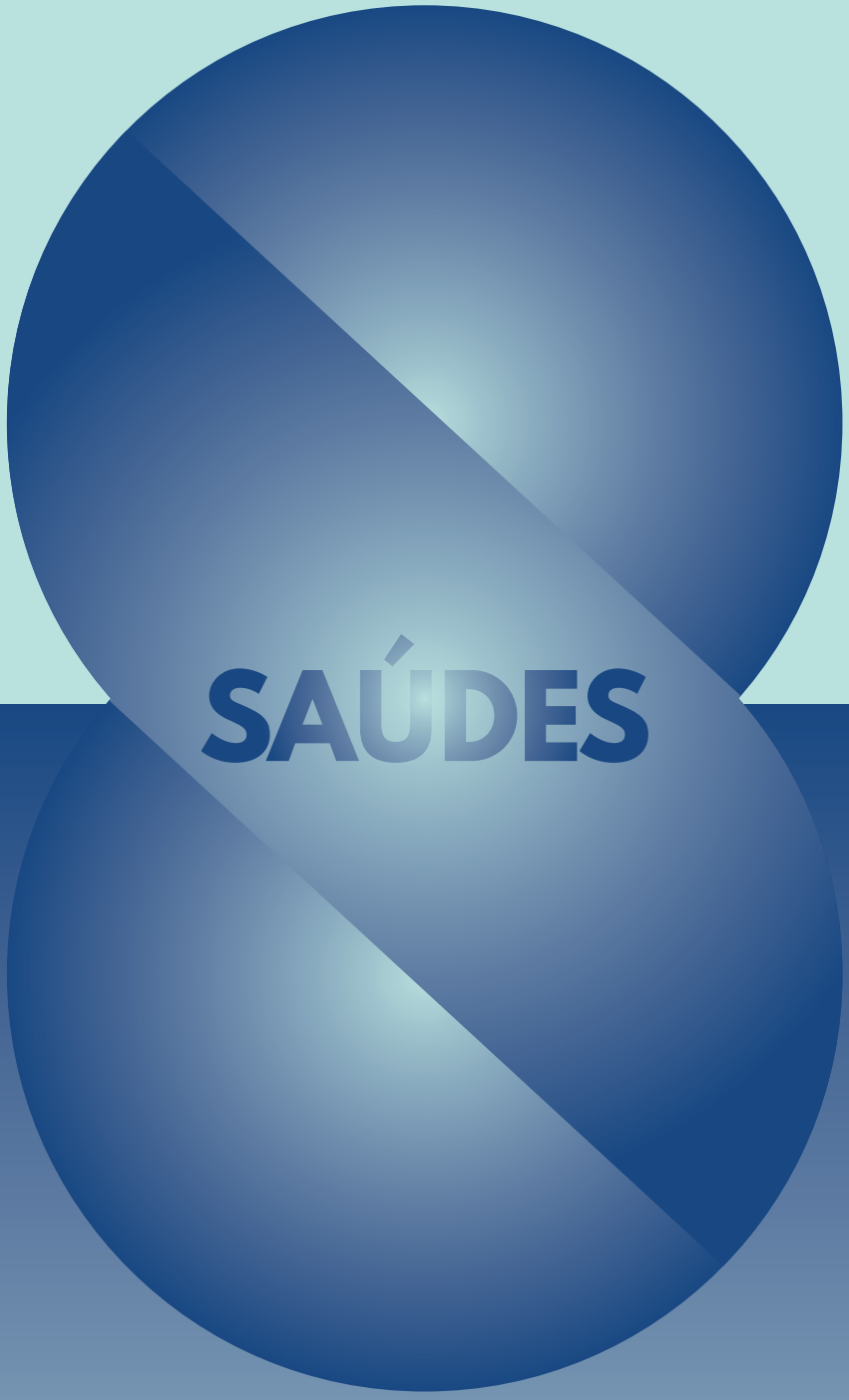
The Health of the Portuguese
An ID

2021



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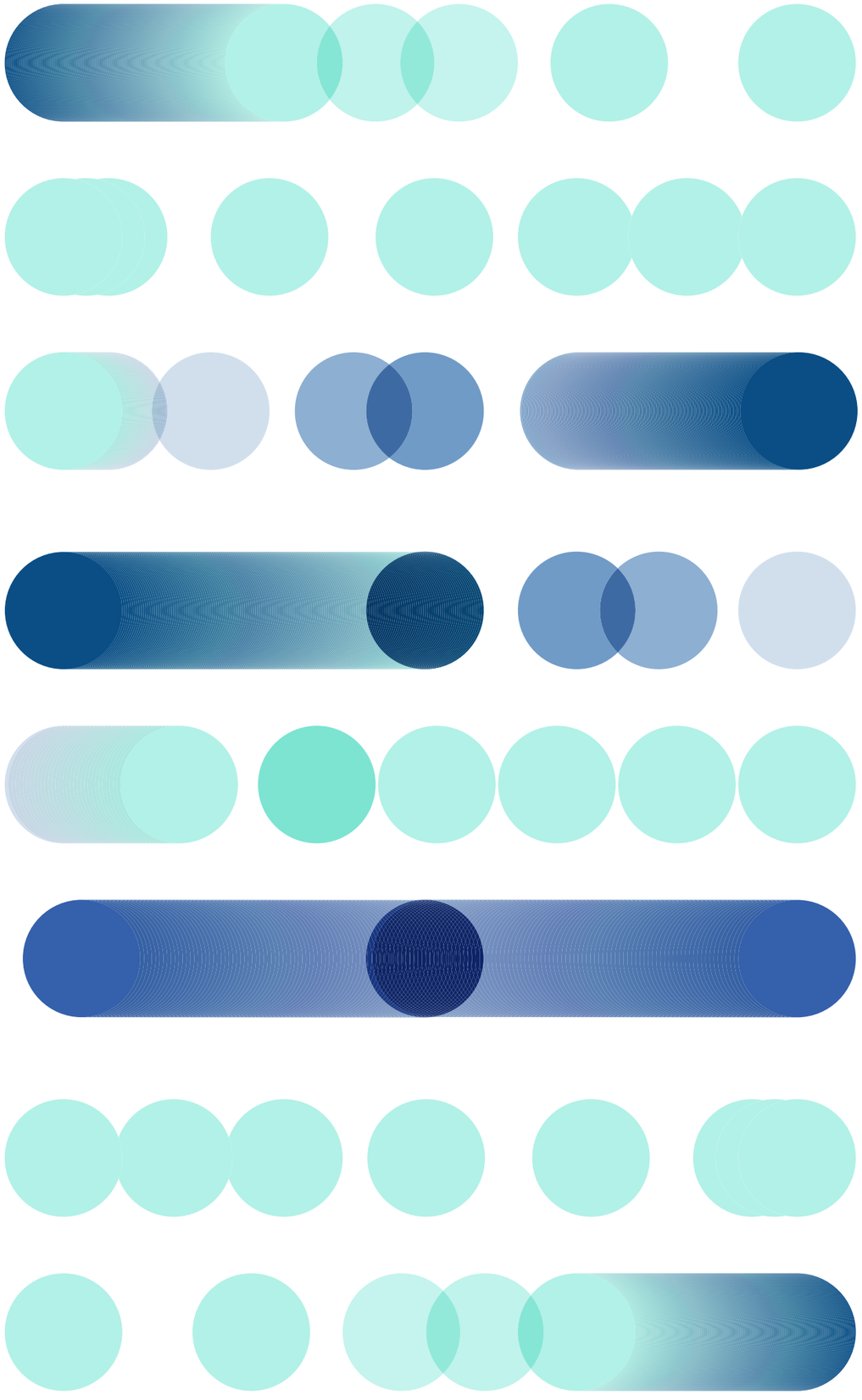
SAÚDES

INDEX



Previous Note

Médis turns 25 in 2021.

Today, as then, much more than being an insurance, our mission is to be the Portuguese Personal Health Service.

We want this celebration to activate our positioning, yes, but above all we want it to be a valuable and relevant contribution to society. This is the ambition of the project *Saúdes*, launched today and to be continued in the future.

Saúdes is a project aimed to be independent, a producer of a more sociological type of knowledge and reflection. The aim is to complement the many studies (mainly statistical) that already exist about health and, thus, to be able to open new doors that enrich and widen public discussion around the health of the Portuguese.

We launched this project with a study coordinated by Return on Ideas and contributions by Professor Maria do Céu Machado - Health of the Portuguese - an ID. In this study, through qualitative interviews followed by a survey that inquired more than 1,000 Portuguese, we propose a different approach, based on a more biographical health perspective rather than a biomedical one. Here it is unequivocally shown how the personal history and experience impacts the way each person perceives and experiences health.

The individuals, presented in this study as co-authors and producers of their own health, were inquired and assessed considering various indicators of individual health - access, use, literacy, positioning and potentiating - which allow us to map, now and in the future, the relationship between the individual(s) and health.

To do good to health, which has always been Médis's guiding principle, also involves expanding knowledge and debate. This is what makes the *Saúdes Project* so meaningful and a milestone that will persist far beyond the 25 years that we are now celebrating.

Eduardo Consiglieri Pedroso
CEO Médis

Preface

By Maria do Céu Machado
Jubilee Professor from the Faculty of Medicine of the University of Lisbon and member of the National Council of Ethics for Life Sciences (CNECV)

Health is a dynamic state of well-being characterized by a physical, mental, and social potential, which satisfies the demands of life commensurate with age, culture, and personal responsibility.

Bircher J, 2005

This study, The Health of the Portuguese - an ID, aims to identify, relying on a robust and well-defined sample, how the Portuguese perceive their health and promote balance between their genetic and acquired potential during their life cycle.

The concept of health has evolved since the WHO, in 1948, defined it as a state of complete physical, mental and social well-being, and not just the absence of disease. Although it introduced a well-being aspect, it did not yet include individual responsibility. Health would be seen more as a consequence of access to adequate medical care than lifestyle.

Recently, and considering what each one can (and should) do for oneself, health and well-being have been defined as the ability of each citizen to adapt and manage the physical, social and emotional challenges that arise throughout life (WHO 2015).

WELL-BEING is a dynamic state that requires a multidimensional understanding and two perspectives: objective and subjective. Dimensions include material (home, environment), HEALTH and safety, education, family structure, and risk behaviours (OECD 2009).

To fulfil this potential, the assets - internal and external resources - that leverage individual capacities and combine support factors (family, work) with those of empowerment (community enhancement) and connection (models and peers) for the acquisition of social skills (planning, decision and resilience), self-esteem and optimistic vision of the future (Morgan A, 2014) are essential.

The concept of well-being is a dynamic process that demands personal and social goals and is associated with quality of life (Machado MC, 2020). But even a person with a disease has the responsibility to manage it, upon proper information, understanding and acquisition of skills, the so-called chronic disease self-management, so that people build a perception of health that goes beyond the greater or lesser complexity of the disease (Allegrante JP, 2019; Madison R, 2019).

More important than information is individual empowerment and the promotion of health (and disease) literacy, a strategy that not only health institutions are accountable for. All healthcare professionals should practice comprehensive, proximity and opportunity medicine, which means taking advantage of a situation when a person seeks healthcare to identify critical periods and use them as windows of opportunity. Education professionals are also a vehicle for promoting health among children and families. In addition, companies, within the scope of their civil liability, should also promote actions for their employees in these areas.

Informatics is also an access tool for prevention and intervention, such as eHealth and mHealth, useful for the generation of digital immigrants - the older ones - and for the digital natives - the younger ones (Prensky M, 2001). Same for social networks such as several German insurers that have promoted health via Facebook posts (Loss J, 2021).

This study, The Health of the Portuguese - an ID, that resulted from teamwork, is not Big Data analytics but managed to discover hidden patterns, unknown correlations, trends, citizen preferences, and new opportunities.

I would like to highlight two aspects of the results.

First, the obesity pandemic, that came much earlier than the SARS-CoV-2 (zoomed in very accurately here). In the literature, reasons for overweight and obesity are identified as oversupply, hypercaloric food, or lack of exercise, but one must look much further back to find its origns and explain it.

According to Darwin's evolutionary theory, we are the survivors of a species exposed to danger and famine (Machado, 2014). The invention of fire and cooked food are the first steps towards *globesity*, an obesity epidemic within the context of globalization (Delpeuch, 2009). Also, the voracity of the human appetite was determinant for the re-engineering that food companies conceived, studying rearrangements of sugar, fat, and salt. This food industry strategy is called *conditioning hyper-eating*, with effects similar to compulsive gambling or drug use (Kessler, 2009).

These are our daily constraints, but knowledge is essential to perceive that a healthy lifestyle involves proper nutrition and regular physical exercise.

The second aspect to highlight is growing and worrying - the mental health problem with an emphasis on adolescents and young adults. One out of five adolescents has mental health problems that persist into adulthood, and the insufficient organization of mental health care is well known (Lee F, 2014).

Within this field, prevention is everyone's responsibility: health, education, local authorities, and civil society.

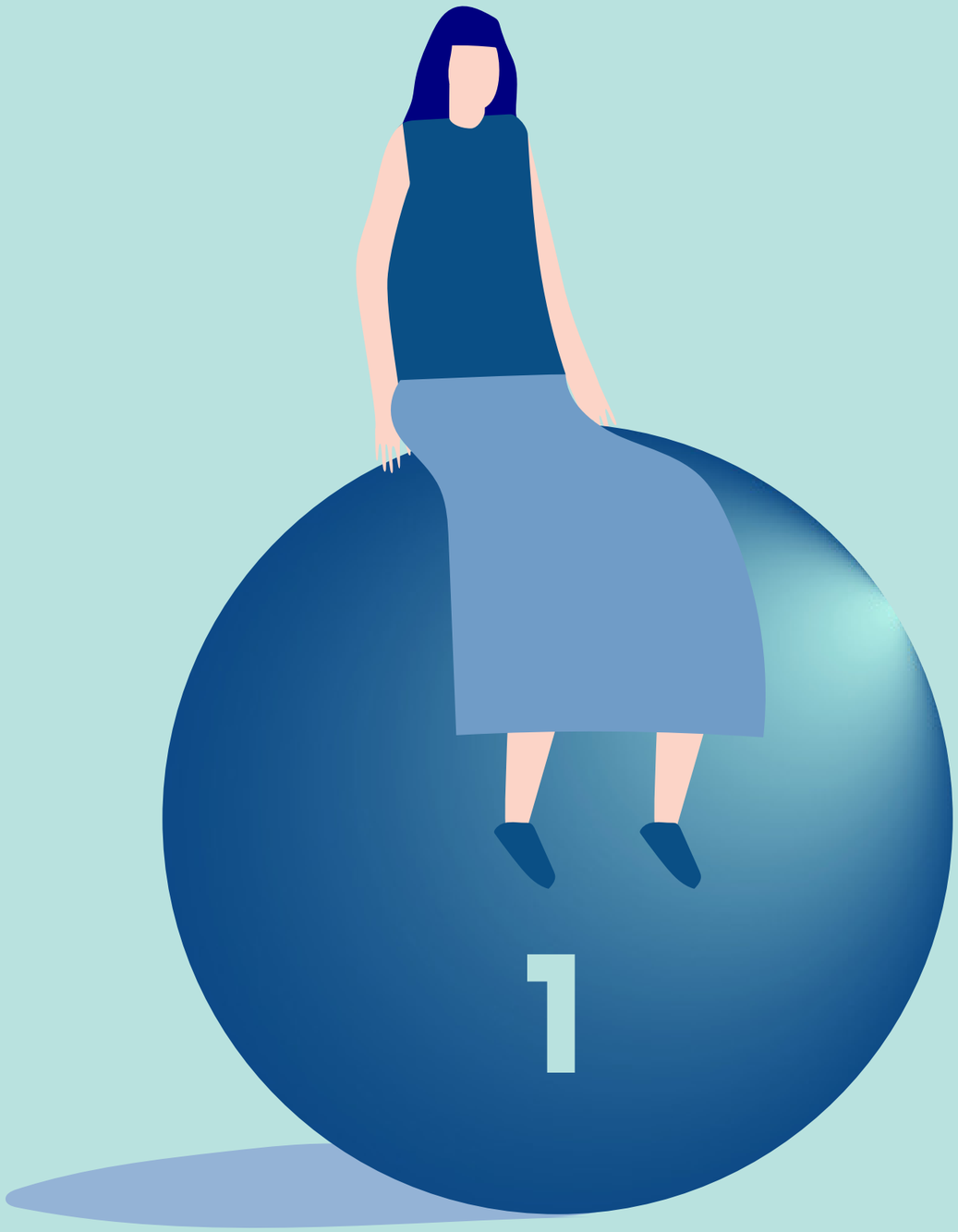
Finally, this study was analysed with creativity allied to scientific rigour. The creativity demonstrated in the nomenclature - territories of health and disease, their margins and limits, their tributaries, mental health as reconfiguring, differences and similarities as to gender, age, region or academic qualifications and, in design. The 7 segments identified in health that one aims, Quitters, Distant, Equilibrists, Sort of Engaged, Committed, Boosters driven by an Ideal or by Fear are real and we can immediately relate to one or at least to one we would like to be. An exercise one should do in family!

Finally, the calculation of an indicator of the Portuguese commitment to health reveals a modest 6.03 out of 10 which shows that we can and must improve.

The First World Conference on Health Promotion, held in Ottawa, Canada, in November 1986, concludes: *The citizen of the 21st century* is a health manager, an agent of change and an active voice that influences health decision-makers (Otawa Charter, 1986).

This was the vision of Médis, which invested in the development of this first study, and is committed to research further, allowing, throughout this decade, to achieve a better knowledge about the perception of the Portuguese on their health and facilitating strategic planning for its improvement. In the 21st century, we are the ones who build the future.

Maria do Céu Soares Machado



Health biography(ies) as a starting point

Looking at health inside out: that is the proposal of this study. To understand the inner circuits of what one thinks and feels about health. It is not a matter of replacing the knowledge that exists about health, but of looking at it from another perspective, from the people's experiences perspective.

A common misconception is to consider that changes in habits or behaviour occur when people are informed, and therefore recommendations to promote information decrease. Information is important, but it is not enough. As in all dimensions of life, also in matters of health, human action goes beyond rational or voluntary actions.

Nor is an objective reality that is in itself a structuring factor for the individuals' behaviours. It's how reality is perceived by each person that influences behaviours. In this sense, it is important to understand how the repertoire of human experiences that shape the vision of health is experienced and perceived, along with the contradictions and inconsistencies that personalise and enrich it.

The ambition to look deeper at experiences in order to explain the relationship with health led, first, to a qualitative approach, based on individual interviews, where conversations and in-depth listening took place - which is the cornerstone of this work. It is from these personal narratives that one can reach the meanings that people give to their experiences and health behaviours. The methodology is in itself useful for showing how, through biographical incursion, people are offered an opportunity to reflect about the relationships between behaviours and health.

Often, in an attempt to make sense of their history, the participants managed, in retrospective, to relate causes and effects, to venture hypotheses about what might had been the origin of a critical period of their health. This process supports what several experts have long argued for: first-person narrative is essential for self-awareness. This reinforces the importance of empathy and understanding in the relations between doctors and other health professionals and their patients.

As researchers, we know that we face something obscurely complex: the relationship that each person establishes with health is bound up with the way he or she deals with his/her own life and death. But subjectivity did not prevent us from creating, throughout the analysis process, a map that simplifies and organizes this complexity. The ambition of this work is also this: at the end, and by looking at the way people relate themselves with their own heath, we aim that each reader can relate with it.

The research has essentially shown that people's health behaviour can only be understood if their beliefs about their story, their self and their context are considered. It is therefore the Biography of Health - far beyond biology - that determines the relationship that is established with health.

Health Biography is based on a concept of health that i) is influenced by personal history (and the reasoning that the person makes about his/her history), ii) is highly personal and subjective and iii) has limits that go beyond the natural territory of health. These are the key characteristics of Health Biography that are developed here.

Key-characteristics of a Health Biography

Behind each health there's a story

It suggests an understanding of health about a biography that becomes rich by the action of time, as people are marked by their stories and build perceptions about events that were significant in their lives. It means not only taking into account people's lives, but also the opinion they form about them.

A hyper personalised interpretation

Everyone has an explanation for their health status and an understanding of how their health can be managed. The relationship with health is based on people's self-perception about themselves and about what they can be. This self-perception (more or less discordant from reality) is determinant for the way people negotiate with themselves their health behaviours.

Multiple tributaries

Looking at health from the inside out is thinking about health as an objective and subjective perception of well-being. It's aiming to understand the individual as a whole and not by an atomized analysis of his/her parts. For assessing well-being, people cannot be reduced to organs and nerves; the body is not detached from human intelligence and its projects.

Behind each health there's a story

It was expected, concerning a theme such as health, which interweaves with life, that the respondents would surrender to a sort of inner ethnography. Autobiography is a natural resource instrument for organizing in a coherent way the self-perception about oneself and about of the world.

What was less expected in an experiment that cannot be detached from the physiological aspect, from genetic inheritance and from behaviours, was that personal history had such weight. People settle their convictions, instincts, fears, and even alleged abilities for managing their health status, on their own health chronology.

While analysing the interviews, what seems to contribute most to the concept of health are the events experienced - personally or through close people - that had great importance, and the tensions or meanings that people developed in each of these events.

It is through the trauma of having watched a father die prematurely that a child reacts disproportionately to any symptom that may lead to the same diagnosis. It is because a person has been experiencing panic attacks for no apparent reason that great humility is gained regarding changes in the health status.

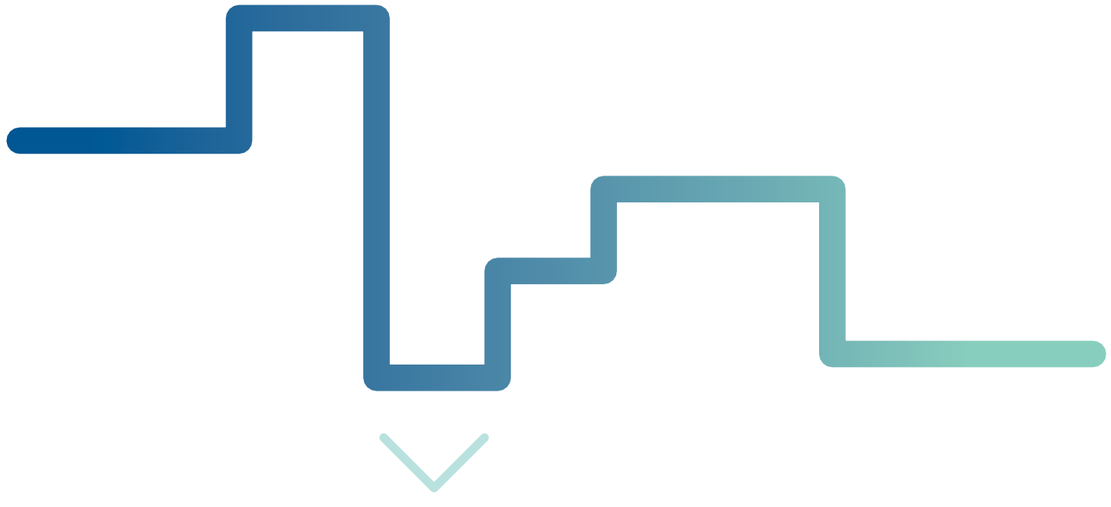
It is because a person survived (or keeps surviving) a certain disease that this patient became a specialist. The experience of life determines the behaviours and the perspective that one has of health.

Each person is the author and protagonist of his/her drama - a story with a beginning, a middle and an end. This autobiographical narrative is a collection of memoirs build from what people lived (and the knowledge they gained), from what they remember and believe. But this representation of reality is essential to the extent that it provides a context for the intention, that is, it makes the actions (and reactions) of people intelligible. It allows others to enter their world, it draws the basis of their motivations.

For what we aim to determine, it is less important the closeness of that narrative to the facts than the interpretation made by those who lived it.

Health biography, more than health biology, is what conditions identity and legitimises the assessment each one makes of their own health status.

People narrate the facts that, at least in their imagination, are the most relevant and impacted most their construction as individuals.



"My grandfather had a tumour in his large intestine, he died from it.

My father also passed away with pancreatic cancer. I lived my father's illness intensively; I was studying, and I was the one providing support. We were aware that a tumour in the pancreas was incurable, and that the survival rate was very low. That's when I became hypochondriac, vigilant for all the symptoms. That's why I have so much fear... Because of my family history. It limits me."

W, 30 years old, without any diagnosed disease, Coimbra

A hyper personalised interpretation

The second observation is the enormous distance from the interpretation each one makes to their actual healths status. It is possible to find people that, despite their biological or physiological similar realities, evaluate (and rate) their health status in a completely different way, as well as people who rate their health very similarly, even though one suffers from a severe disease and the other is perfectly healthy.

Personal experience cannot be translated into figures. Knowing how many women in Portugal face breast cancer says little about how they experienced the disease, i.e. how they experienced the psychological, emotional and identity changes caused by the disease. How they welcomed the diagnosis, how they reacted to each moment of therapy, what information they collected, what efforts they made, what support they received, what hopes and traumas resulted from this process? Every cancer is a cancer; the experience is always unique.

Beyond the distance between reality and context (economic, social, cultural), there are intrinsic characteristics of the person, determinant for the way one deals with health and disease. The self-concept — the images people create about who they are, what they think they can accomplish, what they think others think of them and what they would like to become — explains behaviours and shapes the relationship one establishes with health.

Several studies argue that the perception of personal competence and high self-esteem explain, for example, a greater probability of adopting a healthy lifestyle. Other studies reveal a relation between low levels of self-esteem and the likelihood of adopting behaviours that harm health, such as smoking. Adding to the theme of breast cancer, studies conclude that the initiative of performing breast self-exams is higher among women with a higher self-concept.

In short, what we can conclude is that, in addition to access, literacy or understanding risks, adopting healthy behaviours is profoundly influenced by self-perception, that is, how one perceives his/her own characteristics, and by the confidence one has in the ability to successfully tackle the challenges. In other words, what each person considers to be their potential and how far they are from that potential.

On a scale of 1 to 10, how do you rate your current health status?

"I exercise, I eat a balanced diet - I eat a chocolate square and I feel bad. (...) I take care of my oral hygiene whenever I can and have the money to do so. I moisturise my skin every day after bathing, and every night I use my face moisturiser. I always have this routine. I'm also aware that I must drink water to hydrate the body... [I would choose a 7] Maybe because I live in the city centre, and I spend many hours breathing polluted air, and because I drink 6 coffees a day, and because I have little sleep. Perhaps if I had a healthier diet, I could be a 8 or a a 9."

