European Commission

State of Health in the EU

Portugal

Country Health Profile 2019

OECD
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European Observatory on Health Systems and Policies
a partnership hosted by WHO

The Country Health Profile series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The 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 the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Information.

Contents

Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated 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. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: http://www.oecd.org/health/Country-Health-Profiles-2019-Portugal.xls

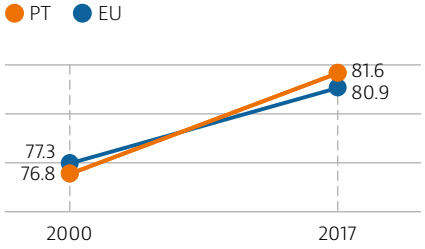
Demographic and socioeconomic context in Portugal, 2017

Demographic factors	Portugal	EU
Population size (mid-year estimates)	10 300 000	511 876 000
Share of population over age 65 (%)	21.1	19.4
Fertility rate[1]	1.4	1.6
Socioeconomic factors		
GDP per capita (EUR PPP[2])	23 000	30 000
Relative poverty rate[3] (%)	18.3	16.9
Unemployment rate (%)	9.0	7.6

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 60 % of median equivalised disposable income.
Source: Eurostat Database.

1 Highlights

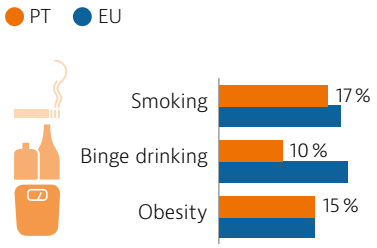
Portugal's tax-funded National Health Service (NHS) provides universal coverage and a broad range of benefits. There is cost-sharing, with out-of-pocket expenditure being higher overall than the EU average, although more than half of the population is exempt. In January 2019, some municipalities took over new competencies in primary care as a first step towards greater decentralisation. Other reforms have focused on improving access to care and tackling shortages in the health workforce.



Life expectancy at birth, years

Health status

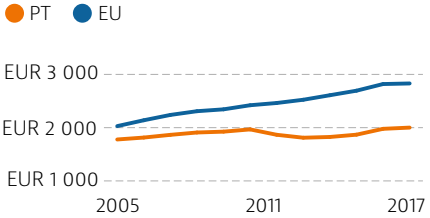
Life expectancy in Portugal has increased continuously since 2000, reaching 81.6 in 2017, which is slightly higher than the EU average. However, inequalities by gender and by socioeconomic status are prevalent, with around a six-year gap between women and men and between those with the highest and lowest levels of education. Mortality from Alzheimer's disease is growing, although stroke and ischaemic heart disease are still the leading causes of death. People live longer but often with chronic diseases and disabilities.



% of adults

Risk factors

More than one third of all deaths in Portugal can be attributed to behavioural factors, mainly poor diet, smoking and excessive alcohol consumption. Although smoking rates have fallen since 2000, one in six adults (17 %) is still a regular smoker. Some 10 % of adults report binge drinking, which is considerably below the EU average (20 %). Adult obesity is around the average across the EU, at 15.4 % in 2017. However, rates among teenagers are growing, with nearly one in five 15-year-olds being overweight or obese in 2013–14.



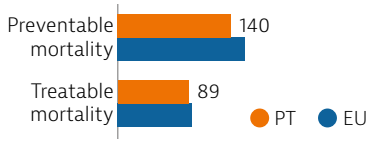
Per capita spending (EUR PPP)

Health system

Although spending has recovered since the economic crisis, in 2017 Portugal spent EUR 2 029 per capita on health care (9 % of GDP), which is about one third less than the EU average (EUR 2 884). Out-of-pocket payments have grown to be the second largest source of revenue, reaching 27.5 % of total health expenditure. As part of efforts to strengthen primary care, the government is taking action to bring more general practitioners (GPs) into the NHS, boost patient registrations with GPs, and give municipalities a greater role in primary care planning and management.

Effectiveness

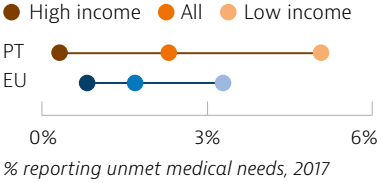
Mortality from both preventable and treatable causes in Portugal are now below the EU averages. Very low avoidable hospitalisation rates indicate the general effectiveness of primary care services.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

Although barriers to accessing primary care have decreased, and self-reported unmet need for medical care also have fallen, out-of-pocket spending remains relatively high.



% reporting unmet medical needs, 2017

Resilience

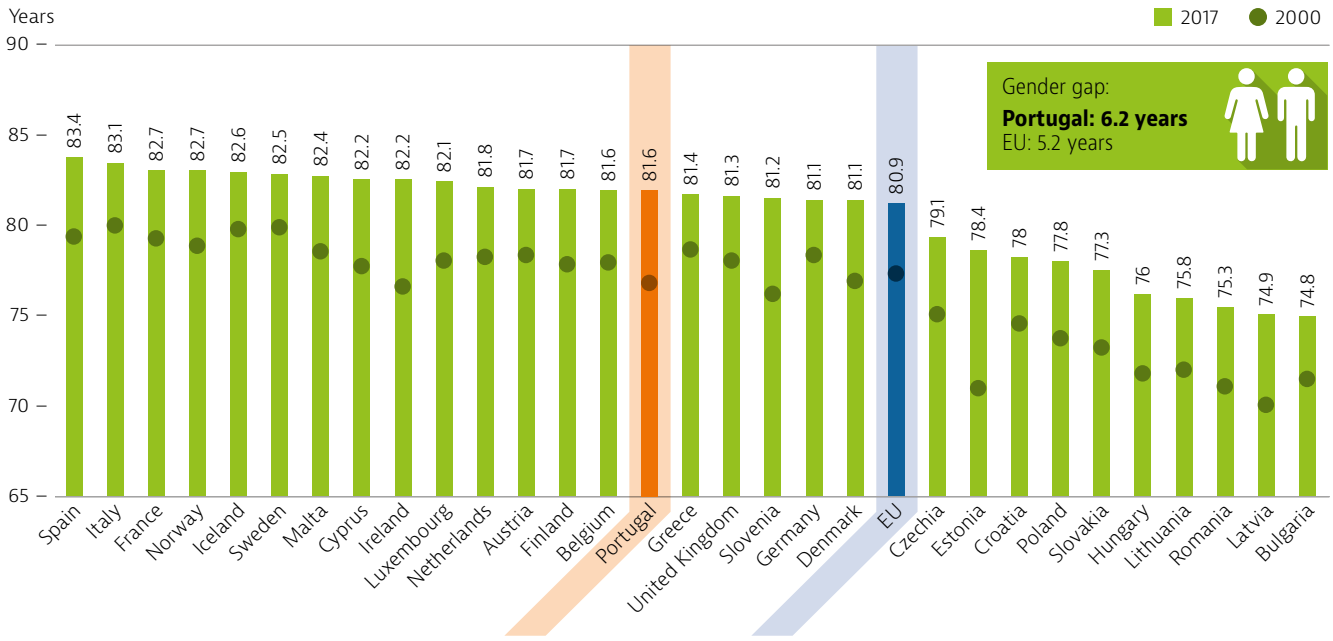
Concerted efforts to boost the efficiency of care delivery have increased value for money in the health system's activity levels. However, public hospitals have accumulated large arrears that persist and undermine the financial sustainability of the NHS.

2 Health in Portugal

Life expectancy has increased over the last decade

Life expectancy in Portugal increased by nearly five years between 2000 and 2017 and is now slightly higher than in the EU as a whole. However, it still lies about two years below the best performing EU countries (Figure 1). While the life expectancy of women in Portugal is well above the EU average, for men it is in line with the average. As in other EU countries, the gender gap in life expectancy is substantial, with women living 6.2 years longer than men in 2017, which is more than the EU average (5.2 years).

Figure 1. Life expectancy in Portugal is higher than the EU average, but the gender gap is large



Source: Eurostat Database.

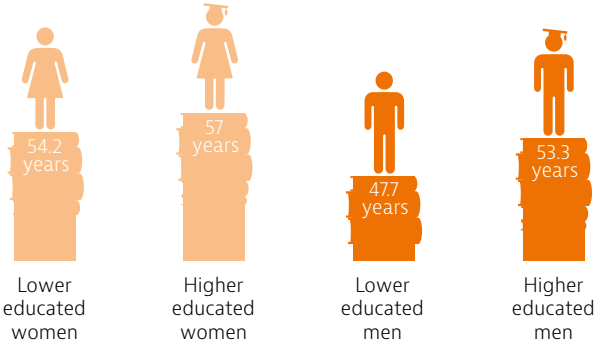
Inequalities in life expectancy follow a socioeconomic gradient

Inequalities in life expectancy exist not only by gender, but also by socioeconomic status. In 2016, the life expectancy of Portuguese men with the lowest level of education at age 30 was approximately five and a half years lower than for those with the highest level of education. For Portuguese women, this education gap was less than three years (Figure 2). Although these differences are less pronounced than the EU averages, the life expectancy gap by education can be explained, at least partly by differences in income that stem from educational background as well as by differences in exposure to various risk factors and lifestyles. Individuals on low incomes in Portugal face a greater challenge in paying for pharmaceuticals and in accessing health services not covered by the NHS, such as dental care. Differences in health literacy may also have an impact, although this is overlaid with issues around access to the internet and the health-related information available online, which may be difficult to access for the older population as well as those with a lower educational level.

Deaths from circulatory diseases are falling, but diabetes mortality is above the EU average

Since 2000, increases in life expectancy in Portugal have been driven mainly by reductions in mortality rates for circulatory diseases, notably stroke and ischaemic heart disease (Figure 3). Nonetheless, these remain as the leading causes of death in Portugal. Mortality rates for diabetes also continue to be very high in Portugal – with a death rate of 38.7 per 100 000 population compared to 22.2 in the EU on average in 2016, although there has been a notable improvement over the last five years. Lung cancer and colorectal cancer are the most frequent causes of cancer death in Portugal, with mortality rates for both having increased since 2000.

Figure 2. Highly educated Portuguese people live 3 to 6 years longer than those with a low level of education



Education gap in life expectancy at age 30:

Portugal: 2.8 years
EU21: 4.1 years

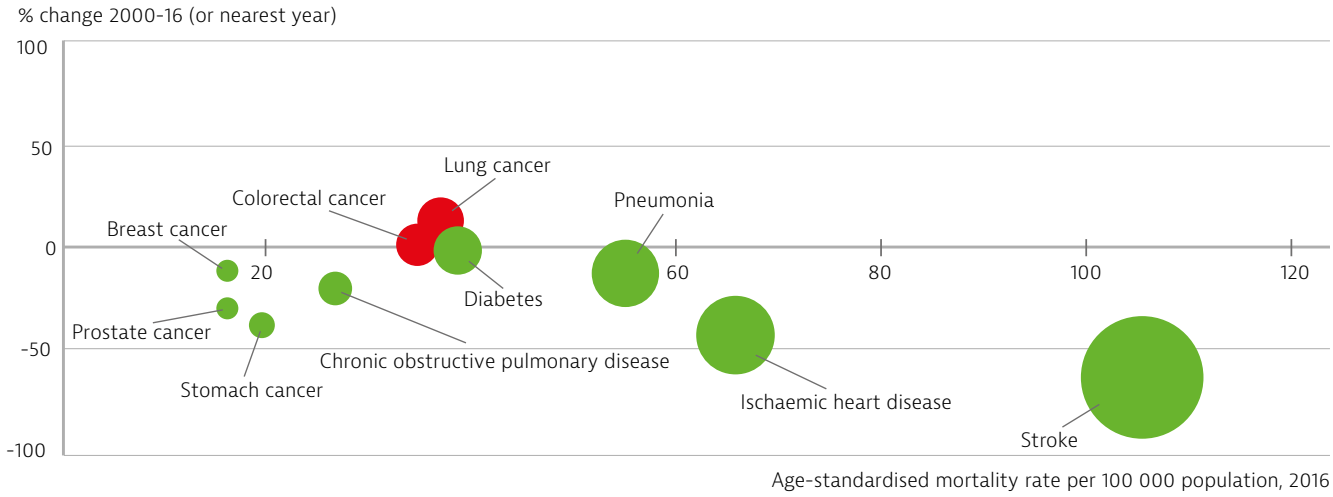
Portugal: 5.6 years
EU21: 7.6 years

Note: Data refer to life expectancy at age 30. High education is defined as people who have completed a tertiary education (ISCED 5-8) whereas low education is defined as people who have not completed their secondary education (ISCED 0-2).
Source: Eurostat Database (data refer to 2016).

