

# State of Health in the EU

# Portugal

## Country Health Profile 2017

## The Country Health Profile series

The *State of Health in the EU* profiles provide a concise and policy-relevant overview of health and health systems in the EU Member States, emphasising the particular characteristics and challenges in each country. They are designed to support the efforts of Member States in their evidence-based policy making.

The Country Health Profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by Member States and the Health Systems and Policy Monitor network.

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## Data and information sources

The data and information in these Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated in June 2017 to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following StatLinks into your Internet browser:  
<http://dx.doi.org/10.1787/888933593760>

## Demographic and socioeconomic context in Portugal, 2015

	Portugal	EU
<b>Demographic factors</b>	Population size (thousands)	10 358
	Share of population over age 65 (%)	20.3
	Fertility rate <sup>1</sup>	1.3
<b>Socioeconomic factors</b>	GDP per capita (EUR PPP <sup>2</sup> )	22 200
	Relative poverty rate <sup>3</sup> (%)	13.8
	Unemployment rate (%)	12.6

1. Number of children born per woman aged 15–49.

2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries.

3. Percentage of persons living with less than 50% of median equivalised disposable income.

Source: Eurostat Database.

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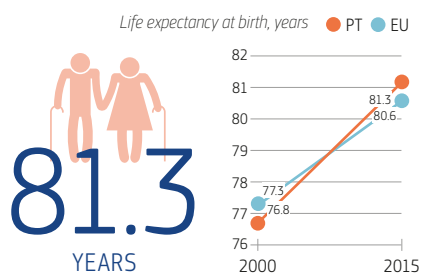
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# 1 Highlights

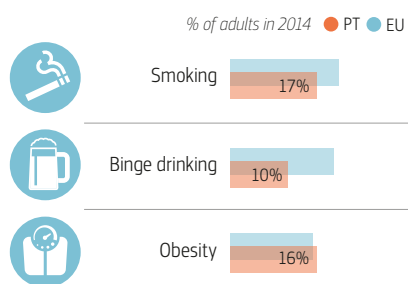
The health status of Portuguese people has improved considerably over the last decade. People live longer but health-related quality of life has not always improved, particularly after age 65, and there are significant differences between men and women. The latest reforms of the Portuguese health system aim at improved fiscal sustainability primarily by focusing on efficiency and transparency.

## Health status



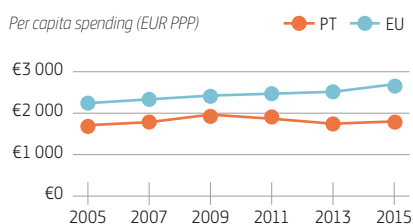
Growth in Portugal's life expectancy has outpaced the EU average. In 2015, life expectancy reached 81.3 years, up from 76.8 years in 2000. However, these improvements have not been followed at the same pace by other important dimensions of health. Less than half of people in Portugal regard themselves as being in good health, and there are substantial disparities by income group.

## Risk factors



In 2014, 17% of adults in Portugal smoked tobacco every day, which is below the EU average, and down from 18.6% in 2008. Overall alcohol consumption per adult has also decreased and binge drinking is half the EU average. Adult obesity rates, however, have increased over time, reaching 16%, and remain slightly above the EU average, while rates among children have also grown substantially.

## Health system

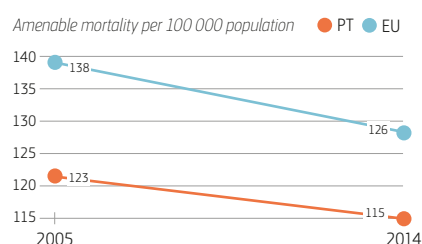


Health expenditure is below that in many other EU countries, with Portugal spending EUR 1989 per head on health care in 2015, some 30% below the EU average (EUR 2797). This equals 9% of GDP compared to the EU average of 9.9%. Two thirds of health spending is publicly funded, but the share of out-of-pocket spending has increased. However, a range of co-payment exemptions ensures financial protection and the affordability of services for vulnerable groups.

## Health system performance

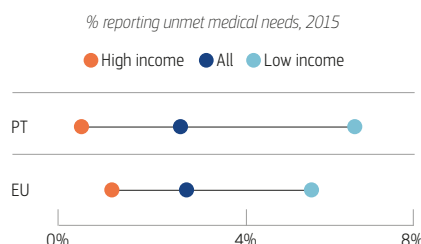
### Effectiveness

Amenable mortality rates are in line with EU averages, albeit with large differences by gender. Portugal has among the lowest avoidable hospital admissions rates in the EU.



### Access

Unmet needs for medical care are around the EU average, but geographical disparities in the availability of services are the main barrier to access in Portugal.



### Resilience

The health system may face fiscal and workforce sustainability challenges, owing to population ageing and staff retention hurdles. Recent reforms aim to enhance the efficiency and transparency of the health system, but areas such as hospital management have yet to be tackled.



## 2 Health in Portugal

### Increases in life expectancy at birth have outpaced the EU average

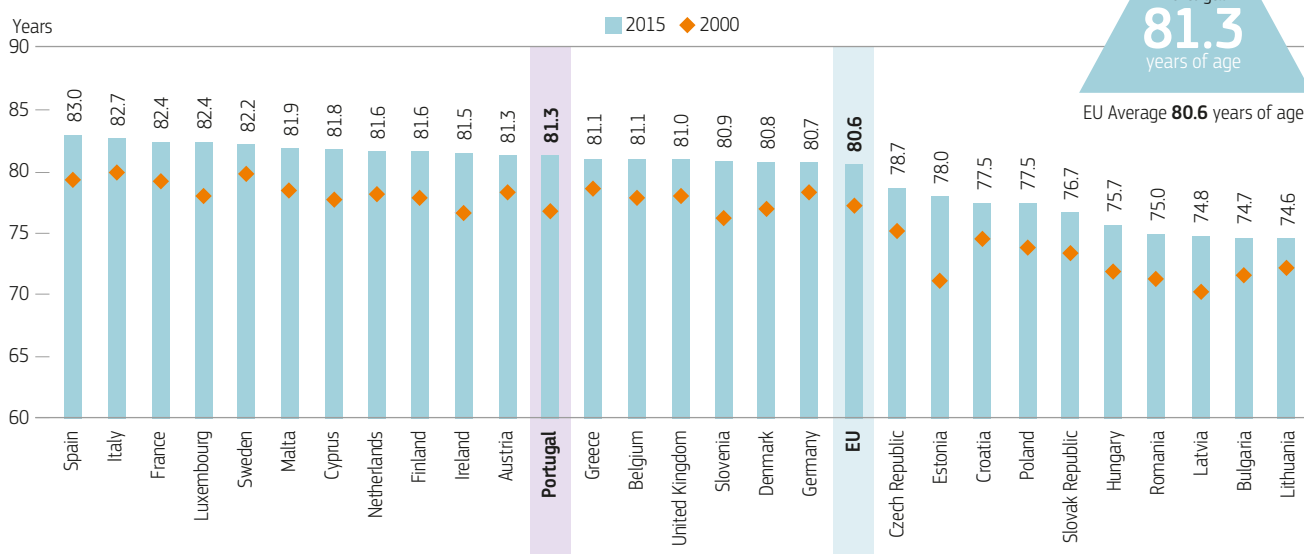
Life expectancy at birth in Portugal increased by over four years between 2000 and 2015, to 81.3 years (Figure 1). It is almost half a year longer than the EU average, but remains two years less than in Spain or Italy. As in other EU countries, a substantial gap persists in life expectancy between men and women, with men (78.1 years) living on average six years less than women (84.3 years). A sizeable and persistent gap also exists between socioeconomic groups (Stringhini *et al.*, 2017) and by education level<sup>1</sup>, especially for men: Portuguese men with a university education live five years longer than those with lower education, compared to a three-year gap for women.

Most of the gains in life expectancy since 2000 have been after the age of 65: for Portuguese women life expectancy at age 65 reached 21.7 years in 2015 (up from 19.1 years in 2000) and for men it was 18 years (up from 15.4 years in 2000). Despite these rises, at age 65 Portuguese women can expect to live only a quarter of their remaining years free of disability, while men can expect to live almost two fifths (38%) of these years in good health.<sup>2</sup>

1. Lower education levels refer to people with less than primary, primary or lower secondary education (ISCED levels 0–2) while higher education levels refer to people with tertiary education (ISCED levels 5–8).

2. These are based on the indicator of 'healthy life years', which measures the number of years that people can expect to live free of disability at different ages.

