ACSS ADMINISTRAÇÃO CENTRAL DO SISTEMA DE SAÚDE, IP

OTIMIZAR RECURSOS
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ACSS – CENTRAL ADMINISTRATION OF THE HEALTH SYSTEM

"OPTIMISE RESOURCES / GENERATE EFFICIENCY"

Terms of Reference for the contracting of health services in the Portuguese SNS (National Health Service) for 2017

November 2016

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0. PREAMBLE

The purpose of this document is to establish the principle guidelines for the contracting of health services from a National Health Service (SNS) perspective in 2017, in relation to achievable activities, objectives and results, thereby contributing to the consolidation of a rigorous, well-balanced, responsible and transparent Portuguese health system.

The aim of the contracting process for 2017 is to strengthen the diagnosis of health needs of the Portuguese population, as well as to reinforce the implementation of good health services and organisational practices that, in turn, shall ensure high levels of access, quality and efficiency within the SNS, thereby placing citizens and their families at the heart of health provider activities and to reinforce communication and coordination between all parties involved by valuing performance of health professionals and providing clinical and health governance incentives.

The Terms of Reference that sustain and support this contracting process are focused on the operationalisation of health policy guidelines, and are generally considered to be cross-over mechanisms for the various entities of the Ministry of Health, specifically the Central Administration for the Health System (ACSS), the Directorate-General for Health, INFARMED - the National Authority for Medicines and Health Products, I.P., SPMS, E.P.E. - the Shared Services of the Ministry of Health, the Regional Health Administrations, I.P. - ARS, the National Coordination of NHS Reform in the area of Primary Health Care (CNCSP), and Hospital Care (CNCH) and Integrated Continuous Care (CNCCI), and for the National Commission of Palliative Care (CNCP), the National Commission for Reference Centres (CRe), and the National Program of Education for Health, Literacy and Self-Care, among others bodies.

This document gathers guidelines and tasks for the contracting of primary, hospital, integrated and continuous healthcare, with this being the first time that such a document has been put together in an integrated manner for the Portuguese National Health System (SNS).

The current approach to the contracting process defined for 2017 adheres to a conceptual matrix that highly values the specificities of the health care delivery process, based on finding concrete solutions and flexible and appropriate answers in accordance with needs, resources and existing conditions, so that this can, in turn, be provided to the general public, and which is organised into five different areas of analysis: service provider performance; services available to health service users; the quality of care provided; the training of healthcare professionals; and implemented research practices.

In addition to conceptual changes and the previously mentioned cross-over guidelines, the 2017 contracting process further enables the introduction of improvements into each of the health service delivery processes, with particular emphasis on:

- The profound reformulation of the philosophy governing the operationalisation of primary health processes, which reinforces the Clinical and Health Governance process and dematerialises contractual focus on health indicators and goals, while driving the entire operationalisation process forward into negotiation on clinical practices that need to be implemented, including appropriate levels of activity and efficiency that need to be achieved, as part of existing resources;

- The development of new payment and contracting modes for hospital activity, that aim to strengthen a quality, efficient and timely provision of healthcare, towards the development of health related programmes (such as chronic disease management programmes, surgical treatment programmes for obesity or gamete banks for medically assisted procreation), for organisational improvements (such as the creation of Reference Centres [CRe], Integrated Responsibility Centres [CRI] in response to Palliative Care or eHealth), while strengthening the incentive performance mechanisms for hospital institutions, based on benchmarking activities and the sharing of good healthcare and efficiency practices, which are currently part of the SNS system;

- The definition of specific objectives to be achieved by the Local Healthcare Units (ULS), as organisational structures ensuring the provision of integrated healthcare for a population located in a specific geographical area, as well as necessary adaptations for ensuring that these entities also meet all specific goals and objectives in terms of primary and hospital healthcare provision;

- The creation of an innovative Incentive Programme for the Integration of Health Services and the Valuing of SNS Patient's Pathways, including the creation of financial incentives for the formation of shared projects by various SNS services, with the overall aim of promoting communication, coordination and integration in relation to health services.

The herein presented document is comprised of nine different chapters which are explained in more detail after the presentation of this preamble. In addition to the chapter that reinforces the need to carry out a diagnosis of health needs and an adequate definition of healthcare outputs priorities, this document is comprised of six chapters that detail the guidelines and rules that must be followed by all agents from a health service contracting perspective for the SNS in 2017, and further two chapters: one, on evaluating the satisfaction of SNS patients and, another, on the need to carry out additional audits and accreditation processes with the aim of continuously improving health service responses provided by the SNS.

1. DIAGNOSIS OF HEALTH NEEDS AND DEFINITION OF HEALTH SERVICE PRIORITIES

The health service contracting process is focused on responding to citizens' healthcare needs and, in this respect, the needs of the various agents involved in its execution, specifically the Regional Health Administrations (ARS) and healthcare providers, who must consider the guidelines and objectives set out in the National Health Plan (PNS), and who shall compete, in turn, for operationalisation of the four cross-over strategic axes labelled as: "Health Citizenship", "Equity and Appropriate Access to Healthcare", "Quality Health Services" and "Healthy Policies". This will enable the National Health Plan to efficiently align itself with multiple Health Governance instruments and contribute in such a way as to enable contracting and financing for leverage and compliance with all defined goals.

Without prejudice of considering other instruments, studies and supplementary regional and local information, the established health service priorities for the SNS health service contracting process in 2017 shall comply with the below identified conditions.

1.1. PRIORITIES DEFINED IN THE NATIONAL HEALTH PLAN - 2020 REVIEW AND EXTENSION

The National Health Plan (PNS) is a basic component of the existing Health Policy in Portugal, outlining its strategic path of intervention and performance through an "aggregating and guiding role in relation to the measures considered to be more relevant in obtaining better health gains for the resident population of Portugal".

The health service commitments to be established in conjunction with healthcare providers must assume the priorities and goals defined in the National Health Plan - 2020 Review and Extension, specifically:

1. Reduce premature mortality (≤70 years of age), to a value lower than 20%;
2. Increase healthy life expectancy to 65 years of age in 30%;
3. Reduce the widespread tendency to consume tobacco at >15 years of age, and eliminate exposure to passive smoking;
4. Control the widespread tendency to be overweight or obese in infants and school children, limiting such growth until 2020.

1.2. PRIORITIES DEFINED IN REGIONAL AND LOCAL HEALTH PLANS

The Regional Health Administrations (ARS) are currently developing Regional Health Plans that are suitably aligned with the National Health Plan, acting as guidelines for the Local Health Plans associated with the multiple SNS healthcare providers, for suitably identifying and ranking all population based needs, establishing goals to be reached, and defining strategies and measures for subsequent implementation.

1.3. INFORMATION ON MORTALITY

Mortality indicators are used to monitor the state of health of the Portuguese population, in addition to identifying

and prioritising the needs and activities related to principal health-related issues.

Reduction in premature mortality is one of the objectives defined in the National Health Plan - 2020 Review and Extension, focused on mortality remaining below 20% by 2020 (22.8% in 2012), with the contracting of health-related processes for 2017 being required to prioritise all relevant information to mortality in Portugal (general and premature).

Various sources of information are now available based on the attainment of detailed opinions on mortality rates in Portugal, with special emphasis being put on publications from the National Institute of Statistics (INE) and the Directorate-General for Health (DGS), specifically through the <<Health Dashboard>> available at the DGS website (www.dgs.min-saude), which provides information on "mortality below 70 years of age", "general mortality", "child mortality", "mortality under 5 years of age" and "mortality caused by road accidents" for all regions of Portugal.

1.4. INFORMATION ON MORBIDITY

The analysis of health morbidity makes it possible to define the health service priorities that multiple healthcare providers must follow, making it possible for professionals to carry out their work on clinical records that, in turn, will make it possible to monitor the health services provided to the general public.

There are at least two systematic and regular processes, from an SNS perspective, for collecting information on the current state of morbidity of the Portuguese population, namely the primary healthcare morbidity records and the registration of morbidity for hospital inpatients and outpatients (used for the grouping of episodes into Homogeneous Diagnostic Groups - GDH).

REGISTRATION OF MORBIDITY IN PRIMARY HEALTH SERVICES

A scheme is currently being implemented for statistically coding the burden of disease at primary health service level, based on the International Classification of Primary Care (ICPC), enabling information to be obtained on the morbidity levels of the population in contact with these health services, through systematic coding of the health problems obtained during appointments with family doctors.

The benefit of this work is now deemed to be at a very high level within the SNS (94.1% in 2015, as opposed to only 69.2% in 2011), based on the involvement of doctors from various USF and UCSP health units pertaining to the Health Centre Groupings (ACES), to the percentage of personal medical appointments with ICPC statistical coding; with the importance of carrying on this work in 2017 being evident, not just by using the medical appointment ICPC model, but by also incrementing the use of the International Classification of Nursing Practices (ICNP) for nursing activities.

Knowledge of the health problems obtained from the list of SNS patients facilitates an improved Clinical and Health Governance process, with it now being possible for all Health Centre Groupings (ACES) and functional

Hospitals units to determine, via detailed SIARS information on the population of the region receiving coverage, the following factors: (1) patient characteristics; (2) characterisation of all activities; (3) the scheduling of activities.

REGISTRATION OF MORBIDITY IN HOSPITAL HEALTH SERVICES

All activity taking place through inpatient services, in addition to a large part of activity being carried out through outpatient services, specifically through surgical outpatient services, is currently coded through a medical coder who is responsible for transcribing this information into International Classification of Diseases (ICD) codes related to the clinical information registered during the clinical process for each patient. The clinical code is strictly related to the quality of the clinical registrations and records made by the professionals and teams who aid the patients at hospitals, including the subsequent need for greater efforts being made in terms of the quality of clinical records on the part of the medical institutions[1].

The coded information is grouped into Homogeneous Diagnostic Groups (GDH) and subsequently forwarded to the National Database on Hospital Morbidity located at the Central Administration of the Health System (ACSS), which is then distributed on a quarterly basis to all Regional Health Administrations for better understanding of hospital morbidity in patients throughout Portugal.

The ICD-10-CM/PCS clinical coding system entered into force in Portugal on January 1st 2017, replacing the ICD 9 CM system, representing a significant improvement in the ability to characterise hospital morbidity, with the new coding system utilising terminology that is more compatible with current clinical practices, and enabling a greater degree of thoroughness, specificity and accuracy in relation to medical records.

1.5. HEALTH DETERMINANTS AND CHARACTERISTICS OF THE RESIDENT POPULATION

Understanding the social, behavioural, cultural, economic and other factors that positively or negatively condition the health status of the Portuguese population, is a contributing factor in being able to identify all health-related requirements, specifically in terms of the capacity to understand the risk factors present in the population and in anticipating the occurrence of health-related problems.

The ACSS in partnership with the National Institute of Statistics (INE), the ARS and with other SNS institutions has gathered demographic and epidemiological information on the population of Portugal, making it possible to go ahead with the contracting process and provide an adequate response to all institutions involved. The benefit of this type of work is being able to periodically provide the Regional Health Administrations with a Characterisation Sheet of the main health determinants of the Portuguese population, grouped together by ACES, USF and UCSP (Family Health Units and Personalised Healthcare Units).

[1] The current GDH grouping system, type APR, can be used for the review of clinical processes and for specifically identifying episodes grouped at levels of low severity (1 and 2), but including hospital internment periods that are very close to the upper exception threshold, or episodes grouped together at mortality risk levels that are equally low (1 and 2), but in instances where the patient still died. Without putting good clinical practice into question, these indicators serve, in the sense of providing support, as a review of clinical information quality present in the respective clinical processes, in addition to the suitability of such information for good record-making practices. On the other hand, episodes with a 'Present On Admission' indicator, or which are classified as Unknown or Undetermined, are also good indicators for review of the information contained in the patient process.

1.6. RISK ADJUSTMENT TOOLS

Risk adjustment tools gather information together on diagnoses, clinical prescriptions, costs and historical usage of the Healthcare System, among other factors, enabling a respective stratification of the population based on the risk of requiring health services, i.e. a system that makes it possible to explain a significant part of the usage variability of healthcare services, in addition to the identification of predictive models in relation to the need for health services, plus the associated costs.

Risk adjustment tools will be implemented in Portugal in 2017 which are currently being aligned with the health service contracting process, which will make it easier to adequately define the effective needs of the population, in addition to benefiting healthcare professionals in terms of activities and healthcare planning, as well as being used for various other purposes such as the selection of patients for disease management and case management programmes, health-related research, the allocation of financial resources, performance evaluations and incentive payment systems, the appropriate scaling of patient lists and the quality analysis and/or productivity of medical practitioners, based on individual population risk levels.

1.7. ACCESS MANAGEMENT AND RESPONSE TO DEMAND

Improvements in health service access is one of the main goals of the SNS health contracting process, equally in terms of primary healthcare, hospital response times or the National Network of Long-Term Integrated Care (RNCCI).

Implementation of the Integrated System for managing access into the SNS service (SIGA SNS) which began in 2016, is aimed at ensuring equitable, timely and transparent access to all SNS institutions, while contributing to the fulfilment of Guaranteed Maximum Response Times in order to change the existing healthcare provision paradigm and to reorganise the system around citizens, their needs and their expectations.

The SIGA SNS system gathers together not only information that has been dispersed by the various information systems that previously supported SNS access management - namely the Integrated Management System of Subscribers for Surgery (SIGIC), the Reference System for First Consultation of Hospital Speciality, as determined by the Time and Hour Consultation system (CTH) or the RNCCI application, but also ways on how to gather information relative to other areas that, up until now, have not been monitored, such as the supplementary means of diagnosis and therapy (SMDT), subsequent hospital speciality appointments, primary healthcare, emergency services, etc.

2. GENERAL GUIDELINES FOR THE NATIONAL HEALTH SERVICE CONTRACTING PROCESS IN 2017

The aim of the national health contracting process in 2017 is to contribute to overall SNS objectives to ensure high levels of access, improved quality and efficiency of the health services provided to the general public, and to encourage overall improvements in performance in terms of the management of available resources within the healthcare sector, requiring the inclusion of three instruments presented in a balanced manner:

- The contracting of activity – contracting the volume and mix of services in accordance with population requirements and therefore bringing supply closer to effective demand;

- Financing models and modes of payment - leveraging the behaviour of healthcare providers and aligning individual objectives with the global health provision process;

- Performance measurement – measuring and comparing the performance of institutes in strategic and priority areas at national level through process, output and results indicators.

From this perspective, the health service contracting process for 2017 deems that the following **general and cross-over objectives** should be observed by all stakeholders for each health service level:

i. Take into consideration all priorities and goals defined in the National Health Plan - 2020 Review and Extension, in addition to all Regional and Local Health Plans;

ii. Strengthen epidemiological surveillance, the promotion of health services and the primary and secondary prevention of diseases and illnesses, with further emphasis being put on activities covering the main health determinants through strategies aimed at reducing the burden of disease and ensuring the sustainability of the SNS institutions;

iii. Encourage implementation of Clinical and Health Governance programmes, the creation of appropriate responses to health problems and requirements, and promote the rigorous pursuit of clinical activity, taking place with appropriate levels of efficiency and quality;

iv. Encourage accountability from SNS entities through negotiation on yet to be developed clinical practices, objectives and concrete measures that need to be implemented, while ensuring timely monitoring and rigorous and transparent participative assessment;

v. Promote technical autonomy of SNS professionals and institutions, while valuing the participation of all stakeholders through the definition and implementation of strategies used to achieve agreed objectives based on effectively available human, technical and financial resources.;

vi. Promote the internal contracting process while strengthening the autonomy and responsibility of healthcare professionals and teams, in addition to promoting alignment, commitment and continuous improvement;

vii. Optimise the introduction of self-regulation mechanisms and positive competition between all SNS

entities which, in turn, will benefit patients, professionals, healthcare providing entities, paying agencies and citizens in general;

viii. Improve interconnection and communications between healthcare providers (primary, hospital and continuous), in addition to all structures from the Social Sector and the Community, while adjusting to activities based on the individual risk of the population, in addition to developing cross-over monitoring plans aimed specifically at chronic and multimorbidity patients;

ix. Encourage a healthcare provision culture in multi-disciplinary teams while seeking to improve access and the quality and continuity of health services, whether from a perspective of personalized treatment given to the patient in acute and chronic instances of disease, or instances involving the family and the community;

x. Promote literacy in healthcare and self-care systems, appreciating the pathways of SNS patients while ensuring that Health Plans involving the concrete needs of patients are properly defined and can be monitored on associated information technology systems in parallel with the reference circuits, including the fulfilment of Guaranteed Maximum Response Times from a SIGA SNS perspective;

xi. Involve citizens and communities through organisations and formal practices (citizen services and community councils) aimed at strengthening the power of the SNS citizen and promoting participation and citizenship in health, while encouraging patient education in terms of informed self-management;

xii. Reward institutions and teams through an incentive scheme for improved healthcare and economic-financial performance.

xiii. Develop organisational management and management control skills, specifically in the areas of financial management, human resources, facilities and equipment, material resources and supply, information technology systems, the implementation of SIMPLEX measures, among others;

xiv. Determine staffing plans, investment plans and the allocation of finances for each institution based on the healthcare needs of the population, while taking into account the budgetary availability and the portfolio of services of each institution, in addition to evaluating the calculated efficiency of benchmarking in relation to each institute and each professional group;

xv. Implement a rational and effective usage policy for all medicines (encouraging the use of Generic and Biosimilar products among other measures contained in the Resolution of the Council of Ministers no. 56/2016, Official Journal of the Portuguese Republic, 1st Series, 13th October 2016), Medical Devices and supplementary means of diagnosis and therapy, all combining into an innovation introduction with subsequent containment of expenditure;

xvi. Encourage integration, dematerialisation and sharing of data between all information systems, in

addition to the continuous improvement of data accuracy and reliability, utilising the Electronic Health Record (EHR) as an essential tool for access management through equity, quality and efficiency in the SNS;

xvii. Fully appreciate the use of communication and information technology services for the provision of health-related services, while encouraging the dissemination of TeleHealth responses (from a National TeleHealth Centre perspective, created through the Resolution of the Council of Ministers no. 67/2016 of 26th October, 2016) contributing to improvements in equity in terms of access to the SNS, and increasing diagnosis and monitoring capacity in real-time in relation to the State of Health of the population and overall efficiency;

xviii. Provide a processes and results auditing service to ensure correspondence between health practices and pre-established procedures or criteria for continued good health services, in addition to making sure that health providers continue to register and invoice activities.

For this process to be effective it is necessary to promote a culture of commitment and responsibility at all structural levels of healthcare, while fully appreciating the value of the following three contracting process phases, namely:

1. NEGOTIATION: cover all preparatory negotiation work up until the signing of all commitments between parties, touching on matters of supply and demand, and considering all matters advocated by the Health Policy, including budgetary restrictions and other conditions associated with negotiations and the sharing of risks. This phase is not merely limited to the exchange of proposals, but requires that such proposals are rationalised andjustified;

2. MONITORING AND FOLLOW-UP - a phase in which the systematic gathering of information on the commitments assumed by various dimensions shall take place (production, access, healthcare and economic-financial performance, etc.), including discussion on measures that enable potential deviations to becorrected;

3. EVALUATION - a crucial phase that closes the contracting cycle and evaluates the accounts provision process, enabling reflection on the performance of all stakeholders, who should then have sufficient capacity to evaluate achieved results in an objective manner, and act on such results accordingly. This has enormous transformation potential, contributing to changes in behaviour, attitudes and management practices.

3. TERMS OF REFERENCE FOR THE CONTRACTING OF PRIMARY HEALTH SERVICES IN 2017

The primary healthcare component of the 2017 contracting process represents a social commitment in favour of the citizen and communities, incorporating a strategic and dynamic reformulation by the National Coordination for the reform of the SNS in the primary healthcare area, and through the contributions added by the Technical Group created through Ordinance no. 3823/2016 of 4th March, 2016, issued by the State Secretary for Health.

The contracting process is a longitudinal procedure at all organisational levels, acting as an essential management instrument organised by objectives, including the following operational model:

- Based on the identification of health-related requirements, in addition to National, Regional and Local Healthcare plans;
- Based on the definition of a results compromise;
- Based on promoting the planning and operationalisation of service provisions, with necessary identification and allocation of available human and material resources.

Contracting is a clear example of an "Adaptive Policy", with the following characteristics:

- High conceptual and methodological complexity;
- Widespread functional autonomy and high differentiation between its sectors;
- A concept undergoing change, requiring supervision, continuous assessment and the ability to adapt.

Its full implementation requires strategic and prospective analysis, and must ensure the following aspects:

- Inclusion and participation;
- The capacity to adapt to change;
- The promotion of self-organisation and full networking functionality;
- Maximisation of innovation;
- Continuous and timely monitoring.

3.1. INSTRUCTIONS FOR THE PRIMARY HEALTH SERVICE NEGOTIATIONS PROCESS

The primary health service negotiations process for 2017 has the following **specific objectives**:

i. Deepen the diagnostic process on specific needs and health service planning through the Public Health Departments of the Public Health Administrations (ARS), in addition to the public health units of the Health Centre Groupings (ACES), for assessing alignment of the health service planning instruments in relation to the contracting process;

ii. Encourage, through Clinical and Health Councils, the implementation of Clinical Governance programmes and preventive responses to the health service needs of the population in general and specific groups;

iii. Increase the presence of primary health services in the life of Portuguese citizens, families and communities by means of promotional and protection policies (individual and collective), disease prevention, empowerment of individuals and the co-responsibility of certain sectors of society, thereby fighting against the fragmentation of the current healthcare service and helping the SNS to achieve a more integrated and appropriate practice in relation to health requirements;

iv. To better appreciate and manage the pathways of individuals made in terms of health services, while promoting health related results within a good practice context;

v. To establish communication mechanisms between the Clinical and Health Councils of the Public Health Administrations, and the responsible clinicians of Hospitals, to ensure continuous interconnection, effective use of all available resources, and reserve access to hospital care for situations that require this level of commitment, while generating value for the patient and for the Health System in general;

vi. Encourage a culture of healthcare provision within a family healthcare team (family doctor and family nurse), through citizen referral and through various health service levels, thereby promoting effective clinical integration and coordination of healthcare in general;

vii. Strengthen the capacity of primary healthcare services through improvements in coverage in areas of oral and visual health, as well as through supplementary support in areas such as mental health, psychology, ophthalmology, obstetrics, paediatrics, and physical medicine and rehabilitation;

viii. Fully outline the ACES financing model in accordance with the healthcare needs of the population, not on a historical basis in terms of incurred costs, but culminating in the signing of a contract-programme agreement;

ix. Development organisational management and management control skills within the ACES, specifically in the area of health planning, financial management (improvements in economic-financial reporting quality of the ACES and subsequently in the Regional Health Administrations) and human resources;

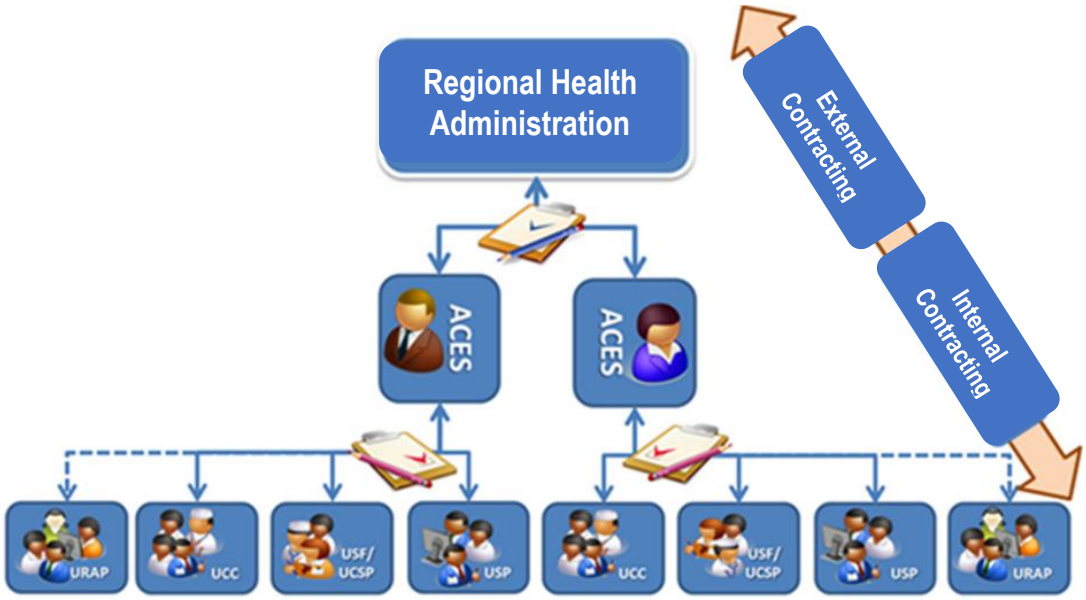
x. Promote the internal contracting process in the different functional units while strengthening the self-sufficiency and levels of responsibility of all associated teams, while progressively extending the degree of scope of all functional units with the appropriate conditions to be integrated into this process.

