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Title: Inter-sectoral Health Policy in Portugal: Competition, Cooperation and Control

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Introduction

During the past 15 years, scholars have analyzed the structure and nature of intergovernmental relations in a diversity of social policy sectors. Attention is now focused on the mechanisms by which governments interact to develop public health policy. This focus is on governance in public health policy. The nature and success of the multi-sectoral response to public health issues have accelerated debate on the need for either major legislative or structural reform of the public health system (Ståhl & Lahtinen, 2006). In this paper, we would like to present a focus on the strategy of the inter-sectoral cooperation and the role of the Portuguese National Health Plan in policy-making. Some of the questions we would like to answer are:

(i) Does the National Health Plan represent a relevant approach to achieving health gains in Portugal and is this view based on **inter-sectoral public health policy** coherent with the values, principles and commitments of the EU member states?

(ii) Was the National Health Plan implemented in a way conducive to the attainment of **health gains**, and are there appropriate governance mechanisms in place to ensure that health system stakeholders focus on achieving the targets of the health system?

(iii) How did the involved actors, the politicians, administrative officers, technicians and experts differ in regard to the initiation, formulation and implementation of the targets set for the **national health plan**?

In this paper we begin by proposing a framework for understanding the various combinations of inter-sectoral relations that could exist in public health (Ståhl & Lahtinen, 2006). We then apply this framework to describe the Portuguese national health plan that deals with inter-sectoral policies mainly through the health setting approach. Next, we compare the effectiveness of the new set of relationships in the national health plan. With this information we present some conclusions on the benefits of different governance structures for public health reform.

1. THEORETICAL FRAMEWORK

The HiAP – Health in All Policies- approach is firmly embedded in the public health sciences and the interaction and knowledge of health, governance and public policies (Sihto, Ollila, Koivusalo, 2006). Knowledge about factors outside of health care which contribute to health is well established. This approach focuses on the decisions and actions on other sectors which are detrimental to health. It emphasizes that many contemporary health problems are social rather than individual ones, by nature, and in order to deal with the essential mechanisms of these health problems there is a need to concentrate on policies in other fields (Marmot, 1998).

Health is an outcome of a large amount of determinants together with those relating to individual, biological and genetic factors, and those concerning to individual lifestyles, as well as those related to the structures of society, policies and other social factors[1]. Determinants of health refer to the context of addressing structural rather than individual, biological or genetic determinants of health. Nevertheless, public policies also influence individual behavior and lifestyle choices[2].

Determinants of health can often be directly influenced through policies and interventions in the various arenas of policy-making, as well as in the various contexts in which people live and work (Bullock, Mountford & Stanley, 2001). The same causes can influence a large amount of health issues and at the same time, individual health problems are the effect of a variety of determinants. This means that **policies, interventions and actions** outside the health sector can address **determinants of**

[1] *Socio-economic determinants of Health*. WHO Regional Office for Europe, 2006.
[2] N. Milio, Making healthy public policy; developing the science of art: an ecological framework for policy studies. *Health Promotion*, 1988, 2(3): 236-274.

health more directly than they can address **health outcomes**[3]. Since health determinants are amendable to political interventions, the improvement of health through determinants is better and simpler than traditional interventions based on health problem approaches.

One of the problems of public health governance is its lack of clear allocation of responsibilities across different levels of government, producing a variety of systems of intergovernmental relationships (Asensio, 2011). Confusion remain in many public health sectors as to which order of government is responsible for doing what, producing a situation in which coordination of activities is challenging and gaps and overlaps in activities can arise. The consequences of these problems become worse with public health because it threats to cross local, territorial and national borders. Decisions made at the national government have a direct impact upon the public health activities of local governments. This creates a situation in which national, regional and local governments must coordinate their approaches to public health challenges to ensure they are effectively managed. Intergovernmental relationships are very important in public health and very difficult to establish. So, by gaining a better understanding of the various combinations of intergovernmental relations that can exist in public health and their potential impact on the development of policy, decision-makers will be able to construct more effective approaches to manage public health threats in the future.

