DIRECTORATE-GENERAL OF HEALTH
MINISTRY OF HEALTH

NATIONAL HEALTH PLAN 2004-2010

VOLUME I - PRIORITIES

MORE HEALTH FOR ALL
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LISBON, JULY 2004

MINISTÉRIO DA SAÚDE
Direcção-Geral da Saúde

Saúde XXI

Portugal em Acção

INDEX OF VOLUME I

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARS	Regional Health Services
CAP	Commission for Plan Follow-up
CAT	Communities for Assistance to Drug Addicts/Abusers
CT	Therapeutic Communities
CVA	Stroke (Cardiovascular Accident)
DDD	Defined Daily Dose
DGS	Directorate-General of Health
DGSP	Department of Prison Services
DMFT	Decayed, missing, filled teeth
DSE	School Health Division
DSIA	Information and Analysis Department
EP	State Prisons
EU	European Union
GNP	Gross National Product
HC	Health Centres
HIV	Human Immunodeficiency Virus
ICD	International Common Denomination
IDT	Institute of Drugs and Drug Abuse
IGIF	Institute for Financial and Informatic Management of Healthcare
INFARMED	National Institute of Pharmacy and Medicine
INSA	Dr. Ricardo Jorge National Health Institute
MOP	Major Options for the Plan
MOP	Major Options of the Plan
NHI	National Health Inquiry
NHP	National Health Plan
NHS	National Health Service
NVP	National Immunization Programme
OECD	Organization for Economic Cooperation and Development
OSHS	Occupational Health and Safety Services
PHC	Primary Healthcare
PIDDAC	National Programme for Investment and Development Costs
PRP	Public Selling Price
PYLL	Potential Years of Life Lost
R&D	Research and Development
RNEPS	National Network of Schools Promoting Health
RPS	Reference Price System
SPTT	Drug Abuse Prevention and Treatment Service
UD	Drug Withdrawal Units
UMIC	Commission for Mission, Innovation and Knowledge
WHO	World Health Organization

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PREFACE

The National Health Plan, as a whole, represents what one may call the guiding principles with which institutions within the Ministry of Health, other bodies in the Health Sector – state, private and social welfare institutions – as well as other activity sectors, can assure or contribute to the achievement of Health Gains between 2004 and 2010, aiming at the promotion of health and the prevention of disease.

The National Health Plan was discussed publicly throughout 2003 and during the first few months of 2004, and received extensive contributions from a wide range of individuals, institutions and different sectors of society. Thus, one may claim that this document represents a broad consensus with regards to the kind of intervention that the Country needs. This document was sent to Parliament, where it was supported by most parties. It was recognised that its implementation would stretch over more than one cycle of government and will require the continued support of all political forces.

This key tool of management works like a lever, with its strategic guidelines designed to sustain the National Health System politically, technically and financially. It acts as a common denominator, allowing for better coordination and collaboration of the multiple entities in the health sector. It considers health in its widest sense, in its interdisciplinary richness, making every Portuguese responsible for it.

As a strategic document, the National Health Plan plays a uniting and guiding role in terms of what needs to be implemented in order to promote "More Health for All" among the Portuguese. It brings together the necessary debates on health and guides the activities of the institutions within the Ministry of Health, on a national as well as a regional basis, and also within civil society.

Being already committed to the fulfilment of the goals set in the Plan, namely through the Action Plan for Health in 2004 – among other initiatives – which was defined in the latest Major Options of the Plan (MOP), and which brings together in one single tool all the agreed interventions by central and regional services. In July 2004, the activities developed in the first semester of the year were assessed and the Action Plan for 2005 was prepared. The plan also provides the basis for the Health contribution to the revision of the National Plan for Sustained Development.

The strategies identified in the Plan will be ensured through the Major Options of the Plan and the yearly action plans, and defined by these two means. In addition, the current and investment budgets of the Ministry of Health, as well as EU Community funds, should grant the resources necessary for the implementation of the NHP.

The fulfilment of the National Health Plan includes the gradual implementation of 40 national programmes, into which the main plan unfolds.

Recently, and according to the Plan, I have approved several new national programmes, some of which I would like to highlight:

- The National Programme for Integrated Intervention in Health Determiners Related to Lifestyles;
- The National Programme for Prevention and Control of Cardiovascular Diseases;
- The National Programme for the Health of the Elderly;
- The National Programme for the Fight against Rheumatic Diseases;
- The National Programme for Palliative Care.

Several other national programmes are at a late stage of preparation (Vaccination, Obesity, Eye Care and Environmental Health Programmes, among others).

Publicising the document, monitoring its targets, sustaining interest from the different sectors of the public that it targets and coordinating the various parties involved will require a continuous effort through contacts with the media and other key figures in civil society, academia, professional organizations and health institutions. This effort will be backed up with regular regional and national forums, among other mechanisms contemplated in the Plan. These forums will be a means for assessing and revising the plan through feedback on a regular basis.

One particularly important aspect of ensuring that the Plan is carried out is related to the dialogue between sectors, with a view to mobilizing the will to contribute to the fulfilment of health objectives through other domestic policies such as agriculture, environment and education. In Portugal, this approach would result in the achievement of what other countries already have - health impact assessment.

Within the spirit of the initiatives needed for the Plan's success, I considered it fitting to set up a commission responsible for its follow-up, essentially consultative in nature, although it would also put forward proposals for updating and making any revisions necessary for the proper development of the Plan. It should also write reports enabling the Ministry to make regular assessments of the evolution of the National Health Plan and to make the decisions necessary for its enhancement and viability.

Therefore, I have decided to announce the setting up of a Follow-up Commission for the National Health Plan. This Commission, through open dialogue excluding no one, will guarantee that the Plan is galvanized, followed up, monitored and revised whenever necessary. Throughout this process, the Follow-up Commission will not work alone, as many other parties will be ready to collaborate on this mission so as to bring the Plan to a successful end.

I am grateful to all those who helped to build the National Health Plan, particularly the core team and especially the World Health Organization, represented by the Regional Director for Europe, Dr. Marc Danzon, as well as the international experts who so kindly helped us. I hope that our above-mentioned goals are fulfilled, for the sake of every Portuguese person's health.

Lisbon, 30.6.2004

Luís Filipe Pereira
Minister of Health

STRATEGIC GOALS

The National Health Plan 2004 – 2010 defines strategic guidelines with a view to sustaining - politically, technically and financially – what might be described as a national will, lending it a unified character and facilitating coordination and inter-collaboration among the multiple sectors, which contribute to Health.

All the work considered in this document aims at three principal strategic goals:

- Achieving health gains, by raising the level of health in the different stages of the lifecycle and by reducing the burden of disease;
- Using the necessary tools, in an appropriate organizational context, namely by centring the change on the citizen, while equipping the health system for innovation and re-orienting the healthcare system;
- Ensuring the right mechanisms for the fulfilment of the Plan through adequately securing resources, promoting inter-sector dialogue, adapting the legal framework and creating follow-up and updating mechanisms for the Plan.

Therefore, this is a far-reaching document which aims at forging joint inter-sector policies. The administrative result of this will be seen in cooperation between ministries, with a view to the overall impact on the improvement of Health.

THE PLANNING PROCESS

Planning in Health is typically defined as a process to establish a consensus on priorities, goals and activities in the health sector, in line with policies adopted, interventions selected and limitations on resources. This being the main concern in the preparation of this document, planning was also approached as:

- An opportunity for consensus on values which can work as guidelines for thought and action about health;
- A tool for coordination between the multiple participants;
- A way of intensifying collaboration between sectors in order to achieve development in health;
- A means of contributing to technical, political and financial sustainability within the health sector;
- A way of contributing to changes in the ways of working within the Ministry of Health and the institutions associated with it.

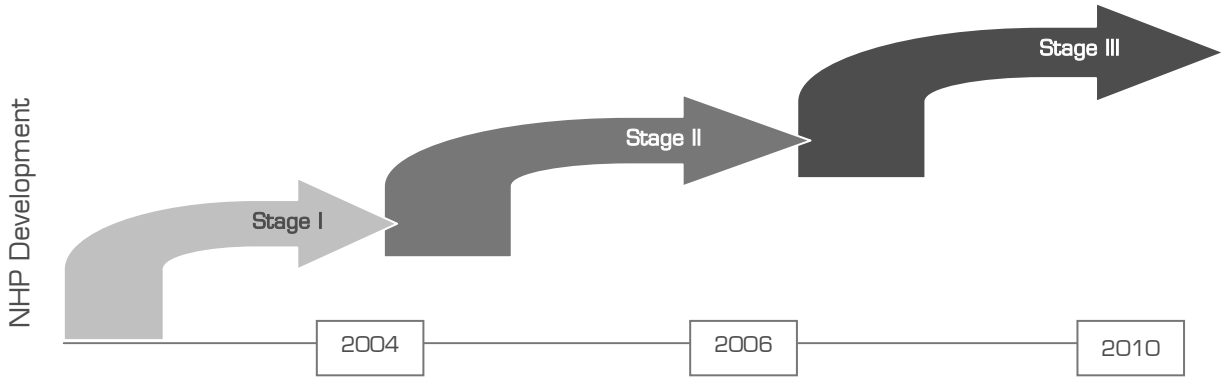
This increase in the value given to planning as a learning process has led to the adoption of a dialogue and research-driven approach on a long term basis. The approach developed for the drawing up of this plan can be outlined in the following way:

- The creation of several permanent support groups, coordinated by the Directorate-General of Health, namely, a Coordination Commission, a Follow-up Commission and a Technical Secretariat. A series of special interest groups[1] was also created, made up of experts in the related fields;
- The development of a discussion document, which was publicly debated between January and December 2003. A great effort was put into the widespread publicising of this document (with the help of the media, who were widely involved, as well as entities belonging to the Ministry of Health and civil society, among others);

1 Namely, "Social Care in Health", "Communicable Diseases", "Health and Social Exclusion", "Sexually Transmitted Diseases", "Health and Research", "Clinical Pathology", "Environmental Health", "Eyesight Health", "Dental Health", "Transplants" and "Principles and Values".

- Consulting international expertise: through the organization of a meeting with WHO, on July 28 and 29 2003, and consultation with the Organization for Economic Cooperation and Development (OECD) as well as the European Council;
- Consulting regional sources: organization of three regional forums (in Faro, Lisbon and Oporto), so as to integrate the different perspectives of the main regional participants in the planning process.
- A broad national debate, which included a national health forum that took place in Lisbon, in February 2004, to close the public debate.

Given that we value planning as a continuous process, we do not consider this plan to be a final product, but rather a permanently updated tool, which makes it more sensitive to the perceptions we get of its suitability or unsuitability to the present moment. As such, we expect to witness a natural, easy and logical evolution between the successive stages of this National Plan (picture 1).



Picture 1. Stages of Development in the National Health Plan.

Stage I corresponds to the definition of the Plan's structure and its general goals, as well as specific strategy guidelines and priority targets. This stage, which was over by the end of the first quarter of 2004, coincides with the presentation of the present version of the Plan to the Ministry for its assessment and approval.

Stage II, which runs between 2004 and 2006, corresponds to the "launching" of the Plan and to the activation of its structures and the follow-up process.

Stage III, which goes up to 2010, will involve monitoring the accomplishment of the Plan by duly appointed entities.