There are marked differences in how the rich and the poor feel about their health

Cross-country differences in perceived health status can be difficult to interpret because social and cultural factors affect responses. Nonetheless, more than two thirds of adults in the EU rate their health to be either good or very good. In contrast, less than half of the population in Portugal reports being in good health (Figure 4). As in other countries, disparities in self-reported health across income groups are substantial. About 61 % of Portuguese in the highest income quintile consider themselves to be in good health compared to only about 39 % in the lowest income quintile, far below the EU averages (80.4 % and 61.2 %, respectively).

Figure 3. Although rates are decreasing, circulatory diseases are still the main causes of mortality



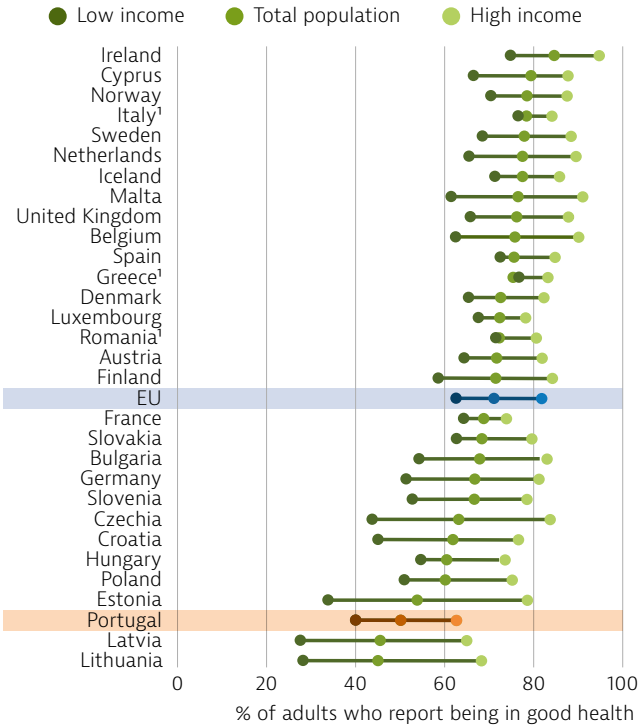
Note: The size of the bubbles is proportional to the mortality rates in 2016.
Source: Eurostat Database.

Most additional years of life are spent with disability

Due to the steep increase in life expectancy in Portugal over the past few decades, the share of people aged 65 and over is growing steadily. In 2017, more than one in five people (21 %) were aged 65 and over, up from one in six (16 %) in 2000 and one in nine (11 %) in 1980. In 2017, Portuguese people at the age of 65 could expect to live another 20 years, the same as in the EU as a whole (Figure 5). However, about 13 out of these 20 years were likely to be lived with some disability.[1] Although the gender gap in life expectancy at age 65 is almost four years in favour of women, men have a higher number of healthy life years because women tend to live a greater proportion of their lives after 65 with health problems.

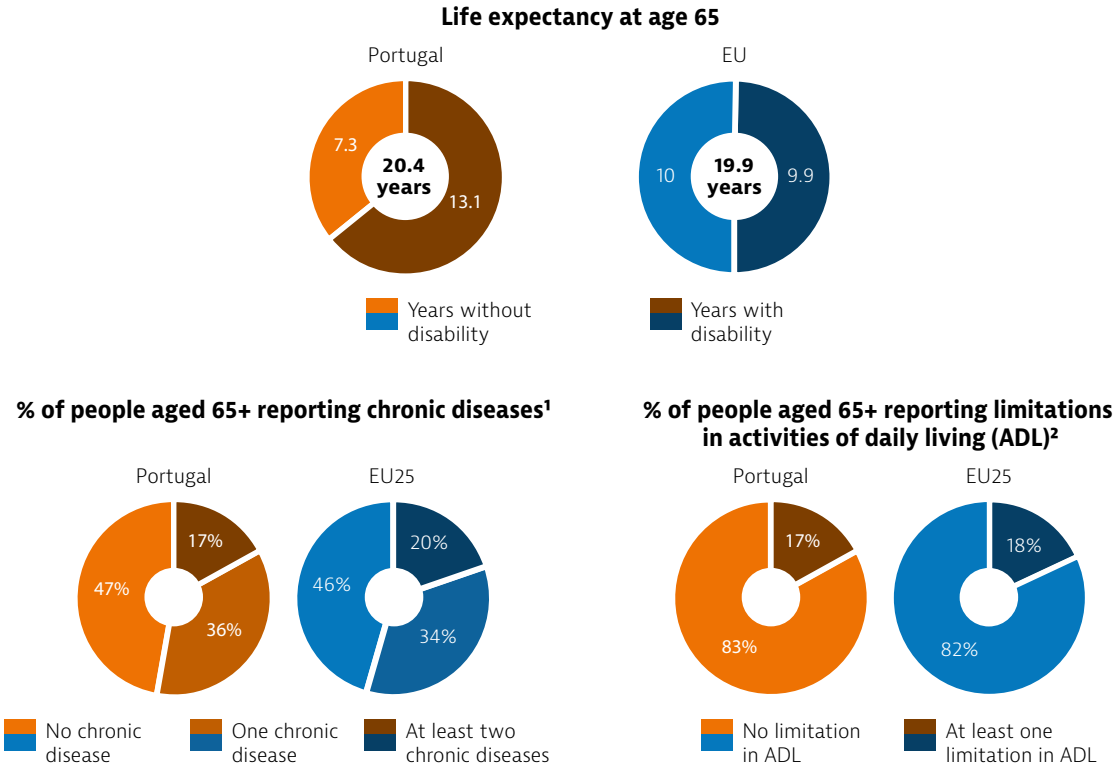
Around half of people aged 65 and over in Portugal (53 %) report having at least one chronic disease, with many of them reporting two or more chronic conditions – a situation similar to the EU average. Some 17 % of the population over 65 report some limitations in basic activities of daily living (ADL), such as dressing and showering, which again is similar to EU levels (Figure 5).

Figure 4. The Portuguese rate their health lower than most other EU citizens



Note: 1. The shares for the total population and the population on low incomes are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2017).

Figure 5. Just over half of people over 65 report having at least one chronic disease



Note: 1. Chronic diseases include heart attack, high blood pressure, high blood cholesterol, stroke, diabetes, Parkinson disease, Alzheimer's disease, rheumatoid arthritis and osteoarthritis. 2. Basic activities of daily living include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet.
Sources: Eurostat Database for life expectancy and healthy life years (data refer to 2017); SHARE survey for other indicators (data refers to 2017).

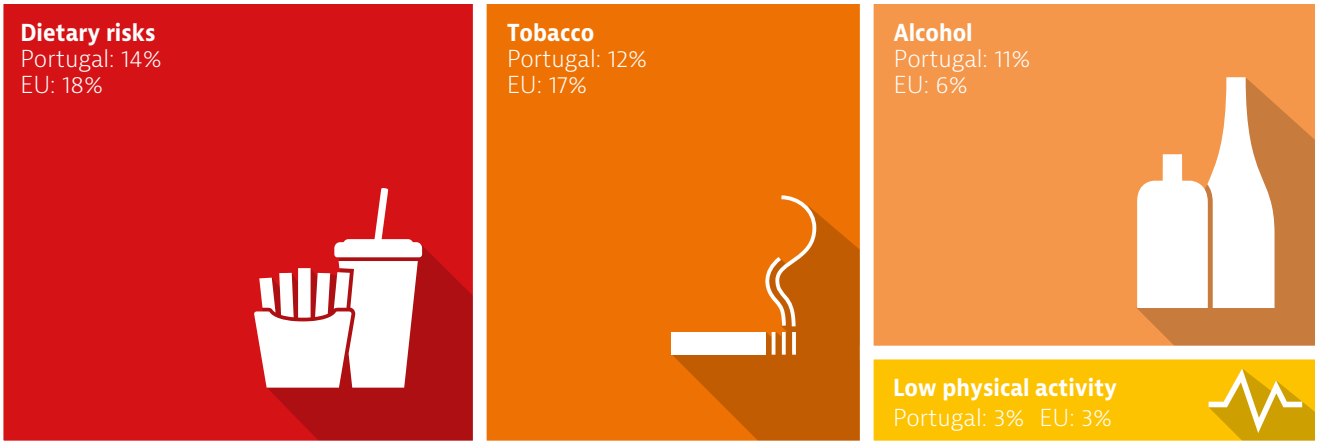
1: These are measured in 'Healthy life years', which are the number of years that people can expect to live free of disability at different ages.

3 Risk factors

Behavioural risk factors have a considerable impact on mortality in Portugal

Despite recent measures to address behavioural risks (see Section 5.1), around one third of all deaths in 2017 can be attributed to behavioural risk factors, compared to around 39 % across the EU (Figure 6). Some 14 % of deaths in Portugal were linked to dietary risks, including low fruit and vegetable intake, and high sugar and salt consumption while tobacco use (both direct and second-hand smoking) was linked to 12 % of all deaths which is below the EU average. In contrast, about 11 % of deaths were associated with alcohol consumption, nearly twice the EU average rate of 6 %.

Figure 6. Around one third of all deaths in Portugal can be attributed to behavioural risk factors



Note: The overall number of deaths related to these risk factors (39 000) is lower than the sum of each taken individually (45 000) because the same death can be attributed to more than one factor. Dietary risks include 14 components, such as low fruit and vegetable consumption and high sugar-sweetened beverage and salt consumption.
Source: IHME (2018), Global Health Data Exchange (estimates refer to 2017).

Smoking rates have declined but alcohol consumption is over the EU average

The proportion of adults who smoke every day has declined from about one in five adults in 2000 (21 %) to one in six in 2014 (17 %), below the EU average of 19.2 % in that year. Recent efforts to support smoking cessation may lead to further decreases (see Section 5.1). In 2015, nearly one fifth of 15-to 16-year-olds in Portugal reported that they had smoked cigarettes in the past month: while this share is lower than in many other EU countries, it remains nonetheless an important public health issue (Figure 7).

Alcohol consumption among adults in Portugal has decreased steadily over the last decade, but at 10.7 litres per person is higher than the EU average of 9.9 litres. However, the number of adults reporting binge drinking[2] is the fifth lowest in the EU (10 % compared to a 20 % average in the EU), with rates being much higher in men (18 %) than women (3 %). Binge drinking among teenagers is among the lowest in the EU, with the rate having stabilised for girls (18.2 % in 2015) and decreased for boys (22 %).

