

## Primary Health Care Reform in Portugal: Portuguese, modern and innovative

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**Abstract** *The 2005 Portuguese primary health care (CSP) reform was one of the most successful reforms of the country's public services. The most relevant event was the establishment of Family Health Units (USF): voluntary and self-organized multidisciplinary teams that provide customized medical and nursing care to a group of people. Then, the remaining realms of CSP were reorganized with the establishment of Health Center Clusters (ACeS). Clinical governance was implemented aiming at achieving health gains by improving quality and participation and accountability of all. This paper aims to characterize the 2005 reform of Portuguese CSP with an analysis of its systemic and local realms. This is a case study of a CSP reform of a health system with documentary analysis and description of one of its facilities. This reform was Portuguese, modern and innovative. Portuguese by not breaking completely with the past, modern because it has adhered to technology and networking, and innovative because it broke with the traditional hierarchized model. It fulfilled the goal of a reform: it achieved improvements with greater satisfaction of all and health gains.*

**Key words** *Primary healthcare, Healthcare reform, Organizational innovation*

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## Introduction

The last Portuguese reform of primary health care (CSP – “Cuidados de Saúde Primários”) (equivalent to the Brazilian “Atenção Primária à Saúde”) formally began in 2005 and is one of the most successful reforms of public services in the last decades in Portugal. The most relevant event and the first field change was the establishment of Family Health Units (USF – “Unidades de Saúde Familiar”): voluntary and self-organized multi-disciplinary teams that operate in health centers run by the State and that respond with autonomy and flexibility to the health needs of a group of people, with a focus on customized medical and nursing care. This first change broke with the very hierarchical organizational structure of public services; then, the remaining realms of CSP were reorganized with the establishment of Health Center Clusters (ACeS – “Agrupamentos de Centros de Saúde”). In order to give consistency and sustainability to changes, actions focused on clinical governance, seeking to achieve health gains by improving quality and participation and accountability of all.

This reform did not emerge from a situation of chaos, very bad results, great inefficiencies or great dissatisfaction. It started from a 35-year evolution that built a tax-financed National Health Service (SNS) that covered the entire population with a network of health centers and hospitals nationwide, where State professional careers were structured, quality residencies were organized and excellent results in many health indicators were achieved<sup>1</sup>. However, there was a hunger for more: more quality with greater accessibility, better care aligned with current technical-scientific guidelines, active participation and greater satisfaction of all, users and professionals alike. Then, what was done is what has happened during the various Portuguese CSP reforms: health systems of other countries were studied, namely those that have historically served as reference for Portugal, as well as scientific literature, and a Portuguese solution was constructed.

In this particular reform, the main reference was the British National Health Service (NHS), namely with regard to the NHS Community Care Act<sup>2</sup>, to the activity of primary care trusts, especially their development to Clinical Commissioning Groups<sup>3</sup>, and focus on the Quality and Outcomes Framework (QOF)<sup>4</sup> incentive scheme to boost quality care delivery. Following the trend of many other countries, since 2004, Portugal has started a practice (that it still main-

tains) of achieving consensus in the National Health Plans<sup>5,6</sup> (which are then broken down into regional and local plans), giving coherence to the health system as a whole, with a view to eliminating regional inequalities, achieving health gains, focusing change on the citizen and providing capacity to the health system for innovation.

In the origins of this reform, even before their publication and building on ongoing discussions on CSP, conclusions of the 2006 Report<sup>7</sup> of the European Observatory on Health Systems were followed up, which pointed to the need to promote teamwork, the registration of users by CSP health team to ensure longitudinality of care, achieving greater accessibility to services, to pursue a differentiated payment and linked to the performance and computerization of services.

Fueled by all these inputs, the Portuguese solution emerged in the form of a professional utopia – *free translation from the Portuguese*: the Blue Book “A Future for Family Medicine in Portugal”, the Portuguese Association of General Practice/Family Medicine<sup>8</sup>. Written 15 years before the reform, in 1990, it was refined, tested in various field experiences, discussed with other professional groups, civil society and political parties until it was included in the electoral program of a party (the Socialist Party), who won the elections and implemented it. This document presented a detailed solution, ready to be implemented, already matured by years of discussion and experimentation and that managed to be put into practice in just over six months.

