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Primary healthcare in Portugal: 10 years of contractualization of health services in the region of Lisbon

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Abstract *Contractualization consists in the development and implementation of a documented agreement whereby one party (payer) provides compensation to the other party (provider) in exchange for a set of health services to a targeted population. We describe, through a case study, the history and the process of implementation of primary health care contractualization (since 1992) in Portugal, emphasizing the consolidation and future challenges of the primary healthcare reform started in 2005. This article resorts to a case study to reflect on the results obtained in the Cluster of Health Centers of the Northern West, Regional Administration of Lisbon and Tagus Valley, between 2009 and 2015, following implementation of contractualization. It was found that the incentive-related payments will have to be weighted considering the results obtained, strongly influenced by epidemiological and socioeconomic change.*

Key words *Contractualization, Primary healthcare*

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Introduction

In Portugal, the right to health was only recognized in 1971. This led to the establishment of first-generation health centers, with the primary concern of integrating multiple institutions with preventive and public health concerns, so far organized vertically. These centers were strongly influenced by public health concepts, preferably geared to vaccination, mother and child surveillance and school health.

Subsequently, second-generation health centers were characterized by a bureaucratic organizational structure within sub-regional structures, coordinated among themselves in the Regional Health Administrations (established in 1982). The activity of these health centers was based on the medical career of general practitioners set in 1983. The organizational model of these health centers proved to be out of alignment with regard to the needs of both users and professionals and created a space for the development of an experimental project of organizational innovation, called Alfa Project (1996) and the Experimental Remuneration Scheme (RRE) (1998).

The Alfa Project was an example of a new organization and provision of healthcare by general practitioners and family doctors with the aim of providing autonomy in exchange for objective accountability for improved access and quality. It also sought to encourage the initiative of small groups of family physicians in collaboration with other health professionals to autonomously and innovatively care for a list of users, taking into account their capacity and available means.

The evaluation of this project pointed to the centrality of professional remunerations, aiming at the best performances. This is how the RRE (1998) was established and defined a new payment mode for physicians, with a salary component associated with the quantity of work and quality of professional performance, a weighted training component as an alternative to the traditional salary model. The cost-effectiveness of this measure and the satisfaction of the professionals attested the benefit of introducing the RRE.

In 1996 (with the experience gained in ARSLVT), Portugal started the contractualization process, as an important instrument to support financing in a perspective of greater equity and guaranteed access to health by citizens. It was incumbent upon the Health Service Monitoring Agencies (AASS)[1], founded in 1997 and later renamed Health Service Contractualization Agencies[2], one for each health region, to be the intervening entities in the system, with representation of citizens and administration and with the mission of spreading health needs and advocating the interests of society in general. Therefore, equity and technical rationality should guide the distribution of financial resources by health institutions in each region.

The establishment of agencies aimed mainly at ensuring the best use of public health resources, associated with the concept of "middle-agency' between citizens and healthcare services. It is governed by a clear distinction between the State financing of providers and the payment of health care actually provided. The relationship of "perfect agency would be one in which the health status achieved would be exactly what the users would have been able to achieve if they were to choose by knowing the situation"[3].

Thus, program-agreements, which are necessary to combine the planned activity with the level of financial resources delivered to the institution are shown here, instead of combining these financial transfers and the internal structure. As a first step, the program-budget model was partially implemented and only involved part of the public health institutions. According to an author[4], a second stage would see an extension to general services and the development of new financing models would occur in the third stage.

These AASSs became five (in 1998 and 1999), and should contractualize with all hospitals and health centers. In those years, contractualization with health centers was only successful in the ARS of Lisbon and Tagus Valley and Alentejo, whereas contractualization only occurred with hospitals in the remaining three health regions of the continent. In these cases, the ARS carried out the performance control.

In 1999, the AASS were renamed Health Care Contractualization Agencies, and the National Council of Agencies was established and responsible for cross-linking and concerted analysis of information and action, in the pursuit of the respective attributions[5].

The ARSLVT Contractualization Agency started its activities with the competence of negotiating the programmed budgets[6] of the hospitals of the region, and the process included contractualization of Primary Health Care (PHC) in the year 1999, with an evaluation of the performance of the 86 Health Centers at the time, based on a list of analysis and follow-up indicators provided in documents prepared[7] by the Health Services Monitoring Agency.

The analysis and monitoring indicators were bundled in five groups, namely: production and production progress, productivity and produc-

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tivity progress, access and access and use progress, health surveillance (quality) and efficiency and expenditure control. Reference values were set for each indicator or benchmark, from which a comparative analysis of health centers was performed and a final classification for each institution was calculated.

