

## Overview

In the last thirty years the social and economic conditions of Portugal have seen extraordinary progress. Some areas of health policy, such as immunization policy, primary health care, care for diabetics, have seen significant achievements. At the same time, the Portuguese health care system continues to face numerous challenges: these include for example health inequalities, the high level of private expenditure, a poor coordination between primary and secondary health care.

## Health expenditure and GDP

In 2001 Portugal spent 9.2% of GDP on health care, fairly close to the EU15 average of 8.7%. It is worth noting Portugal is the EU country with the highest public expenditure on pharmaceuticals when calculated as a percentage of GDP. The Portuguese spend 1.4% compared with France (1.2%), or Denmark (0.4%).

## Introduction

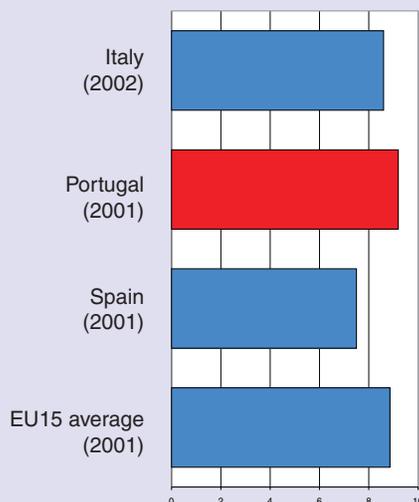
### Government and recent political history

Portugal has been a constitutional, democratic republic since 1974, when a revolution put an end to the 48 year-long dictatorship of the Salazar-Caetano regime. The main state institutions are the president, the parliament, the government and the courts. Both the president and the parliament are elected by direct universal suffrage.

### Population

According to the 2001 census, the total resident population of Portugal was 10.4 million which

**Fig. 1. Total health care expenditure as % of GDP, comparing Portugal, selected countries and EU average**



Source: WHO Regional Office for Europe health for all database.

represents a 4.9% increase over the last decade. One factor which contributed to this increase in population, together with the increase in life expectancy at birth, was the return of more than half a million Portuguese from the Portuguese administered overseas territories of Angola, Mozambique, Guinea-Bissau, Cape Verde, Sao Tome and Principe and Timor following independence in 1974. According to the same census the immigrant population represents 2.2%

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of residents. Another important demographic phenomenon is the migration out of Portugal. It is estimated that between 1960 and 1970 approximately 1 200 000 Portuguese migrated mainly to other European countries.

While in 1970 only 26% of the population lived in urban areas, by 2000 this percentage rose to 65.6%. Since 1960 (24.1 live births per 1000 population) the number of births has been declining steadily. In 2000, the crude birth rate was 11.75 live births per 1000 population, ranking above the European Union 15 average of 10.69.

### **Average life expectancy**

Life expectancy at birth virtually doubled during the twentieth century for women (40.0 years in 1920, 79.7 years in 2000) as well as for men (35.8 years in 1920, 72.6 years in 2000). Although this trend has continued to develop favourably in the past 20 years, life expectancy in Portugal still remains below the European Union 15 average.

### **Leading causes of death**

In 2000 the leading causes of death could be attributed to circulatory system diseases (39%) and cancer (20%). External causes represented 4.5% of all deaths in 2000, predominantly in men (73%). In the same year 29% of deaths caused by external causes were due to motor vehicle accidents. The mortality rate associated with motor vehicle accidents was 20 per 100 000, the highest among EU15 countries in 2000.

### **Recent history of the health care system**

In the 19th and 20th century respectively public health services were introduced, replacing the tradition that health care services were provided by religious charities only. In 1946 the first social security law mandated compulsory contributions shared between employees and employers, and free ambulatory services. At this time the German model of covering the employed population and their dependents through social security and

sickness funds was in place. In 1979 with the establishment of the National Health Service the Portuguese State assumed full responsibility for providing health services that were universal, comprehensive and free of charge.

### **Reform trends**

Since the 1974 revolution, three primary periods of health care reform have been identified:

- 1974–1984: introduction of the National Health Service (NHS)-based health care system
- 1985–1995: NHS regionalization and a new role for the private sector; emphasis on cost containment
- 1996–2001: focus on the balance between the private and public health sectors: a “new public management” approach to NHS reform
- Current reforms (since April 2002): efforts to combine policies of previous governments with new approaches to the role of public, private and social sectors.

### **Organizational structure of the health care system**

The Portuguese health care system is characterized by three co-existing systems of health care coverage: the National Health Service (NHS), special social health insurance schemes for certain professions (health subsystems) and voluntary private health insurance.