The purpose of this 2005 CSP reform, as in all reforms, was to improve and it was decided that improvement should specially focus on accessibility, organization, timeliness, ease and comfort in the use of services, without forgetting health care quality and aiming at satisfying both professionals and users<sup>9</sup>. Several strategies were followed to achieve these objectives. The first sought to ensure a structure that would allow the whole process to be carried out in an autonomous way - for this purpose, the CSP mission was established by resolution of the Council of Ministers, that is, supra Ministry of Health “to conduct the global project of launching, implementing, coordinating and following-up the strategy for the reconfiguration of health centers and implementation of family health units”<sup>10</sup>. The second strategy aimed at implementing the process based on what D. Swanson et al.<sup>11</sup> characterized as adaptive policies, which are based on integrated and forward-looking situation analyzes, reflect inputs from as many stakeholders as possible, promoting and encour-

aging varied responses (not just one) and automatic policy adjustments through the monitoring of key indicators and lifelong learning, as well as focusing on self-organization, social networking and decentralization of governance.

In a 2005 paper, Atun et al.<sup>12</sup> illustrate the success of these adaptive policies in a CSP reform and complement the package needed to succeed: (i) strong leadership; (ii) good coordination between the political and operational spheres; (iii) a practical approach to implementation, emphasizing the clarity of interventions in order to be quickly apprehended by potential recipients of such policies; (iv) engagement strategies to avoid unnecessary conflicts with status quo; (v) careful management of change, so that reform is not politicized too early and with strong and early investment in training to establish a critical mass of professionals who can quickly operationalize and implement policies.

These authors also considered that it is extremely important to address reform in multifaceted and coordinated fashion, with changes in legislation, organizational restructuring, changes in financing and payment systems of providers, establishment of incentives for innovation and investment in the development of human resources.

In general terms, this was the “primer” proposed and promoted for the 2005 CSP Portuguese Reform.

This paper seeks to describe the CSP reform started in 2005 in Portugal in general, the changes that have taken place at the systemic and local levels, the models that inspired it and the reasons for its success.

## Methodology

This is a case study on a CSP reform in a health system with an analysis of its systemic and local realms. We reviewed the legal documents that included the reform, reports, studies and papers produced on the subject by national and international bodies, as well as analyzed the internal documents and activity reports of a health unit established in the scope of this reform – the Marginal family health unit. The two authors work in this facility – one as one of its founders and the other as its resident. It is, therefore, a paper that combines both an inside view lived since the preparation of the reform, its onset and its development, and an extensive documentary analysis that aimed to cover all reference documents.

