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The Portuguese family physician: a narrative

O médico de família português: uma narrativa

El médico de familia portugués: una narrativa

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Work cycles of community-based physicians: from private practice to the public career, from disconnected to connected and well-informed, from isolated work to teamwork with autonomy, responsibility, and solidarity

The professional life of a Portuguese family physician in the early 21st century has that bittersweet taste of something that has been well thought-out, but which cannot escape the pitfalls of a system with overwhelming economic factors. However, over the last nearly 50 years, science and ideology in turn, and in more or less utopian fashion, have succeeded in winning out and have thus remained as the pillars of a health system in which primary health care (or *cuidados em saúde primários* in Portugal) is the center, not of the system, but of what really matters: people's health, that which defines personal, family, and social daily life with health. Even in times of harsh economic and social crisis as in 2008-2014 [1], the social security, educational, and health care systems in Portugal not only survived, but served as an important factor for social recovery, preventing greater losses and empowering innovation [1].

Primary health care has a long history, alongside that of family physicians, dating back even before Alma-Ata. The history of primary health care features cycles, and each cycle has added attributes to the community physician's work.

Primary health care in Portugal began in 1970 and reached a milestone in 1982 with the establishment of public professional careers for physicians and another more recent milestone in 2005, with the attempt at a more innovative approach, wagering on teamwork, goals orientation, and self-organization.

Prior to the career in general and family medicine (until 1981): from private medical practice, disconnected and isolated, to careers as public employees in the National Health Service in isolated professional group practice

Since the late 19th century, Portugal had searched for an organized response to the country's health need, but without major success until 1970 [2], when the country took a step ahead in the spirit and guidelines of the *Alma-Ata Declaration* (and anticipating the latter by nearly a decade).

Until 1970, government was not involved directly in health care, and individuals, companies, and professional groups organized their care, with some of these so-called "subsystems" surviving to this day. In 1970, Portugal decided to wager more decidedly on the implementation of public primary health care

with health centers focused on preventive care and particularly maternal and child care. This reform suffered fierce opposition and was only partially implemented. The year 1974 witnessed the political revolution of April 25, ending decades of dictatorship, and efforts began in pursuit of "Health for All", with a National Health System (SNS in Portuguese) and medical careers, aiming at equity and improved access [2].

The National Health System (SNS in Portuguese) was launched in 1979, with health care reaching more and more people, initially free of cost and later "tendentially free". Even so, half of users now receive treatment entirely free of cost.

Medical work changed from totally private practice, disconnected from other health professionals and services, isolated in private offices (many with only one physician), to work conducted mostly in public services as general practitioners linked to primary health care and interacting within their professional group, although rarely working in multidisciplinary teams. The numbers of physicians and nurses grew during this period from 94.0 and 158.9 per 100,000 inhabitants in 1970 to 245.7 and 239.3 per 100,000, respectively, in 1985. The effect could not have been more dramatic. Physician consultations increased from 174.4 [3] per 1,000 inhabitants to 242.8 between 1970 and 1982 , infant mortality began to drop faster than the overall improvement in economic and social conditions [3], from 55.5 per 1,000 live births in 1970 to 19.3 in 1983, maternal mortality improved at the same pace, and life expectancy increased from 64.2 to 69.3 years [2] (PORDATA – Base de Dados Portugal Contemporâneo. Base de dados de Portugal. https://www.pordata.pt/Portugal, accessed on 20/Jun/2018).

Beginning of the public medical career (1982-2004): public career as family physicians, in professional groups working in health centers

Following a period in which many of the original objectives had been achieved, the priorities shifted and primary health care lost its leadership role, political backing, financing, and momentum. The reform in 1995 attempted to react and proposed radical changes and a reorientation in primary health care. It planned, legislated, and attempted to materialize, but failed to find the necessary political stability for its effective implementation. What it did find (again) was furious opposition from the "status quo", which succeeded in blocking the process. Still, the theory and innovative experiments in the organization of care survived, along with accumulated experience for future strategies to implement reforms.

