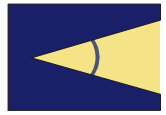


European

**Observatory**

on Health Care Systems



# Health Care Systems in Transition

**Portugal**



The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine

# Health Care Systems in Transition

## Portugal

1999

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Target 19 – RESEARCH AND KNOWLEDGE FOR HEALTH

By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.  
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### Keywords

DELIVERY OF HEALTH CARE  
 EVALUATION STUDIES  
 FINANCING, HEALTH  
 HEALTH CARE REFORM  
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 PORTUGAL

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**European Observatory on Health Care Systems**

WHO Regional Office for Europe

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## Foreword

**T**he 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 Care Systems.

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Norway and Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines

and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) health data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at <http://www.observatory.dk>.

## Acknowledgements

The Health care system in transition report on Portugal was written by Anna Dixon, (European Observatory on Health Care Systems) in collaboration with a Working Group led by Professor Vasco Reis (Adviser in the General Directorate of Health, Ministry of Health and Professor in the National School of Public Health). The Research Director for the Portugal HiT was Elias Mossialos, who edited the HiT.

The Working Group was composed of Ana Lisette Santos Oliveira, Trainee Senior Officer (Statistics) in the General Directorate of Health (Ministry of Health), Avelina Pereira, Medical Doctor (Ministry of Health), Luís Filipe Salles Camejo, Senior Officer in the General Directorate of Health (Ministry of Health), M<sup>a</sup> do Rosário Sepúlveda, Economist and Hospital Administrator (Ministry of Health), Cecília Lopes, Senior Officer in the General Directorate of Health (Ministry of Health) and project coordinator, and Vasco Pinto Reis, Adviser in the General Directorate of Health (Ministry of Health), Professor in the National School of Public Health and project director, editor and liaison.

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The current series of the Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems. The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the Government of Norway, the Government of Spain, the European Investment Bank, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat and the research directors Martin McKee, Elias Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof.

The series editors are Anna Dixon, Judith Healy, Elizabeth Kerr and Suszy Lessof. Administrative support, design and production of the HiTs has been undertaken by a team led by Phyllis Dahl and comprising Myriam Andersen, Sue Gammerman and Anna Maresso. Special thanks are extended to the WHO Regional Office for Europe health for all database from which data on health services were extracted; to the OECD for the data on health services in western Europe, and to the World Bank for the data on health expenditure in central and eastern European (CEE) countries. Thanks are also due to national statistical offices which have provided national data.

# Introduction and historical background

## Introductory overview

The Health Care systems in transition profile of Portugal gives a broad overview of the Portuguese health care system, its organization, financing and delivery. It describes in detail some of the reforms which have taken place in recent years and the changes which the system is presently undergoing. Following a general introduction to the country and its people the report describes the historical development of health care services in Portugal since the eighteenth century up to the present day. The section on *Organizational structure and management* provides a description of the administrative bodies which make up the health care system of Portugal. It also introduces some of the other institutions and bodies which operate in the areas of health care financing, purchasing and provision of services both within the National Health Service and the private sector. *Planning, regulation and management* looks at the mechanisms for capital, human resource and expenditure planning and the bodies responsible for the regulation of services and pharmaceuticals. Pharmaceutical regulation and policy are discussed in more detail in the final part of the section on *Health care delivery system*.

There are well-documented difficulties in obtaining reliable comparative data, particularly on health care expenditure. The section on *Health care finance and expenditure* attempts to bring together available national and international data on this subject and provide a brief analysis of the trends. It firstly considers the multiple sources of funding for health care including out-of-pocket payments and voluntary health insurance. It goes on to describe the levels of coverage and benefits offered. Finally it presents and analyses health expenditure data.

The health care services and provision offered in Portugal and the organization of the delivery of health care are described in the section on *Health care delivery system*. Primary, secondary and tertiary medical care services are

described as well as public health services and social care services. A separate part on human resources and training describes issues relating to the number and type of health personnel in the workforce, their distribution and the training requirements. Finally, this section concludes with a description of pharmaceutical and technology assessment including the regulation of medical equipment (standards, quantity and distribution), approval of drug products, drug pricing and control of pharmaceutical sales.

The section on *Financial resource allocation* describes the flow of money through the system, from the population/patient through the various funding agencies to providers. Changes in the mechanisms for funding allocations from the centre to regional authorities are described, as is the new model of purchasing being introduced for hospital services. The changes to the methods of funding hospital services, primary care services and the payment of health care professionals are also described.

Much of this report is descriptive with limited analysis of data. As well as describing the current system it indicates the pressures for change, the nature of planned reforms, the process of implementation and possible outcomes. The section on *Health care reforms* brings together this information by highlighting the general pressures for change within the system and the barriers to change. It also presents a chronology of health legislation which has been enacted. Finally it describes the process of implementation and the extent to which reforms have achieved their stated objectives.

## Country background

### Physical and human geography

Portugal is part of the Iberian Peninsula which lies in the south-west of Europe. The archipelagos of Azores (nine islands) and Madeira (two islands) in the Atlantic Ocean also form part of Portugal. The mainland is 91.9 thousand km<sup>2</sup> with 832 km of Atlantic coastline and an inland border with Spain that stretches for 1215 km. It is one of Europe's smallest countries, measuring 560 km north to south and only 220 km from east to west. Portugal's two main cities are Lisbon (resident population 1 834 000 in 1995) and Porto (population 1 188 000 in 1995).

**Fig 1. Map of Portugal<sup>1</sup>**

The River Tejo, which rises in Central Spain, divides the country into two distinct geographical areas. The northern and central regions are characterized by rivers, valleys, forests and mountains – the highest range is the Serra da Estrela, peaking at Torre (1993 m). The south is less populated and, apart from the rocky backdrop of the Algarve, much flatter and drier.

<sup>1</sup> The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

Portugal has a temperate climate influenced by the Atlantic Ocean. However, it experiences considerable variations in climate; the southern region of the Algarve can experience extremely high temperatures in midsummer whilst, during winter, the north receives plenty of rain and temperatures can be chilly, with snowfall common in the mountains, particularly in the Serra da Estrela range. As a result, the natural flora is very varied. It is possible to find not only species from western Europe, but also those characteristic of Mediterranean countries.

The total population of Portugal was 9 893 000 (mid-year estimate 1997) (51), which represents a small decrease of 1.9% over the last decade. The demographic profile follows that of other west European countries with an increase in life expectancy at birth from 71.15 years in 1980 to 74.9 years in 1996 (51). The median age of the population has risen from 31 years old to 36 years old over a ten-year period 1986–1996, whilst the dependency ratio has fallen from 79.7 in 1984 to 68.3 in 1994 (based on the relation of the population under 20 and over 65 years of age to the 20–64 year olds) (32). Demographic changes have followed an improvement in the socioeconomic conditions.

## **Economy**

Economic growth which began in early 1994 has gathered pace and real GDP growth increased to an estimated 3.5% in 1997. This growth is as a result of stronger domestic demand and new export capacity (31). The GDP per capita was 1.7 million Escudos or US \$PPP 13 672 or Euros PPP 12 783 in 1997 (32). The inflation rate was just above 2% in 1997, down from 3.2% in 1996 (31). Unemployment has fallen slightly from 7.3% of the total population in 1996 to 6.9% in 1997; however, it is still considerably higher than the rate of 5.5% in 1993 (31).

Table 1 shows the relative importance of different industrial sectors in the Portuguese economy. The main industries are textiles, tourism and agriculture. The textiles sector is the only sector of the manufacturing industry which has sustained its share of the total workforce whilst service industries connected to tourism have seen an increase from 13.4% to 17.3% of total employment (1980–1993).

## **Political and administrative structure**

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

**Table 1. Structure of the economy according to category of industry (% share of GDP and % of total employment), 1980 and 1993**

	% share GDP		% total employment	
	1980	1993	1980	1993
Agriculture, forestry and fishing	10.3	3.7	27.2	14.2
Manufacturing	31.0	23.9	25.1	23.4
Electricity, gas and water	2.1	4.2	1.9	0.9
Construction	7.1	5.3	4.5	4.9
Services	49.5	61.9	36.8	51.1

Source: OECD Economic Surveys 1997–1998 Portugal (1998) (31).

The parliament is made up of 230 members elected according to a system of proportional representation and the highest average method (Hondt method). The Prime Minister is appointed by the President on the basis of the election results, and after consultation with the political parties. The President also appoints the other members of government on the recommendation of the Prime Minister.

Portugal's administrative system comprises 18 districts and 2 autonomous regions (the islands of Azores and Madeira). The islands have their own political and administrative structures, although executive power remains with the central government. The President appoints a Minister of the Republic to represent the Republic in each of the autonomous regions. These Ministers are proposed by the national government.

The districts are further divided into municipalities and boroughs. The municipalities have their own level of elected government.

Macau is a small territory situated to the south of China which formally has been under Portuguese sovereignty since 1887. The Sino-Portuguese Joint Declaration on the Question of Macau, which was signed in April 1987, declares that China will resume sovereignty over the territory on 20 December 1999.

## Health indicators

The health of the Portuguese population can be summarized as follows:

- life expectancy at birth has continued to develop favourably in the past twenty years (see Table 2);
- indicators of child health are improving, and are near the average European rate. The infant mortality rate decreased fivefold between 1970 and 1990, the perinatal mortality rate by 66%;

- there have been improvements in women's health – female mortality from all cancers has been declining since the early 1970s.

Improvements in health status of the Portuguese population are connected to a general improvement in economic and social conditions (e.g. housing, education, sanitation, communication and transport infrastructures), as well as to the increase in human, material and financial resources devoted to health care.

Despite the overall improvement in living standards, there are inequalities between the regions, and probably between social classes. These disparities are evident in the variation of some health indicators, e.g. mortality rates and infant mortality rates, as well as in inequalities of access, e.g. the ratio of inhabitants to hospitals and the ratio of inhabitants to health professionals.

**Table 2. Health indicators for Portugal 1970–1996**

	1970	1975	1980	1985	1990	1995	1996
Infant mortality, deaths per 1000 live births	55.1	38.9	24.3	17.8	11	7.4	6.9
Perinatal mortality, deaths per 1000 total births	37	31.3	23.9	19.7	12.6	9	8.4
Life expectancy in years at birth (females)	71	72.6	–	76.7	77.9	78.2	78.5
Life expectancy in years at birth (males)	65.3	65.2	67.7	69.7	70.9	71	71.2

Source: OECD health data 98 (32).

The leading causes of death are shown in Table 3. After diseases of the circulatory system which account for 29.59% of all deaths, cancers represent five out of the eleven leading causes of death. For diseases caused by lifestyle or behaviour, trends are not so clear; however, the mortality from road traffic accidents is the highest in Europe.

**Table 3. Leading causes of death in Portugal 1998**

Cause of death	Percentage of all deaths	Cause of death	Percentage of all deaths
Cerebrovascular disorders	20.86	Chronic liver disease	2.50
Ischaemic heart disease	8.73	Motor vehicle accidents	1.92
Pneumonia	3.77	Colon cancer	1.80
Diabetes mellitus	3.03	Prostate cancer	1.59
Cancers of the respiratory tract	2.52	Breast cancer	1.4
Stomach cancer	2.50		

Source: Division of Epidemiology, General Directorate of Health, Ministry of Health, Portugal 1998 (3).

## Historical background

Portugal's health care system is complex as a result of its historical development. In order to examine the existing system it is important to recognize some of the main factors which have influenced the development of the Portuguese health care system to date.

Prior to the eighteenth century, health care was provided only for the poor by the hospitals of the religious charities called *Misericórdias*<sup>2</sup>. During the eighteenth century, the state established a limited number of teaching hospitals and public hospitals to supplement the charitable provision. This was further extended in 1860 with the appointment of salaried municipal doctors who provided curative services to the poor.

The development of public health services did not begin until 1901. The first act of public health legislation in 1901 enabled the creation of a network of medical officers responsible for public health. A further public health law was introduced in 1945, which established public maternity and child welfare services. It was also under this law that the national programmes for tuberculosis, leprosy and mental health, which were already operating, were legally established.

The more recent development of health services can be traced back to 1946 when the first social security law was enacted. Health care provision at this time followed the German Bismarckian model which provided cover to the employed population and their dependants through social security and sickness funds. This social welfare system was financed by compulsory contributions, shared between employees and employers, and provided out-of-hospital curative services, free at the point of use. Cover was limited to industrial workers in the first instance. Other sectors of the workforce and their dependants were added through extensions to social security coverage in 1959, 1965, 1971 and 1978.

Primary health care was not the subject of public intervention until the 1960s when new powers were established for its financing and organization.

Despite the efforts made prior to 1970, the following major problems still existed:

- asymmetry in the geographic distribution of health facilities and human resources with concentration in urban areas;
- poor sanitation and inadequate population coverage;
- centralized decision-making;

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<sup>2</sup> *Misericórdias* still exist in Portugal but no longer provide acute hospital care.

- no linkage or coordination among existing facilities and providers, and little evaluation;
- multiple sources of financing and a disparity of benefits between different population groups;
- a discrepancy between the intentions of legislation and policy and actual provision of health services;
- low remuneration of health professionals.

Up until 1979 and the establishment of the National Health Service, the Portuguese government had traditionally left the responsibility for paying for health care to the individual patient and his or her family. Care of the poor was the responsibility of the charity hospitals and out-of-hospital care remained the responsibility of the Department of Social Welfare. The government only took full responsibility for the costs of health care for civil servants. Otherwise the government limited provision for the general population to preventive care, maternal and child health, the control of infectious diseases and mental health.

The move towards greater public provision of health care and a commitment to universality was embodied in legislation passed in 1971. This law, although never implemented fully, gave priority to prevention over cure and sought to integrate health policy in the context of wider social policy, i.e. to include protection of the family and disabled persons and other social welfare activities connected with health. After the revolution of 1974, a process of health services “nationalization” began which culminated in the establishment of the NHS.

Firstly in 1974, district and central hospitals owned by the religious charities were taken over by government. Local hospitals followed in 1975 and were integrated with existing health services. Finally in 1977, over 2000 medical units or health posts situated throughout the country were taken over by the government. These had previously been operated under the social welfare system for the exclusive use of social welfare beneficiaries and their families. The principle of a citizen’s right to health was embodied in the Portuguese constitution as early as 1976 and was to be delivered through a “National Health Service which was universal, comprehensive and free of charge”. The law enabling the implementation of this principle was not passed until 1979.

The 1979 law establishing the NHS, laid down the principles of centralized control but with decentralized management. Central, regional and local bodies were established to this end. It brought together public health services and the health services provided by social welfare leaving the general social security system to provide cash benefits and other social services (e.g. for the elderly and children).

So by 1979 legislation had been introduced to establish:

- the right of all citizens to health protection;
- a guaranteed right to health care that was “universal, comprehensive and free of charge” through the NHS;
- access to the NHS for all citizens regardless of economic and social background;
- the provision of integrated health care including health promotion, disease surveillance and prevention;
- a tax-financed system of coverage in the form of the NHS for which the government was responsible. (Only when health care could not be provided through the NHS would services provided outside the NHS be covered).

Despite the development of a unified publicly financed and provided health care system and the incorporation of most of the health facilities previously operated by the social welfare and religious charities, some aspects of the pre-1970s system persisted. In particular the health subsystems (from the Portuguese *subsistemas*) continued to operate which covered a variety of public and private employees. These schemes were offering better services and greater choice of provider than would be available under the NHS. Consequently the trade unions, which ran and managed some of the funds, forcefully defended them on behalf of their members.

In the autonomous regions of Azores and Madeira, health policy followed the same general principles, but was implemented locally by the regional governments who retained some flexibility.

At the beginning of the 1990s the health care system in Portugal continued to face problems such as:

- an inadequate supply of public ambulatory services, resulting in an increase in attendance at hospital emergency departments;
- dissatisfaction of consumers and professionals with public services;
- a major increase in health expenditure and extreme difficulties with cost control;
- lack of responsiveness to the needs of some vulnerable groups, such as the elderly, drug addicts, alcoholics, and AIDS patients;
- difficulty in reducing mortality due to traffic accidents and lifestyle diseases.

Discussion of how these problems are being addressed through further reforms is included in each section of this report. The relevant legislation and reforms are discussed in detail in the section *Health care reforms*.



# Organizational structure and management

## 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 insurance schemes for certain professions, and voluntary private health insurance schemes. In this section the various bodies, organizations and institutions which make up the health care system will be outlined. Firstly the internal structure of the Ministry of Health will be described. Then other national and regional government authorities with a role in health care will be examined. Finally the private sector and the health subsystems, including the functions and responsibilities each has within the health care system, will be reviewed.

### Ministry of Health

The central government, through the Ministry of Health, holds the main responsibility for the regulation, organization and direction of the health care system as a whole.

The Ministry of Health is responsible for developing health policy and overseeing and evaluating its implementation. It is also responsible for the coordination of health-related activities of other Ministries, such as social services, education, employment, sport, the environment, the economy, housing and town planning. The core function of the Ministry is the regulation, planning and management of the National Health Service (NHS). Many of the planning, regulation and management functions are in the hands of the Minister of Health. The Secretary of State is a junior Minister and has responsibility for the first level of coordination.

The Ministry is made up of five Directorates and seven Institutes. These are:

**The General-Secretariat of the Ministry of Health**

Provides technical and administrative support to the other sections of the Ministry, coordinates their work and provides assistance to staff within various Government offices.

**The General Directorate of Health (GDH)**

Regulates, directs, coordinates and supervises all health promotion, disease prevention and health care activities, institutions and services, whether or not they are integrated into the NHS.

**The General Inspectorate of Health**

Performs the disciplinary and audit function for the National Health Service in collaboration with GDH and audits NHS institutions and services.

**The General Directorate of Health Infrastructures and Equipment**

Assesses, regulates, plans and coordinates the procurement of equipment and provides technical support for the programme of NHS building work. Supported by regional directorates.

**The Department of Human Resources**

Regulates, directs and evaluates human resource activities for the NHS, namely professional education and practice. Directly oversees schools for the training of nurses and technical staff working in health.

The National Institutes are as follows:

**The National Institute of Pharmaceuticals and Medicine****The National Institute for Medical Emergencies****The Portuguese Blood Institute****The Service for Drug Addiction Prevention and Treatment****The Institute of Financial Management and Informatics****The Social Services for Health Personnel****The National Institute of Health, Doctor Ricardo Jorge<sup>3</sup>**

There are also three vertical programmes run by national bodies attached to the Ministry of Health: the National Prevention Council Against Tobacco Consumption, the National Committee on AIDS and the National Council of Oncology.

Legal provision is made for a **National Health Council**, which is a consultative body for the Ministry of Health. Its function, in theory, is to represent all those concerned with the performance of health care providers: patients; health care employees; government departments in charge of health-related activities

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<sup>3</sup> This institute promotes scientific research in the field of health and is the main reference laboratory for the public health sector. It also functions as the national observatory and surveillance centre on health.

and other bodies. In reality the Council has never met and does not function, possibly because the Ministry and its departments feel threatened by a potential loss of power to the Council.

## **Other Ministries**

### **Ministry of Finance:**

The creation of new posts within the NHS, whether hospital-based or not, requires the approval of the Ministry of Finance. The Ministry of Finance also determines the budget for the NHS based on a submission from the Ministry of Health. See the section on *Third-party budget setting and resource allocation* for more information about this process.

### **Ministry of Employment and Social Solidarity:**

This Ministry is responsible for social benefits, such as pensions, unemployment benefit and incapacity benefit. In 1995, 9.5% of GDP was allocated to social security. Of this 73% was spent on pensions, 11.3% on unemployment benefits and 6.0% on disability benefits. The interface and collaboration between this Ministry and the Ministry of Health has improved in recent years. Joint projects include a review of certification for absence from work, a programme to improve coordination between health and social care services and an initiative to improve continuity of care for the elderly.

### **Ministry of Education:**

The Ministry of Education is responsible for undergraduate medical education and for academic degrees such as Masters and PhDs. Specialty training, however, is the joint responsibility of the Medical Association and the Ministry of Health.

## **Regional health administrations (RHAs)**

The Portuguese NHS, though centrally financed by the Ministry of Health, has a strong regional structure of health administrations. There are five regional health administrations in Portugal: North, Centre, Lisbon & Tagus Valley, Alentejo and the Algarve. In each region a regional health administration board, accountable to the Minister of Health, manages the NHS.

The regional health administrations (RHAs) are responsible for the local implementation of national health policy objectives. They coordinate all levels of health care and allocate resources to hospitals and health centres. They work in accordance with principles and directives issued in regional plans and by the Ministry of Health. Their main responsibilities are the development of

strategic health administration, coordination of all aspects of health care provision, management of hospitals and health centres, establishment of agreements and protocols with private bodies, and liaison with central bodies, *Misericórdias* and other private non-profit bodies, and municipal councils.