The central government, represented by the Ministry of Health, is responsible for developing health policy and managing its implementation in the National Health Service (NHS). The Ministry of Health is made up of four directorates and six institutes.

The regional health administrations (RHAs) are responsible for the regional implementation

of national health policy objectives. Their main responsibilities are the development of strategic guidelines, the coordination of all aspects of health care provision, the supervision of hospitals and health centres, the establishment of agreements and protocols with private bodies, as well as liaison with government bodies, municipal councils, Misericórdias and other private non-profit bodies.

Two decades after the inception of the NHS the historical remnants of the social welfare system persist in the form of health insurance schemes with membership based on a professional or occupational category, and these schemes are known as “subsystems” and cover about 25% of the population. Private health care providers mainly supplement the NHS.

### **Planning, regulation and management**

The boundaries between the main functions of the health care system – planning, regulation, financing and management – overlap, due to the integrated nature of the health provision model, i.e. the government is both the primary provider and payer of care.

Since the NHS does not have its own central administration, most of the planning, regulation and management functions are carried out by the Ministry of Health. The RHAs also play an important role in policy implementation.

### **Decentralization of the health care system**

The Health Law states as one of its underlying principles that the NHS should be managed at regional level.

In practice, however, the responsibility for planning and resource allocation in the Portuguese health care system remains highly centralized even after the establishment of the five RHAs. In theory, the creation of the RHA conferred financial responsibility: each RHA was

to be given a budget from which to provide health care services for a defined population. In practice, however, the RHA autonomy over budget setting and spending has been limited to primary care, since hospital budgets continue to be defined and allocated by the central authority.

Other efforts to decentralize the health system include the attempts to create “regional contracting agencies” and local health units trying to introduce decentralized management at hospital level. Unfortunately, however, most of these projects have never been fully implemented.

## **Health care financing and expenditure**

Like most European systems, the Portuguese health care system is a mix of public and private financing. The NHS, which provides universal coverage, is predominantly funded through general taxation. The health subsystems, which provide either comprehensive or partial health care coverage to about a quarter of the population, are funded mainly through employee and employer contributions. A large proportion of funding is private, mainly in the form of direct payments by the patient and to a lesser extent in the form of premiums paid to private insurance schemes and mutual institutions, which cover respectively 10% and 6.5% of the population.

A number of international studies indicate that overall the theoretically progressive, redistributive income tax system in Portugal turns out to be slightly regressive, reflecting a high share of out-of-pocket payments, along with a heavy reliance on indirect taxes. Indirect taxes on goods and services account for 42.6% of total tax revenue, whereas taxes on income and profits accounts for 28.5% of total tax revenue. These figures show that health expenditure takes a heavy toll on low-income households especially.