3.2. ARCHITECTURE OF THE CONTRACTING PROCESS IN PRIMARY HEALTH SERVICES

The contracting process in primary health services appreciates the value of multidimensional performance in SNS institutions and, consequently, is organised into the following two sub-processes:

1. **External contracting** carried out between the ARS and the respective ACES, formalised through negotiation of the Performance Plans and through signing of the Contract-Programme.

2. **Internal contracting** carried out between the ACES and the respective functional units, formalised through signing of Letters of Commitment.



The Executive Directors and the Clinical and Health Councils of the ACES shall assume full responsibility, in 2017, for all internal contracting processes with the functional units, competing with the Contracting Departments of the ARS in terms of quality control and overall process consistency, thereby ensuring their overall suitability and technical robustness.

It is also important to ensure a natural and desired level of integration between the contracting process for primary healthcare and the Integrated Management and Evaluation System of the Public Administration Services (SIADAP), including the Services Performance Evaluation subsystem of the Public Administration Services (SIADAP 1), which utilises, as a point of reference, the annual commitments assumed by the ARS within an Assessment and Accountability Framework (QUAR).

3.3. PRIMARY HEALTH SERVICE NEGOTIATIONS SCHEDULE

The internal and external contracting processes are dynamic and inter-dependent, having a clear and prior alignment with the National, Regional and Local Health Plans, and with the external contracting process taking precedence over the internal contracting process.

The deep restructuring process that has been implemented for the primary healthcare contracting process for the 2017-2019 triennium, requires review of the Decree that currently governs the current health service development process (Decree no. 377- A/2013, 30th December, 2016).

Faced with these constraints, a system for defining the average time of the negotiation phase has been chosen, with the schedule being determined afterwards. Based on this requirement, the following sequential scheduling system has been defined, which must be adhered to by all stakeholders:

No.1: Submission of the Functional Unit Action Plan – date to be defined (work should start immediately);

No.2: Submission of the ACES Performance Plan – 1 week;

No.3: External Contracting – 2 weeks;

No.4: Internal Contracting – 4 to 6 weeks (variable, depending on the size of the Health Centre Groupings);

No.5: Signature of Letter of Commitment and Programme Contracts – 1 - 2 weeks.

The aim of this process was to initiate the 2017 contracting process by the end of 2016, for the purposes of completing the process as soon as possible during the first quarter of 2017.

3.4. INTERNAL CONRACTING OF PRIMARY HEALTH SERVICES

The internal contracting process for the Health Centre Groupings (ACES) covers all currently functional units (USF, UCSP, UCC, URAP and USP), all of which utilise the same conceptual and methodological reference model, namely:

- Based on the Local Health Plan and the process defined for the Local Health Profile;
- The negotiation of a triennial Action Plan with annual goals;
- Taking into account the specific requirements of the various service portfolios of the functional units;
- Making sure that monitoring and evaluation become operational through a Global Performance Index.

Please note that internal contracting of the various components (negotiation, monitoring and follow-up, and evaluation) must occur in accordance with a group of essential values for the subsequent success of this process, specifically in terms of: transparency, the precision and positive involvement of all stakeholders, and proximity, rationality, leadership and common sense.

3.4.1. INTERNAL CONTRACTING NEGOTIATIONS PROCESS

3.4.1.1. INTERNAL CONTRACTING NEGOTIATIONS PROCESS WITH THE USF AND THE UCSP

Negotiation of the internal contracting process with the USF and UCSP health units in 2017 is based on the discussion of a three-year Plan of Action, which defines annual goals with the overall objective of achieving full operationalisation through a multidimensional matrix of activities, taking place through these units.

The context diversity of the health service provision within the USF and UCSP, in addition to their levels of

organisational development and maturity, requires a level of flexibility that ensures equity, promotes continuous improvement, and eliminates varying degrees of performance.

The essential parameters that define and objectify performance should be:

- Centred on the patient (person/citizen), focused on results, and orientated by the healthcare process.

Focus should be professional in order to achieve an adequate level of management of integrated pathways in health, in addition to defining what should actually take place, all expected results, and acceptable degrees of variation and their overall monitoring process.

The matrix has 5 separate areas: Health Performance, Services, Organisational Quality, Training, and Scientific Activity, which are then split into various sub-areas and dimensions, such as:

Multidimensional matrix for the USF and UCSP

Area	Sub-areas	Dimensions
Performance	**Access** (access qualification)	Health coverage by family doctor and nurse Type of appointment booking Response times Personalisation of healthcare Daily distribution of the offer Home-based activity Others to be negotiated
	Health Management (Pathway management / Health Plan / Results in the prevention and promotion of health)	Child Health Women's Health Adult Health Elderly Health Others to be negotiated
	Disease Management (Pathway management / Health Plan / Results in the prevention and promotion of acute and chronic illnesses)	Acute Cardiovascular Diabetes Respiratory Mental Osteoarticular Multimorbidity Others to be negotiated
	Qualification of the Prescription (Scientific technical adequacy, Effectiveness, Efficiency)	Pharmacotherapeutic Prescription Prescription of SMDT Prescription of Healthcare
	Satisfaction (degree of patient satisfaction)	Patient satisfaction
Services	**Internal** (Additional UF patient services)	Quitting smoking Palliative approach Others to be negotiated
	External (Additional services to non-UF patients)	
	Collaborative (Elements of the UF with external functions)	

Organisational Quality	**Promotion of Access**	
	Promotion of Good Practices (patient care, diagnosis, treatment)	Integrated Healthcare Processes
	Safety	Internal environment Communication Users Professionals Medication Infection Control Other aspects to be negotiated
	Satisfaction (promotion of satisfaction)	Patients Professionals Internal customers
Training	**Internal** (For UF professionals)	Multidisciplinary Team Internal / Students
	External	UF/Professionals as external trainers
Scientific Activity	**Articles, Communications, Conferences**	
	Research Work	

Each area shall be operationalised through the definition of its sub-areas, dimensions and metrics, and/or indicators. Focus is placed on identification/definition of the essential characteristics of each area or sub-area, and the events that should occur in each area, in addition to identifying expected results which are fully orientated by quality control processes. The utilised metrics and/or indicators must be included in the primary health service indicator matrix (naturally respecting all defined requisites), utilising the following priority and preferential criteria for contracting purposes:

- Be centred on the patient (e.g. **P**atient **R**elated **O**utcome **M**easures)
- Results (e.g. avoidable hospital internment, controlled patients, waiting times)
- Composite indicators or indices, for complex healthcare processes that require multidimensional monitoring and analysis (e.g. access, efficiency, results, technical scientific adequacy).

The contract negotiating process must focus on the discussion of all measures and activities included in the Plan of Action, utilising the Global Performance Index as a reference factor in relation to future improvements and achievements.

The primary healthcare indicator matrix integrates all existing indicators, for respecting currently defined requisites and criteria, namely:

- Relevance, technical-scientific robustness, validity, reliability, sensitivity and feasibility;
- An Identity Card (ID) system that clearly and unequivocally describes, in a simplified manner, what to measure, how to measure, where to obtain records, and other technical specifications;

- Back-history of at least two years;
- Expected results and acceptable variations, based on available information.

In relation to the primary healthcare indicator matrix, pages contained on SNS and BI CSP portals should ensure easy access to:

- Lists of indicators that are included in the indicator matrix, in addition to providing full descriptions;
- Monitoring of the results of all integral indicators belonging to the aforementioned Matrix, including its distribution through various observation levels.

It is fundamental for 2017 to ensure that all personalised healthcare units (UCSP) fully execute the internal contracting process, and establish a mandatory inclusion criterion for each UCSP of at least two family doctors. The ACES can establish contracting process with UCSPs, however, that do not fulfil these minimum criteria.

- ADDITIONAL SERVICES PORTFOLIO

Each Regional Health Administration should consider the possibility of a definition and approval circuit for the additional services portfolio of each programme, each involving a proposal presentation phase, further analysis, approval of the execution of the portfolio in the Health Centre Groupings (ACES), plus an additional monitoring and evaluation model for such services (i.e. performance indicators, evaluation schedule, termination/maintenance of the additional portfolio in accordance with minimum performance levels).

3.4.1.2. NEGOTIATION OF THE INTERNAL CONTRACTING PROCESS WITH COMMUNITY CARE UNITS (UCC)

The purpose of the Community Care Units is to contribute to improvements in the health service status of the population with their geographic regions of activity, by providing healthcare and psychological and social support at a domiciliary and community level, especially to the most vulnerable groups of people, families and groups in situations of greater risk or physical and functional dependency, or for diseases that require close medical attention, in addition to providing education on health, integration into family support networks, and the implementation of mobile intervention units, thus ensuring the continuity and quality of all provided health services.

The construction of the service supply for each UCC must take the following central aspects into account:

- The recommendations provided in the National Health Plan and the Regional Health Plans, providing a family orientated and life-cycle approach, including the need to intervene in a more visible manner in relation to health problems of social origin, in addition to prioritising associated activity within different community settings;
- The specific nature of the population covered by UCC services, namely the type of health and social services conducted in these areas of intervention, must be reflected in the diversity of the yet to be implemented programmes and projects.

The internal contracting process with the Community Care Units for 2017 is centred on the negotiation of its triennial,

annually adjusted Action Plan, which adheres to the following multidimensional matrix:

Multidimensional matrix for UCC		
Area	**Sub-areas**	**Dimensions**
Performance	**Access** (access qualification)	Coverage by UCC ECCI coverage Home activity Activity booking type Response times Admission/discharge of patients into/from programmes Other aspects to be negotiated
	Health Management (Health Plan / Results on the prevention and promotion of health)	School Health Reproductive Health (Health Plan / Results on the prevention and promotion of health) Elderly Health Clinical Pathways Other aspects to be negotiated
	Disease Management (Health Plan / Results on the prevention and promotion of acute and chronic disease)	Rehabilitation Mental Health Palliative Approach Chronic Disease Other aspects to be negotiated
	Community Intervention (Targeted programmes, literacy, specific settings)	Regular community programmes Early intervention CPCJ NACJR / EPVA Other aspects to be negotiated
	Satisfaction	Patient satisfaction Caregiver satisfaction
Services	**Internal** (Additional UF patient services)	Intervention in specific settings Community events Promotion of health literacy Other aspects to be negotiated
	External (Additional services to non-UF patients)	Programmes for out-of-area SNS users Other aspects to be negotiated
	Collaborative (Elements of the UF with external functions)	Communication with other structures Other aspects to be negotiated
Organisational Quality	**Promotion of Good Practices** (patient care, diagnosis, treatment)	Quality accreditation Integrated Healthcare Processes (PAI) and Clinical Guideline Standards Other aspects to be negotiated
	Safety	Patients Professionals Prevention and control of infections, and resistance to antimicrobials Notification, analysis and prevention of incidents and occurrences Risk Management Other aspects to be negotiated
	Satisfaction (promotion of satisfaction)	Users Professionals Others to be negotiated

Training	**Internal** (For UF professionals)	Multidisciplinary team Internal / Adults
	External (For non-UF professionals)	UF and Professionals as external trainers Group training Training of caregivers
Scientific Activity	**Articles, Communications, Conferences**	Multidimensional
	Research Work	Multidimensional

Please note that this matrix should be adjusted in line with the regional and local characteristics in which the Community Care Units undertake their activities, affording improved communication with the various functional units, and partnerships with community agents, and also providing visibility in terms of the standard results that are achieved.

Specific indicators shall also be created for the various dimensions of this multidimensional matrix, grouping together the already listed characteristics with the matrix indicators of the Family Health Units (USF) and the Personalised Healthcare Units (UCSP).

3.4.1.3. NEGOTIATION OF THE INTERNAL CONTRACTING PROCESSES WITH PUBLIC HEALTH UNITS (USP)

The objective of the Public Health Units (USP) is to improve the health and well-being of the patients and users covered by the Health Centre Groupings (ACES), in addition to promoting the alignment of sustained efforts in the health sector and the rest of society, for the protection and promotion of health-related issues (including health literacy), the prevention of diseases and incapacity, and the development of healthy practices for all citizens involved.

Below are the essential requirements for the adequate running of a Public Health Unit, in which the ACES:

1. Guarantee appropriate access to an effective information system, to be used by USP professionals;
2. Provide access to appropriate training and necessary levels of technical support;
3. Approve the Internal Regulation - the proposal of which being the responsibility of the USP coordinator;
4. Ensure the availability of sufficient human resources, in number and variety, to respond to all possible eventualities;
5. Provide the USP and its professionals with all necessary technical mediums, materials and transportation, suitable for their respective functions and the characteristics of each USP;
6. Ensure that each USP has all necessary facilities for its work.

The internal contractual framework for 2017 for each USP is based on the following matrix of competencies:

a) To monitor the state of health and the well-being of the population and its determinants, with special emphasis on social determinants of health and on the identification of health inequalities and inequities;

b) To maintain a citizen health vigilance system, with inclusion of epidemiological, entomological and environmental vigilance, ensuring the collection of data and monitoring measures in the areas of communicable and non-communicable diseases, in addition to school health, mental health, occupational health and environmental health,

throughout the entire vigilance life cycle;

c) Monitor, evaluate and collaborate in matters concerning public health risk levels and emergencies, including such measures on chemical, biological, radiological and nuclear related risks;

d) Ensure health protection in all environmental (climate included), occupational, food and other aspects of the National Health Plan;

e) Promote and encourage health in the entire population by means of appropriate health determinant actions, with special emphasis on identifying people and populations exposed to different types of risk, in addition to providing health advocacy and contributing to the elimination of health-related inequalities and inequities;

f) Be active in the prevention of disease, through intervention in behavioural activities, vaccination and participation in early detection programmes;

g) Ensure appropriate health and well-being governance through suitable health planning instruments, specifically through the coordination of regional and local health plans, and through involvement in impact studies into health;

h) Ensure the integrated management of programmes and projects in the areas of health promotion and disease prevention, as part of a National Health Plan (PNS) or Regional and Local Plan framework, in addition to participating in their execution;

i) Promote the management of available financial and material resources, while also intervening in the contracting and auditing process of health services, thus ensuring effective performance based on identified principal health requirements and available resources, including resources available in the community;

j) Promote health literacy while continuously maintaining communication on health and social mobilisation in terms of individual and collective responsibilities for public health, from a results co-production perspective;

k) Ensure appropriate levels of human resources training in the public health sector;

l) Develop public health research activities aimed at generating knowledge for the preparation and implementation of health policies, in full communication with all other health services, the academic and scientific communities, and the community in general.

In this respect, the Public Health Units must work with a "Basic Services Portfolio" in the following areas:

a) Local Health Observatory
b) Governance for health and well-being
c) Epidemiological Vigilance
d) Environmental Health
e) Integrated management and participation in the execution of health programmes and projects (GPROT/GPROM)
f) Health Authority
g) Continuous training, and pre- and post-graduate training of different professional groups (FORM)
h) Health Research

From a Public Health Reform context, currently under way in the document "New ambition for Public Health - Focused on Local Services" (DGS, 2016), recommends the "creation of a Public Health Unit network - pilot (Local

Public Health Services), with units selected based on their capacity to adopt an elevated level of good practice, benefiting from a new investment in information systems and qualified contracting and accreditation processes".

In terms of the characteristics of this pilot-USP, the following characteristics are expressed:

a) The need to have suitable equipment, including fully up-to-date telematic and IT systems, for the full development of activities, enabling higher levels of performance;

b) From 2017 onwards, be subject to contractual procedures (including institutional and financial incentives) and qualified accreditation;

c) Promote alignment of the health services contracting process with local health requirements and gains in desired levels of healthcare;

d) Invest in the improvement of the local healthcare planning process, with emphasis on the various aspects of health-related communication, utilising experience gained from Local Health Plans and the results of the debate on new models of activity in public health, proposed by the WHO;

e) Collaborate on the implementation of a study model into the impacts of health, in full communication with existing regional and national structures.

The internal contracting process for 2017 therefore consists of negotiations with the Public Health Units on its triennial Plan of Action, adjusted annually, and on the definition of its activities within ACES areas of influence, which must take place in accordance with the following multidimensional matrix:

Multidimensional matrix for USP		
Area	**Sub-areas**	**Dimensions**
Performance	**Local Health Observatory**	Diagnosis of Health Situation Local Health Plan Other aspects to be negotiated
	Governance for health and well-being (includes population based health planning)	Contingency plan for Extreme and Adverse Temperatures Other aspects to be negotiated
	Epidemiological Vigilance (including entomological vigilance)	Mandatory Notification Diseases Other aspects to be negotiated
	Environmental Health	To be defined
	Health Authority	To be defined
Services	**External** (Additional services not included in the services portfolio)	To be defined
	Collaborative (UF elements with non-UF functions)	To be defined
Organisational Quality	**Integrated management and participation in health programmes and projects**	To be defined
	Promotion of Good Practices	To be defined
	Safety	To be defined
	Satisfaction (promotion of satisfaction)	User satisfaction Professional satisfaction "Internal Customer" satisfaction
Training	**Internal** (for UF professionals)	To be defined
	External	To be defined
Scientific Activity	**Articles, Communication, Conferences**	To be defined
	Research Work	To be defined

Specific indicators shall also be created for the various dimensions of this multidimensional matrix, grouping together the already listed characteristics with the matrix indicators of the Family Health Units (USF) and the Personalised Healthcare Units (UCSP).

3.4.1.4. NEGOTIATION OF THE INTERNAL CONTRACTING PROCESS WITH SHARED ASSISTANCE RESOURCE UNITS (URAP)

URAP provides consulting and healthcare services to the ACES units, in addition to organising functional connections to hospital services, and undertaking activities with the following principles:

a) Cooperation with other functional units;

b) Citizen accessibility;

c) Technical autonomy;

d) Profitability of installed services;

e) Communication with reference hospitals, favouring the creation of protocols;

f) Participative management based on a communication system and working relationships with all professionals involved, including the promotion of motivational gains and professional satisfaction;

g) Continuous, objective and permanent evaluation, aimed at adopting corrective measures in relation to deviations, likely to jeopardise the objectives of the plan of action and the overall quality of healthcare.

The Shared Assistance Resource Units (URAP) bring together professionals with various skills, particularly specialist doctors who don't work in general medicine, family medicine or public health, but who work at other functional units of the Health Centre Groupings (ACES), plus nurses, psychologists, social workers, nutritionists, physiotherapists, oral health technicians and other technicians with different skills who are already integrated, or are scheduled to be integrated, into the ACES.

The activities of these units will be monitored throughout 2017, plus the design of an appropriate internal contracting process suited to the specific nature and overall objectives of the URAP units, which must pass through a service levels definition related to their communication levels with other functional ACES units, and through the definition of goals included in the following multidimensional matrix:

Multidimensional matrix for Shared Assistance Resource Units (URAP)	
Area	**Sub-areas**
Performance	**Health Management** (Pathway management / Healthcare Plan / Results on the prevention and promotion of health) **Disease Management** (Pathway management / Healthcare Plan / Results on the prevention and promotion of acute and chronic illnesses) **Satisfaction** (Degree of user satisfaction)
Services	**Internal** (Additional services provided to Unit users) **External** (Additional services provided to non-unit users) **Collaborative** (Elements of the UF with external UF functions
Organisational Quality	**Promotion of Good Practices** (patient care, diagnosis, treatment) **Satisfaction** (Promotion of user, patient and "internal customer" satisfaction)
Training	**Internal** (For UF professionals) **External**
Scientific Activity	**Articles, Communication, Conferences** **Investigation Work**

3.4.2. MONITORING OF INTERNAL CONTRACTING PROCESSES

- INTERNAL MONITORING PLAN OF THE FUNCTIONAL UNITS

Each functional unit must implement an internal monitoring plan, integrated into the "Organisational Quality" sector, thereby proceeding with a self-assessment process with the aim of achieving accreditation, especially in relation to the Family Health Unit (USF).

- INTERNAL MONITORING OF THE CONTRACTUALISATION PROCESS

Internal monitoring of each ACES Functional Unit is ensured by the respective Clinical and Health Council, with additional support from the respective Regional Health Administration Contracting Department.

Monitoring must preferably be carried out through electronic functional processes, specifically available from the "Contracting" and "e-Quality" sectors of the BI CSP.

The identification of deviations and/or situations which require improvements in performance, making implementation of an overall improvement plan necessary, subscribed to by both parties.

Monitoring results should be used for discussions on strategies, sharing of responsibilities, and for re-scheduling the allocation of material, human, financial and other resources.

Such results could also be used for the renegotiation of objectives whenever significant changes are verified in relation to contracting requirements. Changes deemed necessary, including their justifications, must be presented by the ACES Executive Director to the ARS Board of Directors, which shall only be considered valid if approved by the aforementioned Board of Directors.

The contracting process for 2017, in all its different phases, shall be fully sustained through the BI CSP portal, accessible at the following website: www.biusf.pt. The aim of this strategy is to strengthen participation, improve transparency and the overall sharing of information from a primary healthcare perspective, in addition to providing a more widespread, timely and comparable monitoring service between teams, with greater levels of detail and flexibility than previously available.

Additionally, the new SNS Portal (www.sns.gov.pt) is now available as an important tool for monitoring the activities of the functional Units, by making up-to-date and useful information available to users and professionals alike (on performance, response times, waiting lists, etc.).

3.4.3. EVALUATION OF THE INTERNAL CONTRACTING PROCESS

- ASSESSMENT OF THE INSTITUTIONAL INCENTIVES OF FAMILY HEALTH UNITS (USF)

The award of Institutional Incentives shall be subject to a ministerial Order on the part of the member of the Government responsible for the health unit which, in turn, shall ensure simplification of procedures and subsequent execution in a timely manner at national level.

– AWARD OF INSTITUTIONAL INCENTIVES

The Plan for the Application of Institutional Incentives (PAII) must be fully integrated into the Plan of Action of each functional unit, and also integrated into the annual Letter of Agreement.

The PAII can be used by the Functional Unit to establish its commitment to the accreditation programme established for the SNS (namely through USF Model B).

– EXTERNAL MONITORING COMMITTEES

The external monitoring committees for the internal contracting process are founded on the basis of each of the five Regional Health Administrations, being comprised of three effective elements and three alternate elements indicated by the respective Regional Health Administrations, and of three effective and three alternative elements indicated by the unions utilised by the USF coordinators who comprise the ACES of each Regional Administration Unit (ARS).

These monitoring committees make it possible to broaden the scope of discussion in terms of the results achieved by the teams during the internal contracting process, consisting of the following responsibilities:

a) To monitor the contracting process and verify the results;

b) To receive information and analyse the conclusions of the annual assessment report;

c) To determine and arbitrate any conflicts between Family Health Units (USF) and the Health Centre Groupings (ACES) emerging from the contracting and results verification processes.

3.5. EXTERNAL CONRACTING OF PRIMARY HEALTH SERVICES

The Contracting rules with the ACES for 2017 are as follows:

3.5.1. NEGOTIATIONS PHASE OF THE EXTERNAL CONTRACTING PROCESS

The external contracting negotiations phase shall be the responsibility of the Board of Directors of the Regional Health Administration, with suitable support from its Contracting Department. The Health Centre Grouping (ACES) shall be represented by the Executive Officer who must, in turn, be accompanied by the members by the Clinical and Health Councils, in addition to having the backing of the Management Support Unit (UAG). The document for discussion at the negotiations must be presented on a mutual basis at least 48 working hours in advance. In the event of an ARS counter-proposal to the initial proposal presented by the ACES (SICA ACES), such a proposal must also be communicated and transmitted in advance.

