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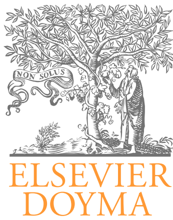

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PLENARY PRESENTATIONS: ABSTRACTS

2nd World Congress of Health Research

Viseu – Portugal, 7-8 October 2014

CONFERENCE I: LONGITUDINAL RESEARCH IN PORTUGAL. COHORTS OF PORTO

7 October 2014, 9:30-10:30

EPITEEN - THE CARDIOVASCULAR HEALTH OF ADOLESCENTS

Elizabeth Ramos

UP, Portugal.

EPIPORTO - A COHORT OF ADULTS OF PORTO

Carla Lopes

UP, Portugal.

GERAÇÃO 21 - BORN AND RAISED AT THE BEGINNING OF THE MILLENNIUM

Ana Cristina Santos

UP, Portugal.

CONFERENCE II: PALLIATIVE CARE IN PORTUGAL AND IN EUROPE

7 October 2014, 11:00-13:00

PALLIATIVE CARE: FROM ONCOLOGY TO ALL NURSING ARENAS — GOOD PRACTICE OR SCARING THE PATIENTS?

Angela Kydd

RGN RMN PGCE MSc Gerontology PhD Nursing; Senior Fellow of the HEA, Senior Lecturer Research, Institute of Older Peoples Health and Well-being, School of Health, Nursing and Midwifery, University of the West of Scotland, Hamilton Campus.

The aim of this paper is to encourage critical discussion on an individual's understanding of palliative care and compare this with a health care professional's understanding of palliative care. In doing this, the paper serves to illustrate the importance of words attached to services — so with palliative care - are we providing good care, or scaring the patients? The paper touches on the historical and contemporary duties of care that all health professionals undertake with their patients and the development of palliative care from being an adjunct of oncology to a specialism in its own right. The conclusions from the literature suggest that palliative care has moved on from becoming an adjunct

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of oncology to becoming an integral part of all care. However, and this is the main message, patients and their families are not aware of such developments and see palliative care services as end of life care. In using an example, if an individual is diagnosed with Motor Neurone Disease — do you think they would want to be seen by a motor neurone nurse specialist or a palliative care specialist? The words (to the public) would suggest that a motor neurone nurse would have an active part to play in a rapidly progressive disease that will end in death, whereas a palliative care nurse is someone who will deal with end of life care. This can have the connotations that palliative care is for 'hopeless cases'. According to the literature, palliative care started as an adjunct to oncology, it grew to become a specialism in its own right and today palliative care is in all health care arenas. But has this changed health care practice? The comfort and care of incurable people has always been a major part of caring. Think of tuberculosis, no cure was available before antibiotics. In the 1800s, Dr. Edward Trudeau, founder of a tuberculosis sanatorium, quoted Hippocrates (400BC) on the duties of the physician, which are 'To cure sometimes, to relieve often, to comfort always'. Even very curable diseases and disorders of the mind, body and soul will need a cure and if no cure will need relief and if no relief will always need comfort. So are we scaring people by providing a service called 'palliative care' when what we are really providing is comfort and caring? It is not part of a health care professionals ethos to cause more grief. To take a quote from the author Maya Angelou illustrates the unique and privileged role of the nurse. Maya states 'as a nurse we have the opportunity to heal the heart, mind, soul and body of our patients, their families and ourselves. They may forget your name, but they will never forget how you made them feel'. How important then is the title of 'palliative care'? How does it makes patients fell? in whose interest does such a label serve? Whatever your thoughts on the use of the term 'palliative care', it is important that you decide what has resonance for your patients. You may not agree with this paper, and I don't expect all of you to agree, but I hope it has made you think. For those who strongly disagree, take heart from a quote be Frank A. Clark (1860-1936) 'We find comfort among those who agree with us — growth among those who don't'.

PALLIATIVE CARE UNIT, HUMANIZING GUIDE

José Carlos Bermejo Higuera

Director Centro Asistencial y de Humanización de la Salud San Camilo; Doctor en Teología Pastoral Sanitaria, Máster en Counselling, Bioética, Duelo.