In 2000, in addition to the process of negotiating program-budgets with health centers, the Contractualization Agency submitted an opinion on the distribution of the amounts of operating subsidies to be allocated to each of the three Health Subregions[8] and to each Health Center, in an innovative exercise that promoted a change in the logic of financial distribution based exclusively on historical expenditure. However, in that same year, contractualization agencies' activity was interrupted, although legislation never extinguished them.

In 2005, the PHC Reform began in Portugal. It was to be based on a new structure to respond to the population's health problems at local, regional and national levels. This was one of the most successful public service reforms of the last decades in Portugal, implemented by the Mission for Primary Health Care (MCSP), with the responsibility of conducting the global project of launching, coordinating and monitoring the reconfiguration strategy of health centers and implementation of the family health facilities (USF).

The process of change had two fundamental vectors: one from "top-down", in line with the restructuring of the State Central Administration and the new macro structure of the Ministry of Health; the other was "bottom-up", with the involvement of health professionals through voluntary application processes, for the creation of autonomous health care teams, the USF. These applications began in March of 2006 and the first USFs were made official in the field in September of that same year. Applications to USF are subject to a technical evaluation, in that they have to comply with a series of previously established requirements, in a dynamic process of continuous adjustment of the organizational model.

Resumed with the PHC reform, the contractualization process established as a priority its introduction into all SNS services. Normative Order No. 22.250/2005[9], of October 3 and Normative Order nº 23.825/2005[10], of November 22, relaunched the project and rehabilitated the ACSS. The new launching of contractualization processes is also associated with the implementation and functioning of USFs and should be an inducing tool for greater accountability and demand, so that better health outcomes can be achieved with greater efficiency, while at the same time ensuring to professionals involved and society, transparency, equity and appropriateness of this whole process. The lack of experience of all those involved in the contractualization process advised that this should be seen as a learning process, but would not be guided by the levels of demand accepted at the outset. In this context of change, the process of contractualization with USFs began on October 2, 2006, with the implementation of the first stage of contractualization, which consisted of direct negotiation with a group of healthcare providers without financial and administrative autonomy. In this stage, two stages were included: in the first one, all the USFs that began their activity until September 30, 2006 were involved; in the second stage, all USFs would be involved and included contractualization for the year 2007 (beginning October 1, 2006). In May 2006, the Health System Central Administration, I.P. (ACSS) identified a "Matrix of indicators to be contractualized for 2006 and 2007", which consisted of a set of 49 indicators distributed in four classes: access, care performance, perceived quality and economic performance, resulting from the work developed by MCSP. The current indicator tables used can be consulted in the ACSS[11].

The evaluation of the compliance with the goals would have a quarterly periodicity, in an automated way, without additional workload for the elements of the USFs, with total veracity of information expected in the computer system used by the USF. Compliance with contractualized indicators was associated with incentives.

Health facilities' models in the Primary Health Care Reform and contractualization

It should be noted that the model A and B USFs were established in the PHC Reform, which are distinguished as follows: (1) Model A actually corresponds to a phase of learning and improved work in a family health team, while at the same time representing the initial contribution to the development of internal contractualization practice. It is an indispensable phase in situations where isolated individual work is deeply rooted and/or where there is no tradition or practice of assessing technical-scientific performance in family health; (2) Model B is indicated for teams with greater organizational maturity, where family health team work is an effective practice and there is a will to accept the contractualization of more demanding performance levels.

The right to incentives implies the elaboration of a Plan for the Application of Institutional Incentives to be applied in training, documentation, equipment and rehabilitation of infrastructures. This institutional incentive represents a qualification of the investment, that is, it prioritizes investment in the units that comply with the contractualized objectives.

The contractual methodology conceived for Model A USF, in operation since 2006, already included institutional incentives for the application of the respective USFs. Decree-Law no. 298/2007[12] consecrated and expanded this possibility to all USFs, regardless of their fitting model.

In this legal document, granting financial incentives to USF professionals in Model B was envisaged, with the incentives of physicians being compensated for the specific activities and those of other professionals – nurses and administrative personnel – integrated in the pay-for-performance. Finally, Administrative Rule no. 301/2008, of April 18[13], would regulate the criteria and conditions for the attribution of institutional and financial incentives to USFs and their professionals.

Again, in 2006, a study commissioned by MCSP was published comparing the performance of the RREs (very similar to the USFs) with the "conventional" Health Centers and, in a second stage, USFs' budgetary impact was analyzed in 2007. Conclusions of Gouveia et al.[14] pointed to a reduced price per patient, per consultation, in medicines and CDTM, in the RRE model, when compared to the current model in the "conventional" Health Centers.