Determinants of health require policy action across different organizations and sectors, not least the health care sector. Often, inter-sectoral relations are critical to formulating and implementing policy towards determinants of health[4]. However, evidence shows that relationships at all levels are hampered by cultural, organizational and financial issues. Different values, different accountabilities and performance measures criteria, and different reasons for collaborating are among the challenges for inter-sectoral relations. Moreover, the public health agenda may be marginal to collaborating organizations, being perceived as beyond their core purpose. It can also be argued that action on determinants of health requires intervention beyond state/government, by civil

[3] Attribution of policy interventions to outcomes is problematic. Such outcomes may not be evident for many years. Consequently, there is often a reliance on process measures as indicators of progress, assuming that they are associated with outcomes.

[4] *Intersectoral Action for Health. The Role of Intersectoral Cooperation in National Strategies for Health for All*. WHO: Geneva, 1986.

society organizations or even private sector agencies. Such collaboration regarding health determinants can even be more problematic[5].

Even within government, inter-organizational collaboration has often been poorly developed. Traditionally, government organizations tend to be organized vertically. Yet, such silo approaches are not well suited to tackle cross-cutting issues. A strong coordination role across government might compensate the silo approach but the balance of power usually remains with ministries. Determinants of health are one of many competing priorities for policy-makers' attention and resources. Economic, foreign or development policies might take precedence over determinants of health. More specifically, determinants of health may be over-outline in the policy process by health care itself. As most states take a prominent role in the financing and/or delivery of health care to its population, it is perhaps inevitable that states take a close interest in such matters. However, this health care focus is often to the neglect of health and determinants of health per se. That said, other spheres of policy can be informed by determinants of health.

Inter-sectoral relationships in Health Care: National, regional and local levels

In order to understand the impact of intergovernmental relations on public health, it is necessary to describe the set of intergovernmental relations that exist in public health sectors, basically the level of interdependency between the national and the regional level (Mindell, 2004). Interdependence refers to the requirement of one order of government for actions by another order of government to ensure that policy is successfully developed and implemented. If interdependence is present, the nature of interdependence then is characterized based on whether the relationship between the two orders of government is hierarchical. Hierarchy refers to the ability of one order of government to coerce another into taking a specific policy action. Hierarchy can result from legislative authority or financial mechanisms.

Based on the experience and nature of the interdependence, three forms of inter-governmental relationships can be described. If no interdependence exists, the relationship is described as **disentangled**. In this form, one of two conditions prevails: one order of government is active in the field while the other is inactive. Alternatively, both levels of government carry out functions in the same policy area independent of

[5] *Healthy Public Policy, Second International Conference on Health Promotion, 5-9 April 1988, Adelaide, Australia.*

each other. The key issue here is that the government involved act largely independently of any other government. If interdependence exists and the relationship is hierarchical, the form of governance is referred to as unilateralism. The national-regional relationship in health care could largely be characterized as **unilateral**. If interdependence exists and there is no hierarchy, the relationship is described as **collaborative**. Collaborative relationships involve constant intervention between levels of government as they attempt to reach consensus on the policy that needs to be developed. They do not necessarily imply harmonious relationships.

To accurately characterize the nature of governance in public health, the importance of a third level of government, local governments, and the various kinds of bodies that operate under it must be included in the model. While public health policy development mainly occurs at national and regional levels, actual policy implementation is largely a local responsibility. The inclusion of a third order of government increases the number of potential threefold intergovernmental combinations. While the previously described national-regional relationships may exist, there may also be similar forms of relationships between regional and local governments. For example, a disentangled regional-local relationship describes a situation where regional and local governments act largely independently of one another. A regional-local relationship describes a situation where a region coerces the local governments into acting in a specific manner. A regional-local collaborative relationship may also exist where the region works in a non-coercive manner with the local governments to develop or to implement a policy. Regions have experimented with a variety of forms of relationships with the local governments in an attempt to achieve the most effective working relationship. The implementation of the National Health Plan (NHP) at local level is a key strategy for successful implementation and involves the active participation of the various relevant social actors in the community: councils and municipalities, social security, educational institutions, private institutions of Social Solidarity (IPSS) and non-governmental organizations, among others. These relationships have given varying degrees of responsibility, funding and revenue raising power to the local governments and have involved different levels of amalgamation of activities.

