Portuguese Journal of Public Health

Editorial

Port J Public Health 2023;41:1–3
DOI: 10.1159/000530024

Received: March 2, 2023
Accepted: March 3, 2023
Published online: May 10, 2023

Public Health, Clinical Governance, and Governance for Health and Well-Being

Victor Ramos

NOVA National School of Public Health, NOVA University Lisbon, Lisbon, Portugal

Downloaded from http://karger.com/pjp/article-pdf/41/1/1/3871833/000530024.pdf by guest on 31 May 2023

The pandemic COVID-19 had and continues to have a disruptive impact on all health systems worldwide. It has accentuated previous weaknesses and caused various troubles, with great physical and emotional strain on health care workers and subsequent negative consequences of attrition and burnout. At the same time, it also helped to highlight the advantage of health systems having a strong public base, especially when they have strong primary health care and public health services. Therefore, the impacts of the pandemic were varied and quantitatively very different in the various countries of the world, in part due to the nature, social orientation, organization, governance, and resources of their respective health and social protection systems.

However, most of the current problems in health systems have multiple roots and go back for decades. In general, countries have devised piecemeal measures and reactions in immediate response to the problems that have arisen and the crises with which they have been confronted. In the UK, for example, a succession of scandals and serious medical malpractice cases led to a reconceptualization of the principles, strategies, and qualitative methods in health services. From this process emerged the conceptual and strategic construct of *clinical governance* [1].

In Portugal, as in other countries, there is an inadequate response of health services to the growing number of people with multiple chronic morbidities, functional deficits, dependence, and frailty. At the same time, the dominant role of social, environmental, commercial, and political determinants in the health of people and populations is increasingly recognized. These new realities have led international organizations, especially the WHO, to recently conceptualize new perspectives for public health and new strategic and methodological approaches, such as *governance for health*, *global health*, and *one health* [2].

All these processes seem to have in common, as a denominator and motivation, the need to reorient the systems and their components and institutions towards tangible health and well-being goals and to align all their institutional components in that direction. This transformation is highly complex and involves connecting and integrating what was disconnected and fragmented, which presupposes developing effective approaches and practices of "connective leadership", based on transdisciplinary knowledge, multi-professional collaboration, and multi-sectorial policies and interventions [3, 4].

In the academic and managerial training of human resources for the health system, it is increasingly necessary to develop skills and capacities for comprehensive vision and action, guided by a sense of mission. That is, by an orientation toward precise purposes, translatable into measurable or verifiable results. Often mentioned are perceptions and phrases of being on the brink of the abyss, and that to face and overcome this threat it is necessary to forge a level of vision, governance, and determined action that is comprehensive and transversal at all levels, both local and global. The aphorism "think global, act local" attributed to René Dubos in the 1970s is giving way to the affirmation and conviction of the need to "think and act, local and global." On another level, but also in a "two-way" trend, the urgency felt to develop health-in-all-policies approaches is being reinforced with a logic of interdependent effects and gains by arguing and evidencing that it is not only health that should be present in all policies, but that health itself can make decisive

karger@karger.com
www.karger.com/pjp

© 2023 The Author(s). Published by S. Karger AG, Basel on behalf of NOVA National School of Public Health

Karger
OPEN ACCESS

This article is licensed under the Creative Commons Attribution-NonCommercial 4.0 International License (CC BY-NC) (http://www.karger.com/Services/OpenAccessLicense). Usage and distribution for commercial purposes requires written permission.

Correspondence to:
Victor Ramos, vramos @ ensp.unl.pt

contributions to the gains and successes of policies in other sectors. The idea conveyed by the phrase "health for all policies" [5].

The "Global Risk Report 2023" reinforces the need to develop new ways of seeing and acting in a world of major ecosystem disruption and inter-and intra-society inequalities in an accelerating global digital transformation. The latter has been given special prominence by the Lancet and Financial Times Commission on Governing Health Futures 2030 [6].

Portugal currently has a guide for action in health, which cannot remain in a drawer. The National Health Plan 2021–2030 is available on the General Directorate for Health (DGS) website and deserves our full attention. It is up to everyone and in all sectors, each in his or her sphere of responsibility and action, to transform this National Health Plan (PNS) into an evolving and adaptive guiding instrument for better health and better well-being for all [7].