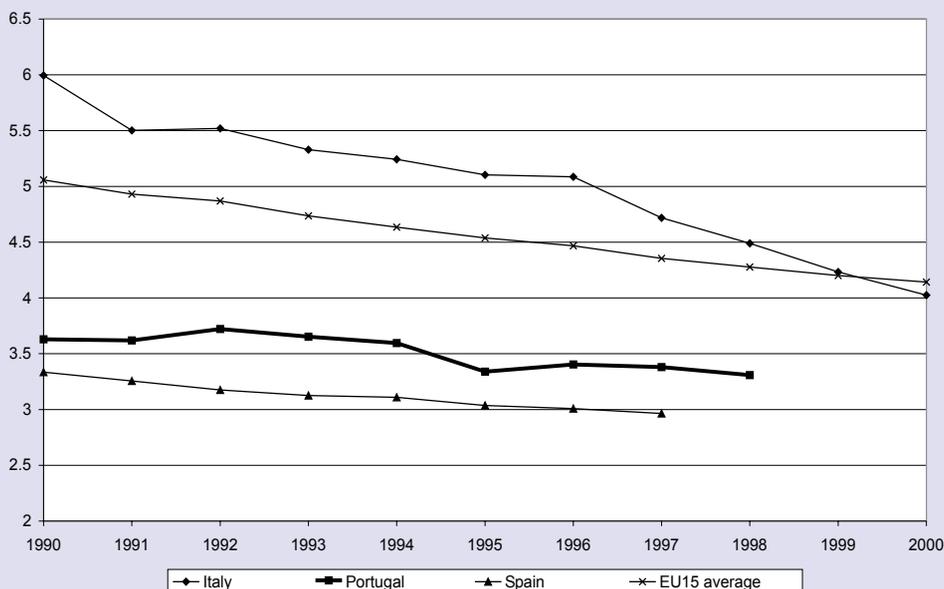
## Health care benefits and rationing

No services are explicitly excluded from NHS coverage. In practice, however, there are some types of care that should be provided by the NHS but are not available (for example, adult dental care). Though there is no rationing per se, there is de facto rationing within the NHS as a result of difficulties of access, the absence of specialists and doctors in rural areas and the lack of certain services. Waiting lists are often viewed as a means of rationing public sector care since they may cause people to opt for the private sector. A national drug formulary lists all active substances and ingredients approved for use in Portuguese NHS hospitals. About 30% of drugs prescribed in hospitals are not included on the formulary. In the ambulatory sector and outpatient departments, doctors are free to prescribe any drug available on the Portuguese drug market; almost all of them are partially or completely reimbursed by the NHS.

## Complementary sources of finance

Approximately 10% of the population is covered by some form of voluntary health insurance (VHI). Most of the times the VHI seems to exist in form of a group insurance provided by the employer. About 7% of the population is covered by mutual funds, which are funded through voluntary contributions. The latter are non-profit organizations that provide limited cover for consultations, drugs and in rare cases some inpatient care. The recent years have seen increasing use of co-payments in health care with the aim of making consumers more cost-aware. As mentioned, out-of-pocket payments have consistently accounted for over 30% of total health expenditure over the last ten years. There are also external funds for health care provided by the European Union 15.

**Fig. 2. Hospital beds in acute hospitals per 1000 population, Portugal, selected countries and EU15 average, 1990–2000**



Source: WHO Regional Office for Europe health for all database.

## Health care expenditure

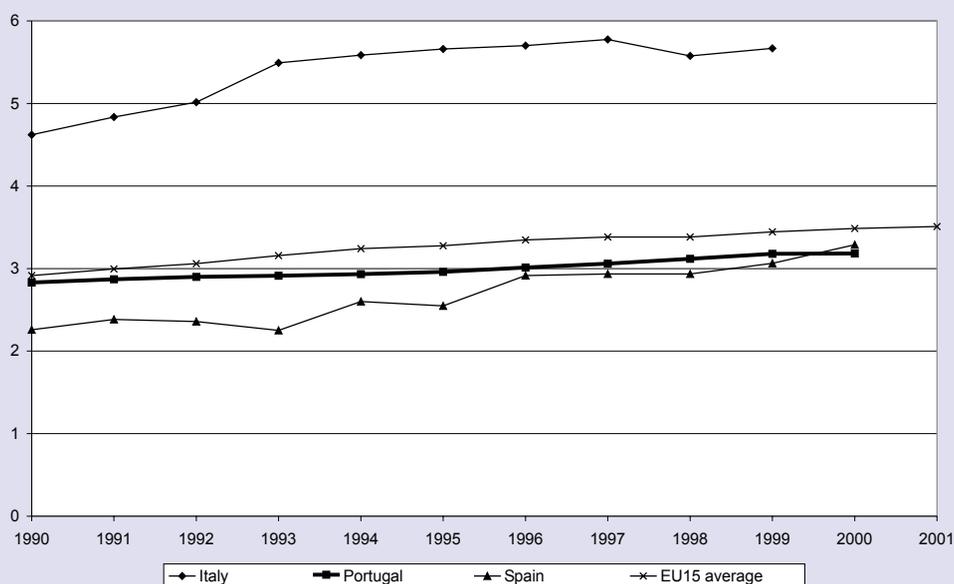
Total health care expenditure in Portugal has risen steadily from as little as 3% in 1970 to 9.2% of GDP in 2001, which was higher than the European Union average of 8.7%. However, expenditure presented as a percentage of GDP is susceptible to fluctuations due to economic growth and does not account for differences in population size. Using US \$ purchasing power parity (PPP) per capita as a measure of health care expenditure the following picture emerges for the year 2000: with US \$1519 PPP spent per capita on health care Portugal fell well below the EU15 average of US \$2123 PPP. The proportion of total health expenditure from public sources accounted for roughly 69% in 2001, compared to Denmark (82%), Italy (74%), and the United Kingdom (81%).

## Health delivery system

### Primary health care (PHC)

Primary health care in Portugal is delivered by a mix of public and private health service providers. Primary health care in the public sector is mostly delivered through publicly funded and managed health centres (HCs). HCs currently have no financial or managerial autonomy and are directly run by the regional health administrations (RHAs), that receive budget allocations from the Ministry of Health. According to international sources, the number of physician contacts per person in Portugal is 3.4 (1998), one of the lowest in the European Region 15, with only Sweden and Turkey having fewer contacts, 2.8 and 2.0 respectively.