M, 45 years old, with no diagnosed disease, Lisbon

7

"I have some circulatory problems and I have this meningioma in my head, but I would say that I'm a 7. I know it's something that can grow back and I have to undergo a new surgery or radiation therapy (...). I consider myself a healthy person. Of course, at the age of 63, we already have blemishes, but for me being healthy means being able to do my job without any physical constraints, to play with my grandchildren, to take walks, to feel that I am mentally capable, with a good memory, and to feel that I am physically well. Despite of the fat, I manage to have a lot of mobility, for example, I can easily reach the ground with the palms of my hands without bending my knees (...). I believe I can say I'm healthy. I take all the medication and I do it religiously, also because since I was operated that I have sleep apnoea and I lost my sense of smell."

W, 63 years old, has Cerebral Meningioma, Porto, Portugal

Multiple tributaries

However personal the discourses are, they all suggest that health is closely related to happiness and a sense of well-being. In simple terms, one can assume this perception as what one thinks and feels about one's life, regardless of how others see it. Therefore, it implies a cognitive and emotional dimension.

There is much evidence that sustains that factors such as socio-economic conditions, income or level of education contribute, objectively and subjectively, to the perception of well-being. Satisfaction with work, mainly in terms of fulfilment rather than money, is also a good predictor of satisfaction with life.

The quality of relationships or the bond with family and friends are also determinants of well-being. There are also events in life that explain lower levels of self-perceived well-being, like widowhood, divorce or unemployment.

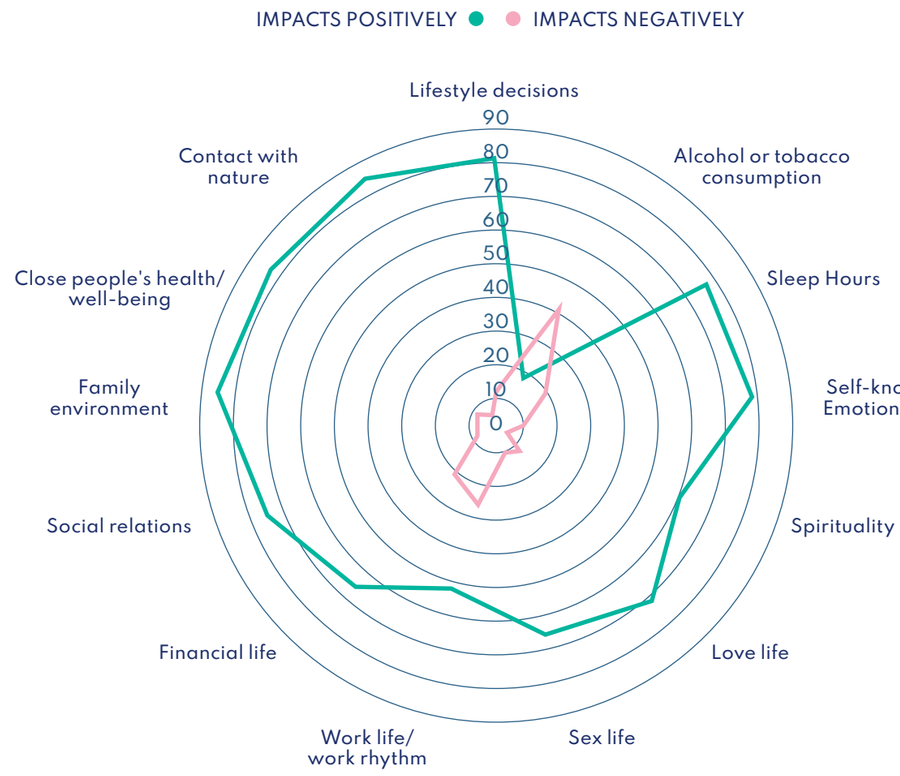
In addition to these factors, other innate predispositions, such as personality or the way one relates emotionally to the environment, are also relevant for this perception. Religion and spirituality itself, insofar as they provide meaning or protect from negative emotions, are associated with well-being.

Each person builds his/her perception of well-being based on these several factors - lifestyle, safety, family relationships, love life, financial life, professional life, among others -, that have very different weights, even if they are not always fully aware of how these factors relate to their health. The concern to take care of a "semi-bedridden" mother, the "disorganization in the attic" caused by divorce or the constant guerrillas "in a marriage that died" interfere so much with the subjective perception of well-being (and with health) as a sedentary lifestyle or any kind of diet.

Although for science is better to separate the different elements that impact well-being (objective and subjective), for individuals the experience is, by nature, holistic. Even when it involves judgments about very different life aspects, well-being is always experienced as a (very vast) whole and not by each part.

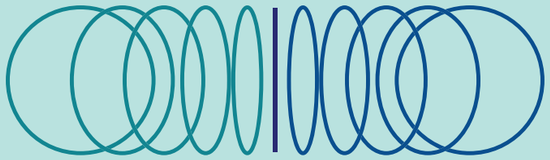
Aspects that impact 'my health status'

TO WHAT EXTENT DOES EACH OF THE FOLLOWING ASPECTS IMPACT YOUR CURRENT HEALTH STATUS? — %



Q: Regarding your current health status, to what extent each of the following aspects has an impact (4 response options: Positively, Negatively, Doesn't impact, I don't relate it to health) N=1029

The impact of family life
in direct discourse

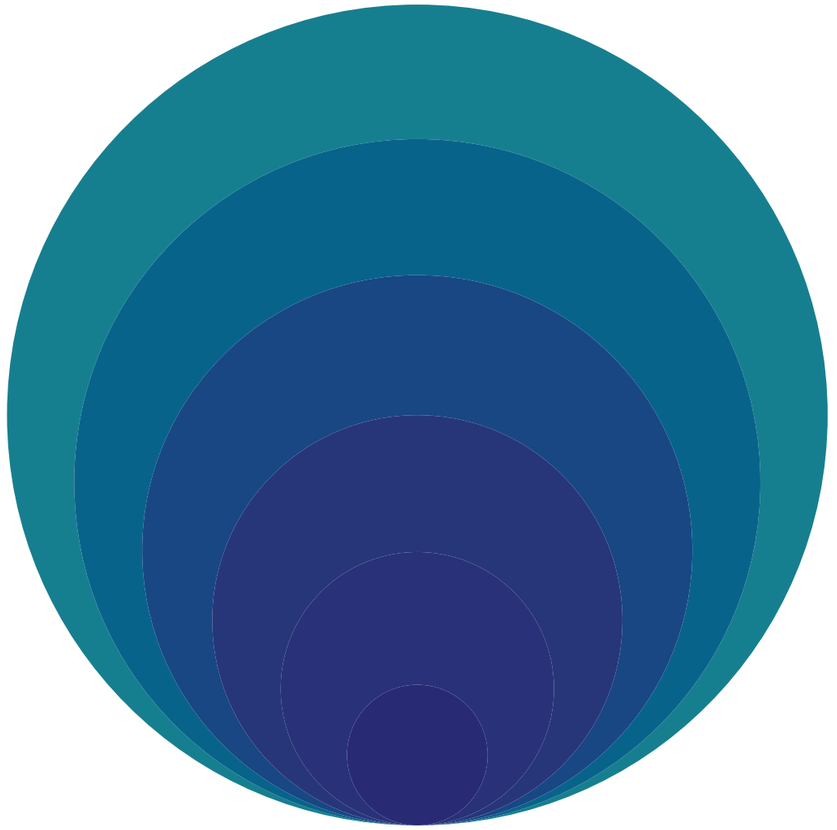


“At that time I felt bad, my right side was caught, and it seemed like I was having a heart attack. And then when I started feeling a numbness in my face, I really got out of control. … Our conversation is making me realise. It was an anxiety attack. Before that I got really nervous. And now that I’m talking to you, I can even hear the nurse, and it’s all connected.”

“My daughter has a disease, a deletion on a chromosome. This brings up Asperger’s, already diagnosed. The BCG vaccine blew her immune system up, so given the situation we’re in, she’s a very high-risk child.”

“It’s not easy to emotionally manage all these issues… it’s a marriage that ended many years ago, it’s being alone, it’s a daughter that isn’t easy. It's a constant battle in my relationship… I know this, but sometimes it’s stronger than me.”

W, 44 years old, Rio de Mouro



Other factors that shape the relationship with health

Attitudes towards health arise from the complex combination of multiple factors, some more intrinsic to the individual, others more circumstantial or variable, such as the income or stage of the life cycle.

Below we identify the factors that this research suggests as being the most determinant for the individual thinks and acts, also as a user of health care services.

[The order they appear does not suggest any hierarchy of relevance]

1 Personality

As important as the environment, it is the more or less skilful way of reacting to the environment. There is a constellation of personal characteristics that determine the ability to enlarge or cushion the effect of adverse events; there are different resistance resources when facing challenges; there are differences in the level of commitment or control that each one wants to have regarding the different dimensions of his life. The mood itself and the natural predisposition to positive emotions (which are possibly genetic), explain health and the relationship with health.

2 Education & Values

Attitudes and convictions about health are intimately connected with the first influencing aspect - education. What routines and values did parents, schools or other people responsible for education seek to provide? What examples were or are given concerning healthcare, whether in terms of preventing disease or promoting a healthy lifestyle? What hygiene, sleep, food, or physical exercise habits were induced? To what extent being responsible for one's own health was or is familiar or culturally induced?

3 Life cycle

Aware that ageing is associated with a higher risk of disease (and a greater perception of this risk), there is a natural evolution in the way health is managed throughout the life cycle. There are biologically and psychologically important events - such as maternity or menopause - that trigger new needs and attitudes. There are limitations and frailties related to an older age. In addition, the relationship with death - the awareness or acceptance of this natural outcome - also changes throughout life and is a determinant for defensive or health promotion behaviours.

4 Literacy

The ability to understand and use health information (more or less anchored in schooling) determines different autonomy levels in health management and different attitudes towards health and disease. To what extent can one become aware of one's own health status or the risks inherent to a particular behaviour or illness?

What are the skills one has to access, interpret and assess health information? What is one's capacity to make health-related choices and decisions such as choosing a health provider?

5 Wealth & Income

Financial resources are crucial, first and foremost, because they limit choices. The health behaviours network - whether prevention or monitoring a disease, or health promotion (even concerning diet) - depends not only, but also, on the capacity to finance them.

It is precisely in areas where the public (and free) health system has an insufficient response, such as oral health, that more gaps in care are identified. There is also evidence that people in economically disadvantaged positions are more exposed to health risk factors.

6 Conjuncture & Context

The relationship with health has channels that connect to the outside world.

The environmental, economic and social context (from air pollution to disturbances within a community) interferes with how one feels or acts regarding health issues, first and foremost because they influence life satisfaction and the perception of well-being. Social acceptance or stigma itself in relation to certain behaviours or diseases influence personal choices.

The impact of the COVID'19 pandemic is a good example of how the environment conditions perceptions and behaviours.

Developed in the following page

CONJUNCTURE & CONTEXT
Zooming-in Covid-19

The first note is that, although research was carried out in the midst of a pandemic [qualitative studies between October and November 2020 and quantitative studies in January 2021], the pandemic didn't come up in most interviews and was rarely pointed out as a health-disturbing factor. Moreover, 69% of the respondents stated that the pandemic had no impact on their health and, out of the 28% that recognized some negative effect, they attributed it mostly to a sedentary lifestyle (62%) and anxiety (52%). For those who have a serious illness, a different perspective was given: 30% blamed the pandemic for harming their health, mainly by making it difficult for doctors to follow up on diseases or problems.

Although, in general, there were no significant implications for the health status, the threat of the disease introduced changes in the relationship with health. Among the respondents, 1 in every 4 recognized that they sought more information about health, and at least 1 out of 5 stated that they reduced the routine visits to doctors or prevention behaviours. In a national study conducted during the summer of 2020[1], a relevant sample of the population considered that they did not have the same access to public healthcare system (33%), emergency services (20%) or healthcare in the private sector (22%).

Public figures estimate that between January and November 2020, 121,000 fewer surgeries and 1.2 million hospital consultations were performed compared to the same year. Thousands of patients were left without a consultation or surgery they needed. The postponement of necessary and undiagnosed interventions suggests a worsening of health indicators in the short term.

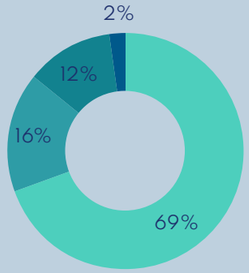
The perception of a lower response by health services and the intensity of information, with daily death tolls and admitted Covid patients, created fear and, besides the hesitation related to going to a doctor, it induced a set of procedures - a new "hygienism" -, from the masks and hand sanitisers to changing clothes and sanitizing the houses. How many of these instincts or habits will become routine and how many will fade away with the end of the pandemic is yet to be written.

Despite health self-rating, experts suggest that the worst consequences of COVID'19, both physiological and mental, remain unseen. In our sample, 13.5% recognise that the context of a pandemic is at the origin of a feeling of some lack of control over one's own health - a loss more related to emotional instability or fragility than to physical. High rates of stress and anxiety are reported worldwide as the main psychological effect of the pandemic. The Mental Health and the Pandemic Study[1], conducted between May and August 2020, shows that healthcare professionals treating COVID'19 patients have a 2.5-fold higher risk of psychological distress, and they are also the group with highest burnout levels, affecting 43% of those professionals in that period. The burden of the underlying problems among COVID'19 patients is also unclear.

We believe that, also because of the need of resisting in a time of uncertainty, there is a lack of distance to self-awareness about the effects of social distancing, enclosure, loneliness, reconciliation of work and family, sedentary life, fear of illness or even concern for preserving work and income, unevenly distributed in this crisis.

[1] Saúde Mental em Tempos de Pandemia (SM-COVID19), INSA

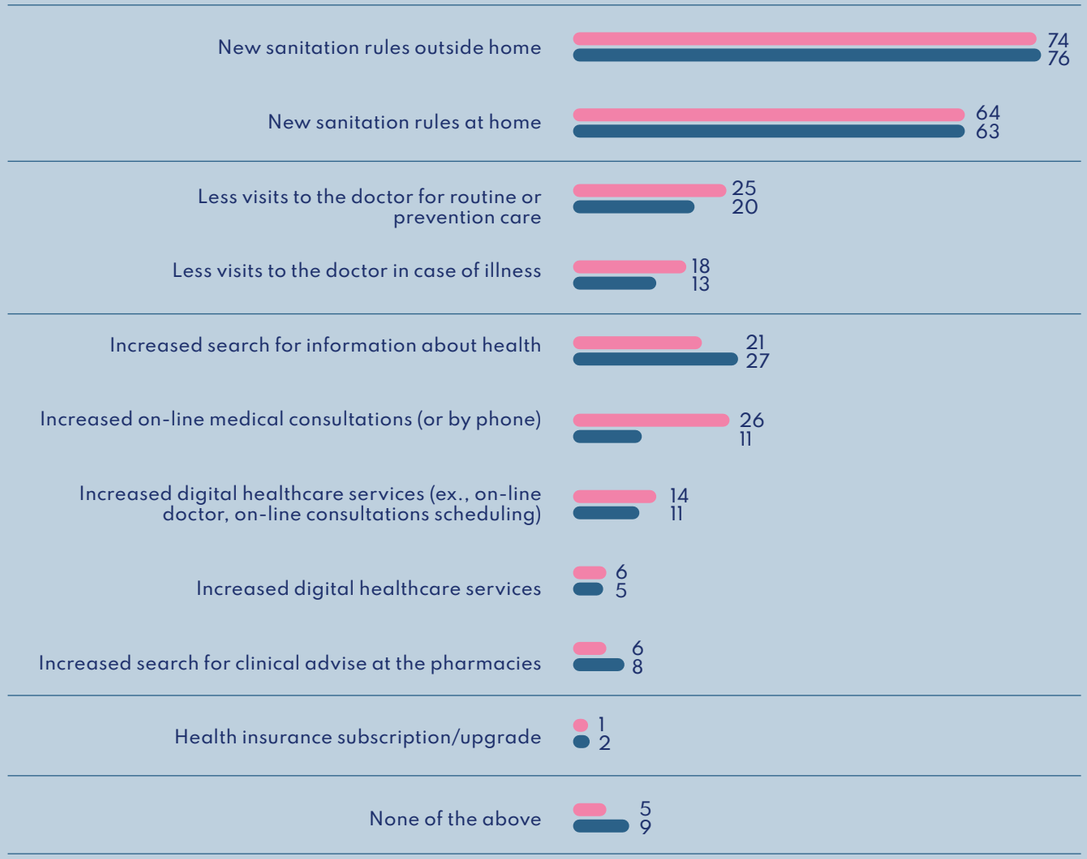
HEALTH CHANGES DUE TO THE COVID-19 PANDEMIC — %
N=514



- No, it didn't impact my health
- Yes, it got worst compared with the beginning of the year (before the pandemic)
- It impacted negatively, but also positively
- Yes, it got better compared with the beginning of the year (before the pandemic)

Q: In the previous months did you experience changes in your health due to the COVID-19 pandemic?

HABITS THAT EMERGED DURING THE PANDEMIC — %



- Diseased
- Non-diseased

Q: From the list, what have you have done or are still doing differently because we are facing a pandemic?

[how people perceive] What is health?

A territory under construction

> "Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place."
>
> Susan Sontag

So efficient and silent is the functioning of our body that we are hardly able to articulate the extraordinary achievement of "being healthy"; while it works, this status deserves little rationalization. It is not surprising, therefore, that the concept of health arises as opposed to disease. In fact, the reasoning that the territory of health ends where the territory of the disease begins was predictable. [see page 31 -"Lay Health Meanings"].

Less predictable was the lack of correspondence between the disease diagnosis and the recognition of the occupation of this territory. There is a gap between the biological event of the disease and the human event that is the integration of the patient. Perhaps this ambivalence explains why in English there is a difference between disease, illness, and sickness.

The disease is not enough for the label. Only those who accept the status of patient, that is, accept the disease as an identity aspect, place themselves in that territory. If the disease does not interfere with the performance of responsibilities (professional, family, social) and, above all, does not jeopardize autonomy, the tendency is for the person to project himself/herself into the territory of health, even if he/she admits living in a frontier - a sort of limbo where he/she tries to behave like a reasonably healthy patient.

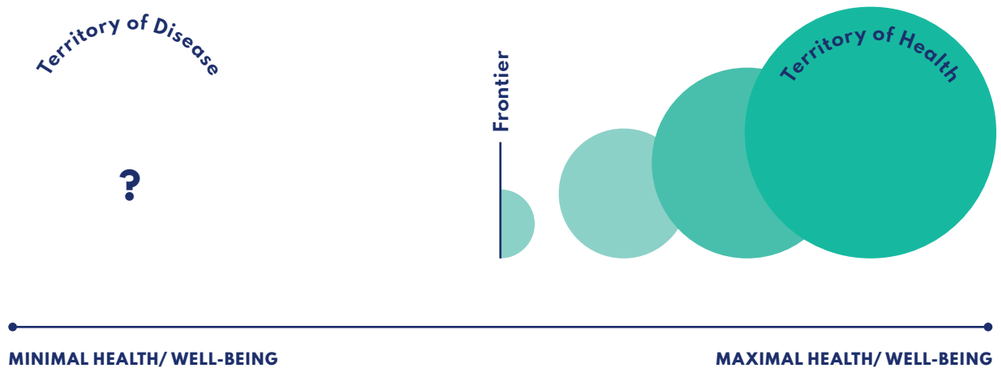
Transmutation into the territory of the disease only occurs when there is a failure of capacity or a loss of identity, in which the patient feels "less person" and dependent on others. This explains why there is not always a correspondence between the view of the doctors and that of the person, hence the frontier between the two territories becomes less obvious.

If there is a consensus about the existence of two contiguous territories, the same cannot be said about the conceptions made of these territories. Those who have never been (severely) sick, distinguish the territories and reveal greater difficulty in providing meaning to health, often summarizing health as a commitment to behaviours that guarantee the maintenance of the status (such as having a balanced diet or exercising regularly).

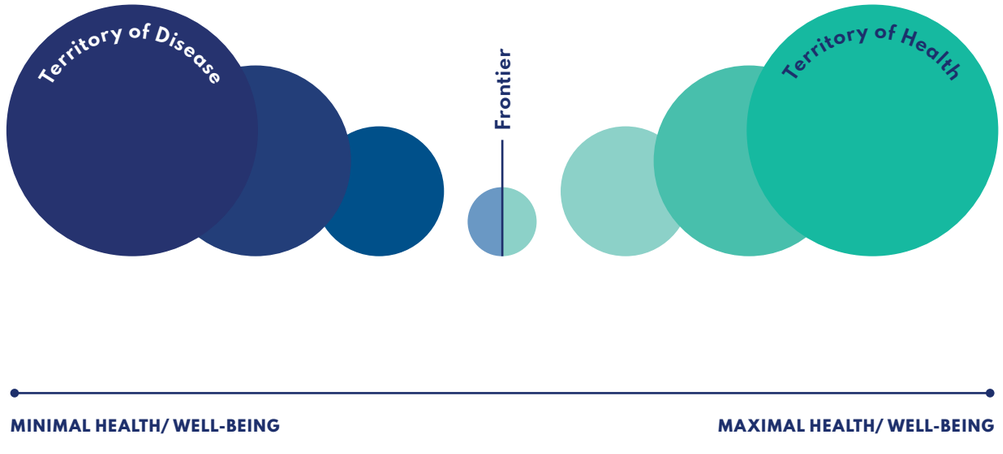
Those who have experienced a disease process manage to make more substantiated assessments about health, by better integrating the notion of susceptibility. From this perspective, the territory of health is not established so much as an opposition to disease, but by the feeling of control over one's own health status. The border between the territories is highly subjective and is established when people feel that they no longer have health under control because that depends on efforts that go beyond their actions (be it treatments, medicines, diet or others).

It is by exploration that one perceives the territory of health. On the internal maps, experience [or biography] indicates their contours, highpoints and critical periods. This applies both to disease and health. When, for example, by changes in diet, the feeling of well-being is improved, it is also a new territory that is explored. To understand the territories of health and disease through the person's eyes and not through the doctor's eyes is what this research proposes.

TERRITORY OF HEALTH
according to the perception
of people who only
experienced health



TERRITORY OF HEALTH
according to the perception
of people who inhabited
the territory of disease

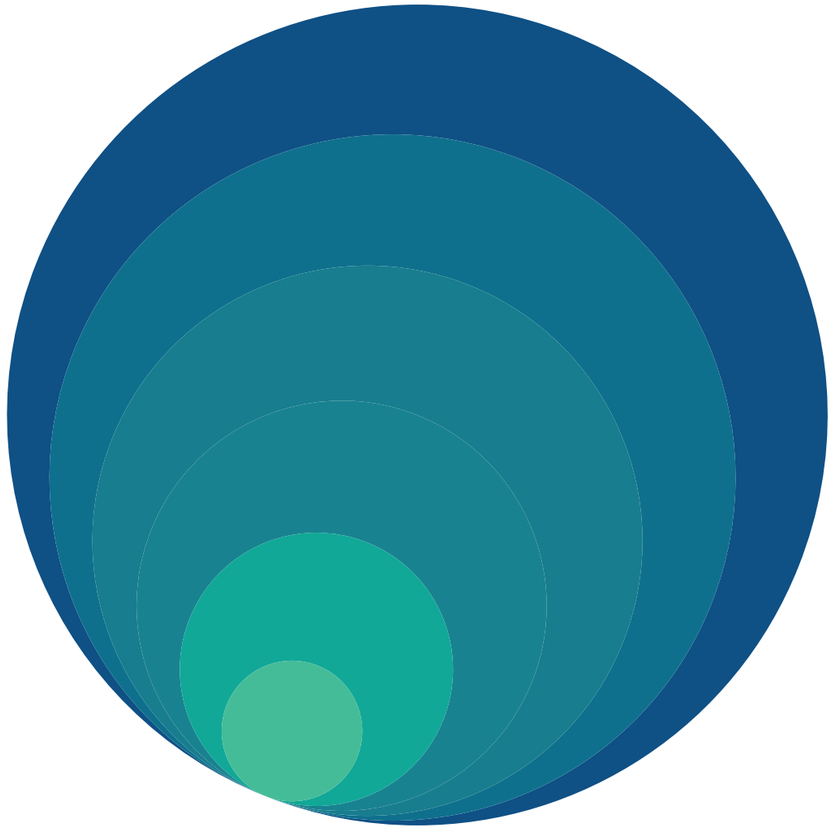


The loss of identity
in direct speech

"This meningioma kept growing, I began to have hallucinating headaches and deviant behaviours. Last year, before I had surgery, I isolated myself a lot, it was a strange thing for me because I'm a social being... But no, I stayed at home, I became sloppy... With my clothing, my appearance. And I didn't realize, I wasn't aware of it."

"I also became sloppy with my house... with the cleaning and tidying up. Luckily, my daughter was already 18 and she would do things. Many times, people would tell her that I was depressed and my daughter would say: No, my mom is not my mom! - That is, my mother is not the same."

W, 63 years old, Porto



Health seen from the outside

The history of Health

The time and resources of this research are not sufficient to portray concepts of health over time, nor is that its ambition. In any case, it provides a valuable understanding of history, to the extent that the current conceptions and intervention models in health represent the evolution of these concepts. From the historical path of health meanings, which is also that of medicine, we go back to the three major periods that mark great inflections in the approach to health and, in a way, coexist with the current conceptualization of health.

Biomedical Model (17th Century): Disease centred approach

It emerges from a scientific guideline that looks at the universe from a mechanical model. In this period, the world and living beings, like machines, are seen as a set of pieces. The human being is a set of pieces that fit together in an orderly manner and according to a rational process. The disease consists of a temporary or permanent breakdown of a component's functioning or of the component-to-component relationship. According to this Cartesian view of the world, healing a disease is equivalent to repairing a machine. The medical attention focuses on the universal characteristics of the disease and not so much on the individual. At this stage, environmental factors (moral, social, behavioural) are less significant, and the holistic view of the person is replaced by the tendency to reduce the systems to small parts, and each are considered separately. This model focused on the body, disregarding environment, and emotions.

1st Health Revolution (19th Century): Disease prevention centred approach

The industrial revolution had profound consequences for health. Large epidemics due to social changes (agglomeration in cities and poor health conditions) facilitated the diffusion of micro-organisms causing high morbidity and mortality and leading to the development of modern Public Health measures. To prevent diseases, it was necessary to control pathogens, which was done via initiatives ranging from building sewage systems to developing vaccines. When they failed, curative medicine intervened, which, in the middle of the 20thcentury found in antibiotics an effective aid for destructing these micro-organisms. One of the developments towards a more current conception was the acceptance that the disease can have multiple causes.