The regional health administration boards have specific duties to:

- draw up regional plans and budgets, and to monitor and be accountable for them;
- guide, coordinate and monitor NHS management at regional level;
- represent the NHS in and out of court;
- regulate the supply of health providers in the region and guide, coordinate and monitor their performance;
- contract with the private sector to provide health care for NHS beneficiaries in each region, subject to national agreements on this matter;
- continuously evaluate the outcomes and outputs attained;
- coordinate transportation of patients within both the public and private sectors.

Regional health administrations are subdivided into eighteen sub-regions each with a sub-regional coordinator.

**North:** main offices in Porto, covers the administrative districts of Braga, Bragança, Porto, Viana do Castelo and Vila Real;

**Centre:** main offices in Coimbra, covers Aveiro, Castelo Branco, Coimbra, Guarda, Leiria and Viseu;

**Lisbon and Tagus Valley:** main offices in Lisbon, covers Lisbon, Santarém and Setúbal;

**Alentejo:** main offices in Évora, covers Beja, Évora and Portalegre;

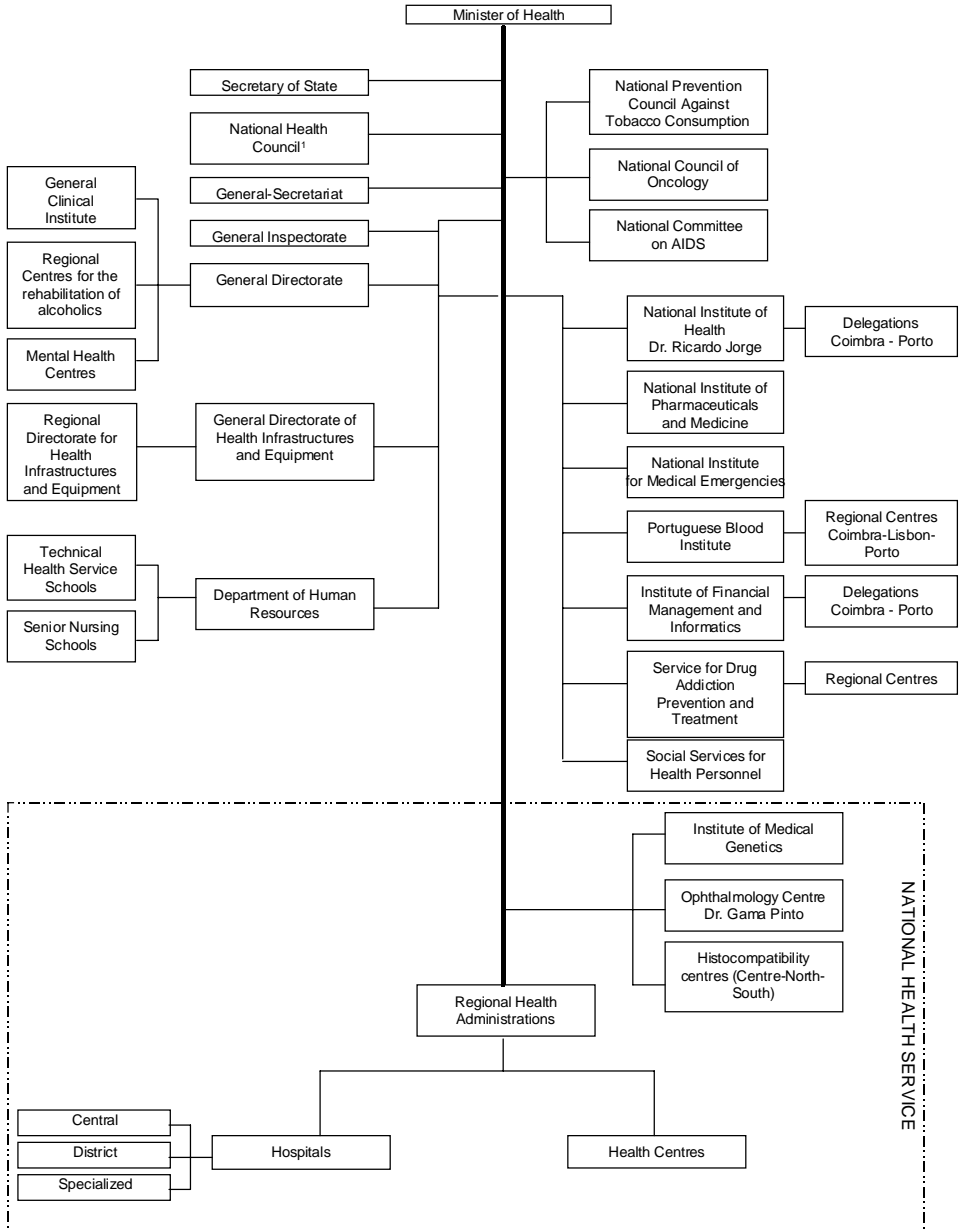
**Algarve:** main offices in Faro, covers the district of Faro.

Since 1998 each regional health administration (RHA) has established a regional agency (RA) within it. The RA is an autonomous part of the RHA with responsibility for contracting with hospitals, health centres and independent groups of doctors. Its two main functions are to increase citizen participation in health decision-making and to develop the separation of purchasing and provider functions.

## Local government

Below the region and sub-region are the municipalities. Health issues at this level are under the jurisdiction of the Municipal Health Commission. For the

Fig 2. Organizational chart of Ministry of Health structure



1 The National Health Council is not a functioning body

purposes of health care provision, boundaries are based on natural communities rather than administrative areas, i.e. some communities may be included in neighbouring municipalities. This ensures that services are provided more quickly and easily. In some cases the larger urban communities have their own system of organization of health care in order to meet the particular needs of the population. There are a number of initiatives being undertaken in cooperation with the municipalities such as promoting greater traffic and pedestrian safety and encouraging physical exercise. Nutrition is also being promoted in close cooperation with the media, the educational system, sports organizations and local authorities.

### Health subsystems

The historical remnants of the social welfare system persist in the form of health insurance schemes for which membership is based on professional or occupational category. These are often referred to as health subsystems (*subsistemas*) and this term will be used throughout the report.

In addition to the cover provided by the NHS, about 25% of the population<sup>4</sup> are covered by the health subsystems. Health care is provided either directly or by contract with private or public health care providers (in some cases by a combination of both). Access is generally limited to members of a specific profession and their families.

The main funds operating in the public and private sector are:

- ADSE (*Assistência a Doença dos Servidores do Estado*) for civil servants;
- ADM (*Assistência na Doença aos Militares*) for military personnel (including administrative staff). It has three separate bodies: ADME (*Assistência na Doença aos Militares do Exército*) for the army, ADMA (*Assistência na Doença aos Militares da Armada*) for the Navy and ADMFA (*Assistência na Doença aos Militares da Força Aérea*) for the Air Force;
- IOS-CTT (*Instituto das Obras Sociais dos CTT*) for post office workers;
- PT-ACS (*Portugal Telecom – Associação de Cuidados de Saúde*) for the employees of the public telecom operator;
- SAMS (*Serviços de Assistência Médico-Social*) for bank employees and associated insurance workers. It has three regional branches: Central, North, South and Islands;
- SSINCM (*Serviços Sociais da Imprensa Nacional Casa da Moeda*) for the workers at the national mint;

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<sup>4</sup> There is no exact figure for the number of people covered by the subsystems as double-counting may occur due to people belonging to more than one subsystem.

- SSMJ (*Servicos Sociais do Ministerio da Justica*) for workers of the Ministry of Justice;
- SSCGD (*Servicos Sociais da Caixa Geral de Depositos*) for the workers of the main public bank.

There are also a few additional smaller funds. Most health subsystems are members of the National Association of Health Subsystems.

The largest fund ADSE covers 15% of the population and is controlled by the Ministry of Finance. It includes amongst its members all employees of the NHS, creating a perverse situation where medical professionals and other professionals are entitled to supplementary care that is not available to patients within the NHS. Some of the funds are associated with and run by trade unions and managed by boards of elected members.

Most of the schemes are compulsory for employees but do not preclude the beneficiary from seeking services directly from the NHS. However, the health subsystems do usually give more freedom of choice to the beneficiaries than they may otherwise have within the statutory system. Whilst users are free to purchase services wherever they choose, most use the private sector for ambulatory care and the NHS for non-elective surgical interventions. A few schemes provide health services directly, in which case members will be expected to seek care from these doctors in the first instance.

## Private sector

Private health care providers mainly fulfil a supplementary role to the NHS rather than providing an alternative to it. Most private sector activity continued to prosper despite the establishment of the NHS and now mainly provides diagnostic, therapeutic and dental services as well as some ambulatory consultations, rehabilitation and psychiatric care services. The key institutions are private practitioners, *Misericórdias*, and private hospitals, clinics and facilities.

The level of activity in the private sector compared to the public sector can be seen in Table 4. The majority of specialist consultations take place in the private sector whereas the public sector provides the overwhelming majority of general consultations.<sup>5</sup> Overall the private sector accounts for 30% of all medical consultations.

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<sup>5</sup> Figures are based on responses to a National Health Survey question about the last visit to a doctor. This included both the type of visit, i.e. to a GPs or several specialities, and where the consultation took place, i.e. health centres, public hospitals, private clinics, etc. No adjustment was made for possible differences in age, sex or place of residence between the survey respondents and the general population.

**Table 4. Percentage of medical consultations in the public and private sector in Portugal 1995/1996**

	General	Specialist	Total
Public	58.5	11.1	69.6
Private	14.1	16.3	30.4

Source: (1) based on the Health Interview Survey 1995/1996 (8).

### **Misericórdias**

*Misericórdias* are independent charitable institutions<sup>6</sup>.

They currently operate very few hospitals, despite their historical role as one of the main providers of health care. The hospitals currently operated by *Misericórdias* provide services which include orthopaedics, plastic surgery, internal medicine and complementary therapies. There are usually no acute or emergency services in these hospitals. There has been a shift in focus of the work of *Misericórdias* and other religious organizations from health to social care. They are now the main providers of social care and psychiatric and rehabilitation services in Portugal.

### **Private hospitals, and other privately provided services**

In 1996, 42% of hospitals in Portugal were privately owned. Of these almost half belonged to for-profit organizations. However only 22.5% of the total bed stock is privately owned. See the section on *Secondary and tertiary care* for more information about hospitals and hospital beds in the public and private sectors. One of the main areas of private activity is in the provision of diagnostic tests and examinations: pathology, blood tests and X-rays are mostly provided privately. In addition treatment by physiotherapists and dental care are largely provided by the private sector.

### **Private health insurance companies**

On the financing side, the main private actors are the private health insurance companies. Voluntary health insurance (VHI) was introduced in 1978. Initially only group policies were offered but since 1982 individual policies also have been offered. Approximately 10% of the population were covered by private insurance in 1998. Most policies are in the form of group insurance provided by the employer: less than 10% of people with private health insurance have individual policies.

<sup>6</sup> *Misericórdias Lisbon* is an exception; it is a public enterprise which means that the Board is nominated jointly by the Ministry of Health and the Ministry of Employment and Social Solidarity rather than elected by members.

## Professional associations and unions

There are three main representative organizations for doctors: the Medical Association and two trade unions. The Medical Association represents the strong corporate interests of the medical profession and membership is obligatory. The Association's functions include:

- accreditation and granting of licences to practise;
- accreditation and certification of specialist training (joint responsibility with the Ministry of Health) (see the section on *Human Resources and Training*);
- enforcing the disciplinary code with powers to censure doctors; however, few doctors are actually censured in practice.

An equivalent body for nurses (the Portuguese Nurses' Association) was established in 1998 with similar powers to the Medical Association. There is also a national association for dentists, which maintains the dental register and receives and investigates complaints against dentists with the power to suspend (though this has never happened).

The representative body for the pharmaceutical profession is the National Association of Pharmacists, for which membership is compulsory. It covers pharmacists and others licensed to work in industry, laboratories and enterprises and is the legal representative of people with a degree in pharmaceutical sciences. In the same way as the Medical Association, it has regulatory and disciplinary powers.

The National Association of Pharmacists also has a powerful corporate role. It operates as a fund which handles the majority of pharmaceutical payments between the NHS and the pharmacists. As mentioned before, almost 95% of pharmacists are members of the National Association of Pharmacists; however some choose to remain independent. The Association offers incentives in order to maintain membership rates such as computers, software, continuous education and other services which are of benefit to the pharmacist.

## Public and consumer groups

There is currently no official organization which advocates on behalf of patients in Portugal. There are a number of quite active disease-based advocacy groups such as those based around diabetics, haemophilia and HIV and AIDS. These are narrow interest groups which usually promote the allocation of more resources for the care and treatment of patients in that particular disease group. The development of mechanisms for giving citizens a voice about their health care is being developed by regional agencies (RAs) as part of their remit. A citizens' representative, who will act as an intermediary between the RHA and

the people, will be involved in the development of local health systems (see section on *Primary health care*). The citizen representative will be chosen either by the local municipal council or a consumer group, where the latter exist.

There are formal mechanisms for consumers to make complaints. In every public medical institution there is an office where patients can complain about any aspect of the NHS (called the Users' Office). All complaints are dealt with through the Users' Office and may be referred, in extreme cases where there is evidence of medical negligence, to the Medical Association in order for the case to be pursued. Patients are free to write directly to the regional coordinators or the Minister of Health or to pursue their case through the courts. This is, of course, expensive and few people do so. On the whole there are few complaints. The majority relate to organizational aspects such as waiting times or aspects of the service rather than technical matters regarding a specific treatment or intervention.

More mechanisms are being introduced to encourage citizens' participation in health; to increase patients' trust in the health system, to encourage the population to take responsibility for its own health and obtain better quality and more appropriate care for users.

## **Planning, regulation and management of health services**

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

### **Planning**

The Portuguese Constitution stipulates that the economic and social organization of the country must be guided, coordinated and disciplined by a national plan. Thus, planning is at the heart of the system of government. The national plan must ensure, for example, the harmonious development of different sectors and regions, the efficient use of productive resources, and the equitable division of resources amongst the population and between regions.

There are central, regional and sectoral planning bodies. Central planning for health is mainly carried out by the General Directorate of Health, based on plans submitted by the regional health administration boards (RHAs).

As 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 Director General of Health has no direct hierarchical authority over the RHAs but is able to make suggestions and advise. Most RHAs will try to follow national policies but there is no obligation to do so. Consequently each region pursues national policies at a different pace.

### **Capital planning**

A separate central investment plan governs capital outlays within the NHS. Capital investment is the responsibility of the General Directorate of Health. Most of the investment is provided internally by the Portuguese state budget through the Central Administration's Investment and Development Plan (PIDDAC). There has also been joint funding of hospital and health centre developments with the European Union through the European Regional Development Fund (ERDF).

Legislation in 1988 gave the Ministry of Health total control over the procurement and installation of high-technology equipment in the NHS and private sector. The legal guidelines for installing heavy equipment established ratios of equipment per inhabitant. In 1995 new legislation was passed which abolished the population ratios. However, the principle of prior authorization by the Ministry of Health for equipment within the NHS was retained.

In 1998 Portugal published a national list of health equipment (21) which describes the distribution of specific items of equipment and services throughout Portugal. It gives information regarding such things as the regional variations in the number of items of equipment, the numbers in public and private facilities and the age of equipment. It is not clear at present how useful this document will be for planning purposes. As there are currently no mechanisms in place for regulating the distribution of health equipment in the private sector it can do little more than highlight the inequalities in distribution. It is also unlikely that ratios will be reintroduced in the NHS as they lack sensitivity to other local characteristics such as the availability of equipment in the private sector. (See *Mechanisms for controlling health care technologies* under the section *Pharmaceuticals and health care technology assessment* for more information.)

### **Human resource planning**

All staff within the NHS are civil servants and all new posts have to be approved by the Ministry of Finance.

A numerus clausus was introduced in 1977 which limits the number of places available in medical schools. This was in response to the excess of

doctors created after the revolution in 1974, when many doctors from the colonies returned to Portugal in order to complete their training.

The distribution of medical personnel is not controlled or regulated by the state. However the high levels of investment in regional facilities outside Lisbon and Porto in recent years means that they are more attractive to doctors wishing to work in a well-equipped environment.

## Regulation

The Portuguese system is highly normative, with extensive regulation. There are numerous and sometimes very restrictive controls over pharmaceutical goods, high-technology equipment and the education, training and registration of health personnel. The defined rules and procedures, however, are not always adhered to or enforced.

The main responsibility for regulation and national quality standards lies at the central level with the General Directorate of Health. Presently there is a Sub-Director of Quality who is responsible for standards within health care provision. A plan to establish a separate institute for quality was announced at the beginning of 1999. This body will have the same status as other institutes within the Ministry of Health and will produce guidelines for the accreditation of medical facilities.

The National Institute of Pharmaceuticals and Medicine (INFARMED) was established in 1993. This body is responsible for the regulation of pharmaceuticals and medical equipment. It is supported by the Pharmaceutical Inspection Service, Pharmacovigilance Service and The Official Laboratory for Pharmaceutical Quality Control. A full description of their respective functions is given under *Regulation and Control of Pharmaceuticals*.

## Management

Primary care health centres (described under *Primary health care*) are directly under the managerial control of the RHAs.

Public hospital services are currently managed by a four-member council or hospital board, consisting of a director, usually a doctor, and a general administrator (both appointed by the Minister of Health), a head doctor and a head nurse (both elected by peers).

There is, however, an experiment to allow public hospitals to be put under the control of private sector management. The legal reform which enabled this practice was part of the 1990 Law on the Fundamental Principles of Health (16). This stated that management of NHS institutions and services could be

handed over to the private sector through management contracts. These contracts could be applied to the whole health institution, i.e. hospital or health centre, a particular service or any functionally autonomous part of them. Health institutions and services managed in this way would be included in the NHS, thus obliging the management authorities to guarantee access to health care in the same way as other NHS services.

This experimental type of management is currently operating at the *Fernando Fonseca Hospital* in Amadora, part of Lisbon. By granting hospitals public enterprise status, it releases them from the constraints of public employment regulations.

In order to facilitate the movement of personnel from the public hospitals to the privately-managed hospitals, the state guarantees a position for all personnel if they return to the NHS within three years. This is causing huge retention problems for the privately-managed hospitals as many doctors leave their jobs just before the three-year deadline is reached. Evaluation of these hospital reforms was expected in April 1999.

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

The five regional health administrations were established by law in 1993 under the NHS Statute (16). Previously the hospitals had been the direct responsibility of the General Directorate of Hospitals and the health centres fell under the direct hierarchical authority of the General Directorate of Primary Health Care. These two directorates were merged to form the new General Directorate of Health in the Ministry of Health. The separation of primary care from secondary and tertiary care within the hierarchy of the Ministry was reflected in the way in which services were organized locally. This reorganization was part of a broader strategy to try and integrate and coordinate further levels of provision.

Previously the NHS was organized regionally through 18 regional health administrations (RHAs). However these had no responsibility for health centres and acted simply as the disbursers of funds for hospitals. The rationalization of the RHAs into five regions has been accompanied by devolution of financial responsibility. RHAs are given a budget from which they have to provide health care services for a defined population allowing them greater autonomy over the way in which the budget is spent.



## Health care finance and expenditure

### Main systems of finance and coverage

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 comprehensive coverage to about a quarter of the population, are funded mainly through employee/employer contributions (including state contributions as an employer). 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 premia to private insurance schemes and mutual institutions, which cover respectively 10% and 7% of the population.

Table 5 shows the percentage of total health expenditure (THE) financed through different agents. Taxation accounts for the largest amount, with 61.6% of the THE financed in this way in 1997. This includes expenditure on direct provision within the NHS and in the form of subsidies to the health subsystems which operate for public sector employees. The proportion attributed directly to social insurance schemes is only 4.8% (1996). Out-of-pocket payments accounted for 44.6% of THE in 1995. This is one of the highest in Europe (see the section on *Out-of-pocket payments*).

**Table 5. Main sources of finance by funding agents (as % of total expenditure on health care) 1985–1997**

Source of finance	1985	1990	1991	1992	1993	1994	1995	1996	1997
<b>Public</b>									
Taxes	51.2	54.8	55.8	55.9	55.6	68.2	62.6	63.0	61.6
Health subsystems	3.4	3.7	4.2	4.5	4.3	5.2	4.8	4.8	–
<b>Private</b>									
Out-of-pocket	45.4	46.3	43.1	44.0	45.3	46.6	44.6	–	–
Voluntary insurance	0.2	0.8	0.9	1.2	1.3	1.4	1.4	1.5	1.7

Source: OECD health data, 1998 (32).

## **Public financing**

### **Taxation**

The NHS is mainly financed directly by taxes. A soft budget for total NHS expenditures is established within the annual national budget. Actual health expenditures usually exceed the budget limits by wide margins, requiring the approval of a supplementary budget. Apart from direct transfers from government, the NHS has its own receipts that are mostly generated and spent by hospitals. These include payments received from patients for special services such as individual rooms, payments from beneficiaries of health subsystems and private insurers, payment received for the hiring of premises and equipment, income from investment, donations, fines, admission charges and co-payments (for drugs, consultations and diagnostic tests). In total this accounts for about 7% of total NHS revenues and is estimated to account for as much as 20% of the overall hospital budget.

