

# Pulse Check: Monitoring of Family Health Units in Portugal

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## Key messages

- The transition to USF-B increases care delivery activity in the short term, but does not show consistent gains in spending on medicines and diagnostic and therapeutic procedures.
- There is strong support for Health Management, Disease Management and Access; there is lower acceptance of avoidable hospital admissions and per capita financial metrics.
- The recommended option is an IDE 2.0, with prevention, care coordination and business intelligence viewed through an equity lens.

## Executive Summary

**Problem:** The Team Performance Index (IDE) shapes financial incentives and the management of Family Health Units (USF). The creation of Local Health Units (ULS) and the transition from USF-A to USF-B demand an **IDE more strongly focused on results, equity and care integration**. The Pulse Check project was designed to support this update.

**Main findings:** **1)** Transition to USF-B is associated with initial gains in service activity (medical and nursing consultations), with no consistent effects on expenditure on medicines and diagnostic/therapeutic tests (MCDT); sustainability over time is uncertain and there is heterogeneity across methods and locations; **2)** There is greater agreement on retaining Health Management (≈84%) and Disease Management (≈83%); Access (≈74%) is largely consensual; Care Integration (≈61%) and especially Prescription Quality (≈41%) have lower acceptance. Indicators most valued by professionals include cervical cancer screening (≈92%), child health surveillance (1st year ≈92%; 2nd year ≈88%) and, in diabetes, assessment of foot ulcer risk (≈94%). The least accepted are avoidable hospitalisations (≈17%) and per-capita prescribing of MCDT/medicines (≈17%); **3)** IDE is useful as a monitoring tool but requires corrections to mitigate current risks; and **4)** Business Intelligence (BI) platforms already map UCC/UCSP/USF-A/USF-B over time and territory, track IDE by dimension/indicator and are sensitive to changes introduced by Decree-Law No. 102/2023; improvements needed include sociodemographic breakdowns by ULS (age, dependency) and urban/rural context to read performance through an equity lens.

**Main policy options and recommendations:** **a)** IDE 2.0: reinforce prevention and disease management; reformulate Care Integration (replace “avoidable hospitalisations” with coordination/continuity metrics) and revise Prescription Quality (risk/case-mix adjustment and appropriateness criteria); **b)** Measure what matters to users and teams: introduce response-time and problem-resolution metrics with feedback between levels of care; and **c)** BI for management and equity: disaggregate by ULS/NUTS III, age/dependency index and urban/rural profiles; provide “traffic-light” panels and drill-down.

**Primary audiences:** Ministry of Health, DGS, ACSS, ULS and PLANAPP.

## Introduction

The IDE structures contracting and pay-for-performance in USFs, aligned with Portaria No. 411-A/2023 (Annex II) (Portugal, Portaria 411-A/2023) and the reorganisation into ULS (Portugal, DL 103/2023; Portugal, DL 102/2023). The ongoing organisational reform (ULS) and the migration from USF-A to USF-B have made it pressing to align the IDE with clinical outcomes, user experience and care integration, while preserving comparability and

a focus on territorial equity (OECD, 2024; Papanicolas et al., 2022). Pulse Check was designed by integrating the four strands of the project—(i) econometric analysis of the USF-A→USF-B transition, (ii) a Qualtrics survey of professionals, (iii) 11 semi-structured interviews with USF coordinators, and (iv) a functional assessment of Primary Care BI platforms.

## Analysis and Main Findings

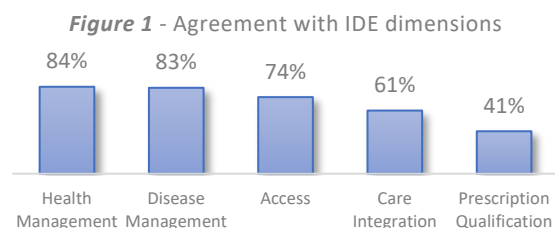
### Impact of the transition to USF-B

The empirical strategy combined an event-study design with the Callaway & Sant'Anna estimator for staggered treatment. The main results show: **an immediate increase in care activity** (medical and nursing consultations) after the change of model; no consistent effects on average expenditure on medicines and MCDT; heterogeneity and attenuation in the medium term, warranting robustness checks and an urban/rural split.

**Implication:** gains in capacity/activity do not automatically translate into economic rationalisation; incentives and metrics need to be refined.