This continuous updating will work simultaneously as a strategic support document for the Ministry of Health and as a tool to facilitate the association of the Action Plan of the Ministry of Health to the development of the MOP at an appropriate moment each year. In addition, it will feed into the development of the respective budget and the necessary annual programmes (national, regional and sub-regional levels).

The NHP as a guide for action and change

This Plan is a guide for the measures to be taken from 2004 to 2010, driven by priorities with clearly defined objectives. As such, it highlights priority action and identifies those responsible for carrying it out. It represents, as a whole, the minimum package that the institutions of the Ministry of Health and other participants in the health sector must assure, in the context of an

agenda towards health gain[2], between 2004 and 2010, with a view to preventing illness and disease, in its primary, secondary and tertiary levels.

Adequacy of the guiding principles

The values that drive this document are social justice, universality, equity, respect for the human person, solicitude and solidarity. Of the principles, sustainability and continuity are to be emphasised, as well as citizen autonomy and the humanisation of health care.

STARTING POINT

These guidelines and activities bear in mind the Programme of the 15th Constitutional Government[3] and the respective MOP[4], what is known in terms of health[5] and the health system[6] in Portugal; a former document about health strategies[7]; the Programme of Community Action in the field of public health (EU)[8]; WHO guidelines on Health for All[9], WHO most recent report on Health in Europe[10], and relevant work done by OECD[11].

The health status of the Portuguese

Potential health can be seen as a possibility for a greater absence of disease, better well-being and better capability to function.

Potential for absence of disease

In 2000/2001, the life expectancy at birth of the Portuguese population was, for both sexes, 76.9 years, which was lower than the European average of 78.2. Men had a life expectancy of 73.5, while the European average was 75.2. Women had a life expectancy of 80.3, which was still below the European average, 81.2[12].

In 2001, Potential Years of Life Lost (PYLL) in the Portuguese population corresponded to a total of 517 082 years. 360 408 of these referred to men and 156 674 to women.

In 2002, mortality registed an increase of only 0.2% in relation to the previous year, with the average age of the deceased becoming increasingly older[13]. In 2002, the child mortality rate

2 Portugal. Ministério da Saúde. Dirrecção-Geral da Saúde - Ganhos de Saúde em Portugal: Ponto de Situação. Relatório do Director-Geral e Alto Comissário da Saúde. Lisbon: Direcção-Geral da Saúde, 2002.

3 The programme for the 15th Constitutional Government is available at www.governo.gov.pt

4 Statute no. 32-B/2002, December 30 – Major Options of the Plan for 2003; Statute nº 107-A /2003, December 31 – Major Options of the Plan for 2004.

5 Portugal. Ministério da Saúde. Dirrecção-Geral da Saúde - Ganhos de Saúde em Portugal: Ponto de Situação. Relatório do Director-Geral e Alto Comissário da Saúde. Lisbon: Direcção-Geral da Saúde, 2002.

6 Spring Reports from 2001, 2002 and 2003 by the Observatório Português dos Sistemas de Saúde, Escola Nacional de Saúde Pública, Universidade Nova de Lisboa, Portugal. See www.observaport.org

7 Portugal. Ministério da Saúde. – Saúde: um compromisso. A estratégia de Saúde para o virar do século (1998-2002). Lisbon: Ministério da Saúde, 1999.

8 Decision no. 1786/2002/CE (JO L 271 of 09.10.2002, p. 1).

9 World Health Organization - Health 21: Health for All in the 21st century. Copenhagen: WHO, Regional Office for Europe, 1999.

10 World Health Organization - The World Health Report 2002: Reducing Risks, Promoting Healthy Life. Geneva: WHO, 2002.

11 Organization for Economic Cooperation and Development - OCDE PWB Reform: Introducing Results–Based Planning, Budgeting and Management. Paris: OCDE, Committee on Financial Markets. October 28, 2003.

12 Portugal. Instituto Nacional de Estatística - Estatísticas Demográficas 2001. Instituto Nacional de Estatística, Eurostat Database, 2001.

13 Portugal. Instituto Nacional de Estatística - Destaque do INE, Estatísticas Demográficas – Mortalidade, Resultados definitivos de 2002. Lisbon: INE, 2003.

seemed to stabilize, after a constant trend to decrease since the 1970's. In 2001, Portugal was already at an average position as far as this indicator was concerned, when compared to other European countries[14].

With reference to 2001, the main causes of death of the Portuguese population are circulatory diseases and malignant tumours. External causes are more relevant among the younger age groups[15]. The development of epidemiology for these pathologies shows important advances, as well as opportunities for more health gains.

Circulatory diseases, particularly cerebrovascular diseases and ischemic heart disease are among the main causes of ill health, invalidity and death in Portugal. They are the third and fourth main causes of PYLL, which is one of the reasons why they constitute a serious public health problem that needs to be solved rapidly. The high predominance of risk factors associated with circulatory diseases, namely smoking, high blood pressure, high cholesterol levels and sedentary habits, makes it obvious that prevention should be given special attention. This should be backed up by integrated and complementary measures, so as to reduce the risk of getting the above mentioned diseases and to allow for their rapid and adequate treatment[16].

Cancer related mortality has stabilized in Portugal. Overall cancer related mortality is higher in men than in women. Within the EU, and as far as cancer related mortality in men is concerned, Portugal represents one of the few exceptions to the current upward trend. Comparing Portugal's figures with those of the best countries in the EU, it seems possible to reduce premature mortality by 38%, in the case of men, and by 10% in women. Breast cancer is still the most frequent cause of cancer-related death in women. However, in Portugal mortality has decreased. Comparing the figures in Portugal with the best countries in the EU (13.5 per 100,000 in 1998), it seems possible to reduce premature mortality in a significant way. Colon and rectum cancer are the third most common cause of death for men and the second most common for women, and mortality has been increasing. Endometrial (or uterine) cancer is now considered preventable through cytology screening. The data show a low mortality rate which has not increased among younger women[17].

Accidents and their consequences (concussions, injuries and lesions) are the main cause of death among children and adolescents, after the first year of life, thus leading to a high PYLL. Alternatively, they lead to a large number of disabled young people and loss of functional capability. The economic and psycho-sociological costs of this are high, albeit difficult to calculate. Among adults, motor accidents and work-related hazards impose high costs upon the victim, their family and society. When these happen to older people they are a significant cause of ill health, disability, dependency and mortality. A considerable number of these accidents, especially motor accidents, are associated with excessive alcohol consumption. Thus, accidents are a significant cause of permanent disability, for which the Portuguese health system has a low response capacity[18].

The existence of regional differences as far as the health status of the Portuguese is concerned reflects, on one hand, different customs associated to lifestyles, but on the other hand, it can reveal certain inequities in access that the population has to healthcare[19].

Potential for greater well-being

The opinion that each person has about their own health is an index recommended by WHO for the assessment of the health status of the population.[20]

14 Portugal. Instituto Nacional de Estatística - Destaque do INE, Estatísticas Vitais, Resultados definitivos de 2002. Lisbon: INE, 2003.

15 Portugal. Ministério da Saúde. Direcção Geral da Saúde – Risco de morrer em Portugal, 2001. Lisbon: Direcção Geral de Saúde, 2003.

16 Portugal. Ministério da Saúde. Direcção Geral da Saúde – Ganhos de Saúde em Portugal: ponto da situação: relatório do Director Geral e Alto Comissário da Saúde. Lisbon: Direcção Geral de Saúde, 2002.

17 *Idem*.

18 Ibidem.

19 Santana, P. – Poverty, Social Exclusion and Health in Portugal. Society Science Medicine; 55(1) 33-45.

Between the National Health Inquiries (NHI) of 1995/1996 and 1998/1999, there was a decrease, albeit small, in the percentage of people who considered their health status to be "very bad" or "bad" and a slight increase in the percentage of people who considered their health status to be "good".

This improvement occurred among men as well as women. The percentage of people who considered their health status to be "very good" or "good" is superior in men, in both NHI's, and across all age groups. Also in both genders, there is a slight increase from 1995/96 to 1998/99. On the other hand, women consider their health status to be "bad" or "very bad" more frequently than men, with a decrease in both genders between the two NHI. The behaviour of the "reasonable" category did not seem to change significantly between both NHI's. The "very good" category did not change at all.

The percentage of people who assessed their health status as "very good" or "good" decreases with age, in both genders, and corresponds to a perception of health status as "bad" or "very bad" more frequently among older people. Also worth mentioning is a clearer distinction between the genders over the age group 45 to 54.

The behaviour of the "reasonable" category is interesting, in that it is different below and above the 45 to 54 age group. In fact, among the age groups below 45, a self-appreciation of a "reasonable" health status is more often in women, whereas after 55, it is more frequent in men. Moreover, the development of this category between both NHI's seems to be different below and above this age group.

These results suggest a possible change in the distribution pattern of self-appreciation in terms of health status in Portugal between 1995/1996 and 1998/1999, which is more evident in age groups above 45 to 54. In younger age groups, the development has not been as clear[21]. Also identifiable is the opportunity to reduce the inequalities in state of health self-appreciation between men and women.

Potential for better functional ability

In 2001, the Dr. Ricardo Jorge National Health Institute published the results of a project which, among other indications, gave information about the functional capability of the elderly. These results indicate that 8.3% of these individuals claim to be seriously incapacitated, with an estimated 12% of individuals who claim that they need help to be able to perform daily routine activities. According to this study, a large majority of these (92.5%) are helped on an almost daily basis[22]. These results are important, as very little is known about functional capability among the different age groups in Portugal. At a time when the first steps are being taken in providing permanent care services, these figures are of great relevance in supporting any decision making.

The Health System in Portugal

The Portuguese Health System will be analysed using an essentially descriptive approach, looking at its resources, the different levels of healthcare available to Portuguese and its performance.

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20 World Health Organization – Health Interview Surveys: Towards international Harmonization of Methods and Instruments. Copenhagen: WHO Regional Publications European Series no. 58. 1996.

21 Graça, M.J.; Dias, C.D. - Como as pessoas avaliam o seu próprio estado de saúde em Portugal. Dados dos Inquéritos Nacionais de Saúde de 1995/1996 e de 1998/1999 *In* Observações no. 11. Lisbon: Observatório Nacional de Saúde, March 2001.

22 Branco, M.J.; Nogueira, P.J.; Dias, C.D. - MOCECOS: uma observação dos cidadãos idosos no princípio do século XXI. Lisbon: Observatório Nacional de Saúde. October 2001.

Financial and human resources

In 2001, the approximately 10.3[23] million Portuguese collectively spent about 9.3%[24] of the Gross National Product (GNP) on health care, and were attended by 174 963[25] workers in the health sector (3.4% of the employed population[26]).

Overall, in 2001[27], about 33.2 thousand medical doctors, 3.7 thousand dentists, 8.4 thousand pharmacists and 39.3 thousand nurses[28] were listed as members of their respective professional associations.

The funding used by the National Health Service (NHS) in 2001, as part of the Health System[29], represented about 13.1% of State expenditure and 6.1% of GNP[30], which shows the investments made to the benefit of the health sector. For comparison purposes, we can see that spending in this area has increased by 24.49% since 1995, when it represented 4.9% of GNP, this being the highest increase in terms of GNP percentage of all countries in the OECD. In 2001, some countries like Spain, Ireland and the United Kingdom spent lower percentages of GNP on public health than Portugal. These values were 5.2%, 4.5% and 6%, respectively.

