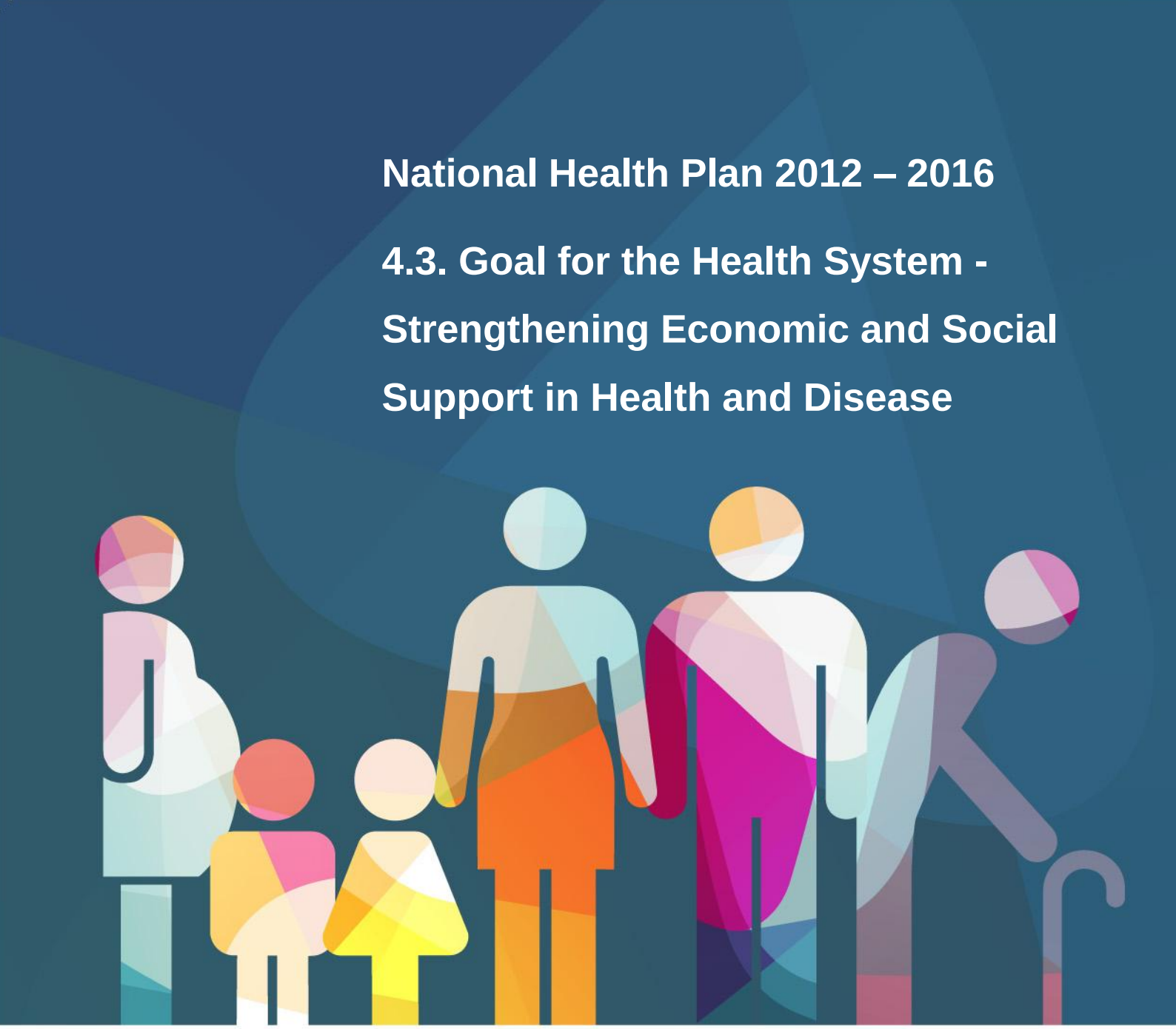
National Health Plan 2012 – 2016

4.3. Goal for the Health System - Strengthening Economic and Social Support in Health and Disease



National Health Plan
2012–2016

4.3. STRENGTHENING ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE

4.3.1. CONCEPTS

RESPONSIBILITIES OF THE HEALTH SYSTEM

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

REFER TO THE GLOSSARY:
Social Justice, Social Protection, Solidarity

- Generating and managing the resources for protecting citizens, families and informal caregivers, socially and economically, in health promotion, disease prevention, access to healthcare, also including rehabilitation and palliative care;
- Developing its services and interventions on the basis of cost-benefit and sustainability criteria, in order to achieve the greatest return in terms of Health Gains (GeS), and economic and social value, with the available resources.

CONCEPTS AND PRINCIPLES

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

.3. Disease represents an extra cost for most people, either in direct care (e.g. medication and diagnostic tests) or in indirect costs (e.g. worker absenteeism and lost productivity, access to medical care).