The ARS may invite representatives from agencies of the Ministry of Health to take part in these meetings, particularly from the ACES and Directorate-General for Health, in addition to encouraging the participation of the Clinical Leaders of Hospitals in the regions of ACES jurisdiction in which the meetings take place.

Minutes shall be drawn up at the end of the negotiations, to be duly validated and signed by all parties involved, with these documents making up an integral part of the contracting process.

After being signed by all parties, the Contract-Programme must then be sent to the ACSS for subsequent submission, and then ratification, on the part of the Assistant Secretary of State and Health, in addition to being published on the Internet websites of each one of the Regional Health Administrations, after having been ratified.

3.5.1.1. PERFORMANCE PLAN

The performance plan is a strategic document that is negotiated on an annual basis with the Health Centre Groupings (ACES), which characterises the ACES through population indicators of a sociodemographic, socioeconomic and health results nature. Health service priorities are defined in the Health Plan, in addition to an explanation of the material, human and financial resources at the disposal of the ACES for fulfilment of all healthcare objectives. This is a very important monitoring tool for all ACES professionals, particularly for ACES management and clinical providers, and therefore needs to be disseminated by the ACES functional units.

The Performance Plan is organised into nine different areas: (1) Characterisation; (2) Strategic Lines; (3) Plan of Activities; (4) Training Plan; (5) Equipment Map; (6) Map of Human Resources; (7) Performance Indicators; (8) Investment Plans, and (9) Budget-Economics.

- CHARACTERIZATION

The purpose of this area of the Performance Plan is the promotion, by ACES, of a detailed as possible characterisation of the population within its area of coverage, aimed at promoting a "health portrait" of the population, preferably using language that enables objective interpretations.

- STRATEGIC LINES

Due to strategic plans generally requiring time periods of greater than one year, it is appropriate that the defined strategic lines are guided by the 2017-2019 contracting triennium, as well as requiring periodic review. Taking the strategic principles into account, these lines must be focused and sufficiently clear in terms of interpreting the expression "pathway" defined by the ACES.

It is important to express [Mission], [Vision] and [Values] in terms of ACES strategic positioning, in addition to explaining a synthetic and focused SWOT analysis that encourages reflection on the current situation, in addition to sketching out a possible pathway. The strategic objectives should also be listed, in addition to duly linked operational objectives that reflect the strategic alignment of the ACES with the Health Plans defined at the various different levels.

- PLAN OF ACTIVITIES

This area should express all of the activities for promotion by the ACES, for the contracting year and for the equivalent calendar-year time period, conducted in a properly linked way in terms of the previous defined

strategic lines (strategic objectives and operational objectives).

Enumeration of the activities should include an implementation schedule divided into yearly quarters, as well as a clear indication of each functional unit encompassed by each activity.

- TRAINING PLAN

Based on this being a contracting strategy, it is important to include a training plan for each of the ACES in which the multiple scheduled activities can be listed and explained, including details of all addressees, in addition to all necessary data for quantifying the intended impact of the plan, specifically the total number of training hours.

- EQUIPMENT MAP

It is the responsibility of the ARS, through the ACES, to ensure the full availability of sufficient medical equipment and systems in good usage conditions for complete fulfilment of contracted production requirements and quality parameters.

It is therefore necessary for the ARS to maintain an Inventory of all medical equipment and systems which are allocated to the ACES, in addition to maintaining appropriate preventive maintenance and investment plans in order to guarantee the integrity of all equipment and eliminate the risk of faults or failures that could put the safety of patients and professionals at risk.

- MAP OF HUMAN RESOURCES

One of the principle components of the external contracting and negotiations phase is the ACES Map of Human Resources, aimed at identifying the group of professionals with whom the institution can undertake activities during the analysis period.

This human resources identification process is carried out in terms of absolute effectiveness, defined by the type of weekly schedule being used (35h, 40h, 42h, etc.), with this information continuing to be gathered and utilised throughout the 2017 external contracting process.

- PERFORMANCE INDICATORS

The most important change proposed in this new external contracting model is related to the inherent matrix pertaining to the model, which dematerialises the contractual focus on the indicators and conducts negotiations for the efficiency of existing and necessary resources within each of the ACES.

This new matrix, at ACES level, recommends an area and sub-area approach, which is comprised of the following two distinct aspects in relation to the ACES Performance Index:

(i) the accumulated result of the Functional Units that comprise the ACES, which leads to a direct contribution in terms of evaluating these ACES;
(ii) the result of key services and processes within the sphere of responsibility of the ACES.

In terms of external contracting with the ACES, the multidimensional matrix to be considered for 2017 is as follows:

Multidimensional matrix for Health Centre Groupings (ACES)		
Area	**Sub-areas**	**Dimensions**
Performance (directly associated with ACES Performance)	**Access** (access qualification)	Coverage by family doctor and nurse Coverage by UCC and ECCI Coverage by ECSCP Home activity Type of appointment booking Response times Personalised healthcare Daily distribution of the offer Other aspects to be negotiated
	Health Management (Pathway management / Healthcare plan Results in the prevention and promotion of health)	Child Health School Health Women's Health Adult Health Elderly Health Other aspects to be negotiated
	Disease Management (Pathway management / Healthcare plan Results in the prevention and promotion of acute and chronic illnesses)	Acute Cardiovascular Diabetes Respiratory Mental Osteoarticular Multimorbidity Palliative Care Other aspects to be negotiated
	Qualification of the Prescription (Scientific technical adequacy, Effectiveness, Efficiency)	Pharmacotherapeutic Prescription Prescription of the SMDT Prescription of Health Services Other aspects to be negotiated
	Satisfaction (Degree of user satisfaction)	User satisfaction Satisfaction of professionals
Integration of Healthcare	**Hospital** (Pathway management / Emergencies / Time and Hour Consultation / SMDT)	Avoidable hospitalisation Avoidable emergencies
	Continuity (Pathway management / references)	Integrated home support Healthcare continuity
Organisational Quality	**Promotion of Good Practices** (Guidelines and references)	To be defined
	Safety	Users Professionals Risk Management Other aspects to be negotiated
	Organisational Management (USF, UCSP, UCC, USP, URAP) (GC)	To be defined
	Continuous Improvement (Accreditation, certification, knowledge)	To be defined
Training	**Internal** (Management of internal ACES training)	Multidisciplinary Teams Internal / Students
	External (Management of external training frequency)	UF and Professionals as external trainers
Information and	**Information Systems** (Management of IT and all related	To be defined

Communication	resources) **Communication Systems** (Management of internal and external communication systems)	To be defined

- INVESTMENT PLAN

It is important to list all necessary investments in addition to the defined conditions of the strategic lines and in the plan of activities, i.e. in addition those included in the objective for the improvement of health provision conditions, as well as to gauge the expected impact at organisational or financial level.

- BUDGET-ECONOMICS

Contracting is based, in 2017, on an ACES budget from a cash and accrual-based accounting perspective, which must be segregated through analytical accounting within a Regional Health Administration budgetary system. This segregation must include all expenses, including expenditure on supplementary diagnostic and therapeutic resources, medications and other relevant expenses and investments. Appropriate conditions must be created within the Regional Health Administrations for this segregation to take place by the end of the scheduled contracting period.

ACES budget negotiations for 2017 must be centred on the containment and streamlining of costs, aimed at achieving greater economic-financial efficiency, effectiveness and sustainability, while increasing the participation of the management and personnel from ACES and all other functional units involved in meeting the efficiency objectives specified for 2017. An ACES revenue component is also under development for 2017, aimed at aligning ACES with financial models adjusted to the reality of primary healthcare, while taking the health-related necessities of the population into consideration.

3.5.1.2. CONTRACT-PROGRAMME

The Contract-Programme is a joint document established between ACES and the ARS, which is also aligned with the Performance Plan, which clearly identifies the obligations and counterparts of each party, in addition to establishing monitoring rules, the financial resources that sustain the contract, and the mode of monitoring and evaluation used for ACES developed activities. The healthcare objectives listed in the Contract-Programme must be as comprehensive as possible, and not restricted to the currently available indicators.

3.5.2. MONITORING OF THE EXTERNAL CONTRACTING PROCESS FOR PRIMARY HEALTH SERVICES

Monitoring results are the exclusive responsibility of the ACES and ARS, and must be used for discussions on strategies, sharing of responsibilities, and for re-scheduling the allocation of material, human and financial resources. The ACSS, INFARMED and the National Committee for SNS reform in the area of primary health services, will also be monitoring the performance of the ACES in 2017, in addition to full communications going ahead between all parties. This communication can also be used for renegotiations on objectives (e.g. matters

that shall occur, which then has to be noted in any changes to the contract-programme and then sent to the ACSS, who will forward such information for subsequent ratification), whenever any relevant and unexpected changes are made to the assumptions of the initial negotiation.

The ARS must encourage participation on the part of the Directorate-General of Hospitals for the region in question, in all monitoring meetings that take place with the ACES of the area of influence, in a similar vein to that expressed in the negotiation phase of the commitments to be fulfilled by all associated ACES.

3.5.3. ASSESSMENT OF THE EXTERNAL CONTRACTING PROCESS FOR PRIMARY HEALTH SERVICES

It is recommended that a final assessment process takes place, as scheduled in the following table:

Table – Performance assessment schedule of the ACES

Limit Date	Procedure	Who Promotes?
15th April 2018	Meeting for presentation and discussion of the 2017 ACES activity report	ARS
15th May 2018	ARS informs as to which ACES shall have access to institutional incentives	ARS

The assessment of the ACES shall be based on Area and Sub-Area Performance Indicators contained in the SIARS and SICA systems, with a 31st December 2017 reference date, and with the definitive calculation only being considered after 1st March 2018

- APPLICATION OF THE GLOBAL PERFORMANCE INDEX

In accordance with the matrix defined for the Performance Index, the ACES shall be assessed within the confines of the areas and sub-areas. The Global Performance Index shall be obtained by weighting the Area Performance Indices which are obtained, in turn, from weighting the Sub-Area Performance Indices.

- APPLICATION OF INCENTIVES

ACES with the right to receive incentives for 2017 should prepare a Plan for the Application of Institutional Incentives (PAII ACES), by 15th June 2018, at the latest.

The PAII ACES should be forwarded by the ACES Executive Director (with acknowledgement of the Clinical and Health Council) to the ARS Board of Directors, which shall have an impact on the economic budget of the ACES in 2018, after conclusion of the assessment process.

The ARS Board of Directors shall decide whether or not to approve the PAII ACES, and thus provide the budgetary commitment for the amount in question. In the event that the PAII ACES does not meet the requirements of the health strategy for the region, the ARS Board of Directors must return the document to the ACES Executive Director by 31st July 2018, at the latest. Through participation of the Clinical and Health Council, this process shall proceed with all necessary changes, followed by the subsequent approval of the ARS.

Contractual Monitoring Information System (SICA) of the ACES

SICA ACES shall continue to be developed in 2017, making it possible to structure and harmonise the negotiation process, while monitoring and assessing the external contracting process in conjunction with ACES.

The responsibilities of all stakeholders shall be assumed in full, with all data being reported and analysed in an appropriate and timely manner, in accordance with the defined schedule.

4. TERMS OF REFERENCE FOR THE CONTRACTING OF HOSPITAL CARE IN 2017

The hospital care component of the contracting process contributes to full operationalisation of the measures proposed in the SNS Reform programme for the hospital health area, also contained in the new Contract-Programme for the 2017-2019 triennium, which takes a triennial strategic planning process into account for the definition of strategic objectives, principle lines of activity, and the necessary investment plans and economical financial projections for the triennium in question, as well as explaining relevant gains in efficiency and productivity for ensuring the sustainability of all relevant entities over the medium-term.

Also aligned with the hospital contracting process and the strategic planning process are Management Contracts signed between members of the Government who are also shareholders of EPE institutions (Ministry of Health and Finance), and each member of the Board of Directors pertaining to these Entities, for contracts which shall remain in force throughout their respective terms in office.

This alignment contributes to the strengthening of the hospital contracting process, in addition to reinforcing responsibilities in relation to the results achieved by the institutions, enabling objectives defined in the Management Contracts to be superimposed on the set of indicators and goals established within the Contract-Programme, as well as on the Strategic Plans defined by the institutions.

4.1. INSTRUCTIONS FOR THE HOSPITAL CARE NEGOTIATIONS PROCESS

The hospital health negotiations process for 2017 has the following **specific objectives**:

4.1.1. CONTRACTING OF ACTIVITIES IN RELATION TO HOSPITAL HEALTHCARE

i. Widen the Free Access and Circulation (FAC) of the SNS user, by diversification of alternatives and by increasing the capacity to intervene in a pro-active and responsible ways in relation to the management of State of Health and Welfare;

ii. Rigorously comply with Guaranteed Maximum Response Times, creating improved access to appointments, surgery and Supplementary Means of Diagnosis and Therapy, in an appropriate and timely manner through the SIGA system;

iii. Encourage the Shared Management of Resources from an SNS perspective - the previously mentioned GPRSNS - while also seeking to maximise the installed capacity of the institutions (particularly at the access levels of Supplementary Means of Diagnosis and Therapy, external appointment, surgical activity and equipment usage);

iv. Foster an environment of equipment and human resources profitability within the SNS, by limiting sub-contracting to external entities in instances where installed capacity is depleted, in addition to fully respecting all principles of transparency, equality and fair competition;

v. Encourage a culture of transparency and effective healthcare provision in a multi-discipline and multi-professional team environment, while also encouraging effective communication, coordination and responses centred on the user;

vi. Develop a hospital response system in accordance with the services portfolios established within the Hospital Reference Networks, contributing to the strengthening of the SNS while the collaborative network is structured, thereby ensuring

suitable access, quality and efficiency, and thus contributing to sustainability;

vii. Encourage SNS Reference Centre (CRe) activity, through which casuistry and resources are concentrated on the diagnosis, treatment and clinical investigation of a set of pathologies, namely that of rare diseases involving multidisciplinary teams, including suitable quality control and the highest possible forms of safety, enabling patients to be referred on the basis of competency and skill hierarchies;

viii. Consolidate affiliation and working attitudes within a collaborative SNS network centred on organising the healthcare needs and pathways of the user, while encouraging cooperation between all institutions involved;

ix. Favour outpatient healthcare (medical and surgical), encouraging the transfer of hospitalised healthcare to the outpatient system;

x. Establish formal and permanent vertical and horizontal communication mechanisms between all clinical leaders of SNS institutions, ensuring the effective utilisation of all available resources, and reserving access to hospital healthcare to users in situations of necessity, thus ensuring full compliance with the Contingency Plan for Extreme and Adverse Temperatures - Summer and Winter Modules, as specified by the Directorate-General for Health;

xi. Encourage the transfer of subsequent appointments to the primary healthcare system (particularly in the area of chronic diseases), reorganising the immediate response concept and encouraging the use of primary healthcare referral instead, while also making full use of TeleHealth responses;

xii. Improve the efficacy and efficiency of health-related responses to urgent and emergency situations, in addition to introducing incentives that redirect users to programmed and locally-based health units, strengthening the respective resolution capacity and reducing user activity in terms of Emergency Services;

xiii. Increase the involvement and activities of SNS institutions in relation to dialysis, while encouraging an increase in hospital treatment programmes for the treatment of chronic kidney failure within an outpatient environment (peritoneal dialysis and haemodialysis);

xiv. Develop hospital responses, as detailed in the Palliative Health Network, in line with the Strategic Plan for the Development of Palliative Care for the 2017-2019 biennium, presented by the Portuguese National Council for Palliative Care (NCPC), accessible at:https://www.sns.gov.pt/wp- content/uploads/2016/09/Plano-Estrat%C3%A9gico-CP 2017-2018-1-1.pdf;

xv. Develop the internal contracting process taking place at various Integrated Responsibility Centres (CRIs), strengthening the autonomy and responsibility of the services, and encouraging commitment and participation between all professional teams.

The healthcare activities of the SNS cover all activities undertaken by SNS users, including the benefits of the subsystems of ADSE, the Social Services of the Public Safety Police (SAD of the PSP), National Republic Guard (GNR) and the Administration of the Armed Forces (ADM), National Press, Currency Exchange and all citizens residing in Autonomous Regions, issued by the Hospitals and Local Health Units, to the Contracting Departments of the ARS through the 2016/2018 Strategic Plan, in addition to being recorded in the Information System for Contracting and Monitoring (SICA).

4.1.2. ECONOMIC-FINANCIAL PERFORMANCE

Institutions prepare their provisional economic-financial documents for 2017 in order to:

i. Comply with the Official Accounting Plan of the Ministry of Health (POCMS) defined for the 2017 financial year, under the terms and conditions defined in Normative Circular no. 5/2016/DFI/UOC/ACCS of 26th February, 2016;

ii. Achieve a positive EBITDA in 2017, eliminating the accumulation of new payments in arrears, and implementing cost containment and streamlining measures that make it possible to achieve thisobjective;

iii. Comply with the provisions of Law no. 8/2012 of 21st February 2012, the Law of Commitments and Delayed Payments, and the provisions contained in Decree-Law no. 127/2012 of 21st June 2012;

iv. Increase their additional Contract-Programme revenue by undertaking proceedings with other SNS entities from a GPRSNS perspective (mainly in terms of Supplementary Means of Diagnosis and Therapy), by attracting patients found on the waiting lists of other hospitals, by rigorously and thoroughly identifying beneficiaries from other health protection systems, by charging insured users or other responsible third-party entities for such activities, and by developing clinical trials associated with health tourism, among other concepts;

v. Ensure that revenue obtained under the terms of the previous point, originating from SNS entities, is duly registered in a coordinated manner with the ACSS, in order to make sure that the same amount is taken into account in terms of payee expenditure;

vi. Register receipts (in the SICA system) that originate from Health Programme entities, with inclusion of a payee service code, in addition to, from an expenses perspective, the code pertaining to the beneficiary entity, with the values initially indicated by the payee being prevalent in the event of any discrepancies;

vii. Proceed with the management of human resources in such a manner as to achieve identical levels of productivity to the best results achieved by the benchmarking standards to which the institution subscribes;

viii. Reduce costs in terms of personnel be encouraging the mobility of healthcare professionals between SNS institutions, in addition to implementing service reorganisation measures and/or the reallocation of professionals.

ix. Maintain overall costs in terms of remuneration supplements and services;

x. Consolidate an effective centralised policy for the acquisition of specific health-related goods and services, specifically in terms of medications and medical devices, under the terms defined in Ordinance no. 1571- B/2016 of 29th January 2016, issued by the State Secretary for Health.

Approval of the institutional investment plans from a triennial strategic planning process perspective is governed by a self-financing production capacity and through the generation of cash-flow, either on projects that are co-financed or non-financed by community funds, with the exception of instances in which safety is at risk to patients and professionals alike.

4.2. NEGOTIATIONS SCHEDULE FOR HOSPITAL CARE

The schedule for the 2017 Contract-Programme negotiations phase is as follows:

1. The Strategic Plan for the gathering of responses from all hospital institutions who support the contracting negotiations process for 2017, shall be made available on the SICA Portal from **11th November 2016** onwards;
2. Hospitals shall be able to submit their proposals on the SICA Portal up until **22nd November 2016**;
3. The ARS and all hospitals involved will be able to negotiate the 2017 Contract-Programme up until **15th December 2016**. This negotiations process will determine the health production and performance framework for 2017, in addition to defining the amount of financing associated with the 2017 Contract-Programme;
4. The 2017 Contract-Programme shall be signed by all parties **by 22nd December 2016**.

Non-compliance with the herein defined deadlines shall result in the ACSS, together with the respective ARS, unilaterally defining the production proposal, the goals of all quality and efficiency objectives (based on the reference values published by the ACSS) and the structure of all costs and revenue to be included in the 2017 Contract-Programme, which shall then be approved by the supervisory body.

4.3. ALLOCATION OF FINANCIAL RESOURCES FOR CONTRACTING WITH HOSPITALS AND HOSPITAL CENTRES

Maximum limits to be contracted with 'Hospitais e Centros Hospitalares EPE', by the Regional Health Administration (ARS) in 2017.

ENTITY	2017
ARS North	1,275,403,554 EUR
ARS Central	737,353,472 EUR
ARS LVT	1,488,445,212 EUR
ARS Alentejo	70,899,640 EUR
ARS Algarve	187,876,864 EUR
National Total for Hospitals	**3,759,978,743 EUR**

The global financing limits allocated to each ARS for the 2017 Contracts shall not be surpassed, with limits that do not adhere to the specified levels not being accepted. Amounts, on the other hand, may be redistributed internally within the scope of the negotiations process defined in the schedule presented in the previous section, provided that this amount respects the allocation ceiling for each ARS.

4.4. EXTERNAL CONTRACTING IN HOSPITAL CARE - CONTRACTING RULES AND PRODUCTION PAYMENT

The main lines of health-related activity and payment modes are grouped into the following three aspects:

A. PROVISION OF HEALTH SERVICES:

A.1. To people with acute illnesses or diseases;

A.2. In specific health programmes;

A.3. To patients who live with chronic diseases;

A.4. In Reference Centres;

A.5. In Integrated Responsibility Centres;

A.6. To patients being monitored by specific palliative care teams.

B. PERFORMANCE INCENTIVES:

B.1. At expected institutional performance level;

B.2. At relative performance or benchmarking level between group institutions.

C. PENALTIES.

Other guideline principles have been defined for the 2017 Contract period, namely:

D. Global budget and marginal production

E. Application of regional flexibility in the fixing of prices by the Regional Health Administrations

F. Specific areas with autonomous financing

G. EBITDA and Contextual Costs

H. Promotional Research and Development Programme

I. Medicines prescribed in hospital environments and given away at community pharmacies

Each one of the guideline areas and principles for 2017 are set out in the following sub-sections:

4.4.1. PROVIDING HEALTH SERVICES TO PEOPLE WITH ACCUTE SITUATION ILLNESSES

4.4.1.1. HOSPITALISATION

In 2017, the inpatient activity for acute illness patients shall be classified into Homogeneous Diagnostic Groups by grouping together the All Patient Refined DRG 31 (APR31) version and the Case Mix Index (CMI) contracted in correspondence with production levels for 2015.

The APR grouping factor creates subclasses within each Homogeneous Diagnostic Group, as well as taking into account the existing differences in the patients such as the severity of illness and the risk of mortality, in which:

- Severity of Illness (SOI) is understood as the extension of a physiological decompensation process or the loss of organ functionality, which is split into four further subclasses;
- The risk of mortality is the probability of death occurring to the patient, also containing four subclasses.

The first considered variable for grouping this episode is the principal diagnostic. Each episode is attributed to the respective severity subclass, with mortality taking additional diagnoses into account such as the association between each subclass, plus its relationship with the principal diagnosis in terms of patient age, gender and any other previously carried out procedures.

Severity is related to the consumption of resources, whereas mortality is related to the risk of death. In spite of this grouping process taking degree of severity and risk of death into account, the relative weight of each Homogeneous Diagnostic Group only takes severity into consideration. The degree of severity will also have an impact on the Case Mix Index.

A unique CMI will be used in 2017 during hospitalisation for medical and surgical activity, in addition to a single base price for all institutions being established at 2,285 EUR, as practised in 2016. The utilisation of a single base price enables the SNS to ensure, irrespective of the health service provider, that an identical price is applied to the same level of treatment, increasing the streamlining of the health system, the possibility of benchmarking, and providing greater incentive for organisational efficiency. Institutions are differentiated from each other in accordance with the degree of severity into which their patients are classified.

The price charged for urgent surgical hospitalisation corresponds to 95% of the base price when taking into account the fixed costs paid through urgent treatment, while also giving encouragement to go ahead with scheduled activity.