The PNS 2021–2030 can and should be seen and used as a common work base and "sea chart" in health until 2030. To this end, it should be known and used in a dynamic and creative way by the leaders of the various sectors that decisively influence health: education, science, social protection, business and labour, culture, and the environment, among others, in addition to the health sector in the strictest sense. Curiously, the diagnostic component of the PNS shows unexpected regional health inequalities that went unnoticed by opinion leaders and the media. For example, in continental Portugal, the Alentejo region has regressed in practically all health macro-indicators over the last 10 years, precisely the opposite of the favourable evolution of these indicators in the other regions. These are facts that call for indignation and intervention. In the autonomous regions, there are also discrepancies to be taken into account. These data indicate serious weaknesses, including a lack of strategic planning and governance in population and political health and, certainly, clinical governance as well.

The recent policy decision to extend the organizational design of local health units (ULSs) based on vertical integration of primary health care, hospitals, and long-term care under a common management body seems to have theoretical and potential adaptive advantages to respond more adequately to the needs of the population and people.

However, there is already enough evidence that simply organizational reconfiguration centred on institutions and common management, which may facilitate care integration, is not enough to ensure it. Strategic coordination that inspires and harmonizes the common mission of these ULSs must be present, and an integrated clinical, organizational, and population health governance device must be instituted within them. This upgrade cannot be achieved by simply producing legal diplomas. It requires the development of specific competencies in a connective leadership network linking the local to the central level. The disparate results evidenced in the few evaluations of the performance of the different ULS, performed already in this century, lead us to suggest as needs: promote a common vision regarding the nature, mission, and opportunities to be explored in this model of service integration and its evolution; ensure an inspiring general strategic framework; stimulate and support local flexibility and creativity to generate responses adapted to the context and circumstances of the different communities; use the National Health Plan 2021–2030 as a general guiding tool and matrix for local health plans that will guide intersectoral action in health, globally and locally; develop digital information systems that facilitate and condition the effective integration of care – necessarily based on the integrated and unique clinical health record of each person; progressively transform the way care is financed and paid for, orienting it toward health and well-being objectives – that is, to give primacy and priority to health promotion, disease prevention in its various categories (primary, secondary, tertiary, and quaternary), to outreach care, and to relegate care for situations that are usually more critical and complex, but less frequent, to a backup line. All this requires a connective and systemic health governance logic and competencies that mitigate and correct as much as possible the disconnected and fragmented existence and functioning that result from the current configuration of services, modes of care delivery, and weak clinical governance. Summarizing in a more comprehensive and integrated way, it is necessary to promote and develop health governance that starts by being grounded at the local level while achieving equivalent progress at the central level.

It is time to deepen governance for health, both theoretically and in practice, including clinical governance in its scope [8]. NOVA ENSP can and should embrace this challenge, given its institutional history, the competencies it brings together, and the traditional connection it has maintained with health services and communities.

Conflict of Interest Statement

The author has no conflicts of interest to declare.

Downloaded from http://karger.com/pjp/article-pdf/41/1/1/3871833/000530024.pdf by guest on 31 May 2023

Funding Sources

The authors did not receive any funding.

Author Contributions

Editorial written by only one author.

References

1 Donaldson LJ, Gray JA. Clinical governance: a quality duty for health organisations. Qual Health Care. 1998;7(Suppl l):S37–44.
2 World Health Organization. WHO regional office for europe. Governance for health in the 21st century. Copenhagen: WHO; 2012.
3 Lipman-Blumen J. The connective edge: leading in an interdependent world. San Francisco: Jossey-Bass Publishers; 1996.
4 Malhó R, Caraça J, Coelho H, Braga de Macedo J, Mendes RV. Complexidade: implicações e políticas globais. Lisboa: By The Book; 2021.
5 Greer SL, Falkenbach M, Siciliani L, McKee M, Wismar M, Figueras J. From health in all policies to health for all policies. Lancet Public Health. 2022;7(8):e718–20.
6 The Lancet. Lancet & financial times commission on governing health futures 2030: growing up in a digital world. Lancet. 2021; 398: 1–2.
7 Ministério da Saúde. Direção-Geral da Saúde. Plano Nacional de Saúde 2021-2030. Lisboa, Portugal: Direção-Geral da Saúde; 2021.
8 Rodrigues A. Governança clínica, governança “corporativa” e governança integrada. In: Frederico M, Sousa F, coord, editors. Gerir com qualidade em saúde. Lisboa: LIDEL – Edições Técnicas; 2022.

Downloaded from http://karger.com/pjp/article-pdf/41/1/1/3871833/000530024.pdf by guest on 31 May 2023