Primary health care

In 2001, primary health care (PHC) by the NHS was provided by 363 health centres on the Portuguese mainland, with a further 1 797 extensions. In the same year, the NHS employed 6 961 medical doctors, 6 850 nurses and 875 diagnostic and therapy professionals to develop activities associated with PHC[31].

More recently, in 2003, the PHC network was redefined and is now made up of " NHS health centres, private profit-making and non-profit-making entities, which provide health care to NHS users according to the conditions of contracts in force (...), and also independent professionals and professional groups, as part of cooperative associations or other entities (...)"[32]. This model for PHC involving a network of other health care services has not yet found a successful formula for harmonising the need for efficient management of the system with freedom of choice for the citizen and the expectations of the professional groups involved.

Hospital care

In 2001 the Health System had a total of 38 452 inpatient beds, distributed in the following way: about 74% belong to the public network, which includes the NHS and the Islands of Madeira and the Azores, 3% to the official non-public areas (namely military, paramilitary and prison facilities) and 23% to other institutions (among which 78% of beds belong to the social sector and 22% to the profit-making private sector)[33].

23 10.299,3 residents in Portugal, according to the resident population estimate 2001, Lisbon: INE, 2001.

24 Organization for Economic Cooperation and Development – OECD Health Data 2004. Paris: OECD, 2004

25 According to the Classification of Economic Activities (CAE-REV2), Lisbon: INE, 2001.

26 According to the average trimestral value in 2001, Estatísticas do Emprego, INE, 2001.

27 Portugal, Ministério da Saúde. Direcção-Geral da Saúde – Elementos Estatísticos: Saúde 2001. Lisbon: Direcção-Geral da Saúde, 2004.

28 In 2003, according to the Nurses Association a total of 43,860 nurses were listed as members of the Association.

29 The Health System is comprised of the National Health Service and all public entities who work on initiatives for health promotion, prevention and treatment, as well as all private entities and independent professionals who collaborate with the former in all or some of the above-mentioned activities, Base XII, no. 1, of Statute no. 48/90, August 24.

30 Organization for Economic Cooperation and Development - OCDE Health Data 2003. Paris: OCDE, 2003.

31 Portugal, Instituto Nacional de Estatística. Estatística da Saúde: 2001. Lisbon: INE, 2003.

32 Statute no. 60/2003, April 1. Art. 1, no. 2 – reorganises Primary Health Care.

33 Portugal, Instituto Nacional de Estatística. Estatística da Saúde: 2001. Lisbon: INE, 2003.

On the other hand, in 2001 the NHS hospital network was composed of 88 hospitals (13 central hospitals, 40 district hospitals, 22 level 1 hospitals and 13 specialised hospitals), with a variable inpatient capacity (from hospitals with about 50 beds to hospitals with approximately 1500 beds), comprising a total of 23 673 beds. With regards to human resources, the NHS hospital network had, in the same year, 15 862 medical doctors, 24 872 nurses and 5 536 diagnostic and therapy professionals[34].

Continuous care

In 2003, the Continuous Health Care network was approved[35], made up of "all public, social and private entities which can carry out health care in order to promote, restore and maintain the quality of life, well-being and comfort of citizens in need of this assistance as a consequence of chronic or degenerative disease, or due to any other physical or psychological cause leading to functional limitation or dependence upon others, including the use of all technical and human means suitable to ease pain and suffering, to mitigate anguish and to maintain dignity in the final period of life". This recent law, during the initial stages of being put into practice, aims at a complementary system and strengthens the links between primary health care and hospital care networks.

Mental health care

The services providing mental health care within the NHS comprised, in 2003, 36 psychiatric and paedopsychiatric establishments and 3 alcohology regional centres, with an overall inpatient capacity of 2 640 beds (60.2% of the existing beds are concentrated in 5 psychiatric hospitals). With regards to human resources, there are 422 psychiatrists, 160 psychologists, 40 paedopsychiatrists, 124 social service professionals, 65 occupational therapists, 1,227 nurses, 5 psychomotricity professionals, 15 speech therapists, 9 pre-school teachers, 3 education professionals, 7 special needs teachers and 7 general practitioners[36].

Apart from the mental health care integrated in the NHS, there is, within the remit of the Institute of Drugs and Drug Addiction (IDT), a national network of non-centralised health services, composed of units specialised in health care for drug addicts. In 2002[37], these units were divided in the following way:

- Forty-five Centres for Assistance to Drug Addicts (CAT) – units giving overall and comprehensive care to drug addicts seeking treatment. These units relied on multidisciplinary teams, made up of medical doctors from different specialisations (with special emphasis on psychiatry, as well as internal medicine, family medicine, public health), psychologists, nurses, social service professionals and psycho-social professionals. This level of health care is complemented by 9 CAT extensions, 17 non-centralised outpatient facilities, 3 units for assistance to drug addicts and 4 day centres. There are also 5 private day centres, working on an agreement basis.
- Five Withdrawal Units (UD) – these units offer a total of 45 short-term (seven day) inpatient places and are spread throughout the country (one in Oporto, one in Coimbra, one in Olhão and two in Lisbon). There are also seven private withdrawal clinics, functioning on an agreement basis, adding another 77 available places that complement this type of service.
- Two Therapeutic Communities (CT) – these units offer a total of 34 places, one in Coimbra and the other in Lisbon. These are long-term residential structures, with an inpatient facility, which includes psychotherapeutic and social-therapeutic assistance. There are also 64 private therapeutic communities, working on an agreement basis, offering another 1,226 available places that complement this service.

34 Portugal, Ministério da Saúde. Direcção-Geral da Saúde - Portugal Saúde: Indicadores Básicos 2000. Lisbon: Direcção-Geral da Saúde, 2003.

35 Statute no. 281/2003, November 8 – Creates the Continuous Health Care network.

36 Portugal. Ministério da Saúde. Direcção Geral da Saúde - Rede de Referenciação de Psiquiatria e Saúde Mental. Lisbon: Direcção Geral da Saúde, 2003 (awaiting publication).

37 Portugal. Instituto da Droga e da Toxicodependência - Relatório Anual 2002: a Situação do País em Matéria de Drogas e Toxicodependências. Vol. I. Informação Estatística 2002. Lisbon: IDT, 2003.

System performance

WHO published the World Health Report 2000[38], where the health systems of the 191 member countries are compared for the first time.

This study examined all the countries according to broad themes, such as overall level of population health[39], distribution of health in the population, the overall level of responsiveness[40], distribution of responsiveness within the population and distribution of financial contribution.

Although this study has been subject to some criticism, specifically for representing only some of the functions of health systems, the truth is that Portugal came out in twelfth place in the overall health system performance ranking, before countries like Great Britain, Germany, Canada and the United States.

In fact, the health systems of the different countries are not compared in absolute terms. This position takes into account the relationship between the health system and the socioeconomic development level of each country. This explains why Portugal, being at a clear disadvantage when compared to other developed countries, stands out when it comes to the quality of its health system in this context.

Thus, despite this honourable position, when Portugal is compared to other OECD countries, health costs are high in relation to the GNP, they show a show low *per capita* public spending, excessive spending on pharmaceutical products, as well as higher spending with the private sector, when compared with other countries with a similiar NHS.

Performance related to equity, efficiency, responsibility and responsiveness is also below what might be expected. Organizational infrastructures are outdated and, although covered by legislation, previous attempts to reform the health system have never been fully implemented[41].

38 WHO - World Health Report 2000. Health Systems: Improving Performance. Geneva: World Health Organization, 2000.

39 Determined mostly by the Disability Adjusted Life Expectancy – DALE – or healthy life expectancy.

40 Which includes respect for the patient's dignity, (namely the right to confidentiality, a person and his/her family's autonomy to decide upon their own health, among others), a patient oriented service (promptness in medical assistance, access to social support during health care assistance, quality of the facilities and freedom of choice) and resource availability. This indicator results from a combination between system performance and patient satisfaction, being, perhaps, the most difficult relationship to measure.

41 Bentes, M.; Dias, C.M.; Sakellarides, C. - Health Care Systems in Transition: Portugal. Copenhagen: The European Observatory on Health Care Systems, 2003.

MAIN STRATEGIES OF THE PLAN

In order to fulfil its goals, as listed at the beginning of this document, the Plan was designed according to strategic approaches that correspond to sets of programmed and executed actions, throughout the course of the Plan.

The main guiding strategies of this Plan, which shall be looked at in the next sections, take into account:

I – Overall strategies
1. Priority for the poor
2. Approach to the programme
3. Approach based on settings

II – Strategies to obtain more health for all
4. Approach centred on family and life cycle
5. An integrated management of disease approach

III – Strategies for change management
6. Citizen-centred change
7. Capacitating the health system for innovation
8. Re-orienting the health system
9. Access to and rationalized use of medication

IV – Strategies for ensuring accomplishment of the Plan
10. Plan follow-up
11. Securing Resources
12. Dialogue
13. Legal framework

Strategies towards *more health for all* (4 and 5) and towards more effective *change management* which is closer to the citizen (6, 7, 8, 9) will be analysed in more detail in the second volume of this Plan.

OVERALL STRATEGIES

The three overall strategies should cut across all the other strategies, plans, programmes and projects of the health system.

Priority for the poor

In the last three decades in Portugal, there have been significant health gains. But there has also been an increase in health problems associated with poverty and social exclusion, without the necessary flexibility of the health system to adapt to these emerging challenges. This is partially a consequence of increasing social inequity, the ageing of the population, higher population mobility and an increasing number of immigrants.

Equated with a greater lack of resources and harsher living conditions, poverty and social exclusion are also associated with a greater prevalence of less healthy lifestyles and more difficult access to health care and pharmaceuticals. On the other hand, these health-related problems tend to worsen socioeconomics situations of need, thus accentuating poverty and social exclusion. The result is a more serious dimension of chronic-degenerative health problems among poorer populations, the reappearance of health problems like tuberculosis, problems associated with addictive behaviour, violence and the persistence of AIDS, to mention but a few of the problems with a higher impact on poorer members of society.

There is significant evidence in other EU countries that some strategies are effective. If adopted by the Ministry of Health, they may have a significant impact on the reduction of health inequities and the decrease of the burden of diseases related to poverty and social exclusion[42].

Of these strategies, a geographical approach should be emphasised in first place, as this would complement the approach based on settings included further in this Plan. This might have a significant impact on the improvement of healthcare for the underprivileged populations geographically concentrated.

Secondly, the recognition that the work to be carry out should be promoted and supervised by the Ministry of Health and its institutions but, in practice, it requires the collaboration of many other sectors of society. The leaders of the Ministry of Health will have to assume an active role as advocates of policies that not only promote health but also positively discriminate in favour of underprivileged citizens.

Approach to the programme

Strategic guidelines for health are essentially centred on already existing plans, programmes and projects, which might be reviewed, but with openings for new national programmes that prove to be necessary.

Due, on one hand, to associated risk and the burden of disease and, on the other, to the existence of interventions with a high cost-effectiveness ratio and to the availability of resources, a great effort has been put into developing National Intervention Programmes. This Programmes are to be put into practice, horizontally, by all participants in the health system, including citizens.