Decree-Law no. 222/2007, of May 29[15], published ARS new structure with the objective of creating a new model, centered in the simplification of the existing organic structure and the reinforcement of its attributions, toward a greater autonomy and functional accommodation required by the progressive extinction of health sub-regions, which, in RSLVT, determined the extinction of the three health sub-regions (Lisbon, Setúbal and Santarém) and the creation of 22 ACeS through Decree-Law no. 28/2008 of February 22[16].

The Statutes of the Regional Health Administration of Lisbon and Tagus Valley (ARSLVT), I.P. are published in Administrative Rule no. 651/2007, of May 30[17], which formalized the establishment of the Contractualization Department (CD) with competencies defined in Article 5 of the diploma, resulting from the 10 year-experience of the Monitoring/Contractualization Agencies, extending to the other four Health Regions of Portugal. Among its competences are the proposal to allocate financial resources to healthcare institutions and services through the negotiation, conclusion and review of program-agreements.

Thus, as part of the PHC reform, in 2007, each USF began to contractualizewith the respective CD 20 indicators for the Basic Services Portfolio and one indicator for each activity conducted within the scope of the Additional Services Portfolio, and from 2008, 15 indicators were contractualized, of which 13 were common to all USFs and 2 were selected by each of them among indicators validated by the ACSS.

PHC external and internal contractualization

The contractualization methodology for 2009 would fit in Step 2 of the contractualization process, in other words, although the ACeS figure was there, they would be in the installation stage during the first semester of 2009, which is why contractualization would continue to be carried out as before between the USFs and the CD of the ARS. There should also be a concern with the development of Local Health Units (ULS), which, since they had previously established a program-agreement with the Ministry of Health, it would be important for a representative of the Board of Directors to be appointed to monitor the contractualizing process between the USFs and the CD, in order to reflect the indicators contractualized in the program-agreement.

Other important changes occurred during 2009: (1) a working paper published by the ACSS[18] stated that the definition of goals would depend on the negotiation between USF and CD and should consider the trend of indicators in the USF itself and in the surrounding health centers. The goals should be demanding, but viable, based on good practices, in order to ensure that the characteristics inherent to the USFs constitution provide better health outcomes without undermining the organizational implementation and development of the teams; (2) a working group[19] was set up to develop contractualization arrangements with PHC; (3) USFs werestrengthened and expanded and the ACeS implemented.

At the contractualization level, it means a turning point, to the extent that the stage of direct negotiation with the USFs has ended and a cycle of internal and external contractualization has begun, in which the support of the CDs of

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the ARS to the ACeS to consubstantiate their management autonomy would be fundamental for the necessary adaptation of its management facilities to a culture of excellence through governance and accountability.

This is one of the great challenges currently faced by contractualization, through the dynamics of articulation between strategic management and the operational management of health organizations. The dialectic between the two forms of contractualization: the external one implies a philosophy of accountability and transparency, transposing it within the organization through internal contractualization. According to Matos et al.[20], internal contractualization is an objective-related management tool capable of promoting an alignment between externally contractualized objectives and the mission of health institutions, in which the establishment of effective health gains should be valued, and not just production of deeds.

Implicitly, internal contractualization has a new form of internal relationship, alternating decision-making methodologies, presenting itself as a participatory management model, creating consistency among all the activities of the organization, through an alignment of activities with a strategy, aiming to achieve objectives outlined from an external component, of the existing means and the desired results.

This new way of looking at contractualization was consolidated during the implementation of the third stage of contractualization, with two different moments: in the first, an internal contractualization process occurred, in which the ACeS negotiated the various goals with the functional units; in the second, there was an external contracting process in which the CDs contractualized with the Executive Directors of the ACeS, which resulted in the signing of program-agreements.

In this context of implementation of the ACeS, we should consider that the USFs are ACeS' functional units, while maintaining the whole philosophy about indicators, metrics for evaluation and allocation of institutional and financial incentives. We should note that CDs also supported ACeS in the internal contractualization process (with USFs and Customized Healthcare Units), participated as analysts at contractualization meetings and developed a critical analysis to identify aspects to be improved. The contractual model with the ACeS implied an additional effort and qualification in the identification of needs, in the planning, in the contractualization of health care and sophistication of payment modes (Figure 1). The Performance Plan and the Program-Agreement are important here. The first is a strategic document negotiated annually with the ACeS, integrating population indicators of sociodemographic and socioeconomic character, but also health outcomes. The second, established between ACeS and ARS, fulfills the commitment in terms of objectives and care goals, in accordance with the Performance Plan. The negotiation process between CDs and ACeS culminates in the signing of the annual Program-Agreement.

Methodology

This case study resorted to bibliographical and files review, both legislative and administrative, in order to contextualize the contractualization process and then to analyze the experience and results obtained in the ACeS Northern West, in comparison to the average obtained in the region of Lisbon, using the Regional Health Administration Information System (SIARS) database.

