditure evolution rate (%)
89	Current healthcare expenditure by the NHS, at current prices (total, per resident) (€)
90	Current expenditure on healthcare by families, at current prices (€)
AREA: PERSONAL RESOURCES	
91	Ratio between private health expenditure and household disposable income
AREA: CONTEXT	
92	Health expenditure in the GDP (%)

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## Z

## 7. ANNEX

This Annex describes the Opportunities and Threats for each of the Strategic Axes and Goals for the Health System.

For a deeper understanding of the NHP or for further information, please read the full version of the NHP, available *online* at <http://pns.dgs.pt/nhp-in-english/>.

### STRATEGIC AXES

#### CITIZENSHIP IN HEALTH

##### *OPPORTUNITIES FOR THE EXERCISE OF CITIZENSHIP IN HEALTH*

###### **FOR CITIZENS:**

- .1. Greater awareness of their ability and power to achieve their health potential;
- .2. Increased participation in clinical decision, in disease management and in the governance of health institutions;
- .3. Greater and more appropriate demands on the Health System;
- .4. Increased attention and interest, on the part of the citizen, for the issues of health and individual and social well-being;
- .5. Strengthening healthy contexts, the promotion of healthy choices, and support in illness.

###### **FOR HEALTHCARE PROFESSIONALS:**

- .6. Promotion of compliance, therapeutic alliance and effectiveness of their practice;
- .7. Greater recognition of the quality and value of their activity.

###### **FOR HEALTHCARE INSTITUTIONS:**

- .8. Greater support to their mission through volunteering, informal caregivers;
- .9. Better use of services and communication with users;
- .10. Greater social recognition of their value.

###### **FOR POLICY-MAKERS:**

- .11. Affirmation of health as a cross-sectional social value and as a defining element of the common good.
- .12. Increased dialogue, social cohesion and response to the challenges of the Health System.
- .13. Focus of the Health System on the needs and expectations of citizens as a primary goal for promoting the integration and articulation of its stakeholders' efforts.



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## ***THREATS FOR THE EXERCISE OF CITIZENSHIP IN HEALTH***

### **FOR CITIZENS:**

- .14. Asymmetry of knowledge between citizen and professional resulting in a barrier to partnership;
- .15. Inadequate expectations regarding the capacity of professionals and institutions;
- .16. The perspective of health as a commodity, supported by the mere provision of services.

### **FOR HEALTHCARE PROFESSIONALS:**

- .17. Litigation and defensive medicine, as well as the dissatisfaction of patients and professionals;
- .18. Breakdown of social structures such as family, community and informal support groups.

### **FOR HEALTHCARE INSTITUTIONS:**

- .19. Imbalance of power between social groups that are excluded or less *empowered*, such as the elderly, the unemployed, immigrants, among others;
- .20. Lack of integration of the activities of civil society with health services.

### **FOR POLICY-MAKERS:**

- .21. Decision-making processes lacking participation and transparency in criteria, rationale and expected gains;
- .22. Absence of strategy, transparency and accountability in the access to and distribution of social resources;
- .23. Information which is partial or biased, lacking evidence, circumstantial or which does not promote literacy.

## **EQUITY AND ACCESS TO HEALTHCARE**

### ***OPPORTUNITIES FOR EQUITY AND ACCESS TO HEALTHCARE***

#### **FOR CITIZENS:**

- .1. Valorisation of care continuity, and of holistic, proximity and personalised care, as an essential condition for the promotion of healthy lifestyles, promotion of health and disease prevention;
- .2. Morbidity and disability improvement resulting from early screening and diagnosis, intervention in key pathologies, fast resolution of health problems and early rehabilitation;
- .3. 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;
- .4. Increase of literacy and empowerment of citizens and informal caregivers.

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#### FOR HEALTHCARE PROFESSIONALS:

- .5. Better communication among health professionals, with quality improvement and less likelihood of error;
- .6. Reinforced multidisciplinary, multiprofessional and interinstitutional work.

#### FOR HEALTHCARE INSTITUTIONS:

- .7. *Empowerment* of the institutions as organisations responsible for the health status of communities and populations, through the reinforcement of needs and response capability assessment in the planning of their services;
- .8. Integrated social support through the planned and proactive mobilisation of social resources;
- .9. Expenditure reduction and release of resulting resources.

