Country Highlights give an overview of the health and health-related situation in a given country and compare, where possible, its position in relation to other countries in the WHO European Region. The Highlights have been developed in collaboration with Member States for operational purposes and do not constitute a formal statistical publication. They are based on information provided by Member States and other sources as listed.

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AN OVERVIEW OF THE HEALTH SITUATION

Positive trends

Life expectancy in Portugal improved rapidly during the 1970s, and after 1980 it rose at about the same rate as the average of the countries that now comprise the European Union (EU). In 1993, it nevertheless remained shorter than that in all the reference countries.¹

The standardized death rates (SDRs) of Portuguese men and women aged 0–64 years for ischaemic heart disease was one of the lowest among the reference countries in 1993, even though the decrease over the preceding ten years had been less than the EU average.

Female mortality from all cancers has been declining since the early 1970s: in 1993 it was the fourth lowest among the reference countries. Lung cancer, and especially cancer of the breast, have on the other hand shown a rising trend during the 1980s, although these SDRs were still among the lowest in 1993.

The population’s Mediterranean nutrition patterns seem fairly healthy. The proportions of adult and adolescent female smokers are still the lowest among the reference countries.

Negative trends

Although infant mortality in Portugal has nearly halved since 1980 (the largest reduction observed among the reference countries), the infant mortality rate was still the highest in 1993.

Mortality of Portuguese men aged 15–34 years is more than three times higher than that of women in this age group. To a large extent this excess male mortality is due to accidents and other violent deaths.

As the SDRs for all cardiovascular diseases (CVDs), including cerebrovascular disease, have dropped by less than in most of the reference countries, the death rate for CVDs has remained above the EU average; for cerebrovascular diseases the SDR is the highest.

Portugal is one of the few countries where mortality of men aged 0–64 years from all cancers and cancer of the lung rose during the 1980s. However, in 1993 male SDRs for these causes were still among the lowest in the reference countries.

Although the SDR for road traffic accidents declined by more than in most of the reference countries, in 1993 it was still the highest.

¹ The 15 countries of the European Union (EU) plus Iceland, Norway and Switzerland.
Highlights on Health provide an overview of the health of a country’s population and the main factors related to it. Based on international comparisons, they present a summary assessment of what has been achieved so far and what could be improved in the future. In order to enlarge the basis of comparison beyond the EU, data for Iceland, Norway and Switzerland have also been included where available and relevant.

A special case of comparison is when each country is given a rank order. Although useful as summary measures, ranks can be misleading and should be interpreted with caution, especially if used alone, as they are sensitive to small differences in the value of an indicator. Also, when used to give an assessment of trends (e.g. the table at the start of the Health Status section), ranks can hide quite important changes within an individual country. Therefore bar charts (to show changes over a relatively short period) or line charts (to show time trends from 1970) have also been used. Line charts present the trends for all the 15 EU countries and their averages, although only the country referred to in a specific Highlight and the EU average are identified. This makes it possible to follow the country’s evolution in relation to that of other EU countries and to recognize how it performs in relation to observable clusters and/or the main trend.

In general, the average annual or 10-year percentage changes have been estimated on the basis of linear regression. This gives a clearer indication of the underlying changes than estimates based on the more simple and straightforward percentage change between two fixed points over a period. For mortality indicators, countries with small populations (e.g. Luxembourg or Iceland) can have fluctuating values, and in these cases three-year moving averages have been used. For maternal mortality, because the number of deaths is in general small, three-year moving averages have been calculated for all countries.

Where possible (and where relevant for trend comparisons), data for Germany up to 1990 refer to the Federal Republic within its current territorial boundaries.

To make the comparisons as valid as possible, data for each indicator have as a rule been taken from one common international source (e.g. WHO, OECD, International Labour Office) or from Eurostat (the Statistical Office of the European Communities) to ensure that they have been harmonized in a reasonably consistent way. It should also be noted that other factors (such as case ascertainment, recording and classification practices and culture and language) can influence the data at times. Unless otherwise mentioned, the source of the data used in the charts and tables is the WHO Regional Office for Europe’s HFA statistical database (June 1995, version with 1992 or 1993 data). The latest data available to WHO as of August 1996 are mentioned, as appropriate, in the text.
THE COUNTRY AND ITS PEOPLE

Portugal is a sovereign unitary republic with a written constitution that came into force in 1982. Executive power is vested in the President of the Republic, elected for five years by universal suffrage. The President appoints a Prime Minister and, on the latter’s nomination, other members of the Council of Ministers.

Legislative power is vested in the unicameral Parliament, the Republic Assembly, whose members are elected by direct universal suffrage under a proportional representation system.

Since 1976 the archipelagos of the Açores and Madeira have been autonomous regions with their own legislatures and governments. Mainland Portugal is divided into 18 districts. Both regions and districts are divided into municipalities and subdivided into parishes. Each level (autonomous regions, municipalities and parishes) has its representative body elected by direct universal suffrage.

Portugal has been a member of the European Union (EU) since 1986.2

Demography

The population pyramid illustrates the changes in the population structure between 1970 and 1994. The most striking feature is the decline in the younger age group due to lower fertility. In 1994, the total fertility rate was only 1.4, far below replacement level (Council of Europe 1995). Therefore, the proportion of the population aged under 15 years has declined to 18%. On the other hand, due to increasing

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2 These introductory paragraphs are based on material from the Statesman’s Year–Book (Hunter 1994, 1995)
longevity, the proportion of the population aged 65 and over is rising steadily and now accounts for 14% while those aged 85 years and over account for 1% of the population (Eurostat 1996). This aging process is even more pronounced for women. They increasingly outnumber men from as early as 30 years, and in 1994, 70% of the population aged 85 and over were women.

As a result of the low fertility, in 1994 the population growth rate was with 0.2% one of the lowest among the reference countries, due half to natural increase and half to net migration (Council of Europe 1995).