A variety of national-local relationships may also exist in public health. The relationships can again be disentangled, national-local unilateral or collaborative ones. Interest in national-local relationships is increasing as the local governments begin

looking at the national government for revenue to compensate for their own limited revenue generating power. In the Portuguese case, support for the preparation of ELSa (Local Strategy of Health)[i] is one of the priorities in the implementation process of the National Health Plan, as regards the mobilization of social partners. One of the main implementation instruments for the National Health Plan concerns the development of Local Health Strategies with clear objectives, duly certificated and supported, which promote change and innovation for citizens and professionals alike. In order to promote cooperation among all, the ELSa wants to bring change and innovation to the public and professionals, and with reference to the incentive of the National Health Plan. Its implementation provides an opportunity to modify the patterns of relationship among the various social actors in the community and strengthen the instruments of governance regarding health and the role of the citizen.

In addition to the vertical intergovernmental relationship we have described, horizontal relationships between members within a level of government may also exist. An inter-regional relationship between regions in Spain and Portugal (Andalucía, Algarve, Extremadura)[6] has been proposed as an alternative to national involvement in regional public policy arenas. In this form of relationship regions and/or territories would work together, either in nations or nationally, to establish agreements to govern the management of policy areas[7].

2. METHODS

The data consisted of scientific articles and grey literature, including a number of policy documents and background papers. The grey literature includes the governmental website where data were found.

The analysis was made in two stages. The first stage was a descriptive analysis to extract the core content of data on aspects such as retrospective and descriptive policy analysis. First, all the data were read through carefully. We then highlighted and extracted the content that was related to policy, the actor's names with regard to this policy, the policy and political process and contextual factors. Finally, the highlighted sections of the data were categorized and organized from the perspectives of agenda

[6] The First Iberian Summit of Leaders in Health was celebrated on 4th and 5th February 2011.

[7] The municipalities of Arraiolos, Coimbra, Faro, Almada and Santa Marta de Penaguião will make up the five pilot projects for the implementation of local health strategies. Health services and other social partners will work in partnership and through networks, aiming to obtain benefits in terms of health.

setting and policy initiation, formulation and implementation. The analysis followed the methodology of theory driven qualitative content analysis focusing on factual statements expressed in the data. The second stage applied the theoretical model of analyzing inter-sectoral health policy to the Portuguese Health Plan. The results of the first stage of the analysis were categorized to enable making conclusions about the data on the basis of this theoretical framework.

3. RESULTS: APPLICATION OF THE FRAMEWORK TO THE PORTUGUESE HEALTH PLAN

Inter-sectoral cooperation is a fundamental task of modern public health (Dahlgreen, 1995). The preparation of health reports can be an entry point serving as a natural way to cooperate with other sectors. Although monitoring the health of the population has been a fundamental task of public health for a long time, only since 2000 has it become more acknowledged to present this information systematically in health reports, thus reviewing policy processes and linking them with health outcomes. Health reporting has thus become an indispensable element in formulating and guiding national health policy in Portugal.

The Portuguese Health Plan (2004-2010)[8] provides a comprehensive organizational framework for health system activities, which has proven useful to many health system stakeholders in strategically aligning their activities. The purpose of the National Health Plan is to pursue health gains and to monitor health system improvements through a public health document that has succeeded in obtaining agreement on health priorities and the support of a broad range of policy and decision-makers and health professionals in Portugal. The Plan prioritizes health gains and relevant performance drivers to reach these goals, such as prevention, health promotion and an emphasis on primary health care. The plan sets out an explicit direction towards more disease prevention and primary health care. Health system financing, efficiency and sustainability are not specifically covered by the Plan.

Agenda Setting

The rationale for creating a public health policy varied depending on different actors' perspectives. From the politicians' perspective, the main concern was the absence of a

[8] Plano Nacional de Saúde 2004-2010. Volume II. Orientações Estratégicas. Ministério da Saúde, 2004.

comprehensive national health plan including national targets and strategies in Portugal. The rationale was to create a comprehensive organizational framework for health system activities to reach health gains and important performance drivers. It was also stated that sectors outside the health sector had an impact on health development. However, there was a lack of coordination and collaboration between different sectors. It was seen as desirable to involve all relevant sectors and actors at different levels, such as experts, the civil society, trade unions and the general public, in the development of the public health policy (PNS, Ministry of Health, 2004).