The Palliative Care Unit of San Camilo is a part of the Centro San Camilo at Tres Cantos (Madrid), integrated into a heathcare centre for elderly people, a day care centre, a home care service, attention to duel centre and a training, publications and cooperation to development centre (Centro de Humanización de la Salud). The unit aim is to provide the highest quality of life possible for people with advanced and irreversible diseases, as well as to their families, with a clear emphasis on respect for the inherent dignity of each person. To do so, all the spaces of the UCP, including stair access, have been decorated, in order to create a human space where patients and family can live healthy and harmoniously the moment whereby cross and enjoy an environment that makes an art of care. A space for Time has been dedicated and decorated, with the intention that patients and their families to experience time more as an opportunity than as a measurement. The watches come from different places, have different forms, such as the personalities of everyone who comes to this House. A space has been engaged with Painting. A cheerful picture gallery, a few frames without content in the ceiling open to the light, the headboards of the beds, bathrooms, cheerful and flowery, all different, portray a clean and bright environment where those who care are available and visible. The sector of Literature, with elements of art writing, books and evocative securities messages, tables with books, bookshelves shaped trees, a tree lit with explanatory parchment of the unit, a box of slices of cedar wood from El Salvador, a large library with effect trompe-l'oeil simulation and constitute what might appear to be the living room of a House. In the Sculpture sector we find bas-reliefs and columns and statues which evoke the art of the meeting when this occurs by way of physical contact, through the hands. In addition, the symbols of gratitude from families are preserved in this space. Tables and counter, foot of stone and glass surface, keep the line and invite the transparency. The last sector is defined by Music with elements from different parts of the world that contribute to decorate it and give identity. Piano, jukebox, violin, they want to evoke that it is music that holds the columns and not the columns which support the music. It is the art and the harmony of the music notes that want to hold the building designed to care. Last but not least, the outside has a practicable terrace and can even make the bed. Some rooms have beautiful viewpoints and two porches extending space and luminosity to the garden and areas in which you can enjoy the serenity that inspires the music and a space for the children who visit their loved. In the room multi-use with fireplace and in the small cellar you can enjoy moments of more intimacy or a wine bottled by the House.

PALLIATIVE CARE IN PORTUGAL AND EUROPE: DIFFERENT CONCEPTS AND ORGANIZATIONAL MODELS, DIFFERENT LEVELS OF DEVELOPMENT, DIFFERENT NEEDS AND (POTENTIAL FOR) FURTHER DEVELOPMENT

Sandra Martins Pereira

Post-doctoral Marie Curie Research Fellow, FP7 2007-2013 project EURO-IMPACT - European Intersectorial and Multi-disciplinary Palliative Care Research Training (grant agreement nr. [264697], Vrije Universiteit Medisch Centrum, EMGO+ Institute for Health and Care Research, Amsterdam.

Diverse international organizations have been defining palliative care in different ways. As an example, while the World Health Organisation defines palliative care as an approach that improves the quality of life of patients and their families when facing a life-threatening disease, other associations, as the European Association for Palliative Care , have been defining palliative care as an active type of care provided to a patient whose disease is not responsive to curative treatment. Although complementary and with similarities, these definitions have been influencing the way palliative care has been developed and implemented across different countries in Europe. Moreover, the development of palliative care in Europe is heterogeneous. This points out to the existence of different levels of development, indicating inequalities in the availability and accessibility of this type of care among European citizens. The objectives of this presentation are: (1) to reflect on how different concepts may influence the organization of palliative care resulting in diverse levels of development, and (2) to highlight the need and potential for further developments of palliative care in Portugal to make it accessible to all citizens who are in need of such type of care. Three country-cases will be presented and analyzed with regard to three diverse levels of development: Germany (advanced integration of palliative care), the Netherlands (preliminary integration of palliative care) and Portugal (generalized provision) . Questions will be raised on why these three countries present diverse levels of development. In addition, a set of inequalities in the access to palliative care in Portugal will be enounced: geographic, financial, diagnose-related, and age-related. Based

on the right of all citizens to palliative care, the intrinsic potential for further developments of this type of care in Portugal will be highlighted.