#### • FOR POLICY-MAKERS:

- .10. Access equity for vulnerable groups or situations associated with poverty and social exclusion;
- .11. Increasing of the Health System's social value, as an accessible, close and personalised resource, of unconditional and continuous support in situations of economic and social difficulties and of disease and suffering.

### THREATS TO EQUITY AND ACCESS TO HEALTHCARE

#### FOR CITIZENS:

- .12. Poor literacy and autonomy of citizens/patients towards health services;
- .13. Healthcare being understood as mere commercial goods, transactionable in a market logic.

#### FOR HEALTHCARE PROFESSIONALS:

- .14. Lack of communication and articulation between providers and care.

#### FOR HEALTHCARE INSTITUTIONS:

- .15. Access difficulties caused by the scattering and fragmentation of care in Hospital Centres united by geographic institutions distant from each other;
- .16. Low planning and organisation capability of institutions.

#### FOR POLICY-MAKERS:

- .17. 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;
- .18. Insufficient perception of the impact of social health determinants on health and on access;
- .19. Health services fragmentation, with low accountability for the evolution of a population's health status.

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## **QUALITY IN HEALTH**

### **OPPORTUNITIES FOR QUALITY IN HEALTH**

#### **FOR CITIZENS:**

- .1. Greater participation in decision-making, better use of care, and integrated management of disease;
- .2. Empowerment to deal with the disease, self-care and support to family and informal caregivers;
- .3. More realistic expectations on getting health outcomes, greater safety and protection from marketing and advertising campaigns.

#### **FOR HEALTHCARE PROFESSIONALS:**

- .4. Increased safety in relation to clinical uncertainty, clear benchmarks for the assessment of work and appreciation of merit, and continued development, with greater satisfaction;
- .5. Fostering multidisciplinary work, focused on achieving results, and raising standards related to safety and excellence in care;
- .6. Encouraging clinical research and improved ability to incorporate evidence and innovation into clinical practice, and greater ease in guiding postgraduate training to increase the quality of clinical practice.

#### **FOR HEALTHCARE INSTITUTIONS:**

- .7. Recognition of the quality and effectiveness of care provided and its valorisation;
- .8. Professionals and patients geared towards continuous improvement, in a culture of assessment and development;
- .9. Greater social confidence due to the transparency in performance information and safety;
- .10. Investment protection and resource development, by acknowledging the impact on results as regards quality, safety, and health gains.

#### **FOR POLICY-MAKERS:**

- .11. Added value in health - public investment translates into increased quality of care and a clearer vision, in the long-term, of the possible care with the available resources;
- .12. *Benchmarking* between units regarding performance from common action frameworks;
- .13. The Health System is recognised as a social engine for the promotion of involvement and excellence.

### **THREATS TO QUALITY IN HEALTH**

#### **FOR CITIZENS:**

- .14. Inadequate pressure from interest groups, through biased processes of communication and use of evidence;
- .15. Decontextualised information used to promote the demand for services, without assessing either risk or gain.

#### FOR HEALTHCARE PROFESSIONALS:

- .16. Processes of continuous quality improvement excessively demanding in terms of time and bureaucracy, ill-adapted to priorities and work context, with no return with regard to clear incentives and resources for an effective and sustained improvement;
- .17. Insufficient involvement in the chain of patient care and poor adherence to action protocols;
- .18. Lack of alignment between goals and priorities of the top management, professionals and citizens, thus resulting in fragmented perspectives of quality.

#### FOR HEALTHCARE INSTITUTIONS:

- .19. Profile of population, with unclear and heterogeneous levels of access and services provided, hampering comparability with institutions of similar responsibilities;
- .20. Lack of sensitivity towards the processes of continuous quality improvement, which require the involvement of top management, professionals, patients/citizens, the coordination of information systems, service organisation and synergy with research and training activities.