## Establishment of Family Health Units and systemic changes

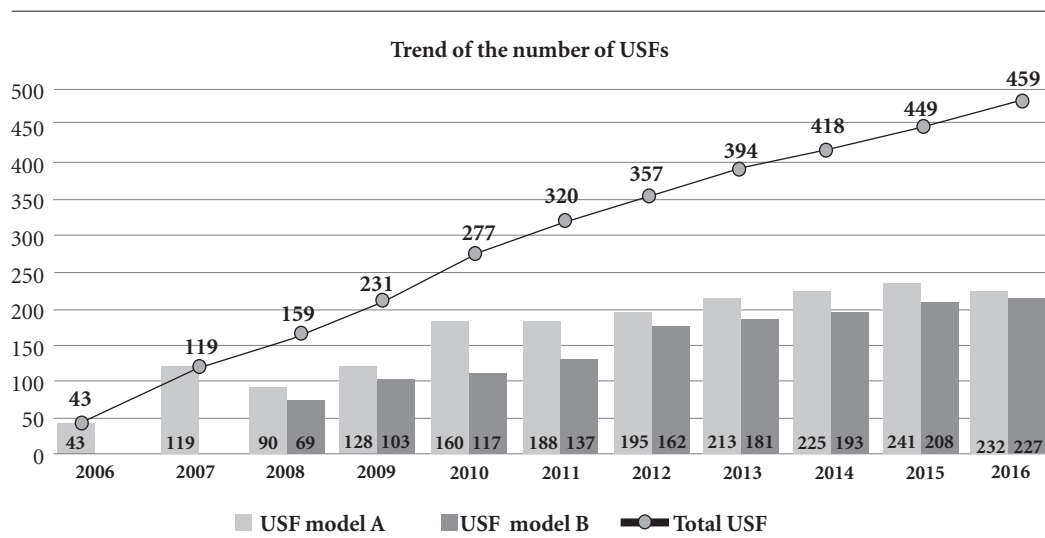
The central aspect of changes was the reconfiguration of the Health Centers according to principles that would allow for the optimization and sustainability of the National Health Service (SNS – “Serviço Nacional de Saúde”), ensuring the quality of care provided in a system of continuous improvement. The following principles were the basis for change<sup>9</sup>: (i) community orientation; (ii) organizational and management flexibility; (iii) debureaucratization; (iv) teamwork; (v) autonomy and accountability; (vi) continuous quality improvement; (vii) contractualisation and evaluation.

The process of moving to the “new health centers” also included<sup>9</sup>: (i) establishment of Family Health Units (USF); (ii) association of Health Centers in Health Center Clusters (ACeS); (iii) creation of other functional units in the ACeS, which will be detailed later; (iv) introduction of a new management model; (v) implementation of clinical governance; (vi) reorganization of support services; (vii) complete computerization of services and dematerialization of most of the support for the practice.

The most relevant event of this reform, as already mentioned, was the establishment of USFs, whose number has been increasing annually since its implementation in 2006 (Graphic 1).

USFs have emerged with the involvement of health professionals through voluntary application processes for the creation of self-organized health care teams with technical, care and functional management autonomy<sup>13</sup>. These teams consist of family doctors, nurses and clinical secretaries (professionals who, in addition to secretarial and administrative services areas, management and information technology skills, master medical terminology, communicating appropriately with users and other health team members).

The reconfiguration of the existing Health Centers in Health Center Clusters, namely, the ACeS, occurred in two stages, with the initial establishment of 74 ACeS, which were reduced to 55 ACeS distributed nationwide after restructuring. According to their supporting legislation, ACeS<sup>14</sup> are public health services with administrative autonomy, decentralized from their respective regional health administrations (ARS), but subjected to their directive power; they consist of several functional facilities that ensure the provision of customized healthcare to the population of a given geographical area.



**Graph 1.** Trend of the number of Family Health Units (USF) - Portugal 2006-2016.

Source: ACSS (2016). Report: Nominations and Constitution of USFs and UCCs. 2016-10-07.

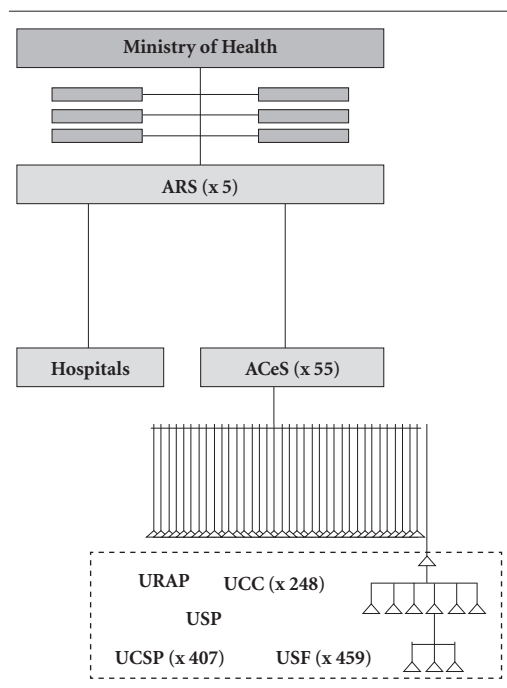
These functional units include: units geared mostly to customized medical and nursing care - the USFs (family health units)<sup>15</sup> and the UCSPs (customized health care units)<sup>16</sup>; the USPs (public health units)<sup>17</sup>, which operate as health observatory of the geodemographic area of the ACeS, of which it is part, and is responsible, in particular, for the elaboration of information and plans in public health areas, epidemiological surveillance, management of intervention programs in the prevention, promotion and protection of health of the population; the URAPs (units of shared care resources that include, for example, social workers, physiotherapist, occupational therapist and psychologists)<sup>18</sup>, who provide care advisory services to all other functional units; the UCCs (community care units)<sup>19</sup>, which provide health care and psychological and social support at home and community level (Figure 1).