Household composition and family structure

As in the other southern European countries, average household size is still comparatively high at 3.1 persons per private household, while the percentage of couples without (dependent) children is the third lowest in the EU. Half the population lives in households consisting of a couple with dependent children.

The proportion of people living in single-person households, albeit growing, is the second smallest in the EU (Eurostat 1995d). However, single-person households are likely to comprise elderly women. The health and wellbeing of elderly people living alone can be significantly affected by the financial resources available for help with housekeeping and personal hygiene. Social exclusion may also result in isolation which can threaten mental health. These issues affect the costs and organization of health care. The situation might, however, be less serious in Portugal than in other European countries, since the traditional household and family composition could have a protective effect.

Migrant population and ethnic profile

Official statistics show 131 593 foreigners living in Portugal, mostly from other EU countries but also from Africa and Latin America. This number is growing fast (Council of Europe 1994). In addition, at the end of the 1980s an estimated 60 000–70 000 illegal immigrants were living in Portugal (Commission of the European Communities 1991). This illustrates the extent of the structural and administrative challenges facing the southern European countries since the number of immigrants began to exceed the number of emigrants (during the past decades many Portuguese have emigrated to countries such as France and Germany). Illegal immigrants are likely to be at a higher risk of ill health due to poor social integration. Immigrants from ethnic minorities can have specific patterns of disease and health needs because of genetic and behavioural factors and exposure to different environments in their countries of origin. Access to health care that

Demographic trends and structure

<table>
<thead>
<tr>
<th></th>
<th>1995a</th>
<th></th>
<th>2015b</th>
<th></th>
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<td></td>
<td>POR</td>
<td>EU</td>
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<td>EU</td>
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<tr>
<td></td>
<td>1000s</td>
<td>%</td>
<td>1000s</td>
<td>%</td>
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<tr>
<td>Population</td>
<td>9 912</td>
<td>371 563</td>
<td>10 799</td>
<td>393 243</td>
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<tr>
<td>Urban population</td>
<td>35</td>
<td>78</td>
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<tr>
<td>Distribution by age:</td>
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<tr>
<td>0–14 years</td>
<td>1 784</td>
<td>18.0</td>
<td>65 423</td>
<td>17.6</td>
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<tr>
<td>15–64 years</td>
<td>6 698</td>
<td>67.6</td>
<td>249 000</td>
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<td>65+years</td>
<td>1 431</td>
<td>14.4</td>
<td>57 140</td>
<td>15.4</td>
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<tr>
<td>85+ years</td>
<td>99</td>
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<td>6 015</td>
<td>1.6</td>
</tr>
<tr>
<td>Total fertility rated</td>
<td>1.4</td>
<td>1.5</td>
<td>1.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Dependency ratio</td>
<td>48.0</td>
<td>49.2</td>
<td>52.8</td>
<td>54.2</td>
</tr>
</tbody>
</table>

a As per 1st January 1995 (Eurostat 1996)

b Forecast, Eurostat intermediate scenario
c 1993 (UNDP 1996)
d 1994 (Council of Europe 1995)
can meet such specific needs or that is culturally and linguistically acceptable can also be difficult. Moreover, immigrants can be at a higher risk of living in relative poverty and being marginalized in their host countries, which can exacerbate their diseases. Illegal immigrants in particular can find it difficult to use health care, and follow-up to any care given can be problematic.

**Education**

The relevance of educational attainment to health has been well documented. In Europe, where primary education is universal, the proportion of the population with more than a lower secondary education would be the appropriate indicator for educational achievement. A recent survey on education of the workforce in the former 12 EU countries (Eurostat 1995c) shows that in this respect Portugal still lags somewhat behind the other EU countries: only about 25% of the adult population have attained at least an upper secondary education. The situation is, however, improving, as among the group aged 25–29 years, some 35% achieved an upper-secondary or higher educational level. Furthermore, there is no sign that women have had less access to education. Indeed in the younger age group, 15% of women obtain a higher degree against 9% of men (Eurostat 1995c). Another study shows that at 16–18 years 15% more girls than boys are undergoing education (Eurostat 1995d).

As women work more frequently outside the home, the availability of preschool facilities becomes more and more important for children’s social integration and mothers’ and children’s psychosocial wellbeing. In Portugal, preschool education provided by the authorities up to now is not available for all children aged 3 years until the beginning of compulsory education at 6 years (Eurostat 1995d).
Economy

The economy includes both private and public sectors. A programme of privatization is under way. Although the economy has benefited from EU membership since 1986, Portugal is still one of the less wealthy EU countries. In the early 1990s:

- agriculture remained important, employing 12% of the civilian workforce although it only accounted for 6% of the GDP in 1994;
- industry employed 33% of the civilian workforce and represented 37% of the GDP. Industry is dominated by the manufacture of textiles and footwear;
- services accounted for 61% of the GDP, employing 56% of the civilian workforce; with more than 20 million visitors in 1992, tourism is important in Portugal but its seasonal nature and the probable large numbers of illegal immigrants working in this area mean that it is difficult to assess its impact on employment.

Unemployment stood at nearly 7% of the workforce in 1994. While the unemployment rate among the active population aged less than 25 years was with 14.5% below the EU average, 35% of all unemployed people are under 25, which is slightly higher than the EU average. Women comprised 44% of all people in civilian employment, which is nearly 10% above the EU average (Eurostat 1995a).

The underground economy, which involves an estimated 17% of the active population, is a serious problem (Morin 1995).

In 1992, Portugal spent 18% of its GDP on social protection (the lowest percentage in the EU), most of it on old age and sickness benefits (Eurostat 1994).