Contractualization results and experience of ACeS Northern West

The West is a space united by a common cultural heritage, with a strong component of agricultural and fishing practice and a very strong attachment to land and sea. The resident population is 172,168 inhabitants (estimate on December 31, 2015), with a population density (162.9 inhabitants/Km²) above the country average (114.3 inhabitants/Km²), but the population enrolled in the ACeS Northern West was 191,275 users (December 2015).

The ACeS Northern West stems from the aggregation of six municipalities (Alcobaça, Bombarral, Caldas da Rainha, Nazaré, Óbidos and Peniche, and consequently of the health centers in these municipalities). It includes: (1) six Customized Health Care Units (UCSP) ; (2) eight USFs that provide personalized care; (3) three Community Care Units (UCCs) providing health care and psychological and social support at home and community level, especially to people, families and most vulnerable groups in situations of increased risk or physical and functional dependence; it also works in health education, integrating family support networks (social networks) in partnership with authorities and school health programs;(4) a Public Health Facil-

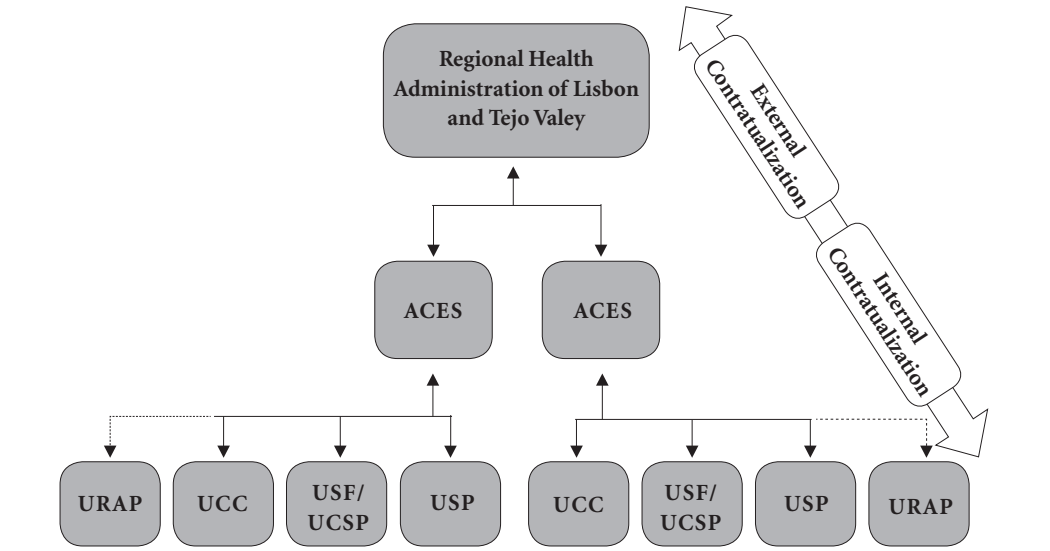

Figure 1. Contractualization model of an ARS with the ACeS (external) and these with the respective UF (internal).

Source: Health System Central Administration. Methodology of contractualization for Primary Health Care in 2015.

ity (USP) that operates as a health observatory of the geo-demographical area of the ACeS in which it is integrated, and is responsible, among other things, for the elaboration of public health information and plans (e.g. Local Health Plan); (5) a Shared Care Resources Unit (URAP) that provides consulting and care services to functional units. It consists of technicians from various areas, namely, social workers, psychologists, physiotherapists and oral health technicians. Doctors with hospital-derived specialties may also be part of this unit and respond to requests from the various units that are part of the ACeS (Figure 2).

Summarily, the inhabitants of the geographical area covered by the ACeS Northern West are mostly female, with a birth rate ranging from 7 (Alcobaça) to 9.3 (Nazaré), evidencing an aging population. In fact, the highest aging index is 172.5 in Bombarral and the lowest is 138.4 in Peniche, values that are in line with the dependency rates that record, respectively values of 44.9 and 39.6. All these values are higher than the averages recorded in the Region (Table 1).

In terms of compliance with contractualized indicators between ACeS Northern West and ARSLVT, from 2012 to 2015, we noted that access has always remained higher than the ARSLVT's average, although it had a negative fluctuation between that first and last years. There were significant increases in enrollments of people aged 14 or older, with smoking habits (from 25.2% in 2012 to 53.6% in 2015) are relevant, and the proportion of low birthweight term newborns that achieved in 2015 the same values as in 2012, that is, 3.04%.

In terms of care performance, it is important to highlight the incidence of major lower limb amputations in residents, which was 0.9‰ in 2012 and recorded 0.3‰ in 2015 (Table 2).