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

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

REDUCING THE SOCIAL AND ECONOMIC IMPACT OF COSTS IN HEALTH

.6. Treatment costs can be a barrier to access, equity and GeS, as less privileged socioeconomic groups will be less able to access healthcare if they have to pay for care at the time of use (Pereira *et al*, 2010).

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

- In the protection of underprivileged socioeconomic groups, i.e. those that fall below a threshold that prevents access to healthcare;
  - *This group includes policies related to the exemption from direct costs with health;*
  - *All direct expenses, especially in chronic patients, unemployed and the elderly, are considered the main contributor to the situation of financial catastrophe associated with disease, i.e., a precipitating factor of poverty (WHO Europe, 2009), occurring in those most in need of healthcare (WHO. Primary health care, 2008). All direct expenses not co-paid by the State ('out-of-pocket expenses') are the most damaging and hindering of access to care among the underprivileged, and should be reserved for access to non-essential care.*
- In reducing the impact of health costs in socioeconomically vulnerable citizens, preventing families from impoverishing due to situations of disease. This group includes the co-payment policies for health expenditures.

.8. Protecting from the impact of healthcare costs can contribute to the achievement of GeS through the following:

- Reducing the impact of socioeconomic and educational disadvantages in health-promoting and disease prevention behaviours;
- Securing access and continuity of care, ensuring quality care to prevent the loss of individual health capital and to promote the return to active and productive life as soon as possible;
- Rehabilitation and integration of citizens with temporary or permanent disabilities, in order to achieve, as soon as possible, their potential in terms of health, and economic and social participation.

SUSTAINABILITY AND INVESTMENT GAINS

.9. The sustainability of the Health System implies the search for a satisfactory balance between health needs, the ability to meet these needs (through health services, interventions, and policies), and the provision of necessary resources. The section on 'SUSTAINABILITY OF THE HEALTH SYSTEM' in the NHP focuses on this topic.

.10. From the point of view of sustainability and investment gains, the Health System is able to STRENGTHEN THE ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE as far as it can:

- Get involved in the windows of opportunity for the prevention and promotion of health, thus reducing healthcare and productivity costs, and increased expenses due to late intervention;
- Achieve higher, more equitable, return, in GeS, bringing the health history of socioeconomically more vulnerable citizens closer to that of those who have better conditions. Thus, the health potential of everyone is maximised;
- Reduce waste, less effective healthcare and interventions with a lower cost-benefit ratio, mobilizing these resources to provide care with higher returns.

.11. Given the increasing ability to improve healthcare and health services, and indeterminable health needs, all health systems try to direct their resources to fulfil their social expectations and to obtain GeS, establishing limits, rules and policies (for example, types of services, waiting times, exemptions and co-payments, etc.). From a

better use of resources, and the ability to generate and mobilise resources, arises the possibility to reduce the degree of rationing and to increase the ability to obtain GeS with greater equity.

.12. In this perspective, the rational and efficient use of resources, as well as the ability to generate and distribute them, is a prerequisite for the ability of health systems to obtain GeS. This aspect is even more important as the growth of *per capita* expenditures on healthcare is much more determined by the introduction of new technologies and by the growing demand for care, than by increased prevalence of chronic diseases (Pita Barros, 2008), and is not necessarily accompanied by additional health outcomes.

THE INFLUENCE OF PERIODS OF ECONOMIC CRISIS IN HEALTH SYSTEMS

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

.14. The patterns of health-promotion and disease prevention behaviours may also change during these periods. In the perspective of the Health System, the following behaviours can be expected from situations of economic crisis (WHO Europe, 2009):

- In addition to an increase in individual and social vulnerability, inequalities between rich and poor increase as well. The number of poor increases, with children and the elderly being the most vulnerable. The poorest become sick more often and have worse health than the wealthiest, while the latter experience the opposite phenomenon: they are less affected by disease and have higher levels of health (WHO Europe, 2010);
- Private expenses decrease as a result of lower family income;
- Public expenditure decreases due to the lower tax return and the need to invest in drivers of the economy;
- Investments in health are postponed or redirected for the maintenance of service levels;
- The use of taxed health services decreases with increased resort to the subsidised National Health Service with no direct costs;
- The differences in access and in quality of services increase, and there is a reduction in the ability to respond adequately to health needs. The levels of satisfaction with the services may decrease.

In times of economic crisis, the Health Systems should focus on protecting those with greater needs and greater social and economic vulnerabilities; should concentrate on areas where they are most effective and where they return greater value in health; should become intelligent economic stakeholders in terms of investment, expenses and employability (WHO Europe, 2009).

KEY PROSPECTS FOR STRENGTHENING THE ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE.