Medical and surgical inpatient and outpatient costs	**Price**
Base price	2,285 EUR
Hospitalisation of chronic patients (daily)	**Price**
Psychiatry *	39.17 EUR
Psychiatry - Psychosocial Rehabilitation	39.17 EUR
Ventilated chronic patients	244.00 EUR
Physical Medication and Rehabilitation	205.00 EUR
Hansen	71.00 EUR

** For HML, CHUC and CHPL institutions with greater complexity of Chronic Patients, the price is 70.75 EUR.*

4.4.1.2. SURGICAL ACTIVITY

From a surgical activity perspective, in 2017 there will be two measures aimed at increasing surgical response capacity in SNS institutions:

- Introduction of an Incentive Programme for the Realisation of Surgical Activity in the SNS from a GPRSNS perspective;
- Keeping on par with the financial accountability of the hospital of origin that did not provide timely surgical care.

These two measures have the following characteristics:

4.4.1.2.1. INCENTIVE PROGRAMME FOR THE REALISATION OF SURGICAL ACTIVITY IN THE SNS

This programme is focused on monetising installed surgical capacity throughout the network of public establishments, consisting of the creation of a competitive mechanism for the carrying out of surgical activity within the SNS, accessible to all SNS hospital institutions with suitable conditions to respond to the needs of the population in an effective and timely manner, consisting of the following characteristics:

a) Operating within the scope of SIGIC rules, including an expected transfer period to these destination hospitals of three months for all situations classified as normal priority;

b) Take into account the volume of surgeries, per nosological group, that surpass the three-month waiting period;

c) This is a voluntary form of commitment by Hospitals, Hospital Centres and the Local Health Units pertaining to the SNS wishing to carry out this extra Contract-Programme activity, which should not jeopardize the existing level of response to users already on their waiting lists under any circumstances;

d) Based on the willingness of hospitals and Local Health Units who participate in the GPRSNS in providing a volume of surgeries per nosological group, the ARS shall be responsible for making negotiations in terms of the availability of its own regions (with each hospital offering to receive patients through the GPRSNS mechanism);

e) The activities carried out by the destination hospitals shall be directly invoiced to the ACSS extra Contract-Programme, in full compliance with all SIGA SNS rules from a surgery perspective, with the ACSS then being responsible for making payments and simultaneously retaining an identical value for advance payments to the hospitals of origin;

f) Patient-flow shall observe the rules outlined for Transfer Notes from a SIGA and surgical perspective, applicable to all transfers between SNS institutions.

4.4.1.2.2. FINANCIAL RESPONSIBILITIES OF THE HOSPITAL OF ORIGIN FOR THE UNTIMELY AND NON-PROVISION OF SURGICAL CARE

The principal of financial responsibility by the hospital of origin shall be applied in 2017 in relation to the non-provision of surgical care in a timely manner, which together with the creation of the aforementioned incentive programme, shall ensure that the following procedures are complied with:

– SCOPE OF FINANCIAL RESPONSIBILITY OF THE SNS HOSPITALS

a) Hospitals, Hospital Centres and Local Health Units shall assume all financial responsibilities for all surgical activities carried out by third-parties (other SNS hospitals or contracted entities) on users registered on their respective Surgical Waiting Lists, while fully respecting all established rules for the SIGASNS;

b) The aforementioned statement does not apply to public-private partnership (PPP) hospitals, or private hospitals with SIGA-SNS agreements from a surgical viewpoint;

c) Surgical activity to be contracted with hospital institutions should estimate the amount of surgical activity that is likely to occur internally in addition to the surgical activities specified on the Surgical Waiting Lists, and which may be carried out by third-parties in the event that the Hospital in question cannot perform such surgery within a Guaranteed Maximum Response Time;

d) Surgical activity to be carried out by a hospital of destination, through issuance of a Transfer Note originating from another SNS hospital (transferred in accordance with SIGA SNS rules), will not be covered by the Contract-Programme, and shall be classified as an extra Contract activity and income on the part of the hospital of destination, to be subsequently invoiced by this entity, on a monthly basis, to the ACSS under the terms described in the following points:

- CONTRACT PRICES

e) The activity registered in the Contract-Programme is contracted in accordance with the standard payment methodology (equivalent patient *CMI* unit price/line of production);

f) The performed activity is carried out and classified as Contract-Programme extra income in relation to the hospital of destination, which shall be invoiced at the value of the Homogeneous Diagnostic Group referred to in the Decree that establishes the in-force price table specified in the Integrated Access Management System (SIGA), from a surgical perspective, and in accordance with the rules contained within.

- CIRCULATION OF USERS WITHIN THE INTEGRATED ACCESS MANAGEMENT SYSTEM (SIGA), AND FROM A SURGICAL PERSPECTIVE

g) The circulation of users is governed by the standards and procedures established within the SIGA SNS system;

h) Transfer to SNS institutions shall take place after three months, with standard priority;

- INVOICING OF THE ACTIVITES CARRIED OUT BY THE HOSPITALS OF DESTINATION

i) The activities carried out by the hospitals of destination included in the SNS shall be directly invoiced to the ACSS, beyond the scope of the Contract-Programme of these entities;

j) Activities carried out by contracted entities shall be invoiced directly to the hospital of origin;

k) Hospitals of origin, within their Contract-Programmes, shall not invoice for activities carried out at Hospitals of public destination with the aim of securing transfer notes, with this invoiced amount being deducted from the maximum value of the respective annual Contract-Programme;

l) Hospitals of origin, within their Contract-Programmes, shall not invoice for activities carried out at contracted hospitals of destination with the aim of securing surgery vouchers, with this invoiced amount being deducted from the maximum value of the respective annual Contract-Programme, adjusted by 10%.

- FINANICIAL FLOW DUE TO PATIENT TRANSFER TO ANOTHER SNS HOSPITAL, AS ESTBLISHED IN THE SIGA SYSTEM, FROM A SURGICAL POINT OF VIEW

m) The SNS hospital of destination, after conclusion of the healthcare process, shall invoice the ACSS for all provided healthcare services, for the amounts listed in accordance with the current price table;

n) The ACSS shall invoice the hospital of origin in relation to the outstanding Contract-Programme monthly

instalments owed to the hospital of destination, which shall then be used to pay the hospital of destination in return;

- FINANICIAL FLOW DUE TO PATIENT TRANSFER TO A CONTRACTED INSTITUTION, AS ESTBLISHED IN THE SIGA SYSTEM, AND FROM A SURGICALPOINT OF VIEW

o) The contracted entity shall invoice the hospital of respective origin for all carried out surgical procedures, at the prices listed in the SIGA SNS table, from surgical perspective.

The competitive mechanism for the carrying out of surgical activities within the SNS shall be improved for the 2017-2019 triennium, by progressively replacing the transfer note concept between SNS hospitals to the SNS "Transfer of Responsibility" concept, including the full transfer of relative responsibility for the entire therapeutic plan, plus all examinations, appointments and treatment that may be necessary before or after surgery.

4.4.1.3. MEDICAL AND SURGICAL OUTPATIENT SERVICES

As explained for the inpatient process for acute patients, the medical and surgical outpatient areas shall be grouped into All Patients Refined (APR) Homogeneous Domestic Groups, adopting an up-to-date CMI adjusted to the production levels of 2015.

With the objective of promoting outpatient surgical activity, the relative weight of this activity is equal to the type of activities conducted in an inpatient system.

4.4.1.4. EXTERNAL APPOINTMENTS

Activities carried out at external appointments are dependent on the type of services provided by each institution. In 2017 it shall be possible to record the complexity of the conditions treated during external appointments through a computerised system, after the project to assign diagnostic codes to external and emergency appointments (ACODCEU) has been fully implemented throughout the SNS.

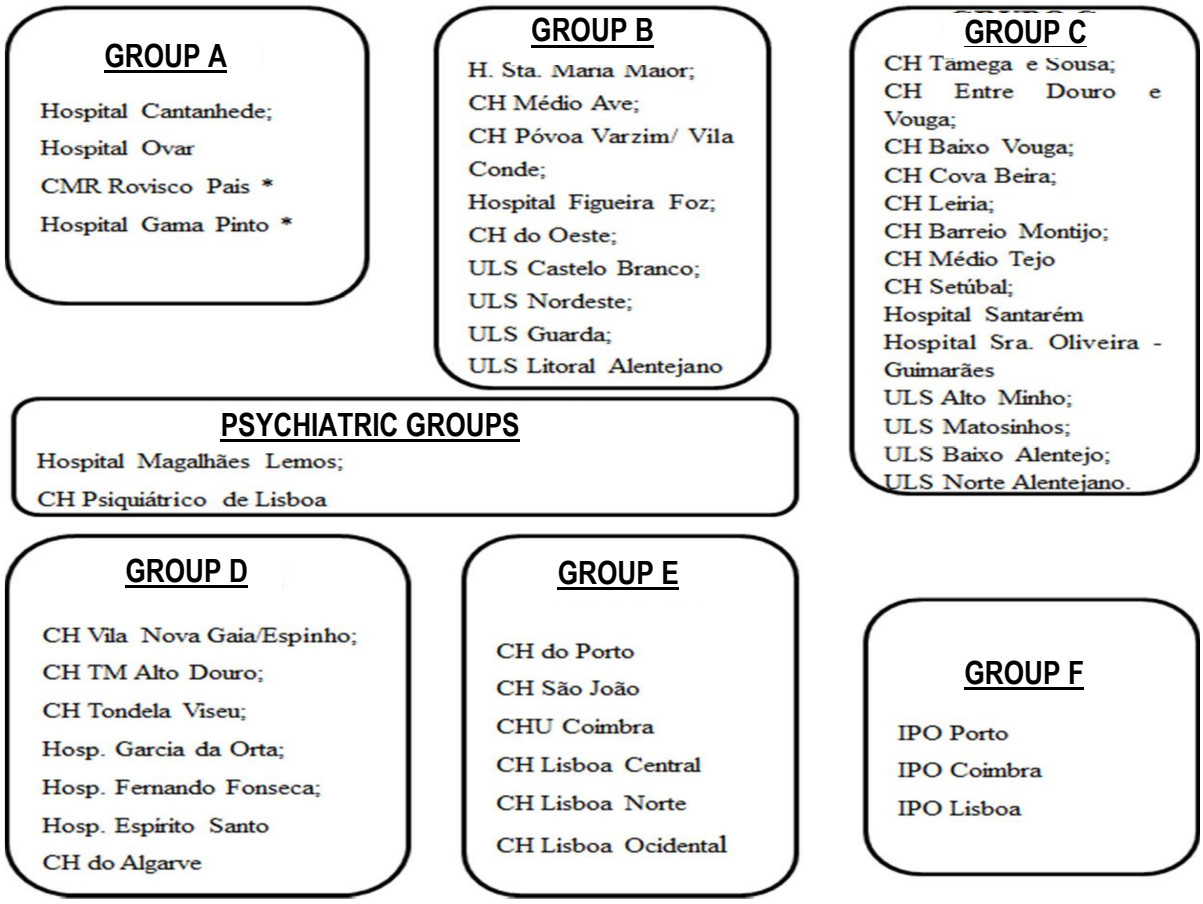
The LAC principle for user access to primary hospital speciality appointments will be fully implemented in 2017, referenced by primary care, and introduced by Ordinance no. 5911- B/2016, making it possible for SNS users, in conjunction with the family doctor responsible for the referral process, to choose any SNS hospital for the carrying out of a speciality hospital appointment or consultation, in addition to having information available on:

- SNS hospital institutions available for specialist appointments;
- Average response times for the primary hospital appointments, by priority;
- Average response times for scheduled surgery, by priority;
- The distance in kilometres between the family doctor unit and the SNS hospital.

The payment for hospital appointments, in addition to activities resulting from user monitoring services, are established in the Contract-Programme, as well as being established on a yearly basis between the SNS hospital institution and the Regional Health Administration of the area of influence.

In addition to changes being made to the circulation of SNS users, with a view to establishing a closer price in

relation to the prices charged by each institution, the process of grouping entities into seven different financing groups shall be maintained for 2017 based on the following heterogeneous typology of services:



Note: The Gama Pinto Institute and Hospital Rovisco Pais are specialist hospitals.

A rule shall be applied in 2017 that associates the payment for doctor's appointments in accordance with the Subsequent Consultation Index, which shall be presented as a promoter of efficiency and clinical practice which makes it possible to monitor patients at the most appropriate healthcare levels. Application of this index inhibits the invoicing of subsequent appointments or consultations, which may result in payment overruns.

The amount defined for each of the hospital groups is the median of the values registered in relation to the cost of subsequent consultations and the very first consultation/appointment over the last five years, shown as follows:

Subsequent Consultations / First Consultations	Group A	Group B	Group C	Group D	Group E	Group F
- C/ Based on the median values over the last five years * -						
Value of the 2nd Quartile (Median)	1,27	2,18	2,31	2,32	2,97	4,37
Value of the 1st Quartile (Efficient)	1,09	1,79	1,90	2,22	2,94	3,38

* 2011 to 2015

The *Subsequent Consultation Index* is not applied to Group F for 2017 due to high rates of annual variation and disparity of values between Hospitals belonging to the Group.

Also encouraged for 2017 is the implementation of measures that connect SNS institutions and professionals involved in the access management of hospital appointments and consultations, with emphasis on cross-over measures at national level such as the implementation of dermatological tele-tracking, or the tracking of diabetic retinopathy, in ophthalmology.

Additionally, this is encouraged by financing the adoption of local solutions that contribute to improvements in response times, signifying that the first consultations referred by the primary healthcare scheme through the SNS SIGA system, shall have prices increased by 10% in 2017.

Additionally, real-time, scheduled or urgent medical tele-consultations shall also be increased by 10% in 2017, irrespective of being first of subsequent consultations. Of particular relevance, please note that access criteria based on areas of SNS user residence are not applicable in this instance, i.e. payments for tele-consultations are not associated with the area of residence of SNS users. In compliance with the National Mental Health Programme, psychiatric appointments taking place in the community shall also be increased by 10%, irrespective of whether they are first or subsequent consultations.

Close monitoring of activities related to the "discharge of external consultations" shall also take place in 2017 in order to facilitate the transfer of health services to more appropriate levels, in addition to obtaining more information on the monitoring practices of patients in hospitals.

External Appointments	Price EUR
Group A	35.00
Group B	38.00
Group C	42.00
Group D	65.00
Group E	68.00
Group F	102.00
Psychiatric Hospitals	94.00

4.4.1.5. DECENTRALISED HOSPITAL APPOINTMENTS IN PRIMARY HEALTH SERVICES

The carrying out of speciality hospital medical appointments in primary healthcare services, contributes to an increase in the accessibility of patients in relation to health services, in addition to encouraging communication between SNS institutions, promoting greater user proximity and the effective continuity of healthcare services.

This is a solution that should be expanded in terms of certain specialities (such as mental health, ophthalmology, obstetrics, paediatrics, physical medicine and rehabilitation, for example) as well as in specific geographic areas, while continuing to remain in full compliance with well-defined clinical protocols so that this line of activity can be introduced accordingly in 2017.

Decentralised Hospital Appointments	Price
First and subsequent appointments	Group price, with increase of 10%

4.4.1.6. EMERGENCY HEALTH SERVICES

For 2017, seeking to ensure that the financing of services which comprise the Emergency and Urgency Network become an inducing factor in terms of communication and coordination between providers of healthcare services in the SNS, in addition to ensuring that the population receives an adequate and timely response, while appreciating the quality of provided services and the results achieved, while also making sure that payment of the Multipurpose Emergency Services (SUP), the Medical-Surgical Emergency Services (SUMC) and the Basic Emergency Services (SUB) are affected in accordance with the following three components:

- A fixed value component, based on service availability within the three emergency typologies;
- A value component based on performance, measured through healthcare access and quality indicators within the Emergency Service.
- A variable value component, based on marginal and unexpected activity that might be necessary.

- FIXED VALUE COMPONENT

Payment for service availability corresponding to a fixed amount, with the aim of covering the efficient costs in relation to the installed capacity of the Emergency Service, in accordance with the emergency typology and the expected level of healthcare activity, as well as taking into account the structure defined for the respective Emergency Service and the average and expected healthcare values for each typology, in accordance with the productive and historic capacity of the realised activity.

- VALUE COMPONENT BASED ON PERFORMANCE

In 2017, the award of 5% of the fixed value component shall be dependent on the evaluation of indicators, done so through the Emergency Service Performance Index, calculated according to the technical guidelines of the Index, and applied in terms of the evaluation of the global incentives of the Hospital contract-programme, as follows:

- Weight of the emergency episodes with attributed green/blue/white priority
- Weight of the emergency episodes with hospital internment
- Weight of frequent users (>4 episodes), in the total number of Emergency Service Users
- Ratio between external appointments / emergency episodes.

- VARIABLE VALUE COMPONENT

The variable value component corresponds to activity that may become necessary in addition to the expected and desirable contracted values, and shall be paid a marginal price in return. Payment for this variable component is associated with the degree of compliance of the indicator that comprises incentives, i.e. the degree of compliance of the goal defined for the indicator classed as the "Percentage of emergency episodes attended to within the waiting time established within the screening protocol"

Other healthcare access and performance indicators will also be monitored in 2017:

- Length of stay after the 1st medical observation, until discharge to the outpatient clinic;
- Length of stay after the 1st medical observation, until discharge into the inpatient system;
- Abandonment rate of the Emergency Service, by screening of colour priority;
- Rate of patients who remain in the Emergency Service for a period of >6 hours.

As a result of the herein referred to method of payment, the prices to be paid in 2017 are as follows:

Emergency Service Typology	Expected Average Volume of Activity	Service availability (Benchmark = 1)*	Variable component price (marginal price)
Basic Emergency Service	35,000 episodes	1,400,000 EUR	1 EUR
Medical-Surgical Emergency Service	100,000 episodes	5,000,000 EUR	5 EUR
Multipurpose Emergency Service	170,000 episodes	17,000,000 EUR	10 EUR

* 5 % of the available service amount shall be dependent on fulfilment of quality indicators

These values represent the expected average activity for each Emergency Service typology, taking into account the offer structure defined within the Emergency and Urgency Network and the amount of financing that should be awarded to each institution in 2017, at a fixed value component corresponding to the application of an index that, in turn, positions each one of the Services in relation to the average values.

– DEDICATED PILOT MANAGEMENT EXPERIENCES OF THE EMERGENCY SERVICES

Pilot-experiences shall be developed in 2017 for the operational reorganisation of the Emergency Services, particularly the São João Hospital Centre (CHSJ), the Occidental Lisbon Hospital Centre (CHLO) and the Leiria Hospital Centre (CH Leiria), among others to be identified by the respective Regional Health Administrations, aimed at improving management autonomy, the maximisation of resources, healthcare optimisation and decision-making processes, in addition to full compliance with Emergency Services response times.

These pilot-experiences shall adopt specific organisational and operational characteristics of the Emergency Services which shall be adapted to the specific conditions of each institution, and which generally comply with the following essential guidelines:

- Autonomous structure (approaching the operating philosophy of the Integrated Responsibility Centres [CRI]), in addition to having a clear mission and objectives, specific self-allocated human resources, appropriate logistical resources, a strong culture and organisational ethics component, and a built-in sustainability guarantee;

- Optimisation of patient flow and organisation of all circuits and spaces in accordance with the clinical situation of the patients (separation of acute patient flows / urgent exacerbations of acute patients / non-urgent exacerbations, for example), or with an expected healthcare consumption need, seeking to reduce overcrowding or the saturation of healthcare resources, and thus contribute to improvements in the accessibility and quality of the undertaken health related activity;

- Financial compensation paid to teams and professionals in accordance with performance;

- Communication with the response structures and mediums in pre-hospital situations of emergency;

- Compliance guarantee of the algorithms and indicators of the green paths;

- Appropriate response time guarantee for critical and urgent patients in terms of medical observation, care and decision;

- Interaction and sharing of primary health services, with National Network of Integrated Continued Care (RNCCI) responses, or responses from the Social Sector and the Community in terms of the prevention of urgent situations, response and care, and the continuity of healthcare.

4.4.1.7. ECMO

The transplantation of donor organs for situations of cardiocirculatory arrest requires the adoption of anticipatory organic preservation/support measures in order to minimise the deleterious effects of hot ischemia due to circulatory arrest.

The operationalisation of a donor organ collection programme for non-controlled circulatory arrest assumes the existence of all necessary technical and human resources on the part of the institution in question.

The following factors need to be considered:

i) the need to increase the number of organs available for donation and, subsequently, the number of transplants which take place in Portugal; ii) the need to strengthen the speed and coordination of ECMO related response times; iii) improved strategic convergence to strengthen the response in relation to extra-hospital cardiocirculatory arrest situations and the gathering of donor organs for instances of non-controlled cardiocirculatory arrest.

A specific payment mode has been created for 2017 for the pre-hospital emergency integration project-pilot, with ECMO centre for health assistance in instances of refractory extra-hospital cardiocirculatory arrest, with involvement of the ECMO Centre of the São João Hospital Centre, the Emergency Medical and Resuscitation Vehicle (VMER) of the São João Hospital Centre, the Porto Hospital Centre, the Vila Nova Gaia Hospital Centre, and the Matosinhos Local Health Unit.

4.4.1.8. DAY HOSPITAL SESSIONS

Three typologies shall be taken into account in terms of day hospital sessions: (a) day hospital session; (b) psychiatric day hospital session; and (c) Haematological / Immunohaemotherapy day hospital session and socio-occupational units.

More specifically, all day hospital sessions are financed at base price, with specific prices being practised for Haematological / Immunohaemotherapy day hospital sessions, in the event that a minimum set of psychiatric day hospital session procedures are carried out.

Day Hospital Sessions	Price (EUR)
Base	20€
Psychiatry	30€
Psychiatry (Socio-Occupational Unit)	30€
Haematology	294€
Immunohaemotherapy	294€

4.4.1.9. RADIOTHERAPY SESSIONS

Payment shall be made for this activity in 2017 through differentiated prices for simple treatments (including simple treatment and 3D treatments) complex treatments (for special techniques, corporal and hemicorporeal irradiation, and IMRT treatments), with continuity being given to recommendations from the Work Group consisting of public hospitals (which have these components) and the ACSS, with the additional proviso that

these treatments should have an autonomous line of activity.

Radiotherapy Sessions	Price (EUR)
Simple treatment price	105€
Complex treatments	251€

4.4.1.10. HOME CARE

In 2017, appreciated value of home care activities shall be carried out in two distinct lines of production:

4.4.1.10.1. HOSPITAL ACTIVITIES AT HOME

Corresponding to the home care based service provided by hospital professionals, needing to be applied as priority to healthcare provided to patients in the areas of mental health and ventilated health, while remaining at the discretion of the ARS whether to include other types of patients.

Home Care Service	Price (EUR)
Home-based appointments	**38 €**

4.4.1.10.2. DOMICILIARY HOSPITALISATION

Both the family and the community must be active SNS partners, not only to avoid unnecessary hospital service stays on the part of the patient for reasons unrelated to their conditions of health, but also to enhance a speedy return to active life, and also to reduce hospital-acquired infections which have a very high level of incidence in Portugal in comparison to other countries.

In this context, the creation of domiciliary hospitalisation integrated into the SNS is encouraged, centred on the needs of SNS users, which thereby ensures a safe and appropriate response to situations of acute illness, in addition to ensuring the continuity of primary healthcare services in relation to the National Network of Integrated Continued Care (RNCCI).

This form of hospitalisation is very diverse in terms of home care related responses and the levels of social support already implemented within the SNS, due to distinct focus on the acute phase of the illness and the high complexity and frequency of the clinical procedures practised, in comparison to other home care responses (namely primary healthcare) which are characterised by low-intensity periodic visits as an alternative to outpatient primary healthcare.

This home-based hospitalisation response must be applied, as a matter of priority, to certain types of eligible diseases - COPD, decompensated chronic heart failure, acute asthma, erysipelas and cellulitis, infections picked up within the community or at hospital, infections transmitted through MDR micro-organisms, types of pneumonia (aspiration, hospital and Community Acquired Pneumonia [CAP]), thromboembolic diseases, diverticulitis, febrile neutropenia - all adhering to patient inclusion and exclusion criteria, in addition to communication with the primary healthcare units, plus RNCCI responses with the social sector and society, in addition to appropriate control and assessment mechanisms.