2nd Health Revolution (2nd half of the 20th century): Health centred approach

In developed countries, because infectious diseases were already under control, the diseases that contribute most to mortality are behavioural caused. The equivalent of the germ is now the individual behaviour. The vaccine would now need to mean a change of behaviours in a broader sense, such as quitting smoking, healthy eating, controlling stress, exercising, sleeping adequate number of hours, and periodically checking the health status. The new concept of health is set by the WHO in the document "Health for All", translated into Portuguese in 1986. It sets out two core concepts: (i) health promotion, by empowering people to control and improve their health, and (ii) promoting healthy lifestyles.

Lay health meanings

In 1973, the researcher Claudine Herzlich interviewed 8,000 middle-class people from Paris and from the rural region of Normandy to study how people define health and disease. In the investigation, he summarizes in three categories the way a lay person in medicine represents health. We bring these concepts here because people still shift between these categories.

HEALTH IN A VACUUM

Health is defined as absence of disease.

People are not aware of their own body or are simply not bothered by body sensations. There's a kind of 'body silence'.

RESERVE OF HEALTH

Health associated with the ability to resist disease, that is, the strength that allows each person to defend from the disease or to activate resources that speed up recovery. This way, health is seen not as a state, but as an intrinsically personal resource that is available due to genetic factors, family context or behaviours that over time led to the strengthening of the individual health stock.

EQUILIBRIUM

Health is related to a concept of physical, emotional, and psychological well-being, which supplants functional issues. It is a holistic concept of health, in which body and mind are related and together lead to a state of harmony. While in the first definitions health is established by the absence of disease or by a structure that allows resisting to it, here it implies a balance that is susceptible to variations in the day-to-day, upon which the individual considers having an active role.

Source: Albuquerque, Carlos & Ferreira de Oliveira, Cristina Saúde e Doença: significações e perspectivas em mudança

Mental health as reconfiguring

There is a geography in the territory of health only known to those who have experienced a mental disorder. Like someone who discovers vertigo at a cliff-edge, it is clear that the fall can be attributed to events beyond a person's control. The legs work, the body is safe, but there is another dimension of health, where its failure is difficult to explain, and that puts one in a situation of profound imbalance.

Mental illness is described as something particularly sombre. Although people with severe illness episodes (such as oncology or autoimmune diseases) were interviewed, only in the discourses of those with a mental illness, descriptions of death as a desired relief came up.

Because it is a situation in which people easily feel they're not themselves, the transition to the territory of disease is much more obvious in these cases than in physical diseases.

Unlike physical disease - which is always cause-specific and objective in therapy - the starting and ending points of a mental disease are not obvious. *"When it's the body, we take a pill and it passes. [In my head] when things are messy, it's different. (...) These things always comeback, but I no longer take the medication. It makes me want to cry. I go somewhere and I cry."* The confidence of a 44-year-old Azorean woman with a history of depression is proof of how difficult it is to cure mental health.

Whoever crossed paths with a diagnosis of mental illness is aware that they are facing a constant struggle.

There is a notion of risk, a maturity for understanding the fragility of their health condition, which leads people to place themselves at a frontier with the disease, even when it is stable.

In the sample, 7% of respondents have a diagnosed mental illness. It is possible (and likely) that the weight of those with mental health problems is higher, since many people do not reach the threshold required for a psychiatric disorder diagnosis, and others don't even seek help. We know that mental health still lives in the shadow of certain prejudices. From the discourses we realize that people attempt to escape this label, also by the stigma associated with this type of disease. 66% of respondents who were diagnosed with mental illness also report that they feel discrimination in society in relation to some diseases, such as mental disorders, and 75% admit being resistant on asking for help when they are ill (a far higher number than those who have another type of disease).

An inadequate response by health services makes it difficult to approach a disease that is difficult to diagnose, and the people are often given the task of solving their mental problems the best they can. Everything suggests, even in terms of public health, that the relationship between the dimension of the problem and the attention given to it is disproportionate. Studies on the prevalence of mental illness in Portugal (such as that of Nova Medical School) record very long intervals between the onset of symptoms with clinical impact and the use of any appropriate form of treatment (e.g. 4 years for Major Depression). In our sample, more than half of the people who report some kind of psychological disorder would like to have more follow-up regarding mental health.

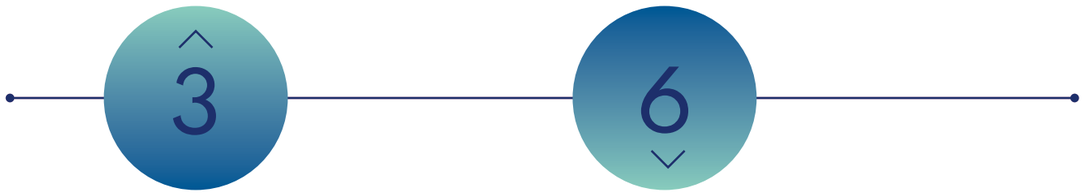
On a scale of 1 to 10
how do you rate your current health status?

"To be healthy is not to experience episodes like the one I experienced yesterday, a massive anxiety crisis. [Yesterday] I felt terrible. We add up so many situations to deal with that it ruins our health. I had cancer, but I know that it is my bad nerves that will kill me one day. Because that's what makes all this out of control."

"I'm a 3, I'm clearly aware. Inside, I'm a wreck. I feel that mentally I'm a total train wreck. ... I've had to call an ambulance. It was the first effective anxiety case, i felt like i was having a stroke. It was about three years ago."

"Yesterday, while I was talking to the nurse, she said that the time to seek help has come... From a psychotherapist. Now I need to take the second step, which is to grow courage and call."

W, 44 years old, married, with children, cured oncological disease, Rio de Mouro



"On 1 to 10... I'm a 6. It has to do with the chronic anxiety problem that I have. It's a disease that has better and worse moments and right now I feel more or less at ease.

"I don't want to explain what a panic attack is. The most serious ones are the ones when I lay on the ground, wrapped up, and the only thing I wish is to die. The feeling of anxiety, the fear, is so great, that the only thing I wish is to end my life at that moment. You can't alleviate those feelings. We become totally uncapable. I may have the best legs, arms and heart in the world, but if my mind doesn't work, there's no use, because I can't even get up from a chair."

"Now I realize that my mother and family have the same problem, but they don't accept it because they're going to be seen by society as weak and unworthy. I had that stigma myself. That's the big problem, it's a hidden disease."

M, 40 years old, married, with children, diagnosed mental illness, Faro

Answers given by the interviewees

Like physical health, mental health is not just the absence of mental illness. It is an inseparable aspect from well-being, which assures the daily functioning - family, social, professional.

The difficulty in dealing with life pressures, the low emotional flexibility or resilience to adversity, leave some people in a grey area that is difficult to delineate. 11% of the sample consider that they have no control over their health situation for psychological reasons, despite not having any diagnosed disease (physical or mental). Instability and emotional lack of control are the feelings that are most associated with this sensation (most common among women).

The weight of those in the grey zone is very unequal by age, and there is a decreasing line between the age segments - from 25% between 18 and 24 years old to 1% between 75 and older.

Since this analysis begins with a self-diagnosis, age distance raises a fundamental question: are youth more susceptible to psychological and emotional disorders, or do new generations have a new concept of health and are more aware of mental health than older generations? Does the line (in the graphic) describe the problem or the ability to recognize the problem?

Although, in general, it is convenient for science to distinguish mental from physical health, this is only a fictitious distinction. Several studies demonstrate the relationship between both and it is known that disorders in one often foresee disorders in the other - even if the specific mechanisms of these relations are not fully known. A negative emotional state can trigger a cascade of changes in the immune system and create greater susceptibility to various physical disorders.

The relationship between physical and mental health exists not only (or always) for physiological reasons, but also due to healthy behaviours' adoption, whether in the logic of prevention or promotion. It is known that a depressed patient is more likely not to stick to the doctor's recommendations than a non-depressed one. Also, in this study, mental health appears to be deeply connected to the efforts people make to maintain or gain health.

Both in quantitative analysis and interviews, a strong relationship between psychological experiences and the effort to be healthy is evident. On the one hand, there is noticeably less pro-health actions - to be healthy and adopt a healthy lifestyle - among people who occupy the so-called "grey zone", that is, who now recognize some kind of psychological stress.

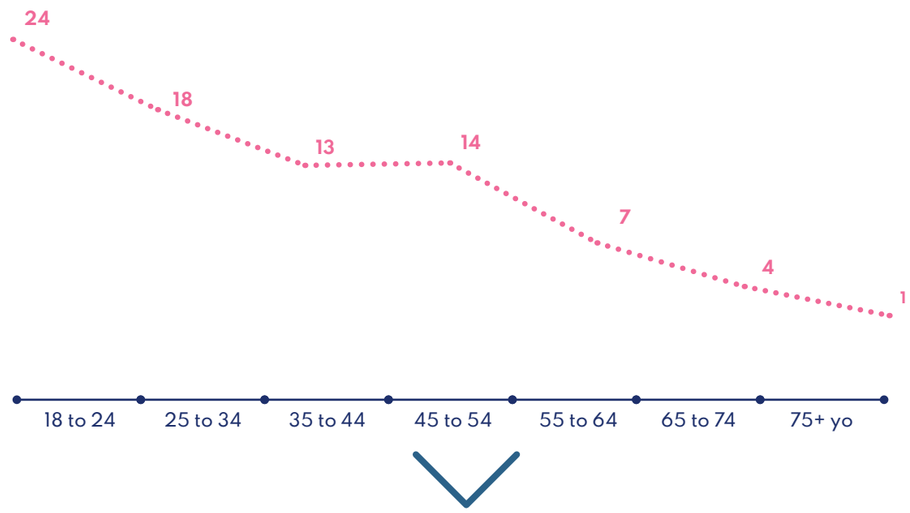
On the other hand, if people admit to having a tendency for psychological problems (i.e., difficulty to manage thoughts and feelings that cause ill-being) but find themselves at a point of equilibrium, they make a significant effort to remain in that position. Precisely to avoid imbalance, they tend to be more vigilant and to adopt behaviours that can hold or stimulate their position in the well-being axis [see 'Itinerant Condition', pages 38-43].

GREY AREA IN THE TERRITORY OF HEALTH — %

11%

Feel no control over their health,
due to psychological issues, despite not having
a diagnosed disease (physical or mental)

N=1029



WHAT TRIGGERS THE FEELING OF LACK OF CONTROL?

64%
The instability I feel

61%
Being unable to control my emotions

WHAT DO TOU BELIEVE TO BE THE ROOT OF THAT FEELING?

55%
The pandemic we are facing

43%
My work

36%
My nature

33%
My economic context

N=117

PATIENT THYPOLOGY:
A Psychological Approach to Disease

In recent decades, researchers argued that psychological factors are determining for how individuals experience health. Such factors will explain why people with very similar biological and physiological parameters reveal very different subjective health experiences, and vice versa. In one of these studies (Stalpers, 2009), a model was developed to describe a pattern of relationships between the subjective experience of health and three psychological determinants: perceived control, acceptance and adjustment.

In short, control is one's belief that a health condition can be influenced or controlled by oneself or others; acceptance is the feeling that a health condition and consequent possible constraints are acceptable and appropriate for oneself as a person. The adjustment corresponds to the willingness and how successful is someone's behaviours adaptation to the constraints the person perceives as imposed by his or her health status. The same study suggests that while perceived control and acceptance have a relatively high impact on (subjectively) experienced health, the impact of adjustment is less evident, at least among the general population.

Based on two main psychological determinants of subjective health - perceived control and acceptance - a patient typology was developed. This segmentation is relevant because it provides a better action-guide for people, i.e. it supports personalization in care.

The crossing of these determinants results in four "mental styles" that set a theoretical basis for exploring more suitable strategies for the difficulties experienced by each person. Regarding the quadrants, one can find the formulation in the picture.

The determinants of control perception and acceptance are dynamic constructions, that is, constructions that can change over time and according to circumstances. This implies that, over time, people don't have fixed positions on the quadrants.

Patient typology can and should serve as a framework for optimizing treatment options - be it services provided, adherence to therapies, or self-management care by people with a disease.

Source: Subjective Experienced Health As A Driver Of Health Care Behaviour - Sjaak Bloem, Joost Stalpers, Nyenrode Research Paper - July 2012

37,5%

Has at least one medical diagnosis
N=1029

	Doesn't feel to have control over the health status	Feels to have control over the health status
Accepts or wants to improve the health status	**14 %** Feels the wish to change, but is not capable or visionary enough to make those changes Needs planning and structure, for example, through practical help.	**31%** High self-sufficiency level Needs information to establish a solid feeling of pride and confidence.
Doesn't believe to be able to improve the health status	**25%** Are passive and inert, unwilling to fight, and with low levels of aspiration. Need personal and close guidance to gain hope.	**30%** The disease is an enemy. They waste energy and are resistant. Need for emotional support to reduce tension and resistance.

METHODOLOGICAL NOTE:

The theoretical model proposed has in the vertical axis 'acceptance of the situation' and in the horizontal axis 'feeling of control'. To adapt the responses of the present study to the model, we used by approximation:

• To the horizontal axis, the answer to the question: Do you consider that have control over your health - physical or psychological?, is Yes or No

• To the vertical axis: the answer to the question: Do you have the ambition to improve your health?, people who feel good where they stand or want to improve their situation were placed at the top of the table; and people who consider it difficult or impossible were placed at the bottom. As the questions are not faithful to those that are at the base of the theoretical model, the dimension of the quadrants is a mere exercise of approximation, and not an exact segmentation of the sample

An itinerant condition

Whatever form or meaning given, health can be represented in a continuous axis that settles between two poles: maximal health (without objective limit), and minimal health, which culminates in death. All people stand somewhere between these two poles, and that position is not fixed over time. No matter how robust or exuberant health may be, everyone experience displacements on the health or well-being axis throughout life. Generally, one slides along the axis as age advances.

The axis' lenght summarizes what each person believes to be their health potential, which, again, is distinct from one person to another, and for the own person, depending on how conscious one is about his/her health over the life cycle.

Although the health potential suffers from a natural degradation (due to ageing), it can be renewed and reconquered by the adoption of behaviours that lead to greater vitality and life time (with quality). This way, the individual can be a health producer.

The position on the axis represents the person's current health condition self-rating. It is the recognition of the distance from this position to the desired or ideal position (within the possible) that induces behaviours that lead to a better position on the axis. When the person is satisfied (or is not aware about the distance to their health potential), they tend to remain in this balanced position until they feel a gap.

Movements on the axis are mainly triggered by a tension between opposite-direction forces. On the one hand, negative forces that subtract well-being - whether they are illness episodes, accidents, specific stages of the life cycle (such as menopause), or others, more subjective, such as traumas due to experienced illness. On the other hand, individual action, supported to some extent by health professionals. These displacements take place at different speeds. There are stops, sprints, midfield tests and there are (slower) marches. Metaphors to illustrate peaks in vitality, episodes of illness of different severity and recovery, and ageing itself, slow and gradual.

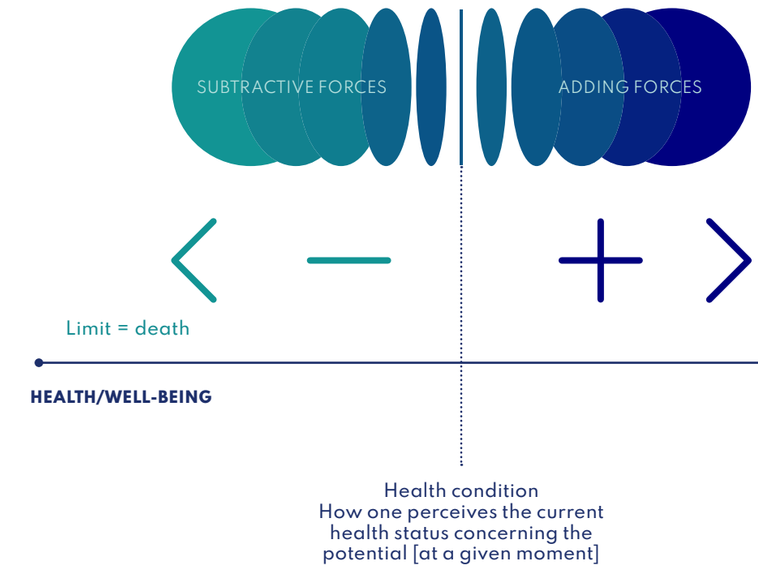
Therefore, the axis has three key characteristics:

1.
It is a straight-line segment, with a maximal end (the well-being potential) limitless in theory, but with a limited minimum end (which corresponds to death).

2.
It has an elastic extension, variable over time – as the potential can degrade or be negotiated and improved by the adoption of behaviours – which, in graphic terms, means the axis' length.

3.
It does not assure the same position for life (other than death). The condition of any person on the axis is always provisional or itinerant, and most displacements are not optional. Staying at a certain position on the axis will always be under threat, it is never a certainty.

GRAPHIC ILLUSTRATION OF THE ITINERANT CONDITION ON A HEALTH AXIS



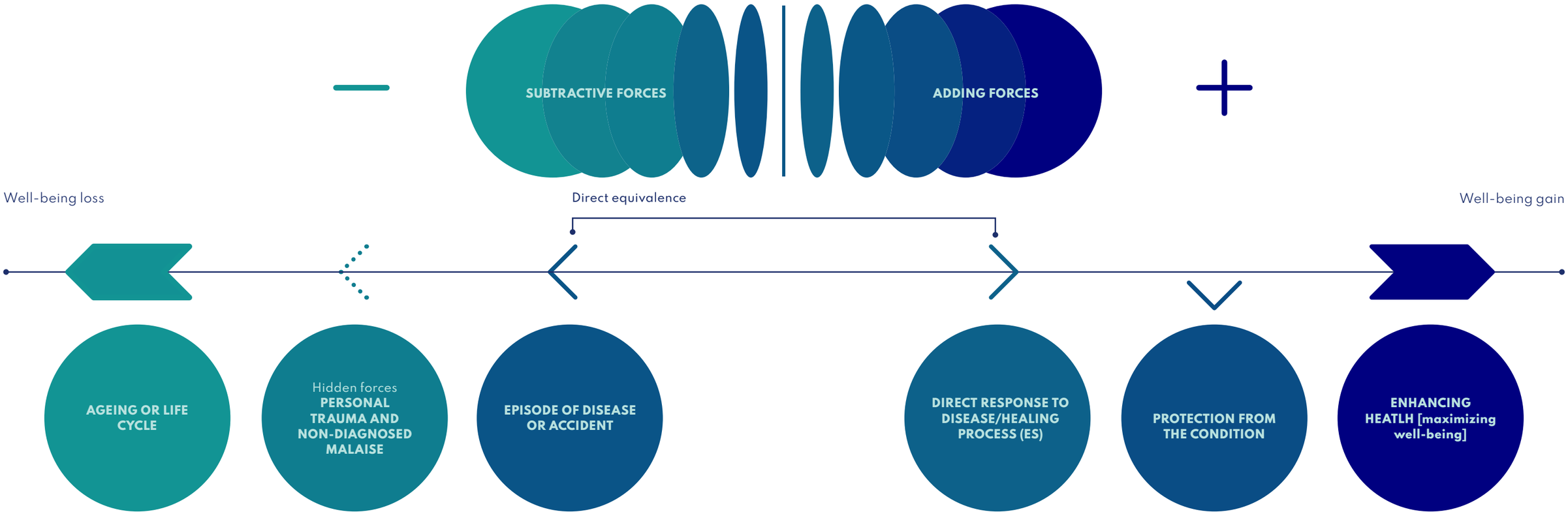
We know that displacements on the well-being axis are caused by tensions between negative force(s) and positive force(s).

What is the scale and nature of these tensions in society? How do they manifest throughout the life cycle? What impulses underlie individual action?

An itinerant condition

Main forces that cause displacement

By creating a model - a subjective and extremely complex simplification -, we wish to list opposite forces that cause displacements on the well-being or health axis. On the left side, the factors that can remove well-being; on the right side, the person actions, more or less induced by health professionals



The Life Cycle originates not only specific needs for each stage of human development - Child, Adolescent, Adult - but also ageing, which is a process of degeneration of the organism that occurs due to the natural passage of time. In addition to possible diseases, the most advanced stage brings with it dysfunctions, fragility and dependencies.

Various subjective forces. They may present symptomatology (despite the absence of diagnosis) or simply be impulses that come from traumas related to episodes of disease (own disease or close ones'); the awareness of genetic inheritance - rational or not - is present in this sphere of fear of having a pathology.

Diagnosed diseases, or accidents of different nature and severity that evidently require care.

Unpredictable or anticipated forces, unlike those that result from the natural ageing process or that are related to specific stages of the Life Cycle.

Actions taken in response to a diagnosed disease; performed by the patient supported by health professionals, through prescribed therapies. Theoretically, they would have a beginning and an end (the cure), except for chronic diseases, in which the healing process is replaced by an effort made to protect oneself from the health condition [See following text].

Actions taken for protecting health and preventing disease. It includes well-being management on a daily basis, disease prevention (due to unhealthy lifestyles), asymptomatic disease detection (e.g. with screenings) or minimizing complications and sequel of a previously diagnosed disease.

Own-initiative actions taken related to healthy lifestyles, and for improving health in general. The person seeks more vitality, self-esteem, well-being, etc. It may be in the long term or more oriented to achieve longevity (with quality of life) - i.e., the already mentioned axis length.

38%

HAS A DIAGNOSED DISEASE
[16% severe disease]

Do you have any medical diagnosis?
N=1029

64%

IS CAUTIOUS OR VERY CAUTIOUS ON PREVENTING DISEASES

What actions do you take on disease prevention and routine follow-up care? N=1029

44%

MAKES A HUGE EFFORT ON A DAILY BASIS TO BE HEALTHIER

Perceived daily proactive effort to be healthy
N=1029

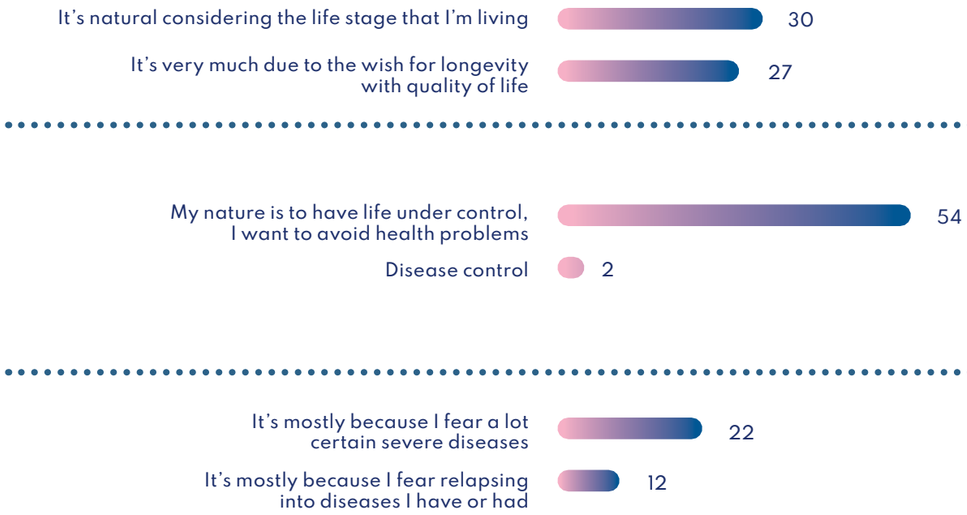
The tripartite expression of the impulses that, at each moment, guide the relationship of the Portuguese with their health status.

By subtracting the actions in response to a diagnosed disease - insofar as they follow a concrete response protocol and require an analysis within the limits of the framework (with a primary cure motivation) -, we attempted to identify - among the subgroups that recognize having prevention and enhancement care - the negative forces that motivate actions or, within the enhancement context, the ambitions or influences from society for adopting the so-called healthy behaviours [identified below].

The outstanding motivation for prevention self-care is the need for control, which the Portuguese recognize as a trait of their nature (or personality), similar among age groups. Equally transversal is the fear of severe illness, which reinforces the idea of hidden forces (or unfounded fears). There are no significant gender differences in any of the options.

Yet, among the reasons for fulfilling the potential, healthy ageing is more evident among the segment that is beginning to feel its effects (between 45 and 64 years old). Enhancement efforts – improving physical or intellectual performance (25%) — are more evident among the younger segment, aged between 18 and 24. Men also express, more than women, the desire to improve physical performance.

REASONS FOR PREVENTION EFFORTS — %



Q: What makes you cautious and seek preventive (or routine) medical care? N=658
(in case being cautious regarding disease prevention and routine care is reported)

REASONS FOR ENHANCEMENT EFFORTS — %

Q: What do you consider to be the main reasons for those efforts (daily efforts made to be healthy or healthier)? N=879 (in case pro-active efforts to be healthy are reported)

Anti-Ageing:
Efforts made for the axis not to shrink

Actions to prevent the health potential from deteriorating

Advances in research devoted to the biology of ageing suggest that ageing is a biological mechanism that can be halted and eventually reversed. For young people, being a centenary is a seductive proposal: 31% of respondents between 18 and 34 would like to live at least up to 100 years old.

The idea of a youth elixir is not new. In addition, there is no shortage of products on the shelves that promise, at least, to delay this natural process of wear and tear of the body. They come from the same industry that suggests aesthetic norms that praise young appearance, subjecting society to an ideal of beauty that refuses ageing. In our sample, 46% know how old they were the first time they felt they were growing old (same for those between 25 and 65 years old), and almost half of these state that it happened when they were between 20 and 40 years old. That the confrontation with ageing itself arises so early is very revealing of this ideal of youth.

The society that for years reduced aesthetics to appearance and fashion has evolved. Today, it is difficult to take care of beauty without considering the health dimension, which is why overweight is overall reproved. Also segments traditionally less concerned with appearance and self-care are now targeted, such as men. This makes it difficult to distinguish whether healthy behaviours, such as those related to nutrition, body hydration or physical exercise, are due to an aesthetic or pure health concern.

Anticipation of ageing as a process in which one is deprived of "being a fully empowered person" - in terms of physical capacities, autonomy, social participation - explains the commitment to pro-health behaviours.

It is an action that aims to preserve the health potential for a longer period. It's not just about moving on the axis but preventing the axis from shrinking.

Health is increasingly about preparing for greater longevity with quality of life, which explains why the segments between 45 and 64 years emphasise motivation. People do not just want to live longer, they want to live longer with quality. In this respect, Portugal can improve.

While average life expectancy has risen to 81.6 years, the number of healthy life years after 65 is only 7.3 years, less 3 years than the European average (10.3 years, Eurostat data). We also rank at the 16th position of the Active Ageing Index, below the European average. This poor quality ageing certainly explains why older people find the idea of living up to 100-year-old less seductive; the goal is to live until one is healthy, regardless of age.