PEDIATRIC PALLIATIVE CARE IN PORTUGAL

Ana Forjaz de Lacerda

MD, MSc Pall Care Paediatric Consultant, Portuguese Institute of Oncology — Lisbon DINAMO Project, Calouste Gulbenkian Foundation Coordinator, Directorate General of Health Taskforce for the Development of Paediatric Palliative Care Coordinator, Paediatric Taskforce of the Portuguese Association of Palliative Care Coordinator, Palliative and Continued Care Taskforce of the Portuguese Society of Paediatrics.

Paediatric palliative care (PPC) is a basic human right for all children, especially for those living with complex chronic conditions that may limit their life expectancy. Worldwide levels of provision are very low, with 65.6% of countries (including Portugal) with no reported activities. Although general principles and symptom management are similar to adult care, some differences must be highlighted. The most relevant is that PPC aims, by definition, to support children and families since the diagnosis of a life--limiting or life--threatening condition, not only at the end--of-- life. Therefore, PPC needs may linger for many years or even decades, as medical and technological advances currently allow for extended survival of children with conditions that used to cause an early death (some young people will need to have their care transferred to adult services, raising yet another topic). Furthermore, the number of children with PPC needs is small and diagnoses are varied (estimated at over 300 conditions, most of them considered rare). The paediatric age group (0–17 years 364 days in Portugal) is also diverse, with differing developmental stages (physical, physiological, cognitive and emotional). Additionally, this population raises unique ethical dilemmas, especially related to autonomy and the relationship with parents. Conditions eligible for PPC are divided in four categories, according to disease trajectories; it must be remarked that in category 1 (e.g. cancer, organ failures, intensive care) if treatment is successful children may return to normal health and no longer require PPC. The most common diagnoses are neurological, oncological, cardiovascular and genetic or perinatal; many situations are highly complex, requiring multiple specialties to be involved. Most paediatric deaths occur before the first birthday (of which around 50% in the first month of life). Prevalence of children with PPC needs is rising, with the most recent study reporting 32 per 10,000 0-−19 year−-olds in England. In Portugal, where the paediatric population is decreasing (in 2013 0-−17 year−-olds represented only 18% f the population), we can estimate that around 6000 children are living with PPC needs. A recent Portuguese study has shown a downward trend in the proportion of home deaths (a recognized quality outcome) for children with PPC needs; currently it is around 10%, the same as for children dying from accidents or other sudden/acute medical conditions, and at least half of that found in countries with PC provision. Portugal has an urgent need to plan and develop PPC services that can reach out to all in need, avoiding inequities related to diagnosis, age or place of residence. These services must become intertwined with the healthcare system, reframing the use of existing resources to their full effectiveness with the maximal quality. Cooperation, both national and international, is fundamental to achieve this goal. PPC regional networks, within a framework for referencing and/or consulting, seem to be sustainable and effective in delivering care. At the same time research must be undertaken to recognize paediatric users' needs and expectations, as well as to produce robust evidence on the effectiveness of PPC interventions.