**Figure 1. Life expectancy has increased by over four years since 2000, higher than the EU average**

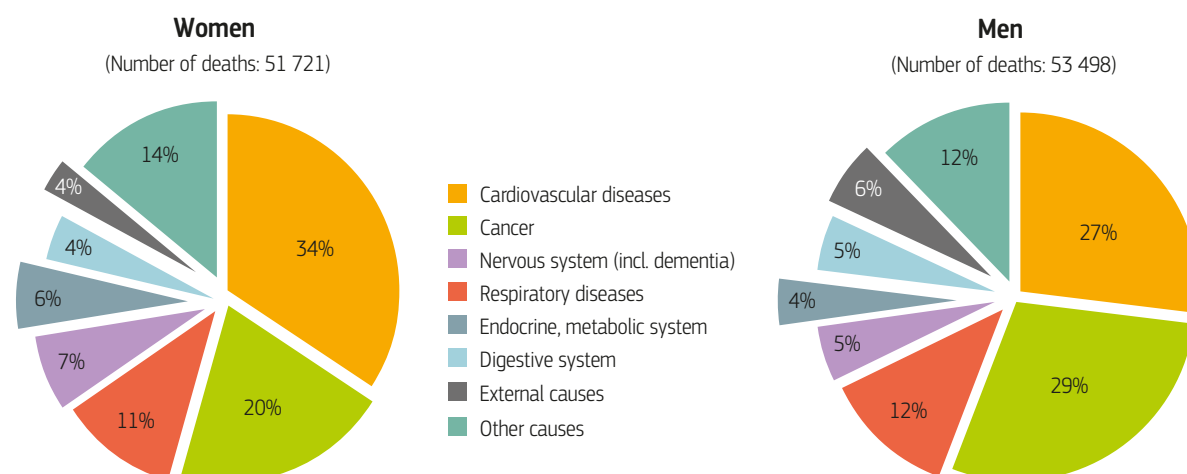


Source: Eurostat Database.

### Cardiovascular diseases and cancer are the largest contributors to mortality

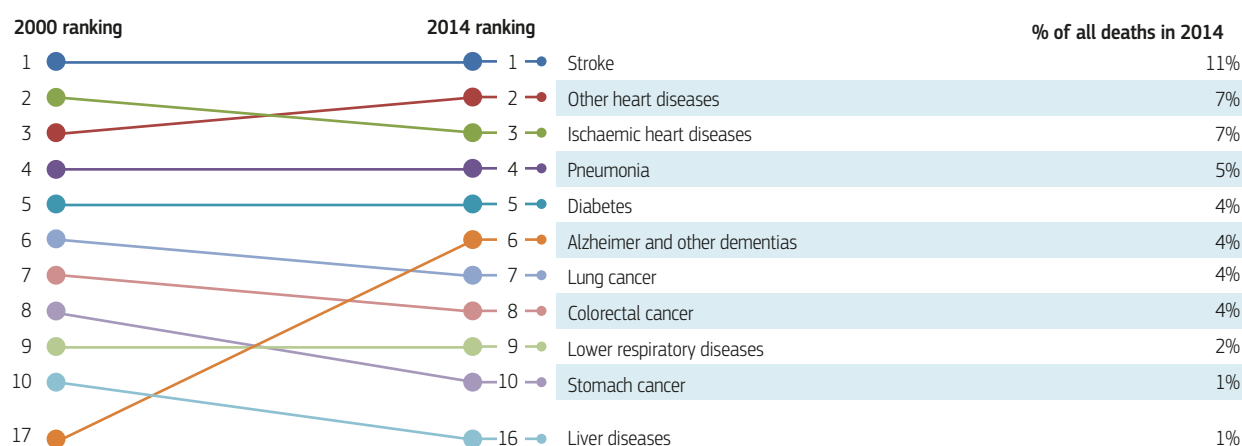
Cardiovascular diseases are the leading cause of death among women but are second to cancer for men (Figure 2). In 2014, cardiovascular diseases accounted for one third of all deaths among women and just over a quarter of all deaths in men, and cancer was responsible for 20 % of all deaths in women and 29 % of all deaths in men per 100 000 population. Death caused by respiratory diseases is also high in Portugal (around one in nine deaths for women and men).

Looking at more specific causes, after stroke and heart diseases, pneumonia was the fourth leading cause of death in Portugal in 2014 (Figure 3). The increase in number of deaths caused by pneumonia and other lung diseases is linked to the ageing of the population, as well as a legacy of higher smoking rates. There has also been a growing number of people dying from diabetes, linked to the growing prevalence of Type II diabetes, with mortality being one of the highest in the EU. The number of people dying from Alzheimer's and other dementias has more than tripled since 2000, also reflecting population ageing, better diagnosis and lack of effective treatments, as well as more precise coding.

**Figure 2. Deaths from cancer are more frequent in men and from cardiovascular diseases in women**

**Note:** The data are presented by broad ICD chapter. Dementia was added to the nervous system diseases' chapter to include it with Alzheimer's disease (the main form of dementia).

**Source:** Eurostat Database (data refer to 2014).

**Figure 3. There has been a remarkable increase in deaths from Alzheimer's and other dementias**

**Source:** Eurostat Database.

## Chronic conditions are among the leading determinants of poor health

After the burden of fatal diseases, musculoskeletal problems (including low back and neck pain) and chronic depression are increasing as determinants of disability adjusted life years<sup>3</sup> (DALYs) in Portugal (IHME, 2016). These are leading health problems that, even if not fatal, have serious life-limiting consequences.

Based on self-reported data from the European Health Interview Survey (EHIS), more than one in four people in Portugal lives with hypertension, one in eight lives with chronic depression, and one in twenty lives with asthma. Wide disparities exist in the prevalence of these chronic diseases by education level, with one in three people with the lowest level of education living with hypertension, compared with only about one in ten of people with the highest level of education.<sup>4</sup>

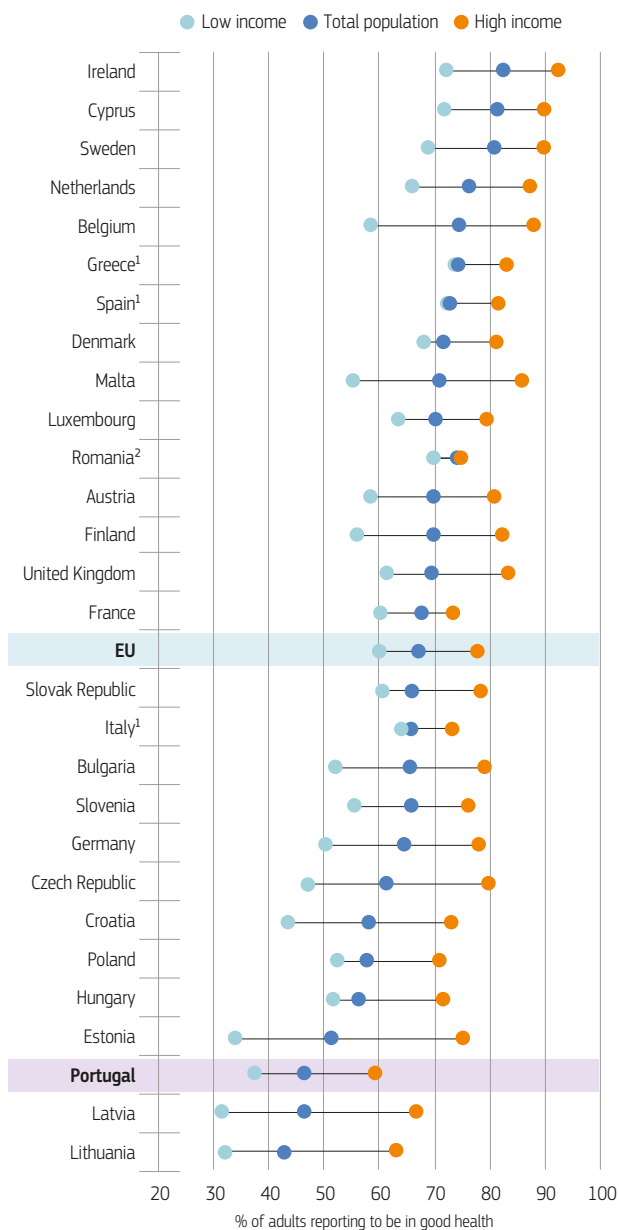
3. DALY is an indicator used to estimate the total number of years lost due to specific diseases and risk factors. One DALY equals one year of healthy life lost (IHME).

4. Inequalities by education may partially be attributed to the higher proportion of older people with lower educational levels; however, this alone does not account for all socioeconomic disparities.

## The Portuguese are more pessimistic when assessing their health, compared to other countries

As can be seen in Figure 4, fewer people in Portugal report being in very good or good health (46.4%) than the EU average (66.9%). As in other EU countries, there is a large gap in self-rated health by socioeconomic status, with 59.4% of those in the highest income quintile reporting very good or good health, compared with only 37.4% in the lowest.

**Figure 4. There are large disparities in self-reported health among income groups**



1. The shares for the total population and the low-income population are roughly the same.
2. The shares for the total population and the high-income population are roughly the same.

**Note:** Self-reported data always need to be interpreted with care, particularly in international comparisons, since it is a subjective assessment influenced by individual and cultural expectations.

**Source:** Eurostat Database, based on EU-SILC (data refer to 2015).

## 3 Risk factors

### A quarter of Portugal's disease burden is due to behavioural risk factors

The health status of the Portuguese population and health inequalities are linked to a number of health determinants, including the living and working conditions of people, the physical environment and a range of behavioural risk factors. Based on Institute of Health Metrics and Evaluation (IHME) estimations, over 26% of the overall burden of disease in Portugal in 2015 (measured in terms of DALYs) can be attributed to such risk factors – including smoking, alcohol use, diet, and physical inactivity, with smoking and dietary risks contributing the most (IHME, 2016).