	Price (EUR)
Domiciliary hospitalisation	No. of episodes * CMI Hospitalisation * 75% Price

*This price is added to the invoicing for the hospitalised production line, becoming applicable after discharge.

4.4.2. PROVIDING HEALTH SERVICES FROM A SPECIFIC HEALTH PROGRAMME PERSPECTIVE

4.4.2.1. PRE-NATAL DIAGNOSIS PROGRAMME

The Pre-Natal Diagnosis line of activity outlines the use of reference centres for the monitoring of pregnant women attended to at health centres, through an ultrasound at the 14th week of pregnancy in unison with biochemical screening for the first quarter (Protocol I) and/or ultrasound of the 22nd week of pregnancy, followed by hospital appointment (Protocol II) for the purposes of ensuring suitable technical responses in relation to preparation of the pre-natal diagnosis.

Pre-Natal diagnosis	Price (EUR)
Protocol I	38 EUR
Protocol II	65 EUR

4.4.2.2. PROGRAMME FOR MEDICALLY ASSISTED PROCREATION (MAP)

Infertility, now recognised as a disease, has gained increasing importance in terms of being a social and health-related problem, and is estimated to affect around 15% of all couples in the western world[2]. In Portugal, the prevalence of lifetime infertility is 9 to 10%, with differences between regions remaining unverified.

Law no. 17/2016, of 20th June 2016, increases the scope of users entitled to receive MAP techniques, to all women, representing a full strengthening of the MAP programme within the SNS.

Classified as an area of priority in terms of health service policy, a specific Health Programme has been

[2] A. Templeton. Infertility and the establishment of pregnancy overview. Br Med Bull 2000;56(3):577-87.

implemented for 2017 for the purposes of improving access to infertility diagnosis and treatment, involving EPE and SPA hospitals belonging to the SNS, and established in conjunction with the ACSS and the Directorate-General for Health, which encompasses the comprehensive financing of all treatments associated with problems of infertility, in addition to all associated medical activities.

Programme for Medically Assisted Procreation	Price (EUR)
Financing of Primary Medical Appointments in support of fertility	88€
IO financing cycles	133€
IIU financing cycles	335€
FIV financing cycles	2.098€
ICSI financing cycles	2.308€
ICSI financing cycles with surgically removed spermatozoids	2.937€

4.4.2.2.1. GAMETE BANKS

Two specific lines of activity have been created for the Contract-Programme in 2017, aimed at financing Gamete Bank activity within the SNS, located in the Hospital Centre of Porto (CHP) and at two affiliated centres located in the Lisbon Central Hospital Centre (CHLC) and the Hospital Centre and University of Coimbra (CHUC). The CHP Gamete Bank, being responsible for the global management of Gamete stock, ensures a continued level of stock diversity with greater response capacity in relation to various criteria (race, blood type, etc.) and greater randomness and lower risk in terms of the use of gametes, with the Affiliated Centres permitting increases in terms of collection capacity.

Gamete Bank	Price * (EUR)
Collection of Male Gametes	1.405€
Collection of Female Gametes	2.097€

*The price to be paid to the CHP shall be increased by 20% for the streamlining and management of the SNS Gamete Bank.

Overall payment for this activity is dependent on the response capacity of the three Centres in terms of contracted volunteers, in addition to the way that collections are handled and the ensuing study of gametes, at an amount of 10% of the total annual amount of this line of financing, to be determined at the closure of final accounts.

4.4.2.3. PROGRAMME FOR REDUCTIONS IN THE RATE OF CAESAREAN SECTION

The National Committee for Reduction in the Rate of Caesarean Section (CNRTC) believes that it is possible to

establish goals in terms of the rate of caesarean sections taking place at SNS hospitals, including any impacts in terms of hospital financing, without such measures resulting in increased health risks to SNS users - an aspect that must continue as first priority when making clinical decisions.

The carrying out of a caesarean section can bring unequivocal health benefits to the pregnant woman and her baby, but abusive use of such a practice, without clinical motives, can result in increased risks to both the mother and baby.

Within a CNRTC framework, receipt of treatment due to episodes of hospitalization involving caesarean section (x) are indexed at caesarean rate, in accordance with the following formula:

Caesarean rate

Perinatal support hospitals	Differentiated perinatal support hospitals
< 25.0% = value x	< 27.0% = value x
25,0% - 26,4% = 0.75 value	27.0% - 28.4% = 0.75 value x
26.5% - 27.9% = 0.50 value x	28.5% - 29.9% = 0.50 value x
28.0% - 29.4% = 0.25 value x	30.0% - 31.4% = 0.25 value x
> 29.5% = no financing	> 31.5% = no financing

For hospitals with caesarean rates equal to, or greater than the maximum limits contained in the previous formula, the following alternative formula was applicable in 2016:

- Reduction in the rate of caesarean section < 5.0% = no financing
- Reduction in the rate of caesarean section of 5.0% - 7.4% = 0.25 × value x
- Reduction in the rate of caesarean section of 7.5% - 9.9% = 0.50 × value x
- Reduction in the rate of caesarean section of 10.0% - 12.4% = 0.75 × value x
- Reduction in the rate of caesarean section > 12.5% = value x

Although this has no direct impact on hospital financing, the ACSS discloses information on the «Monitoring of the National Health Service» microsite and on the SNS Portal regarding the "Obstetric care quality indicators" of each SNS hospital, in order to inform all Portuguese citizens about all existing practices related to childbirth.

4.4.2.4. ‘‘NASCER UTENTE" (BORN USER) PROGRAMME

Operationalisation of Ordinance no. 6744/2016, of 23rd May 2016, on the part of the Assistant Secretary of State and of Health, establishes that all provisions regarding the programme for administrative simplification under the National Program for Children and Young People's Health and the National Vaccination Program, which principally integrates the "Nascer Utente" (Born User) and "Notícia Nascimento" (Birth News) projects, determines that the production payment for childbirth episodes under the Contract-Programme shall, from 1st January 2017 onwards, depend on confirmed registration on the "News of Birth" platform.

4.4.2.5. VOLUNTARY INTERRUPTION OF PREGNANCY

Within the scope of sexual and reproductive health, Voluntary Interruption of Pregnancy is classified as a valid activity up until 10 weeks of gestation.

Voluntary Interruption of Pregnancy	Price (EUR)
VIP medication up to 10 weeks	283€
VIP surgery up to 10 weeks	369€

4.4.2.6. SURGICAL TREATMENT PROGRAM FOR OBESITY (STPO)

Surgical treatment for obesity is a valid therapeutic technique for a set of well-established situations, and is essential for ensuring full compliance in terms of appropriate response times.

This is a multidisciplinary approach involving gastroenterology teams, psychologists, psychiatrists, nutritionists and specialised surgeons, requiring specific treatment already in place at certain hospitals.

This reality, which takes into account increasing indications in relation to obesity techniques, leads to the definition of a specific funding program for this particular activity, to be integrated into the 2017 Contract-Programme, which aims to ensure timely access by the obese patient to quality health services for a period of time of no less than three years.

Institutions recognised by the Directorate-General for Health are covered by this Programme as treatment centres (TC) for the surgical treatment of severe obesity.

- PROCEDURES FOR SURGICAL TREATMENT OF OBESITY WITHIN THE PROGRAMME

Gastric band

Gastric bypass

- PROGRAMME PHASES AND PROVISIONS INCLUDED IN THE FINANCING PLAN:

Phase I - Pre-evaluation and bariatric surgery (preoperative appointment for multidisciplinary evaluation; Supplementary Means of Diagnosis and Therapy; intragastrical balloon; surgical intervention; complications for up to 60 days)

Phase II - First year of monitoring (two AMTCO appointments; Supplementary

Means of Diagnosis and Therapy)

Phase III - Second year of monitoring (two AMTCO appointments; Supplementary

Means of Diagnosis and Therapy)

Phase IV - Third year of monitoring (one or two AMTCO appointments; Supplementary Means of Diagnosis and Therapy)

- ACCESS TIMES

Pre-operation AMTCO appointment (first appointment) - 60 days

Bariatric surgery (priority level 1) - 270 days

- DEFINITION OF COMPREHENSIVE PRICES:

STPO – Phase I	Price * (EUR)
Gastric Band*	3.377€
Gastric Bypass*	4.295€

*Only Phase I applies in 2017 - pre-evaluation and bariatric surgery

4.4.3. PROVIDING HEALTH SERVICES TO PEOPLE WHO LIVE WITH CHRONIC DISEASES

The application of disease management models in Portugal requires the provision of health services in the most integrated manner possible, with the aim of ensuring that access to this form of healthcare is timely, carried out at the most appropriate levels possible, and takes place at health institutions that respond at the highest level of quality and effectiveness.

To promote these disease management models, the financing modality for the treatment of certain diseases has evolved into a model based on the "patient undergoing treatment" unit, which makes it possible to establish payment guidelines for the full resolution of health orientated problems, based on levels of risk and being subject to the full availability of health services. These modalities are characterised by their application to rare and onerous diseases, or to complex pathologies in which treatment requires transfer between multiple lines of activity, in which the "standardisation" or typifcation of the provided health services is possible.

A Medicine Management Platform is being put in place for 2017 with greater economic impact in terms of SNS costs (known as the M20 Platform), with many of these medicines being used in the treatment of chronic diseases. This platform gathers information reported by the hospitals from a National Hospital Medicine Code (CHNM) perspective, as developed by INFARMED and through the Electronic Medical Prescription in Hospitals (PEM-H) system, making it possible to monitor the uses of these hospital medicines in detail, not just by institution, but also by active substance, for example.

The obligation to identify users with chronic and rare diseases will also be strengthened in 2017, in addition to the updating of records on IT systems in terms of participative activities at hospital institutions (in the Rare Diseases Database, for example) in order to gauge the quality of provided healthcare and the effectiveness of currently in use therapeutic techniques within the SNS.

These payment modalities shall be applied in 2017 to the following treatment programmes:

4.4.3.1. TREATMENT PROGRAMME FOR PATIENTS WITH CSII DEVICES

In Portugal, the use of continuous subcutaneous insulin infusion (CSII) devices for the administration of insulin to

people with diabetes type I has enabled a significant improvement in metabolic control, in addition to reductions in serious hypoglycaemia and serious episodes of diabetic ketoacidosis (DKA).

Therapy through continuous subcutaneous insulin infusion, in addition to the characteristics of its use, relies on specific organisational conditions being set in place to ensure an effective experience through this type of therapy, which also requires the full involvement of all hospitals in this respect.

The National Programme for Diabetes, as a Directorate-General for Health activity, is responsible for defining the Treatment Centres (TC) and the inclusion priorities for users eligible for treatment through these CSII devices.

For 2017, and in full compliance with the provisions of Ordinance no. 13277/2016, of 28th October 2016, from the Assistant Secretary of State and of Health, this form of health provision shall be integrated into the hospital Contract-Programme, with additional contracting of Treatment Centres in accordance with the distribution of devices and the undertaking of benchmarking techniques and quality indicators defined by the National Programme for Diabetes (PND), utilising the following pricing scheme:

- **One price for a new patient in the Programme**, applicable to the first 12 months of patient treatment, including the following components:

- CSII device and respective consumables, for 12 months of treatment.
- All Supplementary Means of Diagnosis and Therapy, including regular monitoring of eligible patients in accordance with Directorate-General of Health defined protocols.

- **One price for follow-up patients**, after the first 12 months of treatment, including the following components:

- Consumables for 12 months of treatment;
- All Supplementary Means of Diagnosis and Therapy, including regular monitoring of eligible patients in accordance with Directorate-General of Health defined protocols.

Patient Treatment with CSII devices	Price/patient/month (EUR)
New Patients	225 €
Patients with follow-up treatment	100 €

4.4.3.2. OUTPATIENT TREATMENT PROGRAMME FOR PEOPLE WITH HEPATITIS C INFECTION

Hepatitis C is a rare disease that affects the liver, which is contracted through infection of the Hepatitis C virus, and can lead to cirrhosis, liver failure and cancer. Current forms of treatment for patients with chronic Hepatitis C requires access to therapies exclusively dispensed at hospital pharmacies, associated with high costs, and requiring the creation of a specific centralised financing programme for this particular disease to remunerate the hospitals that treat this disease through specific medicines stipulated by law. Institutions must observe all rules defined by INFARMED, on the Hepatitis C Portal, in order to be able to invoice the ACSS in terms of all

reimbursable costs.

4.4.3.3. OUTPATIENT TREATMENT PROGRAMME FOR PEOPLE WITH HIV/AIDS

This treatment programme involves the monitoring of patients and their subsequent commitment to therapeutic protocols technically recognised and identified by the National Programme for the Prevention and Control of the HIV Virus/AIDS. This programme takes into account all patients participating in antiretroviral therapy (ART), with the result and price per treated patient being established below.

Outpatient treatment for people with HIV/aids	Price (EUR)
Equivalent treated Patient / Year	9.166 €

The introduction of generic medicines and the centralised purchase of antiretroviral drugs is estimated to cause a significant reduction in the monthly cost of treatment through antiretroviral therapy. In order to promote more efficient drug and therapy usage in this area, the price per treated patient shall be applied as set out in the previous table, provided that the specified amount for the cost of medications per patient is lower than the amount corresponding to the average cost of medications of the Health Centre Group in which the hospital is located. The hospital shall be penalised per patient undergoing treatment in situations to the contrary, corresponding to 10% of the difference between the costs of medicines dispensed at hospital pharmacies, per patient, and the average cost of such medicines dispensed by the Health Centre Group to which the hospital belongs.

4.4.3.4. OUTPATIENT TREATMENT PROGRAMME FOR PEOPLE WITH PULMONARY ARTERIAL HYPERTENSION

Pulmonary Arterial Hypertension (PAH) is a syndrome characterised by increases in pressure to the pulmonary arteries, causing subsequent overloading of the heart which can result in the premature death of both paediatric and adult patients.

Treatment currently available for PAH requires access to innovative and expensive therapies, making it necessary to create a specific financing programme for this disease, aimed at promoting the quality of life in all patients and providing them with timely access to respective therapies. Additionally, criteria for the treatment of patients should be unambiguously established due to the reduced number of adult patients, in addition to appropriate treatment centres being identified for monitoring and subsequent tracking of patients with this disease.

The payment modality for 2017 establishes a price for each treated patient on a monthly basis, for the following three stages of the disease in adults: (a) follow-up treatment for the first year; (b) follow-up treatment after the first year CF<=III; c) follow-up treatment after the first year CF IV, as detailed in the following table:

Outpatient treatment for people with pulmonary arterial hypertension	Price
Follow-up treatment for the first year (treated patient/Eq. Year)	8,408 EUR
Follow-up treatment after the first year CF<=III (treated patient Eq. Year)	22,555 EUR
Follow-up treatment after the first year CF IV (treated patient/ Eq. Year)	162,563 EUR

The following indicator has been devised to promote the rational use of therapies:

- % use of bosentan (DDD) in the total quantity of medications for PAH (DDD) dispensed at outpatient hospitals

In the event that the indicator is below the national average registered for the year, a penalty of 1% shall be imposed on the value of the medication charges for PAH (for drugs dispensed at hospital pharmacies and drugs consumed at the hospital). The observed amounts shall be assessed at the end of the year by INFARMED.

4.4.3.5. OUTPATIENT TREATMENT PROGRAMME FOR PEOPLE WITH MULTIPLE SCLEROSIS

Multiple Sclerosis (MS) is an inflammatory, chronic and degenerative disease that affects the central nervous system, and is classified as one of the most common causes of incapacity through neurological disease currently affecting young adults. Available treatment for patients with Multiple Sclerosis requires access to innovative therapy involving the modification of the natural history of the disease (immunomodulators), exclusively dispensed at hospital pharmacies, and associated with very high costs.

The payment modality for 2017 established a monthly price per treated patient, consisting of patients undergoing treatment throughout various phases of the disease: (a) EDSS<3.5 with up to one outbreak per year; (b) EDSS<3.5 with up to two outbreaks per year; (c) 4<EDSS<6.5; d) 7<EDSS<8. Institutions with more than 150 patients receiving treatment shall be eligible for such payments in 2017, and shall demonstrate to the ACSS, in conjunction with the respective Regional Health Administrations, that they are willing to voluntarily comply with this payment modality.

Outpatient treatment for people with multiple sclerosis	**Price**
Treated patient/Eq. Year	12,380 EUR

4.4.3.6. TREATMENT PROGRAMME FOR PATIENTS WITH ONCOLOGICAL PATHOLOGY

Cancer is the main cause of death before the age of 70 and, in terms of all causes of death in all age groups, occupies second place behind cerebro-cardiovascular diseases.

4.4.3.6.1. ONCOLOGICAL PATHOLOGY OF THE BREAST, CERVIX, AND COLON AND RECTUM

The payment modality for oncological diseases establishes a price per patient treated/month, over a 24-month treatment period, with three different pathologies being taken into account: breast, cervix, and colon and rectum.

The following seven institutions shall be eligible for this treatment programme in 2017 (except for colon and rectum treatment, which shall be available at SNS Reference Centres [CRe]): Portuguese Institute of Oncology of Porto, Coimbra and Lisbon, CHSJ, CHUC, North Lisbon Hospital Centre (CHLN) and the Espírito Santo Hospital in Évora.

In the event of positive indication, breast reconstruction and reconstruction of intestinal transit are included.

Treatment of patients with oncological pathology	Price (EUR)
Cancer of the colon and rectum (first year) (patient treated/Eq. Year)	13.237 €
Cancer of the colon and rectum (second year) (patient treated/Eq. Year)	4.957 €
Breast (first year) (treated patient/ Eq. Year)	11.149 €
Breast (second year) (treated patient/ Eq. Year)	4.822 €
Cervix (first year) (treated patient/ Eq. Year)	10.631 €
Cervix (second year) (treated patient/ Eq. Year)	2.531 €

For the purposes of monitoring this payment modality, information shall be gathered through the National Cancer Registry for full evaluation of the results of this programme, in addition to the application of the penalties described in point 4.4.9 of this document.

4.4.3.7. PROGRAMME FOR PATIENTS WITH STAGE 1 FAMILIAL AMYLOID POLYNEUROPATHY (PARAMILOIDOSIS)

Familial Amyloid Polyneuropathy (FAP), also known as Paramiloidosis, is a rare hereditary disease caused by a genetic mutation associated with transthyretin protein, including the subsequent deposit of an amyloid substance into the tissues which provokes a degenerative neurological impairment, in addition to causing cardiac, nephrological and ophthalmic attack.

Liver transplant significantly improves the chances of survival among patients with FAP, and has been the treatment of choice of such patients for many years.

Patients can only be treated under the Programme based on the availability of the Tafamidis drug for stage 1 Familial Amyloid Polyneuropathy (PT-FAP1) at the CHLN and CHP institutions, or at other reference centres to be established in the future for the treatment of this disease. Treatment, under no circumstances, shall involve the doubling up of patients in receipt of the Tafamidis drug.

Treatment of patients with paramiloidosis	Price (EUR)
Patients with paramiloidosis/Eq. Year	58.359 €

4.4.3.8. TREATMENT PROGRAMME FOR PATIENTS WITH LYSOSOMAL STORAGE DISEASES

The diagnosis complexity of genetic diseases from the group of lysosomal storage diseases requires recourse to a set of highly specialised laboratory techniques. In this respect, treatment not only requires correct diagnosis, but also exhaustive clinical study on the part of specialists who are capable of standardising conditions of prescription.

Treatment Centres shall continue to remain in place for the treatment of LSD in 2017, and shall remain in close affiliation with the existing patient treatment centres, in addition to being dependent on Reference Centre guidelines from a clinical and technical point of view, with prescriptions taking place in 2017 through the Medical Electronic Prescription (MEP), with usage registration being recorded on an electronic platform under the scope of the Coordinating Committee for the Treatment of Lysosomal Storage Diseases (CCTLSD):

Treatment of patients with lysosomal storage diseases	Price (EUR)
FABRY financing (Eq. year)	158.685 €
POMPE financing (Eq. year)	244.106 €
GAUCHER financing (Eq. year)	190.617 €
NIEMANN-PICK financing (Eq. year)	39.652 €
MPS I - Hurler financing (Eq. year)	193.797 €
MPS II - Hurler financing (Eq. year)	313.750 €
MPS VI – Marouteaux Lamy financing (Eq. year)	348.669 €

4.4.3.9. PROGRAMME FOR PLACEMENT OF COCHLEAR IMPLANTS

The cochlear implant is an electronic device that works in place of the cellular functions of the inner ear, for people with profound deafness who gain no benefit from the use of hearing aids. The cochlear implant is currently the only auditory rehabilitation method that enables a profoundly deaf person (child or adult) to acquire or reacquire auditory capacity, and thereby develop verbal language as a form of communication. Clinical Guideline Standards are available from the Directorate-General for Health on the Tracking and Treatment of Deafness with Cochlear Implants at Paediatric Age, with payment modalities being established for 2017 per treated patient for cochlear implantation, specifically bilateral and simultaneous implantation at a paediatric age.

Programme for the placement of Cochlear Implants	Price
Unilateral Cochlear implant	18,750 EUR
Bilateral Cochlear implant	32,500 EUR

4.4.3.10. TELEMONITOING PROGRAMME FOR CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

One of the principal objectives in the treatment of COPD is the prevention of hospital readmissions, in addition to improving the likelihood of survival. Timely detection of acute symptoms enables hospitals to identify potential complications at an early stage, before any serious consequences in terms of the prognosis and associated costs of these patients.

A payment modality has been implemented for 2017 for the remote monitoring of COPD patients who adhere to a pre-established home-based protocol in accordance with the inclusion criteria and objectives defined for this Programme. The institutions included in this Programme are defined by the respective Regional Health Administrations, in conjunction with the ACSS, with the prices to be practised in 2017 being established as follows:

Treatment of PPT-COPD patients	Price (EUR)
COPD financing (Telemonitoring elements)	1.296 €
PPT-COPD financing (Patient Eq. Year)	2.053 €

4.4.3.11. TELEMONITORING PROGRAMME FOR POST ACUTE MYOCARDIAL INFARCTION (AMI) STATUS.

Similarities between COPD and the adequate treatment and monitoring of AMI helps to reduce hospital readmissions and avoid hospital internments, in addition to improving the likelihood of patient survival.

Under these terms, a Telemonitoring Programme is scheduled for 2017 on the post-status of AMI, aimed at attaining objectives similar to those obtained for the programme described in the last section. The institutions included in this Programme shall be defined by the respective Regional Health Administrations, in conjunction with the ACSS:

Treatment of patients of post-status AMI	Price (EUR)
AMI financing (Telemonitoring elements)	3.391 €
Financing (Patient Eq. Year)	1.342 €

4.4.3.12. TELEMONITORING PROGRAMME FOR CHRONIC HEART FAILURE (CHF)

Similarities between COPD and AMI, in addition to the appropriate treatment and monitoring of CHF helps to reduce hospital readmissions and avoid hospital internments, in addition to improving the likelihood of patient survival.

Under these terms, a CHF Telemonitoring Programme is scheduled for 2017, aimed at attaining objectives similar to those of the programme described in section 4.3.3.10. The institutions included in this Programme are defined by the respective Regional Health Administrations, in conjunction with the ACSS, with the prices to be practised in 2017 being established as follows:

Treatment of patients with chronic heart failure	Price (EUR)
PPT-CHF financing (Telemonitoring Elements)	1.621 €
PPT-CHF financing (Patient Eq. Year)	1.342 €

4.4.3.13. MANAGEMENT PROGRAMME FOR MENTAL PATIENTS HOSPITALISED IN SOCIAL SECTOR INSTITUTIONS

The provisions addressing this Programme defined in Normative Circular no. 13/2014, of 6th February 2014, and Informative Circular no. 10/2014, of 31st March 2014, shall continue to remain in force throughout 2017

In terms of this Programme, the management of mental patients hospitalised in Social Sector Units is maintained through hospital institutions included in the Psychiatry and Mental Health Referral Network, with the institutionalisation of new patients being exclusively carried out by these institutions.