CONFERENCE III: SYSTEMATIC REVIEW OF THE LITERATURE: FROM THE LEVELS OF EVIDENCE TO THE GRADES OF RECOMMENDATION

7 October 2014, 14:30-15:00

SYSTEMATIC LITERATURE REVIEW: FROM THE LEVELS OF EVIDENCE TO THE GRADES OF RECOMMENDATION

João Apóstolo, Daniela Cardoso

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A systematic review comprises a systematic search and identifies and summarizes the available evidence with particular attention to the methodological quality of studies or the credibility of opinion and text. As a result, systematic reviews occupy the highest position in current hierarchies of evidence. Actually, when a level of evidence is assigned to a specific piece of information based on its study design, the clinician is able to make a preliminary judgement on the methodological quality and rigour of the evidence. The Joanna Briggs Institute has developed its own unique Levels of Evidence and Grades of Recommendation.[1] It is important to note that these Levels of Evidence provide a ranking based on the likely best available evidence, and should not be used as a definitive measure of the best available evidence. It may be that evidence that comes from observational studies should sometimes be preferred over that which comes from experimental studies.[1] According to the JBI, the levels of evidence for therapy/ interventions, Diagnosis, Prognosis have been designed to align with the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach to pre-ranking findings based on the study design, which are then upgraded or downgraded depending on a number of factors. The levels of evidence for costs are different than the other levels of evidence and not based purely on study design.[1] With regard to qualitative and text and opinion study designs, it is not appropriate to distinguish between different qualitative study designs via a hierarchy. Thus, all qualitative research studies start off as 'high' (on a ranking scale of High, Moderate, Low to Very Low), while text and expert opinion are pre-ranked at 'low'. Then, synthesized findings can be downgraded based on their dependability and credibility.[2] Simultaneously, the Joanna Briggs Institute assigns a grade of recommendation to all recommendations made in its resources. The Grades of Recommendation are used to support healthcare professionals when implementing evidence into practice. The new JBI grades of recommendation (informed by the GRADE working group) are a binary system, with two options: 'strong' or 'weak.' The 'strong' recommendation is represented by letter 'A' and the 'weak' recommendation is represented by letter 'B'. This system can be easily interpreted by clinicians and patients.[1] A strong recommendation implies uniformity of choice and a weak recommendation implies variability. Both strong and weak recommendations have a direct impact on the patient-provider dyad at the point of decision making.[3]

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3. Andrews J, Guyatt G, Oxman AD, Alderson P, Dahm P, Falck-Ytter Y et al. GRADE guidelines: 14. Going from evidence to recommendations: the significance and presentation of recommendations. J Clin Epidemiol. 2013;66(7):719-25.

CONFERENCE IV: FROM THERAPEUTIC HYPOTHERMIA TO HEMODYNAMIC, ENDOCRINE AND NEUROLOGICAL CONTROL IN THE ICU. THE PORTUGUESE REALITY

8 October 2014, 09:00-10:15

THERAPEUTIC HYPOTHERMIA IN CHILDREN: TREATMENT OF NEONATAL ASPHYXIA

André Mendes da Graça

H. Sta. Maria, Portugal.

THERAPEUTIC HYPOTHERMIA IN ADULT

Luís Bento

H. S. José, Portugal.

CONFERENCE V: MENTAL HEALTH IN THE XXI CENTURY: WHAT PRIORITIES?

8 October 2014, 10:30-12:00

FROM MEDICALIZATION OF EMOTIONAL PAIN TO PSYCHOTROPIC DRUG PRESCRIPTION

Nuno Pessoa Gil

Centro Hospitalar Tondela, Viseu, EPE.

By looking at the national epidemiologic results obtained from the World Mental Health Surveys Initiative, one could get quite alarmed. According to the data provided from this survey, the annual prevalence of common mental health illnesses (other than psychotic and delusional disorders) in Portugal has reached 22.9%. This means that about one in every five Portuguese adults is afflicted by some mental disorder in one year period. If we consider lifetime prevalence, those numbers are roughly duplicated to 42.7% — which represents almost one half of the living population![1] These numbers place Portugal as one of the worldwide countries with worse mental health figures. In clinical practice, a visible consequence of this reality is the growing use of psychotropic medications (mostly anxiolytics and hypnotics) by patients, irrespective of their limited prescription.[2] In order to understand prevalence numbers and medications sold we need to go deep into the problem's roots and analyze diagnosis itself and its presumed origins. Diagnosing in psychiatry is achieved through mental status examination, but relies a lot on the narrative of the ill-person, meaning that the diagnosis of the supposed underlying pathological process (disease) is strongly dependent and influenced by the subjective experience of being ill (illness). After World War II, occidental and northern-hemisphere societies have evolved towards hedonism and consumption, pursuing beauty, wealth, general well-being and individual success as values. Suffering — both physical, emotional and, even, spiritual — is not accepted nor acceptable. As a matter of fact, the community, the tribe, looks with suspicion at the former member who is afflicted by some form of physical or emotional suffering. Physical suffering, old-age, disease, death and dying are not willingly accepted as a normal part of life but instead are denied by the community and quickly swept aside to hospitals, nursing homes and crematories. By physical elimination of corpses, mankind creates the illusion of defeating the ultimate enemy: Death. On the other hand, emotional suffering became neither a matter of study by philosophers and scholars, nor of intervention by religious ministers, as it used to be. Emotional pain shifted into the offices of psychiatrists, psychologists and behavioral scientists. Emotional suffering has been, therefore, medicalized and emotional pain is nowadays object of narcotization with tranquilizers, regardless of long-term consequences. The same societies that negatively sanctioned alcohol abuse and drug addiction are encouraging the use of psychotropic medications as a mind-numbing alienation from everyday troubles, in the very same way and with the same purpose than those whom they have criticized. In our view, both mental health professionals and general population need to be re-educated in order to normalize the experience of emotional suffering and pain, since these are universal experiences inherent to human condition and normal life. These experiences need to be dealt with and not anesthetized.