From the point of view of the public health experts, the Plan focuses on the population's health gains in terms of level of health but does not draw in-depth attention to the distribution of health across the Portuguese population, such as by socioeconomic or educational status, age group, sex or geography. The Plan mentions health inequalities and focuses on the poor people in general, without specifying a clear strategy about how to reduce such inequalities. Although healthy life expectancy, premature mortality and morbidity rates have improved substantially over the last two decades in Portugal, health inequalities in terms of gender, ethnicity, educational and employment status and income have become more visible on a national scale and between regions over the last few years.

The rationale for using Health Impact Assessment is to raise awareness and put public health higher on the political agenda and to systematically analyze health impacts of political proposals. Promoting joint exercises in consensus building, dialogue, analysis and policy options are a good way towards strengthening the development of government ability to take inter-sectoral action in health. The creation in 2005 of a function (High Commissioner for Health) and a structure (Office of the High Commissioner for Health) responsible for coordinating the development, implementation, monitoring and evaluation of the Health Plan has been an important step in enhancing health system accountability and transparency for measurable health system improvements. The creation of an inter-ministerial committee ("the Survey Committee" led by the High Commissioner for Health), bringing together representatives from the Ministry of Health, various government Ministries involved in the implementation of the Plan, Regional Health Authorities and different health system stakeholders, has provided an opportunity for those responsible to review progress and take relevant action to stimulate performance. Furthermore, the Plan has strengthened

lines of accountability between the government and the regional health authorities and between the regional health authorities and their providers. For instance, the Office of the High Commissioner for Health has initiated regular meetings with regional counterparts to discuss the achievement of regional targets and variations in progress among regions. It should be noted, however, that there are no formal accountability agreements in place between the Ministry of Health and the Regional Health Authorities.

At the local level, in Portugal, the rationale for the creation of an inter-sectoral public health policy was identified in a similar way. Local health strategies have been developed by Regional Health Authorities to support the achievement of the goals set out in the National Health Plan, even if this effort has not been systematic or consistent across the regions. These local health strategies should support the integration of strategies included in the Plan and of the national health programs at provider level. They should allow the empowerment of the local level in planning, foster integration of programs and strategies at local level and enable the development of performance improvement process adapted to local circumstances.

Policy Initiation and Formulation

The National Health Plan was discussed publicly throughout 2003 and during the first few months of 2004, and received extensive contributions from a wide range of individuals, institutions and different sectors of society. Thus, one may claim that this document represents a broad consensus with regards to the kind of intervention that the Country needs.

This document was sent to Parliament, where it was supported by most parties. It was recognized that its implementation would stretch over more than one cycle of government and will require the continued support of all political forces.

This key tool of management works like a lever, with its strategic guidelines designed to sustain the National Health System politically, technically and financially. It acts as a common denominator, allowing for better coordination and collaboration of the multiple entities in the health sector. It considers health in its widest sense, in its interdisciplinary richness, making every Portuguese responsible for it (Hunter & Berman, 1996).

As a strategic document, the National Health Plan plays a uniting and guiding role in terms of what needs to be implemented in order to promote “More Health for All”

among the Portuguese. It brings together the necessary debates on health and guides the activities of the institutions within the Ministry of Health, on a national as well as a regional basis, and also within civil society.

Being already committed to the fulfillment of the goals set in the Plan, namely through the Action Plan for Health in 2004 – among other initiatives – which was defined in the latest Major Options of the Plan (MOP), and which brings together in one single tool all the agreed interventions by central and regional services. In July 2004, the activities developed in the first semester of the year were assessed and the Action Plan for 2005 was prepared. The plan also provides the basis for the Health contribution to the revision of the National Plan for Sustained Development.

The strategies identified in the Plan will be ensured through the Major Options of the Plan and the yearly action plans, and defined by these two means. In addition, the current and investment budgets of the Ministry of Health, as well as EU Community funds, should grant the resources necessary for the implementation of the NHP.