The 2005 CSP reform proposes a central role for clinical governance in functional units, assigning them technical responsibilities and authority independent of the management body of Health Center Clusters. Clinical and Health Governance (GCS – “Governança Clínica e de Saúde”) is a system of knowledge, attitudes and practices of individual, teams and services clinical “piloting” aiming to achieve the quality of care. The purpose is to achieve results in terms of effectiveness with equity to individuals, families and communities, with the involvement of all, through the continuous improvement of the

quality of care processes and health interventions and the participation and accountability of all professionals<sup>20</sup>.

USFs thus constitute an innovative model in the provision of CSP and public services in Portugal. Their main characteristics and integrating principles<sup>1</sup> are as follows:

- They consist of multidisciplinary teams (including family doctors, nurses and clinical secretaries), whose size is subordinated to the registered population, voluntarily established (a group of professionals who are already civil servants decides to work together and submits a proposal to the administration) and self-organized, often grouped into micro-teams that flexibly respond to the health needs of a defined set of people and families (list of users) of a given geographical area;
- They have technical and organizational autonomy regulated by a set of formal tools (such as internal regulations or action plan) and an organizational structure consisting of a team coordinator (elected by the team), a technical council (main responsible for the implementation of clinical governance, also elected) and by a general council (includes all professionals of the unit and where the most important decisions about their functioning are taken by equal vote of all, regardless of one’s professional group);
- They aim to achieve objectives and goals of quality processes and health outcomes, laid down by a contractualized letter of commitment with



**Figure 1.** National Health Service Organizational chart focused on Primary Health Care.

ARS: Regional Health Administration; ACeS: Health Center Clusters; USF: Family Health Units; UCSP: Customized Health Care Unit, URAP: Shared care resources units; USP: Public Health Units; UCC: Community Care Units. The numbers of units currently in the country are shown between brackets.

- - - : Including the functional units of an ACeS.

Source: André Biscaia.

the executive directions of the ACeS, and these, in turn, with the ARS, which are evaluated and held accountable for their performance;

- They can access, in the case of doctors, a mixed remuneration system (base/career, adjusted capitation, pay per service performed – only in the case of home consultations - and associated to the performance, by achieving the team's objectives) that awards the optimization of access, the collective performance for efficiency and quality. Nurses and clinical secretaries can access financial incentives, and their attribution depends on the achievement of contractualized goals related to performance indicators;

- They can also achieve other incentives that aim to support and stimulate the collective performance of USF professionals – institutional incentives – that consist of the attribution of monetary awards for reinvestment in the USF itself,

and are assessed by performance measured by indicators in four areas – accessibility, care performance, user satisfaction and efficiency;

- They have information systems to respond to the contractualized indicators and maintain a reliable computerized database of user files of professionals;

- They must enter into an inter-replacement agreement among professionals that ensures, on working days, the same day assistance service to users enrolled in USF;

- They establish a technical and scientific hierarchy, indicated by the team, to ensure quality service;

- They must structure a competence development and training plan;

- They must accept network integration with other functional units in ACeS and other community entities.