This approach will continue to be carried out in an attempt to identify the need for:
- Better coordination between programmes, whenever there are common issues (for instance, unhealthy lifestyles associated with cardiovascular diseases, diabetes, obesity and some types of cancer);
- Combining different existing programmes as sub-programmes of a more comprehensive, overall programme;
- Modelling programmes according to a logic of integrated management of disease;
- Defining smart targets[43], whenever deemed appropriate;
- Investing in information systems, for better programme monitoring, so as to be able to make necessary revisions at any moment.

Approach based on settings

Schools, workplaces and leisure facilities are places where a great part of the useful time of a normal day is spent. These are three settings, among others, whose environments naturally call for a wide range of different types of intervention. To strengthen this approach, which implies collaboration with other Ministries, the model to be followed is one in which a programme coordinator for the identified settings is appointed by joint order of the Ministry of Health and other entities involved:
- Ministry of Work, for workplaces;
- State Secretariat for Sport, for sports facilities;
- State Secretariat of Youth, for leisure facilities and public leisure areas;
- Ministry of Justice, for prisons;
- Ministry of Education, for pre-school institutions, primary and secondary schools and other educational institutions except higher education.

42 Mackenbach, J.; Bakker, M. – Tackling socioeconomic inequalities in health: analysis of European experiences. The Lancet; Vol. 362 (2003) 1409-1414.

43 A smart objective is specific, manageable, assessable, realistic and time-bound.

Schools, workplaces and prisons, due to their specific characteristics, require special attention.

Schools

School plays a key role in the process of acquiring a lifestyle which the intervention of school health – aimed specifically at school children and teenagers – may favour, while complementing personalized healthcare.

In the School Year 2002/03, 96% of the 357 Portuguese Health Centres were involved in school health programmes. This was undertaken in 4 398 (89%) pre-school institutions, 8 265 (89%) Primary and Secondary Schools and 41 (36%) Technical Schools.

Despite the good coverage of schools, students, teachers and education assistants by the School Health Programme[44], the accomplishment of some activities, such as monitoring student's health status, is still quite low, at the age of 6 (71 %), as well as at 13 (34 %), even though there has been an improvement in the last few years. Of those students who had special health needs, (24 965), only slightly more than 50% (13 160) had their health problem solved by the end of the school year. The assessment of school safety, hygiene and health is the contribution of Health towards risk diagnosis, in the school context. The assessment carried out in 2002/03, at 5 341 schools of the 8 265 which benefited from School Health, shows that there are good conditions of safety and hygine in, respectively, 64% and 81% of school environments, and 18% and 28% in schools buildings and facilities, respectively.

Support for the development of a curriculum for health promotion and education, by school health teams, covers areas as diverse as nutrition guidance, healthy active life, violence prevention, citizenship and sexual and affective education, AIDS, drug abuse (with special emphasis on excessive consumption of alcohol, tobacco and drugs) at different levels of schooling. However, there are not enough technical guidelines for intervention in all these areas.

With a project methodology based on needs analysis and a partnership-building strategy, thus creating or reinforcing social networks for the integration of schools into the community, in 2000/2001 the National Network of Health Promoting Schools (RNEPS)[45] reached one third of the school population in public institutions from pre-school to secondary level. This corresponds to 3,722 schools and 282 health centres (80% of the total number of health centres). RNEPS is part of the European Network of Health Promoting Schools, a joint project between WHO, the European Council and the European Commission.

The strategy of intervention in school health in terms of health promotion and disease prevention is based on activities that will be carried out on a regular and continuous basis throughout the school year. This will ensure that health survaillance, the National Immunization Programme (NVP) and legislation on school eviction are carried out. It will accelerate forwarding processes, through protocols or partnerships, in and out of the NHS, for better responsiveness to children with special health needs, dental health promotion and incentives for healthy lifestyles.

As to other sectors of the community, such as council authorities, cooperation will be reinforced in order to achieve better environments in educational institutions.

WHO *Health for All in the 21st century*[46] strategies indicate that in 2015 at least 50% of children attending kindergarten and 95% of those in compulsory and tertiary schooling will have

44 Normative circular document no. 13/DSE, 10/08/95 – Prototype School Health Programme.

45 Joint Order no. 734/2000 of July 18, subscribed to by the Ministers of Health and Education – establishes rules on the widening process of the National Network of Health Promoting Schools.

46 World Health Organization - Health 21: Health for All in the 21st century. Copenhagen: WHO, Regional Office for Europe, 1999.

the opportunity to be educated in health promoting schools. A health promoting school is one that grants all children and adolescents who attend it, the chance to acquire personal and social competencies enabling them to improve their own health management and act upon the factors that influence it. For that to happen, partnerships, democratic procedures, participative methodologies and sustained development are indispensable.

Table I – School Health Targets

Indicator	Present situation	Target for 2010
% of HC with School Health Teams	96	100
% of coverage for monitoring state of health in 6 year-old students	71	90
% of coverage for monitoring state of health in 13 year-old students	31	75
% of students with up-to-date NVP at pre-school level	82	95
% of students with up-to-date NVP at the age of 6	90	99
% of students with up-to-date NVP at the age of 13	78	95
% of students with solvable special health needs who have their problem solved by the end of the school year	53	75
% of schools assessed for safety, hygine and health standards	65	100
% of schools with good safety and hygine environment standards	64	90
% of schools with good safety and hygine standards for buildings and facilities	18	60
% of interventions for health promotion in school health with specific technical guidelines	20	100
% of 6 year-old children with no dental decay	33	65
Index of DMFT (decayed, missing, filled teeth in permanent teeth) at the age of 12	2.95	1.90
% of young people in need of treatment with treated teeth at the age of 12	18	60

Source: DGS, DSE – School Year 2002/2003.

Workplaces

Perhaps the most important aspect in terms of workplace intervention lies in better information and more knowledge with regards to occupational health. That information would be directed to the general public, to health professionals and to health authorities. It is therefore crucial that the parties involved work together to create an Observatory on Work-Related Disease.

An important issue in the area of intervention in the workplace is related to the development of a National Programme for the Promotion and Protection of Occupational Health based on five strategic structural axes of intervention. These would consolidate the principles defined in the National Prevention Plan resulting from the agreement on working conditions, occupational health and safety and fighting agains accidents in the workplace as established by the Economic and Social Council of 2001.

Support will be given in a more active way to the involvement of health services, particularly Regional Public Health Centres, in support and incentives to companies in the respective regions, not only so that they follow legal requirements in terms of health and safety, but also so that they contribute to employees adopting healthier lifestyles.

It will also assure that both public and private health services, including institutes and central services, organise Occupational Health and Safety Services (OSHS)[47] so as to encourage these institutions and services to follow legal requirements on occupational health and safety. This will guarantee the evaluation and up-to-date records of risk factors, and the planning of actions towards their effective control, as well as the existence of adequately qualified and competent human resources.

47 Statute no. 109/2000, June 30 – Defines the judicial framework of OSHS.

In this way, all services depending on the Ministry of Health, especially healthcare units, should have Occupational Health and Safety Services[48] in place. This will bring added value in terms of health and safety to their own employees, to the community in which they operate, through the support and services rendered to workers in other sectors and, also, by promoting scientific research and the training of technicians through the creation of specific centres.

Prisons

Currently, Portugal has the highest prison population in Western Europe. On October 1 2002, this corresponded to a total of 14,126 prisoners, and an occupation rate of 121.6%. The health status of these prisoners has not been well defined, but drug addiction is the main health problem of this population (65.4% of prisoners are or have been drug abusers). Complaints related to mental health issues represent the other major health problem. This population has precarious mental health and the solution found for this problem, mainly by family doctors (general practitioners), is the use of antidepressants. These are the most frequently prescribed drugs, with considerable costs. There are usually 5 to 10 deaths/year caused by either suicide or drug overdose in Portuguese jails. 16% of prisoners have AIDS or are HIV positive; as for hepatitis, 26.9% of prisoners have hepatitis C and 9.7% have hepatitis B. The incidence of tuberculosis is about 13 times higher than among the rest of the population, multi-resistance being a particularly serious problem. Dental health needs that have not been met are another health issue that seems to affect most prisoners.

Health problems among prison workers should also be considered in a future action programme. There are protocols between State Prisons/Department of Prison Services (EP/DGSP) and the ARS, Health Sub-Regions or HC[49], that determine the conditions in which medical assistance and medicines are administered, given the particular characteristics of each prison, its population and specific needs[50] of Health and Justice. There is need for regional and national assessment of past and present action, in view of statute no. 170/99, of September 18.

Specific joint interventions should be reinforced by DGS, IDT and ARS, related to the organization of a response to drug use[51] and, as far as rehabilitation is concerned, to the development of treatment for drug addicts in prisons, as well as the promotion of social re-integration of drug abusing prisoners through exit homes[52].

Action for promotion of mental health and healthy lifestyles in prison, aimed at prisoners as well as prison workers, should be prioritized.

Also a priority is the creation of protocols for the immunization of prison workers and prisoners against infectious diseases, namely hepatitis B[53], as well as specific interventions from DGS and ARS related to HIV and other infectious diseases. With regards to tuberculosis, screening, diagnosis, treatment and prevention of transmission should also be a priority[54].

48 Statute no. 488/99, November 17 – Defines the application possibilities of the OSHS judicial framework for Public Administration.

49 By February 2002, 38 collaboration protocols had been signed.

50 Protocol of 21/03/97 by the Ministers of Health and Justice.

51 Council of Ministers Presidency - 'Redução de Riscos e Minimização de Danos'. *In* Plano de Acção Nacional de Luta Contra a Droga e Toxicodependência - Horizonte 2004. Lisbon: IPDT, 2001.

52 Council of Ministers Presidency - 'Reinserção Social dos Toxicodependentes', *In* Plano de Acção Nacional de Luta Contra a Droga e Toxicodependência - Horizonte 2004. Lisbon: IPDT, 2001.

53 Protocol of 21/03/97 by the Ministers of Health and Justice.

54 Protocol of 24/03/98 between DGSP and DGS.

Table II – Targets for prison population health

Indicator	Present situation	Target for 2010
% of vaccination coverage of prison personnel	Unknown	100
% of vaccination coverage of prisoners	Unknown	100
Promotion of mental health in prison environments	Non-existent	In place so as to cover 50% of the prison population

STRATEGIES FOR OBTAINING MORE HEALTH FOR ALL

In order to obtain more health for all, two strategies are highlighted: focussing interventions on the family and life cycle and tackling health problems through a disease management approach.

Approach centred on family and life cycle

Among the different possible approaches to understanding health and planning the necessary interventions, those that focus on the family and are based on life cycle are becoming increasingly popular[55], particularly with regards to lifestyles and social problems. A family and life cycle centred approach is justified by the fact that it allows for a better, more integrated perception of the health problems that should be prioritized for different age groups and the different social roles that they take on throughout the course of their lives.