REDUCING THE SOCIAL AND ECONOMIC IMPACT OF DISEASE

BOX 4.3.1. - KEY PROSPECTS FOR STRENGTHENING THE ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE:

- Reducing the economic and social impact of disease;
- Ensuring quality healthcare, provided in accordance with the health needs and the economic level of families;
- Complementarity and competition of Public and Private Services;
- Valuing health and the Health System from a social and economic perspective.

.15. Payment of healthcare is done in different ways: direct and indirect taxes; contributions to health subsystems, either public or private; private insurance premiums; and direct payments made at the time of consumption (user charges) (Pita Barros, 2008). A high proportion of direct payments limits accessibility to healthcare and places an undue burden on poorest households.

.16. There are also questions about double coverage of health services. Basic health services with full coverage for all residents in Portugal are provided by the NHS, which is publicly funded and mostly through tax revenues. However, close to one-fifth of the population also has an insurance coverage through health subsystems, which are distributed according to professional categories or jobs. This coverage may result in the fact that some individuals have faster and easier access to health services (WHO Europe, 2010).

ENSURING QUALITY HEALTHCARE, PROVIDED IN ACCORDANCE WITH THE HEALTH NEEDS AND THE ECONOMIC LEVEL OF FAMILIES

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

- Identify vulnerable or excluded groups and develop specific social mechanisms (WHO. Primary health care, 2008);
- Address the social determinants of health inequalities through inter-sectorial policies at various levels (Health 2015. Public Health Programme. Finland, 2001).

COMPLEMENTARITY AND COMPETITION OF PUBLIC AND PRIVATE SERVICES

.18. Health Systems have to find complex balances between interests that tend to go in opposite directions: generalisation *versus* specialisation and concentration of resources; accessibility *versus* freedom of choice; fiduciary decision and asymmetric information *versus* individual responsibility; patient's interest *versus* interest of the institution with limited resources and/or profit purpose.

From a perspective of complementarity, the objectives, advantages and possible limitations of these 3 sets, necessarily typified, are compared:

TABLE 4.3.2. - COMPARISON OF TYPES OF HEALTHCARE ORGANISATIONS.

	NATIONAL HEALTH SERVICE	PRIVATE SOCIAL SOLIDARITY INSTITUTIONS WITH HEALTH PURPOSES	FOR-PROFIT HEALTH ORGANISATIONS
GOALS	• It aims to ensure the response to health needs through the provision of healthcare and the implementation of health policies, according to the responsibilities of the State and using its resources.	• Aim to respond to the specific needs of population groups, by creating and mobilising social resources.	• Aim at raising revenue by responding to health needs.
ADVANTAGES	• Responsibility for collective and individual health needs; • Integration of health services; • Focus on meeting the needs of the population/community.	• Focus on matching the appropriateness of care to the needs and expectations of specific groups; • Empowerment of groups with specific health needs in developing their own care; • Focus on meeting the needs of subgroups.	• Diversified service offer and expanded freedom of choice; • Freedom of organisation and management, being responsible for proposing services and care that justify their maintenance and economic value; • Ability to offer services and access to innovative technologies without demonstration of cost-effectiveness, from the social perspective. • Focus on meeting the needs of individuals.
LIMITATIONS	• Types of care provided; • Resource management under a perspective of social asset.	• Limited care offer, and integration with remaining care; • Reduced capacity for providing expensive care.	• With no distribution or limited distribution of risks, individual susceptibility regarding expenditures and the use of ceilings for prepaid health expenses.

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

.20. The diversity of responses arises with the co-existence of various health systems, which compete with each other and extend the range of services offered to citizens. Under the Health System, we can find three different sets of institutions and organisations providing healthcare, with their own specific

goals and natures:

- The National Health Service, with the aim of implementing, on behalf of the State, the responsibility for individual and collective health protection (Law No. 11/93);
- Private Social Solidarity Institutions with health purposes (Law No. 48/90) (Decree-Law No. 119/83);
- For-profit private health organisations.

VALUING HEALTH AND THE HEALTH SYSTEM FROM A SOCIAL AND ECONOMIC PERSPECTIVE

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

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

BOX 4.3.3. - OPPORTUNITIES ARISING FROM STRENGTHENING ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE:

FOR CITIZENS:

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

ii) Citizens have informed and realistic expectations about the actual and expected costs of their healthcare, as well as a perception of the solidarity component involved in their healthcare;

iii) Citizens make appropriate use of resources for social and economic support, helping to reduce health inequities and are supported in this process by institutions and health professionals.

FOR HEALTHCARE PROFESSIONALS:

iv) Healthcare professionals become more capable stakeholders and with greater potential to promote empowerment when they consider the social and economic dimensions of their decisions and of their activity, as well as a more useful resource for citizens;

v) Organisations rely on their professionals' good judgment and good resource management, reducing administrative and financial barriers and investing in their activity.