USFs' organizational development is based on three models, which assume different levels of autonomy and to which correspond different levels of risk-sharing and rewarding compensation. Model A – it is a phase of learning and improving of family health teamwork; it comprises USFs of the public sector, with rules and remunerations defined by the Public Administration, with the possibility of contracting an additional portfolio of services paid in extraordinary work, as well as contracting the achievement of goals that can translate into institutional incentives to be reverted and invested in the USF; Model B – indicated for teams with greater organizational maturity, that are willing to accept a more demanding level of contractualized performance; it covers public USFs and has a special remuneration for physicians and financial incentives for nurses and clinical secretaries, and, as in model A, they contractualize indicators related to institutional incentives and a possible additional portfolio of services; Model C – experimental model, with a supplementary character in relation to any shortcomings shown by the SNS; it covers USFs of the social, cooperative and private sectors<sup>1</sup>. At this time, only model A and B USFs are in place.

On the other hand, it is still possible to maintain the previous level of organization, non-USF, in UCSP in cases where professionals are not willing or cannot organize in USFs, functioning in a more vertically hierarchized and less autonomous model that characterized the CSP work model before the 2005 reform.

There are currently 459 USFs<sup>21</sup>. According to October 2016 data<sup>21</sup>, USFs have 11,202 pro-

professionals covering more than half of the Portuguese population: 5,361,959 users.

The reform is actually undergoing a relaunch period aiming at expanding and improving the CSP network capacity, starting a new cycle of bettering the quality and effectiveness of SNS' first line of response. The vision adopted in this stage is "a CSP-based SNS, promoting equity and ensuring access to community-based care, with resolve, continuity, quality and efficiency"<sup>22</sup>.

### The Marginal Family Health Unit in Estoril

The USF Marginal was established in Estoril on April 19, 2007. We will analyze it in detail to transfer to the practical reality the creation and activity of one of the Portuguese long-standing USFs and, thus, to illustrate changes at the local level in the field.

Regarding the characteristics of the biophysical environment, we should point out that the municipality of Cascais belongs to the district of Lisbon and is home to a municipality with an area of 97.4 km<sup>2</sup>, subdivided into 4 counties: Alcabideche, Carcavelos and Parede, Cascais and Estoril and S. Domingos de Rana. The geographic areas of influence of the USF Marginal are the counties of Alcabideche, Cascais and Estoril, with very asymmetric socioeconomic profiles, with some financially better-off families in the country living side-by-side some of the families with the lowest incomes, and both groups are ACeS users.

Seven clinical secretaries, nine nurses and eleven doctors decided to work together and apply to run a State health unit and provide care to 18,000 people. The first task of the group was to agree and write their values<sup>23</sup>:

- human potential is the most precious good - people make a difference;
- the success of the facility is based on trust, responsibility, solidarity, respect and transparency;
- the preservation of the environment and the safety of citizens and professionals are constant concerns;
- lifelong learning and the sharing of information, knowledge and experience are fundamental for the development of all; and finally,
- reflection is one of the most important resources in health.

The next task established its mission: "to provide customized, global, equitable and quality health care, promoting the participation and autonomy of citizens they care for and the professional and personal development of their profes-

sionals, in order to improve the well-being and the quality of life of all"<sup>23,24</sup>. This was followed by the internal rules and the election of the Coordinator and the Technical Council. The logo they chose – the "silhouette" of a wave – was intended to immediately generate ideas or connotations of movement, rhythm, cycles, energy, plasticity, change, force, sea and also bank (*in Portuguese, "margem"*) as in... Marginal<sup>23</sup>. "Marginal" is also the iconic road that crosses in front of the unit's building. The motto "Health partners: together we can achieve" came naturally when we wrote the purpose of the USF: "the development for the greatest possible autonomy of the community and of the citizens who chose this unit as a health partner"<sup>23</sup>.

Thus, the unit assumed the citizen user of the USF Marginal as its core activity (Figure 2). In order to achieve its mission, the group of professionals proposed to work as a team, subdivided into micro-teams consisting of a nurse, a doctor and a clinical secretary to provide customized healthcare to a group of citizens enrolled in the USF, to whom it offers the services that are part of the basic portfolio of clinical services: general consultation, adult and elderly health consultation, newborn, child and adolescent health, women's health, acute care, chronic disease clinical follow-up and multiple pathology and home care<sup>24</sup>.