For the different stages of the life cycle, the goals and targets as shown in tables III to VII have been agreed upon, with regards to the present situation:

Table III - Priority targets to "Be Born Healthy" – pregnancy and neonatal period

Indicator	Present situation	Projection for 2010	Target for 2010
Life expectancy at birth[1]	77.1	78.2	81
Rate of foetal mortality / 1,000 live births[1]	4.6	4.3	4
Rate of perinatal mortality (22 weeks and more)/1,000 live births[1]	7.1	6.2	5.5
Rate of neonatal mortality / 1,000 live births[1]	3.4	2.6	2.5
Rate of pre-term births / 100 live births[1]	6.4	6	5.5
Rate of underweight children at birth / 100 live births[1]	7.4	6.3	6
Rate of cesarian deliveries / 100 live births[1]	24	28	20
% of women who smoke during pregnancy[2]	11.5 (3)	N.A.	< 5

(1) DGS, present situation data refer to 2001. (2) INSA, present situation data refer to 1997/98.
(3) Value refers to the % of children under 6 years-old whose mothers smoked during pregnancy. INSA, INS 1997/98
N.A. – Not available.

Table IV - Priority targets for "Growing Safely" - post-neonatal to 9 years of age

Indicator	Present situation	Projection for 2010	Target for 2010
Life expectancy from 1 to 4 years[1]	76.5	—	78
Child mortality rate/ 1,000 live births (<1 year)[1]	5	4.4	3
Mortality rate 1-4 years/ 100,000 individuals[1]	36.6	36.1	35
Mortality rate 5-9 years/ 100,000 individuals[1]	22.3	21.4	20
Risk of dying before 5 years of age[1]	7.2	5.8	5
Breast-feeding – % of women who breast-feed exclusively for the first three months	22(2)	—	> 50

(1) DGS, present situation data refer to 2001.
(2) Results of study on INS 95/96 and 98/99, "Uma observação sobre o aleitamento materno", ONSA, 2003.
N.A. – Not available.

55 Kuh, D.; Shlomo, Y.B. - A life course approach to chronic disease epidemiology. New York: Oxford University Press, 1997.

Table V - Priority targets for "Young people seeking a healthy future" - 10 to 24 years of age

Indicator	Present situation	Projection for 2010	Target for 2010
Life expectancy from 15 to 19 years[1]	62.8	—	65
Mortality rate from 10-14 years/100,000 individuals[1]	26.2	25.8	25
Mortality rate from 15-19 years/100,000 individuals[1]	61.9	59.9	58
Mortality rate from 20-24 years/100,000 individuals[1]	91.1	90.2	85
Birth rate in adolescent women (age <20 years) / 1,000 live births[1]	5.9	5.5	> 5
Self-appreciation of health status - % of "bad" or "very bad" (15-24 years)[2]	M=0.9 W=2.4	N.A.	M=0.6 W=1.6
Tobacco - %of individuals who smoke daily (15-24 years)[2]	M=25.8 W=10.5	N.A.	M=13 W=5
Alcohol - % of individuals who consumed alcohol several times a week in the last 12 months (15-24 years)[2]	12.9	N.A.	3
Physical activity - % of individuals who spent most of their spare time in sedentary activities in the last 12 months (15-24 years)[2]	M=45.5 W=64.2	N.A.	M=15 W=16
Weight - % of individuals with body mass index between 27 and 29.9 (15-24 years)[2]	M=6.8 W=4.6	N.A.	M=5 W=3.5
Obesity - % of individuals with body mass index ≥ 30 (15-24 years)[2]	M=3.2 W=2.2	N.A.	M=3.2 W=2.2

(1) DGS, present situation data refer to 2001. (2) INSA, present situation data refer to 1997/98. N.A. – Not available.

Table VI – Priority targets for "A productive adult life" – from 25 to 64 years of age

Indicator	Present situation	Projection for 2010	Target for 2010
Life expectancy from 45 to 49 years[1]	34.6	—	36-37
Mortality rate 25-44 years/ 100,000 individuals[1]	174.3	162.8	156
Mortality rate 45-64 years/ 100,000 individuals[1]	595.6	587.4	565
Birth rate in women ≥ 35 years/ 1,000 live births[1]	14.4	15.6	< 15
Self-appreciation of health status - % of "bad" or "very bad" (35-44 years)[2]	M=5.7 W=10.8	N.A.	M=3 W=6
Self-appreciation of health status - % of "bad" or "very bad" (55-64 years)[2]	M=27.3 W=41.4	N.A.	M=14 W=21
Tobacco - % of individuals smoking (25-44 years)[2]	M=45.7 W=17.1	N.A.	M=23 W=9
Tobacco - % of individuals smoking (45-64 years)[2]	M=26 W=4.17	N.A.	M=17 W=3
Alcohol - % of individuals who consumed alcohol several times a week in the last 12 months (25-44 years)[2]	43.1	N.A.	22
Alcohol - % of individuals who consumed alcohol several times a week in the last 12 months (45-64 years)[2]	46.5	N.A.	23
Physical activity - % of individuals who spent most of their spare time in sedentary activities in the last 12 months (35-44 years)[2]	M=67.5 W=77.3	N.A.	M=34 W=39
Physical activity - % of individuals who spent most of their spare time in sedentary activities in the last 12 months (55-64 years)[2]	M=70 W=83.2	N.A.	M=35 W=42
Weight - % of individuals with body mass index between 27 and 29.9 (35-44 years)[2]	M=22.6 W=16.3	N.A.	M=17 W=12
Weight - % of individuals with body mass index between 27 and 29.9 (55-64 years)[2]	M=26.1 W=22.1	N.A.	M=20 W=17
Obesity - % of individuals with body mass index ≥ 30 (35-44 years)[2]	M=11.8 W=11.8	N.A.	M=6 W=6
Obesity - % of individuals with body mass index ≥ 30 (55-64 years)[2]	M=16.2 W=20.3	N.A.	M=8 W=10
% of individuals who claim to have long-term 1st degree disability (45-64 years)[2]	33.7	N.A.	27

(1) DGS, present situation data refer to 2001. (2) INSA, present situation data refer to 1997/98. N.A. – Not available.

Table VII – Priority targets for "Active Ageing" - 65 years of age or more

Indicator	Present situation	Projection for 2010	Target for 2010
Life expectancy from 65 to 69 years[1]	17.55	—	20
Self-appreciation of health status - % of "bad" or "very bad" (65-75 years)[2]	M=35 W=52.6	N.A.	M=18 W=26
Tobacco - % of individuals smoking (65-74 years)[2]	M=14.5 W=0.7	N.A.	M=11 W=0.5
Alcohol - % of individuals who consumed alcohol several times a week in the last 12 months (65-74 years)[2]	39.2	N.A.	20
Physical activity - % of individuals who spent most of their spare time in sedentary activities in the last 12 months (65-74 years)[2]	M=75.5 W=87.8	N.A.	M=38 W=44
Weight - % of individuals with body mass index between 27 and 29.9 (65-74 years)[2]	M=25.9 W=22.1	N.A.	M=19 W=17
Obesity - %of individuals with body mass index equivalent to or above 30 (65-74 years)[2]	M=14,9 W=19.3	N.A.	M=11 W=14
% of individuals who claim to have long-term 1st degree disability (65-74 years)[2]	56.2	N.A.	39
% of individuals who claim to have long-term 1st degree disability (75-84 years)[2]	69.2	N.A.	55

(1) DGS, present situation data refer to 2001. (2) INSA, present situation data refer to 1997/98.
N.A. – Not available.

An integrated management of disease approach

The approach to integrated management of disease, be it infectious or chronic-degenerative, is one of the areas requiring great effort on the part of the health sector. Through the identification of priorities, the development of plans and programmes, the creation of regulations and systems for monitoring and observation, the improvement of access to materials for therapy and self-observation and patient self-responsibility, there is an attempt to create a context that enables a more rational management of disease by all the parties involved: patients, administrators, managers, hospital doctors, public health doctors, general practitioners, nurses and other professionals such as those working in psycho-social, psycho-educational and rehabilitation areas[56].

It is in adulthood that individuals, through family, work and their relations with society, have a greater propensity towards affirming their citizenship and putting it into practice. Several changes have occurred as a consequence of the evolution of society, creating the great challenge of living longer in a functional state. Different constraints, also resulting from the evolution of society, such as stress, violence, pollution, the emergence of communicable diseases related to certain behaviours, the increase of potentially incapacitating chronic diseases and the number of individuals suffering from such diseases, all tend to counter-balance the high health potential of adulthood. This raises specific issues, namely with regard to the suitability of health care for the particular characteristics of those adults who suffer from more prevalent and incapacitating chronic, self-regulable diseases.

In this context, it would be advisable to pay special attention to family support social policies and to drawing up and implementing national plans and programmes. There is a need to improve patient access to information that enables better self-regulation, as well as to materials that allow for self-observation of disease, thus equipping patients for decision making and simultaneously increasing the level of individual and social responsibility for the development of disease. In order to do this, it is crucial to involve Patient Associations and other health-

56 Abreu Nogueira, J. M. - A Propósito da Doença Crónica no Ambulatório … Cuidados de Saúde. Abordagem Integrada Racionalização Inovação. Lisbon: Santa Casa da Misericórdia, 2003.

promoting organizations in the development of action for informing, preventing, screening and early diagnosis, as well as in supporting patients themselves.

The development of disease management programmes will lead to the implementation of a systematic approach to the prevention of these diseases and to the development of a network of continuous care, creating effective intermediary responses between health centres and acute hospitals, directed towards patients in acute chronic situations, who do not require high diagnosis technology or hospital therapy, or patients with problems of disability, whose rehabilitation and overall recovery requires a high investment. On the other hand, there will be a greater need to define and identify, both legally and in practical terms, those diseases whose carriers have access to special benefits.

From public consultation and from the debate at the National Health Forum, a consensus has been reached on establishing the following priorities, as far as disease and illness are concerned:

- Onocology diseases, particularly female breast cancer, uterine cancer, colon cancer and rectum cancer;
- Circulatory diseases, especially ischemic heart disease and cerebrovascular accidents;
- Communicable diseases, particularly AIDS and congenital syphilis.
- Mental illness, especially depression and alcohol abuse and dependence;
- Trauma, particularly motor accidents and work-related accidents.

These priorities will be crucial in determining the approach for each setting, drawing up programmes and establishing follow-up systems and mechanisms for the Plan. Therefore, bearing these priorities in mind, the following targets and goals have been defined, according to the present situation:

Table VIII – Priority targets for oncology diseases

Indicator	Present situation	Projection for 2010	Target for 2010
Female breast cancer			
Screening rate	N.A.	—	60% of target population
Rate of standardized mortality from breast cancer before 65 years / 100,000 women[1]	14.3	13.5	10
% of survival at 5 years[2]	71.9	N.A.	75
Uterine cancer			
Screening rate	N.A.	—	60% of target population
Rate of standardized mortality from uterine cancer before 65 years / 100,000 women[1]	3.5	3.1	2
% of survival at 5 years[2]	55.6	N.A.	68
Colon and rectum cancer			
Screening rate	N.A.	—	60% of target population
Rate of standardized mortality from colon and rectum cancer before 65 years / 100,000 individuals[1]	7.9	7.9	6
% of survival at 5 years (men)[2]	46.3	N.A.	55

(1) DGS, present situation data refer to 2001. (2) Eurocare 3, present situation data refer to 1998.
N.A. – Not available.