### **Health subsystems**

The health subsystems, which pre-date the establishment of the NHS, are normally financed through employer/employee contributions, with a large contribution paid by the state as employer. Contributions by employees are obligatory for most funds.

Most beneficiaries of public sector health subsystems contribute 1% of their salary. In private subsystems the contribution can vary, sometimes beneficiaries pay nothing at all. The employee's contribution is really symbolic with the larger part paid by the employer.

Generally the benefits received exceed those provided within the NHS. The employer-employee contributions are often insufficient to cover the full costs of care and consequently a significant proportion of costs are shifted onto the NHS. Most enrollees of these funds do not declare their membership when receiving treatment within the NHS, thus exempting the funds from responsibility for the full costs of care for their members.

## **Private financing**

The main sources of private financing in Portugal consist of out-of-pocket payments both to the public and private sector and risk rated premia to voluntary health insurance schemes. There are also a small number of individuals who make private contributions to mutual funds.

### **Voluntary health insurance**

Approximately 10% of the population have taken out some form of voluntary health insurance (VHI). Mostly this is group insurance provided by the employer: less than 10% of people with health insurance have individual policies. Policies tend to be selective in nature and lack comprehensiveness. The majority of VHI policies in Portugal are valid for only one year and consequently companies have the power to cancel the contract and/or refuse to renew the contract. As age is strongly associated with increased health care costs, many companies will try to exclude anyone over the ages of 65 or 70 years old.

A tax reform in 1988 made most health expenditures, including co-payments and payments to private doctors, fully deductible from taxable personal income. Tax deduction for health insurance premiums was covered by a general ceiling on insurance premiums up until 1999 when a stand-alone limit was introduced. This policy meant there was little incentive to purchase or use private insurance. The value of this implicit government subsidy has been estimated at 4.8% of direct tax revenues or between 0.2% and 0.3% GDP. Incentives are skewed in favour of out-of-pocket expenditure.

Corporate insurance policies are more generous as the corporate tax laws are more liberal. Even so, few firms currently provide private group health insurance. It seems likely however that if there is to be any further growth in the market it will be in the area of group and employer insurance policies.

The main reasons for a potential growth in the private insurance market can be summarized as follows:

- the tax incentives which encourage high earners and companies to take out private health insurance;
- the social status which VHI confers on enrolees as it is indicative of a certain level of income;
- the difficulty in accessing the NHS and dissatisfaction with the services provided.

### **Mutual funds**

About 7% of the population are covered by mutual funds, which are funded through voluntary contributions. They are non-profit organizations that provide limited cover for consultations, drugs and more rarely some inpatient care. They do not exclusively provide health benefits to associates so it is difficult to calculate the health component of the contributions.

### Out-of-pocket payments

In recent years, there has been increasing use made of co-payments in health care with the aim of making consumers more cost aware.

Out-of-pocket payments have consistently accounted for about 45% of total health expenditure in Portugal over the last ten years (see Table 5). The majority of this expenditure is on drugs, over 50% in 1994/1995 (see Table 6). The share of out-of-pocket expenditure on drugs has increased significantly from 46.2% in 1989/90 to over 55% in 1994/1995. Medical, nursing and paramedical services and therapeutic products make up the bulk of the rest. These three items of expenditure represent over 90% of a household's out-of-pocket payments on health care.

The co-payments on pharmaceuticals vary from 40% to 100% depending on the therapeutic value of the drug. Pensioners pay a reduced co-payment and the chronically ill are exempt from co-payments on some courses of medication. More detail about the level of co-payment for pharmaceuticals is given in the section on *Pharmaceutical co-payments*.

**Table 6. Out-of-pocket spending on health, by type of expenditure (% of total out-of-pocket health expenditure), 1989/1990 and 1994/1995**

	1989/1990	1994/1995
Drugs	46.2	55.1
Medical, nursing and paramedical services	36.2	36.8
Therapeutic products	10.2	4.4
Hospital expenses	6.3	2.6
Private health Insurance*	0.6	0.6
Other	0.4	0.4

Source: National Institute for Statistics 1996 (29).

\* This is the percentage of a household's expenditure which is spent on the purchase of private health insurance policies. This contrasts with Table 5 which shows the proportion of total health expenditure that is financed by voluntary health insurance companies.

Within the European Union, Portugal has one of the highest levels of out-of-pocket payments for health care (see Table 7)<sup>7</sup>.

Flat rate payments exist for consultations (primary care Esc.300, hospital outpatients Esc.600 central and Esc.400 district hospital), emergency visits (health centre Esc.400 and hospital Esc.1000), home visits (Esc.600) and diagnostic tests and therapeutic procedures (variable). (Note: all figures for 1998). Transportation costs are paid by the patient, except in special circumstances,

<sup>7</sup> Other available estimates of the out-of-pocket payments suggest that the OECD values may be overestimates and therefore the figures should be treated with some caution.

**Table 7. Out-of-pocket health expenditure in Portugal and selected European Union countries (% of total health expenditure and per capita US \$PPPs) 1985–1995**

	1985		1990		1995	
	%	Per capita US \$PPPs	%	Per capita US \$PPPs	%	Per capita US \$PPPs
Portugal	45.4	173	46.3	284	44.6	457
Austria	19.6	160	22.4	270	23.7	389
Finland	19.5	166	17.3	223	23.6	323
Denmark	11.3	120	12.5	171	13.3	228
Ireland	14.4	85	15.1	115	13.2	159
Germany	11.2	110	11.1	142	10.8	230
Luxembourg	9.2	82	5.5	82	6.2	129
United Kingdom	3.3	22	3.4	33	2.7	33

Source: OECD health data, 1998 (32).

Note: Out-of-pocket expenditure includes cost sharing and direct payments to providers.

such as when the patient has to travel a long distance, when costs are subsidized. Patients are exempt from co-payments and user charges if they are classed as “low income” (i.e. in receipt of supplementary benefit or unemployed), have special medical needs (i.e. the physically handicapped or those with chronic illnesses) and special patient groups such as pregnant women, children up to 12 years of age, drug addicts in rehabilitation and chronic mental patients.

### External funding

Since 1994 there has been a programme of investment in health care services, co-financed by the European Union. Through the European Regional Development Fund (ERDF) significant investments have been made. For each co-financed project the Portuguese contribution must be at least 25% of total investment. The external funding complements the Ministry of Health’s own capital expenditure plans.

## Health care benefits

Theoretically, there are no services explicitly excluded from NHS coverage. However, throughout Portugal, there are some types of care which should be provided by the NHS but which are not available in practice (for example, adult dental care)<sup>8</sup>. In these cases activity is mostly in the private sector and reimbursed by the NHS. Apart from these instances, the NHS, at least in theory, is totally comprehensive.

<sup>8</sup> According to the *Health Interview Survey 1995/1996* (8), about 92% of dental consultations were in the private sector.

Regarding direct provision, the NHS predominantly provides hospital care, GP and mother and child care. Specialist and dental consultations, and diagnostic services are more commonly provided in the private sector and reimbursed by the NHS. There are also gaps in provision due to geographical inequities. Some areas, for example, are unable to provide certain specialist services to the population.

## **Pharmaceuticals**

A national drug formulary of active substances and ingredients lists all drugs approved for use in Portuguese NHS hospitals. Any drugs which are prescribed to inpatients, yet do not appear in the formulary, must be approved by a committee of pharmacists and doctors in each hospital. About 30% of drugs prescribed in hospitals are outside the formulary. In the ambulatory sector and outpatient departments, doctors are free to prescribe any drug.

## **Waiting lists**

Waiting lists are often viewed as a means of rationing care in the public sector as people may be encouraged to opt for the private sector. The results of a recent study in Portugal suggest that waiting lists are a growing problem. The number of patients on waiting lists amounted to almost 15% of total hospital discharges in a single year (33). There is currently a census taking place of patients on waiting lists. Early results suggest there are more people than expected on waiting lists. However this may be due to duplication, with some patients appearing on two or more waiting lists for the same procedure at different hospitals.

It is not possible to identify any areas of health care where explicit choices have been made about rationing. There have been discussions about defining a “basic package” of health care benefits, but until now there has been no indication of such a policy being implemented. Though rationing may not happen explicitly, it may occur implicitly within the NHS as a result of difficulties in access, the absence of specialists and doctors in rural areas and the lack of supply of certain services.

## **Health care expenditure**

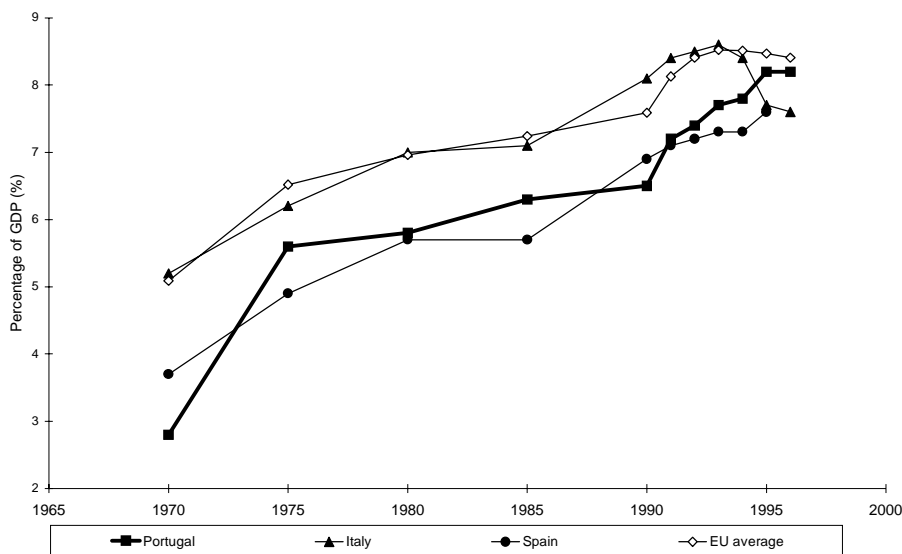
Total health care expenditure in Portugal measured as a share of GDP was 8.2% in 1996. The proportion rose steadily from as little as 3% in 1970 to its present level (see Fig. 3). Portugal spends marginally less than the western European average of 8.4% (1996); however, there has been a convergence

**Table 8. Trends in health care expenditure in Portugal, 1970–1997**

<b>Total expenditure on health care</b>	<b>1970</b>	<b>1975</b>	<b>1980</b>	<b>1985</b>	<b>1990</b>	<b>1995</b>	<b>1996</b>	<b>1997</b>
per capita in current prices (escudos)	642	2 663	8 507	25 335	63 643	125 050	132 864	140 916
per capita in constant prices (1990) (escudos)	17 035	–	42 834	43 628	63 643	–	86 275	–
Value in current prices per capita (US \$PPP)	43	145	260	381	614	1 025	1 071	1 125
Share of GDP (%)	2.8	5.6	5.8	6.3	6.5	8.2	8.3	8.2
Public as % of total expenditure on health care	59.0	58.9	64.3	54.6	65.5	60.5	59.8	60.0

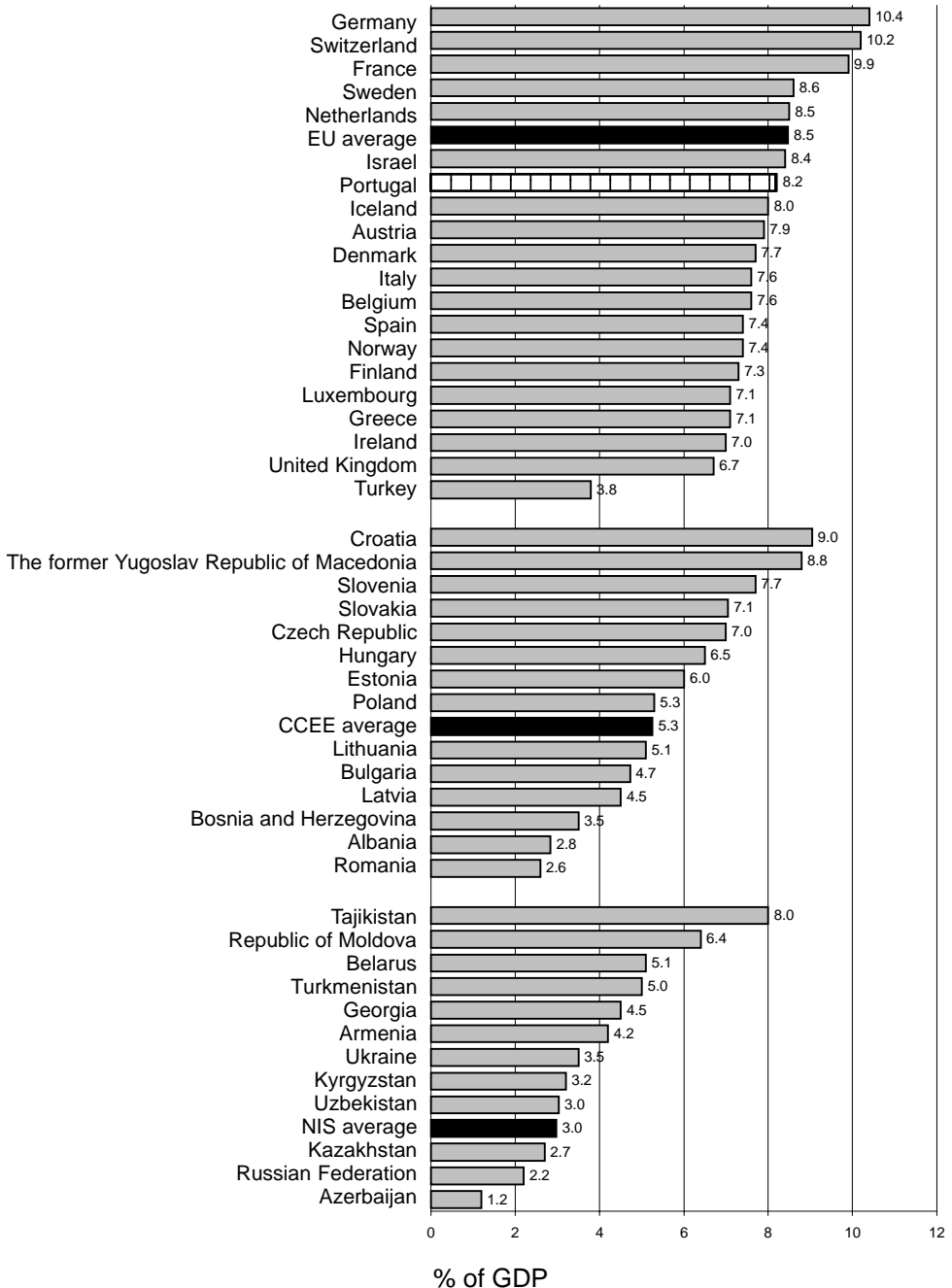
Source: OECD health data 1998 (32).

**Fig. 3. Trends in health care expenditure as a share of GDP (%), in Portugal and selected western European countries. 1970–1996**



Source: WHO Regional Office for Europe health for all database (51).

**Fig. 4. Total expenditure on health as a % of GDP in the WHO European Region, 1997 or latest year**



Source: WHO Regional Office for Europe health for all database (51).

Portugal

over time. Portugal now spends more than both Italy and Spain despite having spent considerably less than both these countries in 1970. Compared to the other southern European countries, it appears that Portugal has not contained health care expenditure growth as successfully. Table 8 also shows that the amount spent on health care has risen both in absolute terms and in relative terms over the last three decades.

Fig. 4 shows that Portugal's GDP spend on health care is near to the western European average of 8.4%. It is one of the highest in western Europe with only Germany, France, Switzerland and the Netherlands spending a larger percentage of GDP on health care. Methodological difficulties with calculating both health care spending and the size of GDP mean that direct comparisons should be made cautiously.

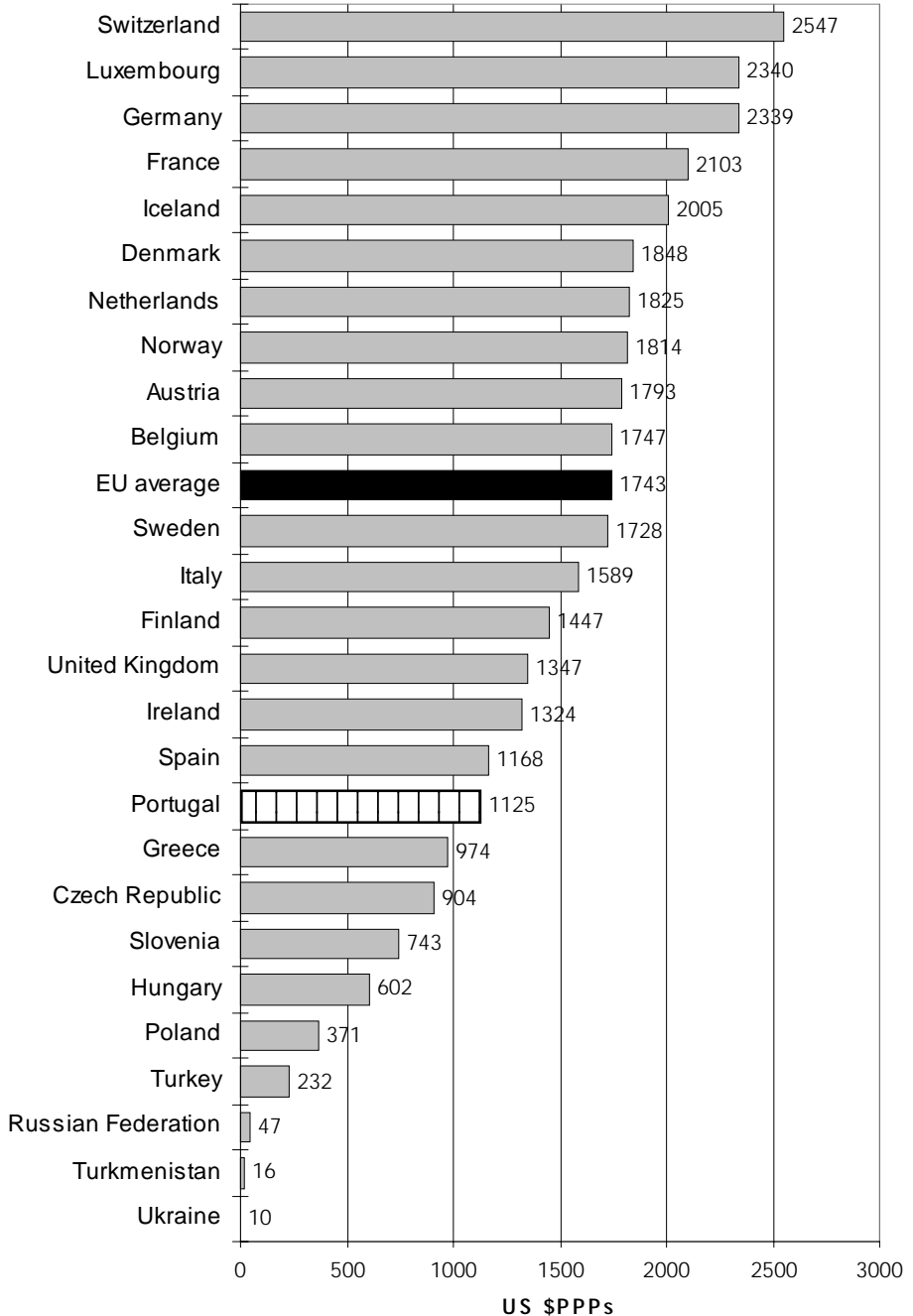
Using instead US \$ purchasing power parity (PPP) per capita as a measure of health care expenditure, one can see in Fig. 5 that Portugal falls well below the European Union average. Portugal spent US \$PPP1125 per capita on health care in 1997 which is similar to other EU countries such as Spain (US \$PPP1168) and Ireland (US \$PPP1324). Within the EU only Greece spends less per capita (US \$PPP974).

In Portugal the proportion of total health expenditure which is from public sources, i.e. money raised through taxation or health subsystems (that are frequently publicly funded), is 60% (see Fig. 6) the lowest in the European Region. Other southern European countries have slightly larger proportions of public expenditure, such as Spain with 78.7%, Italy 69.9% and Greece 74.8%. Portugal contrasts with the northern European tax-based systems such as Sweden (83.3%), the United Kingdom (84.5%) and Norway (82.2%).

Public health expenditure as a percentage of total health expenditure in Portugal has fluctuated over the last 20 years between 55% and 65% of total (see Table 8).

Table 9 shows general trends in the expenditure on different categories of health service provision in recent years. Inpatient care accounted for 36% of total expenditure in 1995, whereas ambulatory care was only 24%. Inpatient care as a percentage of total health expenditure has been rising. Pharmaceuticals consume a growing proportion of health expenditure up from 20% in 1980 to over 26% in 1996.