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WORLD MENTAL HEALTH SURVEYS INITIATIVE: MAIN RESULTS AND IMPLICATIONS FOR MENTAL HEALTH SERVICES IN THE FUTURE

José Caldas de Almeida

UNL, Portugal.

(IM) PATIENT IN MENTAL HEALTH IN A HECTIC WORLD

Jose Carlos Santos

ESEnfCoimbra, Portugal.

CHALLENGES IN THE CONTEXT OF INTERVENTION IN ADDICTIVE BEHAVIORS AND DEPENDENCIES

Graça Vilar

SICAD, Portugal.

THE ASSUMPTION OF THE OBVIOUS: WITHOUT MENTAL HEALTH THERE IS NO HEALTH

Álvaro de Carvalho

DGS, Portugal.

CONFERENCE VI: CULTURE OF PATIENT SAFETY: BAROMETERS OF QUALITY IN HEALTH

8 October 2014, 14:30-15:45

CULTURE OF PATIENT SAFETY

Margarida Eiras

ESTSL, Portugal.

PROGRAM FOR PREVENTION AND CONTROL OF INFECTION AND ANTIBIOTIC RESISTANCE

Elaine Pina

PPCIRA, Portugal.

AUDITS IN THE CONTEXT OF PATIENT SAFETY

Fernando Barroso

H. Setúbal, Portugal.

HOSPITAL INFECTION IN THE UNITED KINGDOM

Etelvina Ferreira

United Kingdom.

HOSPITAL'S MICROBIOME

Eduardo Melo

Comissão de Controlo de Infeção e Resistência aos Antimicrobianos, Intensive Care Unit, Centro Hospitalar Tondela-Viseu, 3504-509 Viseu, Portugal.

Microbes were the ancestors of life on Earth and are still the mainstay of biodiversity. Microbiota is defined as a collective microbial community inhabiting a specific environment. Microbiome is the collective genomic content of a microbiota. The microbes that exist in the human body are collectively known as the human microbiota or microbiome. This amazingly complex group of communities has an enormous impact on humans. Before birth we live in a sterile environment devoid of microbial colonization, but soon the newborn is exposed to the microbiota of the mother setting in motion the process of colonization of mucosal tissues in the digestive, respiratory and urogenital tracts and the skin. The interaction between the microbiota and its human host is the culmination of co-evolution with vertebrates that has reciprocally shaped the repertoires of the microbiota and the immune system. The scope of this interaction is particularly evident in the intestinal tract, in which the greatest diversity and abundance of microbes reside. The gut microbiota protects against enteropathogens, extracts nutrients and energy from our diet, and contributes to normal immune function. Healthcare associated infections (HAI) currently affect 5 to 10 % of hospitalized patients in Europe. According to ECDC the european facilities have to face 4.000.000 HAI/year, 37.000 attributed casualties/year and these infections will cost at least 16.000.000 €/year. HAI are particularly transmissible in susceptible populations if there is a reservoir in the facility and about one third of the infections can be linked to lapses in infection control protocols, such as failure of healthcare workers to wash their hands or to improper attention to cleaning and disinfection of the environment and equipment. Several studies have shown a strong correlation between environmental contamination of patient's rooms with multidrug resistant pathogens and acquisition of infections by roommates or new occupants even after terminal cleaning. Hospitals are complex facilities interspreading the microbiota of infected and colonized patients, healthy visitors and healthcare providers with the environment. How microbial communities persist and change in indoor environments has much interest. Despite the lack of direct evidence to prove that environmental contaminants are responsible for HAI, there is increasing evidence suggesting that the environment may act as a reservoir for at least some of the incriminated pathogens. The Hospital Microbiome Project is being held in a new hospital built in Chicago, and consists of a systematic sampling of the building, patients and staff in a coordinated approach in order to understand the source and development of nosocomial infections. In Portugal we have some evidence that the environment of our hospitals may act as a reservoir for some of the pathogens implicated in nosocomial infections. The bacterial contamination level is related to the presence of humidity on the surfaces and equipment and biofilms of taps can be a point of dispersion of potentially pathogenic bacterial species. We also have evidence of growing disinfectant resistant species in hospital environment.