HIA was mentioned in the policy as a potential tool to ensure inter-sectoral health policy. One particularly important aspect of ensuring that the Plan is carried out is related to the inter-sectoral dialogue between sectors, with a view to mobilizing the will to contribute to the fulfillment of health objectives through other domestic policies such as agriculture, environment and education. In Portugal, this approach would result in the achievement of what other countries already have - health impact assessment.

At the local level, the public health policy was conducted by a commission responsible for its follow-up, essentially consultative in nature, although it would also put forward proposals for updating and making any revisions necessary for the proper development of the Plan. It should also write reports enabling the Ministry to make regular assessments of the evolution of the National Health Plan and to make the decisions necessary for its enhancement and viability.

Therefore, it was decided to set up a Follow-up Commission for the National Health Plan. This Commission, through open dialogue excluding no one, will guarantee that the Plan is galvanized, followed up, monitored and revised whenever necessary. Throughout this process, the Follow-up Commission will not work alone, as many other parties will be ready to collaborate on this mission so as to bring the Plan to a successful end.

Policy Implementation

According to the WHO, it was recommended that a national, high level policy group would ensure and be accountable for the implementation of the policy. To this end, a function (High Commissioner for Health) and a structure (Office of the High Commissioner for Health) responsible for coordinating the development, implementation, monitoring and evaluation of the Plan was established in 2005.

The Plan Follow-up Commission (CAP) was formed by June 2004. The members of the group are nominated for three years, but during this period they may be replaced. CAP will work by influence mechanisms. It will be coordinated by the High Commissioner for Health and it will include selected members to lead the Plan's activities in priority areas – infectious diseases, cancer, circulatory diseases, mental health, traumas and lifestyles. In addition, it will have its own budget for traveling and other expenses, as well as secretarial support. The group will meet every three months and will have the power to request data so as to monitor the development of the indicators associated with the Plan's targets and to access the different institutions' and other commissions' annual plans under the coordination of the Ministry of Health. In this context, the Strategic Regional Health Plans and the Ministry of Health Annual Plans should be seen as key instruments for this monitoring.

The follow-up Group should also report on the MOP for Health, as well as on the annual action plans by the ARS (Regional Authority of Health) and by other institutions and commissions under the coordination of the Ministry of Health; moreover it should assess whether the allocation of resources by PIDDAC, within Health XXI and other similar programs, such as the creation of jobs and the development of continuous training, do or do not follow the priorities set by the Plan.

Moreover, the CAP, has been instructed by the government to conduct a public health policy report every two years to present the activities and priorities for the 40 public health targets / health determinants and this group should also present its recommendations to the Government concerning any revisions to be made to the Plan, in order to better achieve targets or redefine them.

The Plan includes a large number of performance indicators and targets to monitor progress in implementation. These targets are used for public accountability and are released and updated regularly on the web site of the office of the High Commissioner

for Health. To assess the effects of the Plan, a statistical forecast was carried out on all performance indicators for which at least three data points were available between 2004 and 2008. The results of the forecast indicate whether the indicators are statistically on track to meet their related targets. It should be noted that it could be misleading to assess the success of the Plan on the basis of the number of performance indicators having reached their targets.

According to the WHO, the implementation of the Plan suffered from a lack of alignment between strategy, decision-making and implementation. In spite of considerable commitments made in the Plan to reinforce the health system, it has failed to clearly define institutional responsibilities for managing change. As a consequence, a number of commitments have remained vague and there were no or few consequences for the non-achievement of performance objectives[9]. Furthermore, the Plan has put forward a programmatic approach as its instrument of implementation, but has failed to define formal mechanisms to link strategy and decision-making in the Ministry of Health, across government and for the Regions. There has also been a lack of a clear policy for health system accountability.

Implementation has also suffered from the fragmentation of the health system management function of the Ministry of Health between different divisions with programmatic responsibilities (Directorate-General for Health), a coordination role related to the National Health Plan as well as a responsibility for managing key programs (Office of High Commissioner for Health) and the direct management of strategic responsibilities, such as the management of waiting times and contracts for health care providers or health information systems (the central administration of the health system). Furthermore, secretaries of state are directly responsible for managing key health system reforms such as those of primary health care or long-term care (Who, 2010).