Fig. 3. Physicians per 1000 population, Portugal, selected countries and EU15 average, 1990–2000



Source: WHO Regional Office for Europe health for all database.

## Public health services

On the national level the organization of public health services is the responsibility of the General Directorate of Health. The public health services in Portugal are responsible for the surveillance of the population's health status as well as the identification of its determinants. Public health services are also responsible for health promotion and disease prevention at community level and for the evaluation of the impact of health promotion and disease prevention activities.

Some of the health education initiatives are run as vertical programmes by separate bodies within the Ministry of Health, for example, the National Prevention Council against Tobacco Consumption or the National Committee on AIDS. The National Institute for Drug Dependency, mainly concerned with research activities on drug and alcohol dependency, was recently merged with the coordinating structure for drug addiction treatment and prevention (SPTT) within the Ministry of Health. In 2001, the measles immunization rate was 87%. Immunization rates for other diseases in 1999 were: tuberculosis 88.0%, diphtheria 97.0%, poliomyelitis 96.0%.

## Secondary and tertiary care

Secondary and tertiary care is mainly provided in hospitals, although some health centres still employ specialists who provide specialist ambulatory services. In 1999, Portugal had 205 hospitals, 110 public (NHS) and 84 private. Almost half of the private hospitals belong to for-profit organizations. Non-clinical services such as maintenance, security, catering, laundry and incineration have for some time been outsourced to the private sector. Also, diagnostic and therapeutic services in the ambulatory sector are mainly provided by the private sector.

Trends in hospital numbers have been similar to those in other European countries. There has been a significant decrease in the number of hospitals over the last 30 years, from 634 in 1970 to 205 in 1999 (a reduction of 67%).

There is an uneven distribution of resources between the regions, Alentejo and Algarve being the most disadvantaged ones. For example, Algarve not only has the lowest number of total beds, but also has the lowest number of beds per capita. The Lisbon and Vale do Tejo region has the highest proportion of total hospital beds (over 35%).

## Social and community care

There is very little state provision of community care services in Portugal. The latter includes for example long term care, day centres and social services for the chronically ill, the elderly and other groups with special needs such as the mentally ill and the mentally and physically disabled. There is a traditional reliance on the family as the first line of care in Portugal, particularly in rural areas. However, demographic changes such as an increase in female employment and a breakdown of extended family structures due to migration to urban centres mean that many people are no longer able to rely on such informal care. As in many other European countries, Portugal's elderly population is growing and so is the pressure to provide appropriate social as well as medical care.

## Human resources and training

There has been a significant increase in the size of the health care services labour force, from 2% of the total workforce at the end of 1974 to 2.7% in 1998. In 1999 the Ministry of Health was the second largest employer in the public sector, with 115 590 employees, 19% of the total public workforce.

According to data of the Portuguese Medical Association in 1998, 31 758 medical doctors were registered. Data from the General Directorate of Health showed that 23 158 of these were employed by the NHS, the majority in secondary and tertiary care. General practitioners/family doctors, those specialized in family medicine, accounted for 29.5% of the total number of doctors in the NHS; 42.5% were hospital doctors

and 2% were public health doctors. In 2000, there were 3.2 physicians per 1000 population, which was lower than the European Union 15 average of 3.9.

Portugal has steadily increased the ratio of nurses to inhabitants, but has one of the lowest ratios in Europe. The number of dentists also remains low, at 0.43 per 1000 inhabitants in 2000. The number of pharmacists in Portugal is also low compared to other southern European countries, with a ratio approximately half of that of Spain and Italy respectively.

### **Pharmaceuticals and health care technology assessment**

Since 1990 several legislative changes have resulted from the implementation of European Union directives to guarantee the quality and safety of pharmaceuticals. The National Institute of Pharmaceuticals and Medicines (INFARMED) was established in 1993 and is responsible for approving all drugs to be reimbursed by the NHS and for setting co-payment levels. Since 1994, its authority has been widened to cover not only pharmaceuticals, but also medical equipment and other medical products.

Portugal does not have a tradition of technology assessment. In 1995, new legislation lifted the restrictions on CT and MRI scanners. A National List of Health Equipment was drawn up and published in 1998, detailing the distribution of specific items of equipment and services throughout Portugal. It was not primarily intended as a tool for determining the distribution of equipment, but it enables planners and hospitals to identify areas where there are gaps in service provision.

### **Financial resource allocation**

The NHS budget is set annually by the Ministry of Finance, based on historical spending and

the plans put forward by the Ministry of Health, within an overall framework of political priority setting across the different sectors. The Ministry of Health allocates a budget to each regional health administration (RHA) for the provision of health care to a geographically defined population.