The relationship with ageing and death itself changes throughout the life cycle. 34% recognizes being difficult to deal with ageing, but while from the age of 45 the issue is unsettling, after the age of 75 the perspective is softened, and the level of acceptance of this unavoidable reality (for now) is higher.

46%

Is able to identify the age when they first felt they were ageing

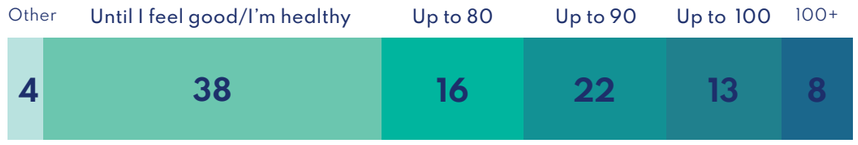
N=1029

45%

Felt for the first time they were ageing between the ages of 20 and 40

N=552

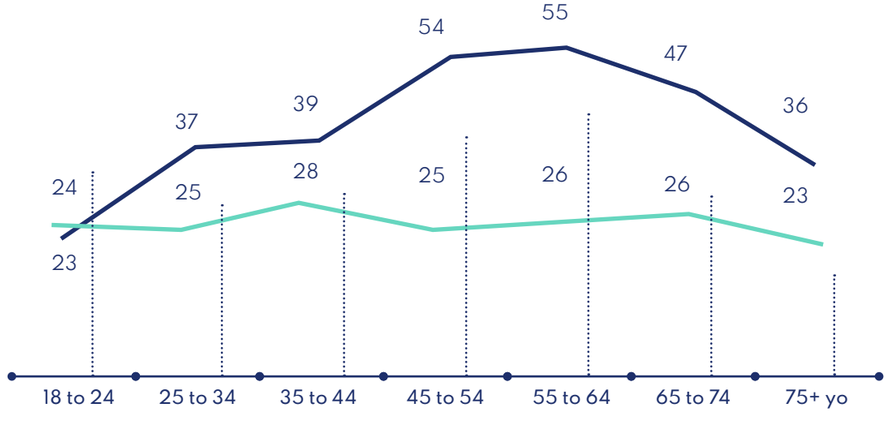
TAKING INTO ACCOUNT THE AGEING CASES AROUND YOU, UP TO WHICH AGE WOULD YOU LIKE TO LIVE? — %

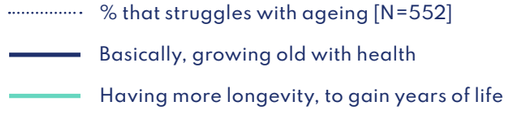


N=515

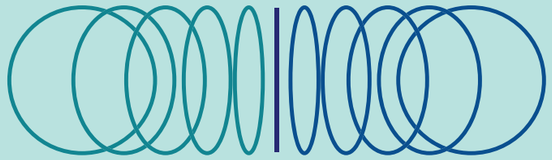
MAIN REASONS FOR MAKING PRO-ACTIVE EFFORTS TO BE HEALTHY? — %

N=879 (reports some efforts)





Delaying ageing
in direct speech

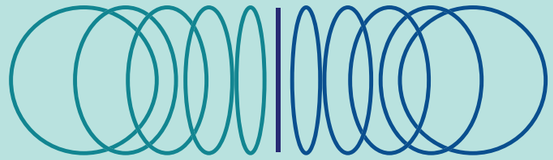


"It’s also related to age. Ever since I've been older, that I worry about things that my 17-year-old doesn't care about. (...) People begin to look themselves at the mirror, to perceive themselves as someone who’s ageing. Since I've never had any severe health problems, it turns out to be a bit about aesthetics only.
A wish to delay early ageing or natural ageing.”

"As for personal care, I moisturise my skin every day after bathing, I use face skin moisturiser every night... I always have this routine and it came with age.
I'm trying to slow down the inevitable."

M, 45 years old, Lisbon

The fear of "being a burden"
in direct speech



"I'd like to live at least until I am eighty and something. More than that, one thinks: if the head doesn't function properly, I'm just here giving trouble... I believe this age is a good goal. I’ve already seen the boys [grandchildren] grown up, it's a good goal."

"We always have that thought of what death is and what it's going to be. My only fear is to become bedridden and unresponsive... one doesn't even feel, but the close ones, are who suffer the most. Besides that, I have no other fears. Regarding this aspect [of disease], I believe I’m strong."

W, 66 years old, Lisbon

Potentiating Health: How far can one extend the axis?

Actions to expand health potential

Health potential is determined, by nature, by the DNA we inherit. We are all subject to a genetic lottery that establishes, at birth, certain health risks and a certain ability to resist the deterioration of physiological functions (i.e., ageing). In addition to this genetic burden (and, of course, eventual diseases or accidents), the health potential of each person depends on the lifestyle and behaviours that, throughout life, can either stimulate it or harm it.

Although the genetic structure plays a fundamental role, the health potential can be improved. Any high-level athlete plays for the championship of surpassing their potential, that is, they seek, through work and permanent stimulus, to expand their resistance, strength, flexibility, speed and even ability to focus, by challenging the genetically assigned limits of the heart, lungs and muscles.

By doing so, they contradict theories that until recently argued that the structure of the human brain would be static. Neuroscience defends that the brain (within certain limits) is plastic, and this is a life time feature. Each learning act physically modifies the brain, and it is precisely because it remains plastic throughout life that we witness a remarkable development of the human brain.

There is evidence that body and brain can be reprogrammed by integrating behaviours, which vary from exercise and meditation to diets.

This plasticity claims a health potential higher than the one determined for each person by nature, that is, it suggests that the axis can be extended, as it is possible to negotiate not only quality of life but also years of life.

Although the idea that it is possible to manipulate the organism and influence genetics is exciting, it is not common.

Even if in Portugal there is a growing adherence to physical exercise and similar activities, and important improvements regarding diet, it is difficult to say that there is a body and mind culture. Even among those who report doing some kind of effort to be healthy (85%), the majority are motivated by day-to-day well-being (66%), that is, they aim to maintain or improve the position on the health axis and not to improve their physical (21%) or intellectual (13%) performance. Even gaining years of life (26%) comes behind the intention of ageing with quality (44%).

The discussion that perhaps matters is whether this little action for health improvement is due to the lack of motivation or due to the lack of awareness. For most people, their 'individual health stock' is something that was meant to be and is not negotiable. The health effort must therefore focus on the preservation of what it was inherited, and this effort is more guided by fear of loss than by the dream of conquest.

How many people, thin and healthy, would adopt a healthier diet if they knew that this would result in improved intellectual performance? What areas in health are not improving because the dream is not being suggested?

Challenging the potential

How can human beings overcome what is destined

Joseph Pilates was born in Germany in 1883 to a gymnast father and a naturopathic mother. He had poor health, suffering from asthma, rheumatic fever and rickets. The philosophy of natural stimulus of the body that he inherited from his parents, coupled with childhood experiences of bullying, led him to be interested in the body and to a desire of challenging his limitations. The physical disadvantage he started from and the threat of a wheelchair-dependent life, led this autodidact to study anatomy and everything related to human body functioning.

It is told that his ideas were based on the comparison of babies with cats; what intrigued him was how cats could always perform better movements, not necessarily by using all the parts of the body, but always in an economic manner.

Over time, after several experiments, also in sports, his method developed into what would become a system of around 500 exercises performed on a mattress or other equipment specifically designed for problems he had on his own body.

His method implies a customised approach, fully adapted to the needs and limitations of each person, always using a challenging approach by increasing the level of difficulty, strength, and flexibility. With this method, which focus not only on the body but also on the mind (through breathing), Pilates managed to redesign his own body and the health condition that was destined for him.

A perfect example of how one can extend the health axis beyond its natural potential.

A daily equation

Leaving the macro-sphere and looking at the daily life, health emerges as a manifestation of better or worse well-being that can be managed daily. There are cumulative experiences that lead to actions in the day-to-day, either because the person feels the need to act upon some kind of malaise, or because people are not willing to go below a certain level of well-being, or because they wish to fulfil certain self health goals to which they are committed to. In fact, 'feeling good in everyday life' is the first reason mentioned for being committed to a healthy life, reported by 66% of people who make some kind of pro-health effort.

This daily health equation is composed of behaviours that can have positive or negative effects on health. Positive or negative correspondence has, implicitly, a "reflected" (cognitive) and "sensed" (physical) rating.

Smoking a cigarette may be pleasurable, but those who smoke it know that they are harming their health.

Eating a very heavy meal, in addition to the related (reflected) judgement, can effectively create discomfort. The equation works for those who are willing to be vigilant and to take action to maintain well-being at a certain point of equilibrium.

However, if one looks at the statistics, it cannot be stated that this daily management model is universal (only 29% recognizes it fully). As it cannot also be ignored that about half of the sample somehow relates to the statement "regarding my health, I believe I make up for unhealthier behaviours with healthier ones, which I am more cautious about."

In this compensation game, diet and physical exercise stand out, both as slips and amends. There is even a tendency towards symmetrical compensation, meaning that food excesses are counterbalanced with physical activity and sedentary lifestyle with a healthier diet.

This logic regarding health is triggered by different psychological mechanisms. In some cases, the equation works like a process of damage control: the slips trigger a sense of guilt that leads to restoring actions, that result in a repetitive cycle of damaging and restoring.

When there is a high tendency for behaviours with negative consequences (and awareness of the harm), making amends is more demanding. In the case of diet and physical exercise, this cycle is contaminated by overweight concerns, which, as we have seen, are not about health, but about aesthetics. Among some women [see chapter 4 - Equilibrists] this game of sums and subtractions is particularly evident.

In other cases, the mechanism responds to an extreme concern about health, veiled by the fear of disease, which leads to permanent judgements about what may mean preserving or harming one's own health. There is a sense of restlessness concerning the relationship with health that does not allow us to relax when it comes to be vigilant for symptoms, originating a permanent process of regulation, more based on the desire to control all aspects that can influence health rather than on guilt feelings.

It is precisely in the segment of people highly concerned with their health [see chapter 4 - Health Hostages] that this equation is more evident.

56%

Relate somehow to the statement

"Regarding my health, I believe I make up for unhealthier behaviours with healthier ones, which I am more cautious about."

Answers TOP 5 | N=1029

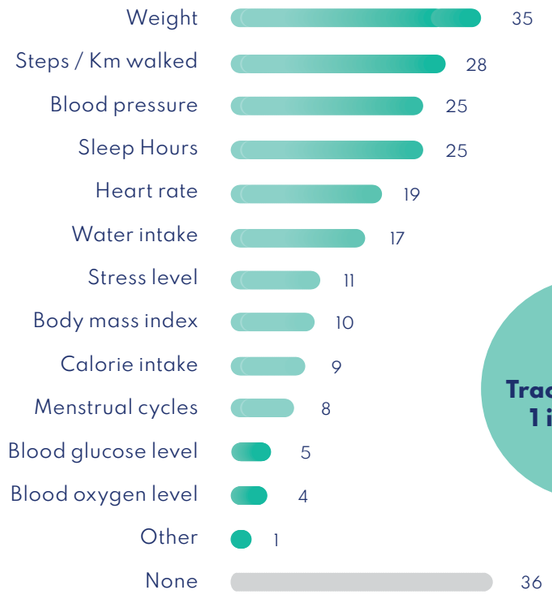
UNHEALTHY BEHAVIOURS, SLIPS OR OMISSIONS — %

AMENDS — %

Base Identifies (6 to 10): N=655

THE METRICS: DAILY MICRO-MANAGEMENT

Health indicators that you track daily with devices — %
N=514



64%
Tracks at least 1 indicator

With what purpose? — %
N=328 (if selects at least 1)

It should be made clear that, although the vast majority reports that they have a healthy diet - 78% of respondents state they have that daily concern on a daily basis - we are dealing with very different people in terms of sophistication and food requirements. The journey demands learning and experience until it is possible to assess functionally what one eats, and to integrate healthy eating routines. Although some principles such as fruit and vegetable consumption have been generalized, the diet depends on the time one devotes to it, on financial resources, information and motivation - some want to lose weight, others are trying to avoid diseases; some seek ingredients with specific functions, and others only avoid the consumption of certain products, such as salt or sugar. For that reason, it wouldn't be possible to analyse thoroughly a behaviour that is increasingly determined by highly individualized rules and motivations.

While it is true that the discourse focus mostly on topics around diet, an active life and physical exercise [weren't we heirs of a public health narrative that for decades has been praising these behaviours as foundations for a healthy life], there is a multiplicity of factors that nowadays people are taking closely into account.

In recent years, technological developments - such as smartphones, applications, smartwatches, bracelets and other devices for personal use - have trivialized access to metrics that measure various health dimensions' daily performance , whether related to health indicators (such as the level of oxygen in the blood or blood pressure), or behavioural caused. The fact that some of these applications exist by default in mobile phones favours experimentation and adherence.

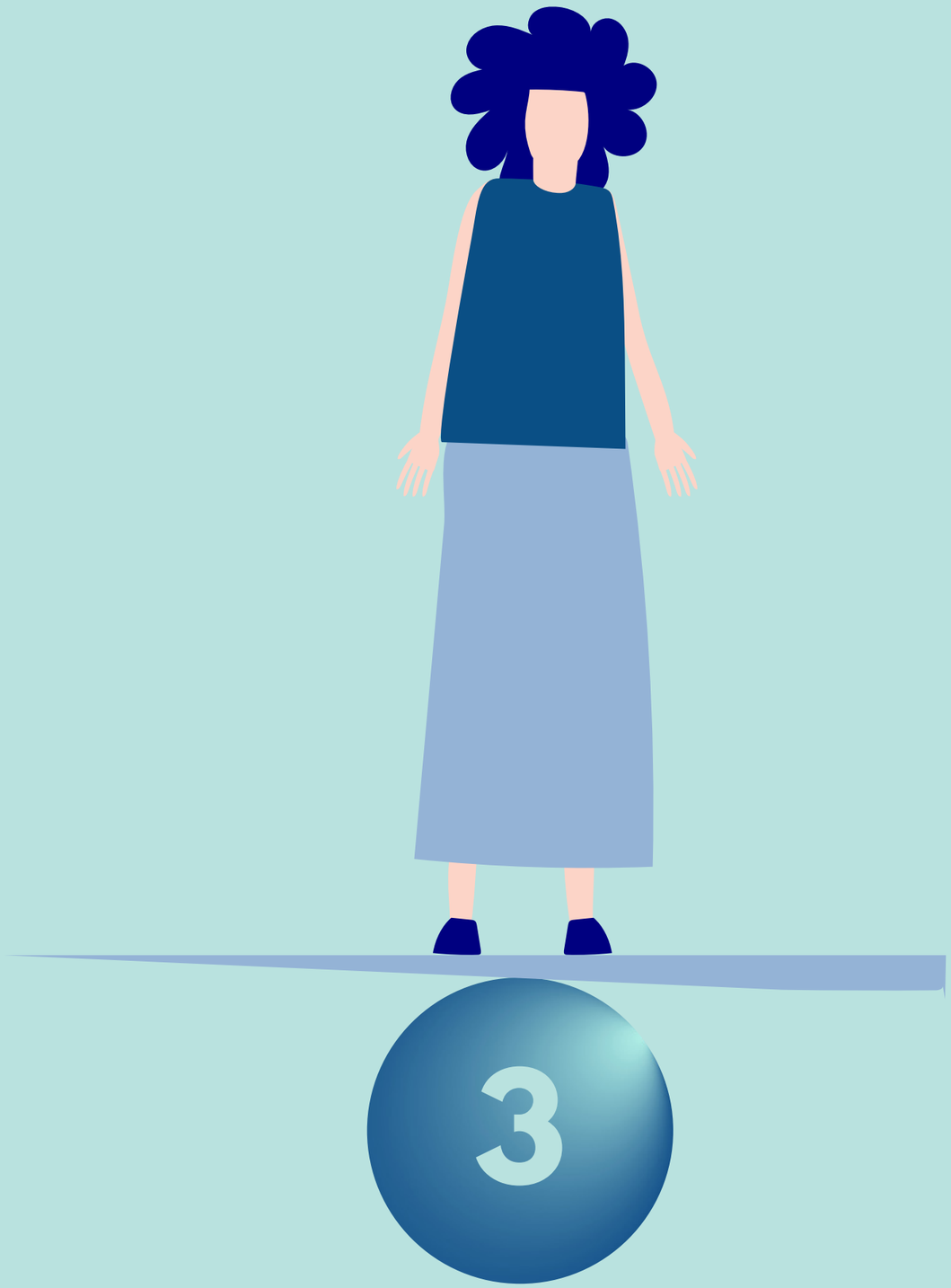
Therefore, more and more Portuguese are willing to voluntarily monitor their health indicators and behaviours: 35% track their weight daily, 28% track their steps or kilometres walked, 25% track their hours of sleep, 19% track their heartbeat, 17% track the water they drank, among others.

More interesting than looking at what people track is to understand their motivation: adopting healthy behaviours arises immediately after weight (the classic candidate to the podium), followed by disease prevention. Within the logic of performance enhancement and improvement, these statistics also help defining and achieving physical activity goals.

Metrics are a way to self-regulate healthy behaviours and they are used not only as an immediate self-diagnosis, but, mostly, as a daily stimulus to achieve goals.

Its objectivity makes it easier to understand how far one is from the goals, and it even works as a lever for exceeding those goals.

Because individual statistics are created daily, they allow something entirely new: to understand the health biography through metrics, by identifying the starting point, evolution, and progression over time.



1 to 10: the Health one has

Research leads us to a concept of health status, based on a worse or better performance over an axis that shows the well-being potential of each person at a given moment. It assumes that there is a life timeline, - a genetic heritage and a history of constraints - which defines a certain health potential, always different for each person.

By determining their position on a (figurative) axis, each person rates how far they are from what they believe to be their health or well-being potential.

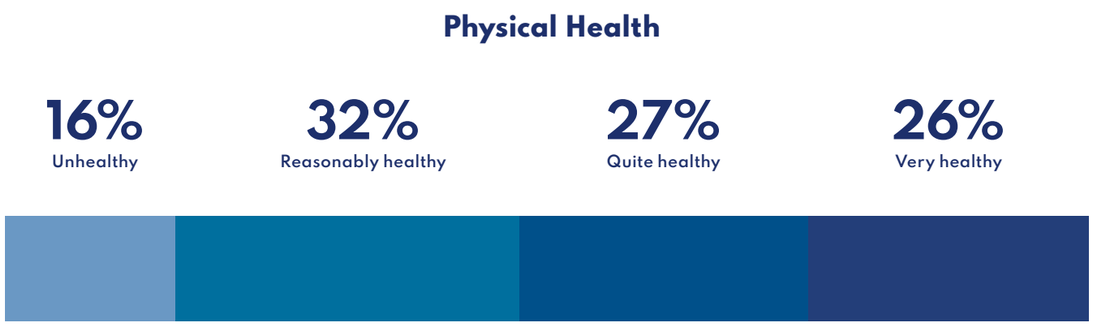
On a scale of 1 to 10, how would you rate your current health status?

Half (52%) of the Portuguese over 18 years old rate their health status as good or very good, 31% consider their health status reasonable and 17% consider their health status as bad or very bad

On a scale of 1 to 10, where 1 is "very unhealthy" and 10 "very healthy", how would you rate your health status?
N= 1029

On a scale of 1 to 10 how would you rate your current

Physical Health



7,4

RESPONSES AVERAGE

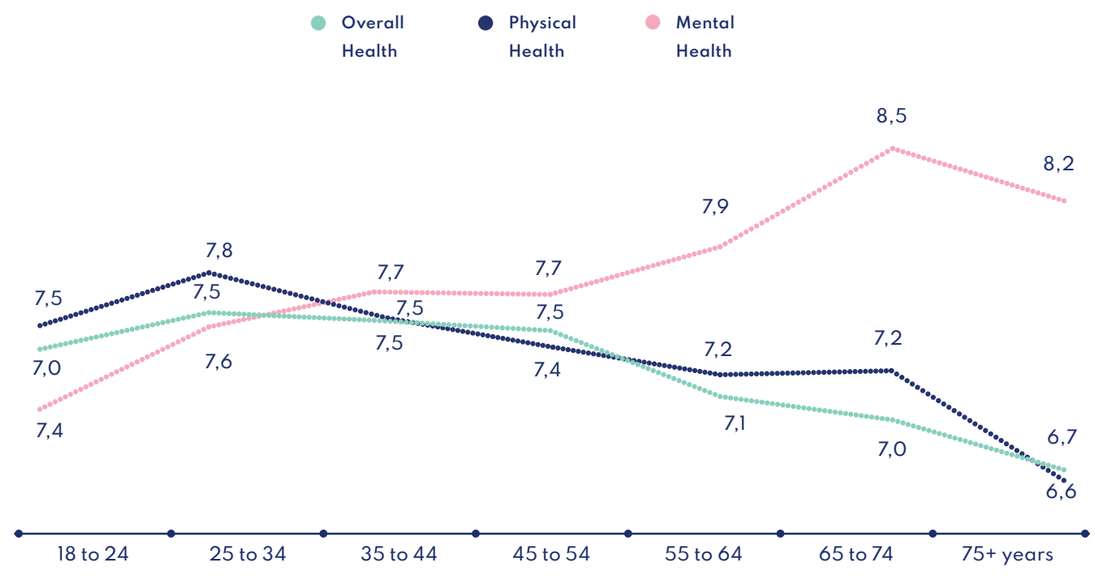
Mental Health

7,8

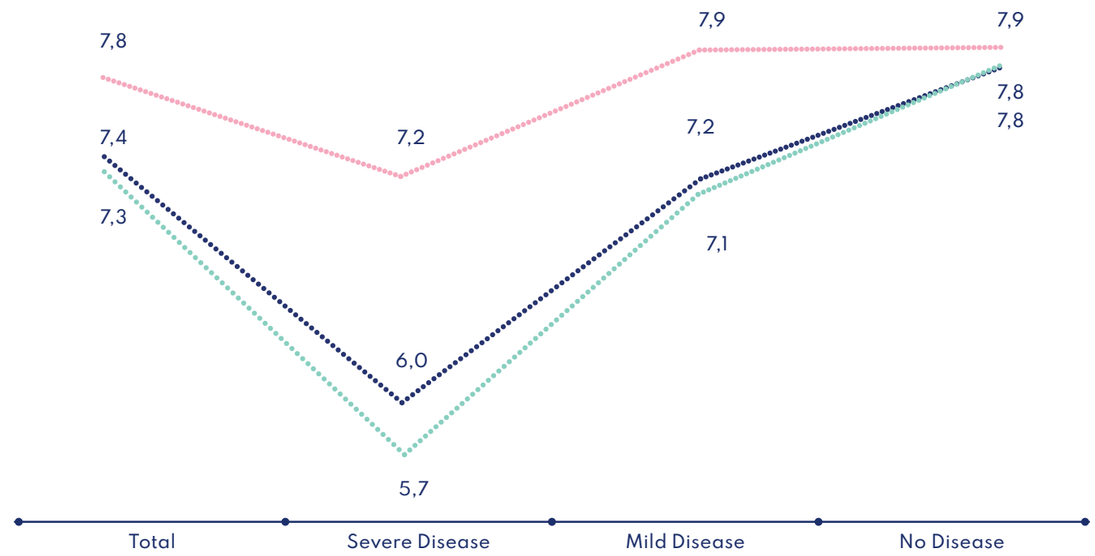
RESPONSES AVERAGE

On a scale of 1 to 10, where 1 is "very unhealthy" and 10 "very healthy", how would you rate your physical health and your mental health, respectively? N=1029

DISTRIBUTION BY AGE



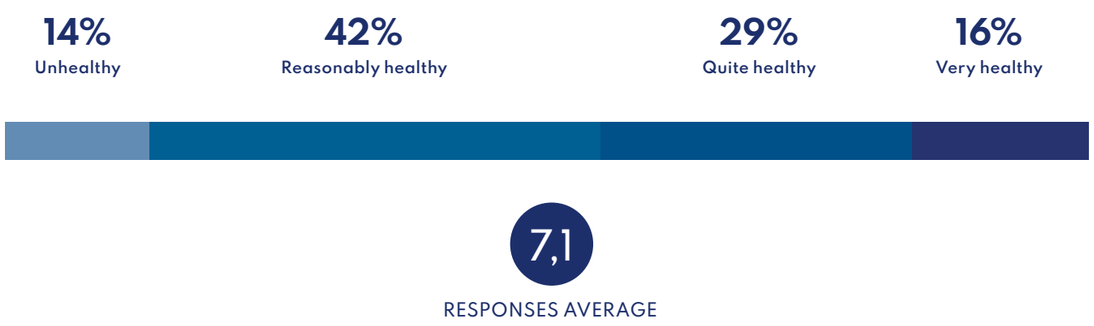
DISTRIBUTION BY HEALTH STATUS



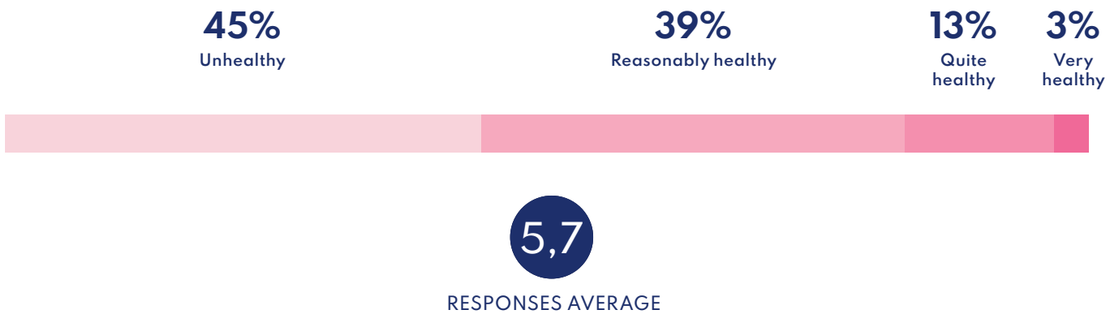
How would you rate your current health status?