#### FOR POLICY-MAKERS:

- .21. Lack of critical structures to create, monitor and assess, in a systematic and extensive way, the guidelines and technical-scientific recommendations;
- .22. Punitive vision of error and lack of quality, which is a disincentive to the professionals' initiatives;
- .23. Difficulty in freeing resources resulting from increased quality, not providing any evidence on the return attributable to the improvement and the value of investment;
- .24. Lack of long-term vision and insufficient mandate duration (political cycle) to obtain efficiency gains attributable to policies;
- .25. Lack of coordination between the policies related to information systems, contracting and incentives, investment in resources, integration and continuity of care, training and research, around the promotion of quality assurance.

### HEALTHY POLICIES

#### *OPPORTUNITIES FOR HEALTHY POLICIES*

- .1. The existence of international and national reference documents that promote Healthy Policies (WHO Tallinn Charter, 2008; National Health Plan 2004-2010);
- .2. The promotion of health intersectoral character by the Ministry of Health;
- .3. The Presidency of the Council of Ministers as a promoter resource of the articulation between sectors;
- .4. Initiatives of other ministries and sectors with positive impact on health;
- .5. Implementation of legislation conducive to health (e.g. Tobacco Act);
- .6. Globalisation of citizen awareness regarding environmental issues, sustainability, health and welfare;

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- .7. Increased number of concerted communication and marketing strategies that promote literacy and empowerment of citizens.

## THREATS TO HEALTHY POLICIES

### FOR HEALTHCARE PROFESSIONALS:

- .8. Insufficient knowledge about the impact of health promotion and education in all contexts, empowerment of citizens and professional satisfaction;
- .9. Lack of benchmarks and feedback on the impact of their activities on community health in the medium and long-term; the impact on the reduction of inequalities, social determinants and vulnerable groups;
- .10. Difficulty in negotiating and sharing power with other sectors and other professionals in the resolution of conflicts of interest and in the creation of synergistic processes; resistance, lack of incentives and confidence to change;
- .11. Lack of investment and valuation of interdisciplinary and intersectoral models.

### FOR NATIONAL, REGIONAL AND LOCAL DECISION-MAKING:

- .12. Low valuation of health promotion as an investment that contributes to the sustainability of the Health System;
- .13. Planning poorly associated with decision-making and resource allocation centres, contracting, monitoring and assessment;
- .14. Low quality and accountability in decision-making, which are not based on medium and long-term strategies;
- .15. Misunderstanding of the role and capacity of local structures on the effectiveness in reducing inequalities;
- .16. Difficulty in articulating sectorial languages, paradigms and cultures; inability to value the impact of health in other sectors; poor management of political opportunities; lack of strategic vision as a value in all policies;
- .17. Lack of interdisciplinary and intersectoral scientific evidence adapted to the national context; inability to formulate useful recommendations and influence planning and decision, assess Healthy Policies and disseminate best practices.

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## **GOALS FOR THE HEALTH SYSTEM**

### **PROMOTING SUPPORTIVE ENVIRONMENTS FOR HEALTH OVER THE LIFE CYCLE**

#### ***OPPORTUNITIES FOR THE PROMOTION OF SUPPORTIVE ENVIRONMENTS FOR HEALTH OVER THE LIFE CYCLE***

##### **FOR CITIZENS:**

- .1. A culture of health and well-being which is coherently valued, extended and integrated, into all contexts of life, with greater support to the desire of leading a healthy life.

##### **FOR HEALTHCARE PROFESSIONALS:**

- .2. Strengthening of the network of support and work in other sectors, according to the needs of citizens;
- .3. Ability for an intervention that promotes health, prevention and early diagnosis of the disease in other contexts;
- .4. Action and knowledge that facilitate interventions and multidisciplinary strategies, within teams and among institutions.

##### **FOR HEALTHCARE INSTITUTIONS:**

- .5. Sharing of resources, management mechanisms, knowledge and strategies. Strengthening of local health strategies;
- .6. Empowerment, transparency and social accountability, intervention capacity, evidence and identification of the best practices;
- .7. Valuing social responsibility of institutions and their professionals.

##### **FOR POLICY-MAKERS:**

- .8. Strengthening of the accountability and culture of planning and multi-strategic intervention;
- .9. Increased evidence and best practices in planning and sectorial and multi-institutional intervention, networking and institution participation.