How did we arrive to these results? One of the strategies used to involve professionals in ACeS Northern West was quarterly meetings of all unit coordinators, sharing results and then analyzing their level of compliance and sharing strategies developed by each one. Cases of more difficult compliance required the involvement of the clinical council, mainly related to the form of registration in the electronic clinical process.

At the same time, each month, units received maps with the evolution of their contractualized indicators (internal contractualization), as well as those contractualized by the ACeS and influ-

enced by facilities' performance (external contractualization).

The clinical council guides their intervention according to the concept of clinical governance, combining two ideas: (1) to improve health levels and obtain clinical results at the individual level; and (2) to obtain population-based health outcomes. At the same time, it ensures the convergence of three essential guidelines for the health of citizens and communities: (1) person-centered and family-centered care (USF and UCSP); (2) interventions in groups with special health needs in the community (UCC and USP); (3) epidemiological- and population-based approaches (USP).

Figure 2. Map of ARSLVT and locations of respective ACeS.

According to data published in the 2015 PHC contractualization methodology by the ACSS[21], there is a growing codification of health problems at national level, reflecting the increase in computerized clinical records, with increasing demands by users and health care service providers. This fact allows for better planning and better management of health care. As a whole and at the functional units' level, knowledge of health issues of the user lists allows for better clinical governance.

By the end of 2011, 20.6 million health issues were identified at the national level, and by the end of 2013, this figure had increased to 30.2 million issues. The percentage of ICPC-2 coded PHC consultations in Portugal (69.2% in 2011, 83.9% in 2012 and 84% in 2013)[21].

The list of the user's active problems includes health problems for which there is a follow-up plan, the relevant diseases, those that require a continuous medical treatment, which allows us to characterize users, the activity developed or to schedule a future activity. With good records, we can ensure the adequacy of care, monitor and

Table 1. Residents, population density, proportion of women, birth rate, mortality, dependence and aging rates in ACeS Northern West – 2015.

	Residents	Population Density	Proportion of Women	Birth Rate	Mortality Rate	Dependence Rate	Aging Rate
Locations	**Nº**	**/ km2**	**%**	**LB /1000 inhabitants**	**Deaths/1,000 inhabitants**	**/100 inhabitants [15; 65[Years**	**/100 inhabitants [0; 15[Years**
Alcobaça	56.688	138,9	51,6	7	10,2	40,2	141,3
Bombarral	13.193	144,5	51,8	9,3	14,9	44,9	172,5
Caldas da Rainha	51.729	202,3	52,6	8,1	10,8	40,6	143,5
Nazaré	15.158	183,9	52,3	9,3	11,9	38,5	145
Óbidos	11.772	83,2	51,4	6,9	9,7	42,4	150,8
Peniche	27.753	357,9	51,6	7,9	12,2	39,6	138,4
ACES Northern West	176.293	166,8	51,9	7,8	11,2	40,6	144,6
ARS Lisbon and Tagus Valley	3.659.871	299,9	52,5	10,4	9,6	36,7	124,4
Continental Portugal	10.047.621	112,8	52,2	9,1	9,8	37,3	130,6

Source: www.ine.pt (2011 Census final data on resident population).

Table 2. 2012-2015 development of indicators contractualized between ACeS Northern West compared to ARSLVT.

Indicator		Performed in 2015		Performed in 2014		Performed in 2013		Performed in 2012	
		ACeS Northern West	ARSLVT	ACeS Northern West	ARSLVT	ACeS Northern West	ARSLVT	ACeS Northern West	ARSLVT
National level									
Access	Rate of medical consultations use - 3 years	89,0%	78,9%	89,00%	79,9%	89,4%	80,3%	90,9%	79,6%
	Household nursing rate per 1,000 enrollees	151,4 ‰	124,9 ‰	158,2 ‰	127,6 ‰	155,5 ‰	127,2 ‰	136,2‰	105,8 ‰
Care performance	Proportion of participants > = 14 A, with smoking habits	53,6%	45,2%	46,60%	37,9%	34,9%	26,9%	25,2%	17,3%
	Adequate FP follow-up in WCA	0,6%	0,507%	0,561%	0,469%	33,1%	21,0%	14,7%	7,5%
	Proportion of low birthweight term newborns	3,04%	2,51%	2,17%	2,56%	1,70%	2,40%	3,04%	3,31%
	Proportion of young people aged 14 with current medical consultation and NIP	63,3%	48,0%	61,4%	45,1%	43,7%	36,1%	36,0%	28,4%
	CVD hospitalization rate among residents <65 years	8,8%	9,2%	6,74%	8,5%	9,0%	9,9%	7,8%	9,5%
	Incidence of major lower limb amputations (DM) in residents	0,3%	0,4%	0,45%	0,5%	0,5%	0,5%	0,9%	0,7%
	Proportion elderly, without anxiolytics / sedatives / hypnotics	67,2%	67,8%	66,50%	68,2%	65,7%	66,6%	64,6%	65,3%
	Proportion of face-to-face medical consultations with ICPC-2	92,2%	89,5%	84,60%	84,3%	82,8%	77,6%	74,3%	70,0%
	Proportion of prescription drugs that are generic	61,0%	59,4%	57,60%	55,7%	45,4%	43,0%	41,0%	38,7%
Efficiency	Billed drugs expenditure per user (PVP)	140,8 €	138,3 €	141,50 €	149,1 €	138,1 €	133,5 €	156,0 €	154,4 €
	Billed MCDT expenditure, per SNS user (p. conv.)	51,6 €	--	49,30 €	63,4 €	42,3 €	52,7 €	44,7 €	54,8 €