This fragmentation does not promote strategic coalition and a consistent decision-making process based on a problem of information (knowledge about the consequences of different actions, system strategies and available information and evidence) and a problem of capacity (the ability to accomplish intended actions) that usually leads to underperformance. In our opinion, problems of information and capacity are

[9] According to Huber & McCarty (p.482), it explains that polities are trapped in a situation where they have little incentive to reform not only the bureaucracy but other institutions as well. The incentives of politicians to gain policy expertise are smallest when institutional capacity is low.

conceptually distinct. The High Commissioner, for example, may have policy expertise but, because of the problems described above, be unable to execute reliably the policies they intend. So, the only force and tools available to the High Commissioner for Health to ensure implementation of the Plan, according to WHO report, have been limited to moral influence and program responsibilities for four priority programs (Who, 2010).

The public health plan also lacked a culture of performance management, incentives and performance improvement. The National Health Plan itself suffered from a focus on developing provider incentives for performance measurement and management, although some of the regions were moving in this direction. The monitoring of provider performance takes place only on selected aspects of performance, such as efficiency in hospitals (monitoring waiting times) and by various institutions. There are currently no standards in Portugal for processes and desirable outcomes of services need to be defined and applied to public and private hospitals alike. Overall, the public health plan has given little consideration to provider incentive schemes, based on a New Public Management perspective, favoring a culture of continuous quality improvement, such as financial and non-financial incentives related to the implementation of guidelines and clinical pathways (Asensio, 2011).

The National Health Plan was, according to WHO report, unable to resolve the difficulty of coordinating and implementing numerous health programs at local level. Local health strategies have been developed by regional health authorities to support the achievement of the goals set out in the national health plan. Nevertheless, this effort has neither been systematic nor consistent across the regions because of the delegation principle. (Huber & McCarty, 2004)[10]

At the local level, there has been little information regarding the implementation or progress of the policy, only guidelines on how to implement it. Each unit should elaborate its own targets. There are, however, challenges and inconsistencies in how Regional Health Authorities implement the Plan. Put differently, bad bureaucracies are not only inefficient (i.e. less successful at implementing the policies they intent) but also harder to control because their incompetence diminishes their incentives to implement the policies politicians describe in legislation. Only one Region (North) has developed and is implementing a regional health plan. One Region (Centre) has developed a

[10] According to Huber and McCarty, the logic of delegation emerge where politicians typically delegate more discretion to bureaucrats when the bureaucrats are ideologically allies and when ex-post monitoring possibilities are more effective.

preliminary draft of a plan, while another (Lisbon) has faced major changes in executive staff and argued that the development of a regional plan does not match the current electoral cycle in terms of timing. The others (Alentejo and Algarve) have simply not had the capacity to develop full regional health plans. The support provided to the Regional Health Authorities by the Office of the High Commissioner for Health, coupled with knowledge transfer mechanisms, is a useful approach to building the necessary capacity for local planning and should be strengthened (Who, 2010).

It should also be noted that there have been positive examples of inter-sectoral action for health at community level. The dissemination of local health strategies, linked with the Community Health Councils in the new organizational arrangements of the primary health care networks is crucial to ensuring a successful implementation of the Plan.

There have been limits to and variations in inter-ministerial involvement and collaboration, even a number of successes should be built upon. The High Commissioner for Health has set up an inter-ministerial survey committee, which is in charge of monitoring the implementation of the Plan and the achievement of its targets. The survey committee gathers representatives from the different directorates of the Ministry of Health responsible for the implementation of the Plan, the five regional health authorities, national institutes related to the health sector, and other ministries (the Presidency, Land Use and Regional Development, Labor and Social Security, Youth and Sports, and Education) involved in the implementation of the plan (Who, 2010). The survey committee has met four times a year since 2007 and has discussed specific topics of relevance for the plan, such as the four national priority programs. Since then, it has not taken up the task of systematically monitoring the achievement of the targets and actively managing performance gaps. Furthermore, ministries important for the implementation of the plan, such as the Ministry of Justice, the Ministry of Finance, or the Ministry of Foreign Affairs, are as yet not represented on the committee (Who, 2010).