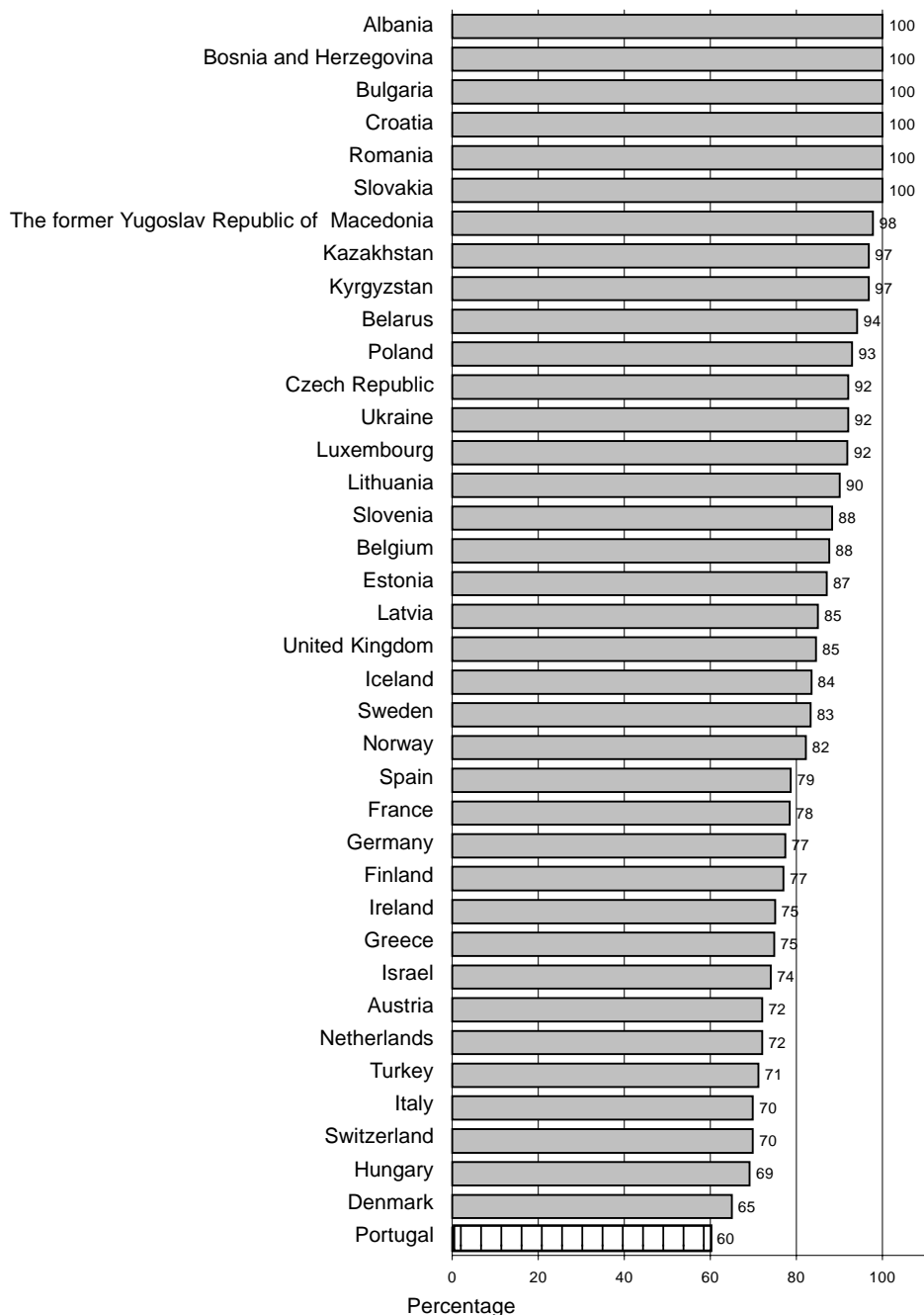
**Fig. 5. Health care expenditure in US \$PPP per capita in the WHO European Region, 1997 or latest available year**



Source: WHO Regional Office for Europe health for all database (51).

Portugal

**Fig. 6. Public (government) health expenditure as % of total health expenditure in the WHO European Region, 1997 or latest available year**



Source: WHO Regional Office for Europe health for all database (51).

As in many other health systems, despite attempts to prioritize primary health care over specialist hospital-based medicine, expenditure on ambulatory care services remains lower than on inpatient care. In the Portuguese health system, the reliance on hospitals may be due in part to the difficulties that health centres have in providing ambulatory care to the population, resulting in large numbers of the population attending emergency departments or specialist outpatient clinics.

**Table 9. Health care expenditure by categories in Portugal (as % of total expenditure on health care) 1980–1996**

	1980	1985	1990	1991	1992	1993	1994	1995	1996
Inpatient care (%)	28.7	26.4	32.3	33.0	35.0	36.5	36.8	36.2	–
Ambulatory care (%) public only	25.2	26.8	23.5	23.9	23.1	27.8	26.1	24.2	–
Pharmaceuticals (%)	19.9	25.4	24.9	24.3	24.7	25.6	25.2	25.2	26.3
Public investment (%)	5.1	2.2	1.7	1.8	2.3	2.5	3.3	1.9	2.5

Source: OECD health data 1998 (32).

## Health care delivery system

### Primary health care

Primary health care in Portugal is delivered by a mix of private and public health service providers. In this section, primary health care will be taken to cover all health care provided out-of-hospital by both generalists and specialists, and other non-specialist care and services such as dental care services, physiotherapy, radiology, and diagnostic services.

#### Public sector

Primary health care in the public sector is mostly delivered through publicly funded and managed health centres (HCs). Each of them covers an average of 28 000 people. They employ in total 30 000 people (including regional health administration personnel). Of these, 25% are doctors (mostly general practitioners) and 20% are nurses. There are on average 80 health professionals per centre, but some have as many as 200, others as few as only one medical doctor. Centres currently have no financial or managerial autonomy but are directly run by the regional health administrations (RHAs). The Ministry of Health allocates funds to the RHAs which in turn determine the budget of each centre based on historical and activity costs.

Most primary health care is delivered by GPs in the health centre setting. However, some health centres also provide a limited range of specialized care. This is a result of the integration of social welfare medical services into the National Health Service at the end of the 1970s. Specialists who had worked for the Department of Social Welfare were transferred and given contracts in the newly established NHS health centres. The specialists who work in HCs belong to the so-called ambulatory specialities such as mental health, psychiatry, dermatology, paediatrics, gynaecology and obstetrics and surgery. However, very few of these posts will be filled when present incumbents leave.

The range of services provided by GPs in HCs is as follows:

- general medical care, for the adult population and the elderly
- prenatal care
- children's care
- women's health
- family planning and perinatal care
- first aid
- certification of incapacity to work
- home visits<sup>9</sup>
- preventive services, which include immunization and screening for breast, cervical and prostate cancers.

Patients must register with a GP. Theoretically, there is freedom of choice of GPs. People can choose among the available clinicians within a geographical area. Some people seek health care services in the area where they work but most choose a GP in their residential area.

GPs work with a system of patient lists, on average approximately 1500 patients. There are GPs with patient lists exceeding 2000 and others with fewer than 1000. People may change GP if they apply in writing, explaining their reasons, to the RHA board. There is no statutory limit to how often someone may change their GP.

According to international sources, the number of physician contacts per person in Portugal is 3.2 (1996/1997), one of the lowest in the EU with only Sweden having fewer contacts (2.9) (see Fig. 7).

National data used in Table 10 shows the number of medical appointments in health centres per capita has grown from 2.9 in 1980 to 3.3 in 1996. The number of home visits is insignificant.

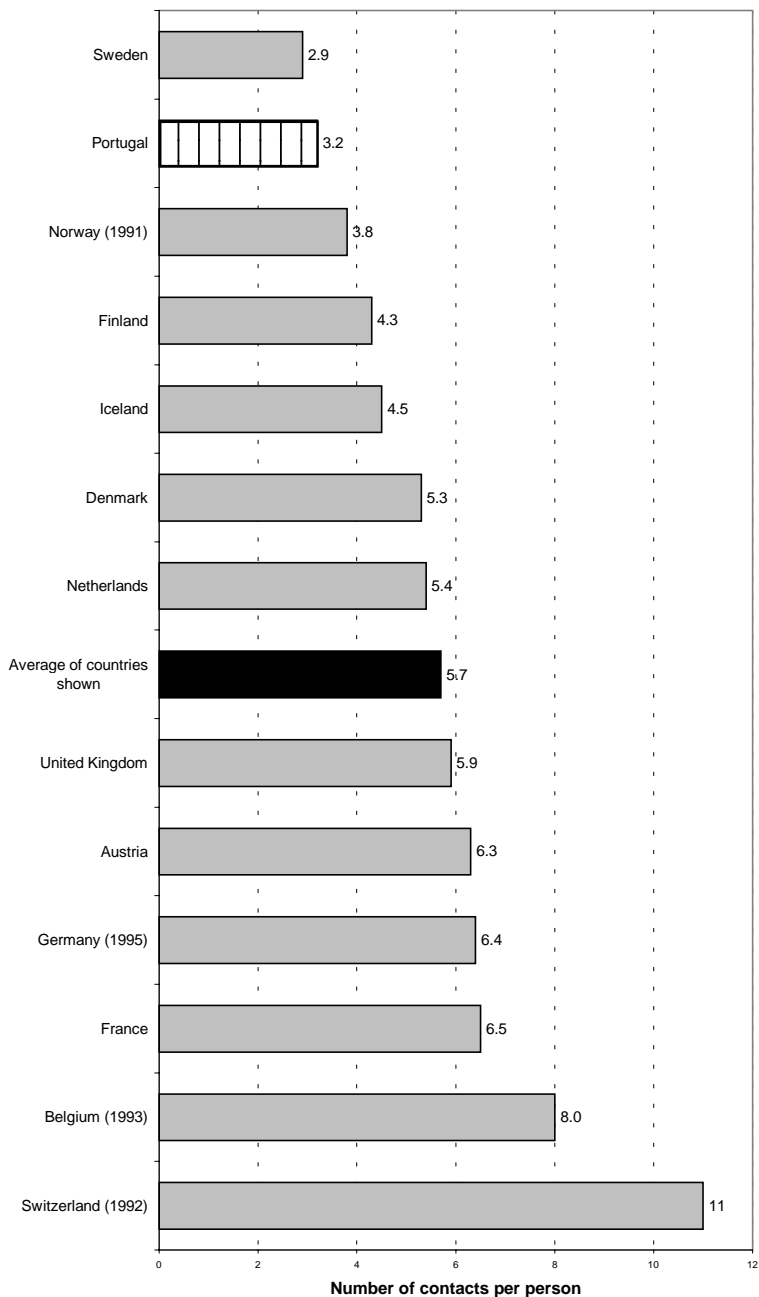
**Table 10. Medical appointments in health centres and home visits, 1980–1996**

	1980	1990	1991	1992	1993	1994	1995	1996
Medical appointments per capita	2.9	3.1	3.1	3.1	3.1	3.2	3.3	3.3
Home visits (1000)	1 031	191	162	141	141	130	125	122

Source: Department of Health Studies and Planning (38,40,42,44,46,48,50).

<sup>9</sup> There are very few home visits made by GPs – less than 48 per year per health centre.

**Fig. 7. Physician contacts per person in OECD countries within Europe, 1996/1997 or latest available year**



Source: OECD health data 1998 (32).

## Facilities

The number of health centres and health posts has continued to grow throughout the 1980s and 1990s with a total of 2424 primary care medical units in 1996 (see Table 11).

**Table 11. Number of primary care facilities in Portugal 1970–1996**

	1970	1980	1990	1996
Medical Units	1 935	2 195	2 249*	2 424
Health Centres	-	265	354	382
Health Posts	-	1 682	1 895	2 042

Source: National Institute for Statistics, 1990–1995 (23,24,25,26,27,28).

The facilities provided by each health centre (HC) vary widely across the country in terms of the physical structure and layout of the HCs:

- Some HCs were purpose-built and are therefore of a reasonable size, with a rational distribution of space, and discrete and segregated areas for different purposes;
- Some HCs, mainly those in large cities, were incorporated into residential buildings and consequently many are badly designed and are not patient-friendly;
- Some HCs, mainly those in rural areas which are operated by *Misericórdias* or belong to the church, were established in ancient hospitals and monasteries (in the 1960s).

Due to the long waiting times for access to diagnostic facilities in the health centres, many patients prefer to go directly to emergency care services in hospitals or the private sector. In emergency departments the full range of diagnostic tests can be obtained in a few hours. This leads to excessive demand at emergency departments and considerable misuse of resources as expensive emergency services are used for relatively minor complaints.

## Challenges and reforms

The major problems currently facing primary health care are:

- Inequitable distribution of health care resources;  
Although there are a large number of health centres inland, there is a lack of health care personnel (mainly doctors and nurses) because the coastal areas are more attractive.

- Difficult access to primary health care;  
Barriers to accessing health centres means that excessive numbers of people go directly to hospital emergency departments.
- Very limited public provision of services in continuing and home care;
- Weak reputation of the public primary health care system;  
For many people, the system lacks credibility and therefore encourages many patients to seek second opinions from private doctors or hospital out-patient departments;
- Lack of quality control programmes;  
There is no quality assurance process.
- Lack of coordination;  
There is very little coordination between primary health care centres, hospital doctors, hospitals and private doctors, leading to unnecessary repeat examinations and tests, which merely waste time and have no impact on health outcomes or quality of care.
- Lack of motivation of general practitioners;  
GPs in many places work in isolation and with poor incentives for productivity due to their salaried status.
- The shortage of qualified ancillary staff in health centres.  
Recent health care reform proposals aim to tackle these problems by:
  - increasing accessibility
  - improving continuity of care
  - increasing GP motivation, through changes in the payment system
  - stimulating home care services
  - identifying quality.

A number of pilot projects were established in 1995. Of particular interest is the *Alfa Project* which began in the Lisbon and Tagus Valley Region.

The objectives of these projects were:

- to increase GPs' job satisfaction;
- to increase patients' satisfaction with primary care services;
- to increase access to public health services – a greater availability of post-natal care, care centred on the citizen and more time for consultations;
- to improve quality;
- to rationalize prescriptions of pharmaceuticals and the number of diagnostic tests and examinations.

The *Alfa Project* experimented with a revised GP payment scheme in which groups of GPs were given overtime payments and other incentives in return for

an assurance of providing 24-hour cover and adequate referral and follow-up of patients. A preliminary internal evaluation of these pilots indicated that the integrated models were successful, mainly because there was an improvement in satisfaction from both citizens and providers. Some of the principle ideas behind the reforms have been adopted nationally and new methods of remuneration for GPs are being introduced (see the section on *Payment of health care professionals*).

More radical reforms to grant greater autonomy to health centres have been proposed but not yet enacted. These would grant both financial and administrative autonomy to the centres. There is currently no solidarity between GPs who often feel isolated within the health centre. The proposal aims to increase a sense of team spirit by establishing smaller groups of GPs within the centre. Each group of doctors would be contracted by the RHA and would be accountable to the RHA for the care they provide. In order to encourage doctors to join the scheme the RHA are considering offering incentives such as bonus-payments, improved quality of premises and a special credit scheme for equipment and investment in facilities (this is awaiting approval from the Ministry of Finance). One of the additional responsibilities which will form part of the contract is the provision of 24-hour cover.

### **Diagnostic and therapeutic services**

Portugal also has a large independent private sector which provides diagnostic and therapeutic services to NHS beneficiaries under contracts called “*convencões*”. These medical contracts cover ambulatory health facilities for laboratory tests and examinations such as diagnostic tests and radiography (they are scarce in medical consultations). The contracts operate as follows: the NHS publicly declares the terms of service and prices that the NHS is willing to pay. All providers who are prepared to meet the criteria and who meet basic quality standards can register. A list of all those providers who have registered is published annually. In principle, patients can choose from any of the providers who appear on the contracts. Many patients actually go directly to the emergency departments of hospitals where they can obtain all necessary tests within a much shorter time. Prices do not vary according to the level of service which means providers have little incentive to improve the quality of services.

### **Dental care**

The publicly-funded oral health care system in Portugal is not very comprehensive. There are very few NHS dentists, so people normally use the private sector. Some dentists contract with one or more of the health subsystems. Each scheme defines its own list of eligible treatments and fees. The schemes are

usually slow to pay and the fees are low. Those dentists not under contract may provide care to patients covered by the schemes; patients pay directly and are then reimbursed by the scheme. As well as dentists, dental hygienists (who have a more limited training) provide dental care though it must be under the direction of a dentist.

### **Referral process and links between primary and secondary care**

The first point of contact within the public system is the GP in a health centre (HC). Theoretically, people have no direct access to secondary care and GPs are expected to act as gatekeepers, i.e. patients should have a prior consultation with a GP before they can access specialist hospital or ambulatory services. Frequently, there is a delay in obtaining a consultation depending on the specialty.

In reality, most people go directly to the emergency department in hospitals if they have any acute symptoms. A very large number of the attendees at hospital emergency units do not however need immediate care. People who go to emergency departments and genuinely need specialized care are immediately referred. There are user charges for emergency visits (currently Esc. 400 for visits to health centres and Esc.1000 to hospital emergency departments). However these do not appear to affect the inappropriate use of emergency services.

Those patients who are covered by the health subsystems can go directly to private hospitals and specialists allowed by their schemes. Private doctors can also refer them to NHS hospitals. Those patients covered by private health insurance may be eligible for private specialist consultations but this will depend on the benefit package offered.

### **Reforms**

The problem of lack of coordination between hospitals and health centres and the large numbers of patients by-passing the referral system has prompted reform. One of the reform proposals, which has been on the agenda since the foundation of the NHS, is the development of local health units. The idea was to link a hospital (or several hospitals) with a number of health centres based partly on geographical proximity and partly on the balance of specialities and availability of an accident and emergency department. These “health units”, whose main focus was health care institutions, were established but they failed to achieve any improvements in coordination and did not fulfil the aim of integrating, coordinating and facilitating continuity of care.

The latest reform, enacted in May 1999, goes further and proposes the establishment of “local health systems”. These would include private institutions and local councils as well as the medical services provided within the

NHS. These local health systems are expected to lead to a more adequate and functional interlinking between secondary and primary, public and private care. They aim to change the present scenario of lack of coordination among services and embrace a broader sense of health care with the focus on the population. They are community-based and include all providers, both public and private, as well as representatives of citizens' groups (either someone nominated by the municipal council or a consumers' association where they exist). The proposal is to calculate population-based budgets based on total health expenditure in the area covered by the health system. These resources will then be allocated at a local level amongst all providers based on an assessment of health needs in the area. The RHAs are currently developing a methodology to assess health needs on which decisions about financing priorities and allocations will be based.

## Public health services

The public health services in Portugal are responsible for surveillance of health status and 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.

The organization of public health services nationally is the responsibility of the General Directorate of Health (GDH). The GDH is responsible for the establishment of programmes, definition of strategy and approval of national plans.

At a regional and local level the main actors are as follows:

- Local health authority – an extra level of administration in the public health system, which consists of a public health doctor usually in a health centre;
- Public health doctors and sanitary technical staff;
- Regional health authority – work in health sub-regions and support public health services through the provision of regional laboratories;
- GPs – responsible for health promotion as part of their day-to-day work including family planning, antenatal services and screening programmes.

Public health doctors have the primary responsibility for the promotion of health and surveillance of disease. However in many health centres these responsibilities are transferred to GPs. Their responsibilities include:

- Ensuring compliance of local services, e.g. restaurants, hotels, etc. with health and safety standards;

- environmental inspections of places of work;
- building safety and housing inspection;
- communicable disease surveillance and notification.

### **Reform of public health services**

There is a policy to strengthen public health at both regional and local levels through provision of epidemiological expertise and leadership functions in health promotion issues. Of particular note is the establishment of SARA (Rapid Response System), a new information and management system for health emergencies, whether related to food safety, communicable diseases or environmental health. This project aims to build a national information network for all public health staff, connecting all levels of public health care. It will provide the basis for the continuous development of standard guidelines and enable rapid responses to such emergencies.

Public health doctors currently have a low status within the NHS and there are problems with recruitment (half of all public health doctors' vacancies were unfilled in 1998). Their work up to now has been to act as health inspectors and occupational health officers, which was heavily bureaucratic and meant working to old directives. The aim of the latest reform is to link the development of "local health systems" with the new public health structures, giving public health doctors a broader remit for the health of the population. New teams of public health doctors and nurses will be established. By creating these new "public health units" previously disparate resources will be brought together.

A National Health Observatory is also being established as part of the National Institute of Health which will be responsible for coordinating disease surveillance.

### **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, e.g. the National Prevention Council against Tobacco Consumption and the National Committee on AIDS. Proposals have been put forward to establish a Drug and Alcohol Institute in order to bring together the work of all government sectors on this issue. This would be a multi-ministerial initiative led by the Prime Minister. It should be noted, however, that vertical programmes have tended to have low success rates.