No disease

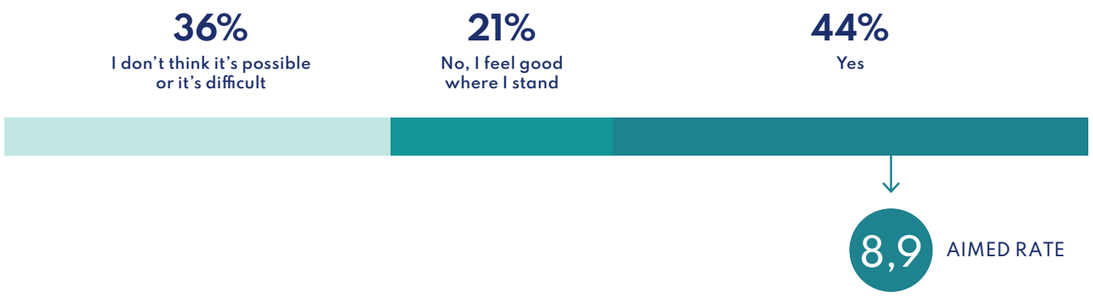
Mild disease



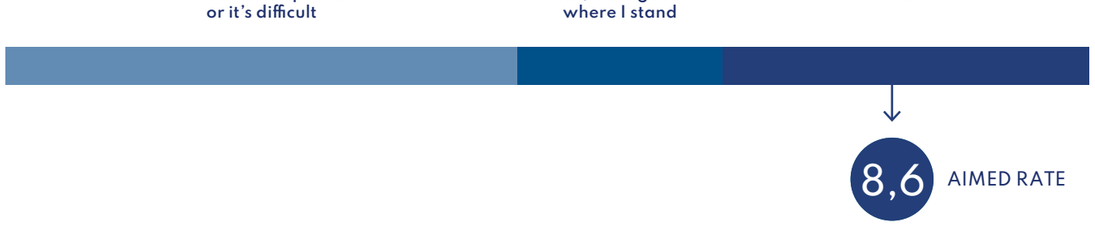
Severe or very severe disease



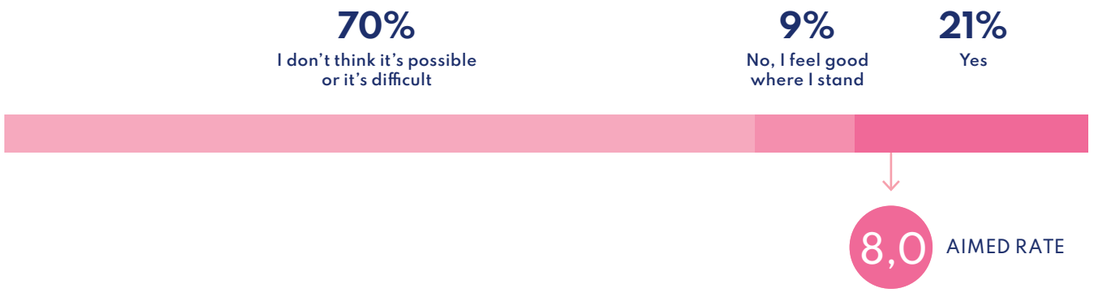
Do you have the ambition to improve your health status?



Base: No disease or specific diagnosis I N=643



Base: Has a disease or specific diagnosis that considers not be severe or very severe I N=168



Base: Has a disease or specific diagnosis that considers very severe or severe or relatively severe I N=218

The different self-rates allow three important conclusions.

1. Distance to potential explains health self-rating.

Although the disease affects health status' self-rates, people seem to find it relative (considering the health that one can achieve), which explains why people with no diseases perceive themselves as unhealthy and why people with specific diagnoses (even severe) consider themselves reasonably and even quite healthy. Because it is subjective, people's health self-rating may contradict that of doctors and health professionals.

2. The first association to health is physical well-being.

It is the physical dimension, and not the mental one, that determines the health rating in general terms, even among those who have a diagnosed disease. The health line accurately describes that of physical health and is detached from the mental health line. This does not mean that there are no mental problems, but that they are less perceived or interfere less on health self-rates.

3. Mental health has very different meanings among different age groups.

Even if satisfaction with life improves with age, this is not enough to explain the great difference in mental health rates between younger and older people.

It's hard to believe that age dissolves problems like anxiety, depression or even substance dependence such as alcohol. No matter how much work or family tensions are softened, and how much one learns to live with what one is and has, there are several other aspects related to advanced age - a greater disease prevalence, physical weakness and limitations, inaction, loneliness, grief - that certainly determine psychological ill-being.

The hypothesis will be that, among older people, mental health is more associated, on the one hand, with the capacity for logical reasoning and memory (especially regarding mental issues that are more common in old age, such as Alzheimer's disease) and, on the other hand, the historical stigma about those who suffer from mental disorders. Until recently, a mental problem would mean only diseases that lead to undesirable social behaviours. The excellent rate that people aged 65 and over give to their mental health will (probably) be anchored in this more antiquated view of looking at mental health as a form of dementia or madness.

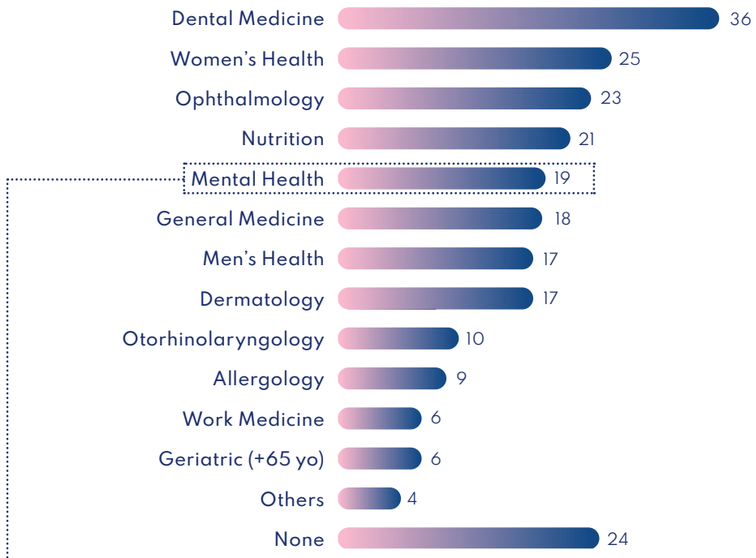
Although health is reasonably well-rated and there is a clear desire for improvement, we believe that there is a deviation related not only to the inability to identify mental issues, such as establishing relationships between these disorders and overall health.

The results of this study show evidently that there is a psychological and emotional ill-being that jeopardises the health of the Portuguese. However, there is an ignorance or illusion of well-being that veils the examination and prevents a correct diagnosis.

Areas you feel lacking care

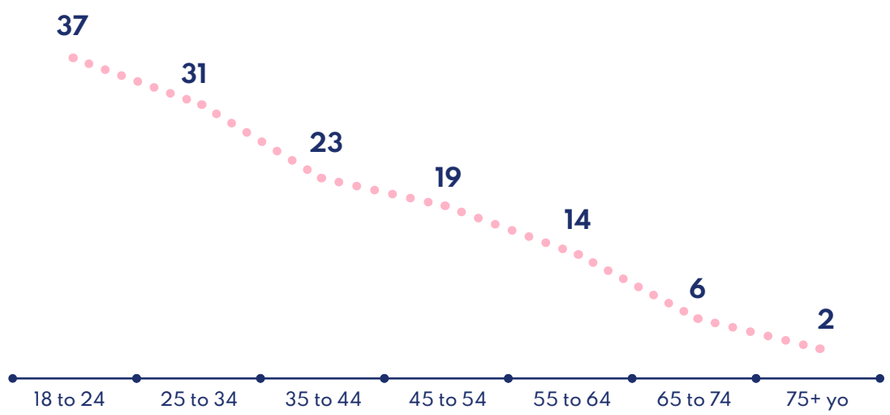
From the following list, which areas do you feel you're not monitoring or you would like to have more advise — %

N=1029



Do you feel you're not monitoring your mental health or that you would like to have more advise — %

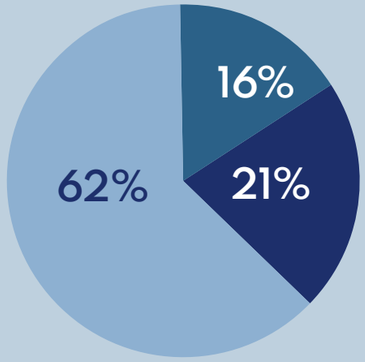
N=1029



Clinical portrait

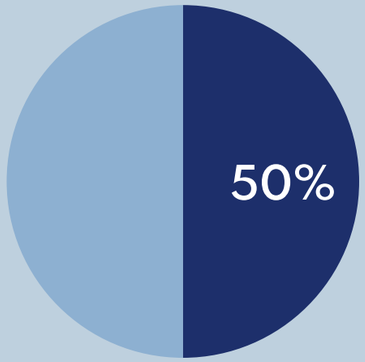
N=1029

HEALTH STATUS



- No disease
- Has a mild disease
  Has a specific diagnosis
  that considers mild or not severe
- Has a severe Disease
  Has a specfic diagnosis that considers very
  severe, severe or moderately severe

TAKES MEDICATION REGULARLY



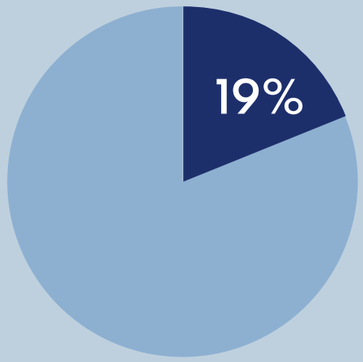
MEDICATION BY TYPE OR ACTION

TOP 5 I N=517

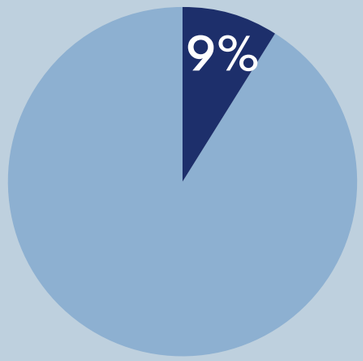
- 31% Blood pressure
- 17% Cholesterol
- 16% Mental disorders (tranquillizers, antidepressants, etc.)
- 12% Diabetes
- 9% Cardiacs

Regular medication intake weighs significantly. The most common are the ones for the cardiovascular system and mental disorders.

WAS ADMITTED TO THE HOSPITAL IN THE PREVIOUS THREE MONTHS



SUFFERS FROM DISABILITY



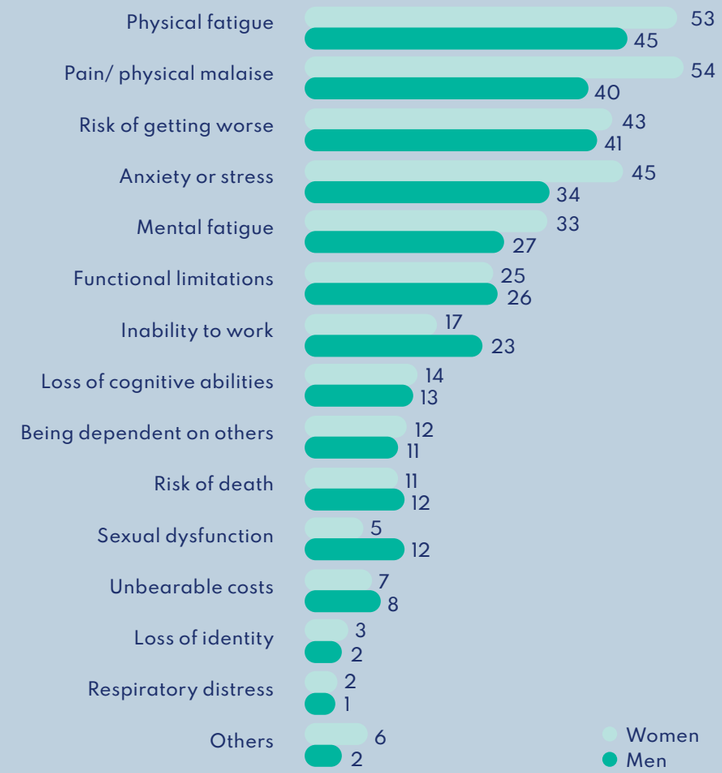
Severely diseased

Has a specific diagnosis that considers very severe, severe or moderately severe
N=218

TYPE OF DISEASE — %

TOP 10 (among who reports severe disease)

WHAT FEARS OR DISCOMFORT DO YOU ASSOCIATE TO YOUR DISEASE? — %



A matter of age

Between birth and death, we are naturally subject to biological, psychological and social changes that affect different dimensions of life and, in particular, health. Advanced age not only increases the risk of death and illness, but also vulnerability to various disorders, frailties and dependencies that are not diseases but impact quality of life. Our figures unsurprisingly are in line with all the statistics that suggest an increase in disease (severe and mild) with chronological age.

Likewise, and because risks become closer, prevention behaviours increase with age, namely through consultations and routine screening, being the most advanced argument by unwary young people, the fact that they are healthy and think that their age doesn't require this kind of care. Except for young people, most Portuguese consider themselves careful and obedient to the recommendations. As it is difficult to discover to what extent people know what is recommended for their health or age, the possibility of some illusion concerning complying with these prevention rules cannot be ruled out.

Also the efforts made for a healthier lifestyle increase with age, which does not mean that there are no healthy behaviours among the youngest, but that they will do so with less effort or not strictly related to a health issue. (such as sports).

Age works as a marker that triggers greater concern with health, not only by obedience to a protocol (medical) very well settled in age, but also by reaction to changes in the body that are observed or anticipated.

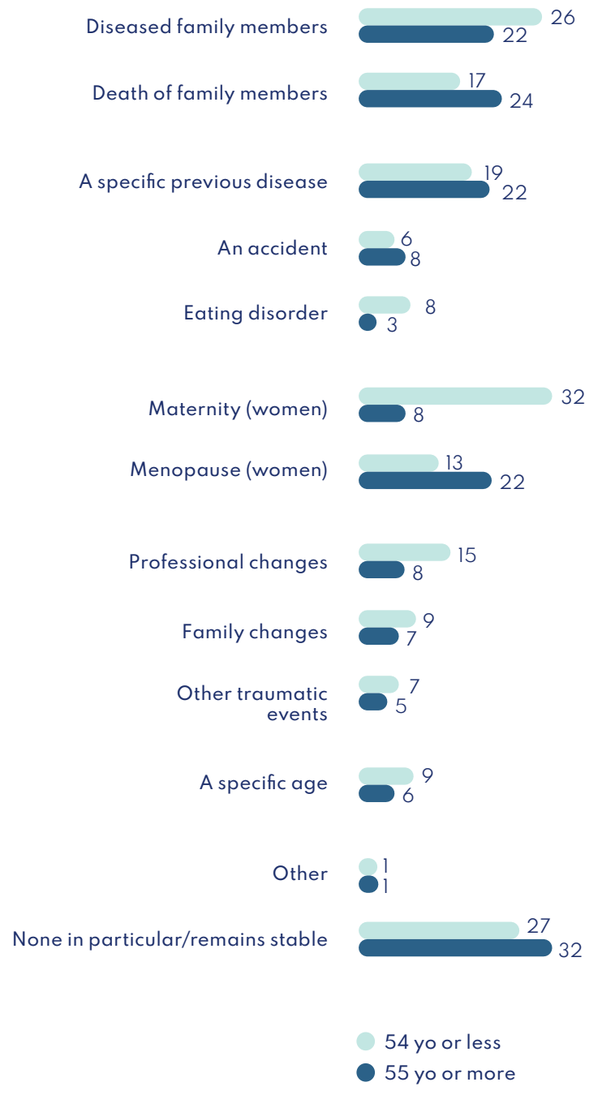
Although individuals of the same chronological age experience different physiological ages, there is a common reaction that is caused by the number of years one lives, especially when approaching the senior age.

Research also shows that, despite the age aspect, the relationship with health changes due to events that are often external to the person or to his/her health condition. There are occurrences in the chronology of life that dictate disturbances in this relationship, either because people start valuing health in a different way, or because the event itself can originate health problems. The death of a family member, divorce, widowhood, the disease of someone close, are inducers of psychological states that can interfere with health. Stress itself can be a precursor of disease. These problems are not of an age.

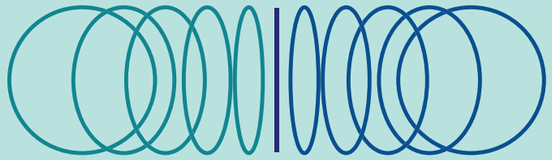
Even for those who lived a good deal of their lives (people aged 55 and over), the death and illness of family members might have contributed more to the change of their relationship with health than age, as much as menopause or their own disease.

Finally, throughout the life cycle, hierarchies of concern are established, which changes the relationship with health. Being healthy is not a priority for everyone, nor does it have the same importance for each person over time. In addition to the relative importance compared with other dimensions of life, there are moments when people, who become carers, place themselves often in the background as they prioritize the health of their children or sick relatives.

LOOKING BACK AND THINKING ABOUT YOUR LIFE, WHICH EVENTS MOST CHANGED YOUR RELATIONSHIP WITH HEALTH? —%
N=1029



Disorders that trigger health problems
in direct speech

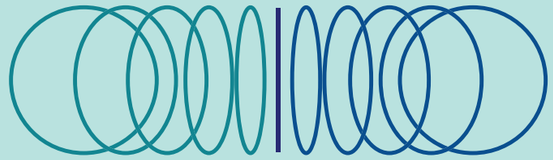


"When I received the diagnosis [of autism] for my 18 months son, it felt like a bomb. No parent is prepared for this."

"At that time, it affected [my health]. At work, I had lots of things, I was always running. That was possibly the trigger. Stress and a rushed everyday life can trigger this [ankylosing spondylitis]. There may be a predisposition, but it can be triggered by stress. Professionally speaking, I was overwhelmed. When my colleague joined in, I slowed down and decompressed. When I decompressed, everything came up. This came up – the uveitis –, and it triggered the autoimmune disease. It looks like that's when it all came out."

W, 42 years old, Odivelas

Moments you were pushed into the background
in direct speech

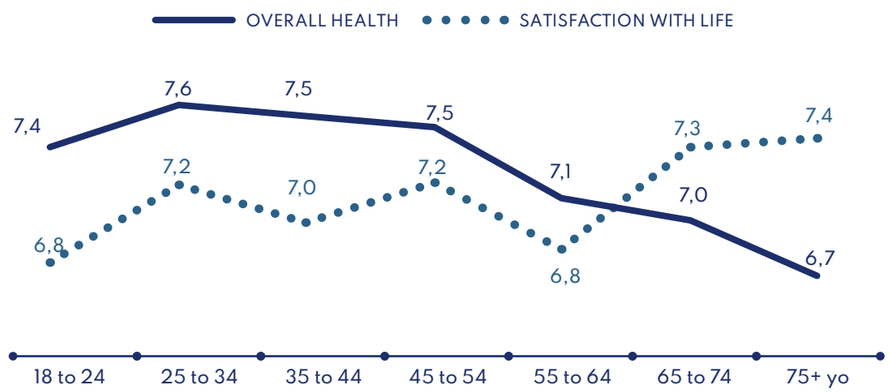


"I'm working and I have to support my mother. I don't feel physically tired. It's my mind that is tired. I cannot sleep... My mother is alone. Her bones are falling apart, and I have to help her. ... My life got more complicated, heavier. I can't get out much, it's limited in certain things. It's just house, house, house. (...) I leave everything finished in the morning. I come in at seven and leave at four [from work]. When I come, I finish what I have to do. I wash the clothes, stretch them out, clean the floor. She does what she's able... but she sits around waiting for me to come. On vacation,we can't travel. ... My sisters come by sometimes, but it's a quick visit. They don't bath her, nothing. It's different."

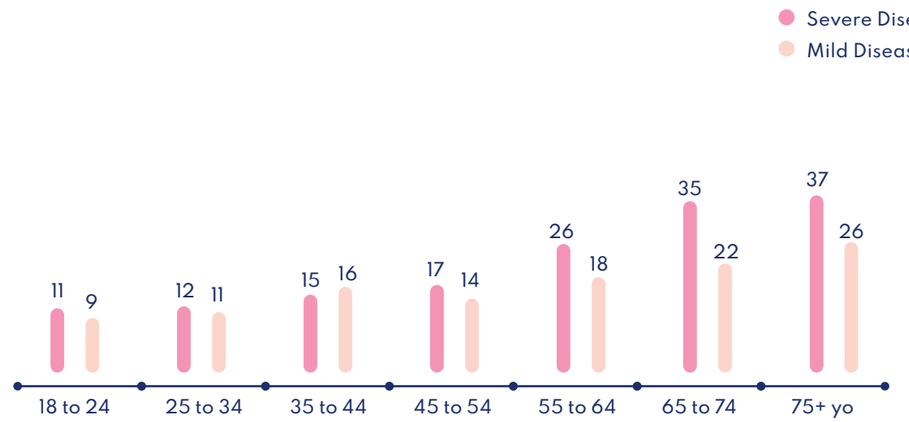
W, 44, Ponta Delgada

HEALTH STATUS AND SATISFACTION WITH LIFE

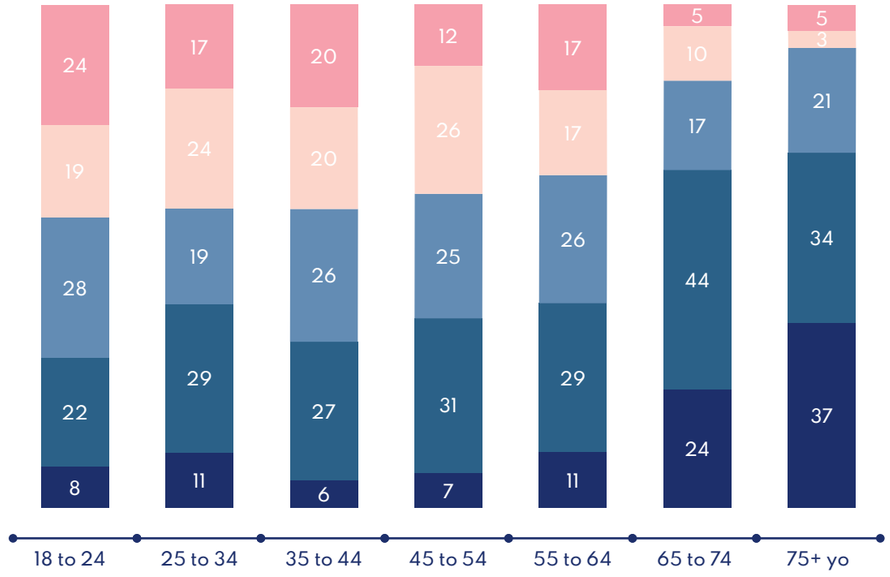
(Average values on a scale of 1 to 10 I N=1029)



DISEASE PREVALENCE — %

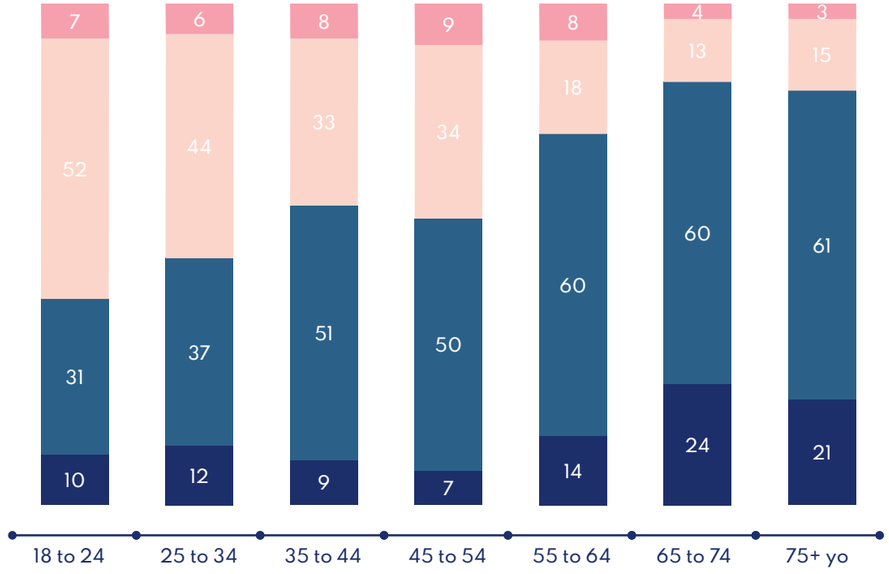


DAILY PRO-ACTIVE EFFORTS TO BE HEALTHY OR HEALTHIER — %



- I make little or very little effort
- I make enough effort to compensate the less healthy behaviours
- I just make an effort to not ruin it
- I make a huge effort to keep my balance
- Being healthy is a central goal in my life

WHAT ACTIONS DO YOU TAKE REGARDING DISEASE PREVENTION AND ROUTINE MEDICAL CARE — %



- I don't take care of my health; I often postpone going to the doctor even when I have symptoms or alerts
- I only act when I have symptoms or alerts
- I'm careful, I go to the doctor and do tests according to what is recommended
- I'm very careful, I do tests and I go to the doctor beyond what is recommended for my age or condition

A matter of gender

The difference between genders begins, first of all, in the life expectancy at birth, in which Portuguese women can expect to live at least five years longer than men. In addition to lifestyle, which leads to more risky behaviours and more aggressive activities, men will have a biological disadvantage compared to women.

While men tend to die earlier, women have higher disease rates - mostly chronic. According to the INE, women also have more limitations when performing activities due to health problems. In 2019, 9.2% of women said they were severely limited and 28.8% limited, but not severely, figures that compare with 6.5% and 20.9%, respectively, in men. Despite the average life expectancy, the estimate of healthy life years is lower for Portuguese women.

In our study, women also show a higher disease rate, and self-rate their health worst: 1 out of 5 perceives herself as unhealthy or very unhealthy. They also recognize, more than men, the feeling of lack of control over their health status, and in this regard psychological issues seem to weigh more for them than for men, . The instability they experience and, above all, the feeling of not being able to control their emotions are not women-exclusive, but it distances them from men.

Although the difference is not significant, women tend to be more compliant in terms of routine medical care, to be more cautious about their diet, and to adopt less harming behaviours, such as drinking alcohol or smoking.

Women are also more alerted to the issue of mental health, as they not only report making a greater effort in their daily lives concerning it, but also adhere more to psychotherapies or activities such as yoga or meditation. Interviews also show that they tend to be more vigilant and more connected with their bodies than men, even because of aesthetic concerns that always weigh more for them. The only lifestyle behaviour in which men excel over women is in physical exercise.

How can we explain, then, that women score worse in terms of health status? Can the biological aspects and the sexual and reproductive life of women, alone, explain their health deviation compared with men? Are there other factors, related to their role in the family, such as increased household tasks and their role in supporting others, harming their health? Or is there, as some researchers suggest, a historical devaluation of women's health in general, or even, a connotation of weakness that leads not only health professionals, but women themselves, to see women as being (more) fragile?

On a scale from 1 to 10 how would you rate your current health status?

N=1029

The distinction between a body sign that must be accommodated and a disease symptom that requires medical help has a cultural interference. In addition to risk perception or symptoms tolerance, people's judgements about what they feel or how they think they will be judged lead to complaints that are not shared with doctors.