### Smoking and binge drinking rates are far below the EU averages

The proportion of adults who smoke in Portugal has decreased since 2000 (from one in five to one in six) and is now the fourth lowest among all EU countries (see also Figure 5). Bucking the normal trend for significant inequalities in this area, the prevalence of daily smoking in Portugal is about the same among the lowest



and highest educated. Moreover, sharper declines in regular smoking have been seen for 15-year-old girls (from 26% in 2001–02 to 10% in 2013–14) and boys (from nearly 18% in 2001–02 to 12% in 2013–14). These positive results are being reinforced by public health actions that target tobacco control (Section 5.1).

There has also been progress in reducing alcohol consumption, with adults consuming 10 litres per capita in 2014 (equal to the EU average), a drop from 12 litres in 2000. Moreover, binge drinking<sup>5</sup> among adults (10% in 2014) is half the EU average (20%), with only a small difference by education level. At age 15, 15% of girls and 18% of boys reported in 2013–14 having been drunk at least twice in their life, which is nonetheless near the bottom quintile among EU countries. This represents a very large improvement for boys, 26% of whom had reported repeated drunkenness in 2001–02.

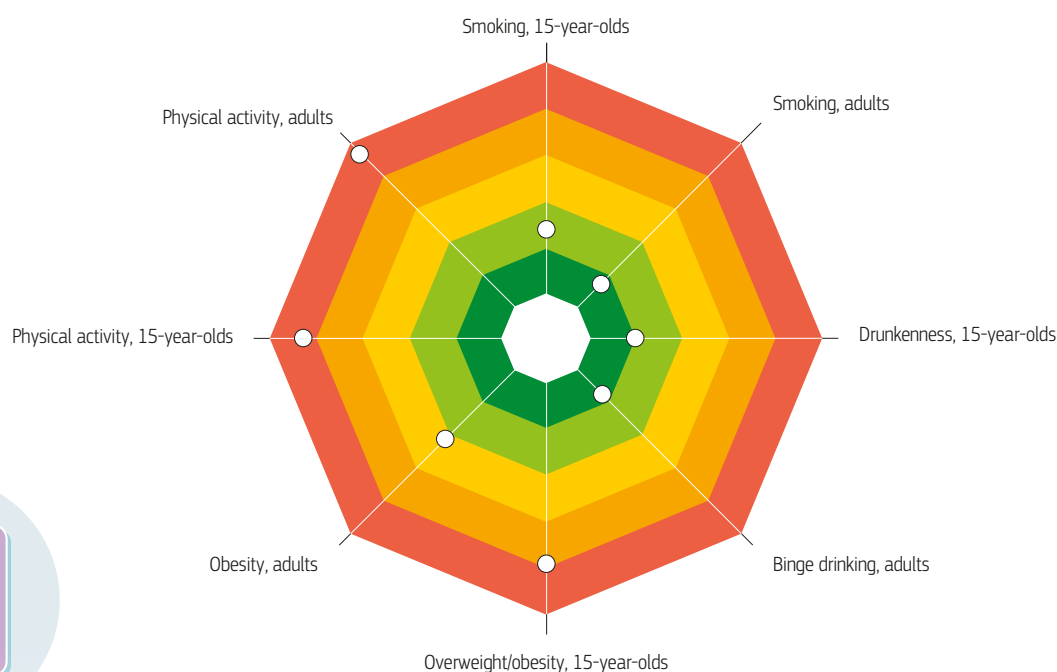
### Rising rates of obesity and physical inactivity present a growing challenge

On the other hand, poor diet and lack of physical activity can lead to high blood pressure, high body-mass index, high cholesterol and

other risk factors for cardiovascular diseases, diabetes, and some cancers. Based on 2014 self-reported data (which tend to underestimate the true prevalence of obesity), about one in six (16.1%) adults in Portugal is now obese, which is nearly one percentage point above the EU average. Consistent with the pattern in other EU countries, the obesity level among those with the lowest level of education is more than twice as high as the level among the highest educated.

While the prevalence of overweight and obesity among 15-year-olds remains close to the EU average, it grew by almost 60% (from one in eight to one in five adolescents) between 2001–02 and 2013–14. Rates of physical inactivity for both adults and 15-year-olds are among the highest in EU countries. Portugal has implemented national strategies on nutrition, preventing and treating obesity, and promoting physical activity to address these challenges (see Section 5.1).

**Figure 5. High levels of physical inactivity and obesity are important public health issues**



**Note:** The closer the dot is to the centre the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.

**Source:** OECD calculations based on Eurostat Database (EHIS in or around 2014), OECD Health Statistics and HBSC survey in 2013–14. (Chart design: Laboratório MeS).

5. Binge drinking behaviour is defined as consuming six or more alcoholic drinks on a single occasion, at least once a month over the past year.

## 4 The health system

### The National Health Service co-exists with other health subsystems

The Portuguese health system is characterised by three overlapping systems. The NHS is universal, comprehensive and almost free at point of delivery, financed mainly through taxation. All residents are covered, irrespective of their socioeconomic, employment or legal status. In addition, special health insurance schemes cover particular professions or sectors; these are called 'health subsystems' and can be either public (e.g. for civil servants) or private (e.g. banking sector). Private Voluntary Health Insurance (VHI) is supplementary and speeds up access to elective hospital treatment and ambulatory consultations; it also increases the choice of provider. At the central level, the Ministry of Health takes care of planning and regulation, while the management of the NHS occurs at the regional level, through five regional health administrations (RHAs) whose autonomy over budget setting and spending is limited to primary care.

Some of the more recent reforms in the health sector were linked to Portugal's Economic Adjustment Programme (EAP) and

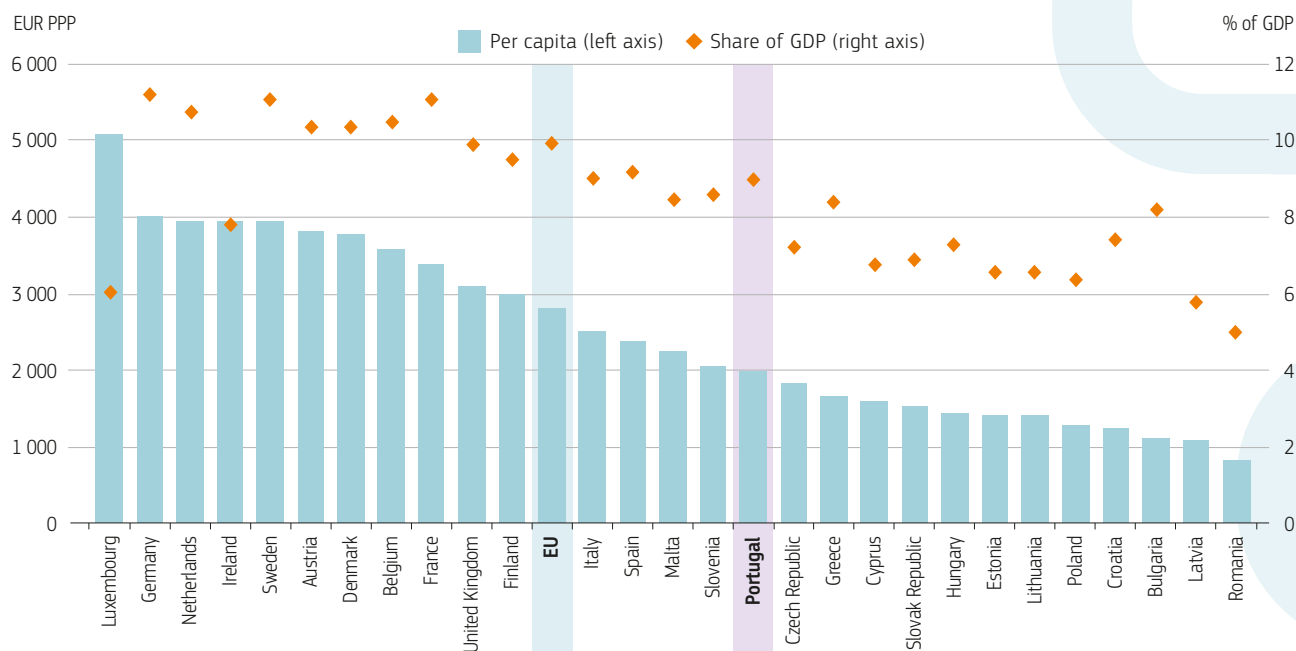
EUR 78 billion international loan agreement, in place between 2011 and 2014. EAP measures included reductions in pharmaceutical spending and increased use of co-payments. They also required removal of some generous compensation schemes for health staff and promoted the use of family doctors.

### Spending on health has declined in response to the economic crisis

In 2015, Portugal spent EUR 1 989 per capita on health care (adjusted for differences in purchasing power), about 30% below the EU average of EUR 2 797 (Figure 6). The steady rise in health expenditure that had occurred since 1995 was reversed after 2010 when economic recession and fiscal consolidation measures reduced spending by nearly one percentage point, from 9.8% to 9% of GDP in 2015, compared with the EU average of 9.9%.