Yet, as Fig. 8 shows, Portugal has one of the highest immunization rates against measles in the European Region at 99% (1996/1997). Immunization

rates against other diseases are also quite high: tuberculosis 86.6%, diphtheria 93.5%, tetanus 93.5% and poliomyelitis 92.6% (all figures for 1997) (51). Responsibility for the implementation of the national immunization programme lies with the health centres, whose activities include school health services. Such high rates of immunization may be due to the strong network of primary health care centres built up during the 1980s.

## Secondary and tertiary care

Secondary and tertiary care is mainly provided in hospitals although, as discussed above, some health centres employ specialists who provide specialist ambulatory services. These positions are gradually diminishing in number and do not form a significant part of secondary and tertiary care provision. This section will focus on hospital inpatient and outpatient services.

### Hospitals

In 1996, Portugal had 211 hospitals: 122 public and 89 private hospitals (see Table 12). Almost half of the private hospitals belong to for-profit organizations. The sharp decline in hospitals owned by *Misericórdias* between 1970 and 1980 follows the incorporation or “nationalization” of these facilities into the NHS during this decade. *Misericórdias* currently operate hospitals and facilities in the areas of rehabilitation, long-term care and residential care for the elderly, disabled and chronically sick (see the section on *Organizational structure of the health care system*).

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 211 in 1996 (a reduction of 67 %).

**Table 12. Numbers of hospitals by category, 1970–1996**

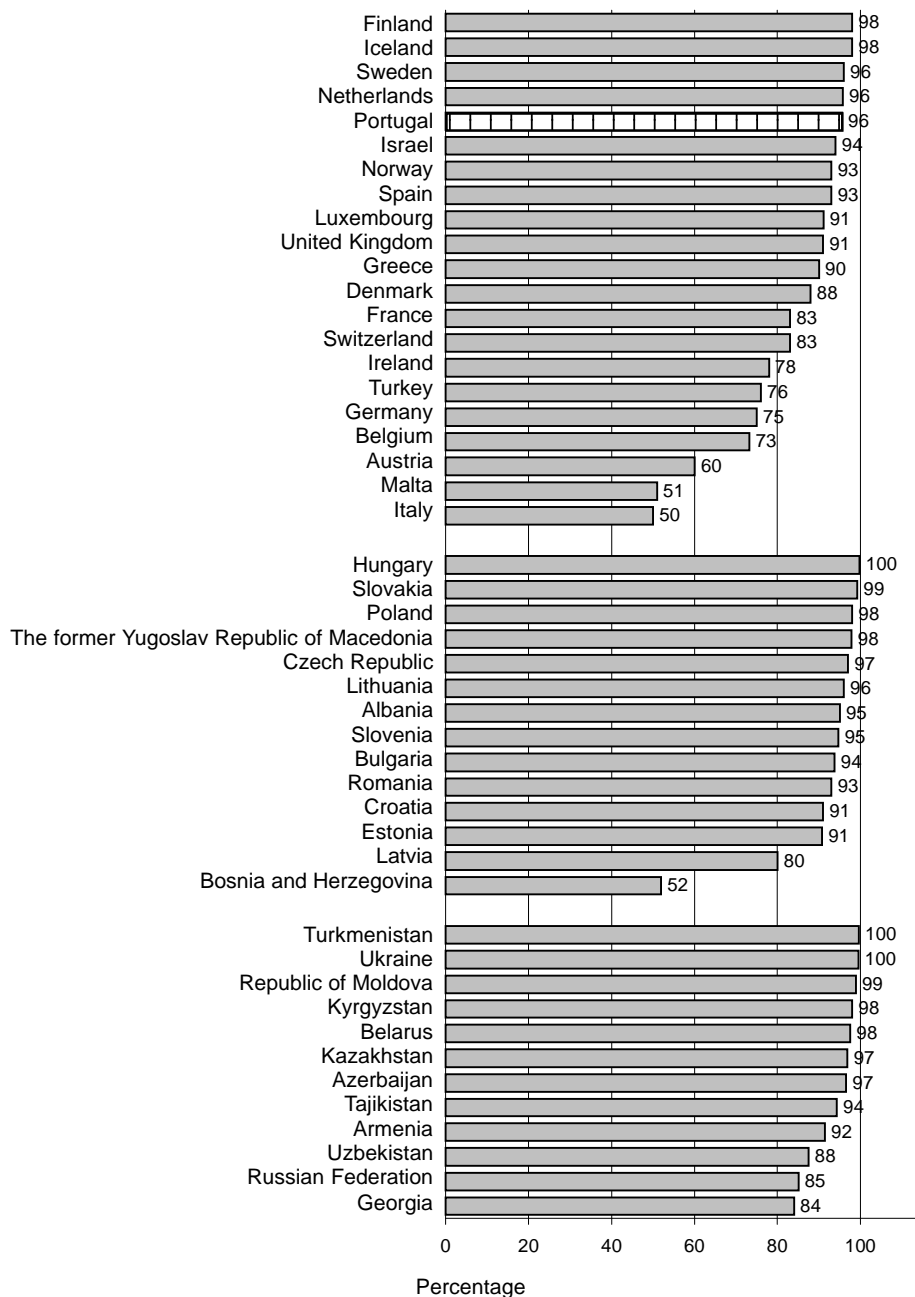
	1970	1980	1990	1996
<b>Total</b>	<b>634</b>	<b>493</b>	<b>257</b>	<b>211</b>
Government	171	394	145	122
Misericórdias	284	8	–	–
Other Private	160	89	95	89
For Profit	–	–	44	40
Not For Profit	–	–	51	49
Other	19	2	17	10

Source: National Institute for Statistics, 1990–1995 (23,24,25,26,27,28).

Note: Hospitals do not include psychiatric, rehabilitation or hospitals outside the mainland.

Most hospital services are provided according to the integrated model, i.e. directly by the NHS. However, non-clinical services, e.g. maintenance, security,

**Fig. 8. Levels of immunization for measles in the WHO European Region, 1997 or latest available year**



Source: WHO Regional Office for Europe health for all database (51).

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 to the NHS through all-willing provider contracts. A very limited number of clinical services are being contracted out, usually in specific areas where waiting list reductions are needed, for example, cataracts.

Hospitals are classified according to the services they offer:

- central hospitals provide highly specialized services with advanced technology and specialist human resources;
- specialized hospitals provide a broad range of specialized services;
- district hospitals are located in the main administrative district and provide a range of specialist services;
- district level-one hospitals only provide internal medicine, surgery and one or two other basic specialties.

Health resources are concentrated in the capital, Lisbon, and along the coast. There are no specialized or central hospital facilities in the regions of Alentejo and Algarve and only five and three district hospitals respectively (see Table 13).

Many of the hospitals inland lacked resources and had poor facilities compared to those in Lisbon and Porto. The investment programme in recent years has concentrated heavily on these poorer rural regions and the hospitals there have benefited greatly. In fact, many of the district hospitals inland now have better facilities than those in the coastal areas.

**Table 13. Number of NHS hospitals by health regions (1996)\***

Region	Central	Specialized	District	District Level 1	Total
North	3	4	11	9	27
Centre	2	1	12	12	27
Lisbon and Tagus Valley	9	9	11	2	31
Alentejo	–	–	3	2	5
Algarve	–	–	2	1	3

Source: Institute of Financial Management and Informatics (1996) (14).

\* This table only includes mainland NHS hospitals. It does not include psychiatric hospitals, military hospitals and other government hospitals, autonomous regions or private facilities.

## Hospital beds

The total number of hospital beds in 1996 was 39 212. Government-controlled hospitals accounted for 30 392 beds or 77.5% of total beds in Portugal (see Table 14). The beds in the charitable hospitals have become obsolete since the 1980s as a result of nationalization and the specialization of these organizations

in the provision of rehabilitation, psychiatric and long-term care. The decline in total bed numbers between 1980 and 1990 actually reflects a dramatic decline in beds within the NHS. This has been accompanied by an increase in the number of privately-owned beds.

**Table 14. Total number of beds\* by category in Portugal, 1980–1996**  
(% of total in brackets)

	1980	1990	1996
<b>Total</b>	<b>51 255</b>	<b>39 690</b>	<b>39 212</b>
Government	42 883 (83.7)	31 075 (78.3)	30 392 (77.5)
<i>Misericórdias</i>	464 (0.9)	-	-
Private and other:	7 908 (15.4)	8 615 (21.7)	8 820 (22.5)

*Source:* National Institute for Statistics, 1990–1995 (23,24,25,26,27,28).

\* This table does include beds in mental health hospitals, observation beds in emergency departments and joint beds with health centres used by long-stay patients. This accounts for the difference with Table 15.

The number of hospital beds per 1000 population, according to WHO statistics, has dropped by 11% over the period 1990 to 1995/1996. This is mostly due to the decline in hospital beds for the long-term care of the elderly and mentally ill. The decline is less dramatic in Table 14, which only includes acute beds on the mainland of Portugal (-1.2% over the same period). Portugal has one of the lowest number of hospital beds per 1000 population in western Europe (4.1) just below Spain (4.3) and above Turkey (2.5) and Ireland (3.7) (see Fig. 9).

**Table 15. NHS hospital beds\* by region in Portugal, 1995**

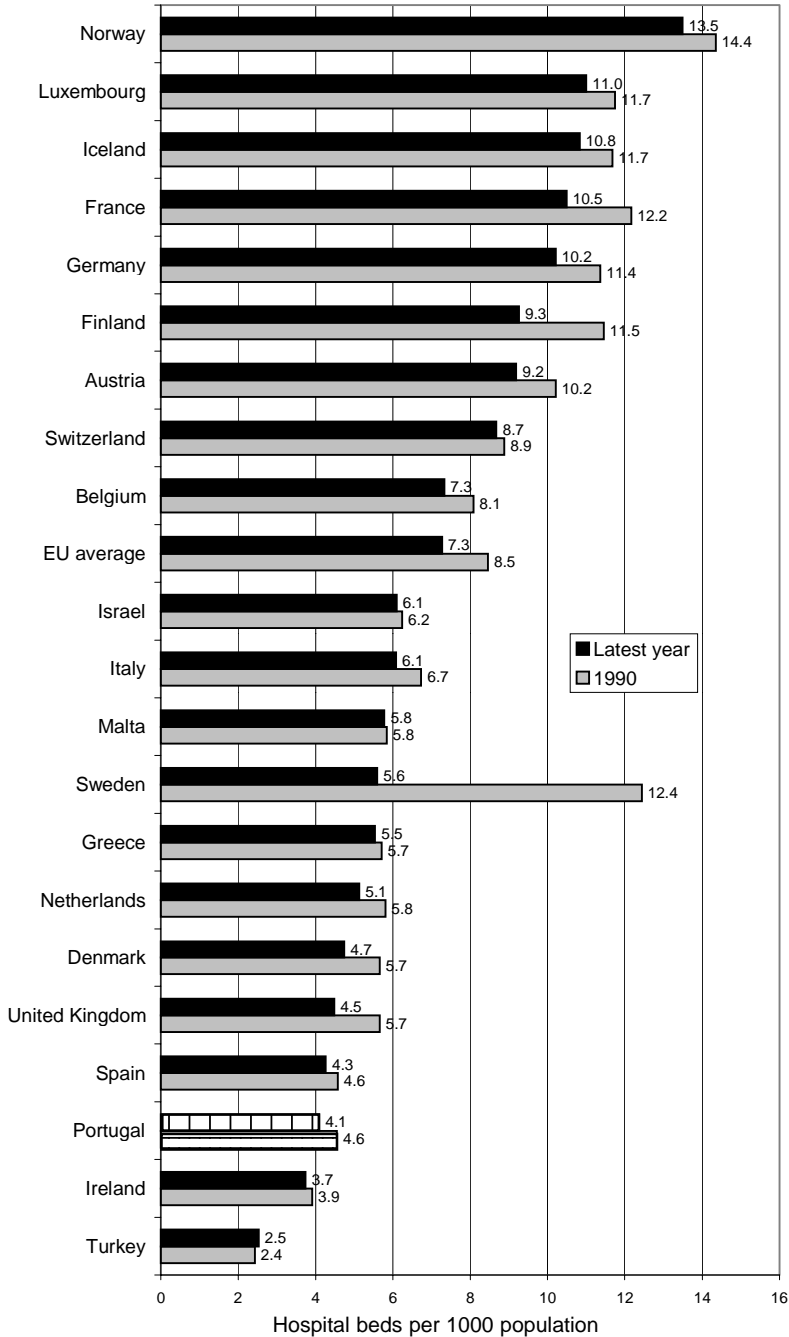
Region	Total	% of total	per 1000 population
North	6 845	29.3	2.2
Centre	6 214	26.5	2.7
Lisbon and Tagus Valley	8 738	37.3	2.7
Alentejo	969	4.1	2.2
Algarve	651	2.8	1.9
<b>Total/average</b>	<b>23 417</b>	<b>100</b>	<b>2.34</b>

*Source:* Institute of Financial Management and Informatics (1995) (13).

\*This table only includes mainland NHS hospital beds. It does not include beds in psychiatric hospitals, observation beds in emergency departments or joint beds with health centres used by long-stay patients.

As has been noted previously, there is an uneven distribution of resources between the regions. For most indicators of resources both human and material,

**Fig. 9. Hospital beds per 1000 population in western Europe, 1990 and latest available year**

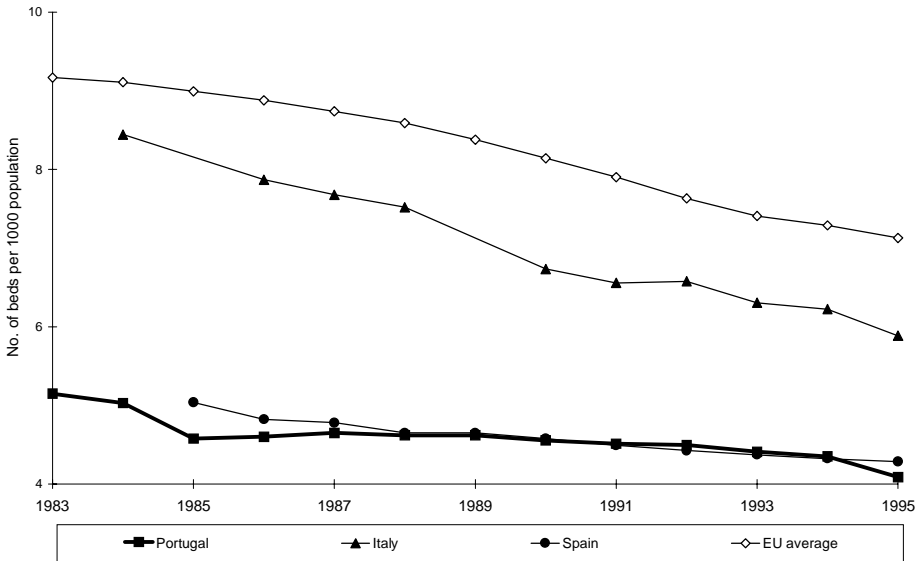


Source: WHO Regional Office for Europe health for all database (51).

Portugal

the regions of Alentejo and Algarve are the worst off. Table 15 shows that the Algarve not only has the lowest number of total beds but also has the lowest number of beds per capita. The Lisbon and Tagus Valley Region has the highest proportion of total hospital beds (nearly 40%) and has a similar per capita concentration as the Central Region.

**Fig.10. Hospital beds per 1000 population in Portugal and selected European countries, 1983–1995**



Source: WHO Regional Office for Europe health for all database (51).

Both Spain and Portugal have fewer hospital beds than the European average. The numbers have declined slightly between 1985 and 1995 but not nearly as dramatically as the steep decline in numbers experienced in other countries. Many of the cuts in bed numbers in other countries were due to a perceived oversupply, resulting from changes in technology, such as day surgery, and the increasing number of drug treatments which have reduced the demand for hospital beds. In other European countries a large proportion of the bed reductions were in long-term and psychiatric beds which did not account for such a high proportion of total beds in Portugal and Spain where services in these sectors were less developed.

## Utilization

The number of outpatient appointments per capita has increased steadily since 1990. Table 16 shows that the average length of stay decreased between 1990 and 1996 from 9.6 days to 8.0 days. The occupation rate has remained fairly low at about 75% since 1993. A slightly higher average length of stay can be seen in Table 17 because these figures include all facilities (i.e. long-stay beds for chronic, elderly and psychiatric patients). Similarly occupancy rates are even lower as figures in Table 17 include the autonomous regions and non-acute sector NHS hospitals.

**Table 16. Inpatient facilities utilization and performance in NHS hospital facilities in mainland Portugal\*, 1990–1996**

	1990	1991	1992	1993	1994	1995	1996
Outpatient appointments per capita	454	466.7	497.2	520	541	590.1	578.5
Average length of stay in days	9.6	9.27	8.8	8.4	8.3	8.2	8.0
Occupancy rate (%)	74.2	75.3	69.3	75.9	75.9	75.2	74.6

Source: Institute of Health Financial Management and Informatics (1995–1996) (13,14).

\*This table only includes mainland NHS hospitals. It does not include psychiatric hospitals, military hospitals and other government hospitals, autonomous regions or private facilities.

**Table 17. Inpatient facilities utilization and performance in both public and private health care services in Portugal\*. 1970–1996**

	1970	1975	1980	1985	1990	1995	1996
Admissions per 100 population	6.69	8.3	8.9	8.5	10.8	11.3	11.4
Average length of stay in days	23.8	17.6	14.4	13.9	10.8	9.8	9.8
Occupancy rate (%)	74.1	72.0	62.6	69.2	69.4	71.0	73.9

Source: OECD health data, 1998 (32).

\* Includes psychiatric hospitals, autonomous regions and private facilities.

Admission rates increased dramatically throughout the 1970s and 1980s but have now stabilized at  $\pm 11\%$  in the 1990s. Length of stay has fallen in line with trends in the rest of Europe due to advances in technology. The occupancy rate has been fairly consistent at around  $\pm 70\%$ .

Compared to other western European countries, Portugal has a relatively low number of hospital beds per 1000 population and an average utilization rate, measured by admission and occupancy rates (see Table 18).

**Table 18. Inpatient utilization and performance in the WHO European Region, 1997 or latest available year**

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
<b>Western Europe</b>				
Austria	9.2 <sup>a</sup>	25.1 <sup>a</sup>	10.5 <sup>a</sup>	75.1 <sup>a</sup>
Belgium	7.3 <sup>a</sup>	20.0 <sup>a</sup>	11.3 <sup>a</sup>	81.4 <sup>b</sup>
Denmark	4.7 <sup>a</sup>	19.8 <sup>b</sup>	7.3 <sup>a</sup>	79.1 <sup>b</sup>
Finland	9.3 <sup>b</sup>	26.7	11.0	74.0
France	10.5 <sup>a</sup>	22.8 <sup>b</sup>	11.2 <sup>a</sup>	75.0
Germany	10.2	—	14.3 <sup>a</sup>	79.8 <sup>a</sup>
Greece	5.5 <sup>a</sup>	15.0 <sup>b</sup>	8.2 <sup>a</sup>	—
Iceland	10.8 <sup>e</sup>	28.0 <sup>c</sup>	16.8 <sup>e</sup>	70.3 <sup>h</sup>
Ireland	3.7 <sup>a</sup>	15.1 <sup>a</sup>	7.5 <sup>a</sup>	82.3 <sup>a</sup>
Israel	6.1	19.0	13.0	93.0
Italy	6.1 <sup>a</sup>	17.5 <sup>a</sup>	9.4 <sup>a</sup>	77.4 <sup>a</sup>
Luxembourg	11.0 <sup>c</sup>	19.4 <sup>c</sup>	15.3 <sup>a</sup>	74.3 <sup>c</sup>
Malta	5.8 <sup>a</sup>	—	—	—
Netherlands	5.1	9.8	13.8	64.4
Norway	13.5 <sup>c</sup>	15.3 <sup>a</sup>	9.9 <sup>a</sup>	81.1 <sup>a</sup>
Portugal	4.1	11.8	9.3	70.1
Spain	4.3 <sup>a</sup>	10.0 <sup>a</sup>	11.0 <sup>a</sup>	73.9 <sup>c</sup>
Sweden	5.6 <sup>a</sup>	18.0 <sup>a</sup>	7.5 <sup>a</sup>	81.9 <sup>a</sup>
Switzerland	8.7 <sup>f</sup>	15.0 <sup>c</sup>	24.5 <sup>h</sup>	77.7 <sup>c</sup>
Turkey	2.5	6.9	6.1	57.7
United Kingdom	4.5 <sup>b</sup>	23.1 <sup>a</sup>	9.8 <sup>a</sup>	76.2 <sup>i</sup>
<b>CCEE</b>				
Albania	3.0	7.7	7.9	—
Bosnia and Herzegovina	4.5 <sup>f</sup>	8.9 <sup>f</sup>	13.3 <sup>f</sup>	70.9 <sup>f</sup>
Bulgaria	10.3	17.5 <sup>a</sup>	12.9	64.1 <sup>a</sup>
Croatia	6.0	14.9	12.9	89.3
Czech Republic	8.8	20.2	12.3	71.8
Estonia	7.4	18.3	10.9	71.4
Hungary	8.3	23.7	11.0	74.4 <sup>a</sup>
Latvia	9.7	21.7	12.9	—
Lithuania	9.8	21.8	12.9	—
Poland	6.2 <sup>a</sup>	11.6 <sup>b</sup>	10.4	—
Romania	7.4	20.9	10.0	—
Slovakia	8.3	19.9	12.1	78.5
Slovenia	5.7	16.2	10.0	77.7
The former Yugoslav Republic of Macedonia	5.2	10.0	13.4	63.9
<b>NIS</b>				
Armenia	6.8	6.7	13.9	36.1
Azerbaijan	9.6	5.8	17.5	—
Belarus	12.4	26.1	15.5	88.7 <sup>c</sup>
Georgia	4.5	4.3	10.5	26.8 <sup>c</sup>
Kazakhstan	8.4	15.1	16.5	80.8
Kyrgyzstan	8.3	17.5	14.5	83.6
Republic of Moldova	11.3	18.7	18.0	80.0
Russian Federation	11.4	20.6	16.6	87.7
Tajikistan	7.0	11.0	15.0	59.9
Turkmenistan	7.1	13.0	13.4	72.1
Ukraine	9.4	19.1	16.2	85.2
Uzbekistan	6.4	15.8	13.8	—

Source: WHO Regional Office for Europe health for all database (51).