During 2017, referenced and provider services included in this Programme shall communicate in accordance with the administrative procedures and clinical referrals stipulated between each other, adhering to a conceptual framework that respects equity in terms of service access, appropriate for the evolution of clinical practices from a mental health perspective, ensuring agile and timely compliance with the referral and hospitalisation processes of these patients without neglecting issues of financial responsibility as explained in the Circulars.

4.4.4. PROVIDING HEALTHCARE IN REFERENCE CENTRES (CRE)

As established in Ordinance no. 3653/2016, of 7th March 2016, published by the Ministry for Health in the Official Gazette of the Portuguese Republic under reference no. 50/2016, on 11th March 2016, the constitution of the SNS Reference Centres is a process of the highest importance at both national and European level, for the provision of quality health services and for the overall prestige and competitiveness of the Portuguese Health System in relation to other Health Systems in the European Union, thus placing the national providers in a favourable position in terms of the European Reference Networks currently under creation.

Various Reference Centres have been identified in areas identified as priority:

Diploma (sets the specific criteria)	Areas of priority intervention	Pathologies/Procedures	Recognised Reference Centres
Notice no. 9657/2015, of 20th August 2015	Cardiovascular Diseases	"Structural intervention" cardiology	CHVNGE; CHSJ; CHUC; CHLC; CHLN; CHLO
Notice no. 9658/2015, of 20th August 2015	Cardiovascular Diseases	Congenital heart diseases	CHSJ; CHUC; CHLC; CHLO + CHLN + HCVP
Notice no. 8402-B/2015, of 27th July 2015	Rare Diseases	Familial paramiloidosis	CHP CHLN
Notice no. 9764/2015, of 20th August 2015	Rare Diseases	Hereditary metabolism diseases	CHP; CHSJ; CHUC; CHLN; H Guimarães[4]; CHLC
Notice no. 8402-N/2015, of 27th July 2015	Refractory epilepsy	Refractory epilepsy	CHP; CHSJ; CHUC; CHLN; CHLO + CHLC[3]
Notice no. 8402-F/2015, of 27th July 2015	Adult oncology	Cancer of the oesophagus	CHSJ; IPO Porto; CHUC; CHLN; IPO Lisboa; CHP
Notice no. 8402-G/2015, of 27th July 2015	Adult oncology	Testicular cancer	IPO Porto + CHP; CHUC; IPO Lisbon
Notice no. 8402-I/2015, of 27th July 2015	Adult oncology	Sarcomas of Soft Tissues and Bones	CHP; IPO Porto; CHUC; CHLN; IPO Lisbon
Notice no. 8402-O/2015, of 27th July 2015	Adult oncology	Cancer of the rectum	CHVNGE; CHP; CHSJ; H Braga; IPO Porto; CHUC; CHLC; CHLN; CHLO; Integrated Hospital Centre CUF Lisbon; H Luz; HFF; IPO Lisbon; H Loures; CHA; IPO Coimbra; HGO; H Santarém
Notice no. 8402-P/2015, of 27th July 2015	Adult oncology	Hepatobiliary/Pancreatic cancer	CHP; CHSJ; IPO Porto; CHUC; CHLC; CHLN; CHEDV; HFF; H Loures; CHL
Notice no. 8402-D/2015, of 27th July 2015	Paediatric Oncology	Haemato-oncological diseases; bone and cartilage tumours and other sarcomas, Wilms tumours;	Centro de Oncologia Pediátrica do Norte: IPO Porto + CHSJ; CHUC; IPO Lisboa +

		tumours of the Central Nervous System; neuroblastomas	CHLC[1] + CHLN[2]
Notice no. 8402-C/2015, of 27th July 2015	Onco-ophthalmology	Retinoblastoma and ocular melanoma	CHUC
Notice no. 8402-A/2015, of 27th July 2015	Transplant	Hepatic	CHP; CHUC; CHLC
Notice no. 8402-E/2015, of 27th July 2015	Transplant	Heart (paediatric age)	N/A
Notice no. 8402-H/2015, of 27th July 2015	Transplant	Heart (adults)	CHUC; CHLC; CHSJ; CHLO
Notice no. 8402-J/2015, of 27th July 2015	Transplant	Renal (paediatric age)	CHP; CHLN
Notice no. 8402-K/2015, of 27th July 2015	Transplant	Pancreas	CHP; CHLC
Notice no. 8402-L/2015, of 27th July 2015	Transplant	Renal (adult)	CHP; CHSJ; CHUC; CHLC; CHLO; CHLN
Notice no. 8402-M/2015, of 27th July 2015	Transplant	Lung	CHLC

Legend

Integrated Centre CUF Lisbon Hospital	Hospital CUF Infante Santo SA and Hospital CUF Descobertas
CHA	Hospital of Algarve, E.P.E.
CHEDV	Hospital Entre Douro e Vouga, E.P.E.
CHL	Hospital of Leiria, E.P.E.
CHLC	Central Lisbon Hospital Centre, E.P.E.
CHLN	Hospital Centre of North Lisbon, E.P.E.
CHLO	Occidental Lisbon Hospital Centre, E.P.E.
CHP	Hospital of Porto, E.P.E.
CHSJ	Hospital of São João, E.P.E.
CHUC	Hospital and University of Coimbra, E.P.E.
CHVNGE	Hospital of Vila Nova de Gaia/Espinho, E.P.E.
CNCR	National Committee for Reference Centres
IPO	Portuguese Institute of Oncology
H Braga	Hospital of Braga, P.P.P.
HCVP	Portuguese Red Cross Hospital
HFF	Prof. Doutor Fernando da Fonseca Hospital, E.P.E.
HGO	Hospital Garcia de Orta, E.P.E.
H Loures	Hospital Beatriz Ângelo, P.P.P.
H Luz	Hospital of Luz

Notes

1. IPO Lisbon + CHLC --> Paediatric Oncology
2. IPO Lisbon + CHLN --> Cent. Nerv. Sys. Tumours
3. CHLO + CHLC --> The CHLC in paediatrics
4. H Guimarães as RC for LSD only

Defined in areas in which Reference Centres (RC) have been accepted, the following groups have been established for contracting and financing purposes: (i) transplantation; (ii) oncology; (iii) rare diseases; (iv) other medical-surgical areas.

In instances where applications for institutional collaboration have been accepted, a principle has been established in which payment is made to the institution that concludes the patient treatment episode.

- GENERIC INCENTIVE PRINCIPLES

In 2017, the generic incentive principles in terms of activities carried out at the Reference Centres are established as follows:

- Increase of 10% in the price of consultations and appointments (first and subsequent) within the scope of Reference Centre activity;
- Reduction of 10% in the price of consultations and appointments (first and subsequent) carried out at other treatment centres in the areas of activity, to be determined at the time of invoicing and also included in the accounts settlement process;
- Increase of 5% for the medical and surgical Homogeneous Domestic Group production lines (hospitalisation and outpatient services) carried out at the Reference Centres, within the scope of this activity;
- Reduction of 5% in inherent activities for the medical and surgical Homogeneous Domestic Group production lines (hospitalisation and outpatient services) carried out at other treatment centres, within the scope of Reference Centre activity, to be determined at the time of invoicing and integrated into the accounts settlement process;
- Progressive elimination of payments for activities carried out by non-Reference Centre entities.

Based on some of the aforementioned groups having particular characteristics; specific and appropriate financing principles shall be defined in certain reference areas.

- TRANSPLANTATION

In addition to activities carried out in the areas included in the hospital Contract-Programmes, it should be noted that transplantation related incentives will be granted under the terms and conditions of Ordinance no.7215/2015, of 23rd June 2015. Financing in this area will take place in the following ways for 2017:

- Maintenance of current prices for transplantation related activities carried out at Reference Centres, for hospital Contract-Programme lines of activity;
- 5% reduction on activities carried out at centres which are not officially recognised as Reference Centres.

- ONCOLOGY AREA

In terms of oncology, and based on the existence of a relatively broad set of activities carried out across various Contract-Programme lines of activity, financing for 2017 shall comply with the following rules:

- Application of the aforementioned generic principles in all areas, except in instances of cancer of the rectum, which already has an agreed payment modality for patients treated in this area.
- 5% reduction on activities carried out at centres which are not officially recognised as Reference Centres.

- RARE DISEASES

In terms of rare diseases, payment modalities are already in place for patients treated at the two areas that have existing Reference Centres, based on the following:

- Maintenance of prices established for familial paramiloidosis, for approved Reference Centres;

- Maintenance of prices established for lysosomal storage diseases (included in Hereditary Metabolism Diseases), for approved Reference Centres;
- A 10% reduction on activities carried out at other treatment centres not officially recognised as SNS Reference Centres, either from a PT-FAP1 perspective, or in terms of lysosomal storage diseases.

- OTHER MEDICAL-SURGICAL AREAS

For all other areas (refractory epilepsy, structural intervention cardiology and congenital heart disease) there could exist, in a similar fashion to oncology, a relatively broad set of activities undertaken in relation to hospital Contract-Programme lines of activity. The generic incentive principles already mentioned in this chapter therefore apply to these areas.

4.4.5. PROVISION OF HEALTH SERVICES AT CENTRES OF INTEGRATED RESPONSIBILITY (CRI)

Pilot-projects will be developed in 2017 for subsequent integration into SNS Centres of Integrated Responsibility, enabling the internal reorganisation of hospital institutions, adapting them to modern conditions, making them more competitive in terms of the global market, and more effective in generating value for SNS users and for society in general.

The Centres of Integrated Responsibility shall preferably be included in hospital institutions with a high degree of technical and technological differentiation and specialisation, making the most out of speciality synergies and complementarity, while also providing citizens with timely and integrated responses.

In this respect, the constitution of a Centre of Integrated Responsibility aims to fulfil the following **specific objectives**:

i. Improve accessibility and response times for all SNS users;
ii. Increase efficiency and monetise the capacity already installed in terms of the SNS public network;
iii. Streamline expenses through reductions in costs incurred for non-SNS activities, bringing such activities into the fold of SNS healthcare provision;
iv. Contribute to increased complementarity and communication between different services and institutions;
v. Increase levels of productivity and satisfaction of all SNS professionals, and associating the award of institutional and financial incentives for effectively achieved levels of performance.
vi. Promote autonomy, including the involvement and levels of responsibility of healthcare professionals in the management of resources, while also providing them with incentives to exclusively develop their activities within the SNS;
vii. Encourage a healthy competition model between all SNS services and institutions.

The Centres of Integrated Responsibility shall implement a work model dedicated to production, training and research, as well as contracting basic and additional production services, in addition to creating payment

mechanisms for performance related activities that contribute to improvements in productivity and reductions in SNS response times.

Healthcare services will be provided at the Centres of Integrated Responsibility at extremely high levels of access, quality, effectiveness and efficiency, with all internal activities being remunerated in the same way as the generic incentive principles for activities conducted at the Reference Centres, specifically in terms of:

- A 10% increase in the price of consultations and appointments (first and subsequent) carried out at the Centres of Integrated Responsibility;
- A 5% increase in medical and surgical Homogeneous Domestic Group production lines (hospitalisation and outpatient services) carried out at the Centres of Integrated Responsibility;
- Application of the prices contained in the SNS table for the invoicing of third-parties (specifically to the ARS for Supplementary Means of Diagnosis and Therapy, and to other hospitals under applicable terms and conditions) for non-billable activities under the scope of the Contract-Programme (extra income Contract, obtained through the Credit and Debt Compensation System between SNS entities, created through the SNS SIGA system, through Ordinance no. 49/2016, of 19th May 2016, issued by the Secretary of State for Health).

4.4.6. PROVISION OF HEALTH SERVICES TO PATIENTS BEING MONITORED BY SPECIFIC PALLIATIVE CARE TEAMS

The provision of health services to patients with serious and/or advanced and progressive diseases, with the aim of promoting their well-being and overall quality of life, is an essential qualitative element of the current health system, aimed at ensuring appropriate levels of development continuity of health services, based on the principles of equity and universal coverage.

The National Network of Palliative Care was created for the purposes of putting this concept into operation, being fully integrated into the SNS and implemented at all healthcare levels, enabling equity in terms of access to quality palliative health services, appropriate in terms of multidimensional requirements (physical, psychological, social and spiritual) and for the preferences of SNS patients and families, in addition to the development of the Strategic Plan for the Development of Palliative Care for the 2017-2018 biennium, presented by the Portuguese National Council for Palliative Care (NCPC).

In terms of this strategy, all SNS hospitals must now have an Intra-Hospital Support Team for Palliative Care for the 2017-2018 biennium, with hospitals from the E and F groups needing to have Reference Palliative Health Services at the minimum, plus an inpatient unit (Palliative Healthcare Unit [UCP]), intra-hospital palliative care support teams (EIHSCP), plus external appointments, day hospital sessions and home-based appointments, in the event that the regional Health Centre Groupings (ACES) do not have a Community Support Team in Palliative Care (ECSCP).

- INTRA-HOSPITAL PALLIATIVE CARE SUPPORT TEAMS (EIHSCP)

The EIHSCP is a specific multi-disciplined team for the provision of palliative care, which carries out its duties by providing advice to the entire hospital structure at the hospitals where they are integrated. The EIHSCP must develop a palliative healthcare consultation service and a suitable day hospital response system (enabling therapeutic procedures to be performed, such as the correct administration of drugs, the application of dressings, paracentesis procedures, etc.) and thereby ensuring that patients who have been released from hospital or referred to other primary healthcare teams, at other hospitals within the National Network of Integrated Continued Care (RNCCI), are still monitored. The carrying out of scheduled and non-scheduled appointments must be coordinated, providing SNS users with specialised access in situations of crisis, and avoiding the use Emergency Services. The EIHSCP teams must provide patients, families, caregivers and healthcare professionals with a telephone support service. In situations where there is not an ECSCP community support team in the area, the EIHSCP team must extend its consulting activities to healthcare professionals from the primary healthcare system, as well as RNCCI Teams/Units from the institutional areas of influence.

- PALLIATIVE CARE UNITS (UCP)

The Palliative Care Units are specific palliative care services operating at hospital units in their own health service areas through utilisation of their own resources, consisting of nurses and doctors employed to monitor patients with more complex palliative necessities, in situations of clinical decompensation or social emergency, at the utmost levels of caregiver urgency and attention. The number of beds must be adapted to the estimated needs of the population served by the unit, in addition to the structural conditions of the institutions in which they operate. Palliative Care Unit services will vary depending on the pathologies being treated (e.g. oncological, neurological, HIV/AIDS), in addition to providing teaching and research activities and, for this reason, needing to be based at central hospitals or universities.

- PRICES TO BE PRACTISED IN 2017

Aimed at encouraging palliative care services of excellence in the SNS, the following financing principles for this activity have been established for 2017:

- A 10% increase in the price of consultations and appointments (first and subsequent) performed by specific palliative care teams.
- A 5% increase in Homogeneous Domestic Group medical and inpatient production lines, undertaken at palliative care hospital admission units;
- A 20% increase in the price of day hospital sessions carried out by specific palliative care teams.

4.4.7. INSTITUTIONAL HEALTH AND EFFICIENCY PERFORMANCE INCENTIVES

The contracting process for measures aimed at improving health and efficiency performance plays an inherent part in increasing the levels of demand and accountability of health service providers, for this reason a financing component being set in place associated with compliance of performance and efficiency objectives included in

the SNS Contract-Programmes for 2017.

Two performance and efficiency incentive typologies have been set in place for 2017, namely:

4.4.7.1. INCENTIVES FOR HOSPITALS AND HOSPITAL CENTRES

This incentive component represents 5% of the value of the Contract-Programme for 2017, and is associated with fulfilment of health and efficiency related performance objectives in specific areas of activity classified as priority, with 60% of this amount being associated with standard institution objectives at national level, and 40% associated with institutional objectives for each health service region, specifically in relation to the following:

	Areas	Weighting
1.National Objectives		**60%**
A. Access		**15%**
	A.1 Percentage of primary medical appointments in the total of medical appointments	3%
	A.2 Weight of external appointments with registered discharge, in the total of medical appointments	3%
	A.3 Average waiting time on Surgical Waiting Lists (LIC), in months	3%
	A.4 Percentage of emergency episodes attended to within the waiting time specified in the screening protocol	3%
	A.5 Percentage of patients referred to the RNCCI and evaluated/confirmed by the Discharge Management Team (EGA) up to two days before discharge, for the total number of patients referred to the RNCCI	3%
B. Quality		**25%**
	B.1 Percentage of outgoing patients with hospital internment above the maximum threshold	3%
	B.2 Percentage of outpatient surgeries performed - in terms of procedures of an outpatient tendency*	3%
	B.3 Percentage of hip surgeries carried out in the first 48 hours	3%
	B.4 Risk and safety index of the patient	2%
	B.5 Programme for the Prevention and Control of Infections and Resistance to Antimicrobials (PPCIRA) Index**	8%
	B.6 Percentage usage variation of biosimilar products (in units, 2017/2016) ***	6%
C. Efficiency		**20%**
	C.1 Percentage of costs due to overtime, supplements and the delivery of external services III (selected) in terms of total personnel costs	5%
	C.2 EBITDA	5%
	C.3 Increase in overdue debt (external suppliers)	5%
	C.4 Percentage of extra Contract-Programme operational income, in the total of operational income	5%
Regional Objectives		**40%**

* Procedures of an outpatient tendency are procedures that, even though not universally performed as outpatient services, have an expected turnaround of less than 24 hours (identified as type B outpatient procedures in the Final Report of the National Commission for the Development of Outpatient Surgery).

** The PPCIRA quality index (Prevention and Control of Infections and Resistance to Antimicrobials) was created through Ordinance no. 3844-A/2016, of 10th March 2016, issued by the Assistant Secretary of State and of Health, and consisting of the following variables in

relation to the entities responsible for defining the objectives for the 2017-2019 triennium.

A - Global hospital consumption of antibiotics, measured as a DDD for 1,000 outgoing patients per day; (objective: reduction of 10% per year);

B - Global hospital consumption of carbapenems, measured as a DDD for 1,000 outgoing patients per day; (objective: reduction of 10% per year);

C - Rate of methicillin-resistant staphylococcus aureus (MRSA) in the total of staphylococcus aureus isolated in invasive samples (blood and liquid); (objective: reduction of 5% per year);

D - Rate of Klebsiella Pneumoniae Carbapenemase (KPC) - producing bacteria in the total of Klebsiella pneumoniae isolated in invasive samples (objective: ≤ 1%);

E - Absence of infections with Carbapenemase-Producing Enterobacteriaceae (CPE) this year;

F - Implementation of the isolation and screening of patients with at least one MRSA risk factor, in accordance with the Standard anti-MRSA 018/2014, of 9/12/2014, updated on 27/04/2014, issued by PPCIRA/Directorate-General for Health;

G - Commitment rate to the interventions bundle for the prevention of local surgical infections, in accordance with Standard 020/2015, of 15/12/2015, issued by the PPCIRA/Directorate-General for Health (objective: number of surgeries with commitment to all bundle measures / total number of surgeries > 75%)

H - Commitment rate to the interventions bundle for the prevention of urinary infections associated with the use of catheters, in accordance with Standard 019/2015, of 15/12/2015, issued by the PPCIRA/Directorate-General for Health (objective: number of catheters with bundle measure length / total number of catheters > 75%)

I - Commitment rate to the primary moment of hand hygiene (objective: > 70%)

J - Participation in epidemiological surveillance programs for catheter-related infection, ventilator-associated pneumonia, infection of the surgical site, and nosocomial infection of the bloodstream (objective: compliance in at least 9-12 months).

*** Indicator conditional upon verification, plus a 20% minimum quota of Biosimilars, as specified in joint normative circular no. 10/INFARMED/ACSS.

Seeking to increase justice and equity, and for the minimisation of possible evaluation discrepancies between institutions, the goals for each institution shall be negotiated between the ARS and the hospital institutions, in accordance with a national methodology.

When the goals that follow the established guidelines for a specific indicator are not negotiated, the ARS must present the ACSS with a justificatory technical specification of the goals that are actually negotiated.

4.4.7.2. INCENTIVES FOR PORTUGUESE INSTITUTES OF ONCOLOGY (IPO)

Taking into account the specific nature of IPO activities, certain indicators shall be defined for SNS Hospitals/Hospital Centres that do not fully align with the healthcare profile for these specialised institutes, with it thus being important to choose additional objectives, such as

:

Areas		Weighting
1.National Objectives		**60%**
A. Access		**20%**
	A.1 Percentage of first medical appointments in the total number of medical appointments	5%
	A.2 Percentage of surgical patients (malignant neoplasms) registered on the surgical waiting lists with waiting time < Guaranteed Maximum Response Time	5%

	A.3 Average surgical waiting list response time for malignant neoplasms, in months	5%
	A.4 Percentage of patients referred to the RNCCI, assessed/confirmed by the Discharge Management Team (EGA) up to 2 days before discharge, in the total number of patients referred to the RNCCI	5%
B. Quality		**20%**
	B.1 Percentage of outgoing patients with hospitalisation above the 4% maximum	4%
	B.2 Risk and safety index of the patient	4%
	B.3 PPCIRA index	4%
	B.4 Variation in the number of standard operations due to malignant neoplasms	4%
	B.5 Percentage usage variation of biosimilar products (in 2017/2016 units)	4%
C. Efficiency		**20%**
	C.1 Percentage of costs due to overtime, supplements and the supply of external services III (selected) in terms of total personnel costs	5%
	C.2 EBITDA	5%
	C.3 Increase in overdue debt (external suppliers)	5%
	C.4 Percentage of extra Contract-Programme operational income, in the total of operational income	5%
Regional Objectives		**40%**

4.4.7.3. INCENTIVES FOR PSYCHIATRIC HOSPITALS

As previously mentioned for the three Institutes of Oncology, certain objectives have been defined for SNS Hospitals and Hospital Centres that are not fully adequate in terms of the health service profiles for specialist hospitals in the psychiatric healthcare area, particularly the Hospital Magalhães de Lemos and the Psychiatric Hospital Centre of Lisbon, for which the following considerations apply:

	Areas	Weighting
1.National Objectives		**60%**
A. Access		**15%**
	A.1 Percentage of first medical appointments in the total number of medical appointments	7.5%
	A.2 Fulfilment of Screening and Response Times	
	A.2.1 Percentage of Users referred from primary healthcare units, for external appointments attended to in adequate time.	7.5%
B. Quality		**25%**
	B.1 Percentage of outgoing patients with hospital internment above the maximum threshold	4%
	B.2 Percentage of re-hospitalisation due to schizophrenia	4%
	B.3 Percentage of re-hospitalisation due to bipolar disorder	4%
	B.4 Ratio between complete hospitalisation days and partial hospitalisation sessions	3%
	B.5 Ratio between acute hospitalisation days and day hospital sessions	3%
	B.6 Ratio between acute hospitalisation days, and resident days of hospitalisation and psychosocial rehabilitation	3%
	B.7 Percentage of generic medicine prescription packs, in the total of generic medicine prescription packs	4%
C. Efficiency		**20%**

	C.1 Percentage of costs due to overtime, supplements and the supply of external services III (selected) in terms of total personnel costs	5%
	C.2 EBITDA	5%
	C.3 Increase in overdue debt (external suppliers)	5%
	C.4 Percentage of extra Contract-Programme operational income, in terms of total operational income	5%
Regional Objectives		**40%**

4.4.8. BENCHMARKING INCENTIVES

A new hospital performance incentive system shall be created for 2017 to evaluate positive comparisons and competition between institutions, to identify health service performance differences and levels of efficiency taking place at hospitals with similar characteristics, while also focusing on operational management leverage in relation to the possibility of attaining improvement potential identified at each management level within the main areas of activity.