FOR HEALTHCARE INSTITUTIONS:

vi) Institutions participate more in the social contract, and get greater social recognition, by including goals of social and economic support in their activities, by monitoring and assessing their impact, by disseminating their results and by sharing best practices;

vii) Institutions achieve better results in terms of efficiency and GeS by including a social and economic perspective in their activity, and by reducing the impact of these factors upon access, quality, continuity of care, and health outcomes.

FOR POLICY-MAKERS:

viii) Greater social value arising from the opportunity and capacity of the Health System to identify and support the situations of social and economic deprivation, in an inter-sectorial perspective and at various levels (national, regional, local);

ix) By reducing inequities, greater GeS return is derived, as well as economic and social return, thus reinforcing the value of social solidarity;

x) Inclusion of realistic and responsible expectations on the capacity and response of the health system, on the potential resources and their distribution according to social gradients, as well as on the added value of investments in health;

xi) Greater autonomy for the stakeholders of the health system, by associating concerns related to the management and distribution of resources with the reduction of inequalities and social and economic support to citizens.

BOX 4.3.4. - THREATS TO STRENGTHENING ECONOMIC AND SOCIAL SUPPORT IN HEALTH AND DISEASE:

FOR CITIZENS:

i) Overly bureaucratic, guarantee-requiring and complex processes for obtaining social and financial support;

ii) Insufficient support both in terms of scope, duration and amount, to meet their goals and respond to their needs.

FOR HEALTHCARE PROFESSIONALS:

iii) The action and the social and economic implications of the decision and activity of healthcare professionals should be construed as being outside the scope of their professional and social responsibilities, and as having merely economic goals;

iv) Low perception of the real impact of socioeconomic determinants on the course of health and illness of individual citizens;

v) Difficulty in keeping up to date, identifying, advising or referring situations of social and economic deprivation;

vi) Instrumentalisation of health services with the purpose of obtaining illegitimate social and economic support.

FOR HEALTHCARE INSTITUTIONS:

vii) Low appreciation and encouragement from institutional actions aimed at achieving a better social and economic support;

viii) Difficulty in monitoring and assessing the impact of institutional interventions.

FOR POLICY-MAKERS:

ix) Difficulty in obtaining and linking data to identify socioeconomic barriers in access, quality, continuity and health outcomes, as well as in identifying socioeconomically vulnerable groups or in measuring the health impact of social policies or of the redistribution of resources;

x) Difficulty in measuring the GeS, economic or social return following from the investment in measures conducive to reducing inequities and in the support to socioeconomically vulnerable situations;

xi) Political and social discussion on the role of the Health System in providing guarantees and social and economic support, overly focused on the political and social principles, values and ideologies, without the corresponding translation into balanced and sustainable decisions with higher return in GeS and in the economy, while respecting the actual capacity of the country.

4.3.2. FRAMEWORK

LEGAL, LEGISLATIVE, REGULATORY AND STRATEGIC FRAMEWORK

CONSTITUTIONAL LAW

.1. Each individual must aspire for the best possible health status, as a fundamental human right (UN, 2000). The right to health is part of the obligations of Portugal as a member of the UN, EU, WHO and OECD.

.2. The right to health protection and the duty to defend and promote it is constitutionally guaranteed (Article 64 of the Portuguese Constitution. 2005) in a dual dimension: individual and collective health - public health (Ombudsman. Lisbon, 2008).

.3. The Portuguese State is characterised by the principles of the Welfare State and social welfare. It performs the functions of promoting and protecting the health of citizens and guarantees social cohesion. The Portuguese Constitution (VII Constitutional Review, 2005) and the Law of the National Health Service (Law No. 56/79) state that health services are universal and shall tend to be free of charge.

BASIC LAW ON HEALTH

.4. The NHS is defined as an ordered and hierarchical set of public institutions and official care providers. Subsequent amendments to the Basic Law on Health brought about changes regarding the free access to the system and explicitly recognised the role of the private sector (Law No. 48/90, Law No. 27/2002).

FUNDING HEALTHCARE IN PORTUGAL

.5. In Portugal the payment of healthcare is done in different ways: through direct and indirect taxes [IRS (Income Tax on Natural Persons), IRC (Corporate Income Tax) and VAT]; contributions to health subsystems, either public (e.g. ADSE) or private; private insurance premiums, and direct payments made at the time of consumption (user charges, co-payments) (Pita Barros, 2008). The funding model of the NHS is traditionally based on tax revenues (Ombudsman. Lisbon, 2008).

TOTAL HEALTH EXPENSES

.6. Like most developed countries, the total expenditure on health in Portugal, both as a percentage of the GDP as well as *per capita*, has increased significantly over the last decade. However, in recent years, a disproportionate amount of this increase stemmed from private funds which originated a decrease in the percentage of expenditures funded by the public sector. Private expenditure on health as a percentage of the total expenditure on health remained consistently above the EU-15 average (WHO Europe, 2010).