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### Basic economic data

<table>
<thead>
<tr>
<th>Indicator</th>
<th>POR</th>
<th>EU</th>
</tr>
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<tr>
<td>GNP per head (US$,1992)</td>
<td>7 510</td>
<td>20 043</td>
</tr>
<tr>
<td>Real GDP per head (PPP US$,1992)</td>
<td>9 850</td>
<td>17 792</td>
</tr>
</tbody>
</table>

*Source: UNDP 1995*
HEALTH STATUS

A description of the population’s health status against the background of the 18 European reference countries shows that, despite considerable improvements in some areas, on the whole Portugal lags behind (see chart below). The comparative positions for some key health indicators were:

- life expectancy remained the lowest in 1993;
- even though infant mortality nearly halved during the preceding ten years (the largest reduction observed among the reference countries), Portugal still has the highest rate;
- maternal mortality improved from the last to the penultimate position, notwithstanding a marked reduction;
- death rates for cardiovascular diseases (CVDs) in the population aged 0–64 years showed one of the smallest reductions since 1980, leading to a fall in the relative position in 1993;
- as regards cancer mortality, Portugal is in danger of losing its previous advantage over the other European countries as there has been little reduction, or even substantial increases, in death rates for cancer among the group aged 0–64 years in recent years; in particular, male mortality from all cancers and cancer of the lung and female mortality from cancers of the breast and cervix rose during the 1980s;
- mortality from road traffic accidents remained the highest; suicide rates, on the other hand,

Note:

- a) Lowest value observed among 18 European countries.
- b) Highest value observed among 18 European countries.
- c) 3 years moving averages.
- d) SDR: Standardized death rate.

See footnote 1 on page 3
are still among the lowest.
Measures relating to the total population often hide important differences between segments of that population, for instance between men and women. In general, women have higher morbidity but lower death rates than men. As a result, Portuguese women’s life expectancy at birth (77.9 years in 1993) is 7.3 years longer than men’s (70.6 years), one of the widest gaps among the reference countries.

Similar differences can be observed between social classes. A newborn baby’s chances of surviving, for example, vary markedly with its mother’s educational level (DEPS 1995: 74f). Death rates for the main causes of mortality, including infant mortality, also vary geographically between the districts and autonomous regions (DEPS 1995: 70ff, 83ff).
**Life expectancy**

Trends for life expectancy at birth and at 65 years rose markedly for both sexes after 1970 but less noticeably during the 1980s, especially for men. In 1993, Portuguese women shared the lowest position for life expectancy at birth (77.9 years) with Danish women and for life expectancy at the age of 65 years (17.3 years) with Irish women. Male life expectancy at birth (70.6 years) is 1.5 years lower than that of the next lowest (Finns), while at the age of 65 only men from Ireland have a somewhat lower life expectancy than those from Portugal (13.6 years). The most recent data (1994), however, indicate a rapid increase of life expectancy for both sexes and in particular for men.

A country’s position as regards life expectancy at the age of 65 years and loss in life expectancy due to premature death (i.e. deaths before the age of 65 years) gives some indication of the potential for improving overall life expectancy.

Although female mortality before the age of 65 years showed the second largest decrease among the reference countries during the last ten years, women still have the second highest premature mortality rate and men, having experienced only a slight improvement, the highest.

**Main causes of death**

Cancers are the most frequent cause of death under the age of 65 years, followed by CVDs. However, over all ages the situation is reversed and CVDs cause more deaths than cancers. A more detailed analysis of age-specific mortality patterns shows that the causes of up to 80% of all deaths in each age group can be classified in three main categories: external causes\(^4\) (which claim the highest number of lives (DEPS 1995: 76ff) until the age of 35 years), cancers and CVDs.

A comparison between countries of standardized death rates (SDRs) related to these causes can indicate how far observed mortality might be reduced. As almost all causes underlying these deaths are influenced by collective and individual habits and behaviour, a wide variety of health promotion and prevention measures can be applied to bring about changes that will reduce health risks and thus diseases and premature death.

The most striking features of the Portuguese age- and sex-specific death rates are the extremely high mortality of both boys and girls aged 1–14 years compared to that in other EU countries, the very marked excess male mortality between the age of 15 and 64 years, and in all age groups by far the biggest

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\(^4\) This category includes all mortality due to poisoning, suicide, homicide and all types of accident.
These charts show age- and sex-specific death rates for the main causes of death in Portugal in 1993. These rates are compared with the lowest corresponding rate observed in any country of the EU, which can thus be considered as a reference value potentially attainable by other countries. The sum of these minima, however, has to be considered as an artificial value which is sensitive to different national coding practices or coding errors. The dashed lines show the smallest overall SDR observed in any one EU country.
proportion of deaths in the category of all other causes, including large numbers of deaths due to "signs, symptoms and ill-defined conditions" (DEPS 1995: 76ff).

- At 1–14 years, the total age-specific death rate is by far the highest in the EU for both sexes and double the EU average for boys. Both boys and girls have the highest SDRs for accidents and second highest for cancers; boys also have the highest mortality from diseases of the digestive and nervous systems (including the sensory organs).

- At 15–34 years, both sexes still have the highest overall death rate of the EU countries. The male overall death rate is more than three times higher than the female, and for accidents five times higher. Both sexes also have the highest SDRs for cancers and diseases of the digestive system of all people in this age group in the EU.

- At 35–64 years, men still have the highest overall mortality in the EU. Whereas mortality from cancer is below the EU average for both sexes, SDRs for CVDs are comparatively high, especially for women. Furthermore, men rank third highest for accidental deaths, second highest for deaths due to diseases of the digestive system, and highest for deaths due to respiratory diseases, although the latter are less frequent.

- At 65 years and over, women have the highest age-specific overall mortality in the EU and men the second highest. The SDR for CVDs is also the highest for women and among the highest for men, whereas cancer mortality is the third lowest for both sexes. Men also have the highest death rate for diseases of the digestive system. Both the female and male SDR for the residual category of “all other causes” are much the highest among the EU countries.