The need to rationalise public sector spending had severe effects on the health sector. Government expenditure on health fell more than in other public sectors, as the share of health to general government spending came down from 13.8% in 2009 to 12.3%

**Figure 6. Per capita, Portugal spends about 70% of the EU average on health**



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2015).



in 2015. The public share of health expenditure fell more rapidly from 2011 and now accounts for 66% of total health financing, below the EU average of 79% (see also Figure 10 in Section 5.2). The share of out-of-pocket payments is the second largest source of revenue for health care spending (28%), well above the EU average (15%). Private VHI has been growing over the years, but still only accounts for 5% of health financing, converging with the EU average.

### The ratio of nurses to doctors is low

While the number of physicians per 1 000 population (4.6) in Portugal is substantially above the EU average (3.5), the number of nurses (6.3 per 1 000) is below (8.4), despite rising numbers over the last decade (see Figure 7).

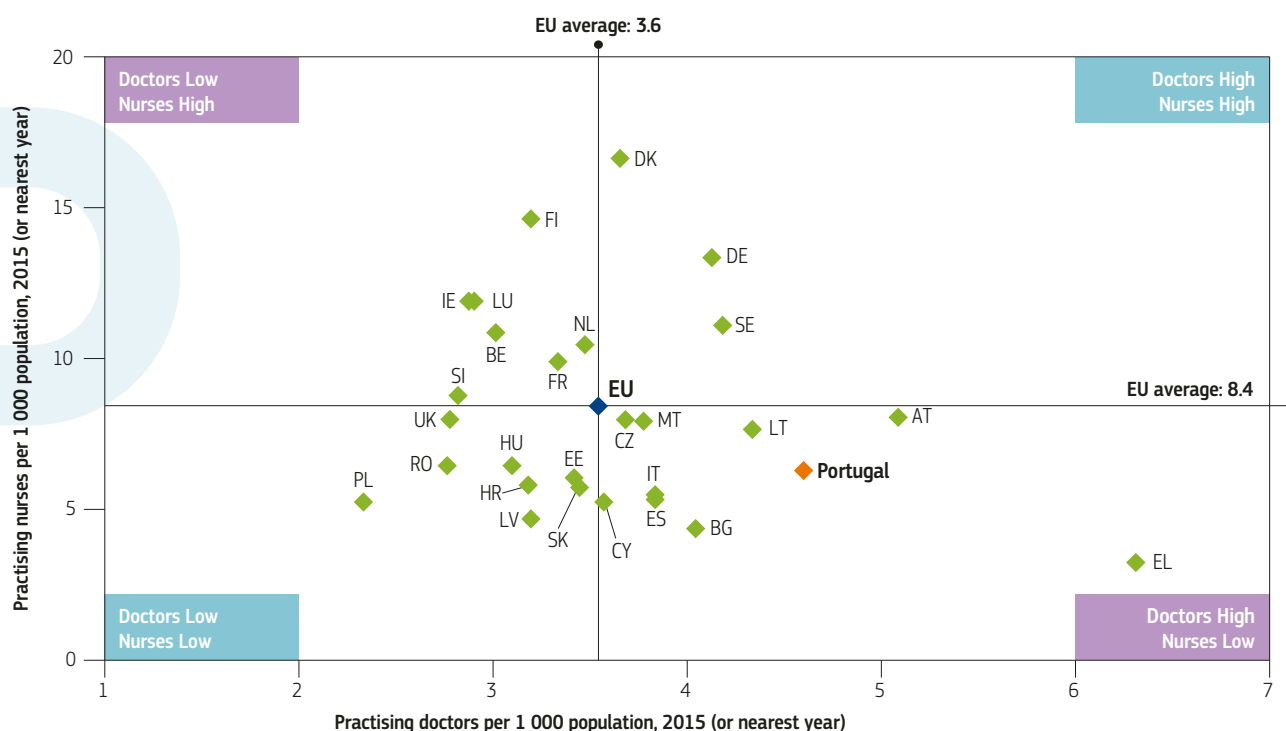
Portugal has a relatively low supply of curative beds per 100 000 population (325.2) compared to other European countries, although it is higher than in neighbouring countries such as Spain (237.4). Over the last few years, progressive improvements have been made to older infrastructure and new

hospitals have opened to replace old ones. The total number of inpatient hospital beds has declined (2006–16), partly due to an increase in day surgery and the bolstering of the long-term care network. There has also been a decrease in the number of psychiatric beds by promoting mental health patients' integration into their communities.

### A mix of public and private providers deliver health services

Primary care in Portugal is delivered by a mix of public and private providers, including primary care units integrated within the NHS, private sector clinics (both profit and non-profit) and groups of professionals in private offices. Secondary and tertiary care is mainly provided in hospitals, although some primary care centres employ specialists who provide specialist ambulatory (or out-patient) services. NHS doctors act as gatekeepers and refer patients for specialist care, but private primary care providers play less of a gatekeeping role. Dental consultations, diagnostic services, renal dialysis and rehabilitation are most commonly provided in the private sector.

**Figure 7. Despite increasing numbers, Portugal's nursing stock remains below the EU average**



**Note:** In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large over-estimation of the number of practising doctors (e.g. of around 30% in Portugal). In Austria and Greece, the number of nurses is under-estimated as it only includes those working in hospital.

**Source:** Eurostat Database.

# 5 Performance of the health system

## 5.1 EFFECTIVENESS

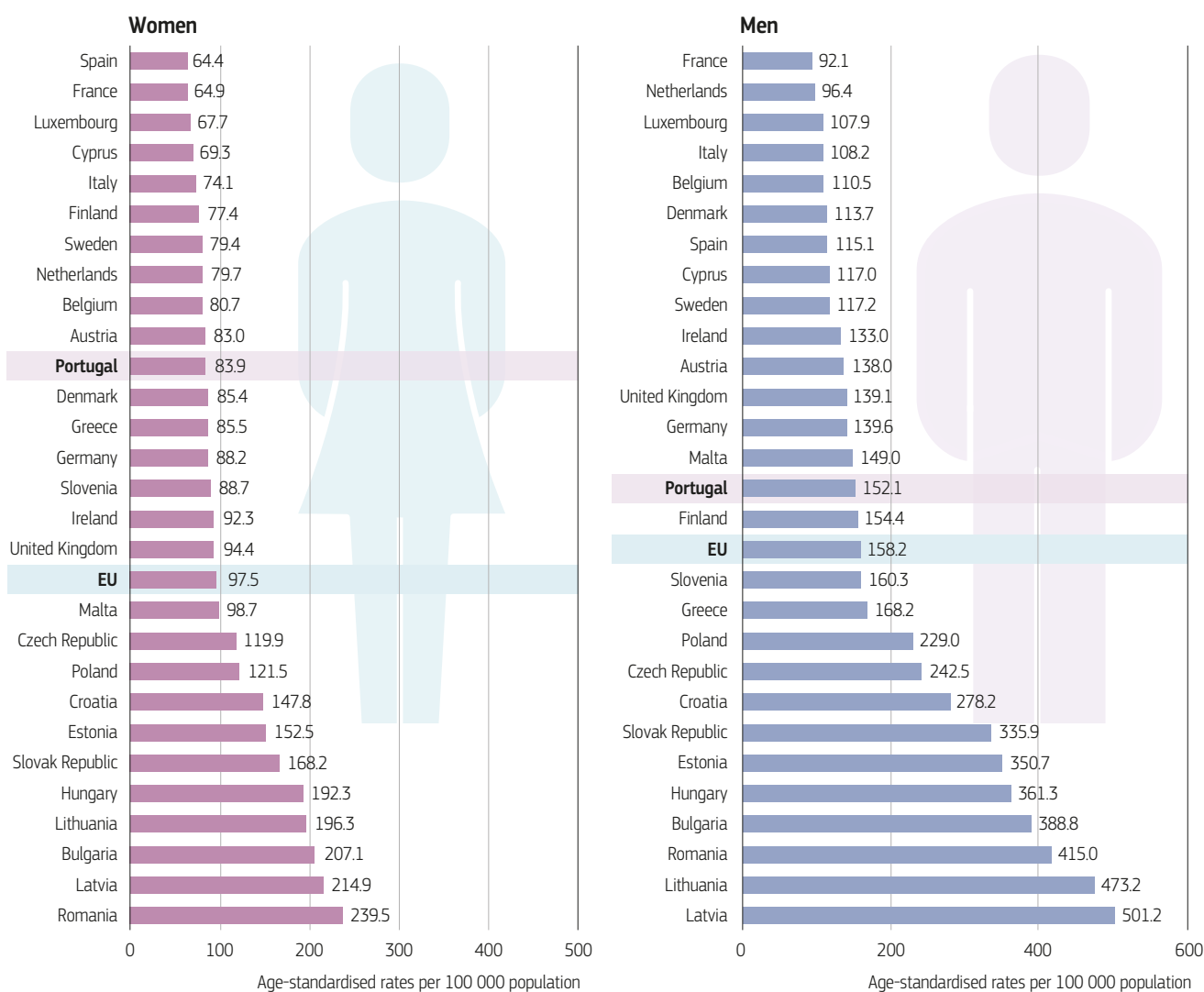
### There are substantial gender differences in amenable mortality

Amenable mortality<sup>6</sup> sheds light on the effectiveness of a health system. In Portugal, mortality amenable to health care interventions has been reduced – by 40% between 2000 and 2014 – and is now below the EU average. However, the rate is higher than in neighbouring countries such as Spain and France. Rates are also much higher for men than for women (Figure 8). Overall, about 10 847 deaths were deemed to be avoidable through the delivery of higher quality and more timely health care

in 2014. Ischaemic heart diseases accounted for 23% of amenable deaths in 2014. Other important causes of amenable deaths were cerebrovascular diseases (20% of the total) and cancer of the colon and rectum (15% of the total).