Table IX – Priority targets for cardiovascular diseases

Indicator	Present situation	Projection for 2010	Target for 2010
Ischemic heart disease (IHD)			
Rate of standardized mortality from IHD before 65 years / 100,000 individuals[1]	16.1	14.4	11
% of internments through coronary green pass for acute IHD episodes	2	—	80
% of intra-hospital lethality from IHD[1]	6.6	—	< 5
% of referrals to rehabilitation units after an acute IHD episode	3	—	30
Strokes (CVA)			
Rate of standardized mortality fom stokes before 65 years / 100,000 individuals[1]	17.9	16.2	12
% of internments through CVA green pass for stoke episodes	Unknown	—	80
% of intra-hospital lethality from strokes[1]	14.5	—	<13
% of referrals to rehabilitation units after a stroke episode	Unknown	—	30

(1) DGS, present situation data refer to 2001

Table X - Priority targets for communicable diseases

Indicator	Present situation	Projection for 2010	Target for 2010
AIDS			
Rate of standardized mortality from AIDS before 65 years / 100,000 individuals[1]	10.3	9.2	7
Congenital syphilis			
Incidence rate / 100,000 live births[2]	21	12	0

(1) DGS, present situation data refer to 2001. (2) DGS, present situation data refer to 2002

Table XI – Priority targets for mental illness

Indicator	Present situation	Projection for 2010	Target for 2010
Depression			
Rate of outpatient / inpatient	5.9 / 1	—	7 / 1
Rate of standardized mortality from suicide before 65 years / 100,000[1]	5	3	2.5
capability to recognize depression from general practitioners	33	—	50
Proportion of indirect to direct costs in depression	83 / 17	—	60 / 40
Alcohol abuse and dependence			
Rate of standardized mortality for alcohol-related diseases < 65 years / 100,000[1]	15.8	15.2	14
Consumption of alcohol in litres/person/year[2]	16.59	—	10

(1) DGS, present situation data refer to 2001 (2) WHOSIS, 2003, present situation data refer to 2000

Table XII – Priority targets for trauma

Indicator	Present situation	Projection for 2010	Target for 2010
Motor accidents			
No. of motor accidents/ year[1]	1863	1580	1100
Rate of standardized mortality from motor accidents before 65 years / 100,000 individuals[1]	15.6	12	8
No. of alcohol-related motor accidents/ year[1]	750	—	0
Rate of gross mortality from alcohol-related motor accidents / 100,000 individuals	7.2	—	0
Work-related accidents			
Rate of standardized mortality from work-related accidents / 100,000 individuals	Unknown	—	?

(1) DGS, present situation data refer to 2001

Efforts made in order to achieve these goals should be coordinated on a national level by the Plan Follow-up Commission (CAP), through National Programmes. These should be more region-specific, so that they reflect a reduction in regional and gender inequalities.

STRATEGIES FOR CHANGE MANAGEMENT

In order to develop the interventions needed for efficiently improving the health status of the Portuguese in a participative and informed way, there has to be a change in culture, working habits and ways of making people responsible for their actions. For this reason, strategic guidelines will be approached from three different perspectives: centring change on the citizen, capacitating the health system for innovation and re-orienting the health system.

Citizen-centred change

Considering equity as a key guiding value in the health sector is essential for ensuring a closer relationship between citizens and political power in order to guarantee that citizenship is based on *active participation* in public life, generally, and in health matters in particular[57]. In effect, the citizen's choices are widened and the mechanisms that allow for participation in the health sector are multiplied, so that civil society organizations are supported, according to a logic that promotes healthy behaviour and health-promoting environments.

Widening citizen choice

Enlightened citizenship manifests itself partly through informed choices that respect the need for rationalization and rationing, so as to allow for the sustainability of the health system. These choices involve the responsibility of the legislator who ensures public health, by creating access conditions to what is considered priority care by society and the responsibility of the citizen, who should adopt healthier attitudes and use health services in the most rational way, according to the best information that he/she is given.

Ensuring access is sometimes related to a systematic organization of care, which seems to limit the citizen's choices. This systematization (for instance, referral networks) is a benefit for citizens, and in fact does not conflict with freedom of choice. At the moment, patients are faced either with centres that are theoretically capable of solving their problems but that in practical terms become too crowded with users, or, on the other hand, with multiple small centres where quality cannot be controlled and where technological innovations are often used, adding to public spending without any significant benefit to users. Therefore, referral networks will continue to be considered as mechanisms for the rationalization of health care and for increasing citizens' options.

57 Villaverde Cabral, M. - Cidadania Política e Equidade Social em Portugal. Oeiras: Celta Editora, 1997.

As far as access is concerned, positive discrimination – channelling the limited resources of the Ministry of Health to the most underpriveleged social groups and classes, especially those who suffer from social exclusion - is clearly established as a guideline for the different intervention programmes and projects on all levels[58]. In this sense, all central entities within the Ministry of Health, as well as Regional Health Administrations, will be asked to put forward proposals that lead to the fulfilment of these priorities, which should be compiled and coordinated by the High Commissioner.

Multiplying mechanisms for citizen participation in the health sector

For people to be able to participate in the decisions involved in their treatment, they need information about the relevant options. However, the little evidence we have suggests that individual consumers cannot, generally speaking, trust professional organizations and bureaucracy to help them get the information they need. If we analyse the information given by organizations or health authorities, one comes to the conclusion that these rarely pass on valid and unbiased information: most of them seem to be more interested in making patients accept what is offered, rather than in trying to help them choose a service or appropriate care. However, it is precisely this kind of help that should be given by the Portuguese Health System.

Besides this involvement in private decisions about one's own health and empowerment through disease management strategy, in other European countries there have been many experiments related to mechanisms for participation in the health sector. These are clearly being developed in Portugal, encouraged and supported by the Ministry of Health, and include direct electronic lines of communication between users and their family doctors, as well as mixed consultative advice (users, professionals and politicians) in the support of hospital and health centre management, among other initiatives.

Apart from more participation from individuals in the health sector, there is a need to promote social and community empowerment through authorised representation of a community or a particular interest group within that community. The proliferation of civil society organizations dedicated to the health sector or to similar sectors indicates the potential for the strengthening of this involvement of civil society.

Giving a voice to citizens through civil organizations

Civil society organizations (patients associations, consumers, users, the media, unions, etc.) are normally more capable than the individual citizen to understand in depth and in the short term what is more relevant in terms of good health consumption.

In fact, it is easier for these organizations to influence the behaviour of health care professionals, health organizations and public health administration in general, with the following aims:

- to strengthen the position of individual citizens in their relationships with health care professionals;
- to expose any flaws in healthcare and assistance in a constructive way;
- to help by channelling the appropriate resources to support actions that lead to the correction of such flaws;
- to collaborate in the improvement of healthcare and assistance;
- and, mainly, to collaborate in the reform of health policies.

On the other hand, the fact that these organizations are sometimes financially supported by the Government, forces them – like all other public entities – to be accountable for their activities.

58 Thus meeting the recommendations of the Economic and Social Council in its "Parecer sobre as Grandes Opções do Plano – 2003".

It should not be forgotten that the expectation of mobilizing civil society depends on the definition of the expected results. But even when these goals are clear, in practical terms there is a need for constant readjustment so as to find a system that is best suited to the situation.

It can be said that the Government will achieve its goals more easily by stimulating the collaboration of civil society organizations. However, involving these organizations is not regarded in the same way by all health care services. If this involvement is not well founded or is unwanted, the success of the whole project may be compromised. Thus, efforts will be made to acknowledge the importance of civil society organizations and to develop partnerships, as long as these fit the strategic guidelines defined in this Plan.

Promoting healthy behaviour

Fighting the causes of the main diseases related to lifestyles is a key priority for action. This demands special attention to specific factors such as the consumption of alcohol and tobacco, eating habits, overweight and obesity, insufficient physical activity, poor management of stress, drug abuse, as well as social and economic factors that lead to violence and social exclusion. Of all these, priority will be given to interventions to decrease the consumption of tobacco and alcohol.

This approach, set out in the recently approved National Programme for Integrated Intervention in Health Determinants Related to Lifestyles[59], will allow for a positive impact on communicable and non-communicable diseases as different as AIDS, tuberculosis, high blood pressure, ischemic heart disease, cerebrovascular disease, some types of cancer (such as lung cancer, breast cancer, stomach cancer, colon cancer and uterine cancer), diabetes mellitus, chronic obstructive lung disease, dental decay, rheumatic diseases, osteoporosis, eyesight problems, cirrhosis, genetic diseases, accidents (domestic, leisure, sport, work and motor accidents), psychiatric diseases and other diseases and illnesses.

The promotion of healthy lifestyles in the context of secondary prevention may also play an important part in the welfare of chronic patients. Sensitizing health professionals to promoting healthy attitudes among users who come into contact with them is a measure with high potential for health gains.

The reinforcing role that local council authorities can play in promoting the health of their populations as well as their natural propensity for channelling energies and willingness in building a healthy and solidary urban environment should be considered, as far as collaboration between central administration and local authorities is concerned. In fact, among the external partners of the health system, local councils have a privileged position owing to the fact that they are authorities who have the greatest knowledge of the issues which affect their communities, as well as relationships between representatives of other administrative sectors (such as education and sport, which are strongly connected with health), or the private sector, such as business, considering that “healthy work” is one of the basic conditions for “healthy societies”.

Creating a health-conducive environment

Environmental Health involves human health issues (including quality of life) which are determined by physical as well as chemical, biological, social and psychological factors in the environment. It also includes the assessment, correction, reduction and prevention of those factors in the environment that may potentially affect the health of present and future generations in a negative way.

59 Ministry Dispatch no. 465/2003, December 15 – approves the National Programme for Integrated Intervention in Health Determiners Related to Lifestyles.

The absence of a clear definition of options for adequate response to environmental health problems, coupled with insufficient knowledge in terms of concepts, methodologies and objectives, explains some of the difficulties in the development of this area of public health intervention. This requires drawing up an inter-sector strategy with regards to health and environment, with a view to endowing the Country with a referral tool for assessing health gains that stem from environment-related determinants. In addition, it would enable the Country to honour the commitments that have been made since 1994, within the Ministerial Conferences on "Environment and Health" by WHO. The development of a National Environmental Health Programme should become a priority for DGS, in agreement with other State entities and relevant non-governmental institutions.

Capacitating the health system for innovation

Capacitating the health system for innovation involves defining suitable policies for human resources, management of information and knowledge, promotion of health research and development and valuing the participation of the health sector in international forums.

Definition and adequacy of a human resources policy

A human resources policy should not only consider work and professional issues, but also the individual, his/her aspirations, wishes and personal concerns, and try to develop ways to respond to these[60].

A human resource policy in the health sector is therefore a formal declaration of priorities, guidelines and procedures so as to ensure that the health sector responds appropriately to satisfy the population's health expectations wherever possible, as well as the expectations of its employees. This results from a set of values and principles and translates into strategies which should consider the performance and welfare of all those who work in the health system throughout their course of life. It involves defining health professionals' needs and ensuring the quality of their performance through measures that lead to cooperation between ministries and also between the organizations involved in their training and development. It includes establishing *numerus clausus* in access to diplomas and post-graduate degrees, the adoption of certifications (and recertifications), the definition of careers, assessment of training capacities, the creation of continuous professional training programmes and, likewise, the recruitment, selection and placement of professionals, salary scales and other incentives. It should also consider retaining professionals for health care services within the NHS and regulating and monitoring all these aspects of the different Health areas through appropriate information systems.