To maintain the standard of good practice it has undertaken, this unit implemented an in-house training and professional development program with weekly 90-minute sessions that mix service and training meetings according to staff needs and interests, and full-day monthly hours for further study of topics selected by all. In addition to these face-to-face meetings, USF members keep in touch and exchange information and opinions in their various internet general and sectoral discussion groups.

They also have two computer applications created from team-developed projects: (a) EPIC<sup>25</sup> (Critical Episodes) tool provides a registration and management form for all types of critical episodes and clinical, administrative or any other nonconformities which take place at the USF Marginal; and (b) the LESMA tool<sup>25</sup> (Reading and Studying at Marginal), which consists of a model for USF professionals to record questions about the practice and training needs that are posted to the USF Internet discussion group with answers in a Q&S model (quick and slow, quick – in the forum on the internet, open to debate among colleagues, with real-time responses; slow



**Figure 2.** USF Marginal, ACES Cascais and the community.

USF: Family Health Units; ACES: Health Centers Clusters.  
Source: André Biscaia.

– more formal response to issues raised, which are validated in a multiprofessional meeting and kept in a proper file).

In the good practices and the constant search of knowledge, development and improvement, the USF Marginal develops own or collaborative lines of clinical investigation and health services (Figure 3).

The three core processes of this unit – customized health care, training and research – require support, quality and management activities (Figures 2 and 3) in order to operate. As the self-organized units they are, in a USF, these activities are the responsibility of their professionals. Thus, it has support activities – accounting, administrative assistance, hygiene, waste management, sterilization, procurement, etc. – that directly or indirectly sustain the implementation of other activities (Figure 3). Management activities – general operations, planning, internal monitoring and internal evaluation of work, schedules, external coordination, etc. – are shared between the coordinator and other professionals to maintain the organization, efficiency and sustainability with the best cost-benefit ratio. Quality activities are implemented so that everything goes well the first time around and sequentially, safely, in a documented format, according to the

best evidence and good practices and to satisfy users and professionals.

USF Marginal thus provides customized healthcare over time to its users, supported by the remaining structuring nuclei of the USF: training, research, support activities, quality and management. The general mapping of USF Marginal's activities summarizes the entire network of interaction and interdependence relations of the structuring nuclei of the unit, which is citizen user-centered (Figure 3). All of these complex interactions create dynamics sustained in personal relationships, technology and science for the provision of citizen-centered, health-oriented care.

The USF also needs to build and maintain its social network. It is part of the Cascais ACeS – they complement each other, inserted in the community in the municipality of Cascais, linked to some private or public services, such as the Hospital of Cascais or the clinical analysis laboratories and establishes partnerships with community services, such as schools, municipal services, among others (Figure 2). This non-isolation also allows the USF to focus on what are its core activities.