Survival rates for some treatable cancers are relatively high. For example, data from the CONCORD programme show that five-year survival for breast cancer for the period 2010–14 was 87.6% while the five-year survival for cervical cancer has improved over the last few years, reaching 66.2%. Timeliness of treatment is greatly aided by effective screening: for breast cancer the screening rate for Portuguese women aged 50–69 is over 80%.

**Figure 8. Amenable mortality rates are better than the EU average**



Source: Eurostat Database (data refer to 2014).

6. Amenable mortality is defined as premature deaths that could have been avoided through timely and effective health care.

Advances in the diagnosis and treatment of colorectal cancer, including improved surgical techniques, radiation therapy and combined chemotherapy, along with increased access, have contributed to increasing the survival rate, which is now around 61% in 2010–14 (up from 57% in 2000–04).

## There is room to improve preventable mortality

Portugal has a shortage of health promotion and disease prevention activities dealing with healthy lifestyles and disease screening. There are no permanent inter-sectoral structures or bodies, and decisions in areas such as urban planning or transport are not carried out in partnership with the health sector. Health impact assessments have not been institutionalised in Portugal, nor have specific guidelines been produced. In 2012, tobacco control measures were introduced, including a smoking ban in public places and the prohibition of tobacco sales to under 18s. Although Portugal lacks good monitoring of tobacco use to track effects of these reforms, some data suggest prevention policies have had an effect. Standardised death rates for respiratory diseases have decreased over time, from 137 per 100 000 population in 2000 to 117 in 2014 (see Section 3).

In addition, the recently extended National Health Plan (2012–2020) provides key main strategies for public health action to be implemented over the next few years. It includes the reduction of risk factors for non-communicable diseases, in particular, the use of and exposure to tobacco/smoke and the reduction of overweight and obesity in the School-age population. This latter is a response to the significant increase in obesity in the Portuguese population (see Section 3). A new Programme for Physical Activity has also been put in place, which aims to promote healthy lifestyles and tackle sedentary behaviours.

## Vaccination levels are high

Although vaccination is not mandatory in Portugal, high levels of immunisation are achieved. This may be related to the fact that people can be vaccinated in local primary care units and that vaccines included in the national programme are free for all NHS users. The vaccine against human papillomavirus (HPV) was introduced into the National Immunisation Programme in 2008 and recent data show that high immunisation rates, ranging from 85% to 93% have been achieved in girls born between 1992 and 2000. Furthermore, the percentage of influenza vaccination among older people has increased over time, most likely linked to

it becoming free (and without prescription) for patients at risk and all those aged 65 and over, particularly elderly people in long-term care residential homes and older people on social benefits (from 2012).

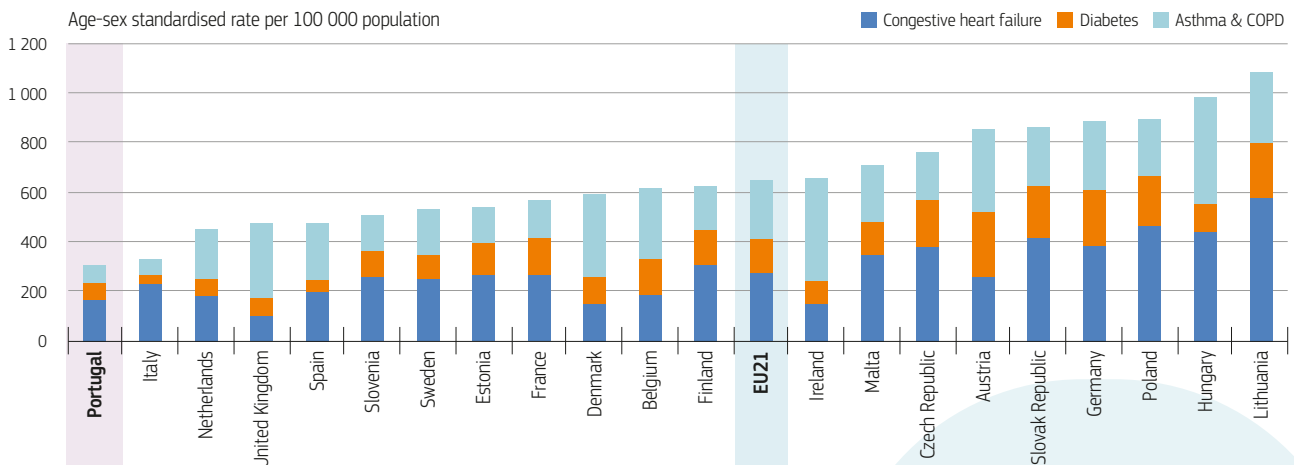
### BOX 1. TACKLING ANTIMICROBIAL RESISTANCE IS A HEALTH PRIORITY IN PORTUGAL

Antimicrobial Resistance (AMR) is a serious public health issue in Portugal. Although the percentage of *Staphylococcus aureus* bloodstream infections that were methicillin-resistant (MRSA) decreased from 53.8% in 2012 to 46.8% in 2015, they remain the third highest in the EU/EEA and way above the EU/EEA average of 16.8% (ECDC, 2017). In addition, the percentage of *Klebsiella pneumoniae* bloodstream infections that were resistant to carbapenems, a major last-line class of antibiotics to treat bacterial infections, was 3.4%, which is much higher than the EU/EEA median (0.5%) and the sixth highest in the EU/EEA (ECDC, 2017).

Portugal published its latest programme on the prevention and control of AMR in 2013. It takes a holistic approach from different areas (information/education, epidemiological surveillance, standardisation of clinical structures, procedures and practices, and financial incentives through hospital financing) and at different decision levels (local, regional and national). An action plan to reduce the use of antibiotics in animals was also introduced in 2013 (DGAV, 2013; DGS, 2016).

## National strategies target health care quality and safety

Health care quality indicators show a mixed picture for health outcomes and health care delivery. The standardised in-hospital mortality rate per 100 patients for acute myocardial infarction (AMI) in Portugal (7.9 in 2015) has halved since 2000 and is similar to that of Spain but higher than in other countries such as Italy and France. A similar scenario can be found for 30-day mortality after admission to hospital for ischaemic stroke and haemorrhagic stroke. With regard to the quality of primary care in dealing with chronic diseases, Portugal has some of the lowest age- and sex-standardised rates per 100 000 population for avoidable admissions due to asthma, COPD and congestive heart failure (CHF) (Figure 9), suggesting that these conditions are being effectively managed at the primary health care level and that such care is of good quality.

**Figure 9. Portugal has among the lowest avoidable hospitalisation rates**

**Note:** Rates are not adjusted by health care needs or health risk factors.

**Source:** OECD Health Statistics 2017 (data refer to 2015).

Quality assurance and safety are steered by two key national documents: the National Strategy for Health Quality 2015–2020, which also aims to reinforce equity as the core dimension of the NHS within a framework of continued quality improvement and safety, and the National Plan for Patient Safety 2015–2020.

## Progressive strategies have promoted greater structural integration

Several initiatives to improve the vertical integration of primary care have been implemented, beginning with the establishment of NHS Local Health Units (in 1999), to integrate hospitals and primary health care units within the same organisation. This was followed by increases in numbers of Family Health Units (from 2007) and Primary Health Care Centre Groups (ACES) (from 2008), which have the task of providing integrated primary care for their local population. Horizontal integration between health and social care is facilitated by the network of long-term care providers (RNCCI), established in 2006. A more recent example of the promotion of better integrated care within the NHS is the management of diabetes patients. In hospitals, patients can be treated by specialists located within Integrated Diabetes Units who are dedicated to handling the complexities of this condition.

### 5.2 ACCESSIBILITY

#### Despite universal coverage, geographical gaps in provision of services hinder access

While all residents in Portugal are covered by the NHS regardless of their legal status, the complexity of administrative procedures and the possibility of having to pay for services limit access for many irregular migrants (WHO, 2014).