Note: <sup>a</sup> 1996, <sup>b</sup> 1995, <sup>c</sup> 1994, <sup>d</sup> 1993, <sup>e</sup> 1992, <sup>f</sup> 1991, <sup>g</sup> 1990, <sup>h</sup> 1989, <sup>i</sup> 1986.

## Reforms

One of the main problems facing hospital services in Portugal is the excessive use of emergency departments for non-urgent treatment. In the 1998 National Health Strategy (20), a number of objectives were set out including:

- reducing waiting lists through more efficient services
- an increasingly patient-friendly service with a special effort to cut waiting times
- reorganization of emergency departments
- contracting-out of activities and projects that are considered priorities.

A policy announcement was made at the beginning of 1999 that outpatient departments would be reorganized to give priority to patients with referral letters. As an incentive to patients to use the primary care services and to promote the use of the GP gatekeeping function, those patients without letters of referral will be made to wait longer than those with letters. This may help to reduce the numbers of patients bypassing the referral process.

Another major change for hospital services is the change in their funding from allocation based on historical budgets to contracted budgets. The Regional Agency (part of the RHA) will contract with the hospital board who will, in turn, contract with a multidisciplinary team of health professionals for the delivery of services in fulfilment of the contract. (This process is more fully described in the section on *Payment of hospitals*.)

## Social care

There is very little state provision of community care services in Portugal, including 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 and cultural reliance on the family as the first line of care in Portugal. This reliance on an informal network of care is particularly strong in rural areas. However, demographic changes such as the increase in female employment and a breakdown in the extended family 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 faces a growing elderly population and the pressure to provide social as well as medical care is increasing.

## Elderly care

Some social services are provided in each region through the Ministry of Social Security. However, *Misericórdias* which are independent charitable organizations are the key providers of social care services.

Day centres for the elderly provided 41 195 places in 1998 according to the Ministry of Social Security. They provide a range of services including activities, meals, food to take home, laundry services, bathing and even assistance with obtaining medication and attendance at health centres. A small means-tested contribution is usually charged.

Residential care provided by the public sector is often of poor quality and lacks sufficient resources. Means-tested assistance is available, and social services will pay a proportion of residential costs depending upon income. The alternative is the homes run by *Misericórdias* and other non-profit institutions which are of better quality and only request a nominal contribution from patients and their families.

Home care is expanding as a result of a joint venture between the Ministry of Health and the Ministry of Employment and Social Solidarity, called the Integrated Support Plan for the Elderly. In some regions, an infrastructure to deliver support to the elderly has been developed in partnership with RHAs, municipalities and private providers, such as *Misericórdias*.

As part of this inter-ministerial project, the state is facilitating vocational training opportunities in areas such as domiciliary care and informal health care as part of a job creation scheme. Currently in the Lisbon and Tagus Valley region, there are about 20–30 local projects to create local social networks of care. The division of payment between the NHS and the social security department depends on the type of care provided by the project, i.e. nursing care or home help.

There is currently no regulation of nursing homes. All homes are in the private sector and very expensive.

## Mental health

Mental health services are run under the aegis of the General Directorate of Health. Mental health centres are run on a district basis, except in the large cities. Centres are linked closely to the RHAs and to the district hospitals. Mental health centres rely on links with all health services in the community. They provide various services:

- ambulatory care, given (preferably in the centre itself) by mental health teams
- psychiatric services for patients in crisis
- psychiatric services for patients with long-term problems.

Every mental health centre has a staff member responsible for child mental health.

There has been a massive reduction of acute psychiatric and long-term beds in recent years as part of a process of de-institutionalization. Most mental health services have been integrated with general hospitals.

There still remain several general obstacles to the development of social care in Portugal:

- lack of provision, very few nursing homes and none in the public sector
- lack of trained personnel
- no tradition of community care
- regarded as family responsibility
- lack of tools and skills to develop social care, i.e. few educational courses, etc.

The state continues to encourage the *Misericórdias* to invest in social care and develop the basic infrastructure of services and facilities through reinvestment of money obtained from the NHS for hospital facilities which were nationalized during the 1970s. Ownership of many of the properties, which had been incorporated into the NHS at the end of the 1970s, was handed back to the *Misericórdias* in 1982 following a change of government. Despite the fact that the hospitals had been rebuilt or refurbished with public funds in the intervening years, the NHS rents back the facilities. Most of the new funds generated by this policy are being reinvested by the *Misericórdias* in social 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.

### Human resources

According to the Portuguese Medical Association, there are 29 000 medical doctors in Portugal. The data of the Department of Human Resources showed that 21 132 of these were employed by the NHS in 1995, the majority in secondary care. General practitioners, i.e. those specialized in family medicine,

account for 35% of the total number of doctors, 46% are hospital doctors and less than 3% public health doctors (see Table 19).

**Table 19. Doctors by area of activity, (%) 1996**

Area of medical activity	%
Secondary care	46.14
General practitioner	35.13
Medical trainees	13.76
Public health	2.58
Other	2.38

Source: Department of Human Resources (1997) (9).

There has been a steady increase in the number of active doctors in Portugal since 1990. Before this there was a rapid increase from as few as 0.95 per 1000 in 1970 to 2.83 in 1990. As can be seen in Fig. 11, Portugal has very closely followed the European average. However it has many fewer physicians per 1000 population than either Italy or Spain.

Fig. 12 shows that Portugal has steadily increased the ratio of nurses to inhabitant but remains a long way below the European average. Spain and Italy also have lower than average numbers of nurses per capita. Progress with expansion of nurse numbers has been slow and Portugal has one of the lowest ratios of nurses to inhabitants in Europe. About 74% of nurses work in central and district hospitals and only 20% in primary care services and 3% in psychiatric services.

As Table 20 shows, the number of dentists remains low at 0.26 per 1000. The number of certified nurses rose considerably during the 1970s from 0.97 per 1000 to 2.24 per 1000 in 1980. The number of pharmacists in Portugal is also low compared to other southern European countries, with a ratio approximately half that of Spain and Italy.

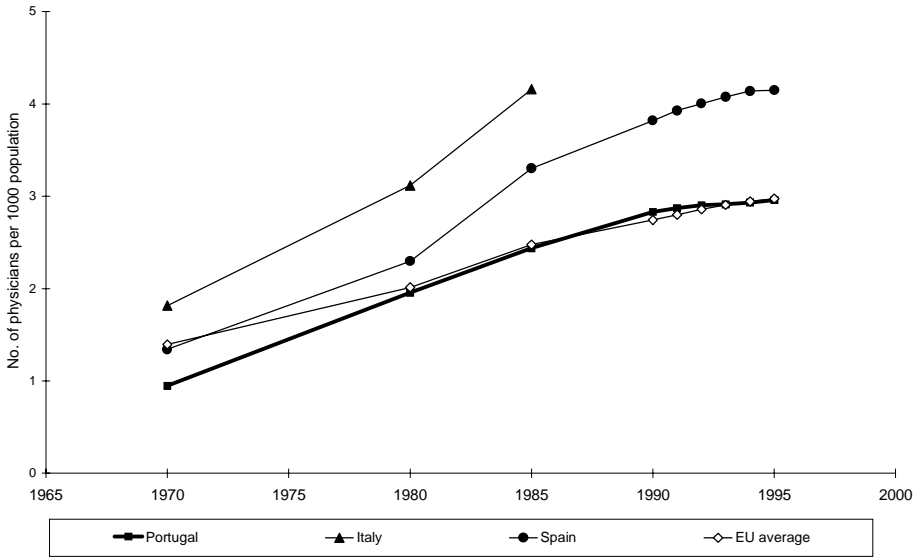
**Table 20. Health care personnel in Portugal, per 1000 population, 1970–1995**

	1970	1975	1980	1985	1990	1991	1992	1993	1994	1995
Active physicians	0.95	1.17	1.96	2.44	2.83	2.87	2.90	2.91	2.93	2.96
Active dentists	0.007	0.05	0.11	0.13	0.17	0.17	0.18	0.21	0.23	0.26
Nurses*	0.97	1.92	2.24	2.46	2.79	2.86	3.00	3.14	3.23	3.38
Active pharmacists	0.31	0.32	0.48	0.48	0.55	0.60	0.60	0.61	0.64	0.65

Source: WHO Regional Office for Europe health for all database (51).

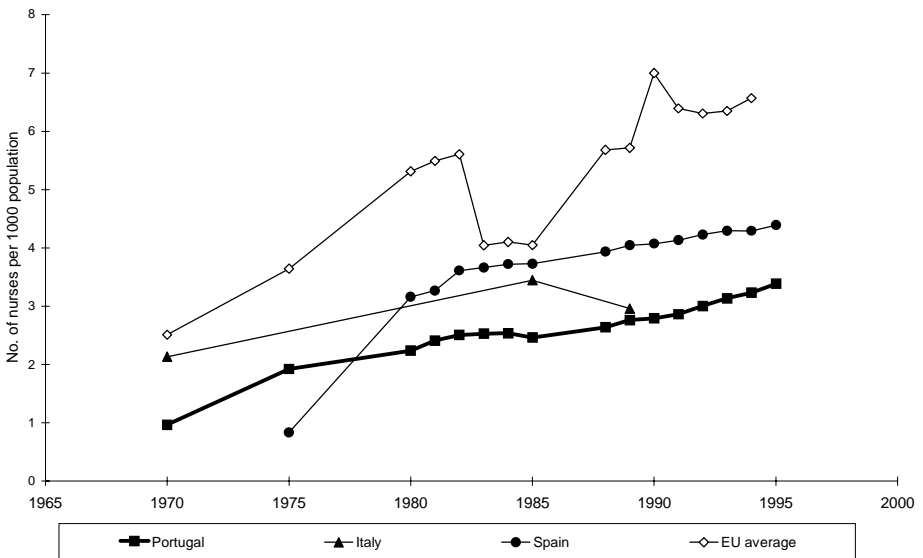
\* A nurse is defined as a person who has completed a programme of basic nursing education and is qualified and authorized to practice nursing in all settings. Basic nursing education is a formalized programme of study of at least two years or more. The Portuguese figures will include midwives as they have to first complete nursing training before specialization.

**Fig. 11. Physicians per 1000 population in Portugal and selected European countries, 1970–1995**



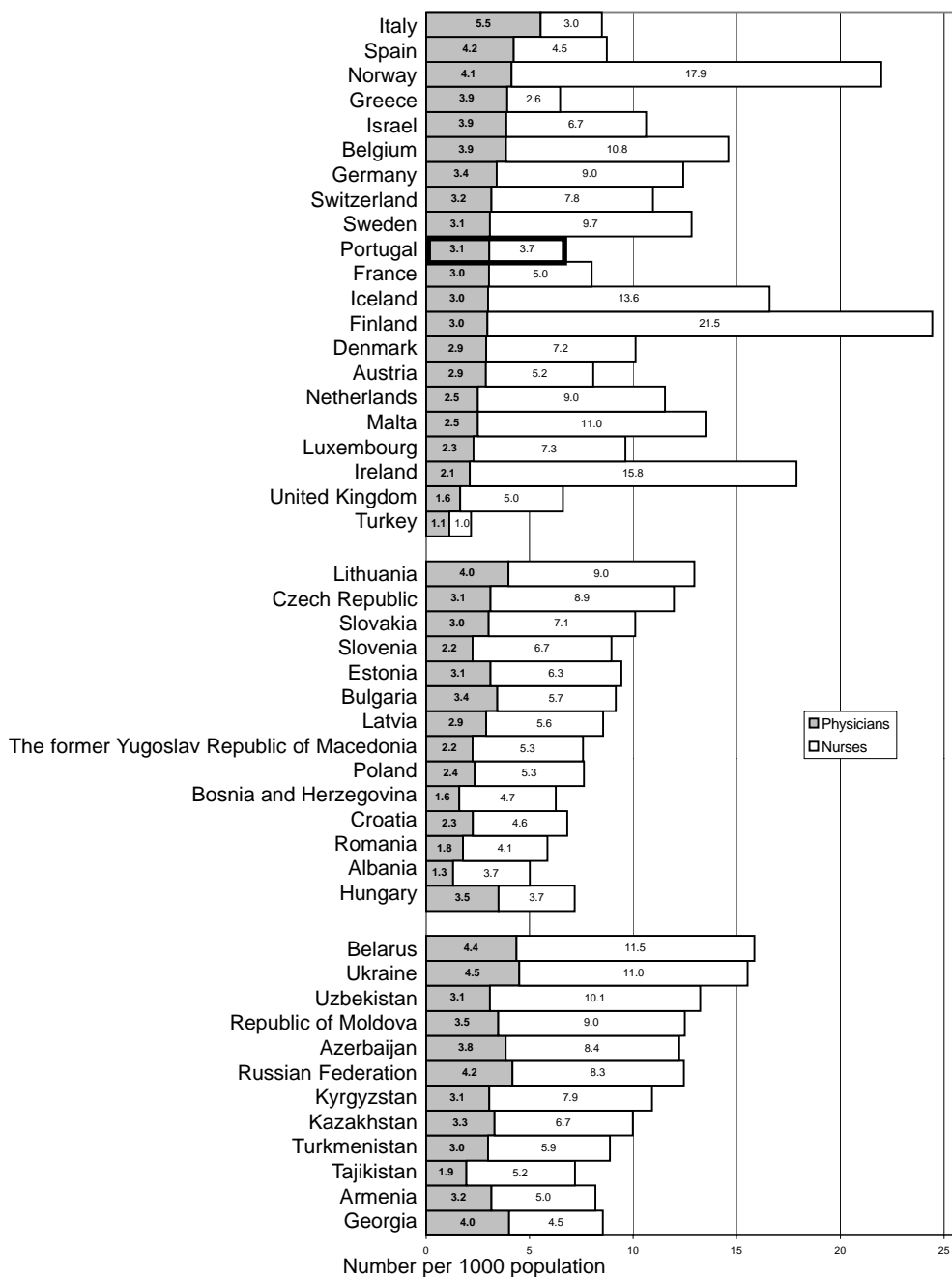
Source: WHO Regional Office for Europe health for all database (51).

**Fig. 12. Nurses per 1000 population in Portugal and selected European countries, 1970–1995**



Source: WHO Regional Office for Europe health for all database (51).

**Fig. 13. Number of physicians and nurses per 1000 population in the WHO European Region, 1998 or latest available year**



Source: WHO Regional Office for Europe health for all database (51).

## Training

Table 21 shows the distribution of health care personnel including dentists, pharmacists and therapists in training in 1996 in Portugal.

There has been a boom in medical training and a large increase in the number of women going into the profession both as medical doctors and other health staff.

**Table 21. Distribution of students by health profession (undergraduate training), 1996**

	1st year	Total	Graduated 1995/96
Medicine	570	3 984	492
Dental medicine	433	2 380	236
Pharmacy	565	3 392	288
Nursing*	1 583	4 689	2 346
Diagnostic and Therapeutic Health Officers	359	1 000	203

Source: Department of Human Resources (1997) (9).

\* All nursing schools included (public and private) from mainland and autonomous regions

## Doctors

The number of doctors entering the workforce per 100 000 population in Portugal in 1995 was 4.1 (see Table 22). This is the lowest in western Europe. The number of dentists was also one of the lowest with just 0.8 per 100 000 alongside the Netherlands and Belgium, 0.7 and 0.6 respectively.

There are currently five medical schools in Portugal (two in Lisbon, one in Coimbra and two in Porto). Two new medical schools are due to open in 2000. All medical training programmes follow the same curriculum and are divided in two phases, which last for three years each:

- i. the core programme which covers the basic sciences
- ii. the clinical programme with practical sessions, oriented to practice and specialized procedures.

A curriculum reform to shorten this university degree to only five years is in preparation.

After university, all graduates must then undertake a general internship for 18 months, with 6 months training in general practice and public health and a year in hospital training.

On completion of the internship medical graduates are recognized as medical doctors and are free to practice medicine without supervision. However, if they want to follow a medical career in the NHS, they must go on to further specialization. The training for different specialities varies as follows:

**Table 22. Health care personnel entering the workforce in the WHO European Region per 100 000 population, 1996 or latest available year**

Country	Physicians	Dentists	Pharmacists	Nurses	Midwives
<b>Western Europe</b>					
Austria	14.1 <sup>d</sup>	—	—	33.7 <sup>c</sup>	—
Belgium	10.9 <sup>c</sup>	0.6	1.7	55.3 <sup>e</sup>	2.3 <sup>e</sup>
Denmark	7.3 <sup>c</sup>	1.6 <sup>c</sup>	2.8 <sup>c</sup>	32.2 <sup>c</sup>	0.8 <sup>c</sup>
Finland	11.3	4.4	4.4	88.2	1.5
France	8.5 <sup>e</sup>	1.8 <sup>e</sup>	4.0 <sup>e</sup>	25.2 <sup>d</sup>	0.9 <sup>d</sup>
Germany	14.8	2.6	2.2	18.9 <sup>d</sup>	0.6 <sup>d</sup>
Greece	—	—	—	—	—
Iceland	12.3 <sup>c</sup>	2.9 <sup>c</sup>	2.6 <sup>c</sup>	25.4 <sup>c</sup>	0.0 <sup>c</sup>
Ireland	12.4 <sup>c</sup>	2.0	1.3	42.4	6.5
Israel	4.7	1.1	1.5	15.3 <sup>c</sup>	0.6 <sup>c</sup>
Italy	—	—	—	—	—
Luxembourg	—	—	—	—	—
Netherlands	9.1 <sup>c</sup>	0.7 <sup>c</sup>	0.8 <sup>c</sup>	39.1 <sup>c</sup>	0.4 <sup>c</sup>
Norway	—	—	—	—	—
Malta	2.6 <sup>a</sup>	0.4 <sup>a</sup>	1.9 <sup>a</sup>	11.5 <sup>a</sup>	0.8 <sup>a</sup>
Portugal	4.1 <sup>c</sup>	0.8 <sup>c</sup>	2.8 <sup>c</sup>	16.2 <sup>c</sup>	0.3 <sup>d</sup>
Spain	—	—	—	—	—
Sweden	7.6 <sup>d</sup>	2.3 <sup>d</sup>	0.7 <sup>d</sup>	45.0 <sup>d</sup>	2.5 <sup>d</sup>
Switzerland	10.6 <sup>c</sup>	1.3 <sup>c</sup>	2.2 <sup>c</sup>	52.6 <sup>c</sup>	1.4 <sup>c</sup>
Turkey	6.8 <sup>c</sup>	1.1 <sup>c</sup>	1.5 <sup>c</sup>	15.9 <sup>c</sup>	7.0 <sup>c</sup>
United Kingdom	—	—	—	—	—
<b>CCEE</b>					
Albania	—	—	—	—	—
Bosnia and Herzegovina	—	—	—	—	—
Bulgaria	—	—	—	—	—
Croatia	14.0	2.3	2.1	—	—
Czech Republic	11.8	0.6	1.9	48.4	2.4
Estonia	9.2	4.5	1.7	16.0	2.8
Hungary	9.8 <sup>c</sup>	1.8 <sup>c</sup>	2.4 <sup>c</sup>	7.2 <sup>c</sup>	na
Latvia	10.8	1.9	2.1	17.3	0.8
Lithuania	16.7	2.9	1.4	19.7	1.8
Poland	9.7 <sup>e</sup>	2.8 <sup>e</sup>	1.7 <sup>e</sup>	—	—
Romania	14.2	2.0	1.6	14.8	—
Slovakia	16.1	—	—	2.0	0.5
Slovenia	7.1	1.2	4.9	39.6 <sup>c</sup>	—
The former Yugoslav Republic of Macedonia	8.3 <sup>c</sup>	3.6 <sup>c</sup>	2.8 <sup>c</sup>	—	—
<b>NIS</b>					
Armenia	14.1	5.7	2.2	44.1	7.5
Azerbaijan	17.2 <sup>b</sup>	1.7 <sup>b</sup>	2.2 <sup>b</sup>	31.1 <sup>b</sup>	4.6 <sup>b</sup>
Belarus	20.2	2.4	1.0	41.6	2.8
Georgia	—	—	—	—	—
Kazakhstan	20.5 <sup>b</sup>	—	1.0 <sup>b</sup>	45.2 <sup>b</sup>	3.5 <sup>b</sup>
Kyrgyzstan	12.8	2.3	0.5	46.5	7.6
Republic of Moldova	15.8	3.1	0.6	28.2	2.2
Russian Federation	15.8	2.3	2.2	25.6	2.3
Tajikistan	14.8 <sup>c</sup>	—	—	62.1 <sup>d</sup>	—
Turkmenistan	12.5 <sup>c</sup>	1.4 <sup>c</sup>	0.6 <sup>c</sup>	56.4 <sup>c</sup>	5.7 <sup>c</sup>
Ukraine	13.8	2.8	2.6	49.6	3.8
Uzbekistan	22.1	1.5	0.7	129.1	5.9

Source: WHO Regional Office for Europe health for all database (51).