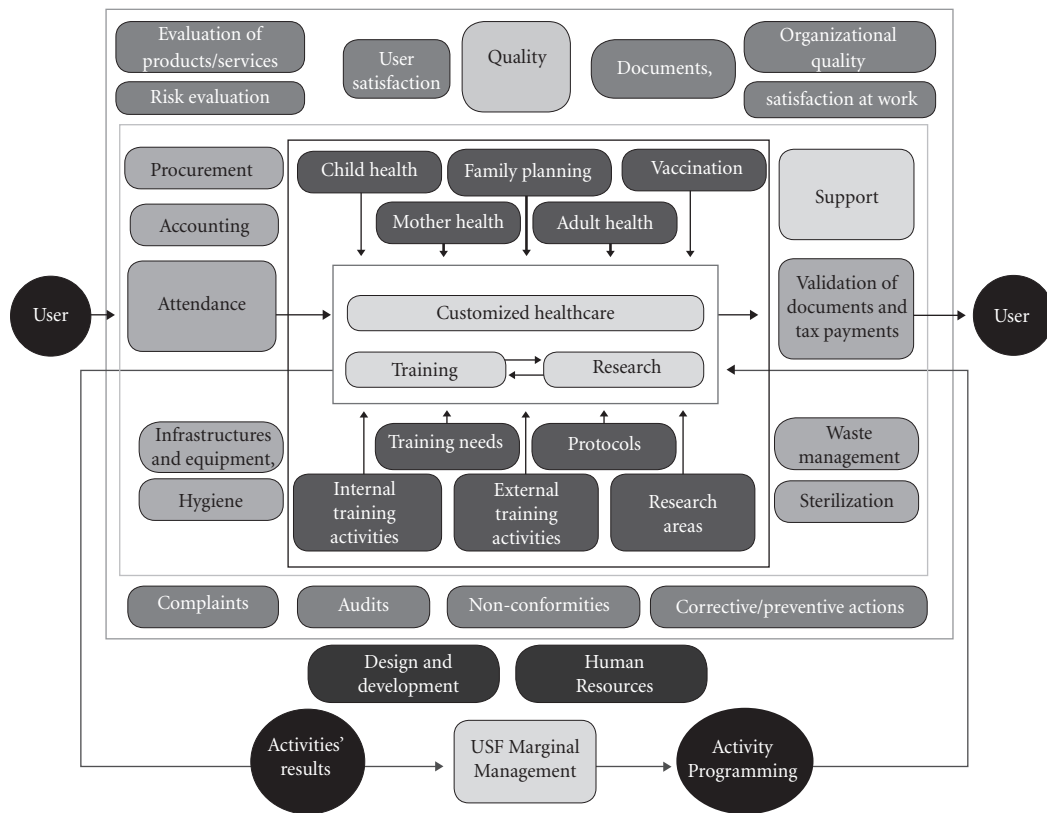
External liaison also happens through external training. The USF Marginal provides training to medical and nursing students, interns / residents of the specialty of General and Family Medicine (permanently between seven and thirteen residents) as well as to clinical secretariat individuals to other functional units. It also provides international observational internships and visits by professionals from other countries<sup>24</sup>.

Other levels of external liaison are participation in professional and multiprofessional associations (which played a very important role in the genesis of this reform<sup>26</sup>); USFs even have a multiprofessional representative association, the USF-AN - National Association of Family Health Units<sup>27</sup>. Interaction in Internet discussion groups where all USF national professionals and the entire USF professional community can participate enables global sharing and universal gains.

Among the core areas of USF Marginal activity, one deserves to be highlighted, given its specificity and complexity: quality activities.

### Quality Center and clinical governance

In the design of this reform, it was recognized that the structuring power of clinical governance was essential for the advancement of the reform. Thus, a quality center was set up with the purpose of boosting unit development to the param-



**Figure 3.** General Cartography of USF Marginal Activities.

USF: Family Health Units.  
Source: André Biscaia.

eters that were, subsequently, considered as those of excellence in the provision of health services.

The performance of USF Marginal Quality Center was based on the “Quality Virtuous Pentagon – Quality for All” (PVQ)<sup>26</sup> developed at the Cascais Health Center. The PVQ is a continuous quality improvement program based on an integrated, systematic and preventive approach to key areas of activity that may affect the quality of service provided by the health organization.

PVQ’s central component is the citizen integrated into the citizen-community-professionals-health organization interdependent dynamics and develops along three axes: citizen satisfaction, professional performance and organizational quality (Figure 4).

The first axis, citizen satisfaction, is one of the primary objectives of any health institution. Citizen satisfaction relates, among other things, to citizens’ perceptions of the extent to which their health needs and service preferences are consid-

ered. However, health needs have their own specificity – they are part of the priorities and preferences of the citizen who seeks care, as well as the technical realms of the definition of a health need scientifically sustained and only apprehensible in its entirety by the citizen/health professional/health system interaction.

The second axis, namely, professional performance, assumes the most visible aspect of the activities and relies on the success and quality of the entire health organization. It has a technical realm, technological contingencies and is supported by professionals who are motivated to work (in which work satisfaction arises as a fundamental component).