A human resources policy values people, the history of their professions, their expectations and motivations, adapting incentives to groups with different identified interests, expectations and motivations. In Portugal, as far as the Health Sector is concerned, so far there has not been a human resources policy, or a strategic line of thought in this matter. This lack results in some of the deficiencies of the current work force[61]. It is therefore a priority that a Human Resources Development Programme is defined and ratified by 2005.

Information and knowledge management

In any health system there are health organizations (structural capital), human resources (human capital) and users (citizen capital). It is the interaction of these three elements that gives rise to knowledge, based not only on the information that is stored and shared in the system of structural capital information (knowledge tools), but also in previous knowledge from citizens as well as from human resources of health organizations, which results in the increase

60 Biscaia, A.; Conceição, C.; Martins, J.; Ferrinho, P. - Política e gestão de recursos humanos na Saúde em Portugal: Controvérsias. Revista Portuguesa de Clínica Geral. May/June (2003), pp. 281-9.

61 *Idem*.

of the intellectual capital of the organization. Knowledge exists only in human beings, and is used only by human beings (figure 2).

The knowledge stored in an organization is its knowledge stock, which, being accessible to communities of practice with similar tasks, contributes to enriching its intellectual capital and vice-versa[62]. These communities encourage their members to explain their individual knowledge clearly, by writing documents, preferably digital ones, which will then be available for discussion and modification by other members of the community (they are known as *smart documents)*.

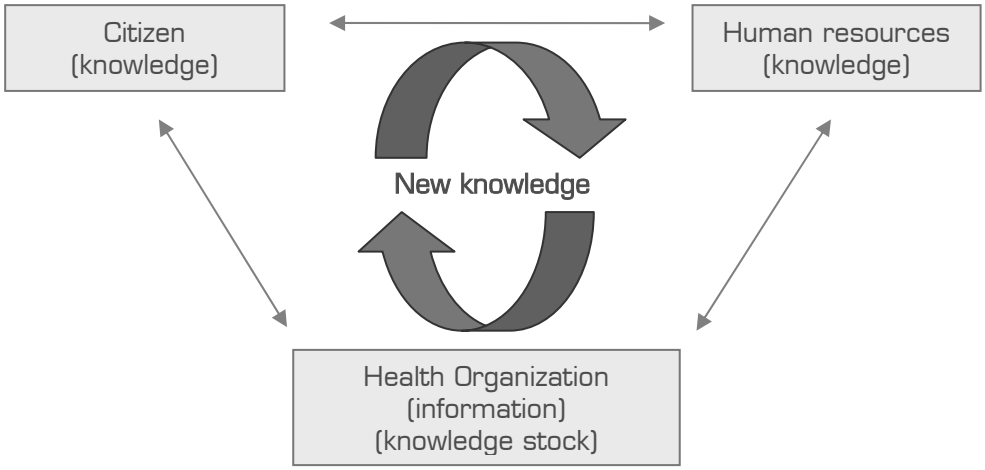

Figure 2. Knowledge management in health organizations.

In this transition from an information society to a knowledge society, we can see that there is minimization of the optimization of decision-making based on foresight and there is an emphasis on pre-cognition and adaptability. In an information society, change is regarded and happens in a non-continuous way, whereas in a knowledge society, change is processed more and more in real time[63].

This knowledge should be centred both on the citizen and on health system professionals. The interface between these participants should be structured so as to ensure effective interaction, which should be as efficient as possible. In Portugal, one of the first initiatives promoting this interaction was the creation of "blue lines", through measures of administrative modernization in statute no. 135/99, from April 22 (Box 1).

Box 1. "Blue lines" in Health

There have also been some initiatives in call centres: a paediatric line (Health 24) and another which was initially meant for flu (Influenza Line) and supported by an internet portal site (www.linhagripe.net) [64]. There have also been different experiments in the private sector. These can be considered as the first steps towards the establishment of a health contact centre which will result in a single phone number to access all call centres, with web sites, so as to create access channels to knowledge that meet the needs of well defined communities. This project, in all its aspects, will be completely operational by 2010.

However, in the health area in Portugal, public entities function under the general characteristics of traditional models, integrated with some more recent tools, and thus being qualified as entities in transition. Only some of these will be able to change in a way that will lead them to management based on information and knowledge. As far as health administration and health service management are concerned, it is clear that these are still

62 Chatkel, J. - A conversation with Hubert Sait-Onge. Journal of Intellectual Capital. 1 (2000), pp. 101-115.

63 McCampbell,, A. S.; Calre, L. M.;Gitters, S. H. - Knowledge management: the new challenge of the 21st century. Journal of Knowledge Management. 3 (1999) 172-179.

64 This line was recently extended to cover other areas of public health. See www.dgsaude.pt

more focussed on rendering immediate health care than on managing the health of the population they serve.

The existence of a transversal structure created to manage information and knowledge, and using these in planning and managing the population's health, in managing the processes of the health services and in providing health information to citizens, becomes necessary. This implies motivating organizations into being part of such a system, into cooperating with it and gaining from its benefits. Therefore, the key role in the system of Management of Information and Knowledge in Health is managing the 'business process', represented here as a process of service production, as well as information about citizens, their health and health determinants. The process is not about "a mere sequence of activities or workflows[65], but about *reality intelligence,* which has three dimensions – structure, management and function – in generating the added value required by the reality of the business"[66]. This means that, to understand a business process deeply, it is not enough to define the functions to be carried out, but also who will carry them out, using what criteria and rules, and what infrastructures are to be used. So, such dimensions have to be redefined in the health system as well as in the organizations that make up the system. Despite a visible infrastructure, the understanding of its complex work, the functions and the participation of the people involved, the process of service rendering and information production and flow is still poor[67].

The *e-Europe* project (*e-Europe* 2002, *e-Europe* 2005), by the European Commission, defines a whole set of guidelines for on-line health care *(e-Health).* In 1999, the Interministerial Commission for the Information Society already claimed that with regards to health the significant improvement in the quality of healthcare services rendered to users involved "(…) a substantial reduction in the bureaucratic process and quick access to information (…)"[68].

So, in 2000, the Lisbon European Council launched the action plan for the *e-Europe* 2002 initiative – An Information Society for All[69], where on-line health (*e-health*) is included as one of the priorities. There were four main guidelines for health: to guarantee the existence of telematic infrastructures, including regional networks, for primary and secondary health care workers; to identify and divulge best practice in on-line health in Europe and define criteria for performance assessment; to establish a set of quality criteria for health-related websites; and to create networks of technology and data analysis in health.

Consequently, *e-Europe* 2005[70] suggests the implementation of three action points, so as to contribute to the improvement of the system in the area of on-line health: i) electronic health cards – a European health insurance card will replace the traditional paper forms that are necessary for treatment in another Member-State; ii) health information networks – by the end of 2005, Member-States should have developed health information networks between the different health care entities (hospitals, laboratories and homes) with broad band connections whenever appropriate; iii) on-line health services – the Commissions and the Member-States guarantee that, by the end of 2005, citizens will be able to use on-line health services (for instance, information about healthy life and disease prevention, electronic health records, tele-appointments or electronic reimbursement). Thus, in 2002, the Government created the

65 In this context, *workflow* refers to a sequence of tasks with a specific outcome.

66 Gattaz, F. – Processo: A máquina contextual nos negócios. O Mundo em Processo, 2000.

67 Cunha Filho, H. - A Organização de um Sistema de Gestão de Informação e de Conhecimento em Saúde em Portugal. Lisbon: Observatório Português dos Sistemas de Saúde, Escola Nacional de Saúde Pública, Universidade Nova de Lisboa, 2003. See www.observaport.org

68 Portugal. Ministério da Ciência e da Tecnologia - Comissão Interministerial para a Sociedade da Informação: Portugal na Sociedade da Informação. Lisbon: Ministério da Ciência e da Tecnologia, 1999.

69 European Union Council and European Commission – e-Europe 2002: uma sociedade da informação para todos. Plano de acção. Brussels: European Union Council and European Commission, 2000.

70 European Union Council and European Commission – e-Europe 2005: uma sociedade da informação para todos. Plano de acção. Brussels: European Union Council and European Commission, 2002.

Commission for Mission, Innovation and Knowledge (UMIC)[71] and, in 2003, within the "Information Society", the programme "Health for All"[72] was launched.

Once they are implemented, these initiatives theoretically have the power to change relationships within the NHS and between health services, especially in terms of the availability and usefulness of health information by and about citizens and in terms of the creation of a basis for future information and knowledge management focused on citizens as well as health professionals. Therefore, IGIF (the Institute for Financial and Informatic Management of Health) and DGS should, in collaboration with UMIC, put forward a Strategic Plan for the Management of Health Information and Knowledge by mid-2005.

Promoting health research and development

Traditionally, the Portuguese health system has not been supported by a strong component of scientific knowledge based on the national context. The impact of this deficiency may have considerable consequences, affecting decision-making processes, clear identification of risk groups and target groups for some interventions, the approach to diseases and, for instance, the effectiveness of a particular intervention. Adopting a strategy that promotes health research and development gives added value to the Portuguese health system. This may have important effects on the populations' health capital.

In all stages of a life cycle, of the observation or intervention activities included in the NHP, it is necessary to have scientific, validated knowledge. Given that this is not always available, and when it does exist, it does not refer to the current situation in Portugal and becomes necessary to develop research and development projects (R&D). These results will come to support the planning, execution and assessment of the different components of the NHP. By the same reason, the execution of the Plan itself will bring up new issues/hypothesis which research alone can answer/test appropriately.

State funds, and therefore health research coordination, are mostly not under the remit of the Ministry of Health, but instead the Ministry of Science and Higher Education, through institutions like the FCT (Foundation for Science and Technology).

Civil Society institutions such as the Calouste Gulbenkian Foundation and the Luso-American Development Foundation have played a crucial role in the promotion of health-oriented research in Portugal. International institutions, namely those from the EU, have promoted research projects within international networks which deal with the major health issues in the EU and which have been very important in terms of topic, in building a culture of inter-institutional collaboration and in terms of methodology development.

However, it is regrettable that the administrations of health institutions evaluate services based solely on the number of professional actions taken. Research is not regarded as a necessity or even as a secondary priority. Research activities have low importance in the criteria considered in the development of career paths for health professionals, which is a consequence of an absurd disregard for the curricular value of research or its more tangible products (conferences and publications). These become inviable when weighed against inquantifiable criteria such as "technical and professional competence" when working as an assistant, or "aptitude and capacity for service management and organization". Research is in fact considered an excrescence of assistant practice and it is forgotten that research is a fundamental guarantee of quality in clinical work as well as an essential component of medical training.

71 Portugal. Resolution from the Ministers' Council no. 135/2002 – Creates the Commission for Mission, Innovation and Knowledge, under the remit of the Deputy Prime Minister.

72 Portugal. Approved by the Minister's Council in June 26, 2003 – Uma Nova Dimensão de Oportunidades: Plano de Acção para a Sociedade da Informação. Unidade de Missão Inovação e Conhecimento - Presidência do Conselho de Ministros, 2003. See www.umic.gov.pt

There is also a limited number of excellence groups, not always with the desirable minimum dimension, and without a tradition of collaboration at a national level, working with a wide variety of themes and with no adequate prioritization, scarcity of resources and constant under-funding. As to this last aspect, the most recent data (2001), revealed by the Observatory on Science and Higher Education, show that health sciences received only 10.5% of the national budget for R&D, falling into last place among the different scientific areas (when compared, for example, to the 11.1% spent on agrarian and veterinary science, to the 15.3% granted to natural sciences or to the 25.3% given to engineering and technological sciences).