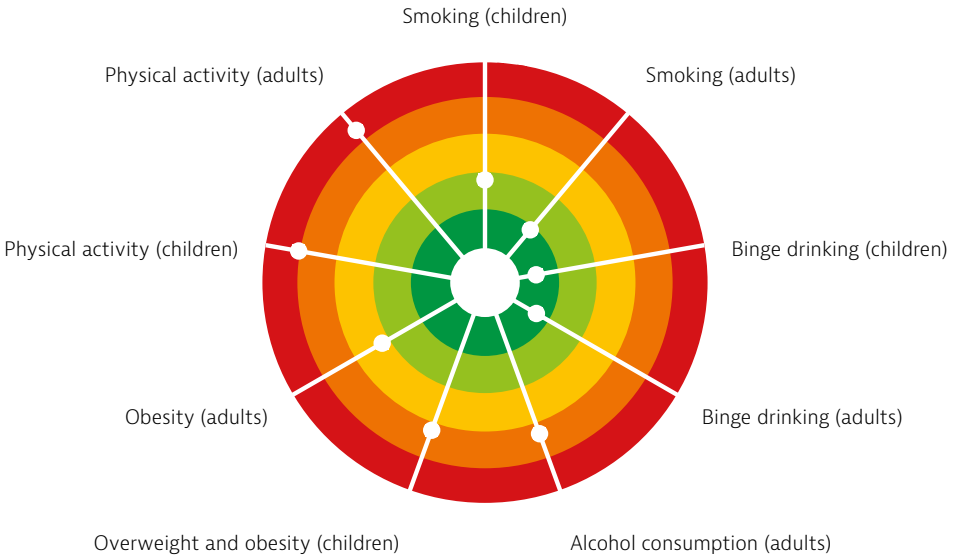
Obesity is an increasingly pressing public health issue across all age groups

Obesity rates among Portuguese adults are around the EU average. Based on self-reported data, 15.4 % of adults were obese in 2017[3], compared to the EU average of 14.9 %. Overweight and obesity rates among adolescents have increased in Portugal over the last two decades and nearly one in five 15-year-olds were overweight or obese in 2013–14, a greater proportion than in most other EU countries. Recent measures to promote healthy eating are aimed at tackling this trend (Section 5.1).

One factor contributing to these levels of obesity is low physical activity. In 2014, only 57 % of Portuguese adults reported engaging in at least moderate weekly physical exercise, a lower proportion than in most other EU countries (EU average is 64 %). The proportion of Portuguese teenagers who report exercising daily is also relatively low. This is particularly the case among teenage girls: only 5 % of 15-year-old girls in Portugal reported doing at least moderate physical activity every day in 2013–14. The proportion was much higher among 15-year-old boys (18 %).

2: Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more alcohol drinks for children.
3: Based on data measuring the actual weight and height of people, the obesity rate among adults is much higher - 29 % in 2015.

Figure 7. Lack of physical activity is worrying given increases in overweight and obesity rates



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 ESPAD survey 2015 and HBSC survey 2013–14 for children indicators; and EU-SILC 2017, EHIS 2014 and OECD Health Statistics 2019 for adults' indicators.

Obesity, unlike many other risk behaviours, is strongly linked to income

People with lower education or income tend to be more exposed to behavioural risk factors, but only obesity shows really striking inequalities in Portugal. In 2017, almost one fifth (18 %) of people without a secondary education were obese, compared to only 9 % among those with a higher education. In contrast, more than one in six adults (17 %) in the lowest income quintile smoked daily (in 2014), but this only fell to 15 % among those in the highest income quintile, suggesting a cultural acceptance of smoking across all income groups.

4 The health system

The National Health Service has a regional structure and is financed mainly by general tax

Portugal's NHS is a universal tax-financed system covering all residents, regardless of their socioeconomic, employment or legal status. Irregular migrants have been entitled to state health services since 2001, although in practice they experience some barriers to accessing care (see Section 2). The Ministry of Health concentrates most planning and regulation centrally, while the five regional health administrations manage the NHS at the local level. The NHS also coexists with 'health subsystems' - special health insurance schemes that provide coverage for particular professions or sectors, either in the public or private sector (e.g. the scheme for civil servants and the banking sector respectively). Over the last decade, the Portuguese health system has undergone important reforms (Box 1).

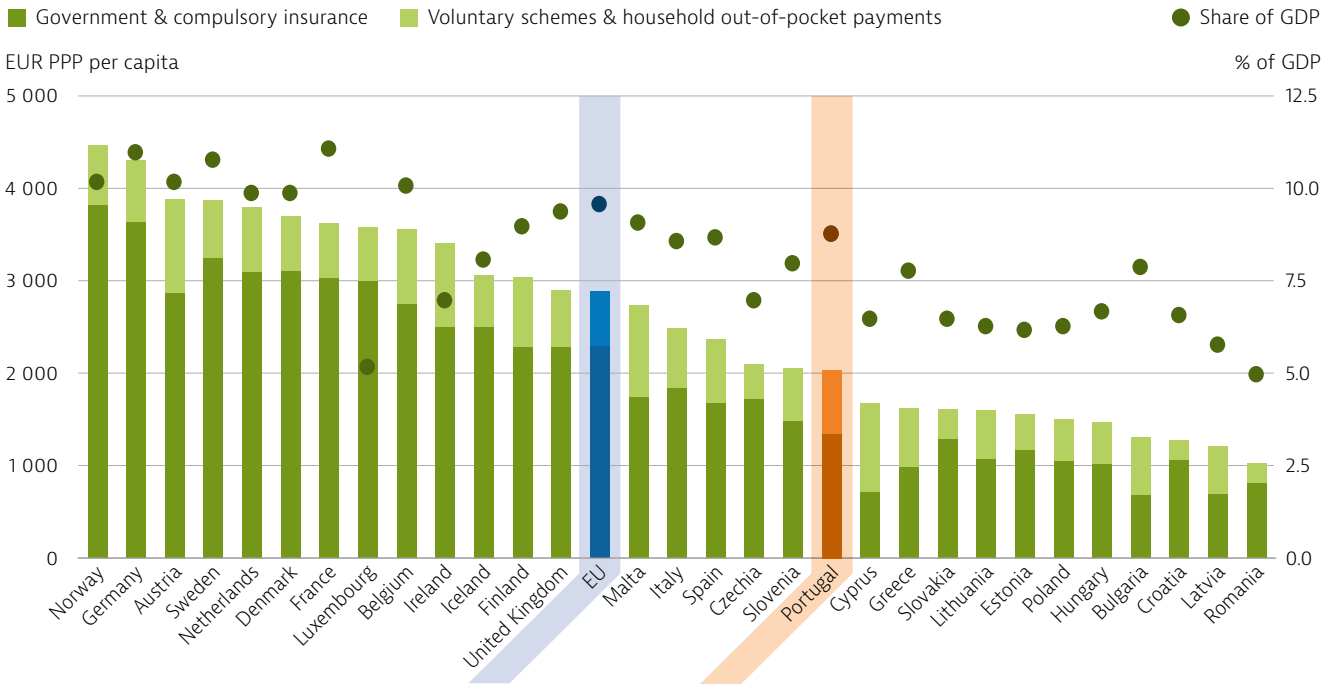
After several years, the negative trend in health spending has turned around

The EAP required fiscal consolidation measures which led to a decrease in total health expenditure. Between 2010 and 2017, health spending decreased as a share of GDP by nearly one percentage point, while government spending on health decreased by around 3 percentage points (from 69.8 % to 66.4 %). Portugal now spends EUR 2 029 per capita on health care (adjusted for differences in purchasing power), which is 30 % below the EU average of EUR 2 884 (Figure 8).

Box 1. Portugal has pursued a wide range of reforms over the last decade

Portugal's Economic Adjustment Programme (EAP) and a EUR 78 billion international loan agreement, put in place between 2011 and 2014, responded to the economic recession and prompted health sector reforms. The EAP measures included reducing pharmaceutical spending, cutting the salaries of health professionals and increasing co-payments. The EAP also gave new impetus to reforms that had stagnated during the economic downturn. These included a primary care reform to expand enrolment in GP patient lists and to create Family Health Units, although in practice few opened because of budgetary constraints. In January 2019, municipalities took over new competencies in primary care planning and management as a step towards further decentralisation. Other recent reforms have focused on strengthening public health interventions (Section 5.1).

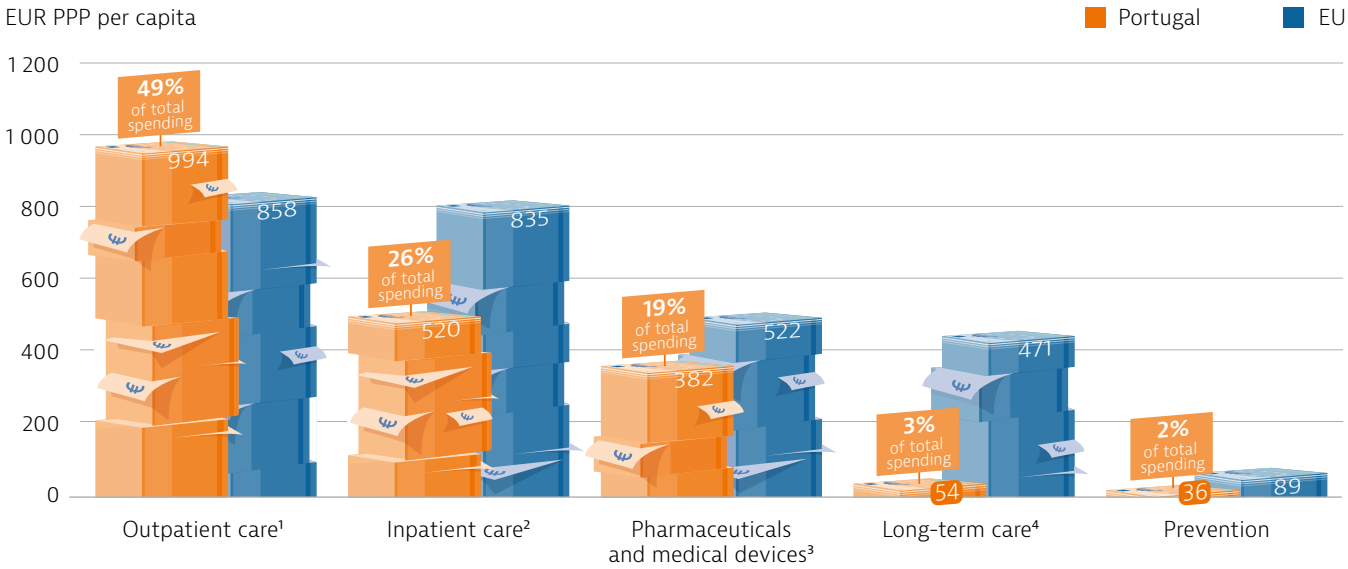
Figure 8. Health spending per person is increasing, but remains below the EU average



Source: OECD Health Statistics 2019 (data refer to 2017).

The largest share of health care spending in Portugal is on outpatient care, and at EUR 994 per person in 2017 it was well above the EU average (EUR 858) (Figure 9). In contrast, expenditure on inpatient care (EUR 520) and pharmaceutical care (EUR 382) were considerably below the EU averages (EUR 835 and EUR 522, respectively). This reflects concerted efforts made over the last few years to increase health system efficiency and contain costs. Portugal also spends less than many other European countries on preventive care with some EUR 36 per person (1.8 % of total health spending compared to 3.2 % in the EU) spent in 2017.