The third axis, namely, organizational quality, supports all the activity of the health organization, making the appropriate means timely available for the unit’s action and structuring the processes of planning, monitoring and evaluation of the activity. It also enables a more efficient use of



knowledge, technology, human resources and the context in which the unit fits. The importance of organizational quality manifests itself in providing the conditions for teamwork within the unit and in a network with different individuals of the health system and society, promoting an active involvement of citizens and health professionals.

In addition to these three axes, the action of the Quality Center relies on two procedural and instrumental areas - measurement / monitoring and analysis / reflection.

An organization that is not able to measure its activities and then to reflect in a useful way on the adopted processes and outcomes can hardly have a performance of quality, much less to grow or innovate. These are essential characteristics of a learning organization<sup>28</sup>. Learning organizations are organizations that are open to the outside world in a reciprocal flow of knowledge and experiences that make learning a core feature of their activity. The knowledge accumulated by each professional is assimilated and expanded by the organization. These organizations create productive learning routines that include identifying mistakes and correct them, the ability to question their goals, norms, structure and results and innovate, and finally, meta-learning - learning how one learns to do it increasingly better<sup>28</sup>.

In the area of measurement / monitoring, appropriate measurement tools have been selected and/or built to monitor the established objectives and the populations in which they are applied (such as clinical recording software). There are also regular internal quality audits and research methodologies that can provide results that can be converted into knowledge, decision and action, with particular relevance to research-action<sup>26,29</sup>.

In the area of analysis / reflection, USF Marginal has the above-mentioned program of service and training meetings that involve the entire team, in addition to discussion groups and computer applications to share ideas, knowledge and questions.

These three major axes and the two procedural areas are the five corners of the “Quality Virtuous Pentagon”. This whole model of approach and action is action-oriented to achieve objectives and produce results, so that the unit can boost health gains.

### The value of change

The value of USF has been demonstrated in several studies. The most important study was published in 2016 by the Health Regulatory Authority (an independent public entity whose mission is to regulate the activity of health care establishments) – *Portuguese free translation*: “Study on the Family Health Units and the Personalized Health Care Units”<sup>30</sup> – whose results indicate a better performance by USFs in most indicators, namely in economic performance indicators.

In 2015, the Organization for Economic Cooperation and Development (OECD) published a review of the quality of health care in Portugal<sup>31</sup>, which refers to the establishment of USFs as the basis for the success of the Portuguese CSP reform. This report says that its innovative and revolutionary model in terms of organization, funding and care provision to the population has allowed USFs to achieve very positive and consistently higher levels of performance and results than UCSPs, as well as a higher quantity and quality of information available in CSP (through the monitoring of a large number of indicators) than the capacity of most OECD countries.

Finally, several studies on the level of user satisfaction have been showing superior results of USF versus Non-USF<sup>32</sup>.



Figure 4. USF Marginal Quality Virtuous Pentagon.

## Conclusion

The 2005 CSP reform was Portuguese, modern and innovative. Portuguese by not completely breaking with the past, maintaining the essential that was already impregnated in Portuguese culture and society, and improving what was to be improved in a system that has been very successful, but which was stagnant. It is also Portuguese because it was based on a professional utopia - the Blue Book "A Future for Family Medicine in Portugal" of the Portuguese Association of General Practice/Family Medicine<sup>8</sup> - written 15 years before the reform and which has been improved through many contributions until the window of opportunity emerged in 2005 for its full imple-

mentation. It is modern because it has adopted technology, total computerization and networking - always connected between units and with the population. It is innovative, especially for a public system, because it broke with the traditional vertical and hierarchized model and engaged in self-selected and self-organized teams with functional autonomy and accountability that can focus on people and communities they served, as well as on their core activities.

The reform was a good student, learning from other reforms while keeping its own identity, following the best evidence, well prepared and implemented, especially with regard to USFs. Finally, it fulfilled the overarching goal of a reform: it achieved improvements with greater satisfaction from all parties involved and health gains.

## Collaborations

LCV Heleno worked on the research, design and final writing. AR Biscaia worked the research, design, writing texts that were the basis of the paper, final writing and review.

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