This analysis of age-specific mortality patterns shows that the greatest potential for reducing mortality lies in improving the health of children and in the prevention of accidents and cancers among young people and cardiovascular and digestive diseases among older people. The high mortality rates across all ages for the “signs, symptoms and ill-defined conditions” category, particularly in the north-east (DEPS 1995: 84), also deserve special attention.

**Cardiovascular diseases**

The overall trend in SDRs from CVDs in the population aged 0–64 years has been falling since 1970 in western Europe. This downward trend has been mirrored in Portugal since the mid-1970s; in 1993, nevertheless, the SDR for women from CVDs was among the highest of the reference countries and that for men around the EU average.

Despite a comparatively small reduction in mortality
from ischaemic heart disease during the last ten years, both sexes had relatively low SDRs due to this cause in 1993. A strong north-south gradient exists as regards SDRs for people aged 0–64 years: they are more than twice as high in some southern regions and Lisbon (DEPS 1995: 83ff, de Sa et al. 1994). Portuguese women and men aged 0–64 years have particularly high mortality from cerebrovascular disease, with SDRs respectively two and two and a half times higher in 1993 than the EU average. Moreover, for both sexes only a modest (below average) reduction in these rates has taken place during the last ten years. Geographical variations have also been observed for cerebrovascular disease, with the highest SDRs in the north-west (DEPS 1995: 83ff).
Cancer

As in other European countries, cancer mortality in the population aged 0–64 years shows clear gender-specific patterns and trends.

- For men, death rates for all cancers have risen steadily over the last two decades from a very low position in 1970 to a medium position in 1993. The last SDR is still somewhat below the EU average, but it nevertheless mirrors the effect of an almost 5% increase during the last ten years, while in the same period the EU average went down by 4%. The development as to lung cancer was even more pronounced: male death rates in 1993 still ranked fourth lowest but with an increase of 28% Portugal was one of the only five countries where an upward trend has been recorded, in contrast to a 4% fall in the EU average.

- SDRs for women aged up to 64 years, how-
ever, followed the main trends in SDRs for women in western Europe, with a slight decrease for all cancers and increase for cancer of the lung over the last ten years. In 1993, the country kept its good position for overall cancer mortality as well as its second lowest position for cancer of the bronchus and lung. On the other hand, the trend for mortality from cervical cancer moved in the opposite direction to the EU average, rising slightly during the last decade, and breast cancer mortality in

Portuguese women has been rising faster than the EU average (see also the section on women’s health page 21).

Cancer mortality also varies between the regions, with relatively low rates in the north-east and the highest rates in Viana Castelo, Oporto, Beja, Lisbon and Setúbal (DEPS 1995: 83f).
External causes of death and injury

This category covers all deaths that are not due to somatic deficiencies such as illness but mainly to accidents, (accidental) poisoning, violent acts (homicide) and suicide. The trend within the EU for mortality from these factors, and in particular from road traffic accidents (which contribute the biggest proportion of all deaths due to external causes), has been falling since 1970. In contrast, a rising trend was observed for Portuguese men and women until the early 1980s, when it began to fall. SDRs for all external causes are thus among the highest in men and average in women.

The risk of dying in a road traffic accident dropped by 16% over the last ten years but is still at the highest level among the reference countries. Moreover, the risk of being injured in such an accident has gone up by almost 70% and was the third highest at the beginning of the 1990s (706 per 100 000 against an EU average of 477). A reduction in both injury and death due to motor vehicle accidents seems possible if the appropriate measures are taken to improve safety on the roads and the chances of survival after this type of accident.

Psychosocial and mental health

Although mental and psychosocial wellbeing are important aspects of health-related quality of life, too little information is generally available to allow a reliable description of this very important dimension of the population’s health. Suicide can be used as an indirect measure of mental disorder or lack of psychosocial wellbeing.

While women are more likely to attempt suicide, the rate of Portuguese men actually committing suicide is three and a half times higher than that of women (12.2 against 3.4 per 100 000). Traditionally Portugal has been among the countries with very low SDRs for suicide, and during the last ten years the decreases for both sexes were greater than the EU average. In 1993, women ranked third lowest and men fifth lowest among the reference countries.

AIDS

The acquired immunodeficiency syndrome (AIDS) is essentially a sexually transmitted disease which can also be transmitted through blood (through the transfusion of infected blood or blood products and use of non-sterile injection equipment). There is a delay of about ten years or more between initial infection with the human immunodeficiency virus (HIV) and development of the clinical illness of
AIDS. The number of notified cases of AIDS is rising all over western and northern Europe, although annual rates of new cases are far higher in the south. Taking into account reporting delays, Portugal had an incidence rate of 6.7 cases per 100,000 population in 1994, placing the country just below the EU average.

By the end of March 1995, a total of some 2400 AIDS cases had been reported in Portugal and it is predicted that 800–1000 new cases per year could be expected after the mid-1990s (European Centre for the Epidemiological Monitoring of AIDS 1994 and 1995). In the cases reported up to the beginning of 1995, transmission by homo/bisexual contact and by injecting drug use accounted for 31% each, while in 27% of all notified AIDS cases the virus was contracted through heterosexual contact.

However, the very long incubation period means that these figures do not necessarily reflect the actual extent of the epidemic or the currently prevailing modes of transmission. As no data about the incidence of infections are available, the prevalence of HIV-positive people can only be estimated. According to...
recent estimates (European Centre for the Epidemiological Monitoring of AIDS 1994), there were almost 15,000 HIV-positive people in Portugal at the end of 1993. There is also likely to have been a shift in the distribution of HIV cases as to the transmission mode. While elsewhere in Europe the largest increases are recorded in the heterosexual contact group, in Portugal transmission appears to be more through injecting drug use than through homosexual contact. Based on back-calculated prevalence estimates, at the end of 1991 injecting drug-users accounted for 45% of all seropositive cases in Portugal, followed by heterosexuals (25%) and homo/bisexual men (22%).