DIRECT EXPENSES ON HEALTH

.7. Direct private spending (co-payments and cost-sharing) represent more than one-fifth of the total (20%), while most of the EU-15 countries have rates below 17%, and the WHO proposes a 15% or lower rate as the most effective in protecting against catastrophic household expenditure on healthcare (WHO Europe, 2010).

.8. It is found that 8% of households in the lowest income quintile reported spending more than 40% of their non-food expenditures on healthcare and medication (WHO Europe, 2010).

COVERAGE OF PRIVATE HEALTH SERVICES

.9. The overlap of care provision between public and private services cannot be understood in a simple way, since citizens with health insurances keep making their contributions towards the NHS and are entitled access to it. About a fifth of the population has double insurance coverage through health subsystems, depending on their professional category or job, which can result in faster and easier access to health services (WHO Europe, 2010).

IMPACT OF SOCIOECONOMIC DETERMINANTS UPON HEALTH

.10. Portugal shows a quite high rate of income-related inequality in the use of medical services. Among 13 countries of the EU-15 it ranked last in income-related inequality in use of specialist visits and second to last for visits with family doctors (WHO Europe, 2010).

STRATEGIES AND INSTRUMENTS FOR ECONOMIC AND SOCIAL PROTECTION

.11. A set of social and economic responses in disease have been developed to try to minimise the barriers that prevent citizens from accessing healthcare and to ensure that their social and economic condition does not deteriorate due to their health condition.

SERVICE OFFER WITH ATTENTION TO EQUITY

.12. In Portugal, in recent years, the NHS has expanded its service offer with attention to equity. Some examples are:

- The National Oral Health Program for children, youngsters (under 16), pregnant women and elderly people (beneficiaries of the solidarity supplement for the elderly) pays for a share of oral health services by distributing private dentist cheques;
- Support for medically assisted procreation (National Programme for Reproductive Health, DGS);
- The implementation of the Personalised Healthcare Units (UCSP), functional units of the ACES, implemented along with the organisational restructuring of Primary Healthcare, allowing the definition of a broader profile of community services.

USER CHARGES

.13. As a strategy for the moderation and promotion of the appropriate access to healthcare services, the impact of user charges as a possible economic barrier to access and use of necessary health services intends to be relatively small, which is due to various exemptions and to the fact that they have essentially the purpose of regulating demand, as they represent a value below the actual cost of the service.

- The system of exemptions from user charges in health services is based on four criteria that reduce selectivity in the benefit they seek: economic incapacity; provision of healthcare inherent to the treatment of certain medical conditions or resulting from the implementation of programs and measures of prevention and promotion of care; particularly vulnerable groups (such as women who are pregnant or in labour, or children under 12); and benevolent groups (Decree-Law No. 113/2011).

CO-PAYMENT OF EXPENSES WITH MEDICATIONS,

.14. As a measure of economic protection, individuals may benefit from partial co-payment or total payment of expenses with medications [e.g. total payment of expenses with generic medications for individuals with a monthly income below the

COMPLEMENTARY MCDT, AND TRANSPORTATION

minimum wage (Decree-Law No. 118/92, Decree-Law No. 129/2009)], with complementary diagnostic tests and therapies, along with support for the transport of patients (Order No. 19264/2010).

ALLOWANCES AND GENERAL SOCIAL SUPPORT

.15. Within individual resources for social and economic support in situations of disease we highlight the retirement and disability pensions, the short or long-term sick pay, the supplement for dependency and benefits associated with health costs, such as tax deductions.

ALLOWANCES AND SOCIAL SUPPORT IN MATERNITY AND PATERNITY

.16. There are tools and resources for family support in the area of economic and social support in health and disease contributing to ensure equity in particularly vulnerable stages of citizens' life cycle, such as during pregnancy, after childbirth or in case of adoption, such as the social welfare allowance for clinical risk during pregnancy and termination of pregnancy and other specific risks; the maternity allowance; the allowance for family assistance, among others.

SOCIAL AND ECONOMIC RESPONSES FOR THE ELDERLY

.17. For senior citizens there are specific social and economic support instruments, namely the solidarity supplement for the elderly, with specific additional coverage for medications and other health needs.

.18. In order to organise and to entrust responsibility to civil society, committees have been set up and are dedicated to specific areas of action in the health of the elderly, such as: the Committee for the Development of Healthcare for the Elderly and Citizens in Situations of Dependency, and the Monitoring Committee for the Programme on Senior Health and Thermal Treatment 2007 (Ferrinho *et al*, 2010).

SOCIAL AND ECONOMIC RESPONSES FOR WORKERS

.19. Within the context of occupational safety there are specific supports and socioeconomic resources available, namely: allowances for incapacity resulting from occupational diseases and allowances for work accidents.

INTEGRATION PROGRAMS AND SUPPORT

.20. One of the support instruments, both financial or technical, when hiring people with special difficulties of integration, are the integration programs and specific measures, namely: Employment-Integration Contract; Employment-Integration+ Contract; Integration Companies Program; Life-Employment Program; or also programs and measures specifically aimed at integrating people with disabilities (IEFP, 2010).