Figure 9. Portugal spends almost half of its health budget on outpatient care



Notes: Administration costs are not included. 1. Includes home care; 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component.
Sources: OECD Health Statistics 2019; Eurostat Database (data refer to 2017).

The Portuguese health system has high out-of-pocket spending

In 2017, the public share of health expenditure was 66.3 % of total health financing, considerably lower than the EU average of 79.3 %. This partly reflects the decrease in public health sector funding during the EAP. OOP spending has grown by just over three percentage points since 2010 and is the second largest source of health system revenue at 27.5 %, well above the EU average of 15.8 %. Private Voluntary Health Insurance (VHI) in Portugal has a supplementary role and accounts for just 5.2 % of health financing. It facilitates access to private hospital treatment and ambulatory consultations.

Recent legislation has abolished user charges

Until recently, most services, including emergency care, GP visits and consultations with specialists required the payment of flat-rate user charges, varying according to the service, in addition to co-payments that are also levied on services. There were always exemptions to these user charges, and in 2016, the criteria were expanded so that 6.1 million NHS users (roughly 60 % of the population were exempted from paying them. Most recently, legislation introduced in September 2019 has abolished user charges for primary care and for all health care prescribed within the NHS (Section 5.2).

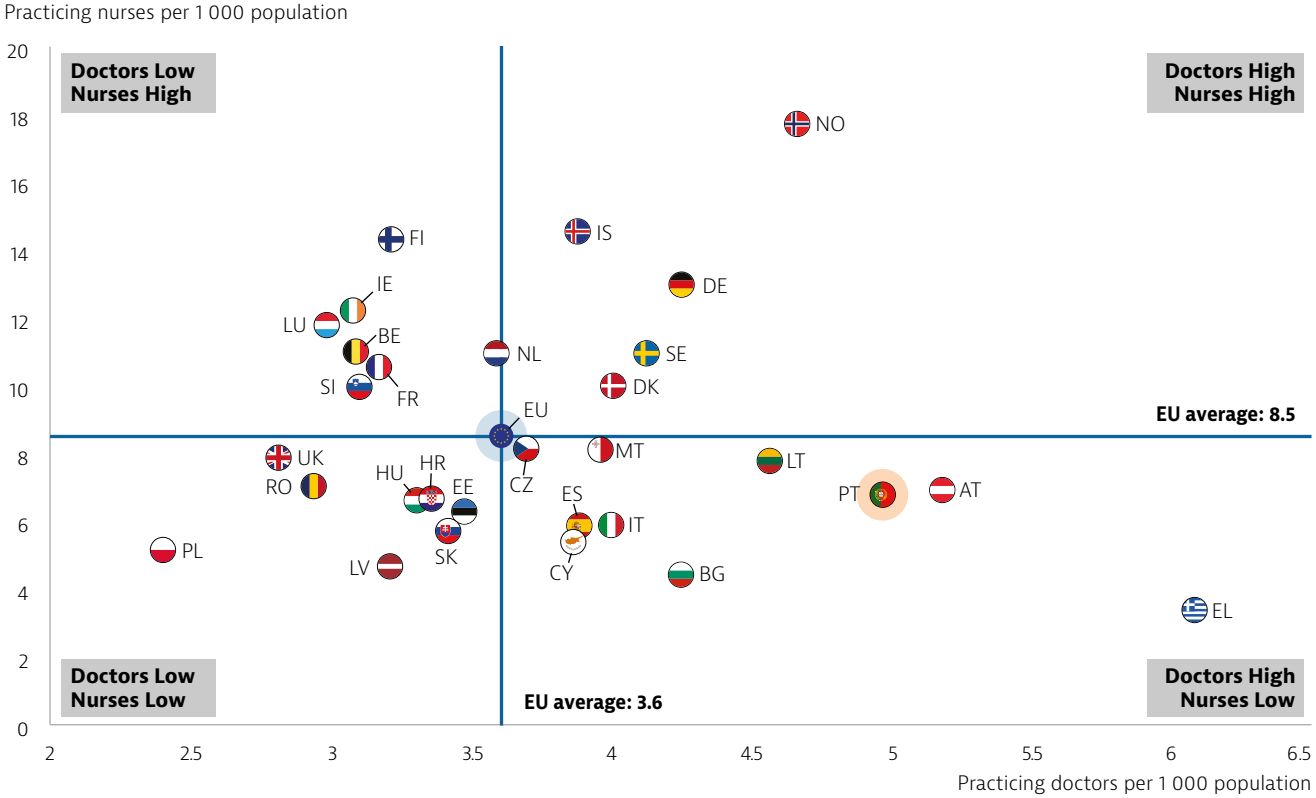
Doctor and nurse numbers have risen and efforts are focussed on recruiting general practitioners

The number of doctors and nurses in Portugal has increased steadily since 2000, with the number of licensed doctors reaching 5 per 1 000 inhabitants in 2017. This figure appears high compared to the EU average of 3.6, but includes all licensed doctors, even those who no longer practise (Figure 10). The nursing workforce (6.7 per 1 000) is below the EU average (8.4), despite numbers rising over the last decade. In 2016, an initiative to increase the number of NHS GPs was launched, linked to efforts to increase the number of people enrolled on a GP patient list (Section 5.2). At the start of the initiative 1.2 million NHS users (11.6 % of the population) were not registered with a GP and this has fallen to 600 000 in early 2019 (5.8 %).

The number of hospital beds has decreased over time, particularly for mental health care

The number of beds per 1 000 population is relatively low (3.4) compared to the EU average (5.1). The total number of inpatient hospital beds has declined in the last decade, partly due to an increase in day surgery and the strengthening of the long-term care network. Promoting mental health patients' integration into communities has also helped to reduce the number of psychiatric beds. Older infrastructure is being improved incrementally: primary care units have been renovated and the construction of four new hospitals is envisaged. There remain some geographical gaps in care provision, with specialists and ambulatory specialist care concentrated in the main cities (Section 5.2).

Figure 10. Portugal has a relatively high number of doctors but few nurses



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: Eurostat Database (data refer to 2017 or the nearest year).

A mix of public and private providers deliver primary care

Primary care is provided by both the public and private sectors. Providers include NHS primary care units, private sector clinics (both for profit and not-for-profit) and group practices in private offices. Dental consultations, diagnostic services, haemodialysis and rehabilitation are most commonly provided by the private sector. Private providers are mostly concentrated in the Great Lisbon and Porto metropolitan areas as well as along the coast between those two cities, with the population in rural and interior areas having more limited access to GPs (Section 5.2).

The Portuguese NHS has initiated a process to support integrated care

The vertical integration of different levels of health care has been promoted since 1999 by local health units (*Unidades Locais de Saúde*), which allow the integration of hospitals and primary health care units within a single provider organisation. GPs are also expected to support integration and to act as gatekeepers. Further integration can be seen at hospital level, with the creation of 'Hospital Centres', i.e., hospital networks comprising institutions within the same geographic area. Other examples include Family Health Units (established in 2007), which are staffed by multi-professional teams (Box 2, Section 5.3) and NHS home hospitalisation initiatives which have been encouraged since 2017. These integrated responses aim to ensure a safe and adequate response to acute illness and continuity across primary care and the national network for long-term care.

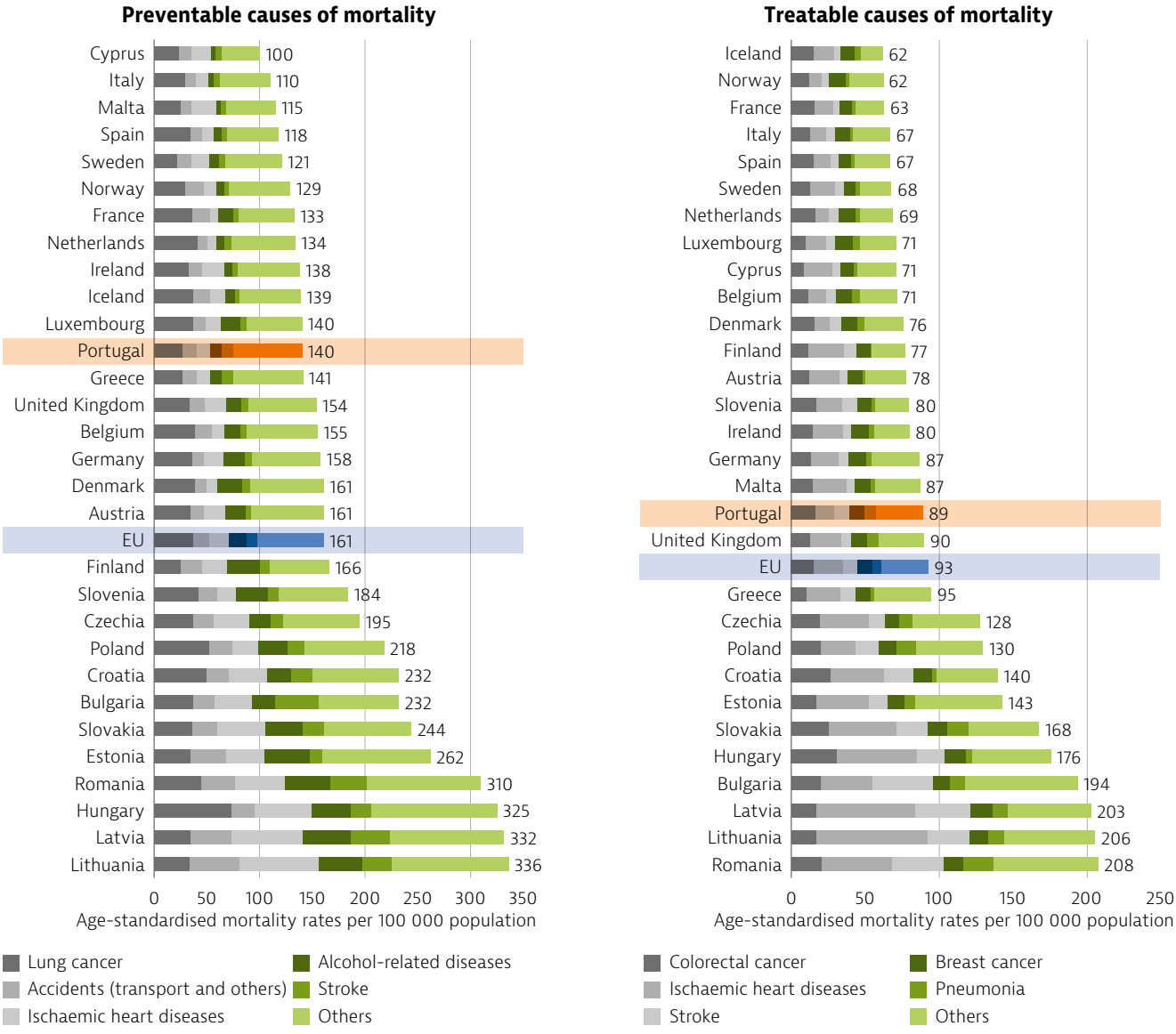
5 Performance of the health system

5.1. Effectiveness

Preventive services have been effective and are now being brought closer to local communities

Portugal reports a lower rate of preventable mortality than the EU average (Figure 11), with 140 per 100 000 population in 2016, down from 149 in 2011. This result reflects government efforts to improve preventive services. In January 2019, the government decentralised some competencies to the municipal level. Local health councils are expected to have a primary role in defining local health policy, developing responsive health promotion programmes and promoting cooperation between all relevant bodies.

Figure 11. Portugal performs better than the EU average on preventable and treatable causes of mortality



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2016).