Some 14% of diagnosed cases up to 1993 were in women. The epidemic is mostly concentrated in the three biggest cities, with more than half of all cases notified in Lisbon (DEPS 1995: 51ff).

Disability

The prevalence of long-term illness and disability is an important criterion of a population’s health-related quality of life. However, such data are not generally available. A recent comparative study (Eurostat 1995b) estimated that in 1992, 9.5% of the population suffered from disabilities resulting in a handicap in social or socioeconomic terms. As no representative data from a health survey are available, this figure has been derived from the number of people under 60 years of age on the lists of disability pension funds. According to this estimate, Portugal has the second lowest proportion of disabled people among the EU countries for which this information has been compiled and markedly below the average of 11.5%. As the study points out, it cannot be excluded that a bias has been introduced by this method of estimation because a relatively high degree of disability is required for entitlement to a disability pension. Although this has been taken into consideration, the estimated proportion might be too low.

A comparison of the rates of disability pensioners aged under 60 years shows that Portugal is in an upper-medium position, with a rate of 5.4% compared to an average of 4.7% in the EU.

According to a national health survey carried out in 1990–1991 in the north and 1991–1992 in the south (the Alentejo region), the following chronic conditions and long-term illnesses are the most prevalent (DEPS 1994):

- diseases of the musculoskeletal system (19% in the north, 21% in the south);
- diseases of the circulatory system (10% in the north, 16% in the south);
- diseases of the respiratory system (6% in the north, 4% in the south).

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![Proportion of disabled, by age group (1992)](image)

**Estimated proportion of population aged <60, receiving disability pension, 1991**

![Chart showing disability pension rates by age group for various countries, with Portugal having the lowest percentage.](chart)
Health of children and adolescents

The first year of life is one of the most critical phases as regards mortality; only after the age of 55 years do death rates return to the same level as in the neonatal (during the first 28 days after birth) and postneonatal (from 28 days to 1 year after birth) periods. Decreasing on average by almost 35% over the last 10 years, infant mortality rates (IMR) have converged throughout the EU. The Portuguese rate fell by over 45% to 8.7 per 1000 live births in 1993 (7.9 in 1994), the greatest improvement in the reference countries during this period. Even so it remains the highest rate among the reference countries and nearly 30% higher than the EU average.

Between 1989 and 1994 the IMR for the whole country decreased by roughly 35%, the neonatal mortality rate by 41% and the postneonatal mortality rate by 31%. The rates in the north are approximately 10% above the national average, in the centre and areas around Lisbon just under the national average, and in the Algarve and Alentejo 10–20% below the national average. They are highest of all in the Azores and Madeira: 10.8 and 14.1 per 1000, respectively, in 1993 (DGS 1995). Neonatal deaths contribute to approximately two thirds of all infant deaths, and most often occur in very low-birth-weight babies. In 1994, 6.1% of newborn babies in Portugal weighed under 2500 g.

The sudden infant death syndrome is the main cause of death in the postneonatal period. Madeira has the highest postneonatal rate, almost double the national average. A 20% reduction in infant mortality attributed to congenital anomalies was observed between 1989 and 1993 (DGS 1995).

The three major causes of death in the group aged 114 years are accidents, neoplasms and congenital anomalies. For both boys and girls, Portugal has the highest mortality rates among the reference countries from most causes of death.

Immunization coverage of children against most childhood and communicable diseases, such as diphtheria, tetanus, pertussis, measles and poliomyelitis, has continued to rise, reaching over 95% and for measles over 90% in 1994. Children’s oral health has also improved, contributing to long-term benefits for general health, especially the functioning of the digestive system. In 1990, 12-year-old children had an average of 3.2 decayed, missing or filled teeth, about average in the reference countries.

Adolescence is characterized by efforts to take on adult roles. This transition involves experimentation and imitation, which can make young people...
vulnerable to damage to their health. Acute health problems can result from accidents, experiments with drugs, unsafe sex or unwanted pregnancies. In the longer run, the adoption of specific lifestyle patterns can lead to chronic degenerative diseases. Tobacco consumption, for instance, remains a serious problem: 45% of young people aged 15–24 years were regular smokers and the rate is rising among young women (Andrade e Silva 1991). Adolescence is also the phase when social insecurity can be compounded by, for example, unemployment – about one in three unemployed people are aged under 25 years (Eurostat 1995a).

One of the few routinely available indicators of adolescents’ sexual health and behaviour is the frequency of teenage pregnancies, which can reflect social factors as well as access to and use of contraceptive methods. The number of births to young women aged 15–19 years has been falling in almost all the reference countries since 1980. In Portugal, the reported fertility rate for women in this age group is the third highest in the EU at 22.6 per 1000, corresponding to a rate about four times higher than the lowest rates found in 1992 among the reference countries (Council of Europe 1995). A case control study found that teenage mothers who do not receive specialized care are likely to make fewer antenatal visits and give birth to infants that weigh on average some 200 g less than the babies of teenage mothers who do receive such care (Silva et al. 1993).

**Women’s health**

After age, the second strongest correlate of mortality is gender. Women generally live longer than men and have lower mortality rates for all causes of death in the EU. However, women have higher reported rates of morbidity and utilization of health care services (especially around childbirth), and can be indirectly more affected by population and other social welfare policies. Women in Portugal have the lowest life expectancy, both at birth and at age 65, among the reference countries. This is reflected in the country’s overall mortality rate for women under the age of 65, which is the second highest. Specifically, the death rate due to CVD is close to 25% higher than the EU average, and the death rate due to cerebrovascular disease (the highest among the reference countries) is more than twice as high as the EU average. In contrast, mortality from cancer, including lung, breast and cervical cancers, is lower than the EU average, although the SDR for breast cancer showed a comparatively high increase (14%) over the past ten years.