CONFERENCE VII: DEMOGRAPHICS, BIRTH AND HEALTH POLICY

8 October 2014, 16:00-17:00

THE IMPACT OF THE DEMOGRAPHIC CHANGES IN PORTUGAL AND IN THE NHS: CHALLENGES FOR THE FUTURE

Ana Escoval

Hospital Administrator at CHLN, Assistant Professor at ENSP/UNL and President at APDH.

The XXIst Century will witness an unprecedented growth in the history of the humanity in the elderly population. The change in the age structure is associated with the ageing population and will comprise profound changes in the economic growth globally, along with the budget pressures caused by the growth in age related expenses and to the social and political processes. Faced with the expected changes in the fertility, life expectancy and migration rates the estimates point to a dramatic change in the next decades in the global population. For the next 50 years' the projections indicate the worlds' population will significantly increase together with the number of older population (European Commission, Directorate-General for Economic and Financial Affairs, 2012). According to the 2012 Ageing Report, there are some differences in the trends of the populations' growth between the different European States as in the cases of the United Kingdom and Ireland, with more than 27% and 46%, respectively. Portugal is among the countries that will register a strong reduction in the population. Between 2001-2011, the aging index in Portugal increased from 103 to 128 older people per 100 youngsters and the proportion of individuals in the active age (population aged between 15 to 64 years of age) decreased from 67,3% to 66,0%, with an increase in the number of aged population (aged 65 or more) from 16,6% to 19,0% (INE, 2013). In fact the life expectancy is increasing; however, also the burden of chronic diseases, especially of non communicable diseases (ex: stroke, diabetes, dementia or cancer) that more commonly affect the adults and the aged accounting for the highest health burden globally. The potential economic and social costs of these diseases increase strongly with age, also affecting the economic growth (OECD, 2013). An aged population poses challenges for the societies and economies at

cultural, organizational and economic levels. The seriousness of these challenges depends on how the economies and societies respond and adapt to the demographic changes. The decision makers need to ensure the long-term fiscal sustainability, faced with this reality encompasses a significant degree of uncertainty. A reflection of these challenges are the many European recessions in these last decades, which placed an unprecedented level of stress over the workers and companies and impacted negatively in the public finances (European Commission, Directorate-General for Economic and Financial Affairs, 2012). Therefore, it is important to ensure the financial protection and access to the health services as a priority, especially for those at risk of poverty, unemployment, social exclusion and disease; as well as to focus in promoting the efficiency and the cost-effective investment in the health system through the construction of a resilient health system with a sustainable financial policy. It´s also important to plan an integrated response to face the negative effects of a possible economic crisis, ensuring simultaneously that the reforms are in line with the on time objectives, values and priorities of the national policies and at last, the information systems should be improved thus allowing to monitor, evaluate and share the existing best practices. This conjuncture and the impact of the demographic changes in Portugal encompass a profound analysis of the Portuguese National Health Service, aiming to adequate the existing budget to the health and social systems, as well as the definition of the structural measures sustaining this new reality and the associated social changes. For that, it is indispensable to develop a research process, allowing the gathering of evidence, and to provide a rigorous response to the needs represented by the existing data, both at national and international level, thus contributing to a more effective monitoring, evaluation and sharing of the best practices.

AGEING, IMMIGRATION AND CARE IN PORTUGAL

Maria Lucinda Fonseca

Centro de Estudos Geográficos, Instituto de Geografia e Ordenamento do Território, Universidade de Lisboa.