Notwithstanding the voluntary nature of vaccinations, Portugal has achieved high immunisation rates

Immunisation levels are very high in Portugal (Figure 12) despite the fact that vaccinations are not mandatory. In 2018, child vaccination coverage rates for diphtheria, tetanus and pertussis (DTP) and measles reached 99 %, substantially above the EU average and even surpassing the WHO target of 95 %. Influenza vaccination for older people is also above the EU average (61 %) but remains below the WHO target (75 %). These positive results are linked to ease of access: vaccines included in the national programme are free for all NHS users; the influenza vaccine is free for people over 65 and other at risk groups; and vaccinations are readily available in local primary care units. They also reflect active annual outreach and media campaigns that encourage uptake and address anti-vaccination messages (Rechel, Richardson & McKee, 2018).

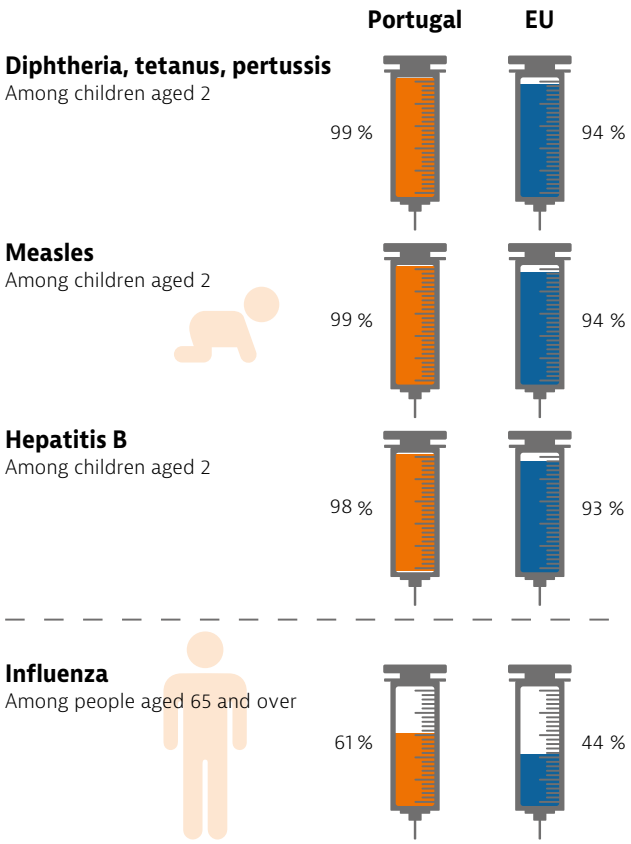
The National Immunisation Programme is regularly reviewed and updated rapidly with new or new combinations of vaccines introduced as health threats emerge. The vaccine against human papillomavirus (HPV) is a good example: introduced in 2008, the vaccine has achieved immunisation rates between 85 % and 93 % in girls aged 9 to 13.

Existing measures to tackle tobacco consumption and obesity are being strengthened

Tobacco control measures were introduced as far back as 2007, banning smoking indoors in workplaces, on public transport, and in schools, universities and health facilities. From January 2018, these restrictions have been extended further to smoking in public places used by children, including outdoor venues, such as holiday camps or playgrounds. The government is also financially supporting people to quit smoking, announcing in January 2017 that the NHS would, for the first time, cover 37 % of the price of smoking cessation medication. The estimated cost of this NHS-subsidised programme is about EUR 1.3 million per year.

In 2017, the government taxed all drinks with added sugar or sweeteners, increasing their prices by 15 to 30 cents per bottle in a bid to reduce their consumption. In the same year, a reform was also introduced banning sweets in cafeterias and vending machines in NHS facilities as part of a wider strategy to promote healthy eating. More recently, in 2019 parliament approved changes to the Advertising Code restricting the advertising of unhealthy food products to children under 16.

Figure 12. Immunisation rates are high compared to the EU average



Note: Data refer to the third dose for diphtheria, tetanus, pertussis and hepatitis B, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository for children (data refer to 2018); OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or the nearest year).

Mortality from treatable causes continues to decrease over time

The mortality rate from treatable causes in Portugal (i.e. deaths that could have been avoided through appropriate and timely health care interventions) has been decreasing steadily over time, reaching 89 per 100 000 population in 2016 (Figure 11), and is below the EU average for both men and women.

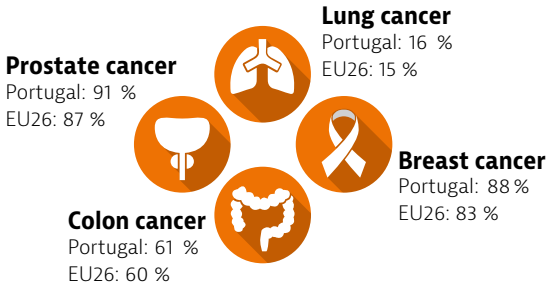
Treatable mortality rates for ischaemic heart diseases were also below the EU average while rates for breast cancer were comparable to the EU average. Stroke, colorectal cancer and pneumonia were slightly higher than the respective EU averages in 2016. However, there is still a significant gender gap, with the treatable mortality rate for men (106) being much higher than that for women (75), similar to the average gap in the EU (around 30).

Participation in cancer screening programmes is increasing, and there are early signs of improved 5-year survival rates

Screening rates in Portugal are above the EU average for breast cancer (84 % rather than 61 %) and cervical cancer (71 % compared to 66 %), with participation rates for both programmes having increased substantially since 2004. GPs are in charge of breast and cervical cancer screening and facilitate access to these services in the primary care setting, which may explain the high uptake. Colorectal cancer screening rates are in line with the EU average, with about half of 50- to 74-year-olds in 2014 reporting that they have undergone screening.

Portugal has experienced advances in diagnosis and treatment of cancer, including improved surgical techniques, radiation therapy and combined chemotherapy along with increased access. Five-year survival rates for some treatable cancers improved in Portugal between 2000–04 and 2010–14 and are generally just above the EU average (Figure 13), especially for breast and prostate cancers. The colorectal cancer five-year survival rate in 2010–14 was 61 %, so in line with the EU average, reflecting the introduction of innovations in diagnosis and treatment, as well as increased screening rates.

Figure 13. Five-year net survival rates for some treatable cancers are higher than EU averages

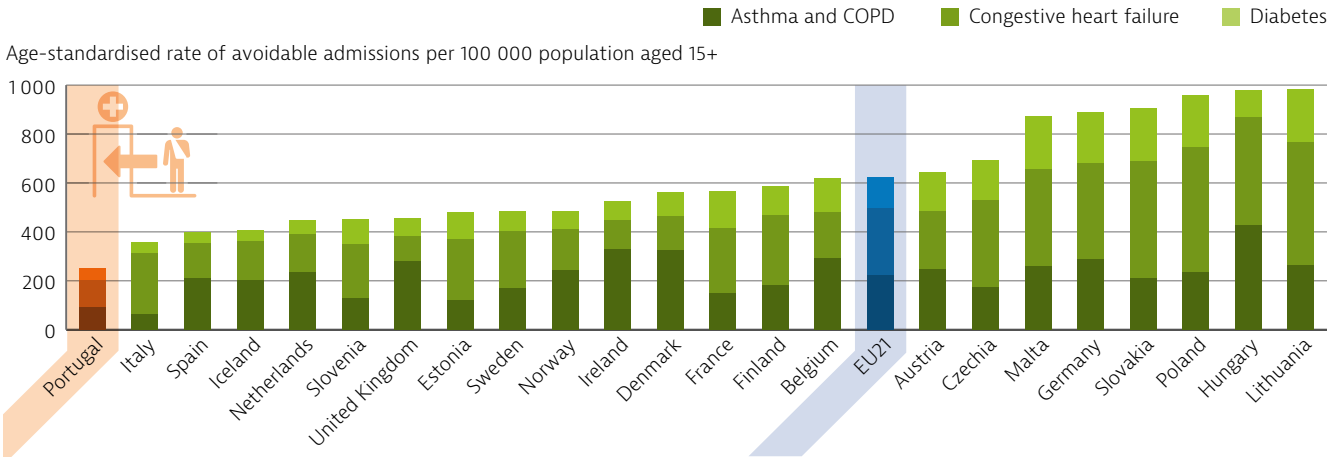


Note: Data refer to people diagnosed between 2010 and 2014.
Source: CONCORD programme, London School of Hygiene and Tropical Medicine.

Primary care is managing chronic conditions well as part of wider quality improvements

Portugal reports some of the lowest avoidable hospital admission rates due to asthma, chronic obstructive pulmonary disease and congestive heart failure in the EU (Figure 14) indicating that these chronic conditions are being effectively managed at the primary and outpatient secondary care levels. Quality of care has been bolstered at all levels in the NHS by the National Strategy for Quality in Health 2015–20. The Strategy defines a large number of priorities, and aims to improve the quality of organisational and clinical practice and increase the adoption of clinical guidelines. It also stresses the importance of local interventions and strengthening patient safety, all of which are supported by the continuous monitoring of quality and safety that the Strategy encourages.

Figure 14. Very low avoidable hospitalisation rates suggest effective primary care



Source: OECD Health Statistics 2019 (data refer to 2017 or nearest year).

Tackling antimicrobial resistance is a public health priority but with limited success

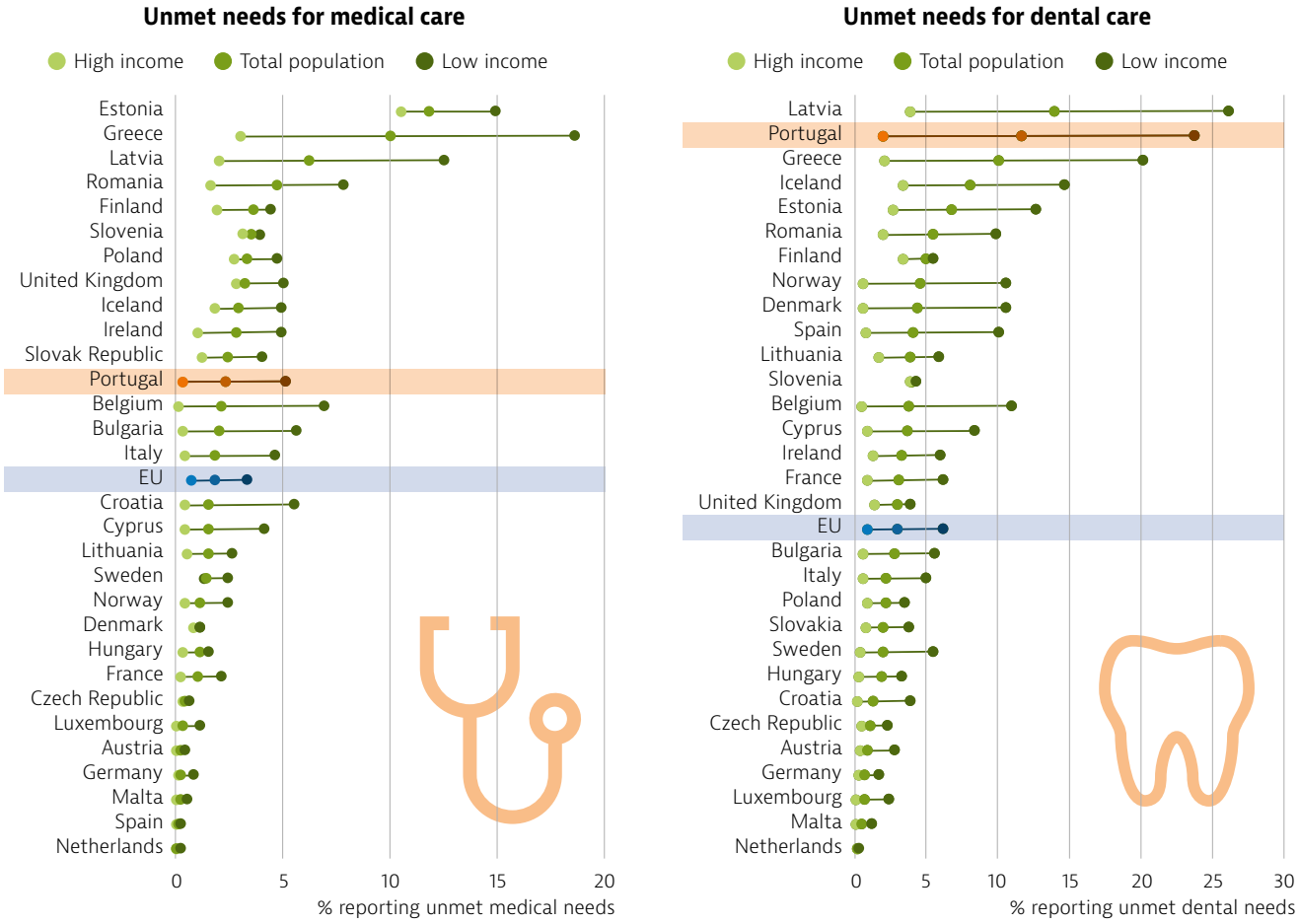
Portugal recognises antimicrobial resistance (AMR) as a significant public health issue. In 2013, the Ministry of Health implemented a programme on the prevention and control of AMR and the Ministry of Agriculture introduced an action plan to reduce the use of antibiotics in animals consumed by humans. Despite these steps, the percentage of bloodstream infections caused by Klebsiella pneumoniae resistant to carbapenems (a potent last-line class of antibiotics to treat bacterial infections), was 8.6 % in 2017 (ECDC, 2018), an increase of more than three percentage points from 2016 (5.2 %), the seventh highest in the EU.