### Professionals Perception

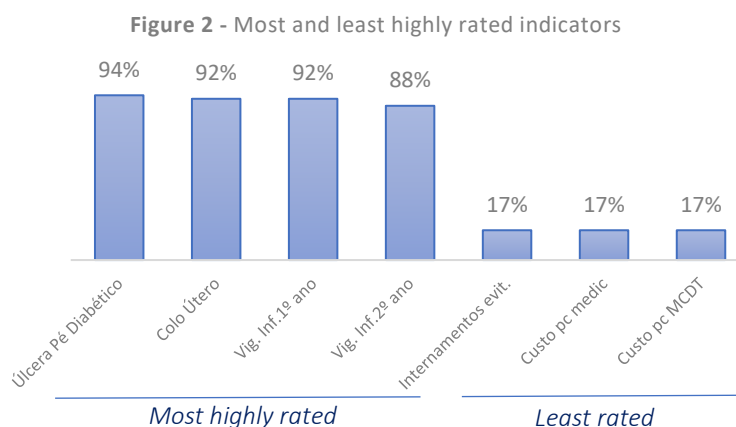
The sample: 351 responses for dimensions and 281 for indicators and characterisation. There is greater agreement on retaining Health Management (≈84%) and Disease Management (≈83%); Access has majority acceptance (≈74%); and there is lower support



for Care Integration (≈61%) and, above all, for Prescription Qualification (≈41%).

**Most valued indicators:** cervical cancer screening (≈92%); child surveillance (1st year

≈92%; 2nd year ≈88%); and diabetes—assessment of risk of foot ulcer (≈94%).



**Indicators with lower acceptance:** avoidable hospitalisations (≈17%) and per-capita costs of MCDT/medication (≈17%).

### Recurrent qualitative suggestions

include waiting time (e.g., scheduled consultation within 5 days), user and staff experience, satisfaction, humanisation, personalisation, training/scientific output, indicators for clinical administration, vulnerability lenses (socio-economic status, migration) and more appropriate weights across indicators.

**Interpretation:** professionals prioritise prevention and surveillance; they contest crude financial metrics (per-capita prescribing) and distal outcomes (avoidable hospitalisations) when used as proxies for integration without risk adjustment.

### Managerial Perception

The IDE is useful as a **tool for focus and detection of deviations**, but coordinators warn about (i) the risk of “managing to the indicator”, (ii) the need for risk and contextual adjustment (urban/rural and availability of specialties), and (iii) caution with crude financial metrics.

### BI Platforms

Existing dashboards allow monitoring of the IDE by dimension/indicator and demographic characterisation; a **re-organisation is recommended into five areas** (National; ULS; Comparator; Matrix; Legislation), an IDE “traffic-light” with drill-down to USF level, and an equity lens (ULS/NUTS III, age/dependency index, urban/rural).

**Critical point:** to support equity-focused decisions, BI must highlight sociodemographic differences by ULS and urban/rural context, enabling local targets/adjustments.

Figure 3 – IDE 2.0: Priorities



## Alternative Policies and Recommendations

### Alternative Policies

A1 — Maintain the current IDE, with incremental adjustments. **Pros:** continuity and comparability. **Cons:** misalignment with evidence and low acceptance of parts of the index.

A2 — IDE 2.0 (recommended): strengthen Health and Disease Management, reformulate Integration (measurable continuity/coordination) and revise Prescription Qualification (clinical appropriateness and case-mix adjustment). **Pros:** focuses on outcomes with equity; greater professional legitimacy. **Cons:** requires transition and capacity-building.

A3 — “Core + Local”: 10 national core indicators + a local module (up to 20%) defined by each ULS/ACES. **Pros:** territorial relevance.

**Cons:** risk of excessive heterogeneity without safeguards.

### Recommendations

- 1) Redesign Care Integration by replacing avoidable hospitalisations with metrics of continuity/coordination (resolutivity within the USF; counter-referral ≤30 days; post-discharge consultation ≤7 days; shared care plans);
- 2) Review Prescription Qualification — replace per-capita cost metrics with indicators of clinical appropriateness with case-mix;
- 3) Consolidate Health and Disease Management (prevention and surveillance with higher acceptance) and update indicators with low pertinence;
- 4) Reinforce Access with operational metrics (time to scheduled consultation,

- service-level agreements for contact handling, no-show), maintaining prescription renewal within ≤3 working days;
- 5) Add a module on Experience and Humanisation (PREMs and team well-being);
  - 6) BI for equity and management (metadata, transparency, exports, pre/post Decree-Law 102/2023 series);
  - 7) Phased implementation with pilot(s) and a participatory annual review of indicators.

## Conclusions

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The evidence indicates that the shift to USF-B increases care capacity in the short term, but is not sufficient to guarantee value and integration. IDE 2.0—anchored in prevention, disease management, response times and

care coordination, with equity-oriented BI—is the most robust path to align incentives with what matters and to reduce territorial asymmetries.

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