##### **AT THE LEVEL OF SOCIETY:**

- .10. Strengthening of the salutogenic approach, adapted to the needs;
- .11. Greater social expectation on intersectoral cooperation and shared responsibility in the definition of policies and actions;
- .12. Enhancement of Health System stakeholders as partners, integrating the social, private and health sectors and family, work and school contexts;
- .13. Reduction of the burden of disease as a result of an effective and customised investment, aligned between stakeholders.

#### ***THREATS TO THE PROMOTION OF SUPPORTIVE ENVIRONMENTS FOR HEALTH OVER THE LIFE CYCLE***

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#### FOR HEALTHCARE PROFESSIONALS:

- .14. Difficulty in sharing perspectives and languages of other sectors and in understanding the potential impact on health of other sectors' operations;
- .15. Lack of training and skills for intersectoral and multidisciplinary work;
- .16. Difficulties in integrating the intersectoral and multidisciplinary relationship in case management and risk management, due to a lack of conditions for an appropriate response to the needs of the citizen/family.

#### FOR HEALTHCARE INSTITUTIONS:

- .17. Resistance in assuming shared responsibility within contexts of other sectors;
- .18. Difficulty in assessing the medium/long-term impact of multisectoral actions on the population's health status;
- .19. Lack of incentive to sharing resources, management mechanisms, information and knowledge between institutions;
- .20. Shy sectorialised and non-integrated investment policies as regards the promotion of health and the prevention of disease.

#### FOR POLICY-MAKERS:

- .21. Lack of capacity-building and/or empowerment of institutions for fulfilling local health strategies;
- .22. Low investment in individualised and integrated actions, within contexts of experience;
- .23. Instability in the professionals' availability and capacity, and non-articulated changes in policies and priorities.

#### AT THE LEVEL OF SOCIETY:

- .24. Lack of perception as to the limitations arising from non-articulated or non-coherent actions across sectors;
- .25. Society dazzled by technological breakthroughs and that devalues salutogenic behaviours;
- .26. Orientation of the society towards the creation of economic wealth, within a highly competitive context that devalues health, quality of life and well-being as at least an equally important social purpose.

### STRENGTHENING ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE

#### *OPPORTUNITIES FOR STRENGTHENING ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE*

##### FOR CITIZENS:

- .1. Citizens have the Health System, both public and private in its mutual or solidarity-based perspective, as a resource and solid and continuous guarantee for social support in health and disease, trusting that their health will be protected irrespective of their social or economic condition and that they shall not impoverish due to the need for healthcare;

- .2. Citizens have informed and realistic expectations about the actual and expected costs of their healthcare, as well as a perception of the solidarity component involved in their healthcare;
- .3. Citizens make appropriate use of resources for social and economic support, helping to reduce health inequities and are supported in this process by institutions and health professionals.

#### FOR HEALTHCARE PROFESSIONALS:

- .4. Healthcare professionals become more capable stakeholders and with greater potential to promote *empowerment* when they consider the social and economic dimensions of their decisions and of their activity, as well as a more useful resource for citizens;
- .5. Organisations rely on their professionals' good judgment and good resource management, reducing administrative and financial barriers and investing in their activity.

#### FOR HEALTHCARE INSTITUTIONS:

- .6. Institutions participate more in the social contract, and get greater social recognition, by including goals of social and economic support in their activities, by monitoring and assessing their impact, by disseminating their results and by sharing best practices;
- .7. Institutions achieve better results in terms of efficiency and health gains by including a social and economic perspective in their activity, and by reducing the impact of these factors upon access, quality, continuity of care, and health outcomes.

#### FOR POLICY-MAKERS:

- .8. Greater social value arising from the opportunity and capacity of the Health System to identify and support the situations of social and economic deprivation, in an intersectoral perspective and at various levels (national, regional, local);
- .9. By reducing inequities, greater health gain return is derived, as well as economic and social return, thus reinforcing the value of social solidarity;
- .10. Inclusion of realistic and responsible expectations on the capacity and response of the Health System, on the potential resources and their distribution according to social gradients, as well as on the added value of investments in health;
- .11. Greater autonomy for the stakeholders of the Health System, by associating concerns related to the management and distribution of resources with the reduction of inequalities and social and economic support to citizens.