Note: <sup>a</sup>1998, <sup>b</sup>1997, <sup>c</sup>1995, <sup>d</sup>1994, <sup>e</sup>1993

- Hospital specialties – three to six years
- General practice/family medicine – three years
- Public health medicine – postgraduate course for 18 months, followed by one year's experience in a public health setting.

The government is jointly responsible, with the Portuguese Medical Association, for the accreditation and certification of specialist training for medical graduates.

The specialist training varies according to each specialty. For instance, internal medicine and neurosurgery take six years of training whereas anaesthesiology takes only four years. The duration of specialist training is defined by the specialist colleges of medicine.

The specialist must be skilled in the diagnostic and treatment procedures of his/her own specialty and must have proficiency in some techniques related to the field. He/she also has to do some research work and publish articles, which are valued in curriculum analysis. At the end, he/she must be evaluated and, after recognition of aptitude, can apply for a hospital position or go on to clinical practice.

**Table 23. "Top ten specialties" showing numbers in each medical specialist category by region in Portugal, 1996**

Specialty	Total	North	Centre	Lisbon and Tagus Valley	Alentejo	Algarve
Internal medicine	<b>1 601</b>	415	250	844	57	35
Gynaecology & obstetrics	<b>1 268</b>	474	285	428	41	40
General surgery	<b>1 167</b>	333	228	514	57	35
Paediatrics	<b>1 161</b>	405	203	484	32	37
Anaesthesiology	<b>1 148</b>	346	226	530	17	29
Orthopaedics	<b>777</b>	254	185	281	26	31
Clinical Pathology	<b>683</b>	143	240	275	13	12
Psychiatry	<b>654</b>	224	127	278	11	14
Cardiology	<b>525</b>	145	104	251	12	13
Ophthalmology	<b>518</b>	128	101	261	15	13
<b>Total</b>	<b>9 502</b>	<b>2 867</b>	<b>1 949</b>	<b>4 146</b>	<b>281</b>	<b>259</b>

Source: Department of Human Resources (1997) (9).

The most popular specialty is internal medicine with 1601 doctors in 1996. General practice and public health which do not appear in Table 22 are less attractive careers at present.

The medical curriculum is highly hospital-oriented and although there are three general institutes for family practice in Coimbra, Lisbon and Porto the

training related to primary health care and general practice is obtained mainly through field experience.

### **Nurses**

To train as a nurse, one must have undergone at least 12 years of school education. The course lasts three years and on successful completion the academic degree of bachelor and the professional title of nurse are granted. There is another degree (licence) for which there is a one-year programme. There are no nursing auxiliaries or equivalents in Portugal.

If a nurse wants to specialize, there are several fields:

- Midwifery – postgraduate course, lasting 22 months, after 2 years of clinical experience;
- Paediatric nursing – postgraduate course, lasting 22 months, after 2 years of clinical experience;
- Psychiatric nursing – 2 years of postgraduate experience and 18 months postgraduate study in mental health and psychiatry;
- Community nursing – 18 months of postgraduate study, after 2 years of clinical experience.

The current priorities expressed by the nursing profession include the development of a code of ethics, legislation on the practice of nursing and the creation of a regulatory body for nursing. Since 1998, nurses have established their own professional body, the Portuguese Nurses' Association which has similar powers to the Medical Association.

### **Other health care professionals**

Since 1986, three state-funded and two private schools of dentistry have opened. Previously, oral health care was provided by stomatologists (the name given to doctors who specialized in dentistry) who undertook three years' dental training after their medical degree. Another grade exists – that of odontologist. This grade was introduced by the government at a time when there was a severe shortage of dentists. This training has been replaced by the main degree in dental medicine which is awarded by higher education institutions.

### **Alternative Medicine Practices**

Despite the general trend towards recognition of alternative health care providers, the Portuguese still prefer mainstream medicine. There are some acupuncturists, chiropractors and homeopaths, but they have not as yet been recognized by the Ministry of Health.

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

### **Mechanisms for controlling health care technologies**

Portugal does not have a tradition of technology assessment. However, since legislation enacted in 1988, prior authorization by the Ministry of Health has been necessary before the procurement and installation of some of the more sophisticated equipment both in the public and private sector. In 1995 new legislation lifted the restriction for some equipment (CT and MRI scanners).

A National List of Health Equipment was drawn up and published in 1998 (21). This list details 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 clearly it will enable planners and hospitals alike to identify areas where there are gaps in service provision. There are currently no methods for regulating the distribution of health equipment in the private sector.

Most heavy medical equipment is located outside hospitals in private facilities. The private sector is more flexible and predisposed to innovation and therefore outstrips the public sector in the acquisition of high technology equipment. In fact, about 67% of this kind of equipment belongs to the private sector (see Table 24). The majority of this investment has taken place in the last ten years, particularly in the past five years (21% of all high technology equipment has been purchased in the last five years). Hospitals reimburse private clinics for the use of equipment providing a strong incentive for this provision pattern to continue.

The distribution of technology is also disproportionate between regions. The concentration of equipment in the coastal area forces people to travel to access certain treatments or tests. There is, for example, an enormous imbalance in the provision of radiotherapy. People only have access to this type of treatment if they go to Lisbon, Porto or Coimbra. This has not only social and economic impacts, but also contributes to the waiting lists of these hospitals.

### **Regulation and control of pharmaceuticals**

Since 1990 several legislative changes have resulted from the implementation of EC Directives, such as that to guarantee the quality and safety of pharmaceuticals. In addition, programmes of public information and education

**Table 24. Number of units of medical equipment in the public and private sectors in Portugal, 1998**

Type of equipment	Public	Private	Total
Linear accelerator	14	2	16
Digital angiograph	23	5	28
Gamma camera	23	7	30
Lithotripter	5	7	12
Magnetic resonance	5	22	27
CAT	39	83	122
<b>Total</b>	<b>109</b>	<b>126</b>	<b>235</b>

Source: National List of Health Equipment, 1998 (21).

on the rational use of pharmaceuticals were also developed and cost-containment policies were adopted.

The National Institute of Pharmaceuticals and Medicines (*INFARMED*) was established in 1993. Since 1994, its remit has been widened to cover not only pharmaceuticals but also medical equipment and other medical products. *INFARMED* is responsible for approving all drugs which are to be reimbursed by the NHS and set co-payment levels. Recently, *INFARMED* have introduced some measures of cost-effectiveness into the assessment process of drugs. Currently, *INFARMED* can request cost-effectiveness data but the Technical Commission, which evaluates drugs, does not automatically provide it for pharmaceuticals. In 1998 *INFARMED* issued guidelines about how best to carry out cost-effectiveness studies, provoking a discussion about the possibility of their mandatory use in drug approval.

The guarantee system for the quality and safety of pharmaceuticals is a complex one and is not limited to the industrial process. Due to the unique features of the pharmaceutical market, decisions are not made under normal market conditions. Pharmaceutical production is controlled by a strong system of regulation.

The following authorities enforce the standards for the quality and safety of pharmaceuticals:

#### **A) Pharmaceutical Inspection Service**

This body verifies the adequacy of industrial procedures and their control systems.

#### **B) Pharmacovigilance Service**

The National Pharmacovigilance Centre is an *INFARMED* body, in operation since 1992. It deals with:

- the monitoring of drug safety
- recalls, if adverse reactions occur which were not previously identified
- rapid withdrawal of a pharmaceutical product from the market.

The National Pharmacovigilance Centre cooperates with the European Agency for the Evaluation of Medicinal Products based in London. This joint work has been very useful because of the discussion and help exchanged as well as the incentive it has provided to implement rules agreed at European level. Relationships with other European Pharmacovigilance Centres are also being developed.

**The Quick Alert System** and participation in meetings of the Working Group of the Medical Commission for Portuguese Medicines contributes to the increasing safety of pharmaceutical products used in Portugal.

### **C) The Official Laboratory for Pharmaceutical Quality Control**

This national laboratory has the following tasks:

- to study pharmaceuticals;
- to test the efficiency of dossier evaluation and the efficacy of inspection of industrial production;
- to link with the National Pharmacovigilance Centre.

Sanitary and homeopathic products are also regulated by INFARMED.

## **Regulation of medical devices**

Medical devices are regulated according to Directive 93/42 EEC and a national directive of 1995. The notifying institutions are the National Institute of Health for active medical devices and INFARMED for non-active medical devices.

## **Regulation and control of pharmacies**

Pharmacies must be owned by a qualified pharmacist. All drugs, including over-the-counter drugs (OTC) can only be sold in a pharmacy. It is not permitted for drugs of any sort to be sold through other outlets. In addition to this regulation which reduces competition, the location of pharmacies is highly regulated. There is a maximum number of pharmacists permitted in each community. The Ministry of Health decides whether there is a need for a new pharmacy in a developing and expanding residential area. In the first instance there must be proof of at least 5000 new clients. If another pharmacy already exists within 200 metres of the proposed site, the licence to open a new one will not be

granted. As a result of the barriers to entry into the market, established pharmacists have a monopoly over the drug market.

There is presently a limited service within hospitals for dispensing prescriptions to outpatients. Only those drugs which carry no co-payment are allowed to be dispensed. The idea of extending pharmacy services in hospitals to allow direct sales by the NHS is being debated within the Ministry of Health.

Similarly, in health centres only those vaccinations which are provided free of co-payment are dispensed directly by the health centre. Otherwise patients have to take their prescriptions to a private pharmacist whether or not they receive the prescription from a NHS doctor in a health centre or from an outpatient department of a hospital.

### **Pharmaceutical policy**

Portugal's pharmaceutical expenditure was 2.2% of GDP in 1996 – a very high position in the OECD ranking. However the country ranks lower in terms of pharmaceutical expenditure per capita – 282 US \$PPPs (32). Generic prescribing in Portugal is virtually non-existent, accounting for as little as 0.1% of total market share in 1995.

There is a national formulary of drugs, which is only used by NHS hospitals for inpatient prescriptions. This does not extend to health centres or outpatient services. Guidelines on prescribing behaviour are issued to doctors, and directors of health centres are encouraged to draw up local formularies. However these are simply guidelines and have no mandatory powers. The lack of a national drug list for ambulatory care together with the powerful influence exerted by the industry over doctors, could be one reason for the high levels of expenditure on pharmaceuticals in Portugal.

Portugal has made attempts to control expenditure on pharmaceuticals through agreements with industry. However, some of them have been unsuccessful to-date. In 1997 a budget cap was introduced as a means of controlling costs. This was the result of a voluntary agreement between the government and the pharmaceutical industry in which the industry agreed to pay back to the NHS 64.3% of the excess over 1996 expenditure. The repayment will only apply to expenditure between 4% and 11% above 1996 levels. Industry would not be liable for spending outside these limits. This policy created a perverse incentive that once expenditure had exceeded the limit, expenditure was inflated further. By the middle of the first year, growth in expenditure on pharmaceuticals was already up by 16%.

Another pharmaceutical policy currently being implemented is the use of reference pricing for drugs. Since 1991 (Decree Law 72/91) the price of drugs has been established using an artificial price based on comparisons with other countries. An attempt was made in 1998 to introduce reference pricing. This system groups drugs according to their active ingredients and sets a reference price for the group (often the average or lower-priced drug in the group). In Portugal, if two drugs of similar properties were already on the market, any new drug entering the market had to be priced at least 10% cheaper than the existing products. But this policy has been shrouded in controversy. Some products were misclassified and it is still unclear whether this controversy will have tarnished the policy irredeemably or whether the government will persist with its implementation.

### **Pharmaceutical co-payments**

Prescription drugs in Portugal are subject to variable co-payments. Patient co-payments on pharmaceutical products are based on efficacy and effectiveness criteria with full payment attached to those drugs deemed to have no clinical value. Since 1992, there have been three categories of NHS co-payment (see Table 25). Pensioners are eligible for a lower level of co-payment on Category B and C drugs.

In 1995 a new policy was introduced whereby private sector prescriptions were subject to cost-sharing by the NHS – previously only available for prescriptions provided in the NHS (Decree Law 272/95 de 23/10). The rationale of this reform was to reduce the number of private prescriptions being taken to health centres to have them repeated on a NHS prescription. However it led to an inevitable rise in the drugs bill.

Pharmaceuticals used by some vulnerable groups are fully paid for by the NHS. The following therapeutic categories are fully covered:

- anti-diabetic drugs
- anti-epileptic drugs
- anti-Parkinson drugs
- anti-neoplastic and immuno-modulator drugs
- growth and anti-diuretic hormones
- specific drugs for haemodialysis
- drugs for cystic fibrosis treatment
- drugs for glaucoma treatment

- drugs for haemophilia treatment
- anti-tuberculosis and anti-leprosy drugs.

**Table 25. Pharmaceutical co-payments in the NHS**

Category	Definition	Level of co-payment		% of NHS consumption 1994
		Public	Pensioners	
A	Substances vital for survival or used to treat chronic diseases	0%	0%	9.4
B	Essential drugs needed in the treatment of serious illnesses, requiring prolonged therapy	30%	15%	63.1
C	Non-priority medicines with confirmed therapeutic value	60%	45%	27.5
	Of little or no proven therapeutic value	100%	100%	27

Source: INFARMED (12); Pereira et al. 1999 (33).



## Financial resource allocation

### Third-party budget setting and resource allocation

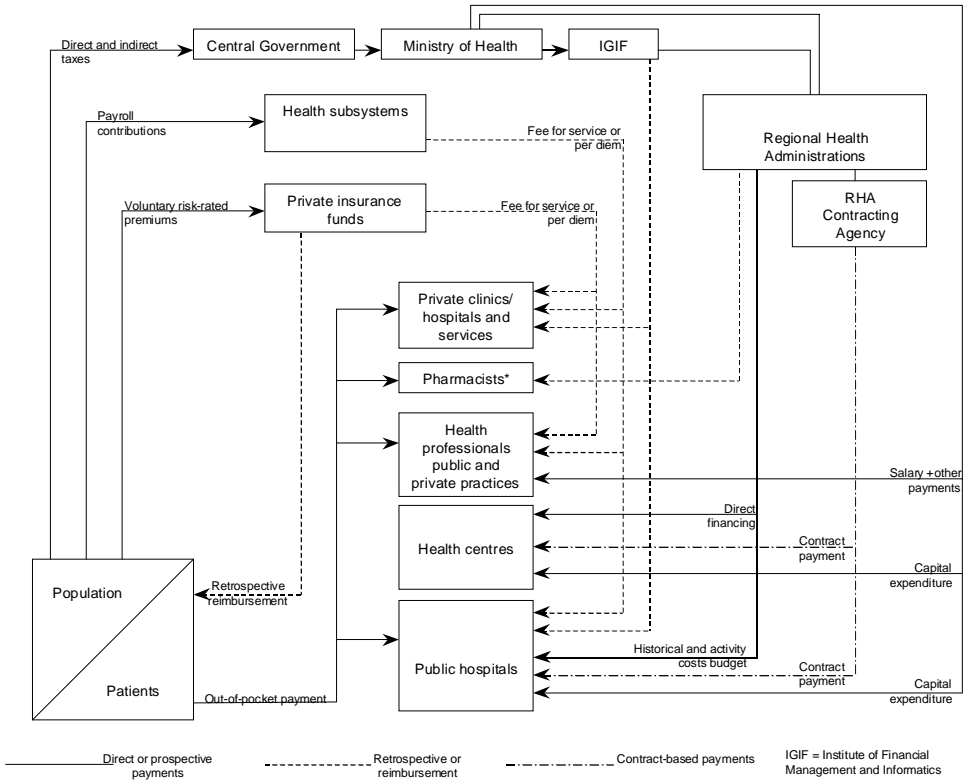
**T**he NHS budget is set annually by the Ministry of Finance based on historical spending and the plans put forward by the Ministry of Health. Capital and current expenditure are separated, with the Ministry of Health retaining control for all capital expenditures.

The Institute of Financial Management and Informatics, which is the department responsible for financial management within the Ministry of Health, prepares estimates detailing the resources required to support planned activities. The estimate of total expenditure for the current year is adjusted by the expected increase in the level of consumption, salary levels and the rate of inflation. The global budget for health is ultimately determined by the Ministry of Finance based on macro-economic considerations.

The Ministry of Health allocates a budget to each regional health administration (RHA) for the provision of health care to a geographically defined population. This budget is currently set on the basis of historical and activity costs. Up until recently the RHA had little freedom over how to spend the budget and acted as a disburser of funds in respect to hospitals. Recent reform proposals intend to increase the purchasing role of RHA to move the system gradually towards a contract model of health care.

The health subsystems, whose revenues are frequently from employer and employee contributions, allocate according to a system of reimbursement to both members and to providers. A few of the schemes also employ doctors and provide services directly for their members. The private health insurance schemes, whose revenue is from risk rated premiums mostly fund health care for their enrollees through retrospective reimbursement.

Fig. 14. Financing flow chart



## Payment of hospitals

Hospital budgets are drawn up and allocated by the Ministry of Health even though funds are disbursed through the RHAs. At present, public hospitals have a global budget that is mainly based on historical data. However, in practice, this initial budget allocation is more indicative than normative. Because public hospitals operate with open-ended budgets, overruns are mostly automatically covered by supplementary allocations. The system has very weak incentives to encourage cost-containment or efficient practices.

Traditionally, the global budget is based on the previous years' allocation, adjusted for inflation but in recent years, a part of this global budget (10% in 1997) was based on diagnosis-related groups (DRGs). The Government planned to expand the allocation on this basis in 1998.

The establishment of regional agencies in each regional health administration in 1998 aimed to change the way in which resources are allocated within the

NHS. They are an autonomous section of the RHA which are developing a role as purchasers of hospital and clinical services. The first regional agency was established in 1997 and was subsequently recognized and endorsed by the Ministry of Health. There are now agencies in each of the five regions.

The aim is to change hospital payment from a retrospective to a prospective budget and to introduce an element related to production costs, i.e. a budget based on predicted costs rather than an historical budget. 1999 is the first year of budget negotiations based on contracts and prospective budgets to involve all hospitals and RHAs. It is proposed that, in its first year of operation, 3% of hospital budgets will be allocated through contracts with the remainder being allocated on an historical basis. It is hoped that this proportion will increase year on year.

The agency negotiates with the hospital board whose responsibility it is to ensure the requirements of the contract are met. The hospital board should establish contracts within the hospital with those who have internal responsibilities.

Contracts are negotiated with both public and private institutions though, in the first instance, with NHS hospitals. This system is expected to increase accessibility to more efficient and better quality services. The power of the agencies is currently quite limited as the leverage of the purchaser is not sufficient to close a hospital or even a service or ward within a hospital. However, it is expected that the loss of a guaranteed income for hospitals based on historical costs and the introduction of productivity-related payments will increase cost awareness and increase incentives for efficiency.

Besides direct transfers from government, public hospitals also generate their own revenue from payments received from patients for special services (individual rooms, for example), payments received from beneficiaries of the health subsystems or private insurance, and flat rate charges.

In theory the health subsystems should reimburse NHS hospitals on a fee-for-service basis for services provided to beneficiaries. However, in practice, very few enrolees actually declare their membership when receiving care in NHS hospitals and thus the transfer of resources between funds and the NHS does not take place.

An historical agreement was reached in 1998 between the PT-ACS, which is the sickness fund for public telecom operators, and the Ministry of Health. The PT-ACS has agreed to take full responsibility for the cost of health care provision for its members in return for a capitation payment from the NHS of Esc. 30 000. This agreement could establish the basis for further political negotiations between the Ministry of Health and the National Association of Health Subsystems. However it seems that at the moment any plans to remove

the duality of the system would be opposed by the National Association of Health Subsystems.