it continues

Table 2. continuation

Indicator		Performed in 2015		Performed in 2014		Performed in 2013		Performed in 2012	
		ACeS Northern West	ARSLVT	ACeS Northern West	ARSLVT	ACeS Northern West	ARSLVT	ACeS Northern West	ARSLVT
Regional level									
Care performance	Proportion of women [50; 70[years, w/ mammography (2 years)	63,1%	49,3%	63,20%	47,2%	58,3%	46,6%	54,3%	44,4%
	Proportion users [50; 75[years,w/ cancer screening CR	37,6%	36,6%	28,70%	31,2%	18,7%	23,6%	14,9%	18,8%
	Proportion of women [25; 60[years, w/ colposcopy (3 years)	51,7%	37,7%	48,50%	35,9%	43,2%	33,3%	35,9%	28,5%
	Proportion DM2 in insulin therapy	78,1%	71,3%	73,20%	61,7%	4,8%	3,7%	4,5%	3,4%
Local level									
Hypertension	Proportion of hypertensive with CV risk (3 years)	52,9%	35,4%	41,3%	26,8%	9,5%	7,7%	--	--
S. Adults	Proportionof hypocoagulated patients in the facility	49,3%	50,0%	43,7%	19,1%	18,0%	12,2%	--	--

Source: Contractualization, ACeS Northern West.

evaluate the work performed and the care provided to the population.

In Table 3 we can observe, in comparison with values for ARSLVT, the development of incidence and prevalence of the problems coded with ICPC-2 in the ACeS Northern West. Worth highlighting are the results obtained in the cardiovascular and diabetes areas, as well as mental health, which are areas that are part of the local health plan projects. In 2013, they had values very different from the ARSLVT, but in 2015 achieved closer values.

However, these same areas should continue to be subject to intervention in the near future, given their prevalence in the population of the Northern West ACeS, according to the analysis of Table 3, with values above the ARSLVT average. The fact's constituting element, namely, demographic characteristic of aging of the population, will not be unrelated to it.

In spite of all the interventions conducted in schools for several years with regard to obesity and overweight, we have verified that the prevalence of this problem has higher values than the RVLT's average.

Discussion

Investment in PHC is essential and a prerequisite for achieving efficiency, effectiveness and equity in a universalist health system such as the Portuguese, believing that good results in these indicators will lead to better health of populations. This statement is true for the case briefly described in this paper: improved access, improved health care and efficiency performance, related to the application of the contractualization model and attribution of incentives to professionals.

The Portuguese incentive scheme closely follows the ideas developed in the United Kingdom, where the Quality and Outcomes Framework (QOF) was introduced in 2004 as the most comprehensive pay-for-performance scheme in PHC[22]. Both the QOF and the Portuguese incentive scheme are more than a remuneration scheme, inasmuch structured organizational change around the professional autonomies was intended to be developed, organized according to the local health needs and a profound change in the clinical records, essential to demonstrate the results.

Gillam et al.[22] concluded that the effect of QOF on performance was modest, with uncertainties about possible adverse effects, and therefore recommending that policymakers be cautious in disseminating the project, even with regard to quality indicators (such as user satisfaction and equity), and requires a cost / benefit assessment, since incentive payments remain an imperfect approach to PHC improvement and should therefore be considered as one of the possible alternatives among the existing ones to obtain continuous improvement in this area of health care.

The advised consideration is of particular relevance in contextual terms, for example: both the creation of the National Health Service, the great and profound reform of the health system in Portugal, and the very significant and successful PHC Reform were carried out in counter-cycle. If the former was contemporaneous with the first oil blockade, the April Revolution and the mass return of the Portuguese population residing in the former colonies, the second is contemporary with the greatest financial crisis we have experienced worldwide after 1930. If the former lacked crucial funding for the launch of the SNS bases, the latter lacked the financial basis for completing the entire reform process.