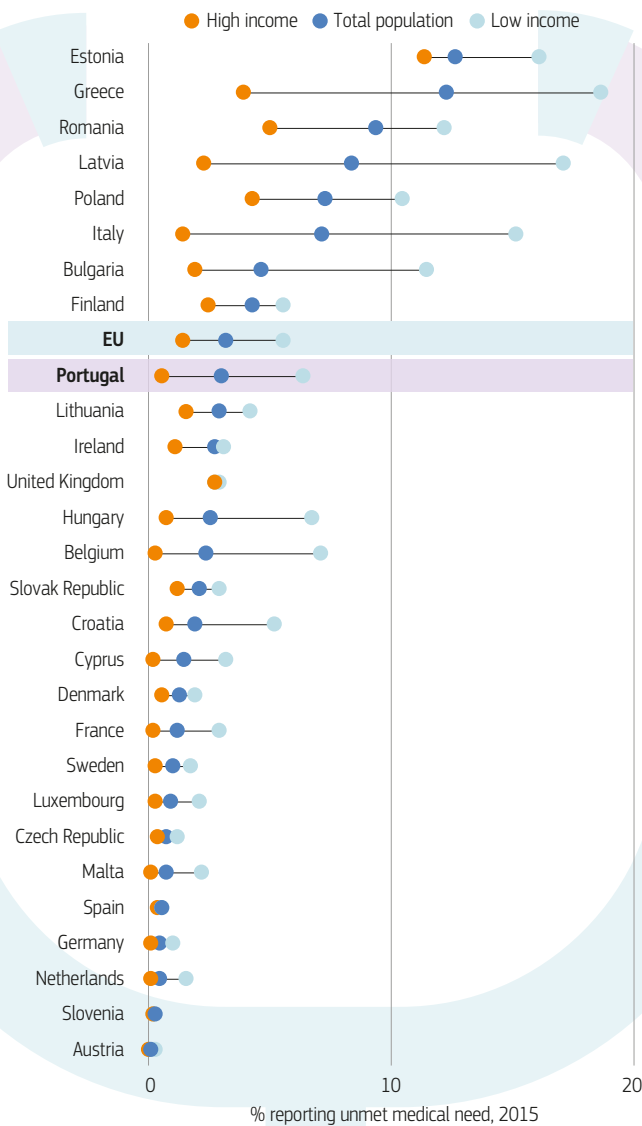
There are gaps in the provision of services due to geographical imbalances, as hospitals located outside great metropolitan areas such as Lisbon, Oporto and Coimbra do not provide all medical specialties. However, the high levels of investment in regional facilities outside Lisbon and Oporto in recent years seek to address these geographical disparities.

Some 3% of the Portuguese population reported unmet medical care needs due to cost, distance or waiting time (2015), which is equal to the EU average (Figure 10) and reflects well on these efforts. However, data on unmet needs have fluctuated quite broadly for Portugal, making it difficult to pin down a definitive trend over the past ten years. Still, when disaggregated, the recorded rate in 2015 was ten times higher for the lowest income group (6.4) than for the highest income group (0.6).

#### The scope of coverage in the NHS is comprehensive, except for dental care

Theoretically, no services are explicitly excluded from NHS coverage. However, in general, the NHS does not cover dental care and it is mainly provided by the private sector through direct payment or through VHI. This scenario was slightly improved with the creation of dental pay cheques (in 2008) as part of the National Programme for Oral Health Care Promotion, which allows school-aged children, pregnant women and older people who receive social benefits to have free access to dental care. The Programme was further extended to people living with HIV/AIDS (in 2010), and those who needed early intervention due to oral cancer (in 2014). Recent government announcements signal the intention to provide dental care in some primary care settings.

**Figure 10. Self-reported unmet needs for medical care differ significantly by income group**



**Note:** The data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.

**Source:** Eurostat Database, based on EU-SILC (data refer to 2015).

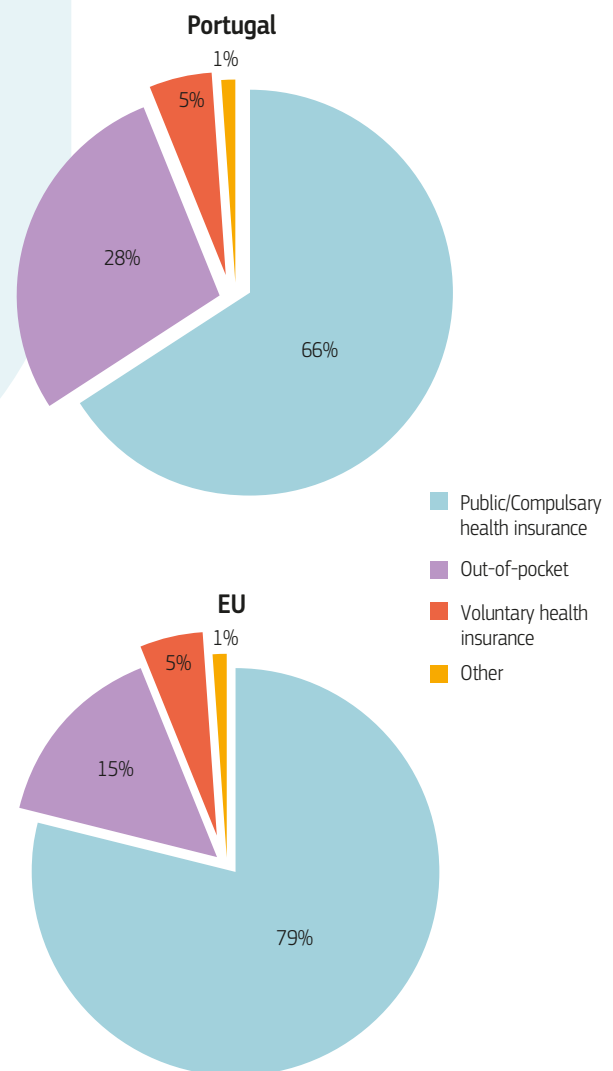
### A range of NHS services incur co-payments but exemptions are in place

Out-of-pocket payments in Portugal represent 28% of total health expenditure (Figure 11), significantly higher than the EU average of 15%, and neighbouring countries such as Spain (24%), with an increasing trend over time (Figure 12). What is more, out-of-pocket payments represent 3.8% of final household consumption, compared to the EU average of 2.3%, the seventh highest among Member States. Out-of-pocket payments include co-payments for a wide range of NHS services, including primary care visits,

outpatient specialist visits, emergency visits, diagnostic tests and home visits, although there are exemptions based on income for certain population groups (see below) and certain medical conditions. In practice, more than 55% of the population is exempted from any cost-sharing in publicly provided service.

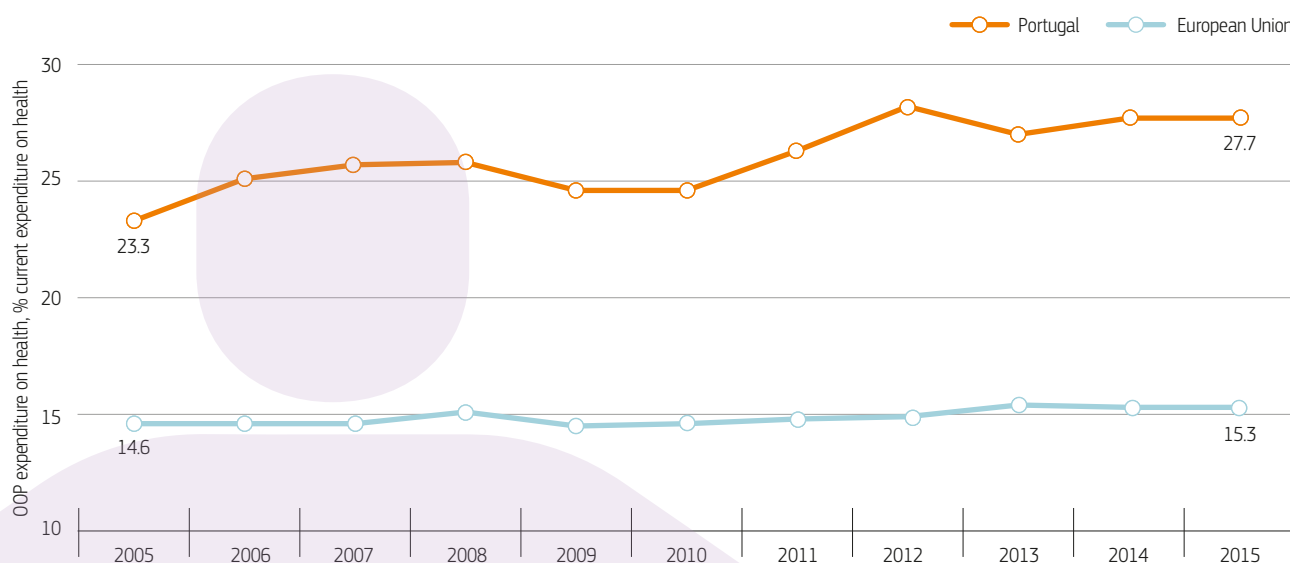
The values set for co-payments are typically small when compared to the cost of the service, although the level of cost-sharing is particularly high for pharmaceutical products, for which different levels of co-insurance are applied according to their therapeutic value. Direct payments take place for those services not covered under the benefits package, including dental care and specialist consultations in private ambulatory care.

**Figure 11. Out-of-pocket payments play a greater role in Portugal than in many other EU countries**



**Source:** OECD Health Statistics, Eurostat Database (data refer to 2015).

Figure 12. Out-of-pocket payments have increased over time



Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database.