ECONOMIC AND SOCIAL RESPONSES FOR CITIZENS WITH DISABILITIES AND INCAPACITIES

.21. The Employment and Vocational Training Institute (IEFP) offers, in addition to the support it provides within the scope of general programs and measures for active employment (some of which are allowances or specific conditions for people with disabilities or incapacities), it also provides a set of specific support tools, both technical and financial, as part of the Employment and Support Program for the Qualification of People with Disabilities and Incapacities (Decree-Law No. 290/2009).

STRATEGIES FOR CITIZENS WITH DISABILITIES

.22. For citizens with a disability, the National Institute for Rehabilitation (INR) develops various initiatives related to the recognition of the dignity, integrity, freedom and fundamental rights, promoting the transversality of issues related to disability in the various areas of political intervention, based on the existing legislation (Decree-Law No. 38/2010).

- One of the instruments used in this context is the International Classification of Functioning, Disability and Health (ICF) of individuals, whose goal is to provide a unified and standard language and a framework for the description of health and health-related states (WHO, DGS, 2004);
- Following the fulfilment of the obligations entrusted under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), the actions that have been undertaken are a response to the recent European Disability Strategy 2010-2020, "A Renewed Commitment to a Barrier-Free Europe." This European strategy essentially aims at empowering people with disabilities to enjoy all their rights on an equal basis with all the others, and at removing obstacles in everyday life (INR, 2010);
- Another instrument of articulation is the National Strategy for Disability 2011-2013 (ENDEF) (Resolution of the Council of Ministers No. 97/2010). It attaches particular importance to the area of promotion of rights and quality of life for people with disabilities and incapacities. It extends the planning of public policies, across several ministries that combat discrimination and ensure the active participation of people with disabilities and incapacities in various spheres of social life.

STUDIES AND SOURCES OF KNOWLEDGE

.23. Statistics Portugal (INE) has held, every year since 2004, the Survey on Income and Living Conditions (ICOR) under the Regulation concerning European Union Statistics on Income and Living Conditions (EU-SILC). The survey focuses on the income and living conditions of the population residing in the country, including a set of observations concerning self-assessment of health status, the existence of long-term health issues and lack of access to medical and dental visits. The collection of data on the existence of long-term health issues contributes to the annual calculation of the Healthy Life Years indicator.

.24. These indicators can be broken down by demographic variables (gender, age), educational level, employment status, and income level.

.25. The OECD, in its report *Your Better Life Index*, mentions that in 2010, 66% of adults in highest income quintile self-assessed their health as 'good' or 'very good', and that percentage came down to 33% in the lower income quintile. This inequality in the self-assessment of the health status made Portugal rank last in the OECD countries regarding income-related social inequalities (OECD, 2012).

.26. Within all the EU countries, Portugal had the highest level of income inequality

(*Gini Index* equal to 43.3 in 2000) (Förster *et al*, 2005).

.27. Portugal, as other countries, has higher levels of self-reported illness in groups with social and economic disadvantage, which is not associated with a more frequent use of the NHS, even when those people are exempted from user charges. This use does not depend exclusively on the existence of services. These inequalities appear to be more pronounced in the homeless and alcohol abusers (Santana, 2002).

ASSESSMENT AND RECOMMENDATIONS

.28. Health in Portugal should be subject of reforms within a framework of sustainability, to ensure the continued quality of care and the competitiveness of the surrounding value chain (Health Cluster Portugal, 2010).

.29. One of the challenges for the Portuguese Health System is to consolidate and further improve the recent GeS, together with improving equity in health, and to be more responsive to the expectations of Portuguese people by adapting its services to the health needs of the population (WHO Europe, 2010).