Private insurance schemes vary in the method of reimbursement. On the whole, this is on a fee-per-item basis, reimbursed retrospectively either to the individual patient or to the hospital who will bill the insurance company for the full costs of care.

## Payment of health centres

Health centres (HCs) are responsible for public ambulatory and primary health care. They do not currently have financial or administrative autonomy. The Ministry of Health allocates funds to the regional health administrations which in turn funds the activities of each health centre. The HC only receives a budget for rent, utilities, etc., based on historical costs. All other costs are directly financed by the RHA. This means there is no global cost control.

More radical reforms to grant greater autonomy to health centres have been legally proposed but not yet implemented. These would grant both financial and administrative autonomy to HCs. A group of doctors within the HC would be independently contracted by the regional agency (part of the RHA) and would be accountable to the RHA for the care they provide. This reform is similar to the introduction of contracting and the shift from historical budgets to prospective activity-related budgets, described above under the section on *Payment of hospitals*.

## Payment of health care professionals

### Doctors

Within the NHS, all doctors are paid a salary and are government employees. This fixed salary is established according to a matrix linking professional category and time of service, independent of any productivity measure.

Different modes of employment exist in the public sector with different levels of remuneration:

1. Full-time: 36 hours per week;
2. Extended full-time: 45 hours per week (40% more pay than full-time);
3. Exclusive employment: the doctor is not allowed any private practice (50% more pay than full-time);

4. Part-time; this option is not compatible with the position of head of service;
5. Extended full-time and exclusive employment; this a combination of items 2 and 3 above (60% more pay).

These additional payments, together with other variable components such as overtime (i.e. work in the NHS over and above the hours stipulated in the contract for such things as on-call duties), make up a significant part of total remuneration. In Lisbon, 36% of all medical salary costs are now for overtime.

In general, doctors perceive their salaries to be relatively low and therefore feel justified in exercising their right to augment their income through private sector activity. However, if overtime payments, which make up a large proportion of income, are taken into account, the total income per doctor is high in comparison to the average wage. Particularly in rural hospitals where there is a small number of doctors and on-call duties come round frequently, overtime can account for the majority of a doctor's income.

There has been little reform or innovation in the primary care sector. However, in 1996, the Lisbon and Tagus Valley RHA initiated the *Alfa Project* which changed the remuneration of doctors. See the section *Primary health care* for a fuller description of these reforms. Groups of GPs were given extra overtime payments and other incentives in return for an assurance of providing 24-hour cover and adequate referral and follow-up of patients on their lists. It hoped to reduce the excessive demand at hospital emergency departments in the cities and subsequently reduce cost.

Following this experiment with a variable payment based on capitation the government is now introducing a new system of reimbursement for GPs. Participation in the scheme is voluntary and experimental. The mixed system comprises a basic guaranteed salary plus:

- Capitation payment based on list size adjusted for population profile;
- Fee-for-service for target services, e.g. home visits and minor surgery;
- Target allowances for preventive care;
- Payment for an episode of care, i.e. overall service to pregnant women including postnatal care.

Half of NHS salaried doctors also work in the private sector and many independent doctors also work under contract for the NHS. The NHS, the health subsystems and private insurance negotiate fees independently with doctors. Fees charged to the NHS are generally the lowest. Private fees are not regulated by the government but are subject to a range of reference prices set by the Medical Association. Thus in practice private doctors are free to determine

their fees and will set them according to reputation. There is, however, a legal requirement to display a price list, though this is not widely conformed to.

## **Nurses**

Nurses are also employed by the NHS as state employees. They are entitled to an annual salary. This fixed salary is linked to a civil service pay-scale which rewards people on the basis of length of service and is in no way related to performance.

## **Professionals allied to medicine**

The majority of the allied professionals are private and independent providers of care. They work under contracts and are reimbursed fee-for-service. These payments are either made directly by the patient, who is then reimbursed by their fund or private insurance scheme, or directly by the NHS if the NHS does not provide that service and has an agreement with the private sector. A system of arrears operates between the NHS and private providers with a variable payment delay dependent on the bargaining power of the provider group. For example the pharmacists negotiated an agreement in 1988 for a maximum wait of two months, whereas therapists, radiologists and pathologists are less powerful and usually wait for between four and seven months.

## **Dentists**

Most dentists in Portugal work in private practice where patients pay 100% of fees. Patients may be reimbursed either by the professional insurance scheme of which they are a member or by their private insurance scheme if dental care is included in the package of benefits. Dentists are free to determine the level of fee within a maximum and minimum amount set by the National Dental Association. These fees are not legally binding but form part of the disciplinary process and ethical code of the Association. There are very few salaried positions within the NHS for dentists. Only the more highly-trained stomatologists are able to work in hospitals.

## **Pharmacists**

Pharmacists obtain their income from two main sources: the co-payment directly from the patient and the remainder from the NHS (via the RHA) or the appropriate insurance fund. The payment system follows a provider pays model. This means that whoever prescribes pays. So in the case of public hospitals,

the individual hospital must cover the cost of the drug. If the prescription is from a health centre the payments are centralized through the RHA. About 95% of pharmacists are members of the National Association of Pharmacists and only few choose to remain independent. Members of the Association invoice the Association who reimburses them immediately; it then bills the RHA in bulk on behalf of its members. The Association is powerful and has negotiated a minimum payment period of two months with the RHA and has the ability to levy interest from the RHA for late payment.

One of the perverse incentives of the payment system for pharmacists is that they benefit from dispensing more expensive drugs. As a result pharmacists do not stock the cheapest drugs. Over-the-counter drugs yield the greatest profit.



## Health care reforms

Over the last few decades, the Portuguese health care system has undergone several periods of reform. Each reform has to an extent reflected the particular political, social and economic organization of the country at that time.

Several common characteristics can be identified:

- Many of the reforms were not implemented in the way that they had been conceived (at least, not until late in the reform process);
- Many remnants of the pre-reform policies and models persisted; thus new policies and models were added to the old rather than replacing them;
- Most of the reforms were of a purely legislative nature and lacked substance about their practical execution.

## Aims and objectives

Debate on health care reform has taken place in Portugal since the 1980s. Successive governments have reacted in different ways to the problems of the health sector and the perceived crisis in the health care system.

Despite the diversity of attitudes, it is possible to identify a series of values and principles on which there is virtual consensus in the Portuguese society. These values and principles, despite being interpreted differently, have remained constant throughout cyclical changes in the sector since 1976.

The following can be considered consensual values:

- unconditional safeguarding of human dignity;
- the right to health protection;
- solidarity among all Portuguese citizens in order to guarantee that right;
- recognition of the social nature of health care delivery;

- respect for the democratic values of citizenship.

These have provided the basis for a set of principles specific to health policy measures:

- the principle of universal coverage;
- the principle of equity of access and utilization;
- the principle of financial protection guarantee, bearing in mind the high costs patients may incur;
- the principle of enabling freedom of choice of providers, whenever possible within available resources.

The reform proposals passed in the early 1990s, however, seem to diverge from these fundamental principles and recommended organizational change which promotes a greater role for the private sector, individual responsibility and entrepreneurial management in the NHS.

## Reforms and legislation

The legislative process dominates the system of policy-making in Portugal. The Assembly of the Republic, the main legislative body, passes general acts of legislation called *leis* which cover the most important policy rules and guidelines.

These general laws, however, are not sufficient to warrant the practical implementation of the law. Further legislation, in the form of Decree-Laws, regulatory decrees, simple decrees, legal documents and ministerial dispatches, is required before implementation can proceed. The most important of these secondary pieces of legislation is the Decree-Law.

Below are set out the key pieces of legislation referred to throughout this report.

### **Income tax reform, Decree-Law 442-A/88 and 442-B/88, 30 November 1988**

Limits on the amount of tax-deductible private health expenditure were abolished. Households are allowed to recoup an amount equal to their marginal tax rate (e.g. 40% for the highest income households). Previously there were limits on the amount of out-of-pocket expenditure which could be deducted (50% at most) and some types of expenditure such as pharmaceuticals were excluded. Eligible expenditure includes the full cost to the patient of drugs

both over-the-counter (OTC) and the cost-sharing component of NHS prescriptions. Health insurance premia are deductible up to a ceiling of Esc 70 000.<sup>10</sup>

### **The Law on the Fundamental Principles of Health, Law 48/90, 24 August 1990**

The key principles set out in this piece of legislation were:

- That the NHS was no longer to be seen as the main form of provision, but as one of several entities (both public and private) involved in the delivery of care;
- That the State should promote the development of the private sector and provide incentives for the expansion of private insurance;
- That the NHS should be structured and should function according to consumers' interests;
- That care provided by the NHS should be provided 'practically free' rather than free at the point of use (in other words legitimising the use of co-payments in the NHS);
- That the management of NHS facilities could be contracted out to the private sector.

This legislation also included a charter of patient's rights and duties.

### **Drug Statute, Decree-Law 72/91, 8 February 1991**

In 1991, the Government adopted the Drug Statute, in response to EC Directives. This law, which legislates for a reorganization of the pharmaceutical system, regulates the process from the introduction of a product onto the market right up to marketing and sales.

The application of rules to blood and human plasma derived drugs was also reformed.

Co-payments in the area of pharmaceuticals were also revised to introduce the criteria of necessity and social justice. This has enabled those in disadvantaged circumstances such as the chronically ill to benefit from free medication.

### **NHS Statute, Decree-Law 11/93, 15 January 1993**

This piece of legislation concerned the organization of the NHS and was in line with the broad principles set out in the 1990 law.

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<sup>10</sup> The latter ceiling was for all insurance premia; this has been changed by a subsequent decree in 1998 to be a stand-alone ceiling for health insurance premia. See the section on *Voluntary health insurance*.

- The number of RHAs was reduced from 18 to 5 and simultaneously they were given greater powers and autonomy to coordinate hospital activities;
- Within each region, health centres and hospitals were to be merged to form health units, in an effort to ensure better continuity of care;
- Rules were created to facilitate the transition or, at least, the temporary transfer of civil servants from the NHS to the private sector;
- Full-time salaried doctors were allowed to engage in private practice;
- NHS co-payments were established on the basis of ability-to-pay (i.e. not only flat-rate payments);
- An ‘alternative health insurance’ scheme was proposed, which would be a substitute for the NHS (i.e. people would opt out of the NHS). Private insurance companies would receive a capitation payment from the government for each person opting out of the NHS;
- A variety of forms of private management of NHS facilities were to be encouraged.

### **Drug co-payments, Decree-Law 272/95, 23 October 1995**

This decree extended cost-sharing by the NHS to include prescriptions written by private doctors. Previously this had only applied to NHS prescriptions, causing a problem with private prescriptions being brought to NHS health centres to be repeated.

### **Health for all policy**

Portugal is committed to the WHO health for all policy and regularly presents reports about the health situation in Portugal. The last report, “The Health of the Portuguese” (19), was published in July 1997 and the next one is already being prepared.

The National Health Strategy (20), is based on the health for all principles and sets a number of outcome targets – the first time this has happened in Portugal. It sets out a coherent plan for health with measurable targets. It gives precedence to health gains and focuses less on the economic constraints in which health care services must be provided. The first strategic document of this sort was produced in 1996 (18).

The main purpose of this document is to ensure good population health and a situation of wellbeing for the largest possible number of citizens. To accomplish this higher mission, the health sector should be run according to the explicit and coherent objectives set out in the health strategy, using resources obtained in a fair and sustainable way.

This document is not an operational document, nor does it set out clear policies for implementation; but it does act as a framework within which all health institutions should operate. A work plan will be developed for each year based on an agreement between central and regional authorities. The first evaluation of progress against the targets and objectives that have been set will take place in 1999.

## **Reform implementation**

It is important to bear in mind, when considering any of the reforms in Portugal, that the stated aims and objectives and the legislative record do not necessarily correspond to the actual changes and developments on the ground. Many of the more interesting and successful reforms have developed from small pilots and experiments. On the other hand, many potentially positive reforms have never come to fruition because of an association with a failed experiment.

There has been substantial legislative activity and some radical reform proposals have been put forward. However, relatively few of the measures have been fully implemented. The process of reform has been incremental with the slow enactment of varied policy measures which have changed the system gradually since the 1980s. Many of the measures, which have been proposed and partially implemented, have not been fully evaluated, both due to the pace of the process but also due to a traditional lack of activity in this area.

One of the main aims of the present reforms has been to improve coordination between primary and secondary care. This was the main determinant for the amalgamation of the Directorate of Primary Health Care and the Directorate of Hospitals at the ministerial level, the formation of local health units at local level and the delegation of responsibility for hospital and health centre budgets to RHAs. Yet all these measures have failed to deliver an improvement in the continuity of care for patients. One fundamental reason for this may be the lack of a clear separation between the system of public and private provision and between the NHS, health subsystems and private insurance schemes. This means that patients shop around for their care, duplicating the use of services and of course preventing adequate follow-up and referral procedures which facilitate good continuity of care. The lack of a social care programme also means that, on discharge from hospital, follow-up and rehabilitation care is almost non-existent or is provided by independent organizations.

As well as a failure to have the desired outcome, there are some examples of failure to implement legislation. The attempt to establish an alternative health insurance scheme never got off the ground. This was mainly due to a lack of interest from private insurance companies but also, in part, due to a change in personnel at ministerial level. This idea is being revisited and due to stagnation in the private health insurance market, companies are now revisiting the possibility of offering an opt-out insurance.

An independent commission (*Conselho de Reflexão sobre a Saúde*), which reported in 1998, proposed that the single most important reform needed in the Portuguese health care system would be the clear separation between the NHS and the other public and private schemes. Despite widespread agreement with its conclusions, the commission's report holds weak powers of execution.

There are many obstacles to the successful implementation of reform in Portugal which can be identified:

- strong and well-organized interest and professional lobbies;
- high and changing public expectations, including lack of cost-awareness and a view that they have a right to health care;
- variable commitment to reforms across the regions;
- little published or independent evaluations of the reform experiments;
- system is in constant state of transition;
- high level of interest in the outcomes;
- high professional expectations which do not match available resources in an economically poor country;
- too many reform proposals being attempted at any one time without the necessary intellectual and human resources to support the process;
- dispersal of financial resources to many small projects means that reforms are never seen through to completion or given a fair chance of succeeding.

## Conclusions

Despite the extensive programme of legislative reform of the Portuguese health care system in recent years, there remain a number of key challenges if the objectives of an equitable, efficient and quality service are to be attained.

When the Portuguese NHS was founded in 1979, it was envisaged that it would provide universal and comprehensive cover to all citizens, free at the point of use. Despite universal coverage being achieved, some citizens are entitled to additional benefits and greater choice through membership of health subsystems or through private voluntary insurance. Equity of access has not been fully realized due to differences in the regional distribution of human and capital resources and the differential access to specialist services.

The extensive use of flat-rate co-payments in the NHS (only since legislation in 1993 have co-payments been means-tested) and the large increase in the number of services for which co-payments were charged during the 1980s, means that the NHS does not, in fact, provide services totally free at the point of use. In fact, according to OECD data on health expenditure, Portugal has the highest level of out-of-pocket payments in Europe. Even if this data is an overestimation of the true level of out-of-pocket payments, individuals are bearing significant direct costs for their health care. Where such a high proportion of the burden of payment falls on the individual directly there are equity implications. Exemptions for low-income and other vulnerable groups have been introduced for some co-payments but the ability to access and obtain quality services may depend on the affordability of the user charges. Further research into the actual level of individual households' expenditure would be useful to measure the impact of user charges on equity in access to health services and on health status.

The multiple systems of coverage which persist in Portugal cause inefficiencies such as duplication of services as well as a lack of overall cost

control due to the open-ended state subsidies paid to some of the public sector health subsystems. One means of reducing the number of repeat tests, etc. is the development of a unified system of identification – “the user’s card” – combined with a system of medical records, which is currently under consideration. This would facilitate improved coordination and transfer of information between the different levels of provision and the different sectors. The user’s card would also include information about cover and enable billing by the NHS of the health subsystems and private insurance schemes. A clearer separation of the systems, however, would be resisted by a number of interest groups – firstly, by those people who currently enjoy the additional benefits and greater freedom of choice offered by health subsystems; secondly, the medical professionals and other private operators who benefit financially from private consultations and the high utilization rates of private facilities.

As in many other European countries, Portugal faces the problem of controlling expenditure growth on drugs and pharmaceuticals. The industrial lobby and the professional lobby are both very strong. The drug market is characterized in Portugal by freedom of prescription for doctors (outside the hospital inpatient setting), lax price controls on the drug companies and a monopoly position for the pharmacist who sells the drugs. Despite attempts by the government to regulate the sector, it remains largely limited to the quality and safety of drugs. Government regulation of pharmacists actually protects their monopoly position and the method of payment creates perverse incentives for the dispensing of more expensive products. Measures to control volume rather than price may be needed through the use of proxy demand measures which affect doctors’ and pharmacists’ behaviour. Regulation may also be required to control the procurement and distribution of medical equipment in both the NHS and the private sector for which a system of technology assessment could provide the necessary information.

The orientation of current reforms towards health gain, through the implementation of the National Health Strategy, have increased the emphasis on service quality and increased patient satisfaction. The combination of salaried employment and the freedom to practice privately of most NHS doctors does not, however, provide real incentives to improve the quality of services within the NHS. Large numbers of patients bypass the system of referral within the NHS and go directly to specialists covered either through private insurance or health subsystems. In NHS hospitals stronger incentives are needed to increase the productivity of doctors and to restrict the hours of private practice in order to improve the service provided to NHS patients. However, a reversal of the 1993 reforms, which allowed full-time doctors to practice privately, would be strongly resisted by doctors. In Portugal the high levels of demand at hospital emergency departments, including many non-urgent cases, are indicative of

poor service standards at health centres. Reforms to the payment of GPs, which would introduce capitation and target payments, have been piloted. In order to ensure basic levels of service for the general population such schemes should be extended. In addition an adequate supply of well-trained GPs must be guaranteed.

The majority of Portuguese respondents (over 65%) in a recent European survey of public attitudes to health care (15) expressed dissatisfaction with the way health care operates in Portugal. Only 16.4% of respondents expressed any satisfaction at all. This represents a fall from about 20% in the same survey conducted in 1996. This is perhaps indicative not of a poor quality of clinical services but of poor customer service standards such as long waiting times, under-investment in facilities and the low morale of staff working in the health sector. It should be noted that other sources, such as the Health Interview Survey, 1995/1996 (8), carried out at a national level, showed different results. Despite the increase in per capita spending in Portugal overall levels of satisfaction appear to have declined. Any inference from these results that the health care system has deteriorated would fail to acknowledge the likely changes in public expectations and the role of the media, which has, as in many other European countries, tended to highlight the “bad” cases.

In an attempt to improve patient choice and to increase service quality, reforms initiated by legislation in 1990 and enacted in 1993 brought about a shift towards a greater role for the private sector. It recognized that the NHS was no longer to be seen as the main form of provision, but as one of several entities (both public and private) involved in the delivery of care. It also gave more purchasing autonomy to the enlarged regional health administrations (RHAs) through a process of devolution and combined responsibility for both hospitals and health centres, with a view to improving coordination. The implementation of these changes has been incremental with a gradual transition of hospital budgets from those based on historical and activity costs to contracts for services provided. Recent legislation (1999) allows for the establishment of local health systems which should further the goal of decentralized financial accountability. These local health systems are intended to have devolved decision-making powers for the allocation of health budgets between all health care provider organizations in a defined area. The intention of these reforms is to improve not only the efficiency of the NHS services but also to improve quality and patient choice. However, without adequate regulation of the private sector the benefits of better quality come at a price and may actually contribute to total expenditure growth. The introduction of a purchasing function for the RHAs needs time in order that the necessary capacities, both as purchasers and amongst public providers, can be developed. In addition the emphasis on needs-based purchasing cannot be realized without adequate information.

In conclusion, the Portuguese health care system continues to experience incremental change. It is in a period of transition. Previous reforms have followed different directions. In the 1970s, reforms were focused on the introduction of comprehensive universal coverage with the establishment of the NHS. The end of the 1980s saw a shift towards individual responsibility and private initiative with the liberalization of the private sector and active encouragement of its development, culminating in the 1990 legislation which, however, was never fully implemented. Already by 1993 the enabling legislation reiterated public responsibility for health care but with the state acting as a purchaser rather than provider within a mixed economy of provision. The focus for the beginning of the next decade is on health outcomes as set out in the National Health Strategy (18). This new direction, if it is allowed to guide future developments, may result in the Portuguese health care system being more responsive to the health needs of the population.

In conclusion, there are a number of challenges still facing Portugal which are to be addressed through structural health care reform, in line with official policy objectives. Firstly, the whole system is to be reoriented towards the attainment of health gains. Secondly, equity between citizens is to be improved, bearing in mind their needs and expectations. Finally, the efficient utilization of available resources is to be promoted.

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