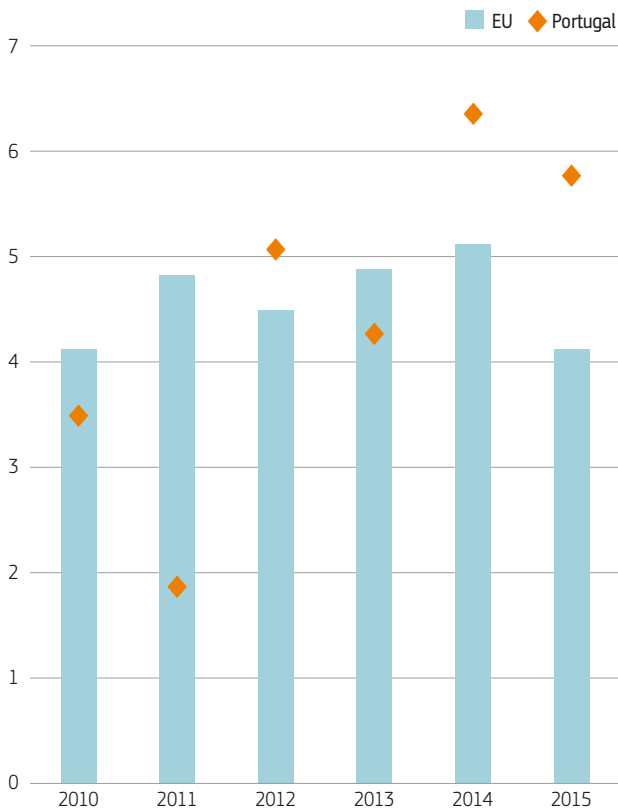
### Financial protection mechanisms aim to maintain the affordability of services for the poor

As in most EU countries, unmet care needs are reported more often by poor people. In Portugal, 5.4% of people from low-income households reported going without a medical examination when needed for financial reasons in 2015 (above the EU average of 4.1%) (Figure 13) and significantly higher than the rate for the highest income group (0.4%), although WHO estimates show modest levels of catastrophic expenditures from private spending on health in Portugal (Barros & Borges, 2017, forthcoming). Equitable access to health care is achieved through exemptions on user charges. Those experiencing financial problems and/or who belong to certain patient groups are exempted from paying user charges and pharmaceuticals co-insurance. The most recent revision of user charges in 2016 reduced their value (for the first time) and expanded the groups eligible for exemptions, including the unemployed, pregnant women, children under 18, blood donors and those with certain medical conditions.

### Health care resources are unequally distributed across the country

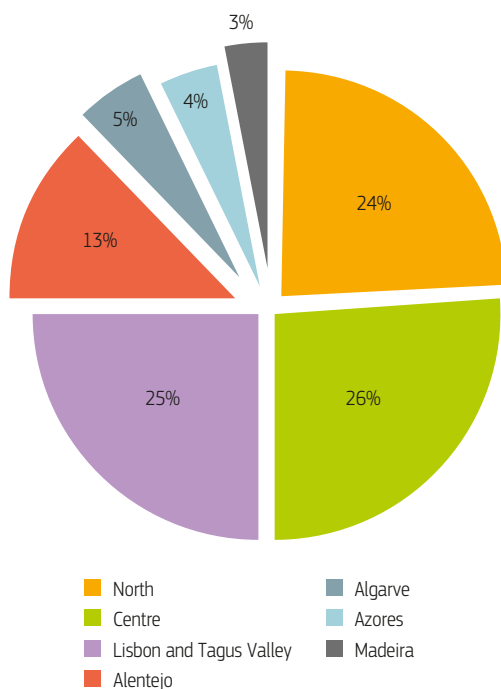
The biggest barriers to accessing health care in Portugal are waiting times and the uneven geographical distribution of facilities. Even so, only 0.1% of the poorest population reported unmet needs for medical examination due to distance in 2015 (lower than the EU average of 0.2%), while 0.9% from this income quintile also reported unmet needs due to waiting lists/times, which is nearly around the EU average (1.1%).

**Figure 13. Unmet needs for medical care due to financial reasons have recently exceeded the EU average**



Source: Eurostat Database, based on EU-SILC (data refer to 2015).

**Figure 14. Primary care facilities are concentrated in the districts of Centre, Lisbon and Oporto (North)**



Source: Based on data available at [www.sns.gov.pt](http://www.sns.gov.pt).

The distribution of health resources in Portugal is not even across different regions and, within regions, across municipalities. There are also significant differences in wealth and health indicators between the great metropolitan areas of Lisbon and Oporto and the interior regions. Many of those living in rural areas are at-risk of poverty and face barriers (particularly distance) to access quality health services. Moreover, health workers are concentrated in the coastal areas and greater Lisbon and Oporto. Evidence suggests that there are also major geographical disparities in the distribution of NHS health workers by profession. This is also the case in the distribution of public primary care facilities (see Figure 14).

The lack of available services is reflected in the number of NHS users not registered with a GP (in 2015, around 1.2 million NHS users remained unregistered), although it should be noted that patients can access GPs without being registered (registration, however, improves the quality of patient follow-up). The government, partly in response, has tried to simplify the recruitment process for new GPs in order to shorten the time to effective placement. By the end of 2016 the proportion of NHS users covered by a GP reached 92.1% of the population.

### 5.3 RESILIENCE<sup>7</sup>

#### Long-term fiscal sustainability remains a challenge

The international economic crisis had a major impact on Portugal, leading to the adoption of an EAP. One of the main challenges in implementing EAP measures related to ensuring NHS financial sustainability while improving underserved areas, such as dental care, mental health and palliative care. There are also concerns around projected increases in public expenditure on health as a percentage of GDP from 6% in 2013 to 8.5% in 2060, higher than the projected EU average (7.8%) (European Commission and Economic Policy Committee, 2015). A large share of costs in the health system are related to caring for people with chronic conditions and therefore long-term fiscal sustainability is challenged by the lack of a comprehensive strategy to address the health-related costs of ageing, especially chronic diseases.

In the short term, risks to the NHS's financial sustainability seem to stem from low quality financial management (budget planning and implementation) in hospitals, which has led to growing arrears in supplier payments. Government measures do not seem sufficient to guarantee the clearance of arrears or to impose robust spending control.

7. Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.

## Pressures on health workers will exacerbate future shortages in the NHS

A further challenge relates to the wages of health care workers in the public sector. Although most of the wage reductions introduced in 2012 under the EAP are currently being reversed, health care personnel in the NHS, particularly physicians, are paid less than in the private sector. The higher salaries in the private sector are incentivising both doctors and nurses to move out of the NHS or even to emigrate to other countries.

In fact, recent years have seen a wave of emigration among health care workers, particularly nurses. The future challenge for the NHS is to be able to maintain the motivation of its workforce, and to contain and reverse the drain of professionals. The low number of nurses, however, is not likely to grow in the near future: while the number of medical graduates has increased consistently over time, the number of nurse graduates has been decreasing since 2009.

## The health system is doing more with less

The recent development of the Portuguese health system suggests that improvements have been made in terms of providing value for money. In particular, health gains and increased activity in the NHS were obtained without extra resources, indicating both an improvement in value for money as well as the existence of large inefficiencies in the system. Following the EAP, the health system became cheaper (due to reductions in spending) and more productive (due to increased working hours and contracting with institutions). However, it is expected that future productivity gains will most likely not lead to significantly decreased spending, as there tend to be fewer opportunities for waste reduction.

## Provider payment mechanisms are being used to drive efficiency

Although Portugal is characterised by low health spending, it performs well on amenable mortality (Figure 15), implying that resources are generally being used cost-effectively (even though on this metric it is not possible to disentangle the influence of health behaviours and other health system factors). Changes to the payment mechanisms for providers is one way to influence health system efficiency in Portugal. Performance-related pay is currently being implemented in primary care and prospective budgets are being used for hospital care. In both cases, the way providers are paid will foster efficiency by rewarding targeted activities. For example, there are incentives for primary care providers to monitor certain groups of the population (e.g. women of reproductive age, pregnant women and diabetes patients, among others); to coordinate care, and to undertake additional activities such as smoking cessation programmes.

## Reforms are also targeting the pharmaceutical sector to enhance value for money

Various changes to pharmaceutical policies reflect evidence-based strategies to contain costs and maintain quality. These include changes to the reference price system and several waves of administrative price reductions (in 2005, 2007 and 2010). Changes have also been made to pharmaceutical co-payment rules and levels (2016). Finally there has been an increase in the use of economic evaluation before introducing new products, both in ambulatory care and hospitals (2015).

The National Commission of Pharmaceutical Products was established in 2013 to define a national list of pharmaceutical products and prescription guidelines. These guidelines are now being produced and updated on a regular basis. Portugal is also developing health technology assessment (HTA) and applying it beyond pharmaceutical products. The Ministry of Health launched a new National System for Health Technology (SiNATS) in 2015 and it is charged with carrying out HTA for all public and private institutions that produce, market or use new technologies.