Thus, the context described witnesses an escalation of the aggregate health deficit imposed by financial and operational pressures on the SNS. The use of efficiency-seeking strategies through reduced funding and staff expenditure is making the situation unsustainable. Funding cutbacks, the main cause of the diagnosed deficits, is not in keeping with the growing demand and the strong epidemiological change.

In a context where the practice of General and Family Medicine remains poorly demanded by health professionals and where restrictions on the allocation of human resources remain difficult, health has been choosing to pay for production, whether higher volumes of service are required or not. More recently, the focus is shifting from volume to quality and efficiency. Guided by the epidemiological changes and the complexity of health states, in a context of increasingly scarce resources that have been responding to the transformation of the health system, the focus has shifted towards remuneration policies.

Final considerations

During these 10 years of reform, the provision of care and information collected has greatly

Table 3. 2013-2015 Development of the prevalence of ICPC-2 coded problems in ACeS Northern West compared to ARSLVT, Portugal.

Disease	ACeS Northern West			ARSLVT
	2013	2014	2015	
Acute myocardial infarction	1,7	1,24	0,96	0,85
Stroke	3,1	2,8	1,72	1,71
Transient ischemic attack	0,6	0,45	0,38	0,38
Diabetes mellitus	15,6	13,2	8,19	7,61
Hypertension	42,3	37,1	21,5	20,6
Obesity	12,3	9,8	10,6	12,1
Lipid metabolism disorder	40,9	34,2	21,7	19
Tobacco addiction	22,6	26,6	16,2	14
COPD	2,1	2,17	1,99	2,06
Asthma	5,1	4,44	2,98	2,95
Anxiety disorder	4,4	5,17	5,98	3,73
Feeling of anxiety	1,8	2,26	2,51	2,3
Depressive disorders	6,1	6,6	8,95	5,56
Postpartum depression	0	0,03	0,03	0,02
Chronic alcohol abuse	0,6	0,62	0,75	0,71
Drug abuse	0,3	0,38	0,43	0,35

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evolved. In addition to indicators compliance data, we have a background that allows us to define strategies for effective health gains.

In this first decade, the programs defined for intervention were linked to pathologies that translate a greater burden of disease in the Portuguese population, often defined in a purely clinical aspect. It is urgent to diversify these areas and make a more familiar and communitarian approach, also fitting the psychosocial area. If, until a few years ago, prevention was more primary and secondary, we now have special emphasis on quaternary hospital-centered prevention, given that we are before citizens with comorbidities and not a single pathology. For effective health gains, it is urgent to define integrated care plans, where each sector intervenes in a whole, with the individual at the center of the intervention.

The definition of new clinical areas of intervention (mental health and respiratory diseases), the integration of care (Facilities / ACeS / hospitals / continued care), the empowerment and autonomy of users and the involvement of the community andthe reorganization of the health care supply should be considered as points of evolution,and expectations of the population should be weighted.

Providers must also be diversified, with teams being acquiring other knowledge and techniques that improve user's quality of life and gradually increase his/her life expectancy.

The driving force of the next 10-year strategy should be curbing hospitalizations and use of hospital services in the broad sense. It will be necessary to change the PHC paradigm in order to pursue this principle. PHC should be equipped with new technologies that avoid users seeking secondary care facilities (hospitals) to perform complementary exams and receive care after work or on weekends.

Collaborations

BR Monteiro was responsible for data collection, writing, critical review and version to be published; AMSA Pisco, for data collection, analysis and writing; F Candoso, for data analysis and paper critical review; M Reis for data collection and interpretation; and S Bastos for data analysis and interpretation.