5.2. Accessibility

Barriers to access are decreasing but with sizable gaps between income groups

The Portuguese NHS is designed to provide universal and comprehensive health care, although in practice there are some access barriers for certain population groups, particularly in rural areas (Box 2). In 2017, 2.3 % of the Portuguese population reported unmet needs for medical care due to cost, distance or waiting times. Unmet needs decreased from 2014, but remained above the EU average (1.8 %). Moreover, reported differences in unmet needs between low- and high-income groups were sizeable (Figure 15). Most of these unmet needs were driven by financial barriers, and, despite a decrease in the rate of unmet needs due to financial barriers among people in the lowest income quintile between 2014 and 2017, the share was double the EU average in 2017 (4.6 % compared to 2.3 %).

Figure 15. Unmet needs for dental care are higher than for medical care



Note: Data refer to unmet needs for a medical and dental 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 2017).

The NHS does not generally cover dental care, which is mainly provided privately through direct patient payments or VHI. As a result, reported unmet needs for dental care (due to cost, distance or waiting lists) are the second highest in the EU and around four times the EU average (11.6 % compared to 2.9 % in 2017) (Figure 15). Financial barriers are the dominant cause for unmet needs for dental care, and 11.5 % of the total population faced unmet needs in dental care due to financial barriers in 2017, compared to 2.6 % in the EU.

Income inequality in unmet needs is much greater for dental care than for health care in Portugal. To address this, in 2008 Portugal implemented a dental voucher programme as part of the National Programme for Oral Health Care Promotion, which has allowed progressive increases in dental care coverage. Currently, Portugal provides free dental care to pregnant women, school-aged children, older people who receive social benefits, people living with HIV/AIDS (since 2010) and those with oral cancer (since 2014). Plans are also currently underway to roll out a pilot project to integrate dentists into 91 primary care units.

The share of out-of-pocket payments is higher than the EU average and mainly driven by co-payments

OOP payments play a very substantial role in Portugal, representing 27.5 % of total health expenditure (Figure 16), which is substantially higher than the EU average (15.8 %) (Section 4). Some 13 % of total OOP payments are spent on outpatient care, and 6.4% on pharmaceuticals (compared to EU averages of 3 % and 5.5 % respectively), mainly due to co-payments.

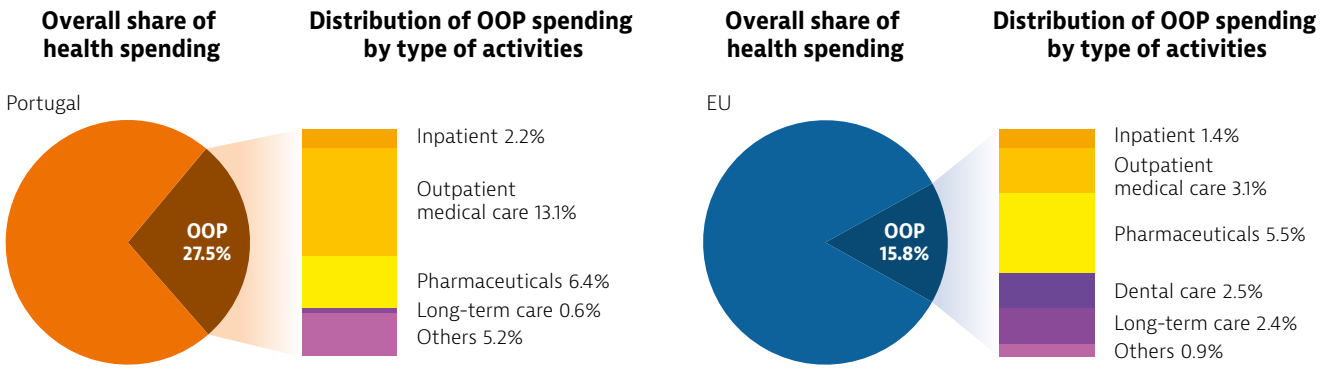
User charges only play a very minor role within OOP spending. Recent legislation in 2019 abolished user charges for primary care services and other health care prescribed within the NHS (Section 4). Given the small value of user charges and the large exemptions in place, the new legislation is not likely to reduce Portugal's high level of out-of-pocket spending.

An excessive reliance on OOP payments for the health system's financing can undermine accessibility and have an impoverishing effect on households. In Portugal, about 8.1 % of households are estimated to have suffered from catastrophic health spending[4] in 2016 (Figure 17). Catastrophic spending is much higher for households in the poorest income quintile, reaching about 30 % (WHO Regional Office for Europe, 2019).

Box 2. Some population groups face significant access barriers in practice

All immigrants who are in Portugal for more than 90 days have access to GP services, irrespective of their legal status. There are no restrictions for pregnant women, children, people with infectious diseases or those needing urgent care. While the NHS covers all residents in Portugal there are barriers that, de facto, prevent immigrants from accessing NHS services, including language, cultural differences and administrative hurdles. The new 2019 Basic Health Law enhances existing legislation and grants access to the NHS to anyone who needs medical care, including tourists and irregular migrants.

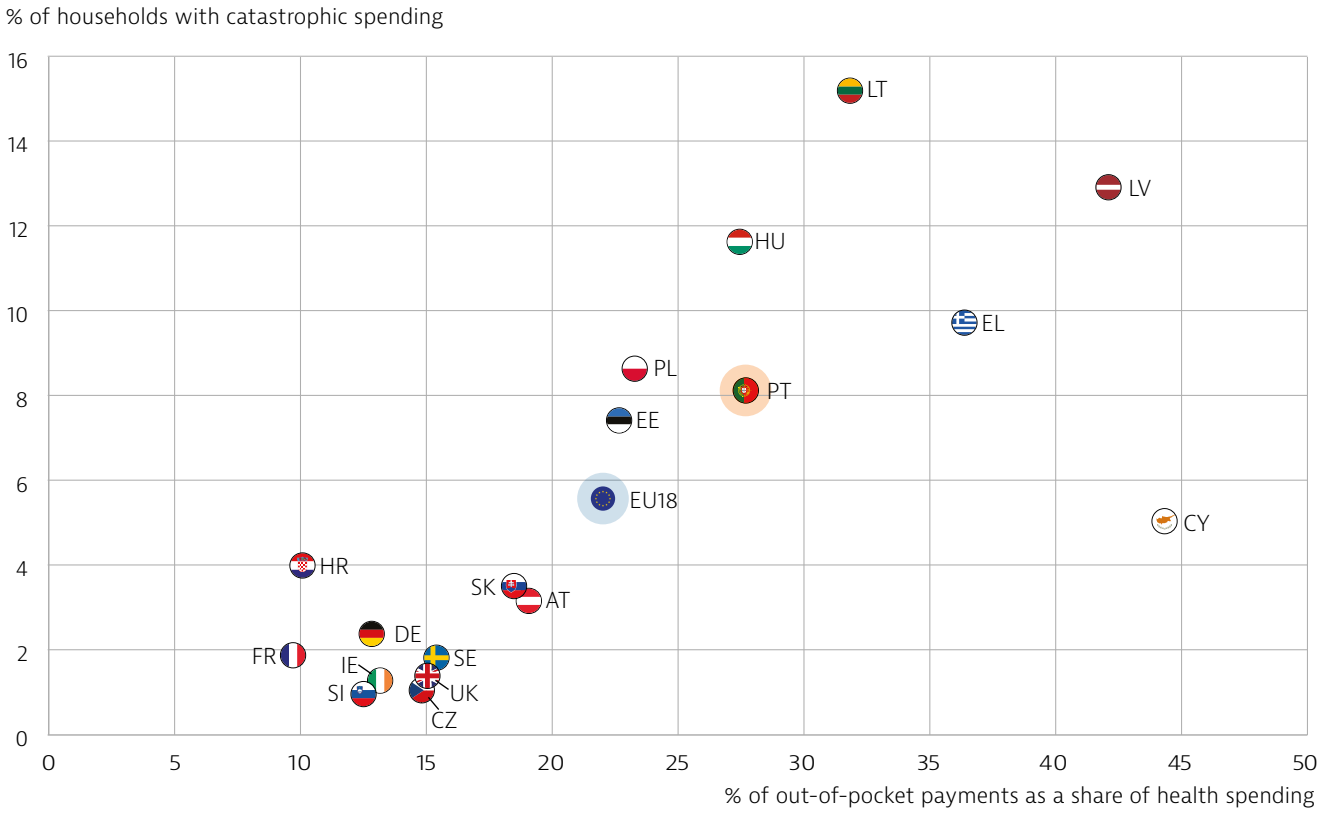
Figure 16. The Portuguese pay more out of pocket for outpatient care and pharmaceuticals



Sources: OECD Health Statistics 2019 (data refer to 2017).

4: *Catastrophic expenditure is defined as household OOP spending exceeding 40% of total household spending net of subsistence needs (i.e. food, housing and utilities).*

Figure 17. High out-of-pocket payments are associated with high levels of catastrophic spending



Source: WHO Regional Office for Europe 2018; OECD Health Statistics 2019 (data refer to 2017 or the nearest year).