In addition to relatively higher overall female mortality levels, the country had the second highest maternal mortality recorded among the reference countries, with an average of 9.2 maternal deaths per 100 000 live births between 1991 and 1993 (3-year moving average). However, the maternal mortality rate has improved considerably, decreasing by half.
over the past ten years to 8.4 maternal deaths per 100,000 live births in 1995.

Sexually transmitted diseases (STDs) are more difficult to diagnose in women (many STDs occur without recognizable symptoms in women) and they suffer more severe sequelae than men (Fathalla 1994). While the occurrence of traditional STDs (gonorrhoea, syphilis and chancroid) has declined, new bacterial and viral syndromes associated with Chlamydia trachomatis, the human herpes virus, the human papilloma virus (HPV) and HIV have become prominent in western Europe. These agents are often more difficult to identify, treat and control and can cause serious complications often resulting in chronic
ill health, disability, infertility or death. A community-based study of over 1000 women attending primary health care centres nationwide found the prevalence of candida albicans (the most common genital candidosis) at over 10% (de Oliveira 1993).

Other female health problems are not limited to women’s reproductive function or reproductive age. The cessation of ovarian function at menopause puts women at special risks, notably of osteoporosis due to bone loss. Osteoporosis-related morbidity, including pain, loss of mobility, periodontal disease and tooth loss, and fractures of the hip, vertebrae and wrist, is affecting increasing numbers of people, in particular women (von Wowern et al. 1994). In western Europe hip fractures are common in elderly people, affecting one in four women up to the age of 90 years, twice the rate for men (Armstrong/Wallace 1994).

Violence against women has in general received limited attention as a public health issue. Data on the occurrence and type of such violence are lacking but recent World Bank estimates indicate that in established market economies gender-based victimization is responsible for one out of every five healthy days of life lost to women of reproductive age (Heise 1994). In Portugal, mortality rates from homicide and intentional injury have increased by almost 35% for women over the past ten years, the most significant increase among the reference countries.
LIFESTYLE

Among the wide variety of factors influencing health (genetic disposition, the physical and social environment, etc.), behaviour has a major impact on each individual’s and the population’s health and well-being. Lifestyle patterns such as nutritional habits, (lack of) physical activity, smoking and heavy drinking of alcohol play an important role in premature mortality, mainly from CVDs and cancers. These diseases alone are responsible for the largest number of deaths under the age of 65 years in Portugal. Unhealthy behaviour also contributes to a wide range of chronic illnesses and thus affects the quality of life, especially in older age. Lifestyle, however, is also influenced by collective behavioural patterns, common to a person’s social group, and by the more general socioeconomic conditions. In most European countries, improvements in lifestyles have largely been confined to the more socially and economically privileged middle classes, who are better placed to live healthy lives (WHO 1993).

Somatic risk factors

The extent to which lifestyle is likely to influence morbidity and mortality in a population can be approximated by the prevalence of well known medical risk factors such as raised blood pressure, high cholesterol level or overweight. These are some of the most common determinants associated with cardiovascular diseases.

In Portugal almost no information is available on the prevalence of raised blood pressure, high serum cholesterol levels or overweight. The very few insights result from specific local studies, for instance the clinical record review of adults attending clinics in the district of Lisbon. According to this investigation, less than half (41%) of the people aged 45–64 years who met the criteria of having hypertension were receiving treatment (Baltazar/Natario 1993). Salt is widely consumed and since excess salt consumption is considered to have an important role in the pathogenesis of hypertension, priority has been given to reducing it as a primary prevention measure for hypertension (Carrageta et al. 1994).

Nutrition

Nutritional habits are deeply rooted in cultural traditions and agricultural production. Nevertheless, in recent decades changes have occurred as food markets have opened up, transport has become more rapid and new and efficient techniques of food conservation have been developed. As a result the highly different nutrition patterns of northern and southern Europe are tending to converge, with Portugal following the southern trends typically referred to as the Mediterranean diet, which is particularly low in saturated fatty acids. However, the intake of vegetables and fruits has only recently increased towards the average for the southern European countries. The average proportion of energy derived from overall fat intake has increased over the past decade to 34% of total energy but remains the lowest level found in the EU.

Alcohol consumption

In the EU as a whole, the consumption of alcoholic beverages has steadily declined since 1980 following an increase in the 1970s, with Portugal following this trend. Many European countries are tending towards a “homogenization” of drinking patterns and diversification of beverages. Thus, in Portugal the consumption of traditional beverages such as wine decreased substantially (by over 30%) between 1980 and 1993, while at the same time beer intake more than doubled from less than 40 to 80 litres per head annually and the consumption of distilled spirits remained almost stable. As a result of this process of substitution, the reduction in the amount of alcohol consumed was about average and the country kept its fifth highest position among the reference
countries. In 1993, total consumption of pure alcohol was 10.4 litres per head (almost 13 litres per head of the population aged 15 years and over) compared to 11 litres in 1980 (Produktschap voor Gedistilleerde Dranken 1994).

As in 1980, in 1993 the death rate from cirrhosis and other liver diseases was the highest among the reference countries and 60% above the EU average. There is nevertheless a promising trend, as this rate has dropped over the past decade by 24% for women and 22% for men.