References

1. Portugal. Despacho Normativo nº 46/1997 de 8 de agosto. Determina a instalação e funcionamento das Agências de Acompanhamento dos serviços de saúde junto das administrações regionais de saúde. *Diário da República* I Série-B. 1997; 8 ago.
2. Portugal. Despacho Normativo nº 61/1999 de 12 novembro. Altera as orientações relativas à instalação e funcionamento das agências de acompanhamento dos serviços de saúde junto das administrações regionais de saúde. *Diário da República* N.º 264, Série I-B. 1999; 11 dez.
3. Portugal. Administração Regional de Saúde de Lisboa e vale do Tejo. *A função de «agência»*. Lisboa: Administração Regional de Saúde de Lisboa e vale do Tejo; 1996.
4. Escoval A, Matos T, Ribeiro R, Santos A. *Contratualização em CSP: Horizonte 2015/20.* 2010. [acessado 2016 nov 8]. Disponível em: http://www.acss.min-saude.pt/Portals/0/Fase%205_Relatorio%20Final.pdf
5. Portugal. Decreto-Lei n.º 11/93. Aprova o Estatuto do Serviço Nacional de Saúde. *Diário da República* I Série -A. N.º 12. 1993; 15 jan.
6. Portugal. Despacho Normativo nº 45/1997. Estabelece as normas a que deve obedecer a distribuição de recursos financeiros, humanos e tecnológicos no Serviço Nacional de Saúde. *Diário da República* N.º 182, Série I-B. 1997; 8 ago.
7. Agência de Contratualização dos Serviços de Saúde. Sistema de Indicadores: Análise e Acompanhamento dos orçamentos-programa dos centros e saúde e Hospitais", Agência de Acompanhamento dos Serviços de Saúde, Lisboa, 1998 e "Orçamentos- Programa 2000: proposta da metodologia de avaliação do cumprimento dos acordos e classificação dos centros de saúde e dos hospitais". Lisboa: Agência de Contratualização dos Serviços de Saúde; 2000.
8. Agência de Contratualização dos Serviços de Saúde. Relatório Final do Processo de Contratualização 2000 com as Instituições da RSLVT. Vol. I e II. Lisboa: Agência de Contratualização dos Serviços de Saúde; 2000.
9. Portugal. Despacho Normativo n.º 22250/2005. Diploma enquadrador do processo de contratualização com os hospitais, que integram a rede de prestação de cuidados de saúde do SNS, para o ano de 2006. *Diário da República* N.º 205, Série II. 2005; 3 out.
10. Portugal. Despacho Normativo nº 23 825/2005. Determina as competências e a composição do grupo de trabalho criado para coordenar a reabilitação do processo de contratualização. *Diário da República* N.º 224. Série II. 2005; 22 nov.
11. Portugal. Contratualização. Serviço Nacional de Saúde. Administração Central do Sistema de Saúde. Ministério da Saúde, 2016. [acessado 2016 ago 11]. Disponível em: http://www.acss.min-saude.pt/category/prestadores/normas-e-metodos/
12. Portugal. Decreto-Lei n.º 298/2007. Estabelece o regime jurídico da organização e do funcionamento das USF. *Diário da República* N.º 161. Série I. 2007; 22 ago.
13. Portugal. Portaria 301/2008. Regula os critérios e condições para a atribuição de incentivos institucionais e financeiros às unidades USF e aos profissionais que as integram, com fundamento em melhorias de produtividade, eficiência, efetividade e qualidade dos cuidados prestados. *Diário da República* N.º 77. Série I. 2008; 18 abr.
14. Gouveia M, Silva SN, Oliveira P, Miguel LS. Análise dos custos dos centros de saúde e do regime remuneratório experimental. *Grupo de Trabalho da Associação Portuguesa de Economia da Saúde*. 2010. [acessado 2016 ago 11]. Disponível em: http://www2.portaldasaude.pt/NR/rdonlyres/4B0B71BD-1620-4168-BB98-60134AB16A49/0/Relat%
15. Portugal. Decreto-Lei n.º 222/2007. Aprova a orgânica das Administrações Regionais de Saúde, I. P. *Diário da República* N.º 103. Série I. 2007; 29 maio.
16. Portugal. Decreto-lei nº 28/2008. Estabelece o regime de criação, estruturação e financiamento dos Agrupamentos de Centros de Saúde do Serviço Nacional de Saúde. Diário da República. N.º 38. Série II. 2008. 22 fev.
17. Portugal. Portaria N.º 651/2007. Aprovados os estatutos da Administração Regional de Saúde de Lisboa e Vale do Tejo, I. P. *Diário da República* N.º 104. Série I. 2007; 30 maio.
18. Portugal. Administração Central do Sistema de Saúde. Departamentos de Contratualização das Administrações Regionais de Saúde e Missão para os Cuidados de Saúde Primários. Metodologia de Contratualização para 2010. Lisboa, 2010. [acessado 2010 out 15]. Disponível em: http://www.mcsp.min-saude.pt/Imgs/content/ page_46/
19. Portugal. Despacho N.º 7816/2009. Determina a criação de um grupo de trabalho para o desenvolvimento da contratualização com os cuidados de saúde primários, cujas atribuições e composição fixa. *Diário da República* N.º 54. Série II. 2009; 30 mar.
20. Matos TT, Ferreira AC, Lourenço A, Escoval A. Contratualização interna vs. Contratualização externa. *Revista Portuguesa de Saúde Pública* 2010; 9:161-180.
21. Administração Central do Sistema de Saúde. Termos de Referência para contratualização nos cuidados de saúde primários em 2016. [acessado 2016 out 15]. Disponível em: http://www.acss.min-saude.pt/wp-content/uploads/2016/07/Metod_Contrat-CSP-2016-vfinal.pdf
22. Gillam SJ, Siriwardena AN, Steel N. Pay-for-Performance in the United Kingdom: Impact of the Quality and Outcomes Framework-A Systematic Review. *Ann Fam Med* 2012; 10(5):461-468.

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