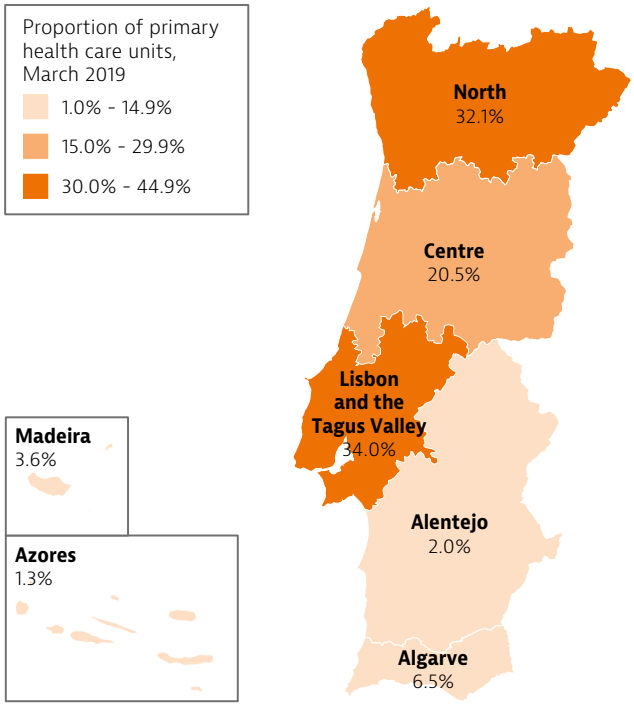
Resources are unevenly distributed, but self-reported unmet needs remain low

There is an unequal distribution of health resources (facilities and professionals) with particular, shortages of psychiatric, ophthalmology and orthopaedic specialists in rural areas. It is notable that municipalities with a higher proportion of elderly citizens also have a lower ratio of doctors per 1 000 population. These municipalities are concentrated in rural inland areas as well as Madeira and the Azores, which are historically underserved by health care facilities, including primary care units (Figure 18). However, self-reported unmet medical care needs related to distance affected only 0.1 % of the population in the poorest quintile in 2017, half the EU average (0.2 %). Unmet needs due to waiting lists are slightly higher for the lowest income populations (0.5 %), but again this is below the EU average (0.8 %).

Waiting times for elective surgery rose in the aftermaths of the recession but are improving again

Until 2010, long-standing waiting times for elective surgery (such as cataract removals and hip replacements) were addressed, by combining maximum waiting time guarantees with options for patients to choose treatment with any public or

Figure 18. The distribution of primary care facilities follows the distribution of the population

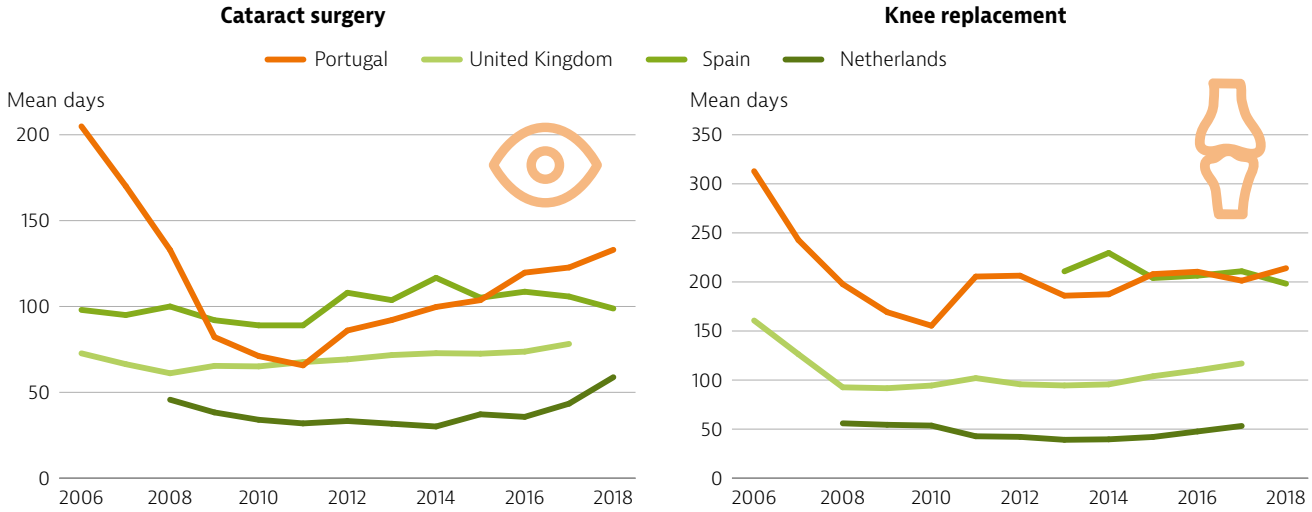


Source: Based on data on the proportion of primary health care units (in % of the total) by health region in Portugal in March 2019, available at www.sns.gov.pt.

private provider. However, the marked successes to that point have been partly reversed due to decreases in the number of professionals and NHS funding during the economic crisis, and waiting times have started to increase again in recent years. Although still below their 2006 levels, waiting times for elective surgery such as cataract surgery and knee replacement are now longer than in Spain, the United Kingdom and Netherlands (Figure 19).

Since May 2016, GPs can refer NHS patients to hospitals outside their area of residence for elective procedures or outpatient consultations if waiting times are shorter. An NHS website provides information on waiting times for outpatient consultations across several specialties.

Figure 19. There has been a rise in waiting times for elective surgery since 2010



Source: OECD Health Statistics.

5.3. Resilience[5]

Health spending is growing at a moderate rate following economic adjustment

The EAP that Portugal implemented between 2011 and 2014 (Section 4) saw the health sector apply measures to contain costs and improve health system efficiency. Public financing of health decreased by 5.7 % in real terms between 2005 and 2012. Since then, current health expenditure started to increase in line with GDP growth and in 2015 slightly outstripped GDP growth (Figure 20) posing questions about the long-term sustainability of the NHS. In March 2018, the government created a Mission Structure for the Sustainability of the Health Budgetary Programme specifically to monitor the financial performance of the NHS and propose measures to enhance resilience and sustainability.

The majority of health system costs are related to caring for people with chronic conditions. This reflects an ageing population, but also the economic crisis, which resulted in the emigration of many younger citizens, including health professionals. The resident population has aged (and has greater life expectancy), while the proportion of economically active people in Portugal has fallen. Public health expenditure is projected to increase from 5.9 % of GDP in 2016 to 8.3 % in 2070 (a 2.4 % increase, well above the 0.9 % projected for the EU). Over the same period public expenditure on long-term care may increase from 0.5 % of GDP to 1.4 %; this 0.9 % percentage point increase is below the forecast rate (1.1 %) in the EU (European Commission–EPC, 2018).

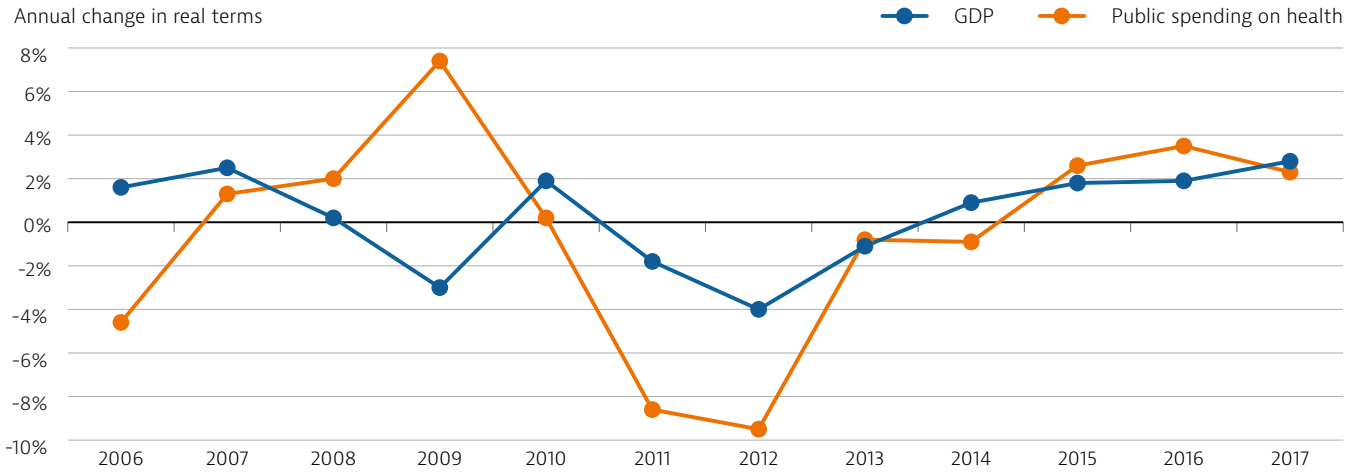
Despite substantial capital injections, NHS hospitals have accumulated substantial arrears

There are also pressing short-term risks to the health system's financial sustainability, particularly the debt accumulated by NHS hospitals. By the end of 2017, the government injected EUR 400 million from general revenues into the public hospital sector to clear part of the accumulated arrears. However, hospital arrears started increasing again in 2018, reaching

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

EUR 903 million in November 2018 (slightly below the November 2017 figure of EUR 1 103 million). A further capital injection of EUR 500 million in the second half of 2018 helped to reduce hospital arrears to EUR 484 million in December 2018 (European Commission, 2019). However, persistent challenges in establishing more effective budgetary planning and control mechanisms in state-owned hospitals continue to hinder progress. A new programme under the 2019 Mission Structure aims to address the underlying causes of the hospital arrears (Government of Portugal, 2019).

Figure 20. Health expenditure growth has mainly evolved in parallel with GDP growth since 2010



Source: OECD Health Statistics 2019; Eurostat Database.

Migration and falling numbers of nursing graduates make the health system vulnerable

When viewed against EU averages, Portugal has relatively high numbers of doctors and relatively few nurses (Figure 10, Section 4). The economic crisis and low health professional salaries linked to the crisis led doctors, and especially nurses, to leave the NHS for better paid jobs in other sectors or elsewhere in the EU. Staff shortages have been identified particularly outside great metropolitan areas, which tend to be underserved (Section 5.2). Most worryingly, the number of nursing graduates has fallen consistently since 2010. The number of medical graduates, however, has increased over the same period, in part as a result of initiatives addressing primary care needs.

Portugal is working to correct some imbalances in human resources. Efforts are focusing on initiatives to train and appoint more GPs to scale-up primary care (and take the strain off hospitals). There have also been changes to postgraduate specialist training for GPs, with training places increasing every year.

Health system efficiency has increased following the economic crisis

Portugal performs relatively well compared to other EU countries: the system became cheaper (due to reductions in spending) and more productive (due to increased working hours and contracting with institutions). This type of evolution has natural limitations, and in the near future productivity gains will most likely entail an increase in spending, which raises concerns about the financial sustainability of the NHS. To further improve efficiency, the Portuguese health system has shifted the focus away from specialist hospital-based provision to primary care, although not all initiatives to develop primary care have delivered the efficiency gains anticipated (Box 3).

Box 3. Primary care innovations have not always delivered on efficiency

Family Health Units were introduced in 2007, restructuring the organisation of Portuguese primary care in order to provide integrated primary care for the local population and improve efficiency. They consist of multi-professional teams, including GPs, nurses, administrators and other health professionals and were intended to allow duties to be shared more appropriately.

Each unit was formed on a voluntary basis and reflects the size of the list of patients registered.