Source: Produktschap voor Gedistilleerde Dranken 1994

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### Annual alcohol consumption (litres of pure alcohol per head), 1993

<table>
<thead>
<tr>
<th>Country</th>
<th>Consumption (litres)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luxembourg</td>
<td>10.4</td>
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<tr>
<td>France</td>
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<td>Austria</td>
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<td>Germany</td>
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<td>Denmark</td>
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<td>Spain</td>
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<td>Switzerland</td>
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<td>Greece</td>
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<td>Belgium</td>
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<td>Italy</td>
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<td>Netherlands</td>
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<td>United Kingdom</td>
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<td>Sweden</td>
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<td>Norway</td>
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<tr>
<td>Iceland</td>
<td></td>
</tr>
</tbody>
</table>

*1992 data

Source: Produktschap voor Gedistilleerde Dranken 1994
Tobacco consumption

Despite the increase in the per capita cigarette consumption for the population aged 15 years and over between 1985 and 1992, Portugal has the lowest overall smoking prevalence found in the EU, approximately 26%. This low rate is primarily due to the lowest prevalence of female smoking in the EU, even though more women smoked regularly in 1994 than in 1987. Bans on advertising introduced in 1983 may have substantially contributed to the relatively low female smoking rates (BASP 1994).

Source: Van Reek and Adriaanse 1995

**Tobacco consumption**

Despite the increase in the per capita cigarette consumption for the population aged 15 years and over between 1985 and 1992, Portugal has the lowest overall smoking prevalence found in the EU, approximately 26%. This low rate is primarily due to the lowest prevalence of female smoking in the EU, even though more women smoked regularly in 1994 than in 1987. Bans on advertising introduced in 1983 may have substantially contributed to the relatively low female smoking rates (BASP 1994).

**Source:** Van Reek and Adriaanse 1995
Tobacco-related deaths in 1990 were estimated at 6800, but only male deaths were recorded given the extremely low prevalence of women smokers during the 1960s and the three or four decade delay between starting to smoke and the occurrence of lethal effects related to it (BASP 1994). Although the death rates due to lung cancer and other tobacco-related cancers are some of the lowest found in the EU, over the past decade the rate has increased by 28% for men and 8% for women.

Between the ages of 14 and 15 years, the prevalence of daily smoking nearly triples for boys to 13% whereas girls are only beginning to smoke at this age. Thus, 7% of the 15-year-old girls smoke daily (Van Reek/Adriaanse 1995). The percentage of adolescents and young adults aged 15–24 years smoking daily decreased for young men but more than doubled for young women between 1977 and 1988, to 45% and 31%, respectively. More recent surveys confirm this trend (BASP 1994).

**Illicit drug use**

In the early 1990s, 60 000–70 000 people were recorded as being addicted to heroin, although cannabis remains the most common drug, used by over 100 000 people (WHO 1995a). Cocaine is used by an estimated 5000 people but appears to be becoming more popular and is often used together with heroin. In 1993, close to 4900 people (49.6 per 100 000 population) sought treatment for drug dependence for the first time at public facilities, a 16% increase. In about 95% of all cases of people seeking treatment, heroin is the main drug used. Of those who enter drug treatment centres, half are aged 35 years or over and about 19% are aged under 15 years. The number of deaths from drug overdose increased from a reported 22 in 1987 to 155 in 1992 and has been fluctuating since then. The increase in drug-related AIDS cases was much larger than the total increase in AIDS cases between 1991 and 1994.

A national representative sample survey of students attending state schools in the 7th, 8th or 9th grades in 1989 found that the lifetime prevalence of any illicit drug use was 2.5%. A survey of the greater Lisbon area in 1992 found a lifetime prevalence for the same group of 5.6%, with cannabis by far the most usual drug tried. According to these surveys, the prevalence of drug use within the previous 30 days was 0.7% in 1989 for the whole country and 2.6% in 1992 for the greater Lisbon area (DEPS 1994). In 1992, heroin was most widely used by the group aged 25–29 years and cannabis by the 20–24-year-olds. Women make up about 20% of the users of both drugs.
ENVIRONMENT AND HEALTH

Environmental conditions affect humans through acute, short-term and long-term exposure to noxious factors. In the long run the main concern is to promote sustainable development compatible with good health and, in particular, to preserve the food chain (water, agricultural production) from contamination by hazardous substances. Short-term environmental protection means avoiding or at least reducing potentially harmful situations, bearing in mind that people are not exposed equally to adverse environmental conditions and not all people and social groups are equally vulnerable to them. Thus, children, pregnant women, elderly or ill people are more likely to be affected by polluted air or contaminated food. Also, adverse environmental conditions tend to accumulate for specific segments of the population. Low income, for instance, is often associated with exposure to environmental hazards at work (noxious substances, risk of accidents) and poor housing conditions (crowding, air pollution, noise, etc.). These situations may affect health and wellbeing either directly or indirectly by causing discomfort and stress, giving rise to unhealthy coping behaviour such as the use of medical drugs or heavy drinking.

Air quality

So far, air pollution does not seem to be a major concern in Portugal. Emission levels of the main pollutants are significantly below the EU average: at the beginning of the 1990s emissions per head of sulfur dioxide were 60% of this average and those of carbon dioxide and nitrogen oxide were less than half. However, the increasing trend observed during the last decade, which has reached over 60% as regards carbon dioxide from fossil fuels (Eurostat 1994: 351ff), may indicate that problems lie ahead. The situation is also likely to be much more critical in areas with a high degree of urbanization and concentration of industrial sites.

Water and sanitation

Water resources are abundant but unevenly distributed over the country and quality is an important issue. In the early 1990s, some 11% of urban and 14% of rural dwellings were not connected to a water supply system, in other words about 20% of the population have no running water at home (DEPS 1994). Some 58% of the water supplied comes from surface water and 42% from groundwater. In 1990, 21% of the population were served by a sewage treatment plant. (Eurostat 1995a: 356). Although this is by far the lowest percentage in the EU, it has gone up ten fold since 1981. Systems have been set up to monitor the quality of recreational (bathing) and drinking-water as well as for the collection and treatment of industrial effluents and household sewage.
Waste

Increasing quantities of waste are being generated in almost all countries with serious implications for health from the resulting pollution of the air, water and soil. The average amount of municipal waste generated in the EU during the 1980s went up by 20% to reach 350 kg per head in 1990. This trend was duplicated in Portugal, although here the figure only reached some 260 kg per head, the lowest quantity among the EU countries. The proportion of paper and cardboard recovered has remained fairly stable since the mid-1970s at around 40% of the material used, while the recycling rate for glass rose from 10% to 30% between 1985 and 1990. The respective maxima recorded among the reference countries are 51% and 67% (Eurostat 1995d: 194).