### THREATS TO THE STRENGTHENING OF ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE

#### FOR CITIZENS:

- .12. Overly bureaucratic and complex processes for obtaining social and financial support;
- .13. Insufficient support both in terms of scope, duration and amount, to meet their goals and respond to their needs.

#### FOR HEALTHCARE PROFESSIONALS:

- .14. The action and the social and economic implications of the decision and activity of healthcare



professionals should be construed as being outside the scope of their professional and social responsibilities, and as having merely economic goals;

- .15. Low perception of the real impact of socioeconomic determinants on the course of health and illness of individual citizens;
- .16. Difficulty in keeping up to date, identifying, advising or referring situations of social and economic deprivation;
- .17. Instrumentalisation of health services with the purpose of obtaining illegitimate social and economic support.

#### **FOR HEALTHCARE INSTITUTIONS:**

- .18. Low appreciation and encouragement from institutional actions aimed at achieving a better social and economic support;
- .19. Difficulty in monitoring and assessing the impact of institutional interventions.

#### **FOR POLICY-MAKERS:**

- .20. Difficulty in obtaining and linking data to identify socioeconomic barriers in access, quality, continuity and health outcomes, as well as in identifying socioeconomically vulnerable groups or in measuring the health impact of social policies or of the redistribution of resources;
- .21. Difficulty in measuring health gains or economic or social return following from the investment in measures conducive to reducing inequities and in the support to socioeconomically vulnerable situations;
- .22. Political and social discussion on the role of the Health System in providing guarantees and social and economic support, overly focused on the political and social principles, values and ideologies, without the corresponding translation into balanced and sustainable decisions with higher return in health gains and in the economy, while respecting the actual capacity of the country.

### **STRENGTHENING PORTUGAL'S PARTICIPATION IN GLOBAL HEALTH**

#### ***OPPORTUNITIES TO STRENGTHEN PORTUGAL'S PARTICIPATION IN GLOBAL HEALTH***

##### **FOR CITIZENS:**

- .1. Higher protection against the vulnerability of foreign policies in health and other sectors;
- .2. Higher protection against transnational threats to health.

##### **FOR HEALTHCARE PROFESSIONALS:**

- .3. Promotion of exchange, vocational training and research between internationally recognised centres;
- .4. Promotion of the incorporation and recognition of the best professional practices, at an international level;
- .5. Making it easy to belong to international networks.

##### **FOR HEALTHCARE INSTITUTIONS:**

- .6. International recognition of excellence, innovation, knowledge and best practices models;
- .7. Incorporation of international evidence and increase on the quality of its services and human resources;
- .8. Making it easy to belong to international networks;
- .9. Access to international funds and resources.

#### **FOR POLICY-MAKERS:**

- .10. Creation of synergies and international opportunities that are in line with national interests and needs;
- .11. Valorisation of organisational, technical and national knowledge capital at an international level;
- .12. Culture of competitiveness, innovation and excellence according to the best international references;
- .13. Greater coherence and alignment of national and other countries' policies.

### **THREATS TO STRENGTHENING PORTUGAL'S PARTICIPATION IN GLOBAL HEALTH**

#### **FOR CITIZENS:**

- .14. Fragmented and uninformed vision of international events and political decisions;
- .15. Insufficient discussion and social engagement in the decisions made by transnational government bodies, with the resulting detachment between the citizen and these institutions.

#### **FOR HEALTHCARE PROFESSIONALS:**

- .16. Lack of valorisation in their career and in institutions of the participation and involvement in projects and international reference training;
- .17. Language and exchange culture difficulties, that affect the participation abroad, as well as the hosting of and communication with foreign professionals.

#### **FOR HEALTHCARE INSTITUTIONS:**

- .18. Difficulty in identifying themselves with international models given the national context;
- .19. Low valorisation of international participation of Portuguese institutions.

#### **FOR POLICY-MAKERS:**

- .20. Occasional and non-empowering projects of cooperation from the host countries and health systems;
- .21. Difficulty in identifying and involving national experts who empower and inform the diplomacy in health;
- .22. Lack of coherence and continuity in policies and foreign relations in health and from health towards other sectors, as well as between internal and foreign policies;
- .23. Volatility and comprehensiveness of the international agenda and the need for proactive and fast and well-informed response representation on the stage of international discussion and decision-making.