This new mechanism assesses a group of objectives used to make performance level comparisons between SNS hospitals, subsequently organised into benchmarking groups for applied focus on specific access areas in terms of quality and efficiency, under the following conditions:

Areas	
A. Access	
	A.1 Percentage of Users referred from primary healthcare units, for external appointments attended to in adequate time. **A.2** Percentage of surgical patients registered on Surgical Waiting Lists, with waiting time < Guaranteed Maximum Response Time
B. Quality	
	B.1 Percentage of 30-day re-hospitalisation, in the same large diagnosis category **B.2** Adjusted mortality rate **B.3** Average adjusted delay/waiting rate **B.4** Percentage of surgical operations performed on outpatients in relation to the total amount of scheduled surgical operations (Homogeneous Diagnostic Groups) – for potential outpatient procedures **B.5** Average waiting time before surgery
C. Efficiency	
	C.1 Operational costs per standard patient **C.2** Standard patient per ETC doctor **C.3** Standard patient per ETC nurse **C.4** Percentage of generic medicine prescription packs, in the total of medicine prescription packs

The award of benchmarking incentives shall be calculated on the basis of a Comparative Performance Index based on the results achieved by each hospital, for a set of indicators compiled by each institution, followed by subsequent ranking of each hospital in relation to the results for the group in which it operates.

The payment of incentives to the better ranked hospitals within this benchmarking process shall be made by the other hospitals comprising the comparison group.

4.4.9. PENALTIES ASSOCIATED WITH THE CONTRACT-PROGRAMME

Seeking, on the one hand, to increase levels of demand and accuracy and, on the other hand, to prevent the systematic occurrence of non-compliance situations on the part of participating institutions, a penalty system shall be maintained in 2017, with consequences being translated to financial amounts which are then applied to the entities.

The overall amount of such penalties shall be reinforced for 2017, but shall not exceed 2% of the established overall value of the Contract-Programme, which shall apply in the following areas:

Areas	Obligation	Penalties (P)
A. Appropriate access promotion programmes (55%)	**A.1 SIGA** – Comply with the rules defined in the Management Manual for Surgery Subscribers (MGIC), in accordance with the methodology of determination and contestation of non-conformities published by ACSS, I.P. **(10%)**	There will be no penalties when % NC < 5% The penalty shall be applied by means of the following formula, until the Contract Amount limit x 2% x 10% is reached: **P** = Simple NC amount + Serious NC amount + Material NC amount Simple NC amount = 1/20 x BRP x No. of simple NC Serious NC amount = 3 x 1/20 x BRP x No. of Serious NC Material NC amount = 1/200 x 3 x 1/20 x BRP x No. hospital entries x No. failures x No. material NC
	A.2 SIGA – Reduction in the number of people on orthopaedic Surgical Waiting Lists, compared to December 2016, of at least 10%. **(4%)**	Variation of the orthopaedic Surgical Waiting List > -10% **P** = contract amount x 2% x4%
	A.3 SIGA – Reduction in the number or registered surgical cancellations, in comparison to the 2016 total, of at least 10% **(4%)**	Variation in the no. of cancellations > -10% **P** = contract amount x 2% x4%
	A.4 SIGA – Dynamic management of the number or people registered for a first Ophthalmology appointment **(4%)**	Variation in comparison to 2016 in the no. of concluded requests > -10% (except in instances where appointments are conducted within a Guaranteed Maximum Response Time > = 85%) **P** = contract amount x 2% x4%
	A.5 SIGA – Reduction in the number of cases whose interval between the request, and scheduling of the first external appointment, is > 5 days in 20% **(4%)**	Variation, compared to 2016, in the no. of cases whose interval between the request and the scheduled appointment is greater than 5 days > -20% P = contract amount x 2% x4%
	A.6 SIGA – Weight of the first dermatology	First dermatology appointments carried

	appointments carried out through telemedicine, in the total number of first dermatology appointments, equal to or greater than 50% **(5%)***	out through telemedicine (Time and Hour Consultation) / total of first dermatology appointments (Time and Hour Consultation) < 50%
	* In cases of institutions that do not have dermatology appointments, the A.7 indicator assumes a weight of 9%	P = contract amount x 2% x5%
	A.7 SIGA –- Reduction in the number of refused first appointments by 25% **(4%)**	Variation in comparison to 2016 in the number of refused requests > -25% P= contract amount x 2% x 4%
	A.8 RNCCI – Average assessment time of the Discharge Management Team =< 2 days **(5%)**	Average assessment time of the Discharge Management Team > 48h P = contract amount x 2% x5%
	A.9 Palliative – Average EIHSCP response time =< 48 hours, for working days (or 72 h, for w/e) **(5%)**	Average EIHSCP response time > 48h P = contract amount x 2% x5%
	A.10 Variation in the use of external resources for Supplementary Means of Diagnosis and Therapy **(5%)**	Variation in the number of SMDT carried out externally > -25% P = contract amount x 2% x5%
	A.11 Variation in SNS costs for **biological medications**, in comparison to 2016, versus the national variation average **(5%)**	Variation in costs > National variation average P = contract amount x 2% x 5%
B. Report and publication of management data (16%)	**B.1** SICA monthly report - % data with inconsistencies lower than 1% **(4%)**	Data quality report for each month with verified inconsistencies above 1% P = contract amount x 2% x4% (1/12)
	B.2 Financial information report in the SIGEF system, on a monthly basis until the 10th day of the month **(4%)**	Report on a subsequent date to the 10th of every month, for each non-compliant month P = contract amount x 2% x 4% x (1/12)
	B.3 Publication on the SNS Portal of obligatory management instruments **(4%)**	Availability < 90% P = contract amount x 2% x4%
	B.4 RON – Data Report for the National Oncology Registry (RON) **(4%)**	Report on a subsequent date to the 10th of every month, for each non-compliant month P = contract amount x 2% x4% (1/12)
C. Registration, appointment, sharing of information and dematerialisation of processes (24%)	**C.1** Availability of medical discharge notes for outgoing patients within the period **(3%)**	Availability < 75% P = contract amount x 2% x 3%
	C.2 Availability of nursing discharge notes for outgoing patients within the period **(3%)**	Availability < 75% P = contract amount x 2% x 3%
	C.3 Availability of Transfer notes for outgoing patients from the UCI **(3%)**	Availability < 75% P = contract amount x 2% x 3%
	C.4 Percentage of emergency episodes with PDS appointment **(3%)**	Appointments <75% P = contract amount x 2% x 3%
	C.5 Percentage of external appointment episodes with PDS appointment **(3%)**	Appointments <75% P = contract amount x 2% x 3%
	C.7 Percentage of prescription packs in Paperless	EHR <85%

	Prescriptions (PP) **(4%)**	P = contract amount x 2% x 4%
	C.8 Percentage of childbirth announcements, in the total number of births **(2%)**	Announcements <75% P = contract amount x 2% x 2%
	C.9 Usage registration fee of the "Surgical Safety Verification Checklist" **(3%)**	Usage rate < 95% P = contract amount x 3% x 2%
E. Revenue collection (5%)	**E.1** Effective revenue collection **(5%)**	Collection < 95% P = contract amount x 2% x5%

% NC - Corresponds to the percentage of annual Non-Conformities in comparison to the number of effective entries on the Surgical Waiting List, i.e. the number of episodes that registered on the list but who cancelled this year due to institution error.

BRP - corresponds to the Base Reference Price for surgical activity within the scope of the Contract-Programme(2,285.00 EUR)

4.4.10. PROMTIONAL RESEARCH AND DEVELOPMENT PROGRAMME FOR 2017

This research and development component is essential for SNS qualification and affirmation. The Programme for the Promotion of Research and Development was applied in 2017 for this particular purpose, aimed at awarding incentives and encouraging scientific production carried out at SNS hospital centres and Local Health Units.

From a Programme for the Promotion of Research and Development perspective, institutions compete with each other for the annual allocation of EUR 2 million, distributed in terms of the relative weight of the points attained through the number of registered patents and scientific articles published in 2016, abiding by the following rules:

- Each article with primary author pertaining the hospital institution, corresponds to the impact factor of the Science Citation Index (SCI) for the respective scientific article. The relative points weighting of the respective scientific articles is obtained by taking the articles published in the last three years into account (utilising the actual publication date);
- Each co-authored article from a hospital institution element, not written by a primary author, shall corresponds to an SCI points weighting of 25% for the respective magazine;
- In situations of multiple authors, the points given for each article shall not surpass the SCI points weighting for the respective magazine;
- Each patient registered within the designated period corresponds to an impact factor of 5 for national patients, and an impact factor of 15 for international patients.
- Each finalised clinical trial corresponds to an impact factor of 10.

- CLINICAL RESEARCH CENTRE PILOT-EXPERIENCES – MANAGEMENT OF CLINICAL TRIALS

Clinical research is one of the main objectives of hospital centres, assuming an important role in improvements gained in medical knowledge, the development of clinical practices, and in the provision of patient healthcare, it therefore being of the utmost importance to constantly improve all related skills at hospital clinical research

centres, making them increasingly more effective and efficient specifically in terms of clinical trials.

In terms of the research centres currently available for the undertaking of clinical trials, such activity shall commence from 2017 onwards based on the initiative of each institution and after the approval of the respective Regional Health Administration, with the organisational and functional models of each centre, in full or in part, needing to comply with the following guidelines:

a) Appropriate training and qualification of centres, through motivated professionals and leadership focused on pursuit of the defined mission.
b) Identification of a single contact person, working as the research facilitator and managing relationships with all stakeholders.
c) Streamlining of processes aimed at internally optimising regulatory time-frames.
d) Implementation of a formal internal contracting process for identifying technical and human resources, focused on the definition of all measurable objectives and goals which can be easily identified and understood by all professionals involved.
e) Financial compensation for all teams and professionals based on performance, including the authorised use of all resources gathered by the institution through the Development Research Programme.
f) Competition for trials in unison with global promoters and through promotion and recognition of the centre, including the need to identify, verify and disclose a set of Key Performance Indicators for this particular purpose, as follows:
    - The number of concluded clinical trials
    - Recruitment rate of patients for clinical trials
    - The internal processing time of such processes, up until signature of the contract
    - Time taken since signature of the contract, until the initial first trial visit
    - Time taken since the initial first trial visit, to acceptance of the first patient
g) Network communication with other national and international institutions for the purposes of maximising resources, improving the scale of production, achieving more effective responses, and getting access to further financing opportunities.

4.4.11. SPECIFIC AREAS WITH AUTONOMOUS FINANCING

In addition to these lines of activity, the autonomous financing of the following components has also been defined:

- **Training of Internal Doctors** from the first and second year of the medical intern programme;
- **Hospital-delivered medicines, obligatory in the outpatient clinic**, including a legal framework understood to be the financial responsibility of the institutions.
- **Home Portuguese Institute of Oncology**

The Contract-Programme for 2017 shall also takes the following programmes into consideration:

- **Technical Help**: financed under the Support Products Allocation System (SAPA), defined by Ordinance no. 10909/2016, of 8th September 2016, by the Ministries of Finance, Education, Labour, Solidarity and Social Security, and published in the Official Gazette of the Republic of Portugal, 2nd Series, No. 173;

- **Medical Assistance Abroad**: highly specialised medical assistance taking place on foreign soil, due to lack of technical or human resources, under the terms and conditions of Decree-Law no. 177/92, of 13th August 1992;
- **International Conventions**: encompassing healthcare provided to citizens from the European Union, bound by Community Regulations, and to citizens covered by Bilateral Agreements between other countries;
- **Transplantation Incentives**: awarded under the terms of specific laws.
- **Invoicing of Supplementary Means of Diagnosis and Therapy performed through ACES prescription:** covers activities carried out by hospitals at the request of ACES, from a GPRSNS perspective;
- **Incentive programme for the integration of healthcare:** based on the terms defined in chapter 6 of this document.
- **Oncological pathology of the head and neck:** for prostheses to be applied to patients with cancer of the head and neck, namely to restore the ability to eat, on the part of patients without active oncological disease, applicable in 2017 at the following eight institutions: CHP, CHSJ, CHVNGE, IPO Porto, CHUC, IPO Coimbra, CHLN and IPO Lisbon.

4.4.12. APPLICATION OF REGIONAL FLEXIBILITY IN SETTING PRICES BY THE REGIONAL HEALTH ADMINISTRATIONS

Regional flexibility is a mechanism that enables the Regional Health Administrations to modify current prices in accordance with the acting status of its hospitals – health-related factors, teaching and research, differentiated services, etc. - enabling adjustments to be made in line with potential characteristics that pricing or financing groups are unable to establish.

This mechanism increases the level of responsibility of each Regional Health Administration enabling enables them to vary financing levels per hospital, in full compliance with well-defined requisites, with any such changes being made known to all hospitals in the region.

The existence of regional flexibility enables a global model to be applied to all regions with a minimum level of disruption, enabling the ARS to pay separately for more valuable services in each region. Through this mechanism the ARS will be able to vary the production line prices of certain hospitals in order to compensate them for any extra costs that they may have incurred through responding to certain ARA requests, namely:

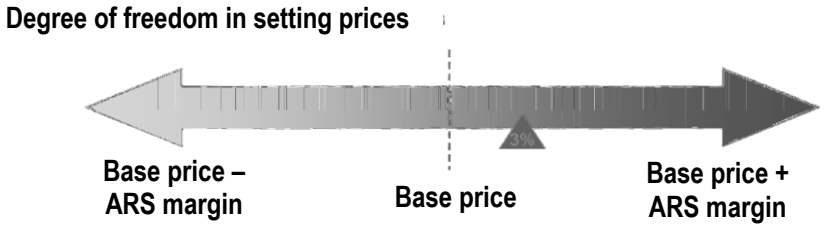
- The introduction of innovative techniques
- Increments in complex factors (which are only reflected in financial terms two years later)
- Strengthening of emergency service responses

On the other hand, regional flexibility also enables the lowering of prices when hospital service levels are below standard, due to:

- Factors in emergency service response times
- Lack of response to reference networks
- Lower quantity of complex factors

For 2017, in terms of acute inpatient lines of activity, medical and surgical outpatient services, external appointments and day hospital sessions, the Regional Health Administrations will be able to vary the base price

by 3%. A justificatory technical specification must therefore be presented to the ACSS for subsequent analysis and approval.



4.4.13. EBITDA AND CONTEXT COSTS

Institutions shall present a balanced Provisional Income Statement (EBITDA, positive or null), accompanied by a Provisional Balance Sheet and a Provisional Cash Flow Statement.

It is mandatory for each institution to specify which quantified and time-bound measures shall be used for ensuring a positive EBITDA is achieved in 2017.

The value of the context costs to be attributed to institutions for 2017 requires financial backing in order to compensate for extraordinary situations that may occur in the institution itself, when compared to the national average of the entities included in the same benchmarking group. The value must be limited to the minimum amount of time necessary to enable the cost structure to be adjusted in relation to prices and the volume of contracted production, and/or the elimination of extraordinary context costs. The award of an amount relative to the context costs shall be dependent on an express request made by the Executive Board of the institution validated by the respective Regional Health Administration, in addition to being accompanied by a viable adjustment plan as defined in the triennial strategic plan.

4.4.14. GLOBAL BUDGET AND MARGINAL PRODUCTION

Hospital contract-programmes shall not establish provisions deemed to be greater than the amounts specified in the contract, as a counterpart to the contracted levels of production, i.e. with remuneration for contracted activity being limited to the maximum amount established in the Contract-Programme – known as the global budget principle.

Specific criteria shall be used for the invoicing of marginal activity (between production lines), with the overall amount being limited to the overall valuation of contracted production. This financing "transfer" possibility between production lines makes it possible to increase the management flexibility of the Contract-Programme, and adapt the hospital response to possible changes in terms of the initially planned level of demand, thus ensuring a response to the health requirements of the

Portuguese citizens.

In terms of the production volume assumed by the health units, with the exception of instances in which scheduled surgical production (see appropriate chapter) is greater than the contracted volume, each produced unit that goes above this volume, at maximum limit of up to 10%, shall be valued in the following manner:

- 10% of the contracted price for the internment of Homogeneous Diagnostic Group (GDH) doctors, GDH urgent surgical treatment, hospitalisation of chronic patients, and permanent home residence (Home Portuguese Institute of Oncology) ;
- 15% of the contracted price for home appointments and services;
- 10% of the contracted price for emergency services;
- 15% of the contracted price for day hospital, and GDH outpatient doctors.

In 2017, the specific programs referred to in point 4.3.11 are excluded from the overall budget principle.

4.4.15. MEDICATIONS PRESCRIBED IN HOSPITAL ENVIRONMENTS AND SUPPLIED AT COMMUNITY PHARMACIES

The prescription of medications in hospital environments which are then supplied at community pharmacies represents around 17% of SNS expenditure on medications.

Mechanisms have been developed in recent years to monitor and control prescriptions carried out in hospital environments, with the following incentive mechanism being applied for 2017 for Hospitals, Hospital Centres and Local Health Units:

- Incurred penalties if the variation of SNS expenditure through medications exceeds the national variation average registered in relation to the previous year (20% of the difference between the amount corresponding to the national variation average and the observed amount);
- Incentives awarded if the variation of SNS expenditure through medications is below the national variation average registered in relation to the previous year (20% of the difference between the amount corresponding to the national variation average and the observed amount);

In order to encourage the rational use of medications, and specifically to promote the use of first line therapies in key medication areas of the outpatient market, the following therapy indicators for Diabetes, dyslipidaemia and the use of Oral Anticoagulants, shall be introduced in 2017.

- **DIABETES:**

  Percentage of sulphonylurea and metformin packs in the total number of oral antidiabetic packs.

- **STATINS:**

  Percentage of commercialised generic statin packs in the total number of statin packs, including fixed medication associations containing at least one statin.

- **ORAL ANTICOAGULANTS:**

  Percentage of vitamin K antagonists (VKA) in the total number of oral anticoagulants.

All of the previously identified indicators shall be considered as met if verified as being above the national average. The aforementioned penalty or incentive mechanism shall have a variation of 5% based on the results of these indicators, under the following conditions:

	% of incentive	% of penalty
Complies with at least 2 indicators	25%	15%
Does not comply with at least 2 indicators	15%	25%

*percentage applies to the difference between the value corresponding to the national variation average and the observed value

Note that the prescription of exclusive medicines through dematerialised electronic prescription is mandatory, including automatic signing with an electronic signature, under the terms of Ordinance no. 2935-B/2016, of 24th February 2016, issued by the Secretary of State for Health, which now provides a prescription and dispensation process with more monitoring authenticity and capacity, plus the streamlining of the availability of certain medications, and an overall reduction in prescription costs.

4.5. INTERNAL CONTRACTING AT HOSPITALS

The internal contracting process is integrated into a modern, responsible and rigorous management culture that enables the promotion of responsibilities and the full autonomy of professionals and teams, in addition to contributing to increases in motivation, commitment and overall levels of productivity, plus the effectiveness of services aimed at reducing inefficiency and waste within an NHS institutional environment.

Taking into account verified levels of development in relation to IT systems, it is now possible to monitor standardised information in relation to production, access, quality, productivity and economic-financial performance, disaggregated at hospital/hospital centre level, or at the level of the SNS departments, services, teams or professionals themselves, while appreciating the value of internal negotiations on objectives, processes and results, utilising a logic of continuous improvement, contributing to the strengthening of organisational autonomy and the management of the departments and services for improved alignment, in addition to providing transparency.

In 2017, all hospitals and hospital centres must implement internal contracting processes that appreciate the value of Clinical Governance, healthcare related performance, and the efficiency of all related services and institutions, as well as ensuring that all commitments and objectives are internally assumed by the organisation, in addition to being disaggregated by the currently available services in terms of an accountability, performance and merit evaluation philosophy.

To this end, a participated management model must be created with suitable proximity and appropriate definition of objectives and goals, outlined in accordance with existing resources and yet to be achieved results, capitalising on the existing levels of professional and organisational experience and knowledge, encouraging the development of pro-active skills and attitudes, and promoting competition through comparison. An internal communication plan must also be developed that includes internally contracted professionals.

4.6. MONITORING OF THE HOSPITAL CONTRACTING PROCESS

All activities contracted with the hospitals or hospital centres shall be subject to a monthly monitoring process utilising reports available on the SICA Portal, as well as through monthly monitoring dashboards and benchmarking tools published on the "SNS Monitoring" microsite, hosted on the institutional site of the ACSS and on the SNS Portal (www.sns.gov.pt).

The contracts-programme monitoring process for hospitals and hospital centres for 2017 must take place in accordance with the schedule and methodology proposed in the following table:

Table - Monitoring of hospital and hospital centre performance

Limit Date	Procedure	Who Promotes?
15-MAY-2017	First quarter follow-up meeting.	ARS/GAH
15-SEPT-2017	Second quarter follow-up meeting.	ARS/GAH
30-OCT-2017	Third quarter follow-up meeting.	ARS/GAH

The monitoring dates defined in the above table are promoted by the Regional Health Administrations (ARS) and by the Hospital Monitoring Group (GAH) functioning within the ACSS, which shall be used for the discussion of strategies, the sharing of responsibilities, and the rescheduling of activities to be carried out by the institutions, in addition to being used for the renegotiation of indicator goals whenever significant changes are made to the contracting assumptions. The ACSS and INFARMED shall also monitor the performance of hospitals in 2017, in full communication with the appropriate authorities.

Any changes deemed necessary, including the justifications for such, must be presented by the ARS to the ACSS, and will only be considered valid if approved by the appropriate authority.

Also note that institutions must prepare their respective monthly Analytical Reports in relation to healthcare and economic-financial performance, subsequently sending them to the respective ARS and the ACSS.

4.7. EVALUATION OF THE HOSPITAL CONTRACTING PROCESS

The amount of institutional incentives shall be awarded in accordance with subsequent compliance with a set of goals to be negotiated with the respective ARS Executive Board (through its Contracting Departments), for all selected objectives, which shall then be evaluated in accordance with the mechanism defined in the Global Performance Index.

The funds set aside for incentives shall be used by the management personnel of hospital institutions for the awarding of incentives to the departments and services that achieve their respective goals, as defined for internal contracting processes, followed by the acquisition of technical data and the subsequent participation by professionals in conferences, symposiums, colloquiums, seminars and training sessions, in an attempt to support research and development, increase the quality of amenities and the development of quality improvement processes, as well as to achieve suitable accreditation for their respective departments and services.

4.8. INVOICING OF THE CONTRACT-PROGRAMME

Execution of the Contracts-Programme shall be finalised through invoicing for activities effectively carried out by the institutions within the year of validity of these contracts. A Normative Circular will be published in 2017 for the purposes of defining the payment conditions and procedures for the health service provisions carried out within the scope of the Contract-Programme for this year. The contract-programme invoicing process is based on a set of objectives contained in the current architecture of the validation, invoicing and negotiations process for the hospital institutions, namely:

- For the production validation process: validation of all production lines invoiced by the institutions, adhering to a group of verifications that, in turn, make it possible to ensure full compliance with all rules defined on an annual basis through the Normative Circulars;

- In terms of the invoicing cycle: reflective of income associated with activity effectively carried out by the institutions (taking into account, as proxy, the values of the report on the estimated provisions contained in the SICA system), i.e. not actual cash flow, thus ensuring the validity of the accounting principle for the increase;

- In relation to the invoice issuance period – invoicing shall be carried out on a periodic basis (monthly) in accordance with pre-defined time periods and procedures;

- In terms of reporting obligations – all hospitals are committed to the timely and monthly delivery of the invoiced amounts (up to the 15th day of each month) in addition to providing justificatory files for all production carried out for various types of health service provisions (up until the 21st day of each month).

Invoicing of activity will only be accepted in 2017 if it is coded in accordance with the standardisation of the nomenclature of inpatient and outpatient clinical services, as defined in Normative Circular no. 20/2015/DPS of 19th November 2015.

From 2017 onwards, the invoicing negotiations process carried out by SNS hospital institutions shall take place through the SNS Control and Monitoring Centre, devised as a profound structural change to the current invoicing and negotiations process in relation to hospital activity.

5. CONTRACTING METHODOLOGY WITH THE LOCAL HEALTH UNITS FOR 2017

The Local Health Units are organisational structures for ensuring adequate delivery of all necessary health provisions for the subsequent promotion of suitable healthcare services, the prevention of disease, treatment and rehabilitation of the state of health of the resident population within the areas of coverage, all carried out in a fully integrated, efficient and sustainable manner.