The ageing of the Portuguese population is a long-term trend that has become more evident and worrying in the present decade. During the last 40 years the number of persons aged 65 and older increased 2.4 times while in the same period was observed a remarkable decline in the proportion of young people. The recently released results for 2013 show a country with an old age dependency ratio of 30.3, an index of renewal of the active population of 86.2 much lower than the figure for 2001 (142.4) and a declining proportion of young people (only 14.6% are aged 14 or less). These demographic transformations have major economic, social, political and cultural repercussions. Therefore, the policy implications of demographic ageing have gained significant ground in policy debates during the last years, in diverse domains (e.g. fertility, international migration, increased productivity, and workforce participation rates, increasing retirement age, intergenerational relations, risk of poverty and social exclusion of elderly population and changed patterns of providing care for old age).

Giving this context, the goal of this paper is to explore these processes, through the analysis of three inter-related topics: i) The link between international migration flows and demographic change in Portugal in the last decades. ii) The main characteristics of elderly care services, social policies and institutional arrangements to respond to the aforementioned demographic trends. iii) A brief review of research linking migration and care in Portugal. Despite the preliminary nature of this study, the results allow to conclude that according to demographic scenarios in forecasting models, developed in a previous paper (Fonseca, Abreu & Esteves, 2014), in the next decades, there will be a strong trend of reduction of the resident population in mainland Portugal, as well as a growing proportion of ageing people. In 2011, the Potential Support Ratio (PSR) was 3.42. In 2051, even considering the most favourable scenario (which is very unlikely to occur); there will be 2.44 working-age individuals for each retirement-age person. According to the most likely scenario to take place, the PSR will be only 1.8. Therefore, population ageing is unavoidable and cannot be compensated for by any population policy, neither immigration policy, or family policy. Immigration is essential to maintain the absolute numbers of active population and contribute to the good functioning of home care and institutional care. However, the performance of the Portuguese economy in the future will be the main drive of net migration and, consequently, of main demographic trends. The Portuguese elderly care system is still a mixed care model, where family and care services complement each other, depending on family's affordability and recipient's disability's levels. Following the trend observed in other Southern European countries, albeit with less intensity, the number of migrant women working in care services in Portugal is growing, both in formal and informal sectors. However, due to the lack of empirical data and the "grey labour" in home-based care services, further research is needed to understand the links between ageing, migration, social and family policies, social classes, family structures and long-term care (Fonseca and Pires, 2013).

HEALTH POLICIES AND PROGRAMS OF HEALTH: INFORMATION STRATEGY

Paulo Jorge Nogueira

Directorate-General of Health, Portugal.

In Portugal, since 2004, there are National Health Plans in place that are important strategic tools for the country. The current NHP 2012-2016 - currently under possible extension to 2020 to align temporally with more global counterparts - has the vision to maximize the gains in population health through the alignment and integration of sustained efforts of all sectors of society, focusing on citizenship, equity and access, quality and the sound policies; and is conceptually based on four pillars: Citizenship in Health, Equity and Access, Health Quality and Healthy Policies. Concurrently, the Ministry of Health established a set of nine National Health Programs - said Priority Programs - that require indicators and data to know the respective evolutions and support the adopted measures. The Law Dispatches of January 3, 2012 (8 programs) and February 22, 2013 (1program) of the Secretary of State Assistant to the Minister of Health established: National Program for Prevention and Control of Tobacco; National Program for the Promotion of Healthy Eating; National Program for Brain Cardiovascular Diseases; National Program for Cancer Diseases; National Program for Diabetes; National Program for Mental Health; National Program for Respiratory Diseases; National Program for Infection HIV / AIDS; Program for Prevention and Control of Infections and Antimicrobial Resistance. Historically, the performance balance of a PNS is made based on a large set of indicators defined a priori, of which only a part is really observed. In fact a more comprehensive strategy for monitoring the health of the Portuguese Population is required. The health ministry has strengthened the role of the Directorate General of Health (DGH) as coordinator platform for health information. Additionally, DGH has created instruments that allow a regular, open and transparent monitoring of many health outcomes (this includes the Health Dashboard - http://www.dgs.pt/dashboard -, and GEOSAÚDE - http://www.geosaude.dgs.pt/); has also committed to a regular timely dissemination of information available strategy - particularly with the publication of reports for all priority programs started in 2013 (for 8 of them, 1 started earlier) and will take place on a yearly basis.