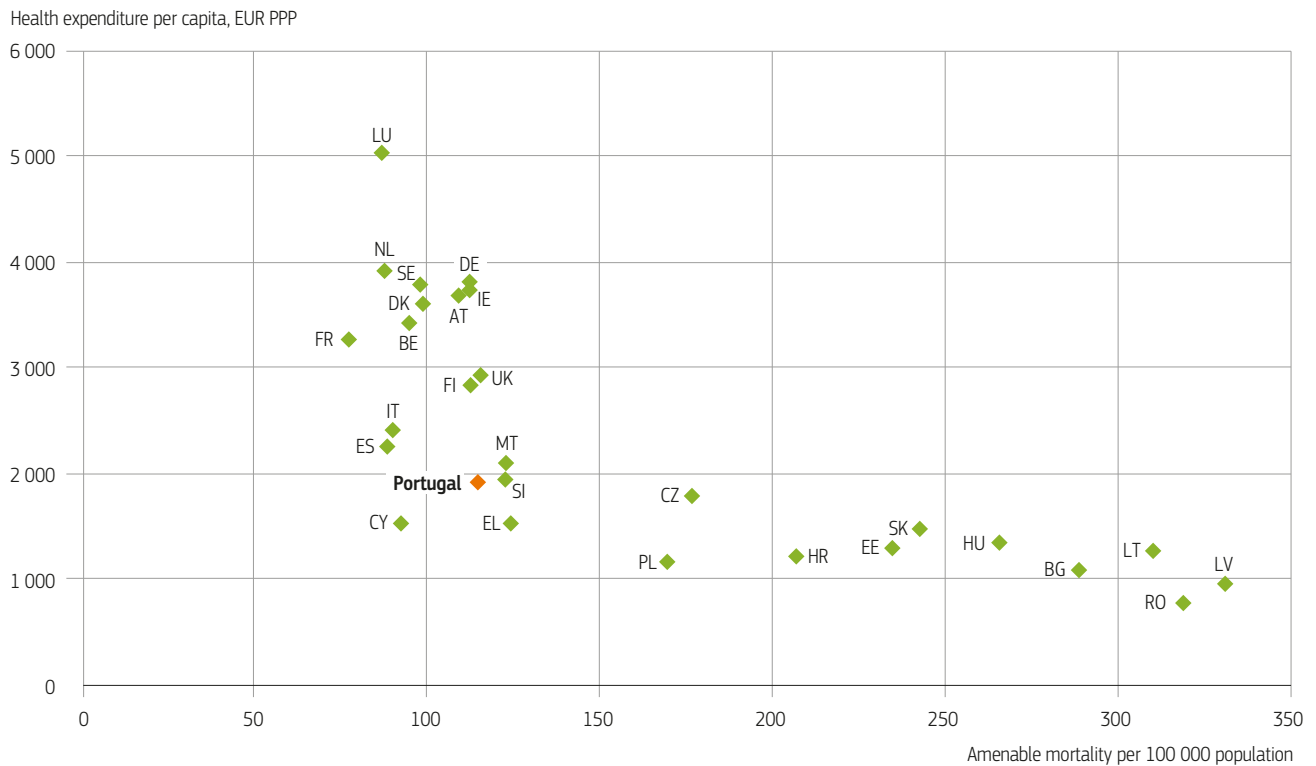
## Resource allocation is shifting to a needs-based model

The way health resources are distributed in Portugal is moving away from historically based allocation of funds towards an approach that is closer to needs-based allocation. Regional contracting agencies within RHAs identify the health needs of geographically defined populations and prospectively negotiate activity programmes and budgets with the provider institutions. This is the case for primary care, especially since 2012. Hospital care is moving towards a contract-based approach, where explicit targets for 'production' are set and the corresponding payment is specified.

## New measures have been implemented to enhance transparency

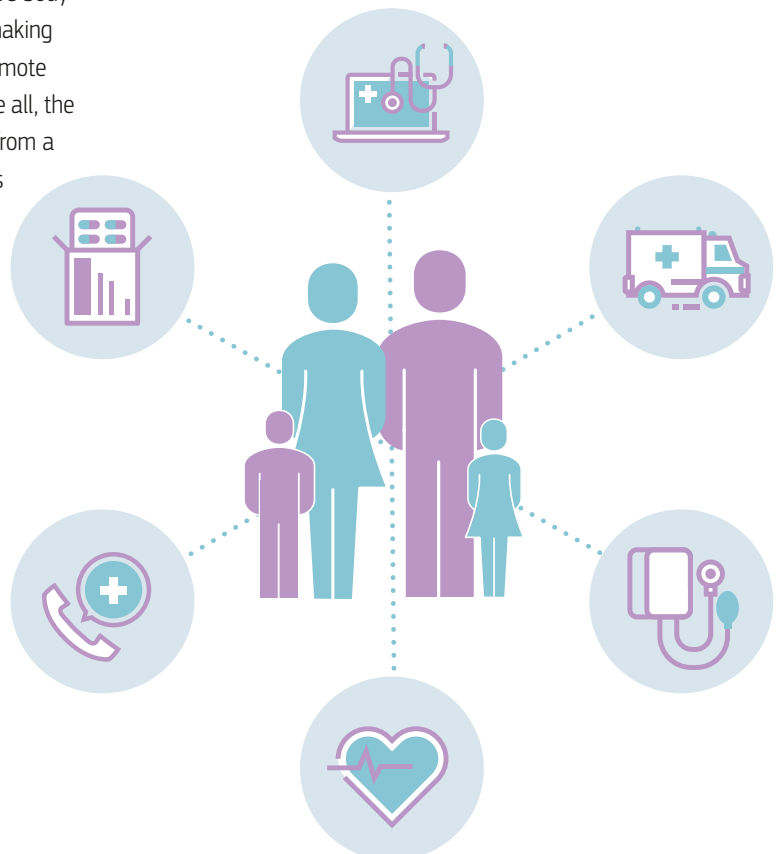
Portugal has been formally committed to public participation and patient empowerment for decades but with little practical impact. Two recent government decisions seem to suggest a new intent to achieve these goals: the National Health Council (which was established legally over 25 years ago but never put to work) has been 'activated' and an NHS portal ([www.sns.gov.pt](http://www.sns.gov.pt)) has been launched.



**Figure 15. Portugal has low levels of amenable mortality with a low level of health spending**

Source: OECD Health Statistics, Eurostat Database, WHO Global Health Expenditure Database (data refer to 2014).

The National Health Council is an independent consultative body and aims to ensure NHS users participate in the policy-making process. It works at arm's length from the Ministry to promote system transparency and accountability to society. Above all, the Council seeks a broad consensus around health policies from a wide range of stakeholders. The new NHS Portal provides detailed information about how NHS facilities function, including waiting times for outpatient consultations, emergency services and elective surgery. The new NHS Portal also provides a 'transparency' area, making a wide range of indicators on NHS access, efficiency and quality available in real time.



## 6 Key findings

- Less than half of Portuguese people report that they enjoy good health. However, life expectancy at birth has increased by over four years since 2000 and is higher than the EU average. Mortality rates for the most common causes of death (cardiovascular diseases and certain cancers) have been decreasing, but some unfavourable trends have emerged, such as the increase in number of deaths caused by diabetes.
- Smoking and binge drinking rates are far below the EU averages, but rising rates of obesity and physical inactivity represent one of the main challenges for population health. Efforts to address these risk factors include a new programme for physical activity to promote healthy behaviours and tackle sedentary lifestyles.
- The National Health Service covers the entire population for everything except for dental care, but there are inequities in the access to health care services due to geographical disparities. Out-of-pocket spending comprises 28% of total health care spending, although a range of exemptions is in place to protect vulnerable groups. Co-payment values are typically small, except co-insurance levels for pharmaceuticals, and recent measures have reduced them and extended exemptions.
- Several attempts to improve the integration of primary care have taken place over the last 10 years. However, there is a shortage of GPs – a situation that is likely to worsen in the future, as current GPs start to retire. Motivating and retaining the health workforce, particularly nurses, is a major challenge.
- The economic crisis had a major impact in Portugal, which resulted in the implementation of several policies to rationalise health sector costs, as part of its agreed Economic Adjustment Programme from 2011 to 2014. Measures in the health sector included a reduction in health workers' salaries, cuts to public pharmaceutical expenditure and a price review of private providers. Medical practices were also targeted with the introduction of clinical guidelines.
- While measures were initially successful in reducing costs and increasing efficiency, several challenges remain, including the implementation of effective measures to ensure financial sustainability, while improving underserved fields such as dental care, mental health and palliative care. Recent efforts have targeted changes to provider payment mechanisms, the development of Health Technology Assessment and defining a national list of pharmaceutical products and prescription guidelines.
- New measures also have been implemented to enhance transparency and to focus on public participation and patient empowerment through the establishment of a new NHS Portal, which contains detailed information about the functioning of NHS facilities, and the activation of the National Health Council, to ensure NHS users' participation in the policy-making process.



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## Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Malta	MT	Slovenia	SI
Belgium	BE	Estonia	EE	Ireland	IE	Netherlands	NL	Spain	ES
Bulgaria	BG	Finland	FI	Italy	IT	Poland	PL	Sweden	SE
Croatia	HR	France	FR	Latvia	LV	Portugal	PT	United Kingdom	UK
Cyprus	CY	Germany	DE	Lithuania	LT	Romania	RO		
Czech Republic	CZ	Greece	EL	Luxembourg	LU	Slovak Republic	SK		



# State of Health in the EU

## Country Health Profile 2017

The Country Health Profiles are an important step in the European Commission's two-year *State of Health in the EU* cycle and are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies. This series was co-ordinated by the Commission and produced with the financial assistance of the European Union.

The concise, policy relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU Member State. The aim is to create a means for mutual learning and voluntary exchange that supports the efforts of Member States in their evidence-based policy making.

Each Country Health Profile provides a short synthesis of:

- health status
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

This is the first series of biennial country profiles, published in November 2017. The Commission is complementing the key findings of these country profiles with a Companion Report.

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