The Local Health Units must maximise the efficiency, technical quality and effectiveness of healthcare services, while also providing full satisfaction to all SNS users, with a view to obtaining health-related gains, namely:

a) Correctly identify the resident population within its area of coverage, specifically through the understanding of all social, cultural and epidemiological characteristics, in addition to understanding all health-related necessities.
b) Establishing partnerships with local entities, who intervene in the social determinants of health;
c) Encourage participation in civil society for the promotion of healthy lifestyles;
d) Involve the user in the management of their own health, in strict collaboration with their family doctor;
e) Adjust available resources to healthcare requirements.
f) Facilitate user access to health services;
g) Ensure the continuity of health-related services, including increased levels of user quality and satisfaction.
h) Promote and encourage gains in Local Health Unit efficiency and sustainability, in addition to achieving enhanced social development.

5.1. INSTRUCTIONS FOR THE LOCAL HEALTH UNIT NEGOTIATIONS PROCESS

Activities to be contracted with the Local Health Units shall ensure that integrated health service provision is sustained at primary healthcare units in terms of their capacity to manage the State of Health of the population of Portugal, thus ensuring the provision of services at the most appropriate and effective levels, with the Local Health Unit negotiations process for 2017 being inclusive of the following specific objectives, in addition to the objectives that also apply to primary healthcare services, hospitals and hospital centres:

i. Encourage the effective transfer of traditionally provided healthcare services in a hospital environment for proximity care, namely, primary healthcare and continuous care, at outpatient clinics and in the community - as a result of deepened coordination levels with other health institutions, in addition to the internal strengthening of the current integration level of vertical care;

ii. Promotion of user accessibility to health service provision levels, sustained through involvement of family healthcare teams and through the adoption of procedures to facilitate institutional referral;

iii. Strengthen coordination between primary healthcare services, management teams for discharged patients and RNCCI responses, while ensuring the full monitoring of patients that require further treatment after discharge, with the aim of guaranteeing the continuity of the efficient provision and management of hospital services;

iv. Optimise resources for the operationalisation of Clinical Governance and Health related services, thus enabling meticulous, responsible and effective health service provisions for the attainment of gains in health;

v. Encourage the realisation of health-related activities/programmes in specific environments such as schools and in the workplace, including the development of partnership projects from a promotional healthcare perspective.

5.2. ALLOCATION OF FINANCIAL RESOURCES FOR THE LOCAL HEALTH UNITS

The maximum limits to be contracted with the Local Health Units in 2017 are:

ENTITY	2017
ULS Alto Minho, EPE	129.545,844 €
ULS Matosinhos, EPE	103.290,417 €
ULS Nordeste, EPE	81.365,869 €
ULS Guarda, EPE	85.394,830 €
ULS Castelo Branco, EPE	63.272,818 €
ULS Litoral Alentejano, EPE	50.588,049 €
ULS Baixo Alentejo, EPE	78.712,341 €
ULS Norte Alentejano, EPE	76,908,447 €
Total ULS	**669.078,615 €**

These values correspond to the results of the mixed financing model applicable to Local Health Units (ULS) for 2017, consisting of a risk-adjusted payment process for capitation, in addition to the payment component for patients receiving treatment, associated with the provision of healthcare services in areas of high financial service provider risk, such as with the treatment of chronic pathologies that require higher costs and are difficult to accommodate in the traditional capitation payment system.

5.3. EXTERNAL CONTRACTING WITH THE LOCAL HEALTH UNITS - CONTRACTING RULES

The ULS contracting process for 2017 is essentially a copy of the contracting process already defined for primary health units and hospitals, in addition to incorporating a contracting philosophy for integrated services which aims to encourage, through the creation of the Incentive Programme, the integration of Healthcare Services, as presented in chapter 6 of this document.

5.3.1. ADAPTATIONS IN PRIMARY HEALTHCARE INSTANCES

The primary health service contracting process defined in chapter 3 of this document shall apply in full to all Local Health Units. The internal contracting process shall include the Executive Board of each ULS and all internal management personnel responsible for the provision of healthcare services at primary healthcare level, in full respect of the internal principles of technical autonomy of the primary healthcare services, including the delegation of appropriate skills from a ULS perspective, and the appropriate distribution of professional responsibilities aimed at ensuring full alignment with the specific objectives of each ULS, in addition to ensuring a continuum of health related services provided to the public.

In this respect, the application of the ACES Information System for Contracting and Monitoring (SICA) in relation to the Local Health Unit, shall involve an internal support process implemented by these entities for the sharing of internal organisational responsibilities in order to meet these objectives, in addition to obtaining information that makes it possible to monitor already carried out and scheduled activities, in addition to making assessments and comparisons with similar structures in order to detect ways of improving internal efficiency.

5.3.2. ADAPTATIONS IN HOSPITAL HEALTHCARE INSTANCES

The general guidelines defined for the hospital contracting process in 2017 are also applicable to the Local Health Units, as explained in chapter 4 of this document, particularly in relation to the general rules that apply to activities at this level of healthcare, for the strengthening of autonomy associated with the creation of the Reference Centres of Integrated Responsibility, and the provision of palliative care.

The internal ULS contracting process shall also involve the Executive Board and all other parties responsible for the intermediate management of relevant hospital services, while fully respecting the inbuilt technical autonomy principles of these services, plus the appropriate delegation of skills and subsequent distribution of professional responsibilities aimed at ensuring full alignment with the specific objectives of the Local Health Units, while also ensuring the continuity of health related services provided to the public.

5.4. ULS INCENTIVES

In terms of contracting with the Local Health Units, the allocation of 10% of the Contract-Programme for the achievement of objectives shall be distributed as follows:

ULS Indicators	Weightings
1. Primary Health Care	**40%**
National Objectives	**75%**
Medical appointment usage rate - 3 years	5,0%
Household nursing rate per 1000 registered elderly patients	4,0%
Proportion of prescribed generic medicines	6,0%
Proportion users >= 14 Y, w/ registered tobacco habit	4,0%
Proportion of in-person doctor appointments w/ICPC-2	6,0%
Rate of CVD hospitalisation between residents < 65 Y	3,0%
Index of adequate monitoring in Women of Fertile Age	6,0%
Proportion of new-born babies of low weight	1,5%
Proportion of 14+ y/o with active medication and PNV	2,5%
Incidence of major amputations, Minf. (DM), in residents	3,0%
Proportion of elderly w/o prescription of prol. ansiol/sedat/hipnót	4,0%
Invoiced medical expenditure per user (PVP)	16,0%
Prescribed SMDT expenditure per user (p. conv.)	8,0%
Regional Objectives	**17%**
Local Objectives	**8%**
2. Hospital Care	**30%**
National Objectives - Access	**25%**
A.1 Percentage of first medical appointments in the total number of medical appointments	**3%**
A.2 Weight of external appointments with registered discharge, in the total no. of external appointments	4%
A.3. Fulfilment of Screening and Response Times	3%
A.3.1 Percentage of patients referred from primary health units for external appointments attended to in adequate time	4%
A.3.2 Percentage of surgical patients (malignant neoplasms) registered on Surgical Waiting Lists, with waiting time < Guaranteed Maximum Response Time	4%
A.3.3 Average waiting time on Surgical Waiting Lists in months	4%
A.3.4 Percentage of emergency episodes attended to within the waiting time specified in the screening protocol	4%
A.3.5. Percentage of patients referred to the RNCCI, and assessed/confirmed by the Discharge Management Team up to 2 days before discharge, in the total number of patients referred to the RNCCI	**3%**
National Objectives - Healthcare performance	**35%**
B.1 Percentage of re-admissions within 30 days, in the same major diagnostic category	4%
B.2 Percentage of outgoing patients with hospital internment above the maximum limit	3%
B.3 Percentage of hip surgeries carried out in the first 48 hours	3%
B.4 Percentage of surgical procedures carried out at outpatient clinics, in the total no. of programmed surgeries (Homogeneous Diagnostic Group) - in terms	3%

	of outpatient procedures	
	B.5 Percentage of surgical procedures carried out at outpatient clinics, in relation to procedures of an outpatient tendency	3%
	B.6 Average adjusted delay/waiting rate	4%
	B.7 Adjusted mortality rate	4%
	B.8 Patient risk and safety index	8%
	B.9 Percentage of generic medicine prescription packs, in the total number of generic medicine prescription packs	3%
Regional Objectives		**40%**
3. Economic-Financial Performance		**10%**
	C.1 Percentage of costs due to overtime, supplements and the supply of external services III (selected) in terms of total	2,5%
	C.2 EBITDA	2,5%
	C.3 Increase in overdue debt (external suppliers)	2,5%
	C.4 Percentage of extra Contract-Programme operational provisions, in the total number of operational provisions	2,5%
4. Results in terms of hospital internments, hospital appointments and avoidable emergencies		**20%**
	D.1 Internment rate due to acute diabetes complications	2%
	D.2 Internment rate due to non-controlled diabetes	2%
	D.3 Internment rate due to asthma or COPD in adults	2%
	D.4 Internment rate due to asthma in young adults	2%
	D.5 Internment rate due to arterial hypertension	2%
	D.6 Internment rate due to congestive heart failure	2%
	D.7 Internment rate due to pneumonia	2%
	D.8 Internment rate due to chronic diabetes problems	2%
	D.9 Percentage of specialities (categories) with clinical protocols of ascending and descending elaborated referral	2%
	D.10 Percentage of frequent emergency service users (>4 episodes in the last year) with established health plan between primary and hospital healthcare	2%

5.5. INTERNAL CONTRACTING IN THE LOCAL HEALTH UNITS

In a similar way to the principles already established for hospitals in 2017, all Local Health Units must implement internal contracting processes that fully appreciate the value of Clinical and Health related Governance, in addition healthcare related performance and the economic-financial sustainability of institutional services at global level, while also ensuring that all commitments and objectives are internally assumed by the organisation and disaggregated by all relevant services and departments in accordance with an accountability, performance and merit evaluation philosophy.

5.6. MONITORING OF THE LOCAL HEALTH UNIT CONTRACTING PROCESS

All activities contracted with the Local Health Units shall be subject to a monthly monitoring process through monitoring reports available on the SICA Portal, as well as through monthly monitoring dashboards and benchmarking tools published on the "SNS Monitoring" microsite, hosted on the institutional site of the ACSS and on the SNS Portal (www.sns.gov.pt).

The monitoring times are promoted by the Regional Health Administrations (ARS) and by the Hospital Monitoring Group (GAH) functioning as part of the ACSS, which should be used for the discussion of strategies, the sharing of responsibilities and for the rescheduling of activities to be carried out by the institutions, in addition to being used for the renegotiation of indicator goals whenever significant changes are made to the contracting assumptions. The ACSS and INFARMED shall also monitor the performance of hospitals in 2017, in full communication with the appropriate authorities.

Any changes deemed necessary, including the justifications for such, must be presented by the ARS to the ACSS, and will only be considered valid if approved by the appropriate authority.

Also note that institutions must prepare their respective monthly Analytical Reports in relation to healthcare and economic-financial performance, subsequently sending them to the respective ARS and the ACSS.

5.7. EVALUATION OF THE LOCAL HEALTH UNIT CONTRACTING PROCESS

The value of the institutional incentives shall be awarded in accordance with subsequent compliance with a set of goals to be negotiated with the respective ARS Executive Board (through its Contracting Departments), for all selected indicators, which shall then be evaluated in accordance with the mechanism defined in the Global Performance Index.

In a similar way to that already established for hospitals in 2017, the funds set aside for incentives shall be utilised by the management personnel of hospital institutions to award incentives to departments and services that are able to achieve their respective goals, as defined for internal contracting processes, followed by the acquisition of technical data and the subsequent push for participation by professionals in conferences, symposiums, colloquiums, seminars and training sessions, in an attempt to support research and development, increase the quality of amenities and the development of quality improvement processes, in addition to achieving accreditation.

The penalties applicable to hospitals (as specified in item 4.4.9.) are also applicable to Local Health Units.

6. INCENTIVE PROGRAMME FOR HEALTH SERVICE INTEGRATION AND APPRECIATION OF SNS PATIENT PATHWAYS IN 2017.

The creation of an Incentive Programme for the Integration of Health services in 2017, at an amount of 35 million Euros, shall be finalised through the creation of financial incentives for the formation of shared projects by various SNS services, with the overall aim of promoting the communication, coordination and integration of health services.

The purpose of this programme is to contribute to the alignment of supplementary interests between institutions, for the subsequent approximation of management instruments and for Clinical and Health Governance, in addition to defining standard programmes for harnessing nationwide SNS production and performance levels, while also adjusting care and/or services in relation to real and specific health needs.

The incentive programme for the integration of healthcare services requires all involved entities to communicate between each other, to focus on the four following principal areas of activity:

6.1. THE CARRYING OUT OF SCREENING AND EARLY DIAGNOSIS PROGRAMMES

Due to the importance and necessity of increasing communications between SNS institutions in order to improve responses given to the Portuguese public, the following three areas have been established:

6.1.1. POPULATION-BASED ONCOLOGICAL TRACKING

Cancer is the main cause of death before the age of 70 (i.e. the main cause of premature death), and in terms of all causes of death in every age group, occupies second place behind cerebro-cardiovascular diseases. Significant progress has been made over the last decade in the prevention and treatment of cancer in Portugal. Programmes to improve the amount of time spent on waiting lists have been implemented, with subsequent reductions, plus the installation of new radiotherapy units, leading to the filling up of existing waiting lists and the subsequent recording of significant gains.

Population-based tracking mechanisms have progressed slower than expected and desired in Portugal. Tracking dynamics have been very regional and, therefore, extremely variable, causing access inequities in geographical terms, specifically in relation to the tracking of breast cancer, the cervix, and the colon and rectum (the only cost-effective types), with the Programme aiming to encourage and provide incentives for this activity in 2017.

6.1.2. TRACKING FOR THE SYSTEMATIC DIAGNOSIS AND TREATMENT OF DIABETIC RETINOPATHY

In accordance with standards related to the Systematic Diagnosis and Treatment of Diabetic Retinopathy, all post-puberty diabetic patients and pregnant women shall be subject to systematic diagnosis of diabetic retinopathy on a quarterly basis. The systematic diagnosis of diabetic retinopathy

should be straightforward, in addition to being focused on the identified needs of the diabetic population in order to detect injuries that could be treated in a timely manner, in addition to identifying diabetic patients at risk of blindness, eliminating the need for hospital appointments and making patient diagnoses more rapidly.

A number of ophthalmology speciality difficulties are evident at national response level, with a significant number of requests being related to Diabetic Retinopathy, i.e. situations involving patients waiting for a specialist ophthalmology appointment which can be potentially resolved through a population tracking process, in addition to the use of retinography and orthoptic technicians for the gathering of images at ACES, followed by the sending of such images for subsequent analysis at the patient hospitals, plus the inclusion of SNS Incentive Programmes aimed at leveraging this activity throughout 2017.

6.1.3. TELEDERMATOLOGICAL TRACKING

The teledermatological tracking programme (implemented in accordance with Standard no. 5/2014, of 8th April 2014, by the Directorate-General for Health) is focused on the early diagnosis of dermatological injuries and cancer of the skin, in addition to improving access to dermatological appointments, and contributing to full compliance with Guaranteed Maximum Response Times monitored through the SNS SIGA system. This tracking system consists of making an appointment for subsequent teledermatological tracking, with the attachment of relevant images and clinical data, followed by analysis by a hospital specialist who studies the clinical case and, based on this analysis, a diagnosis and subsequent therapeutic activity.

The purpose of this Incentive Programme is to create suitable conditions so that teledermatological tracking can be disseminated at national level, thus replicating the very good results already achieved at certain institutions.

6.2. REDUCTION OF AVOIDABLE HOSPITALISATION, HOSPITAL APPOINTMENTS AND EMERGENCIES

In terms of changes required to population health, it is important that greater emphasis be placed on the implementation of articulated measures between healthcare providers and subsequent contributions in strengthening autonomy, health related responsibilities and the empowerment of citizens in terms of control and management of personal health and the correct use of health related services, while also creating synergies with other society sectors.

To this effect, joint project incentive programmes have been designed for 2017 aimed at reducing the inadequate use of healthcare services, in addition to encouraging communication between all health structures in the following areas:

- Avoidable hospital internments, especially in terms of Causes Sensitive to Outpatient Care, for pathologies that can and must be prevented and/or treated at first-line healthcare level, but which are usually treated through hospital internment in instances of asthma, diabetes, COPD, Arterial Hypertension, Cardiac insufficiency, etc.

- Avoidable emergency episodes and external appointments;

- Appointments with primary healthcare services carried out by hospital doctors.

6.3. IMPLEMENTATION OF INTEGRATED HOME SUPPORT PROGRAMMES

The implementation of integrated response programmes provided to home-based patients is of great importance in terms of SNS development; programmes that not only take Home-Hospital responses into account, but also responses at Integrated Continuous Care Team (ECCI) level of the EIHSCP and ECSCP, the home doctor and nursing teams of the USF, UCSP and UCC, and existing home support responses at various social and community health support institutions.

6.4. PROGRAMMES FOR THE APPRECIATION OF PATIENT PATHWAYS IN THE SNS

Increasing the management of patient pathways through services focused on the subsequent management of health services is currently the main "transforming idea" of the Health Systems. Multiple circumstances have occurred in recent decades that make it clear and viable in terms of the need to increase the management of patient pathways through "services" focused on the management of health services. The growing centrality of citizens is one of these circumstances. In fact, a health system and SNS architecture focused on the "vertical management" of health organisations does not make much sense from an individual user perspective, being more interested in the ability to easily travel to the various services they require when the existing services lack them, without unnecessary barriers, in reasonable comfort, while also demonstrating good results through an intelligent use of standard resources.

The management of health service pathways signifies:

- Identification of population groups in relation to the proposals to be acted on, in an integrated manner, in terms of responses to health-related problems, within a predetermined period of time through explanation of the results to be achieved through a suitable notation ("planning") device for this purpose;
- Act concertedly in the management of the personal pathways identified for this effect, with collaboration on the part of all parties that appreciate the value of this process, while not forgetting that literacy levels of the persons/patients for each one of the identified objectives is a critical factor for the successful realisation of these objectives;

- Monitor the carrying out of all activities and objectives adopted through the information system, being accessible to all participants;
- Assess results and learn through them.

A limited number of management projects for health-related pathways have been proposed for 2017, with the intention of developing, testing and evaluating all methodological approaches and other instruments to this effect, in strict collaboration with all stakeholders involved in this process.

6.5. FINANCING OF THE INCENTIVE PROGRAMME FOR THE INTEGRATION OF HEALTH SERVICES

Financing of this Programme shall occur through competitive fund allocation mechanisms, with the best integration proposals representing a relatively higher level of funding, in addition to utilising an evaluation system that incorporates national and regional components.

To be awarded funds for this Programme, all interested parties must present the ACSS with a detailed implementation plan for each one of the areas for which they intend to apply, by 31st March 2017, while also meeting the following generic principles in terms of merit assessment:

- A joint agreement between all entities involved in the provision of services, and the plan of action to be implemented;
- A definition of local plans, aimed at the creation of the proposed responses;
- Evidence of improved sharing of resources and information between providers;
- A definition of risk sharing principles;
- An estimate of the impact of all implemented changes, particularly in terms of acute care and gains in health services;
- The creation of internal incentive systems focused on coordination between all units involved.

<table>
<tr><th colspan="3">Incentive Programme for the Integration of Health Services and Appreciated Value of SNS Pathways</th></tr>
<tr><td colspan="2">A. Screening and early diagnostic programmes</td><td>60%</td></tr>
<tr><td rowspan="2">Screening of Cancer of the Colon and Rectum</td><td>A.1. Percentage of screened users between 50 and 74 years of age.</td><td rowspan="2">40%</td></tr>
<tr><td>A.2. Percentage of colpocytologies carried out at hospital after positive iPSOF in < 30 days.</td></tr>
<tr><td rowspan="2">Screening of
Diabetic Retinopathy</td><td>A.3 Percentage of identified diabetics with retinopathy screening carried out in the last year</td><td rowspan="2">30%</td></tr>
<tr><td>A.4 Percentage of diabetics with retinopathy, diagnosed with laser photocoagulation.</td></tr>
<tr><td rowspan="2">Teledermatological Screening</td><td>A.5 Percentage of telescreening appointments carried out within GMRT.</td><td rowspan="2">30%</td></tr>
<tr><td>A.6 Percentage of dermatological appointments carried out through telescreening.</td></tr>
<tr><td colspan="2">B. Results in terms of hospital internments, appointments and avoidable emergencies</td><td>30%</td></tr>
</table>

	B.1. Internment rate due to acute diabetes complications.	60%
	B.2. Internment rate due to decompensated diabetes.	
	B.3. Internment rate due to asthma or COPD in adults.	
	B.4. Internment rate due to asthma in young adults.	
	B.5. Internment rate due to arterial hypertension.	
	B.6. Internment rate due to congestive heart failure.	
	B.7. Internment rate due to pneumonia.	
	B.8. Internment rate due to acute diabetes complications.	
	B.9. Number of appointments conducted by hospital doctors at Primary Healthcare Units.	15%
	B.10. Percentage of non-scheduled readmissions into Emergency Services	25%
C. Integrated home support programmes		**10%**
	C.1. Ratio between the number of home hospital places (HH+CSP) and the number of hospital beds.	100%
	C.2. Percentage of users monitored at home with fully prepared health plan (CSP, HH, Social Sector).	
	C.3. Percentage of patients monitored at home through the telemonitoring programme.	
D. Programmes for appreciated value of SNS Patient Pathways		**10%**
	D.1 Programmes for appreciated value of SNS Patient Pathways	100%
	D.2. Percentage of people with health plans, whose realisation of the objectives expressed in these health plans are considered to be above the values of the standards established to this effect	

* Group 1 — frequent users of health services: frequent users (or very frequent) of health-related services, corresponding to people with more than one pathology or dysfunction ("multimorbidity");

Group 2 — People at risk of no longer using the health services they require, e.g. elderly people who live on their own;

Group 3 — People with multiple health risks: families, biomedical patients, psychological/mental, behavioural, occupational, environmental instances.

7. USER SATISFACTION ASSESSMENT

Assessing the satisfaction of users at any health unit is recognised as being a quality indicator aimed at directly measuring the level of quality perceived by the users, and for indirectly measuring the suitability of the services on offer based on the requirements of each user.

Even though these satisfaction indicators on health provisions group together items of a more technical nature in relation to personal interactions between professionals and patients, with inclusion of an inescapable emotion-reason component, such indicators reveal a difference between patient expectations and the service levels they actually receive. This is a precious tool for the continuous improvement of services.

Satisfaction assessment is an important tool for a policy of continuous improvement in terms of quality, including the contracting process developed within the SNS, and is explicitly referred to in annually established contracts at multiple health service levels.

8. AUDITS, ACCREDITATION AND CONTINUOUS IMPROVEMENTS

From an objectives and goals perspective, defined in accordance with existing resources and yet to be obtained results, it becomes necessary to develop a systematic auditing mechanism that makes it possible to assess correspondence between already carried out procedures and a set of pre-established criteria.

It is within this framework that an auditing plan for activities related to the contracted indicators for primary health solutions will become operational in 2017, contributing to continuous improvements in processes and registrations made by primary healthcare professionals and teams, which can further strengthen the levels of responsibility, transparency, and assessment levels assumed at this health service level. This work shall enable the full implementation of an auditing process for primary health services, contributing to assessment in terms of the degree of suitability of health professionals in relation to established standards, for assessing the quality of health services provided to the population, and to encourage the continuous improvement of health services and the economic-financial performance of all ACES functional units.

Multiple audits on the execution of the contract-programmes performed by the Local Health Unit hospitals shall also be carried out by the ACSS, for the clinical coding and the administrative data components found in the Homogeneous Diagnostic Group database (directed and random), and for activities effectively invoiced from a contract-programmes perspective.

Development shall also be encouraged in 2017 on accreditation processes involving SNS institutions, aimed at the continuous improvement of health responses provided to the population.

CENTRAL ADMINISTRATION OF THE HEALTH SYSTEM, IP

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