The testimony of a 22-year-old participant is proof of how one naturalizes symptoms. *"These are very strong aches. Sometimes I really can't breathe. I've never taken anything for these pains. They're not ongoing aches, they come up ... every week I feel them. This has been happening for many years now. ... I don't know which expert I should consult, because I don't know where the pain comes from. (...) Apart from a mammography, I did nothing. Because I never told [the family doctor] the truth about what was going on."*

The Portuguese Association for the Study of Pain (APED) mentions the prevalence of chronic pain in women and the fact that, despite the high figures, there are still under-diagnosed diseases and without adequate treatment, also because of the barriers that influence how pain is perceived. Among the various types of pain that affect women, APED highlights fibromyalgia, which causes chronic generalized pain, and 80 to 90% of the diagnosed cases are among women.

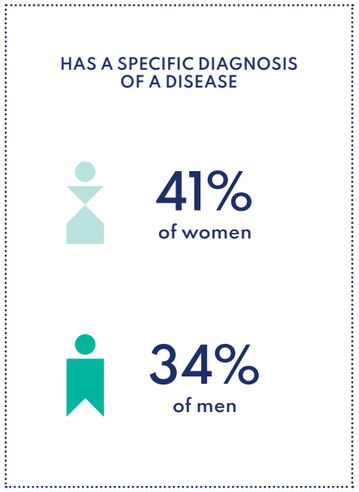
Irritable bowel syndrome, rheumatoid arthritis, osteoarthritis, low back pain, chronic pelvic pain and migraines are other conditions that disproportionately affect the female gender. There are also other conditions related to gynaecology problems, such as endometriosis, which are often undiagnosed.

Women are not the only victims of a society where people feel justified by what can be considered an "excess of sensitivity" or a "lack of masculinity".

Although emotional deregulation is more attributed to women, the number of suicides in men is always much higher. In Portugal, it is three times higher. Usually, people who commit suicide have mental health disorders. These problems also exist in men, but they are less visible.

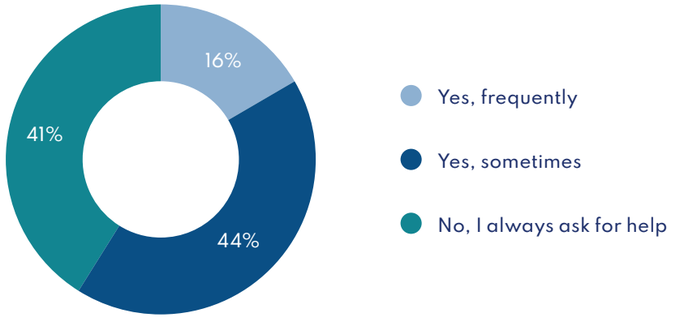
A problem that is silenced by men is erectile dysfunction. A study by King's College London estimates that up to half of men have already suffered from this problem and that rates have more than doubled in the last 25 years, due to lifestyle related aspects. The study estimates that 11.7 million men in the United Kingdom had this problem and 2.5 million had given up sex as a result. The estimate is disturbing, not only because of the problem itself, but because it predicts a number of other problems that are not being diagnosed because men tend to hide these kind of problems.

Women's health has been historically devalued by research and medical practice. The effort that women make to escape the `fragility' related connotation, and, by contrast, men's tendency to hide their fragility because they believe that's what is expected from them, lead to several inhibitions, taboos and gender-related barriers (yet) to be solved if we aim to move towards a well-being society.



When you are ill or don't feel well, do you resist or hesitate on asking for help because you don't want to admit a condition of fragility? — %

N=386



"I still feel discrimination in society in relation to some diseases"

39%
of women with diagnosed disease

28%
of men with diagnosed disease

"Women's suffering portrayed by Rego is disturbing, because it shows us the taboo, the female pain represented through the female gaze. Basically, Paula Rego is painting for decades what only now is beginning to get into the head of medicine and of society in general: the gynaecological and neurological condition of women comes along with a specific pain that is not a mere echo or replica of male pain."

Henrique Raposo @ Expresso
Paula Rego - Giving Fear A Face

Are women overlooked by medicine?

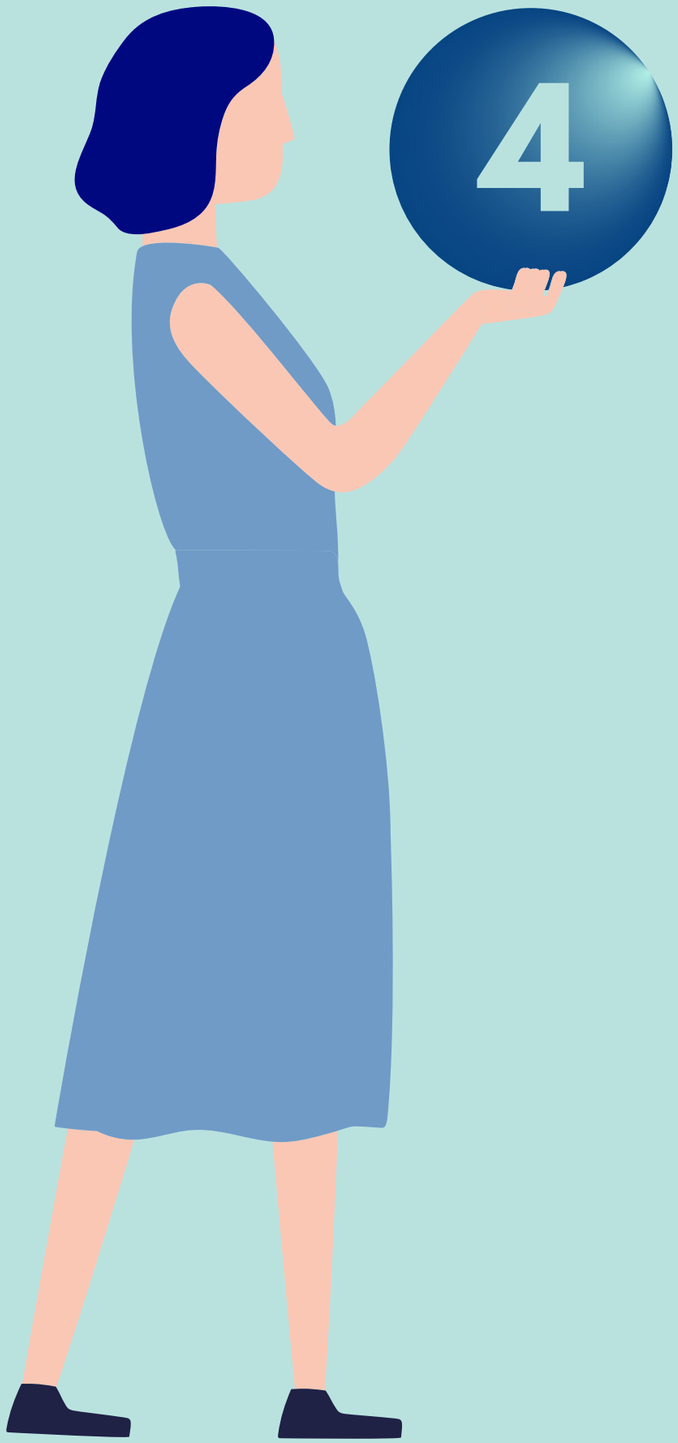
Due to psychosocial or biological factors, women are more sensitive than men. Over time, this sensitivity (even by the way it has been culturally explored) associated women with connotations of weakness, overreaction and even hysteria that, according to some researchers, hinder the assessment of their clinical state. The problem, they say, lays not only in gender bias concerning symptoms' assessment (by doctors), but in the fact that women, while escaping this label of fragility, become skilful in disguising their symptoms.

In the book "Pain and Prejudice", Gabrielle Jackson presents several arguments that attest that women are overlooked by medicine, not only because medical research always favours the male universe, but because medical practice itself tends (by social or cultural deviation) to undervalue their symptoms.

As an example, the author refers to a study in which 200 doctors and doctors assessed cardiac patients (men and women) with the same symptoms; the evaluation is correct until the patient reported that he/she had a stressful event recently. This information marks an inflection in diagnoses by gender: in the case of women, doctors tend to attribute the symptom to an anxiety problem and not to a heart attack warning. Only 15% of male and female doctors consider a heart problem in women, as opposed to 56% in men. The man has a heart problem, the woman has an anxiety problem.

Likewise, the British Heart Foundation argues that women are 50% more likely to get a wrong initial diagnosis and that in 10 years from now more than 8 200 women in the UK have died unnecessarily from a heart attack.

Short-sightedness on women's health condition is not just medical. Women themselves have preconceived ideas about diseases and tend to disregard some symptoms, either because they are unaware of the risks they face (such as heart attacks, which they associate with men), or because they have become used to being devalued and to living in silence when it comes to their problems.



The health one aims: a segmentation exercise

The health one aims

More important than mapping society through the health one has or perceives, is mapping a society in motion for the health one 'aims'.

The belief in a moving action or, by contrast, a handover to inaction are the most interesting aspects for debating a futuristic perspective and promoting a (desirable) well-being society.

The proposed segmentation is based, therefore, on the understanding of the relationship of the Portuguese with health through the lens of their pro-health actions. Actions concerning prevention were considered for segmentation purposes, however the wish to enhance well-being (physical and psychological) is favoured as a guiding axis.

This option stems from an understanding of prevention mostly as an act of individual defence, rooted mostly in fear, clinical history and obedience to pre-established protocols (i.e. external to the individual). On the contrary, the aim for health enhancement reflects, above all, an attitude towards life that, while being constrained by socio-economic or professional aspects, results mainly from individual choices, self-belief (the ability to determine destiny), and from ambition or dreams.

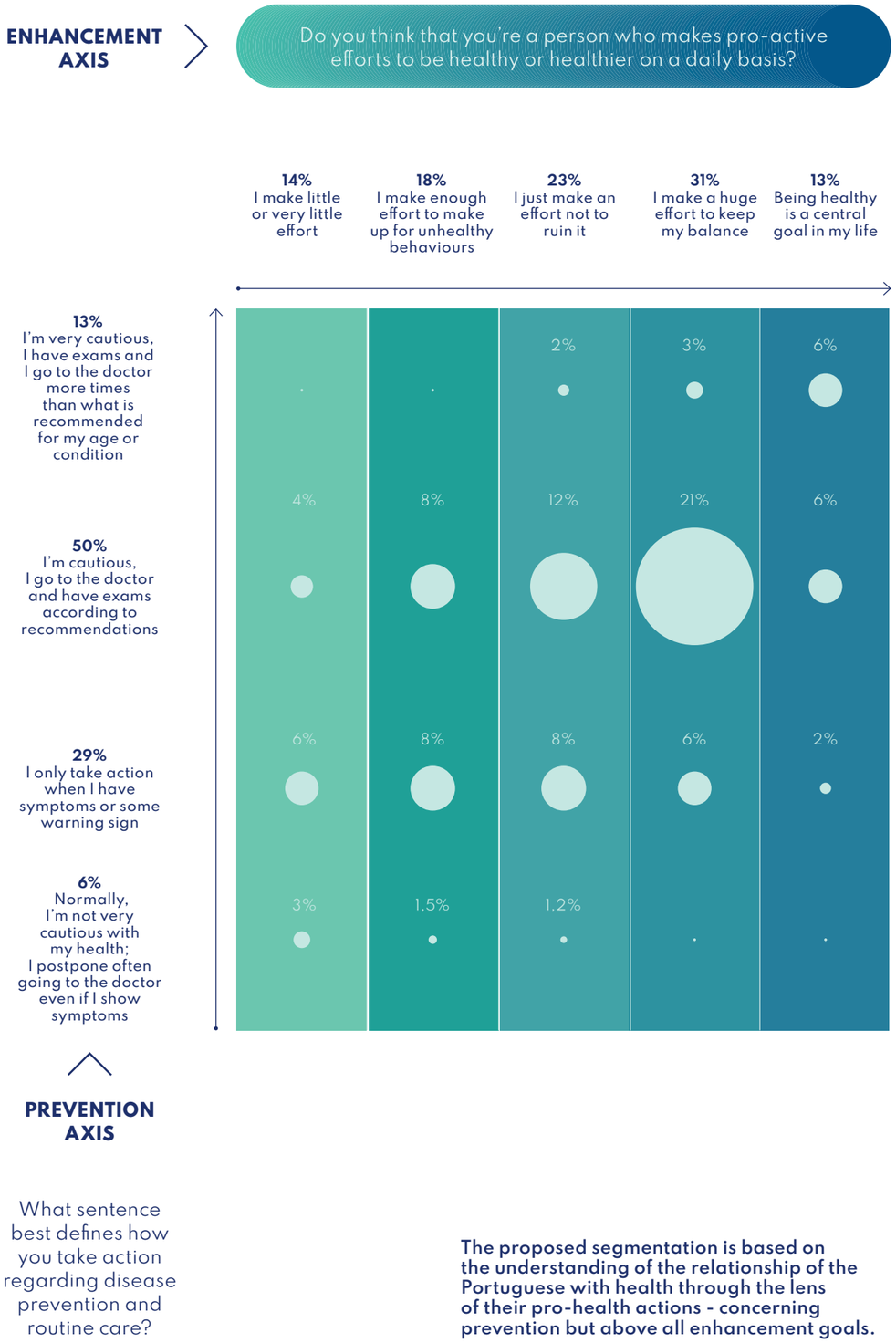
The distribution throughout the prevention and enhancement axes reveals a predominantly preventive population - 64% recognize, at the very least, that "they are cautious, go to the doctor and have exams as it is recommended" – and that they are relatively educated for a healthy life, even if for the majority the actions towards enhancement still mean, in a simplistic manner, choice of diet, practice of physical exercise, and moderate consumption of alcohol and tobacco.

Despite the sophistication of the efforts undertaken, extremely different from person to person, the proposed segmentation suggests that 59% of the population fit into so-called "pro-health lives" - people for whom 'being healthy' is part of their identity.

How to look at a distance to the pro-health society identified here and the one that was portrayed by the NHS Health Report in 2018? This report highlighted, among other data, the fact that 5.9 million Portuguese and 8 out of 10 people are overweight and that 'only 41.8% of citizens practice physical, sports and/or planned leisure activities regularly'. It added that "considering all physical activities, no more than 25% of the population achieve international health recommended goals". On the other hand, developments seem to be a fact. COSI Portugal data released in 2019 showed a consistent decrease in the last decade of overweight and childhood obesity prevalence in Portugal. Between 2008 and 2019, childhood overweight prevalence decreased from 37.9% to 29.6% and childhood obesity from 15.3% to 12.0%.

Will we maintain these positive developments? Data seem to say yes. 23% of the population states clearly that they would like to try harder; the majority (50%) would like to, but believes is difficult to do so; and only 25% integrated the idea that they are already making the possible effort[1].

[1] 'Do you have the ambition to work harder to be healthy or healthier' was made only to individuals that didn't self-rate as 'making a huge effort' (score from 1 to 8; N=900)



The proposed segmentation is based on the understanding of the relationship of the Portuguese with health through the lens of their pro-health actions - concerning prevention but above all enhancement goals.

The health one aims:
7 different population segments

The definition of the 7 segments resulted from a process of comparative analysis of similarities in key variables for enhancement (i.e. effective action or willingness to do so) among the groups from the matrix on the previous page (formally there would be 20 groups, but considering that 10 didn't correspond to more than 3% of the respondents, only 10 were eligible for analysis).

In the image, the segment areas correspond to the scale of each one; as for the layout in the matrix, although it's not statistical, it aims to show behavioural distances and proximity between the different segments.

A FEW IDEAS TO HIGHLIGHT:

· When reading non-prevention (i.e. individuals who 'only take action when they have symptoms or warning signs' or are 'not very cautious'), about 1/3 of the respondents who recognize it, refer exclusively to the fact that they have no physical malaise or that they're healthy (mainly younger age groups).

· 65-year age limit for enhancement: age that is decisive for changing health attitudes towards enhancement (see below age characterization by segment).

· 55 years old limit: concerning prevention, despite being less evident, there is an increase regarding the actions taken by 55 years old [which exceeds 70% of this population]

· The attitude towards prevention has a high correlation with the existence of a diagnosed disease [regardless the severity perceived by the respondent].

· The segmentation confirms that the territory of disease is not equivalent to decontrol perception, which is more relevant for overall (subjective) well-being or ill-being.

The health one aims:
7 different population segments

Quitters
Disconnected from the body

9%

Lives and bodies unstructured.

They are not conditioned by illness, age or income, but are extremely disconnected from the body and from physical and psychological well-being. Satisfaction with life is extremely low.

Considering the influence of the different dimensions of life for health, they penalize their work, sleep, love life, sexual and spiritual life.

A more 'male' way of being.

Distant
Lack of willpower

14%

High emotional lack of control and lack of willpower is the common denominator of this group.

With very low or very inconsistent health care effort.

Here we find people who are more penalized by financial difficulties, professional difficulties or by the disease.

In general, they recognize the distance to the desirable effort, but they believe that making it possible is "distant".

Equilibrists
In sums and subtractions

18%

The ongoing balance management in a lifetime of sums and subtractions.
'Healthy life' does not define them.
It is a group where men and women reveal different faces of the exercise of equilibrism.

Women take more preventive actions, in greater mental effort and guilt; men are more disconnected or pacified with their inaction.

41%

PRO HEALTH LIVES

Sort of Engaged
Well-being driven

14%

Healthy lifestyle is 'something that defines them as a person' but they don't make a consistent effort in that direction.

They place their action more in the field of intentions, without concrete targets.

Being 'healthy by nature' or young people will be partly at the origin of a level of effort that is necessary to manage wellbeing in everyday life.

Committed
Pro-health lives

31%

High conviction that 'a healthy lifestyle is something that defines them as a person', and they are consequent.

The commitment is undisputed, both regarding physical exercise and diet, with evident intentionality: not only to "feel good everyday", but also to improve physical performance, intellectual and ageing with quality.

Boosters
For an ideal

8%

The purest intention to enhance care energy, productivity, and happiness [Health and happiness go hand in hand].

Athough that desire (or ideal) for more health seems to be unlimited, they are the ones who consider themselves closest to their maximum threshold.

They're an expressive group that accept their condition, even by the high % of people aged 65+. Prevention is seen as natural.

Boosters
Health hostages (and fear and disease hostages)

6%

Health and well-being are central goals of their lives, but mobilization is highly contaminated by fears.

They show concern and are extremely cautious, anticipating in terms of prevention the established protocols; they show signs of a high self-control effort.

They are the most knowledgeable, which may explain why they are the ones who don't request help when necessary. High % of people aged 65+.

59%

	QUITTERS Disconnected from the body	DISTANT Lack of willpower	EQUILIBRISTS In sums and subtractions	SORT OF ENGAGED Well-being driven	COMMITTED Pro-health lives	BOOSTERS For an ideal	BOOSTERS Health hostages (and fear and disease hostages)
	9%	**14%**	**18%**	**14%**	**31%**	**8%**	**6%**

SOCIO-DEMOGRAPHICS — %

	QUITTERS	DISTANT	EQUILIBRISTS	SORT OF ENGAGED	COMMITTED	BOOSTERS	BOOSTERS
18-34	33	32	28	14	20	16	20
35-44	27	20	22	20	16	9	7
45-54	15	26	21	20	19	8	12
55-64	19	14	18	22	16	16	13
65+	6	8	12	24	30	51	49
Male	53	50	46	47	46	45	47,5
Female	47	50	54	53	54	55	52,5
Have a degree	57	47	51	44	42	30	21
Don't have a degree							
Income adequate/above	63,5	56	63	74	70	71	70,5
Income below needs							

DISEASE PREVALENCE VERSUS LACK OF CONTROL PERCEPTION — %

Disease: Do you have a disease or a specific diagnosis?; Lack of control: Currently, do you consider that you have your health – that is, your physical and psychological condition – under control?

	QUITTERS	DISTANT	EQUILIBRISTS	SORT OF ENGAGED	COMMITTED	BOOSTERS	BOOSTERS
Lack of control	62	47	36	39	40	36	46
Disease	33	33	34	25	25	9	15

CURRENT HEALTH STATUS (1 TO 10 SELF-RATING)

On a scale of 1 to 10, where 1 is "unhealthy" and 10 "very healthy", how would you rate your current health status?

QUITTERS	DISTANT	EQUILIBRISTS	SORT OF ENGAGED	COMMITTED	BOOSTERS	BOOSTERS
6,5	6,9	7,4	7,3	7,4	7,6	7,3

EFFORT LEVEL (1 TO 10 SELF-RATING)

On a scale of 1 to 10, where 1 is "no effort", 5 "a reasonable effort" and 10 "a huge effort", how would you rate the daily efforts you make to improve your health?

QUITTERS	DISTANT	EQUILIBRISTS	SORT OF ENGAGED	COMMITTED	BOOSTERS	BOOSTERS
4,3	5,4	6,4	6,5	7,3	7,6	7,8

	QUITTERS Disconnected from the body	DISTANT Lack of willpower	EQUILIBRISTS In sums and subtractions	SORT OF ENGAGED Well-being driven	COMMITTED Pro-health lives	BOOSTERS For an ideal	BOOSTERS Health hostages (and fear and disease hostages)
DAILY BEHAVIOURS YOU ADOPT TO MAINTAIN OR IMPROVE YOUR HEALTH —%							
% of answers 'I have' to each behaviour							
Eating	33	60	77	88	91	91	92
Physical Exercise	17	31	45	58	68	62	71
Sleep Hours	50	57	74	78	81	86	92
Vigilant about diseases	42	68	72	73	74	71	89
Reduce medication	23	37	33	41	37	42	49
Medication; Activ. For mind health	10	8	16	20	21	26	34
Psychotherapy/ similar therapies	7	8	8	8	12	15	15
Vitamins/supplements	18	21	32	31	34	43	43

TOBACCO CONSUMPTION REDUCTION EFFORTS — %

% of answers 'I make/I don't make efforts to reduce'

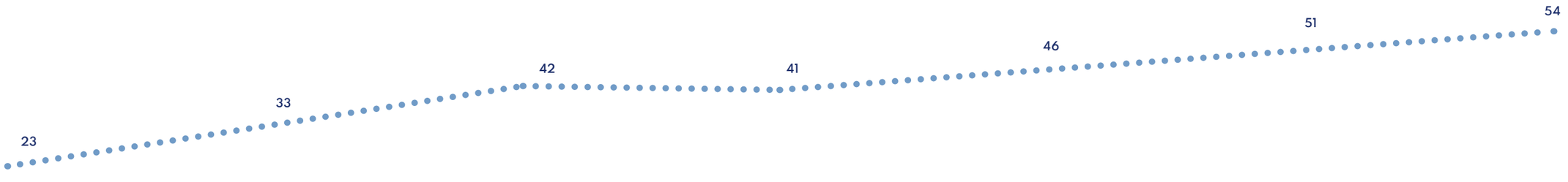
ALCOHOL CONSUMPTION REDUCTION EFFORTS — %

% of answers 'I make/I don't make efforts to reduce'

QUITTERS Disconnected from the body	DISTANT Lack of willpower	EQUILIBRISTS In sums and subtractions	SORT OF ENGAGED Well-being driven	COMMITTED Pro-health lives	BOOSTERS For an ideal	BOOSTERS Health hostages (and fear and disease hostages)

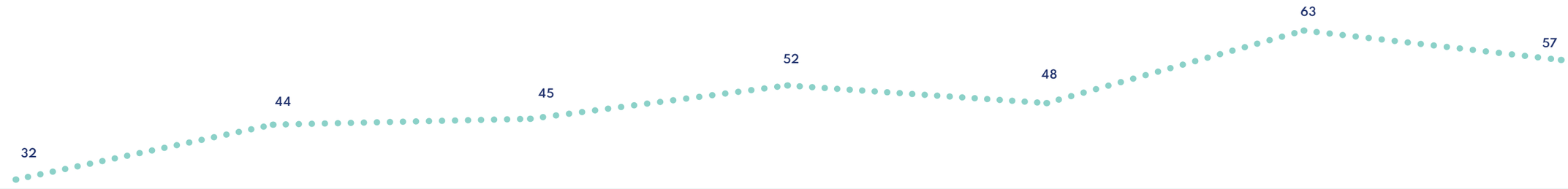
ACCESS TO HEALTHCARE SERVICES — %

Facing a specific health problem, to what extent do you consider that you have easy and timely access to the services you need? Use a scale from 1 to 10, where 1 is 'very difficult access' and 10 'very easy access'. Answers TOP 3



SATISFACTION WITH HEALTHCARE SERVICES - %

Thinking of pre-covid times, how would you rate the quality of healthcare services? Use a scale on 1 to 10, where 1 is 'no quality' and 10 'very high quality'. Answers TOP 3



HEALTHCARE SERVICES QUALITY EVOLUTION — %

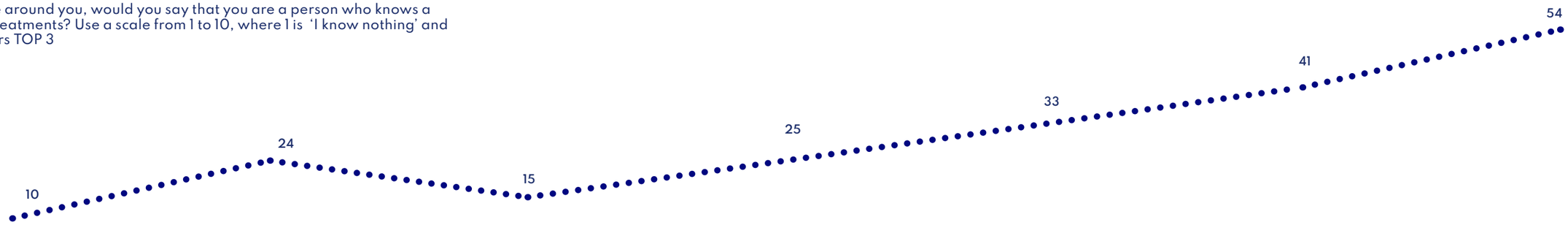
Thinking of pre-covid times, would you say that the quality of your health monitoring remains the same, has improved or got worst. Answers TOP 3

- It got worst
- Remains the same
- Has improved

Difference to 100% = I can't tell

KNOWLEDGE/LITERACY — %

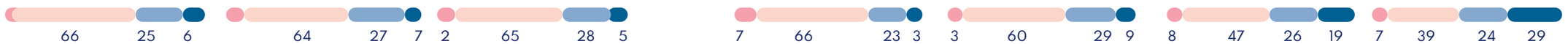
Compared with the people around you, would you say that you are a person who knows a lot about symptoms and treatments? Use a scale from 1 to 10, where 1 is 'I know nothing' and 10 the 'I know a lot' Answers TOP 3



SEARCH FOR IINFORMATION ABOUT HEALTH — %

Do you feel that you search for more information about health?