4.3.3. GUIDELINES AND EVIDENCE

AT THE LEVEL OF POLITICAL DECISION-MAKING

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

- Following and defining co-payment and cost-containment policies, policies for purchases of healthcare services, and pharmaceutical and rehabilitation products that may reduce both direct and indirect health costs and respect the range of different socioeconomic capacities of citizens and families, particularly focusing on chronic, rare, and long-term disabling diseases and also diseases with high treatment costs;
- Reviewing the most regressive elements of the health funding system in order to improve health equity. Particular attention should be given to economic barriers for accessing healthcare, as direct payments for services are relatively high and co-payments in Portugal may require policies to reduce their impact, especially for the most disadvantaged families;
- Investing in proximity care that may allow patients to remain close to home, minimizing travelling expenses and time off work (Pereira *et al*, 2010);
- Adopting a charter of principles to support prepaid mechanisms that ensure the provision of tendentially free healthcare services, and financial and inter-generational solidarity in a spirit of financial sustainability of the NHS, of accountability of citizens and of enhanced value of the social contract;
- Developing leadership and investing in capacity-building to include health in all policies and to strengthen the mechanisms for inter-ministerial coordination and inter-sectorial action focused on strengthening economic and social support in health and disease. There are several partnerships to help leverage the existing responses, such as:
  - *The Ministry of Labour and Social Security, contributing to the development of structured and sustainable inter-sectorial actions that promote an increased GeS and reduce inequalities (e.g. National Long-Term Care Network);*
  - *Private non-profit organisations, as the Misericórdias, Associations and Non-Governmental Organisations, which act as key partners in a social and economic support structure in situations of health and disease.*
- Internationally, countries have tried to strengthen the existing social solidarity mechanisms through various types of responses (WHO. Primary health care, 2008) (NHS, 2009), namely: allowances and pensions for the most needy (International Labour Organization, 2005) (Health 2015 Public Health Programme. Finland, 2001); funding through prepaid social insurances (Correia de Campos, 2008) (Pita Barros *et al*, 2008); inter-sectorial measures to combat unemployment and for reintegration into active life; occupational health for individuals with incapacity (Health in Germany, 2008); support to informal caregivers of elderly and dependent citizens (Ministry of Health, Brazil, 2007); among others.
  - *Most countries choose to strengthen the role of Primary Healthcare, as well as to use inter-sectorial approaches emphasizing the role of local stakeholders in the sector of health and social security, specifically: in the field of cooperation and incentives to the*

work developed by NGOs and Private Social Solidarity Institutions (Health 2015 Public Health Programme. Finland, 2001) to support the most vulnerable in a closer way (WHO. Primary health care, 2008). These responses are generally focused on people with chronic illnesses, people with disabilities, vulnerable groups and/or children (Health 2015 Public Health Programme. Finland, 2001) (Health in Germany, 2008). For example, in Belgium, the local stakeholders of the health and social support sectors were grouped into 11 thematic forums: legal assistance, support and security of minors; services for youth and teenagers; childcare; cultural ethnic minorities; people with disabilities; senior citizens; housing; work and employment; people living on "critical income"; and health. Chile developed a social protection program with three components: direct psycho-social support, financial support, and priority access to social programs. The priority targets of this program are children from 0 to 18 years, support to working mothers, and the integration of women in the labour market (WHO. Primary health care, 2008).

.2. **Prioritising access and quality response of Primary Healthcare, Long-Term Integrated Care, Community Care and Public Health** as the basis for meeting first line proximity health needs and for freeing funds from hospital care.

- Developing the appropriate expansion and cost-effectiveness of telemedicine as a means for promoting and empowering proximity care, for containing patient transportation costs and for a swifter response ensuring greater well-being to patients, who are thus treated closer to home (Pereira *et al*, 2010);
- Investing in a system/network of domiciliary care that allows older people to remain supported at home, in the most independent and autonomous way possible.

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

- In face of scenarios of economic uncertainty, it is the responsibility of the Ministry of Health and of the levels of regional and local planning to define scenarios of prospective budgets that ensure the maintenance of essential services and key strategic options with higher GeS returns, as well as a variable investment policy based on the assessment of health technology;
- Clarifying the scope of action for the private sector through appropriate regulation: developing and ensuring compliance with the requirements for the presentation of results to the public, adherence to quality and safety standards, rules for the dual employment of healthcare professionals and payment mechanisms rewarding improved performance in the public and private sectors;
- As far as possible, choices with consequences in the medium-term that pose threats should be avoided, such as (WHO Europe, 2009):
  - *Reduced access and increased waiting lists due to less efficiency (fewer services per cost unit) exacerbate the situation of disease and encourage the use of private services, with decreased savings and satisfaction, and increase transaction costs (e.g. repetition of diagnostic tests);*
  - *Compromised quality, with a consequent decrease in patient safety and lower cost-effectiveness of care, decreasing the levels of confidence in the services;*

- *Indiscriminate decrease of expenditures, which focuses mainly on costs rather than on the value of the service, keeping the previously existing inefficiencies;*
- *Disinvestment in human resources, followed by loss of motivation, reduced training, reduced productivity and drainage of professionals of higher value;*
- *Disinvestment in prevention and cost-effective public health activities, to protect curative services.*