The most outstanding event was the establishment of public medical careers [4], including general and family medicine, leading nearly all of the physicians in primary health care to work for the government, most of them fulltime. The residency in general and family medicine as a specialty was created during the same period, the only current channel to access the career. The general and family medicine residency currently takes 4 years, with approximately 400 family physicians completing the residency every year.

The medical career is defined as a series of steps, which are thresholds of technical and scientific differentiation with increasing responsibility, obtained through training with public skills-based exams and a variable number of paid positions, accessed via annual performance assessments.

During this same period, the population coverage of the public or social health system increased from 60% in 1970 to 100% in 1995, where it remains today. The infant mortality rate decreased by a factor of six, from 19.3 to 3.5 per 1,000 live births [2].

Following the primary health care Reform of 2005 (2005-2015): autonomy, responsibility, and solidarity with work as a team and goals-oriented

The population of Portugal exceeded 10 million in 2005. The number of health professionals and the average life expectancy continued to grow. Primary health care coverage and improved communications allowed decreasing the country's hospital units.

This reform resumed the 1995 path and provided another opportunity for primary health care. Consistent with and continuing the past experience and the culture of Portuguese health professionals and Portuguese society, the reform went much further, expanding concepts and practices, proposing a renewed and more effective primary health care, closer to the populace and with greater case-resolution capacity.

The highlight was the implementation of Family Health Units (USF in Portuguese). The wager was decidedly on the autonomy of health professionals and the citizens, on multidisciplinarity, and on the integration and computerization of care. A mission with power was created for the primary health

care reform, the result of the learning process in the previous reforms. The first USF emerged within 6 months, together with one of the most radical reforms, not only in health, but in all of Public Administration. This success was fueled by the decision to follow a document originally published in 1991 [5], but permanently updated, by the Portuguese Association of General and Family Medicine, which laid out a detailed plan for the reform – a veritable professional utopia that was successfully implemented.

Since then, voluntary application processes allowed creating teams with broad functional autonomy, the USF, consisting of family physicians, nurses, and clinical secretaries (who manage the administrative side of care), who are required to be public employees, assuming the commitment to provide care to the population in a specified area. All of the USF were assigned information systems for managing practice (patient flows, administration, clinical practice, and performance – practically everything is dematerialized and computerized) that allowed calculating the results of indicators and maintaining a credible and trustworthy database of patient files, in addition to a big database on all the activity in primary health care and its relationship to the other levels of care. The pay scale for USF staff varies according to health profession and USF model. In addition, the attainable incentives are determined by the overall work done by the entire team and not according to individual work [6,7].

The USF can be organized in micro teams with a family physician, a nurse, and a clinical secretary and are part of a health center which in turn is included in a Group of Health Centers (ACeS in Portuguese), in order to keep management close to the health professionals and to ensure a size that allows economy of administrative scale [8]. These ACeS (55 in Portugal as a whole), together with the hospitals, are integrated into a Regional Health Administration (ARS in Portuguese) (5 in the country as a whole), and the latter comprise the SNS [7], established to ensure the right to health as provided under the Constitution [9].

In addition to the USF, the reform created functional units with the other health professions in the ACeS [10]. The common denominator in each functional unit is a multidisciplinary team with organizational and technical autonomy, guaranteeing mutual cooperation. These functional units aim to achieve health quality goals according to a letter of commitment signed with the executive boards of the ACeS, and between the latter and the ARS. Goals-based teamwork is central to the entire activity. Autonomy, accountability, and solidarity form the triad that makes the difference in all the functional units: organizational autonomy coupled with accountability in all senses of the word, backed by team solidarity.

As of 2015 there were 449 USF that provided care to just under half of the population. The professionals that did not want or could not work in the new USF model were allowed to continue in the traditional model of care.

A key player in the implementation and evolution of the entire reform was the National Association of Family Health Units (USF-AN; https://www.usf-an.pt/, accessed on 22/Jun/2018), created in 2008 as one of the first multiprofessional health associations in Portugal. The USF-AN conducts political lobbying and media advocacy and promotes training and permanent collaboration and debate on the reform via a highly active online chat group.