### **Payment of hospitals**

Hospital budgets are drawn up and allocated by the Ministry of Health through the Institute of Financial Management and Informatics. At present, public hospitals are allocated global budgets that are partly case-mix adjusted. Traditionally, budgets had been based on the previous year's funding updated for inflation, but since 1997, a growing portion is based on diagnosis-related groups (DRG) information as well as on non-adjusted outpatient volume.

### **Payment of health centres (HCs)**

HCs do not have financial or administrative autonomy. The Ministry of Health allocates funds to the RHA, which in turn funds the global activity of each health centre through the sub-regional coordination level. The HC only receives a small budget for rent, utilities, etc. based on historical costs. All other costs are directly paid by the sub-regional coordination level. This means there is no global cost control.

### **Health care reforms**

The reform agenda since 2002 aims to improve access to health care, management of hospitals, the strengthening of Public Private Partnership initiatives and primary health care.

Measures were taken to reduce the surgical waiting lists. A more intense use of private and social services was promoted. In January 2003, approximately 30% of Portuguese hospitals (34 former NHS hospitals out of 114) were converted into "hospital-companies".

The Ministry of Health has announced that 10 new hospitals to be constructed over the next few years will become PPPs, with private investment, public financing and private management and public ownership.

The Ministry of Health has been very active in the area of drug policy. Strong emphasis has been placed on prescribing generic drugs, coupled with reference pricing and the international common designation.

In the primary health care sector the government has adopted new legislation on the organization of health centres, including the possibility to manage them with the help of professional cooperatives, the private for-profit sector, or the social non-profit sector. GPs' organizations as well as medical unions and associations have expressed strong opposition to this reform.

## Conclusions

In the early 1970s, Portugal was one of the first European countries to adopt an integrated approach in primary health care through the development of an impressive health centre network. The latter has been responsible for some significant advances in health status: for example in the late 1960s, the Portuguese infant mortality rate was in the 60 per 1000 range, by far the highest among the up to 1 May 2004 15 European Union countries. Thirty years later (2001) it was 5.0 per 1000 representing a better ratio than Greece, Holland, Ireland, Luxembourg and the United Kingdom showed and equal to Belgium, ranking ninth in the EU.

Despite the remarkable achievements in health policy, numerous challenges remain: in comparison to other OECD countries, expenditure of the Portuguese health care sector is characterized by a high level of resources relative to the GDP, a low level of public per capita expenditure and high levels of pharmaceutical expenditure. Especially when comparing Portugal with other NHS based systems the very high level of private expenditure needs to be mentioned. It has also been shown that the system's performance regarding the equity, efficiency, accountability and responsiveness objectives is limited. Many health care reforms have been legislated, but so far never completely implemented.

A trend toward increased diversity in health care delivery organizations can be seen in Portugal as well as in many other European countries. New forms of public management and public-private partnerships emerge, aiming to increase accountability and cost containment in the health sector. Whether there will be an acceptable balance between this diversification and the country's regulatory and governance capacity to ensure the public interest is likely to be a critical issue for the immediate future. The limited and unbalanced human resource structure, reflecting poor long-term resource planning, might represent one of the biggest challenges the Portuguese health sector may have to face in the years ahead. After taking the initial steps in the recent past, there now seems to be good prospects for developing a comprehensive health strategy for Portugal. This process is expected to combine health promotion and protection issues with health service concerns.

**Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available year**

| Country      | Hospital beds per 1000 population | Admissions per 100 population | Average length of stay in days | Occupancy rate (%) |
|--------------|-----------------------------------|-------------------------------|--------------------------------|--------------------|
| Italy        | 3.9 <sup>a</sup>                  | 15.6 <sup>a</sup>             | 6.9 <sup>a</sup>               | 76.0 <sup>a</sup>  |
| Portugal     | 3.3 <sup>d</sup>                  | 11.9 <sup>d</sup>             | 7.3 <sup>d</sup>               | 75.5 <sup>d</sup>  |
| Spain        | 3.0 <sup>e</sup>                  | 11.5 <sup>d</sup>             | 7.5 <sup>d</sup>               | 76.1 <sup>d</sup>  |
| EU15 average | 4.1 <sup>a</sup>                  | 18.1 <sup>c</sup>             | 7.1 <sup>c</sup>               | 77.9 <sup>d</sup>  |

Source: WHO Regional Office for Europe health for all database.

Notes: <sup>a</sup> 2001, <sup>b</sup> 2000, <sup>c</sup> 1999, <sup>d</sup> 1998, <sup>e</sup> 1997.

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The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

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