- The Ministry of Health should explain which services, treatments and activities constitute the core of public service and should be protected, especially in times of crisis.
  - *Coverage and access timings to those services should be monitored;*
  - *Co-payment by the state of complementary services may be made for those whose access is conditioned by economic reasons, may require the use of contracted private services and may vary depending on the financial resources available;*
  - *Regional and local specificities in this profile of essential services may exist, as long as they are justified in terms of public health.*
- It is the responsibility of the Ministry of Health, and its institutions, to review the plans and programs that preserve the accessibility and quality of services, even in scenarios of reduced resources, namely by resorting to:
  - *Mechanisms for the acquisition of skills and redistribution of responsibilities among the various professional groups (e.g., screening and follow-up protocols);*
  - *Reduced investment in sophisticated technology and non-essential or redundant infrastructures with low added value;*
  - *Regular information and advocacy with representatives of the various stakeholders, either professional groups, patients, citizens, service providers or the industry;*
  - *Decentralised management and rationalised decision-making regarding resources, keeping the focus on health outcomes, access, quality and citizen engagement;*
  - *Concentration of common services in order to maximise cost-effectiveness and quality of resources, while preserving access;*
  - *Certification and standardisation of clinical procedures and support to clinical and managerial decision-making, with a focus on quality and safety, together with monitoring and evaluation of abnormal situations.*
- Reinforcing compliance with minimum standards for public and private providers and ensuring the public presentation of results regarding a set of response and performance indicators.

.4. **Increased rationalisation in the allocation of health resources** in order to achieve more cost-effective GeS.

- Improved performance of a Health System with limited resources should be able to follow strategic options for the allocation of resources to areas where they are most effective;
- The State must ensure the response to the health needs of individuals and populations, according to its functions as the main funding agent, regulator, administrator and care provider. Such guarantees must be fulfilled by:
  - *Effective and equitable access to health services that cover the basic health needs, expressed in terms of minimum and optimal criteria regarding distance to such services, waiting time for access, quality, cost and continuity of care;*

- *A rationalised policy of access to health technologies in terms of cost-effectiveness, maximizing the use of resources, and equitable geographical distribution;*
- *A policy of interventions that promote health and minimise health needs, reduce the effect of population ageing and promote health and social cohesion.*

- The role of Regional Health Authorities and institutions should be valued in seeking efficiency and productivity gains with better access, quality and safety through optimised planning at local level and according to the needs of the populations being served.

.5. **Organising public health policies, vertical health programs and the integration of technology in a logic of prioritisation through cost-effectiveness criteria, increased equity and impact on GeS.**

- The use of a health promotion strategy develops guarantees of health equity, since it reduces inequalities in the levels of population health and ensures equal opportunities and resources, in order to boost their health potential. To achieve this goal, a robust deployment of the population in a supportive environment is required, with access to information, and to lifestyles and opportunities that enable healthy choices (WHO, Geneva, 1986).

.6. **Implementing information and monitoring systems for the social and economic determinants of health and for notifying/referral situations of social and economic disadvantage**, abnormal expenditure on healthcare, and difficulties of access and continuity of care derived from socioeconomic limitations.

- Policies to strengthen the economic and social support in health and disease must be adaptable to the community, to families and to institutions. The information systems shall be able to monitor the socioeconomic impact of disease and healthcare, promote early intervention and provide support in evaluating policies. It includes crossing data from several institutions, while ensuring the maintenance of privacy, the capability for carrying out the analysis disaggregated by socioeconomic determinants (such as education, individual and family income level, employment status), and the consideration of the various dimensions of direct and indirect health-related expenses. These systems should make it possible to characterise the unequal distribution of socioeconomic factors related to risk, access, quality and health outcome factors;
- A comprehensive review of the social determinants of health and health inequalities should be performed, in a monitoring model that enables periodic reporting and monitoring of equity.

AT THE LEVEL OF INSTITUTIONS

.7. **Taking up, as part of their social function, the objective of strengthening economic and social support to the populations being served,** translated into policy and institutional services, with a focus on accessibility, public and private expenditure, capacity-building, empowerment and equitable health outcomes.

.8. **Developing and disseminating best practices for social inclusion, accessibility for vulnerable groups, capacity-building and empowerment, as well as solidarity support to citizens.**

.9. **Proactive collaboration in social and inter-sectorial national, regional and local groups, with the mission of promoting health and well-being of vulnerable populations.**

.10. **Strengthening articulation with social services and social resources of the**

communities they serve, in order to identify and refer situations of social and economic need with an impact on health, while supporting episodes of illness, continuity of support and care, and social reintegration.

.11. **Monitoring and assessment of the impact of institutional policies on accessibility, equity, costs and health outcomes in the populations they serve,** in general and according to their socioeconomic status, and make this information available, in compliance with the legal guarantees.

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

AT THE LEVEL OF HEALTH PROFESSIONALS

.13. **Increasing the sensitivity and considering the social and economic issues in health-related decisions,** from the point of view of the implications for citizens/patients, their families or carers, for institutions and for society at large.

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

.15. **Identifying situations of risk or social and economic deprivation and refer to or provide advice on the available services and support resources.**

AT THE LEVEL OF CITIZENS

.16. **Knowing their rights and responsibilities regarding the resources of social and economic support in health and disease.**

.17. **Promoting the solidarity and responsiveness mechanisms of the health system,** by taking responsibility for their own health, and for that of their family and community, appropriate use of health services, and involvement in health institutions and organisations of a social and volunteer nature.

4.3.4. VISION FOR 2016

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

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

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

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

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

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