Overall, it seems that coordinated governmental action targeting health gains needs to be strengthened. The national health plan deals with inter-sectoral policies mainly through the health setting approach. The degree of involvement, however, varies considerably between different sectors. In some cases, there seems to be close interaction and a contribution from other sectors (such as education). Others may be moderately involved in some focus areas (for instance, the Ministry of Labor and Social

Solidarity in long-term care and in health and safety at work). In some cases, there is little awareness of or involvement in the Plan (for example, Ministry of Justice). In other cases, there is a fruitful collaboration between the Ministry of the Environment and the Ministry of Health (through the Directorate-General for Health) which has produced a National Environment and Health Action Plan that is monitored and updated regularly and consistently. Collaboration with the Ministry of Education on school curricula, health and sex education, the school meals program and promoting a "healthy schools" approach all over the country also seems to have been close. Collaboration with WHO and other international bodies has again been used as a catalyst for active involvement in monitoring health behavior among young people and focusing programs accordingly (Who, 2010).

4. Conclusions

The main findings of this study show that the Portuguese development correlated with the international progress and promotion of inter-sectoral health policy; the process of policy change was more expert-based at the national level and more politician-based at the local level;) that the interest of inter-sectoral policy mainly took place from the 2000's and at least up to the approval of the national health plan in 2004. In Portugal, public health is perceived as a universally important subject, but it rarely reaches the highest national policy level. However, if the HiAP strategy would be put into practice properly, having enough political support for implementation activities, it should place inter-sectoral health policy higher on the political agenda. To realize HiAP requires support and engagement from all relevant sectors, not just from the health sector. The formulated targets at both national and local levels were limited in regard to suggestions for action and plans for implementation. The policy did not manage to open the way to involve actors in other policy sectors and was not clear about their responsibility in relation to the new policy. There is a general idea that the Portuguese political-administrative culture and traditions are not favorable to fostering inter-sectoral collaboration. Particularly, at the central level, there seems to be a tendency to work in a fragmented way, which in itself is not conducive to inter-sectoral action in health. If this is the case, there are great challenges in working towards a collaborative-governmental approach and further steps will have to be taken to strengthen inter-sectoral action.

There are certain barriers limiting the use of health information to support the decisions of policy-makers, clinicians, managers, patients and consumers. A primary concern is the lack of common definitions and reporting on common indicators by all (public and private) health care providers. Another key challenge is related to the absence of a unique information database. Numerous databases are operated by policy-makers, administrators and care providers but are not interoperable. Finally, some data are not collected systematically, such as those on health financing, health expenditures and services utilization. The value of these data for policy-making, planning and general decision support is therefore limited. This situation places serious constraints on the Office of the High Commissioner for Health in effectively carrying out its role of monitoring the Plan and performance management.

These problems seemed to derive from many directions: lack of an inter-sectoral public health policy including national targets and strategies; lack of awareness of how other sectors affect the health development of the population; lack of collaboration and coordination between the health and other sectors; and a widening health gaps between different population groups. Simultaneously, international organizations such as the EU Commission and WHO (1985, 1997) pushed the agenda on inter-sectoriality in health and health impacts of political proposals.

Compared to some other policy areas, public health is still regarded as low politics: In other words, there is low political weight in the overall coordination of politics. When the national public health policy was launched, it emphasized the need for inter-sectoral action for implementation around which there was a relatively strong consensus between politicians, bureaucrats, experts and other groups. Thus, there seemed to be sufficient political support and scientific evidence to realize the policy. However, it has been claimed that a formulation was achieved because the targets were quite vague. The results of this study indicate that the guidelines for translating the policy into implementation and action plans were insufficient. There were some reservations about the policy, which suggested that not only the politicians but also experts had difficulty agreeing on action plans, such as Health Impact Assessment. Since the policy is not accompanied with clear action plans and accountability mechanisms, there is ambiguity about the role and responsibilities of the political and administrative actors in regard to the policy and its implementation.

There are no effective incentives to support the inter-sectoral and health impact assessment development in a more bottom-up manner. To date civil society linkages to ensure the effectiveness of policy implementation and accountability seem not to be in place. Consequently, it may be assumed that actors from either high or low politics areas are not yet fully involved in the realization of the public health policy in order to achieve its aim.

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[i] “Estratégias Locais de Saúde”.