In this context, support will be given to initiatives that conceive and implement a system that manages and promotes research in health sciences and other related areas under the supervision of the Ministries of Health and of Science and Higher Education (through DGS, FCT and Health XXI), with an inventory of national resources of R&D in health sciences (including an estimate of the financial flux allocated to this sector) and the identification of the main knowledge gaps which result in the persistence of the most serious health problems. This will be completed by a definition of priorities for investments in R&D based on population, clinical, or health services (including health economy studies). A work group will thus be remodelled for the study of a health research agenda, within the Ministry of Health.

Regardless of the decision on policies for health science R&D, there is already one priority: the creation of projects for chronic diseases which are particularly prevalent and/or incapacitating, such as cardiovascular disease, cancer, AIDS and other contagious diseases, mental illnesses (including addictive behaviour and related problems) and on health determinants, such as lifestyle or accident causes (considering motor, work, domestic and leisure accidents).

However, there are other fields of investigation which are particularly important in the context of Portugal and Europe. Thus, other priority areas in health service research include:

- strategic and prospective analysis of the evolution of the health system;
- studies to assess health service performance in general (accessibility, quality, efficiency, results) and human resources in particular;
- configuration and assessment systems of health regulation and contracts;
- development of the organizational abilities of the health service;
- analysis of information and knowledge management in health services;
- study of citizen perceptions and satisfaction as to health services, access to information and the performance of the complaints systems.

With a view to adding value to research in health careers, the training course of health professionals will include a formal, compulsory period of training in Clinical Investigation. In the assessment of health services, the research activities conducted by those very services should be valued. In relation to other competences and activities, research activities will be explicitly valued. The Department for Health Modernization and Resources will be responsible for putting these decisions into action.

Valuing the participation of the health sector in international forums

Technical and scientific exchange is considered essential with regards to technical cooperation in terms of health with all Portuguese-speaking countries, namely Angola, Brazil, Cape Verde, Guiné-Bissau, Mozambique, São Tomé and Príncipe and East Timor, and also the Special Autonomous Region of Macau. This exchange should contribute to the development of supported communities, as well as to the reinforcement of the Portuguese presence, including private companies in the health sector (such as haemodialysis or pharmaceutical companies). From a perspective of mutual benefit, this will contribute to the development of the relevant sectors in the countries where these actions take place.

This technical and scientific exchange is considered in the international alignment of the Plan with "Health XXI" Policies defined by WHO-Europe, with the recent Public Health Programme of the EU, with the projects of the OECD and with the deliberations of the European Council.

Re-Orienting the Health System

Investments in the health system should contemplate providing citizens with a *quality service* in *productive time* (access improvement) with *effectiveness, humanity* and *costs that are sustainable* in the long term.

In order to do so, the changes foreseen should focus essentially on the primary care network, the secondary care network, the continuous and terminal care network and medication policies.

As to the main tools for change, the following should be considered:

- more *business-like management*, where managers have clear responbilities and are supported by information that is more accessible and that results from greater attention to the information system;
- *creation of partnerships* with the private and social sectors;
- more top down coordination between care levels, through referral networks and platforms for collaboration with other community forces;
- *reinforcement of horizontal management* in health, particularly in the cooperation between sectors - schools, workplaces, with elderly people and vulnerable individuals within the community, in food safety, road safety and in the development of human resources in health;
- revision of *incentives* for productivity, performance and merit.

Bearing in mind the situation in the EU and the situation in Portugal, the overall targets in the table below have been established for the Portuguese health system.

Table XIII – Overall targets for the health system

Indicator	Present situation	Projection para 2010	Target for 2010
Specialist doctors per 100,000 inhabitants[2]	72	≅ 69	71
Family doctors per 100,000 inhabitants[3]	54	51.9	60
Public health doctors per 100,000 inhabitants[3]	3.9	3.2	5
Dentists per 100,000 inhabitants[1]	43	≅ 60	66
Pharmacists per 100,000 inhabitants[1]	79	≅ 105	90
Nurses per 100,000 inhabitants[1]	347	≅ 420	500
Number of outpatients visits with family doctors per inhabitant/year[3]	2.7	2.8	3
Number of outpatient visits per inhabitant per year: PHC + hospitals[3]	3.5	3.7	4
Ratio between emergencies and outpatient visits[3]	0.9	0.8	>1
% of first-time outpatient visits in the total no. of hospital outpatient visits[3]	24.7	26	33
Number of inpatient discharged per hospital bed per year[3]	37.5	44	50
Average hospital length of stay (days)[3]	7.4	7	6
% of hospitals using *tableaux de bord* for management	Unknown	—	100
% of health centres using *tableaux de bord* for management	Unknown	—	100
% of users who are highly satisfied /satisfied with the health system[4]	24	—	50
Health impact assessment	Unknown	—	should be routine

(1) Present situation data refer to 2000 - European Health for All Database. WHO Regional Office for Europe, 2003.
(2) Present situation data refer to 1998 - OECD Health Data 2003. Paris: OCDE, 2003.
(3) Present situation data refer to 2002 - DGS – DSIA.
(4) Present situation data refer to 1999 - Eurobarometer - OECD Health Data 2003. Paris: OECD, 2003.

These overall figures should be more detailed so that their achievement can come to reflect the reduction of inequalities between regions and genders.

Access to and rationalized use of medication

In 2003, several actions were developed with a view to improving access to medication, so that there would be more health gains through the availability of innovative medication and medication for chronic or debilitating diseases, as well as better sustainability of the system, thanks to the promotion of generic medicines and the introduction of a new state contribution system based on reference prices (RPS).

In 2003, 132 innovative medicines/new active substances were subsidised (+ 26% in relation to 2002), including a total of 38 new International Common Denominations (ICD), 31 of which were for chronic diseases. The percentage of generic drugs used, in terms of value, went from 1.76%, in 2002, to 5.59%, in 2003, and 85% of the total sales value of generic drugs registered in the RPS.

The reinforcement and guarantee of access to and rationalized use of medication by citizens is an agreed priority, and the following goals and targets are defined, according to the present situation:

- Promotion of rational use of medication
    - Creation of a National Network of Therapy Rationality, integrating INFARMED, through the Observatory on Medicines and the Department of Economic and Results Assessment in Health, the ARS, through Regional and Institutional Therapy and Pharmacy Commissions, and the Regional Units of Pharmacy Vigilance;
    - Creation of a National Medicine Information System.

- Assessment of the state contribution system to pharmaceuticals, given the guidelines from the Government Programme in terms of rationalization and sustainability of pharmaceuticals-related expenses for citizens as well as for the health system. At the same time, this should ensure that the most incapacitating diseases and the most underprivileged patients have priority in access to pharmaceuticals. It should also take into account national and international circumstances, namely internal reform programmes and the European Union framework.

Picture XIV - Priority goals for "Access to Pharmaceuticals"

Indicator	Present situation*	Projection for 2010	Goal for 2010
Consumption of medication in Euros *per capita* – total market	288.04	- increase of 4%/ year – 394.20 - increase of 3%/ year – 364.88	—
% of the total expenditure on medication in the GNP	2.2	—	2
% of the expenditure on medication in Health	23.9 (% expenses w/ medication in NHS budget)	—	19
% of generic products in the total medication market (in Jan/2004)	6.22 (at PVP)	—	[15 to 20]
Consumption of anxiolytic, soporific, sedative and antidepressants in the NHS market in the out-patient service DDD/1000 inhab./day	Benzodiazepines – 89 (2001) N05B (anxiolytics) – 67.8 N05C (soporifics and sedatives) – 15.5 N06A (antidepressants) – 36.4	—	20% reduction
% of consumption of cephalosporins/total consumption of antibiotics in out-patient service	12.6 (3.4 DDD/1000 inhab/day)	—	10
% de chinolones/ total consumption of antibiotics in out-patient service	13.2 (3.6 DDD/1000 inhab/day)	—	10.6
% of used orphan medication	N.A.	—	100

Source: INFARMED, present situation data refer to 2002 N.A. – Not available

STRATEGIES FOR ENSURING ACCOMPLISHMENT OF THE PLAN

Plan follow-up mechanisms

A Plan Follow-up Commission (CAP) will be formed by June 2004. The members of the group will be nominated for three years, but during this period they may be changed.

CAP will work by influence mechanisms. It will be coordinated by the High Commissioner for Health and it will include selected members to lead the Plan's activities in priority areas – infectious diseases, cancer, circulatory diseases, mental health, traumas and lifestyles. In addition, it will have its own budget for traveling and other expenses, as well as secretarial support.

The group will meet every three months and will have the power to request data so as to monitor the development of the indicators associated with the Plan's targets and to access the different institutions' and other commissions' annual plans under the coordination of the Ministry of Health.

In this context, the Strategic Regional Health Plans and the Ministry of Health Annual Plans should be seen as key instruments for this monitoring.

The follow-up Group should also report on the MOP for Health, as well as:

- on the annual action plans by the ARS as well as by other institutions and commissions under the coordination of the Ministry of Health;
- whether the attribution of resources by PIDDAC, within Health XXI and other such programmes, such as creating job vacancies and the development of continuous training, do or do not follow the priorities set by the Plan.

Lastly, every two years (in the first quarters of 2006 and 2008), this group should present its recommendations to the Government concerning any revisions to be made to the Plan, in order to better achieve targets or redefine them.

Mechanisms for securing resources

The strategies identified in the Plan should be protected so that the MOP and the annual activity plans are regulated by these very strategies. In order to guarantee this, the Ministry of Health will determine standards, negotiated with the Ministry of Finance and the Operational Health Programme, for the attribution of resources so as to guarantee that the strategies included in the National Health Plan are treated as an absolute priority.

Likewise, from 2005, continuous training and the creation of job opportunities will be regulated by the same priorities.

Mechanisms for dialogue

Efficient circulation of the document, public communication of the targets accomplished, maintaining interest from the different publics for the project and coordination of the parties involved implies the need for continuous communication through contacts with professionals in the media and other participants from civil society, academics, professional organizations and health institutions. This effort should be made through Regional and National Forums, through the mechanisms mentioned in the section on citizen-centred change and through some of the mechanisms considered in the chapter on capacitating the system for innovation.

A particularly important aspect of this programme is related to dialogue between sectors, with a view to mobilizing willingness to contribute to health goals through other policies, namely agricultural, environmental and educational. In Portugal, this approach would result in the attainment of what is already being done in other countries in terms of health impact assessment. The mechanisms designed to ensure this dialogue should be proposed by CAP to the Minister of Health before the end of 2004.

Adequacy of the legal framework

The Portuguese law regarding the health sector is characterized by the absence of a Health Code which would draw together all the fundamental regulations in this area, as well as by the existence of laws of great strategic importance in health which, although never revoked, have become obsolete. For this reason, it is necessary to update health legislation in Portugal, through the creation of a structure to assess and correct insufficiencies and omissions (a Health Legislation Observatory). By the end of 2004, PFC will put forward a proposal on that matter to the Health Ministry.

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