- Less
- Same
- More information
- Much more information



QUITTERS
Disconnected from the body

DISTANT
Lack of willpower

EQUILIBRISTS
In sums and subtractions

SORT OF ENGAGED
Well-being driven

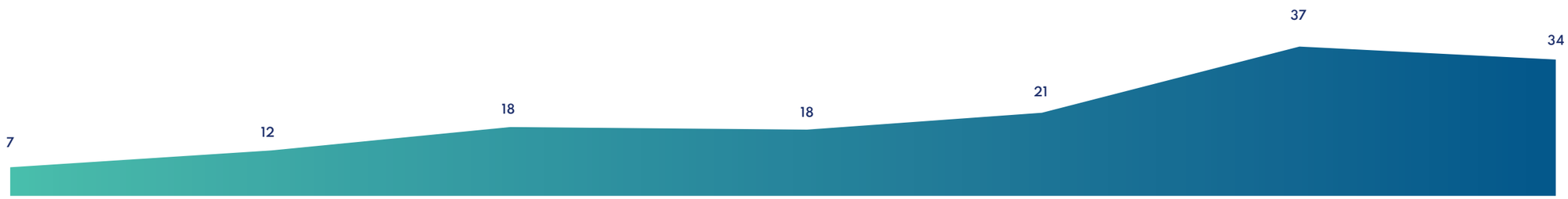
COMMITTED
Pro-health lives

BOOSTERS
For an ideal

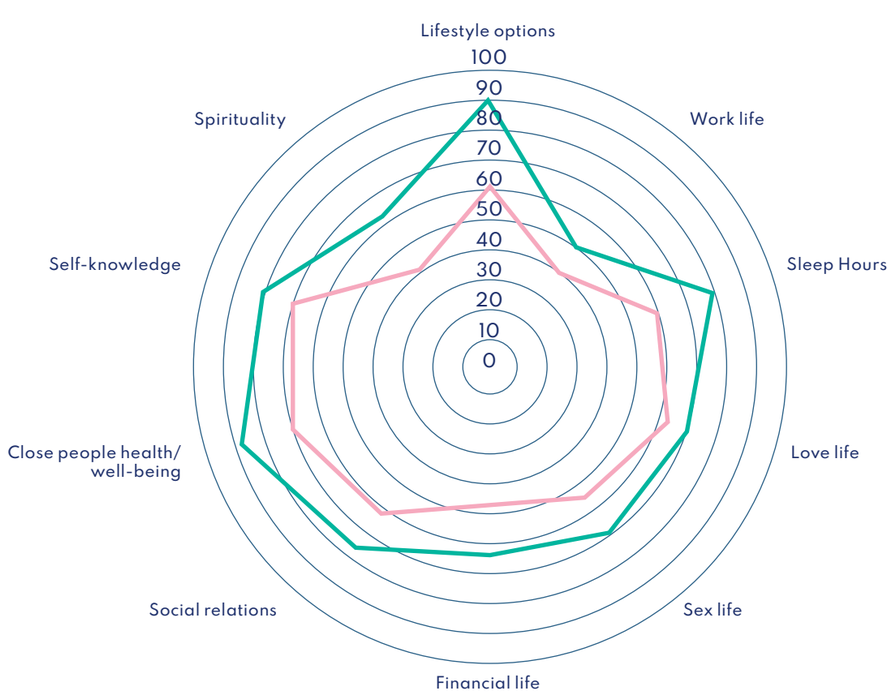
BOOSTERS
Health hostages (and fear and disease hostages)

LIFE SATISFACTION [VERY HIGH] — %

How do you feel today about your life in general. Answer using a scale of 1 to 10, where 1 is "very dissatisfied" and 10 is "very satisfied" [% of responses 9 and 10]



Health tributaries
Assessment of their positive impact



In addition to the correlation between health and the effort made to enhance health, segmentation confirms, above all, the dependency or causal link between health and satisfaction with life.

What society seems to be looking for in health is, in a direct line, happiness.

What inhibits the less-committed is not only their unsuccessful relationship with health (physical or mental), but other issues such as affective, family or social integration - which some researchers synthesize as "difficulties of living"[1]. If, historically, the question of happiness has been defined as an ethical, theological, political or economic problem, it is, nowadays, much more related to a psychological concept related to adaptation to society.

To demonstrate the connection between "health" and diversity of life-tributaries (absolutely "non-clinical"), which are happiness foundations, the two opposed segments regarding their pro-health actions are compared - Quitters and Committed.

How far they rate the positive contribution that each one of these factors brings to their health, underlines this idea.

[1] «by difficulties of living we mean a whole host of things: they actually fail to get what they want; in the pursuit of their goals, they cause trouble or pain to others; and they suffer from feelings of failure, unhappiness, worry, and even from unpleasant symptoms», in On Psychological Well-Being p.5

Boosters
health hostages

A segment that is hostage to health in terms of identity, but also because of their fear of a disease - whether of relapses of diseases they had previously, severe diseases, or COVID'19 (46% are very afraid vs 26% in the overall sample). The highest disease incidence is one of the main roots of this behaviour.

They call themselves a high responsibility, which translates into daily uneasiness: they are the most informed, they live for a balance (high agreement with the idea that "unhealthier behaviours are amended with healthier ones, which they are more cautious about."), they feel the need to control their emotions better and reduce anxiety and stress [data that stand out in comparison with the 'boosters for an ideal' more focused on maximizing energy, happiness, etc.]

They are the only group for whom the definition of health is more associated with mental than physical well-being (mental 57%, physical 43%). In all other groups it is the opposite.

They are autonomous when it comes to asking for help (in the case of illness), they stand out in self-control, i.e. tracking vital signs or health indicators daily [through devices or other technologies], with emphasis on blood pressure (39% in this segment vs 25% in the overall sample), water intake (39% vs 17%), hours of sleep (35% vs 25%), stress level (19% vs 11%), oxygen (12% vs 4%), blood glucose (12% vs 5%).

With higher average age (62% over 54 years). Gender, region or income follow the sample. They are the group with the lowest academic qualifications (only 21% graduates), also because they are mostly of people of advanced age (less qualified population).

57%

Good Health means 'mental well-being'

Q: When you think of 'good heath' what comes first to your mind?

27%
General

20%

Recognises being hypochondriac

Q: Have you ever recognised or been recognised by someone as being hypochondriac?

8%
General

"My biggest fear, because it is 'the' disease nowadays, is related to it [cancer]. I know it's not the main cause of death, but if we have such a diagnosis, even if we have a cure, we think: i'm going to die! Cancer is difficult to control, and if there's no timely response, that's not good. Maybe worse than a cancer, is a stroke or a heart attack. These are things that come and stay. The mother of a friend of mine was a healthy person. She had a sore throat, took a Brufen and had a heart attack; she turned purple and died. Just like that... in five minutes. That's scary. ... I do regular exams to be safe."

"I had a fungus on my nail for two weeks. This is an example so that you to see how much I get stressed... my panic was to know if it was just a fungus or something else. I googled it, and I scheduled an appointment right away."

"I can be disciplined. I have a certified PT, I eat healthy, and I pay attention to calories. The only supplement I take it's proteins, to increase macronutrients. And I've already taken omega 3. Nutrition interests me."

W, 32 years old, married, 1 child, Coimbra

Boosters
for an ideal

The segment that considers to be closest to the maximum health threshold: with an average of 7.6, 34% self-rates a 9 or 10 on a scale of 1 to 10. Few relate to the idea, that 'they would like to, but do not believe it to be possible' - 29% vs 50% in the total sample.

The most obvious signs that health can be continuously conquered and that it is a cornerstone for well-being and happiness can be found in this group.

Regrding the motivations for taking action, the wish for daily well-being, as well as the ideal of a body with more energy, better sportive performance and, given the advanced age among this segment, the desire for a healthy ageing are mentioned.

High levels of 'satisfaction with life', the way they deal with illness or the risk of it (which is very different from how Hostage Boosters fear COVID'19, for example), reveal that these people – despite seeing it as a daily task – commit themselves naturally, and are driven by an ideal of well-being, without manifesting anxiety or obsession over health issues.

With a higher average age (75% are older than 54 years old), higher prevalence of women (58% vs. 53% of the total population). Region and income follow the sample.

33%

Exercises daily

Q: How often do you exercise?

14%
General

47%

More energy on the day-to-day

Q: What aspects could benefit from a potential Improvement of your health status?

29%
Health hostages

"A healthy person is someone who manages to combine a set of factors, such as diet, not being sedentary, sleeping and resting properly, not having a very stressful job, and having a harmonious family life. For me, a healthy life means all these as one."

"In my mind there's not such thing as "oh, I'm going to start taking care of myself" because in my mind I've been doing that since I was young. I swim since I was 12 and I've never stopped doing it. I had to stop some impact sports, like mountain biking and running, because of my spine, but swimming and gym I never stopped doing."

"To be healthy, we need to be good to ourselves. If we're not, we can't get enough balance to eat well, to have a good relationship with people."

"I end up trying to slow down the inevitable. I realize that I must drink water to moisturize the body, in the house we try to see what is healthier to sleep, at dehumidifiers level, etc., because everything contributed to whether or not to be healthy."

M, 45 years old, married, 2 children, Lisbon

Committed
Pro-health Lives

The most expressive segment of the sample (31%) has a daily life oriented to health, although they do not recognize it as a central goal of their lives (unlike the Boosters). Perhaps because age does not yet require it, or because personal, professional or family lives rank higher.

Although health is not the central goal, 62% feel that having a healthy lifestyle is something that defines them as a person. They do not exercise as intensively as Boosters, but 50% work out, at the very least, 'several times a week'. Concerning diet, they are closer to Boosters regarding seeking professional advice - either nutritionists, doctors or personal trainers.

The scale of the group makes generalist ideas difficult, but clearly distinguishes people in the second half of life and in senior age - whose motivation is anchored in the idea of ageing with health [it is the segment aged between 55 and 64 that deals worst with ageing] - and working people that, although they are not Boosters" (in this category), show high motivation for enhancing. Although figures are not overall significant, this is the segment that most reports 'intellectual performance improvement' as motivation (16% vs 11% of the total sample and 13% 'boosters for an ideal').

The average age is close to the sample average (51.6 vs 49.3). The distribution by gender, region or income follows the sample.

62%

A healthy lifestyle is something that defines them as individuals

Q: How often do you exercise?

40%
General

51%

The motivation is ageing with health

Q: What motivates you to make efforts to be healthy?

33% and 41% Health hostages Boosters and Boosters for an ideal, respectively

"To be healthy means to be able to breathe. It means eating what is good for you. Being able to control or manage what age brings and being able to live without being ruled over by pessimism, or by being hypochondriac. To acknowledge that the only great disgrace that happened was to be born. And one day we're going to have to face reality... bearing that in mind."

"I go to the gym. I also have a certain concern in developing my spirit, with moments of reflection and prayer. My activities concern my body and spirit. In short, taking care of the soul."

"I used the lockdown to lose weight. And with this diet I lost eight kilos and ten centimeters of the abdominal perimeter. I controlled the sugar glucose, with half of the medication. And I've slowed my heart rate."

"I feel good about my age. It is appropriate for what I have. I feel adjusted to my living conditions and age."

M, 77 years old, married, 6 adult children, Porto

Sort of Engaged
Focus on well-being

This is the segment in the antechamber of a pro-health daily life. Despite the perception of the value of health, especially as an identity element, the pro-health effort is a "sort of effort" for daily managing well-being and to mitigate some fears - confirmed by the need, above average, to 'keep certain indicators under control' (29% vs 20% of the sample) or by the 'fear of severe diseases' (24% vs 17%).

Although in comparison with the Committed, the average age is not very different, there are fewer people who state that their health is their own achievement (among the Committed and Boosters, health is seen more as an achievement than as a consequence of nature or age).

What separates them from those who are committed to a healthy diet or to exercise is not so much the fact that they state they do it (even more evident in physical exercise) but the effort they employ.

The average age is close to the sample average and the Committed (51.6 vs. 49.3). The distribution by gender and region follow the sample. Income is higher than the sample average.

This segment shows a professional achievement above the sample average, behind the 'boosters for an ideal' (although in these only 46% are of working age).

25%

My health status control is appropriate to my youth

Q: What makes you feel that you have your health under control?

16%
Committed

22%

High effort to improve the health status

Q: How would you rate your efforts to improve your health status? (TOP 3)

46%
Committed

"We have to make some efforts. I don't want to work out sometimes. It is tiring. But we must do it. With food, people love eating lot of sugars. Sugar is something that should be avoided, but it tastes great. It's hard to say no. I speak from experience..."

"I'm a person who does a couple of exercises... At home, outdoors. But I smoke, it is not very healthy. As for drinking, I don't drink much. But I smoke. As for my diet, I'm not a person who eats very healthy food. I don't eat a lot of vegetables, except for soups, and my diet is based on protein, carbohydrates, lots of sweet.
I consider myself reasonably healthy, but in terms of diet, I'm not very much."

"Then I exercise; I'm not very regular, but 3 days a week I do some exercise."

"Some time ago I did a mammogram, because of some chest pains I have. The pain remains. I was supposed to schedule an appointment, but I haven't done it yet."

W, 22 years old, single, no children, Porto, Portugal

Equilibrists
In sums and subtractions

This segment was excluded from the ones considered to be pro-health lives. Manifestly younger, they are people who keep themselves in a difficult position of equilibrium, balancing unhealthy behaviours with healthier ones. Health or aesthetics concerns? A question asked in interviews to which the answer 'both' was often given. In this segment, the same doubt emerges from the data.

It is possible to identify a more female subgroup that shows signs of daily self-struggle, and that balance unhealthy behaviours with healthier ones. The most common weakness is diet (with consequences for weight), which they amend with physical activity. Seeking professional support from nutritionists or the consumption of vitamins and supplements are frequent answers. Regarding aspects of life in which an improvement of the health status exist, self-esteem stands out (women 47% vs men 32%).

Equilibrist men live with less guilt and show greater emotional balance, which is evident when they are asked about the ambition to improve health - 29% feel good where they stand, in opposition to only 8% of women.

An equilibrist in the imminence of the fall is aware of that. The fact that they track a set of metrics such as weight, stress levels, muscle mass index, steps, kms, hours of sleep, menstrual cycles, reveals that awareness. Perhaps because of their life, and because they tend to be younger (and with more aesthetic concerns), they are the ones who do more bodybuilding, among men, and practice more fitness/gymnastics, among women.

The average age is below the sample average (45.3 vs 49.3). Greater presence, albeit minor, of women. Income follows the sample. More graduated people than the sample average (51% lvs 44% total).

33%

"I make up for unhealthier behaviours with healthier ones, which I am more cautious about."
[answers TOP3]

28%
General

34%

Doesn't feel having health under control

Q: Currently, do you consider that you have your health – your physical and psychological condition – under control?

31%
General

"For me to be healthy means not to having severe diseases. Both me and my oldest daughter are healthy. My little daughter too, but she has more issues — she has utopian skin and asthma."

"The nutritionist comes in because a few years ago I got a little fat and was getting to 40 [years old]. I thought: these pounds after the forties will be permanent. They told me about Dr. L. — my sister who tends to gain weight, and two other friends who lost weight and maintained it. I had seen the results in other friends, and the Doctor was all 'modern' and with some great ideas. I really liked her."

"She helps me. There it is: did you slip? Now, you do this way, and it will solve it. She teaches me a few tricks to amend the slips.(...) I go there for self-control purposes; if I didn't go there I would get fat. When I go there, if I have one more pound or two, she rebukes me. In fact, if I realise that I gained a pound or two, I schedule an appointment for the following week. I can reduce the slips, with a little trick here, another there."

W, 43 years old, divorced, 2 daughters, Guimarães

Distant
Lack of willpower

In this segment, overcoming the lack of control over a disease (47% vs 33%) begins to be reported. Among those who feel lack of control, a large majority (71%) identifies psychological difficulties – instability and difficulty in controlling emotions. There are several cases where there is a considerable drop compared to the average – healthy diet, physical exercise, hours of sleep, mind care.

A subgroup of people that has a higher disease prevalence, and who rate their efforts as 'little', feel (more) lost and more guilty. Lack of care may lead to less well-being.

Preventive drugs (in terms of routine medical care) are reported by a minority (37% vs 64% of the sample), acting mostly in reaction to symptoms.

Although 29% recognize that the body does not cause malaise, there are a variety of reasons for not acting, such as inertia (23%) or orientation of care to others (19%).

Although 29% recognize that they don't feel malaise, there are a variety of reasons for not taking action, such as inertia (23%) or taking care of others (19%).

They consider, more than average, that financial life and working life negatively influence their health (27% and 35% recognize it, respectively, compared with 19% and 24% of the sample).

Above average, they report that they don't monitor as they wished mental health (24% vs 19% of the sample), male health (29% vs 17%) and nutrition (30% vs 21%).

The mean age is lower than the sample average (42.8 vs 49.3). Superior, albeit minor, presence of men. It is the segment with the lowest income, although 56% are graduated (44% in the total sample).

ONLY

8%

Makes efforts to improve health

Q: On a scale of 1 to 10 how would you rate the daily efforts you make to improve your health? (TOP 3)

31%
General

43%

Self medicates without medical prescription

Q: Are you the kind of person who...?

28%
General

"I went through very complicated health situations, namely a breast cancer, diagnosed in 2012. After that, diabetes was diagnosed. I had it already, but chemotherapy only came to anticipate the process, because I am a person who's not very wise, not even regarding to my mouth... I always have serious weight oscillations."

"I don't exercise at all. Zero. (...) I have Fitbit, it tells me how much I walked every week. I thought I was going there for motivation, but apparently not. I have lots of protocols to lose weight. Do you think I do them? I start, I do it for a day or two, on the third I quit. The problem is me."

"In food, and in a lot of other things, it's where I go and look for some comfort. It is not easy for me to say this, but I've come to that conclusion. Now the next step is missing, which is to understand how do I deconstruct all this... It's a lot... it's a husband-wife relationship that's over, a life that I don't have, it's constant dissatisfaction. It's the missing father and mother too. It's a lot..."

W, 44 years old, married, 1 child, Rio de Mouro

Quitters
Disconnected from the body (and mind)

Lack of control of the health condition seems to dominate this segment, also because of unstructured lives. Despite having a very physical (or body)-centered conception of health, people show feelings of lack of control such as the 'unpredictability of how they feel' and 'difficulties in managing emotions' (59% both). Is this related to the lack of control over the physical or to being unaware of psychological problems?

Satisfaction with life is extremely low, which reflects their lifestyle decisions and is the first reason reported for the lack of control of the health condition (29%). They are the ones who most recognise as negative all the aspects that can impact health - alcohol and tobacco consumption, sleep, love life, social relations, spirituality, self-knowledge, contact with nature.

The effort to be healthy is low. They reveal not being cautious about their diet, physical shape, work rhythm or diseases prevention. From the confrontation between the ill-being and the little efforts they make for their health (physical and mental), emerge their naming: Quitters.

The greater presence of men in this segment is not random. As mentioned, women seem to be more reflective, conscious, connected to the body and taking care of their well-being.

The average age is lower than the sample average (41.8 vs 49.3). There is a greater presence of men. It is a segment with above average income and academic qualifications.

62%

Doesn't feel having health under control

Q: Currently, do you consider having your health – that is your physical and psychological condition – under control?

31%
Geral

29%

Behaviours/ my lifestyle

Q: Regarding that lack of control, what do you believe the causes are?

8%
Geral

"I'm home because I'm taking care of my mother. She's almost fully bedridden. There are days that she's able to get up, and others that she can't."

"My husband has diabetes, hypertension, he's a kidney patient, pre-dialysis. ... In 2001, he was diagnosed with diabetes, type 2. He never controlled anything, we never controlled anything... Diabetes, and high blood pressure, ruined his kidneys and vision. Diabetes is like this, it messes with the kidneys, heart, arteries. He never took the disease seriously. (...) He's a terrible patient, he has white coat syndrome."

"My daughter's health... is not good. She weighs almost 120 kg. The psychological part is wrong, she's obese. (...) Maybe it is the cystic syndrome that messes with hormones... she is now going to the obesity consultations, as she's young. I know she's not happy about that."

"I have some health problems, I'm not dying or anything like that, but I'm not healthy. I'm a smoker, I drink coffee, I'm not careful with food, I don't exercise. I am far from being healthy. It's my fault, I don't blame anyone else. I'm very lazy..."

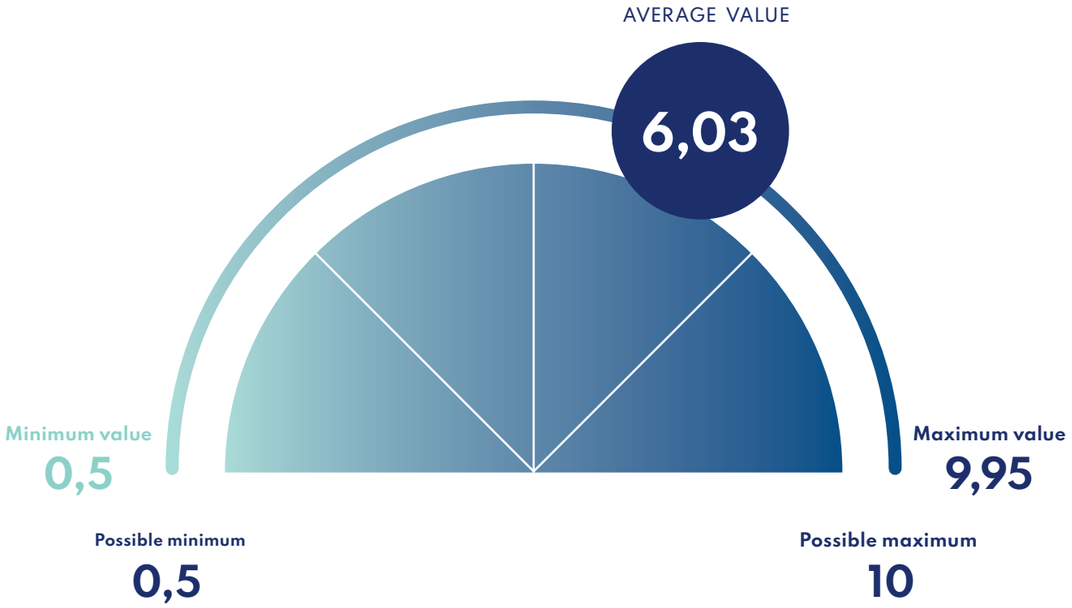
"When one works or meets friends, we tend to dress up a little. As I don't do that, what for am I going to do that? To stay home and change my mother's diaper? ... I take care of everyone but myself."

W, 43, married, 1 child, Valongo

Potentiating Health: the measure of the dream

Potentiating Health

The Portuguese commitment to their health indicator



Portuguese population results in 2021
N=1029

What does it represent?

An indicator that aims to assess to what extent people are engaged with maintaining or improving their health. Based on their self-perception, it measures the potentiating efforts and actions that people direct daily to their health, that is, the investment they make regarding their physical and mental condition, regardless of their motivations or health constraints.

The Potentiating Health Indicator was idealised based on the belief that each person has a certain health potential, and that this potential can be maximized through individual behaviours [that they may control]. Between the effort that each one reports making and what could be done, there is a space for health improvement that can be induced.

How is it measured?

The indicator is calculated based on a subjective rating data of the effort that each person considers to make daily to maintain or improve their health, and on an objective data related to individuals' health behaviours. These data, collected from a representative sample of the Portuguese population, are analysed using a formula that allows categorising individuals regarding the actions taken upon their health.

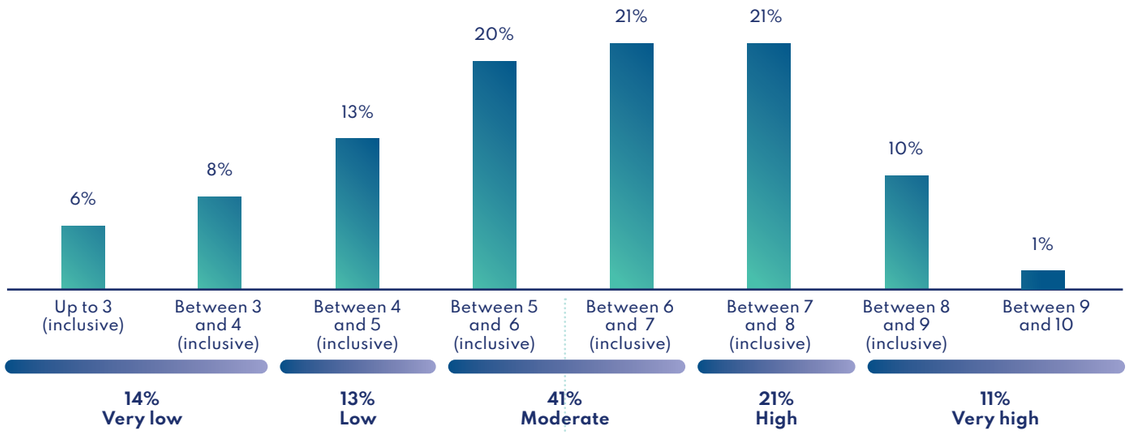
To the behaviours that people claim to adopt - among 12 possibilities, ranging from diet and physical exercise to reducing alcohol and tobacco consumption - a scale of relevance is given, which reflects what society considers to be the most determining factor for health in general at any given time.

What does it reveal?

The results show a moderate average potentiation – out of 6.03 on a scale of 0.5 to 10 -, with 46% of the population standing below this level. This means that a substantial proportion of the population considers that they are less than desirable or possible pro-health, adopting few effective behaviours for improving their state of health and well-being. In the sample, 41% consider making a reasonable effort, 21% a high effort and 11% a very high effort to stay healthy (or healthier).

Distribution of population by Potentiating Health

N=1029



46%
stands below the average

6,03

54%
stands above the average value

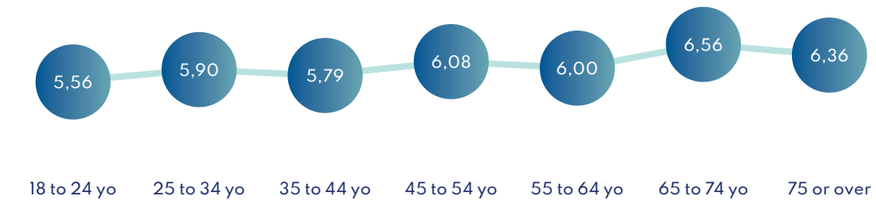
‘Potentiating Health’ Average Value

N=1029

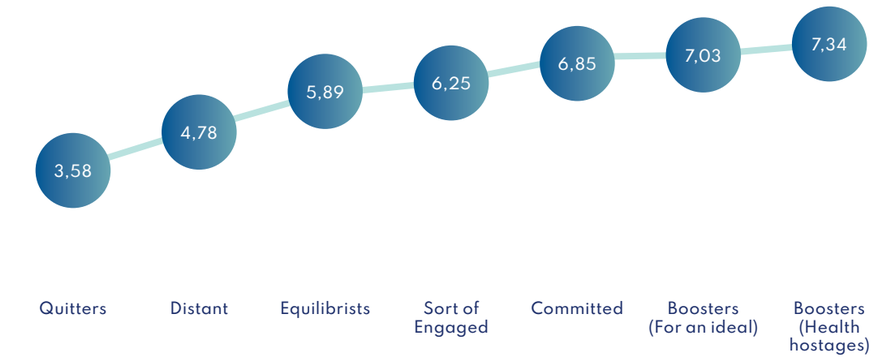
6,10
Women

5,96
Men

BY AGE — %



BY SEGMENT



A moderate potentiation: what benchmark of effort compared with the European Union?