Relaunching of the primary health care Reform (2016-...): well-informed, connected, with intelligent contracting

The intervention by the International Monetary Fund (IMF) in Portugal in 2011 marked the end of an era. Although the memorandum of understanding on the economic policy conditions imposed by the IMF [11] referred to the USF and proposed their expansion, the pace in the opening of USF actually diminished.

Another result of the economic crisis has been a shrinking national population, due especially to the falling birth rate and rising emigration of Portuguese youth, many of whom are trained in the health professions. However, the number of hospitals has grown, and the large cities are witnessing visible investment by major financial groups in private hospitals and health services. Life expectancy continues to increase, as does the population with complete university education (20.7% in 2015). As of 2018 there are 506 USF and 5,501 family physicians in Portugal.

In 2016, in order to relaunch the reform, a National Coordinator was named and the contracting process was renewed, now with a matrix format that integrates training, research, and organizational quality. There was no longer negotiation of targets for each indicator, which were replaced by expected ranges and acceptable ranges for all the units. These improvements were welcomed by the health

professionals [12]. The implementation of clinical and health governance (the process by which health care organizations assume the responsibility for continuous quality improvement) is another of the reform's objectives.

In collaboration with the USF-AN, the Ministry of Health developed the BI-CSP portal (BI-CSP; https://bicsp.min-saude.pt/pt/Paginas/default.aspx, accessed on 20/Jun/2018), which provides the results of various indicators for all the primary health care teams, allowing transparency and clinical governance.

As for quality of care, of all the OECD (Organisation for Economic Co-operation and Development) countries Portugal has one of the lowest rates of avoidable hospitalizations due to asthma, Chronic obstructive pulmonary disease, congestive heart failure, and diabetes, which suggests effectiveness in the management of these conditions by primary health care [13,14].

Onward to the future, emerging digital, in network, in community

The Portuguese SNS of the future needs to deal with the multiple and complex challenges related not only to the economy and financial sustainability, but also to the availability of a health workforce with adequate numbers and with skills in keeping with the population's needs and demographic, epidemiological, and technological changes. The current problems are not confined within national borders. They are expanding, just as it is necessary to expand the debate on the demand for open systems and the internationalization of care, which obviously includes the internationalization of higher education.

Rising life expectancy, along with a short period of healthy life after 65 years of age in Portugal, the growing rates of chronic noncommunicable diseases, especially diabetes and dementia [15], plus such factors as physical inactivity, obesity, smoking, and psychiatric disorders and a limited supply of oral health services [16], require new and daring changes in the SNS. A SNS of the future for the community of the future.

Actions that stimulate health literacy, citizens' participation, and more shared coordination of care with greater patient autonomy are strategies for this takeoff [17,18], where the first steps have already been taken. However, the complexity of health care organizations suggests paths via open innovation [19], beyond the traditional limits in which networks are created and established.

From the remaining Portuguese family physicians' utopias, it emerged a primary health care and a SNS for which we may guess a future guided by "R's": (a) organizational Restructuring of the hospital networks and primary health care for greater autonomy [20] and case-resolution capacity; (b) sustainable Resources, providing for the conscientious use of structural, financial, and human resources; concerning the latter, the recently created specialization in family nursing suggests the expanded scope of activities and autonomy for these professionals, encouraging more collaborative work, with greater integration between the health professions (less physician-centered); (c) connectivity networks (*Redes* in Portuguese) in virtual or real environments.

All three "Rs" are integrated with a community-centered perspective. With shared roles of the digital and non-human space, but never forgetting what is human. Reinvigorating emotions and solidarity, living and caring in the community. That is how we glimpse the digital, community, in network relation of the Portuguese family phsysicians in the future with the citizens of the future.

To quote Salgueiro Maia, one of the captains that led the April 1974 Revolution, "*What's difficult has been done; the impossible just takes more time*".

Contributors

All the authors participated in all stages of article's production.

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