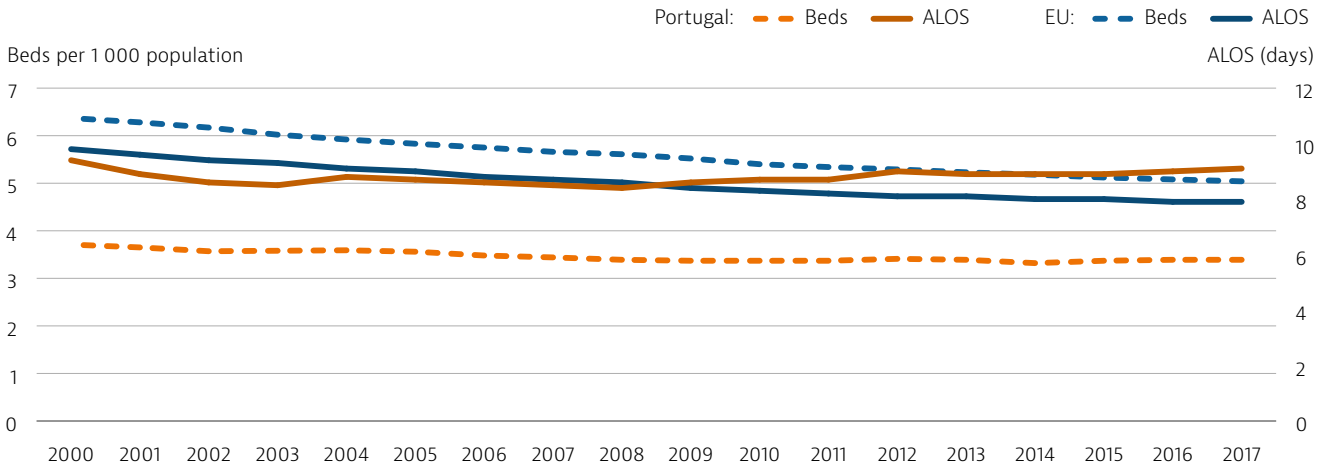
Incentive schemes were designed to reward individual and collective performance and encourage quality teamwork. However, there has been resistance to revising the scope of practice to expand the range of nurses' tasks within the units (Wismar, Glinos and Sagan, in press).

Portugal has also continued to develop its capacity in health technology assessment (HTA). In 2015, the Ministry of Health launched the SiNATS (the National System for Health Technology) initiative. Covering all public and private institutions that produce or use health technologies, SiNATS aims to ensure that health investments and technologies employed in the Portuguese health system represent value for money rate. SiNATS carries out an economic evaluation of all health technologies before new products are introduced into ambulatory care and hospital settings. The capacity of the HTA system is already well developed with international links through the EUnetHTA Network.

New governance arrangements seek to further improve hospital efficiency

The overall number of hospital beds per 1 000 population in Portugal changed little between 2007 and 2016 and is still well below the EU average (Figure 21). The number of acute care beds, however, has declined, with a corresponding increase in more cost-effective beds, for example on rehabilitation and long-term care. There was an increase in average length of stay (ALOS) between 2008 and 2012 to nine days, which is one day more than the EU average.

Figure 21. Portugal has a low number of hospital beds, but a relatively high average length of stay

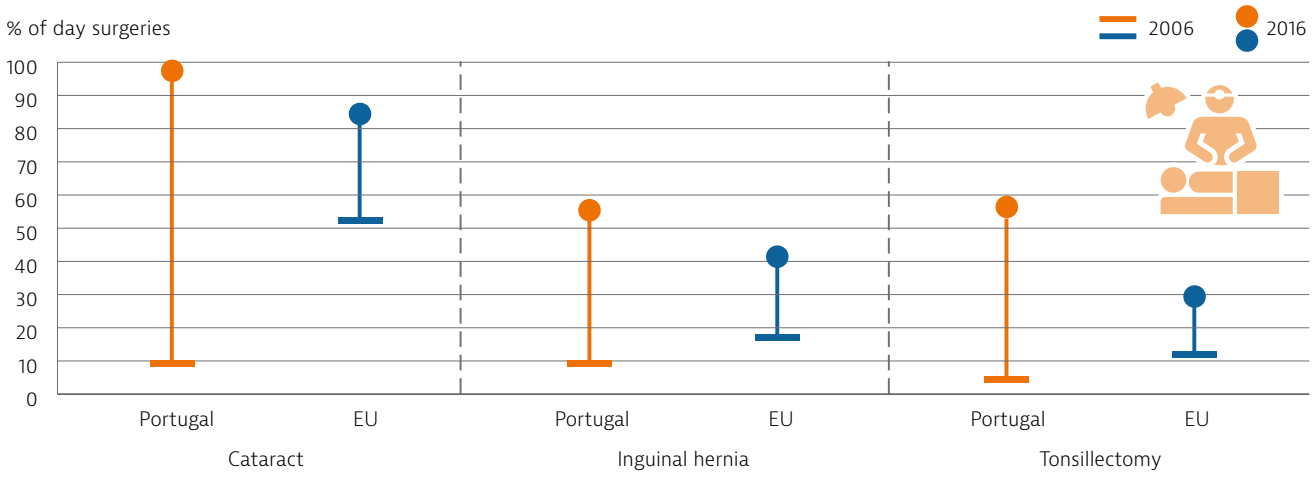


Source: Eurostat Database.

Day surgery rates for cataract, hernia and tonsillectomy have increased considerably across the country over the last decade (Figure 22). This steep increase was prompted by government efforts, which in 2008 published clear criteria for the organisation of day surgery to promote efficiency (Lemos, 2011), and introduced financial incentives for institutions and patients.

A new hospital management regime has been put into place (approved February 2017), specifically to build on improvements in hospital performance. The law establishes that all hospitals with enterprise management status should be organised as 'integrated accountability centres' (*centros de responsabilidade integrada*), which aim to: improve the quality of services; increase productivity; and enhance patient access and accountability. There are also new rules designed to strengthen the capacity of hospital management boards as well as intermediate management structures, and board members are expected to have relevant professional experience and specific training in health care management. By promoting autonomy and the involvement of NHS professionals in managing resources, integrated accountability centres are expected to increase productivity, efficient management and quality of care (Portuguese Government, 2019).

Figure 22. Day surgery has grown rapidly for selected procedures

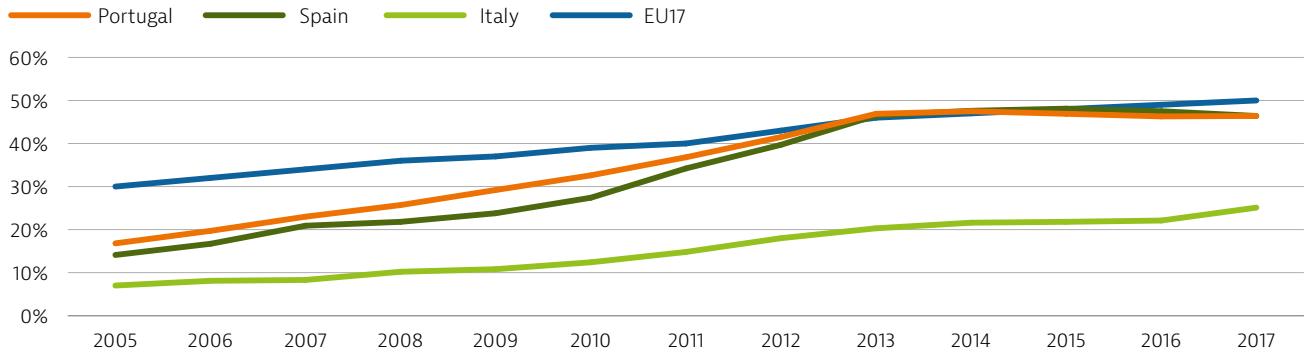


Source: OECD Health Statistics 2018; Eurostat Database (data refer to 2006 and 2016, or nearest year).

The use of generic medicines has increased rapidly to reach just below the EU average

Between 2016 and 2017, generics made up nearly half of all retail pharmaceutical sales (by volume), which is in line with Spain and only slightly below the EU as a whole (Figure 23). This represents 19.8 % of total pharmaceutical expenditure compared to 22.9 % for the EU. The uptake of generics increased at a fast pace between 2005 and 2012, but the trend has levelled off over the last few years. New trade margins for retailers and pharmacies were created in 2011, as well as new prices for generics, with the highest sale price of generics set at least 50 % lower than that of the reference product (or 25 %, if the retail price is below EUR 10). Recent measures, such as the payment of a EUR 0.35 incentive to pharmacies for each pack of generics sold, also has played a role in increasing sales.

Figure 23. Incentives and professional support contributed to the rapid uptake of generics



Note: Data refer to the share of generics in volume.
Source: OECD Health Statistics 2019.

The National Health Plan is using transparency and scrutiny to help strengthen resilience

Portugal's National Health Plan sets health priorities and guides planning for the period 2012-2020. One of the tools currently being used for its implementation is the National Health Council, an independent consultative body for the Ministry of Health, which scrutinises policies and makes recommendations. The Council also aims to ensure NHS users' participation in the policymaking process and promote health system transparency and accountability. The government has further increased transparency with the launch of the online NHS Portal. The portal publishes waiting times for emergency departments and real-time outpatient consultations for NHS patients, as well as information on public expenditure for items like medicines and consultations.

6 Key findings

- Life expectancy in Portugal has increased substantially in the last decade (driven by falling mortality from stroke and ischaemic heart disease), but the gender gap is above the EU average and there are inequalities by level of education. Notably, lung cancer has increased, reflecting the legacy of past smoking rates. Still, only half of the population reports being in good health in contrast to most of the EU where two thirds of adults rate their health positively.

- Levels of physical activity are low compared to the EU average. There are concerns about adult alcohol consumption and the rise in overweight and obesity levels, particularly among children. There are multiple efforts to address these concerns, including taxing all drinks with added sugar or sweeteners. Around one in six adults are daily smokers, although the rate has decreased since 2000. The indoor smoking ban, first introduced in 2007, was recently extended to ban smoking to protect children outdoors, such as in playgrounds and holiday camps.

- The National Health Service provides universal coverage to the entire population. Until recently, user charges were levied on almost all services within the National Health Service (NHS), such as general practitioner or emergency visits, but a large share of the population (60 %) was exempted. New legislation in 2019 abolished user charges for primary care services and other health care prescribed within the NHS. However, given the small value of user charges and the large exemptions in place, this reform is not expected to reduce Portugal's high level of out-of-pocket spending, which currently makes up 27.5 % of total health expenditure, significantly higher than the EU average (15.9 %).

- Portugal has a strong primary care system, which manages to keep patients out of hospital when appropriate. Since 2016, it has successfully increased the number of general practitioners, creating new positions across the country, and increasing postgraduate training. Nonetheless, some 0.6 million NHS users were not registered with a general practitioner in early 2019. Current programmes and incentive schemes are also in place to tackle the uneven distribution of health care resources. Notably, new hospitals have been established, and incentive schemes are in place for health personnel to move to underserved areas.

- There are two significant challenges to the health system's financial and fiscal sustainability. The first is the need to care for an ageing population with rising health needs and chronic conditions. The cost-cutting and efficiency measures that followed the economic crisis contributed to the health system delivering better value for money, spending less than the EU average. This has been achieved alongside relatively low levels of mortality from preventable and treatable causes, and a continued focus on further opportunities to increase the efficiency of the health system is as relevant as ever. Secondly, the high and steadily growing arrears of NHS hospitals are a long-standing and serious problem. A new programme introduced in 2019 aims to address the underlying causes of the hospital arrears and find a more durable solution.

- The Portuguese health system is formally committed to public participation and patient empowerment. It has progressively increased transparency, mainly through its NHS Portal, which shares information on spending and waiting times, and the National Health Council, which strives to engage NHS users in the policymaking process.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT	United Kingdom	UK

European Commission

State of Health in the EU
Country Health Profile 2019

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles 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, in cooperation with the European Commission.

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/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

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

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

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