We do not have a reference to read the moderate value of the indicator in a longitudinal manner, but public data point to positive developments in health at different levels.

Although gender gaps and socio-economic conditions prevail, life expectancy in Portugal has been steadily increasing since 2000 and is (at 81.6 years) slightly above the European average. The percentage of people aged 65 and over increases steadily. The Portuguese live longer, but it is not enough to add years to life; life has to be added to the years.

The indicators that reveal developments in health promotion behaviours of the Portuguese are also growing. There are more and more Portuguese people talking about being cautious with their diet, smoking rates are below the European average (17% vs. 19.2%) and alcohol consumption has been gradually decreasing since 2000. About 10% of adults indicate sporadic excessive alcohol consumption, which is considerably below the EU average (20%), especially among adolescents.

We are undoubtedly better off, but in many respects we are distant from the EU average.

Alcohol consumption:
Alcohol consumption in adulthood is higher than the EU average; in 2017, around 11% of deaths were linked to alcohol consumption, almost twice the EU average rate of 6%.

Obesity:
Although it is closer to the European average, adult obesity remains high. Based on survey data collected for self-assessment of health status, 15.4% of adults reported being obese in 2017 compared to the EU average of 14.9%.

In another National Health Survey (INS 2019), more than half of the adult population was still overweight (36.6%) or obese (16.9%) in 2019; among the behavioural risk factors, it is with regard to obesity that the disparities between people with lower income and educational qualifications are indeed significant, which proves the association of the country's level of development with the health of its citizens.

Sedentary:
According to the same 2019 INS survey, the majority of the population aged 15 or over (65.6%) did not engage in any sporting activity on a regular basis, with only 13.6% reporting physical exercise practise once or twice per week. Exercise is actually a behaviour in which we are quite distant from other countries in Europe. Looking at the time allocated - in number of leisure hours during a typical week -, the Portuguese are among the worst performers in the EU, only surpassed by the Croats (Eurostat, 2017).

Although national figures may improve, particularly in terms of diet or physical exercise, there is a clear transformation underway. Among the respondents aged 55 and over, 40% report walking and 38% report doing physical exercise daily or several times a week; 37% of women report doing it at least once a week. According to the Fitness Barometer, in 2018, women accounted for 53% of entries in gyms. Physical exercise or sport was a rare routine in our mothers and grandmothers (although the lives of these generations were far less sedentary).

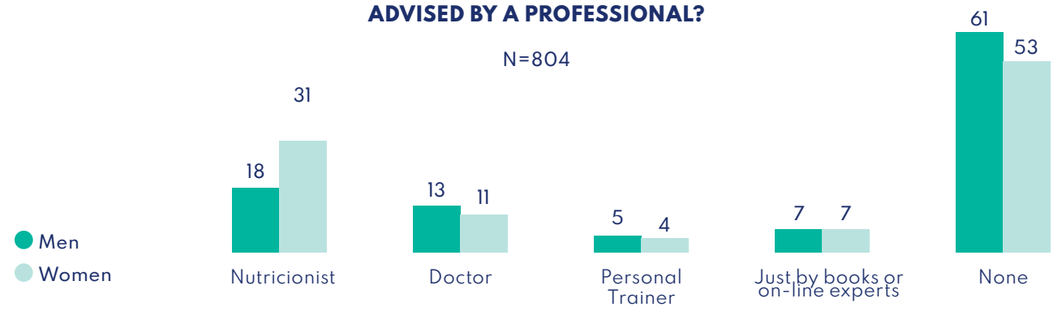
78%
IS CONSCIOUS ABOUT THE DIET ON A DAILY BASIS

83% women

73% men

REGARDING YOUR DIET, ARE YOU OR HAVE YOU EVER BEEN ADVISED BY A PROFESSIONAL?

N=804



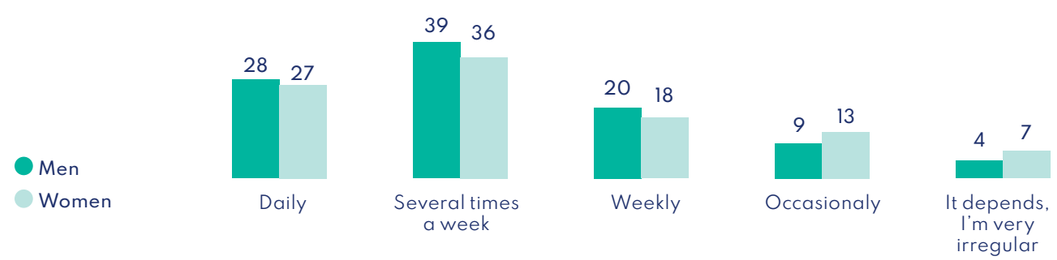
52%
EXERCISES/ PLAYS A SPORT

46% women

59% men

EXERCISE FREQUENCY

N=536



Just 34% of the Portuguese exercise regularly (daily or several times a week)

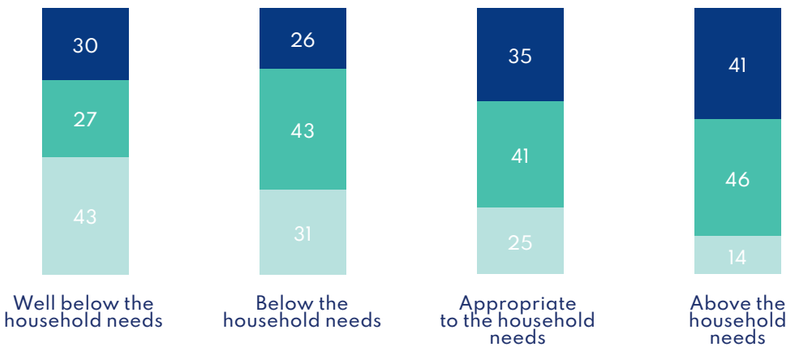
Effort level

N=1029

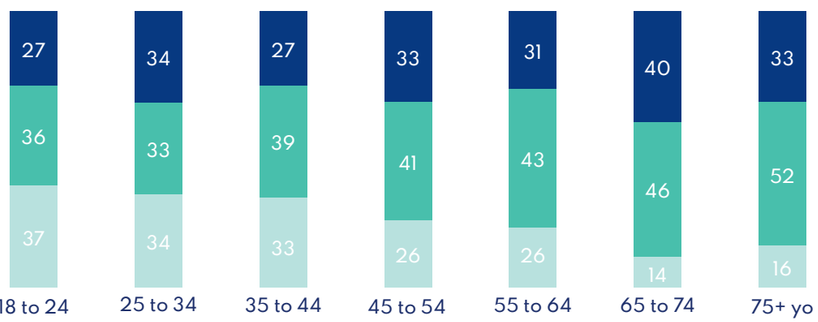
High or very high · Moderate · Low or very low

BY OVERALL SATISFACTION WITH LIFE — %

BY INCOME — %

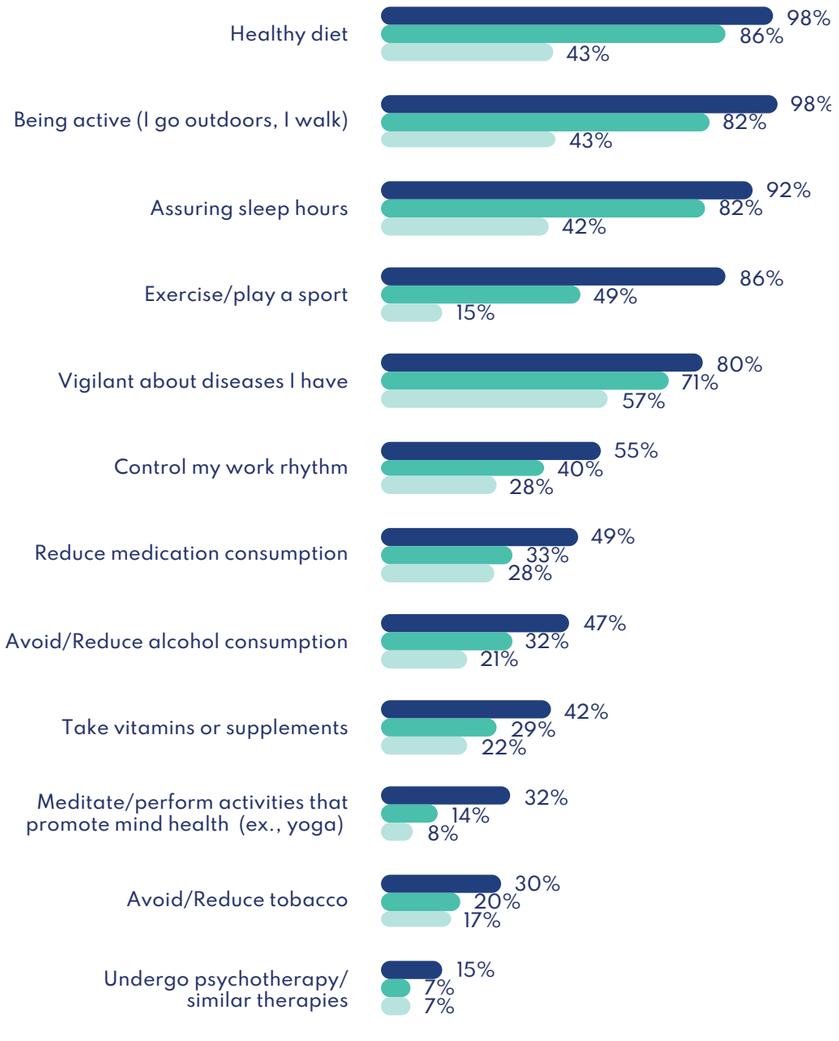


BY AGE — %



High or very high · Moderate · Low or very low

WHAT BEHAVIOURS DO YOU ADOPT ON YOUR DAILY LIFE FOR MAINTAINING OR IMPROVING YOUR HEALTH?



Sample total values
78%
77%
74%
52%
70%
42%
37%
34%
31%
18%
22%
10%

Answers options:
I have; I don't have; I don't need / Not applicable

In terms of behaviours towards health, there is a huge difference in society related not only to living conditions, income and age, but also with satisfaction with life.

A society permeable to change

Responsibility for one's own health condition is an implicit philosophy in the prevention and education campaigns for health that we have been targeted in recent years decades. Everyone is called to answer about their state of health, in so far as their behaviour (by action or omission) influences the illness.

This principle, which stems from the need to ensure sustainability and equity in access to health care, has been expressed by a healthy lifestyle culture that crosses different dimensions of life and labels a number of behaviours as "transgressions" to health rules. Today, one can easily have guilty feelings because of choices made in a simple trip to the supermarket or dinner of friends. Can we say, as Radley (1994) put it in his vision of health and disease, that among the Portuguese there is already "a general feeling that, although we cannot blame ourselves for the disease, we must respond as much as possible to the moral duty of remaining healthy"?

In the present study, only 13% consider that we live in a society that overstates the pressure to be healthy; 38.5% consider that, despite the excess, it is natural to promote health this much; 25% consider it an appropriate and important pressure and 20% that we should promote health even more. The imposition of health as a cultural value regulating behaviour is being normalized.

This helps explain why the main reason for not being more committed to health is the "lack of willpower". There is an obvious self-penalization in justification, which stems from a sense of guilt. This does not mean that other factors are not important, but that first of all is the person's default.

At the very least, we are facing a change in attitude towards what should be done in the dimension of health, even if it is not always consequent in terms of behaviours.

"A healthy person is surely a happy person. You don't have to be vegan, but careful and balanced. Balanced and happy: that's a healthy person. It requires some effort, otherwise we would all be healthy. We all want to be healthy, but you have to work for that."

"I lack the motivation for physical exercise - essential for physical and mental well-being -, and I should be more careful with eating. There was a time when I was very careful. Right now, I do not have the strength to keep up to the rules that were part of my life. In my mind, I know I'm transgressing. But I'm happier now."

W, 48 years old, single, lives with her parents, whom she takes care of (both with Alzheimer's disease)

WHY DON'T YOU TAKE MORE ACTIONS TO IMPROVE YOUR HEALTH OR FOR ADOPTING A HEALTHIER LIFESTYLE — %

(N=335 I IN CASE OF LITTLE EFFORT TO BE HEALTHY)

WOULD YOU LIKE TO WORK HARDER TO BE HEALTHY OR HEALTHIER?

(In case an effort rate from 1 to 8 out of 10 is reported) - %
N=900

WHAT ASPECTS COULD BENEFIT FROM A POTENTIAL IMPROVEMENT OF YOUR HEALTH STATUS — %

N= 605 (in case of having the ambition to improve the health status)

The measure of the dream

In this study, 23% of the respondents say, without reserves, that they would like to do more for being healthy or healthier; 50% report the same ambition, although they find it difficult.

Although they are aware of the importance of making efforts to maintain or improve their health status, the Portuguese save the greatest efforts towards a healthy life when they feel the imminence of losing it. The potentiation is relatively low among the youngest and increases with age, until it becomes acute around the age of 65.

Beyond inertia, research suggests that this delay may be due to the fact the people are unaware of what an optimal health status is, and due to the difficulty in quantifying well-being gains associated with certain behaviours. People may assume how much they would feel better [better relationship to life, better self-relationship, greater
resistance to problems], but they don't know exactly how much they could feel better. In general, only after experiencing the gains - from weight loss, quitting smoking, healthier diet, etc. - health is valued to the point of reprogramming behaviours.

If an ageing population is one of the biggest challenges that the country faces, and the health one has when reaching advanced age is a mirror of what one did over life, mobilization for making efforts should start earlier, in order to increase well-being potential goals. Regarding the relationship that the Portuguese have with their health - a kaleidoscope of memories, beliefs, fears, intentions, and behaviours - it is necessary to shape and colour to the dream.

What should the Portuguese be persuaded to do? In terms of behaviours, should the aim be reaching European averages or top positions? Where should the dream benchmark be set?

Annexes
and Data Sheet

Field Work

Qualitative Study

Total sample: 18 individuals

Field work: conducted from October, 16 2020 to April, 6 2021

Universe: Individuals from both sexes, aged 17 years and over, belonging to the IPSOS-APEME Global Panel (the youngest, aged 17 years, the oldest 77 years)

Methodology: On-line In-Depth Interviews, IPSOS-APEME panel

Quantitative Study

Total sample: 1029 individuals

Field work: conducted from January, 5 to 26, 2021

Universe: Individuals from both sexes, residents in Mainland Portugal, aged 18 or over. Cross-quotas of Sex x Age and Sex x Region were considered, in line with the national distribution, in order to ensure the representativeness of the sample, plus education quotas, in order to avoid the distortions inherent to the educational profile of the internet user population. 45% of the sample have higher education, and 55% of the sample have primary or secondary education.

Methodology: 809 online interviews conducted with the Ipsos APEME Online Questionnaire Panel, plus 220 phone interviews, conducted by the partner company Bestforecast.

Sample characterization

GENDER	
FEMALE	53%
MALE	47%

AGE	
18 TO 24 YO	9%
25 TO 34 YO	14%
35 TO 44 YO	18%
45 TO 54 YO	19%
55 TO 64 YO	17%
75 TO 74 YO	14%
75 OR OVER	9%

HOUSEHOLD	
1 PERSON	14%
2 PERSONS	34%
3 PERSONS	29%
4 OR MORE PERSONS	23%

REGION	
GREAT LISBON	28%
GREAT PORTO	14%
NORTH (EXCLUDING PORTO)	25%
CENTRE	23%
ALENTEJO	7%
ALGARVE	4%

AVERAGE HOUSEHOLD NET INCOME	
LESS THAN 500€	4%
FROM 501€ TO 750€	9%
FROM 751€ TO 1000€	11%
FROM 1001€ TO 1200€	11%
FROM 1201€ TO 1500€	15%
FROM 1501€ TO 2000€	19%
FROM 2001€ TO 3000€	10%
LESS THAN 3000€	6%
DK/DA	15%

PROFESSIONAL SITUATION	
EMPLOYEE - LARGE PRIVATE ENTERPRISE	18%
EMPLOYEE - SMALL MEDIUM BUSINESS	21%
EMPLOYEE - CIVIL SERVANT	15%
SELF-EMPLOYED / GREEN RECEIPTS / INDEPENDENT	6%
SELF-EMPLOYED / BUSINESS OWNER	2%
STUDENT	5%
RETIRED	25%
HOMEMAKER	1%
UNEMPLOYED	7%

PROFESSIONAL SITUATION	
PRIMARY (COMPLETE OR INCOMPLETE)	8%
BASIC EDUCATION: 5TH TO 9TH GRADE	10%
SECONDARY EDUCATION: 12TH GRADE	31%
TECHNICAL COURSES/TEACHER TRAINING	7%
HIGHER EDUCATION DEGREES / POST-GRADUATES	44%

Access to the Health System

CARACTERIZATION BY ACCESS TO THE HEALTH SYSTEM	TOTAL	18 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 TO 54 YO	55 TO 64 YO	65 TO 74 YO	75 + YO
SAMPLE (N)	1029	97	140	186	192	175	144	95
BELONGS TO A HEALTH SUBSYSTEM (EX. ADSE, SAMS)	35%	35%	25%	33%	42%	39%	31%	37%
HAS A HEALTH INSURANCE	40%	42%	48%	53%	45%	29%	33%	26%
HAS A HEALTH PLAN	9%	7%	12%	12%	8%	8%	11%	3%
DOESN'T HAVE A HEALTH PLAN	52%	53%	41%	37%	50%	63%	57%	72%

DO YOU HAVE A FAMILY DOCTOR ASSIGNED BY THE HEALTH CENTRE?	TOTAL	18 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 TO 54 YO	55 TO 64 YO	65 TO 74 YO	75 + YO
SAMPLE (N)	1029	97	140	186	192	175	144	95
YES, AND I SEEK CARE THERE OFTEN	33%	19%	26%	35%	31%	42%	32%	40%
SIM, BUT I DON'T SEEK MUCH CARE THERE	51%	67%	57%	52%	48%	44%	54%	43%
YES, BUT I DON'T SEEK CARE THERE	7%	8%	8%	6%	11%	4%	4%	10%
NO	9%	6%	9%	8%	10%	10%	10%	7%

WHAT DO YOU THINK IS THE MOST IMPORTANT FACTOR FOR FEELING THAT YOUR HEALTH IS BEING PROPERLY MONITORED?	TOTAL	18 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 TO 54 YO	55 TO 64 YO	65 TO 74 YO	75 + YO
SAMPLE (N)	1029	97	140	186	192	175	144	95
HAVING A GOOD PHYSICIAN/FAMILY DOCTOR	33%	30%	30%	31%	34%	33%	37%	36%
HAVING QUALITY DOCTORS TO WHOM YOU CAN SEEK CARE	19%	30%	18%	16%	24%	14%	16%	17%
HAVING ACCESS TO A QUAILITY PUBLIC HOSPITAL	18%	13%	19%	21%	15%	20%	16%	19%
HAVING ACCESS TO A QUALITY HEALTH CENTRE	10%	2%	11%	9%	9%	15%	10%	10%
HAVING A GOOD HEALTH INSURANCE	7%	5%	12%	9%	7%	6%	4%	2%
BELONGING TO A HEALTH SUBSYSTEM	5%	10%	2%	6%	4%	5%	4%	5%
HAVING PUBLIC HEALTHCARE SERVICES NEARBY	5%	5%	5%	5%	6%	5%	2%	2%
HAVING ACCESS TO A QUAILITY PUBLIC HOSPITAL/CLINIC	3%	4%	1%	3%	1%	2%	6%	3%
HAVING PRIVATE HEALTHCARE SERVICES NEARBY	1%	0%	0%	0%	0%	0%	2%	2%
OTHER	2%	0%	1%	1%	1%	1%	4%	4%

Health Monitoring Assessment

THINKING OF PRE-COVID TIMES, WOULD YOU SAY THAT THE QUALITY OF YOUR HEALTH MONITORING:	TOTAL	18 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 TO 54 YO	55 TO 64 YO	65 TO 74 YO	75 + YO
IMPROVED	10%	9%	5%	11%	8%	10%	13%	14%
REMAINS THE SAME	49%	47%	49%	45%	53%	49%	47%	50%
GOT WORST	35%	37%	36%	33%	31%	38%	37%	31%
I CAN'T TELL	7%	6%	10%	11%	7%	3%	4%	6%
DOESN'T HAVE A HEALTH PLAN	52%	53%	41%	37%	50%	63%	57%	72%

DO YOU THINK YO HAVE A DOCTOR THAT YOU KNOW WELL AND THAT MONITORS YOUR HEALTH STATUS?	TOTAL	18 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 TO 54 YO	55 TO 64 YO	65 TO 74 YO	75 + YO
SAMPLE (N)	1029	97	140	186	192	175	144	95
YES, ABSOLUTELY	42%	25%	28%	29%	34%	42%	68%	84%
YES, PARTLY	39%	40%	39%	51%	44%	44%	29%	13%
NO	19%	35%	33%	21%	22%	14%	4%	3%

Relation with the disease

DISEASE IN THE FAMILY HOUSEHOLD	TOTAL	18 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 TO 54 YO	55 TO 64 YO	65 TO 74 YO	75 + YO
SAMPLE (N)	1029	97	140	186	192	175	144	95
DO YOU HAVE A SPECIFIC DIAGNOSIS OF A DISEASE (VERY SEVERE, NOT VERY SEVERE OR NOT SEVERE)	38%	21%	23%	31%	30%	44%	57%	63%

HOW DO YOU DEAL WITH THE RISK OF GETTING COVID-19?	TOTAL	18 TO 24 YO	25 TO 34 YO	35 TO 44 YO	45 TO 54 YO	55 TO 64 YO	65 TO 74 YO	75 + YO
SAMPLE (N)	1029	97	140	186	192	175	144	95
I'M VERY AFRAID	26%	10%	11%	14%	17%	34%	46%	56%
I'M AFRAID, SPECIALLY FOR MY FAMILY MEMBERS	54%	62%	71%	66%	64%	50%	29%	20%
I'M AFRAID, BUT I THINK THERE'S AN OVERREACTION	13%	20%	10%	10%	13%	13%	17%	12%
I'M NOT AFRAID	8%	8%	9%	10%	6%	3%	9%	13%

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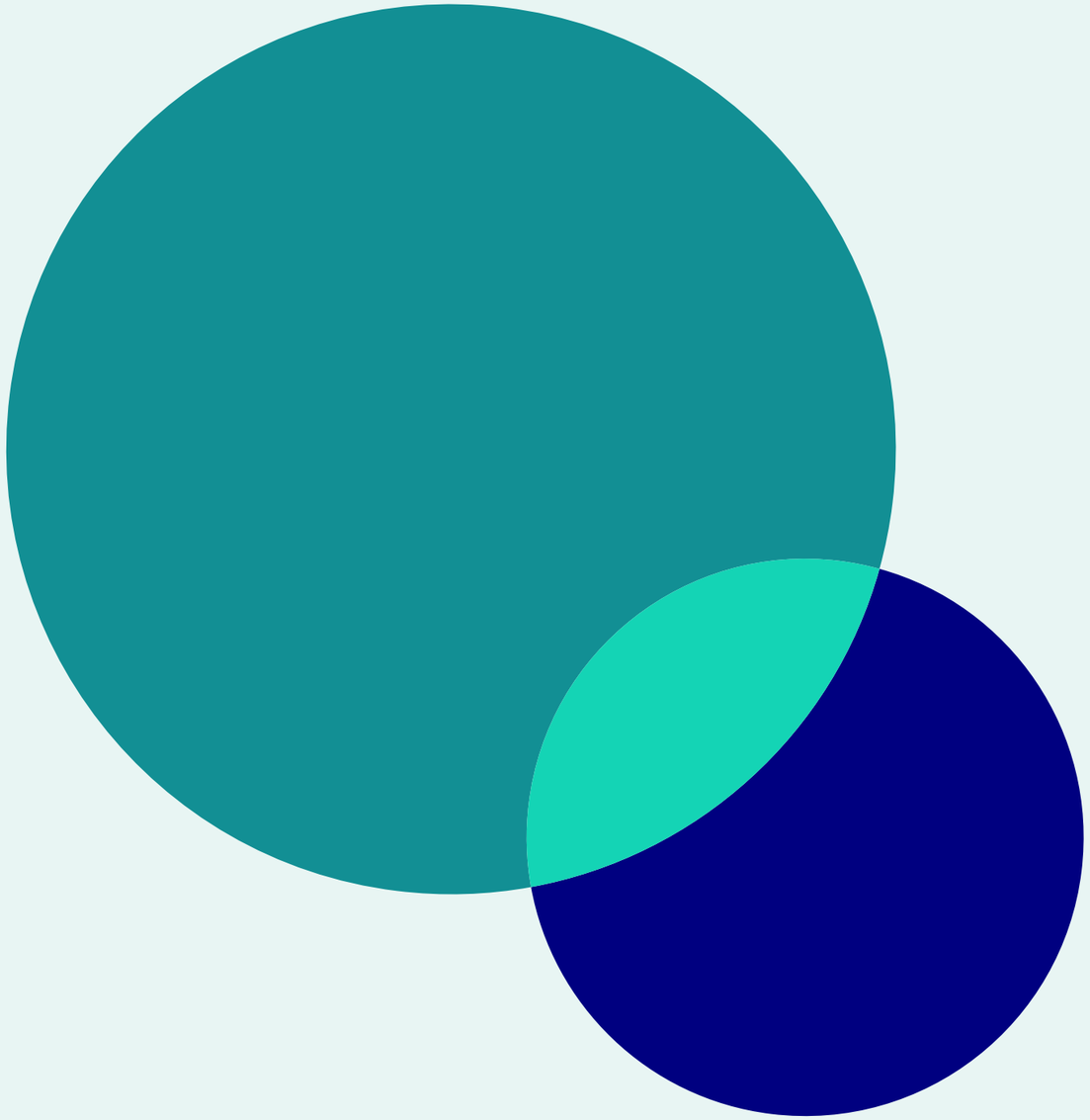

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