Housing

Housing conditions generally have an impact on people’s health and wellbeing, but the health situation of homeless people is particularly critical: they often suffer from health problems typically associated with poverty (malnutrition, infectious diseases, psychosocial stress caused by solitude and insecurity, etc.), and they may be more vulnerable to health problems than the rest of the population owing to traumatic events or personality traits which may play a part in their becoming homeless. In Portugal it was estimated in the early 1990s that 3000 people were homeless on any one day of the year or 4000 over the course of a year, i.e. 3–4 per 10 000 population, the second lowest rate in the EU (Avramov 1995: 92). However, the proportion of people living in emergency accommodation is estimated to be about 1% (DEPS 1994).

In the early 1990s, 18% of homes had no inside toilet and the proportion of households with no bath or shower varied between 5% in urban and 22% in rural areas (DEPS 1994). Some 23% of the population were estimated to live in dwellings which did not meet national criteria of good quality (Avramov 1995: 113).

Increasing urbanization and road and air traffic has brought to the fore the issue of noise and its effects on health. In Portugal it represents a health threat for about half the urban population, since in 1991 one in five people found the noise level at home unbearable and an additional 29% were seriously disturbed.
Portuguese population aged over 45 years the frequency of this type of accident is higher than the EU average (EHLASS 1995).

**Occupational health and safety**

Exposure to health risks at the workplace is still an important cause of ill health and death. However, information about exposure in terms of type, frequency, intensity of hazardous conditions and the number of workplaces or people affected is scarce. The incidence rates of recognized occupational diseases attracting disablement benefit awards provide an estimate of risk levels, although such figures are generally lower than the actual number of cases. Usually, only a small proportion of reported cases are recognized, although delays between reporting and recognition may be considerable.

The death rates in Portugal for occupational accidents are about average for the EU, but the risk of being injured at work is third highest among the reference countries. In 1993, 168 people were killed in work-related accidents (1.7 per 100 000 population) and some 244 000 people were injured. This represents a risk of 2467 per 100 000 population, which is 45% above the EU average of 1700 per 100 000. Data for 1994 indicate a marked worsening of the situation as regards fatal cases (258 people killed in accidents\(^5\), corresponding to a rate of 2.6 per 100 000 population), while cases of injury (roughly 234 000) dropped somewhat.

\(^5\) Defined as deaths occurring at point of accident and not including deaths occurring subsequently.
HEALTH SYSTEM

Institutional structures and resources

Since 1979 a nationwide network of hospitals and health centres has been established under the National Health Service (Serviço Nacional de Saúde – SNS). The SNS is financed from tax revenues and provides free access to primary health care and hospital care. Drugs and medications on an approved list are free or subject to co-payments. However, in some situations there is also rationing of supply and a private sector is developing to meet the remaining demand (Berthod-Wurmser 1994).

The SNS provides universal coverage, but civil servants and their dependants (13.6% of the population) are covered by their own scheme based on co-payments and financed by the Government plus 2.5% of employees’ salaries. Separate contributory schemes also cover people working in banking, insurance and some public enterprises (OECD 1994).

The SNS is centralized: responsibility for its functioning, organization and management is shared between the Ministry of Health and the five regional authorities. The SNS manages all public hospitals and the 350 primary health care centres. Diagnostic tests at primary health care level are usually done privately but co-payments are made by the SNS.

The number of practising physicians is slightly above the EU average but there is a serious shortage of dentists and nurses, despite a doubling of nursing staff in the last 12 years. Moreover, there are wide geographical variations in the availability of health personnel and some districts are clearly understaffed (DEPS 1995). About 60% of health professionals work in Lisbon, 17.6% in Oporto and 9% in Coimbra, leaving the rest of the country with comparatively few staff (OECD 1994).

Primary health care

Primary health care is provided by integrated primary health centres providing a wide range of services, including health promotion and protection, as well as prevention, diagnosis and treatment. Some 74% of all physicians in the health centres are general practitioners (GPs). Other medical disciplines represented include public health, gynaecology, paediatrics and stomatology. Only some of the health centres are equipped for carrying out X-rays and laboratory diagnostic tests, and patients are frequently referred to private practices for these procedures. Primary care is also provided by more than 1800 extensions or health posts. In sparsely populated areas physicians sometimes serve more than one post (Boerma et al. 1993).

General practitioners

General practitioners have a dominant role in health centres as the providers of primary care. People are free to choose their doctor and GPs have lists of at

<table>
<thead>
<tr>
<th>Health personnel per 1000 population</th>
<th>POR</th>
<th>EU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>2.9</td>
<td>145</td>
</tr>
<tr>
<td>Dentists</td>
<td>0.2</td>
<td>200</td>
</tr>
<tr>
<td>Nurses</td>
<td>3.1</td>
<td>135</td>
</tr>
</tbody>
</table>

* Or latest available year

Source: OECD 1995
least 1500 patients. They are state-employed, salaried, and have a gatekeeping function with respect to secondary care (Boerma et al. 1993). General practice is a young specialty in Portugal. It is not yet completely accepted by the population and GPs experience a high level of professional dissatisfaction related to working conditions, low salaries, lack of professional incentives, and the problems of the health system. It is not a popular choice for young physicians starting vocational training (European Union of General Practitioners 1995).

Formally, secondary care is only available after referral by a GP, but people often use hospital emergency departments to gain access to their preferred option of hospital care.

Primary dental care
There is a serious shortage of dentists so that only a limited dental service can be provided at the dental clinics and integrated health centres. In 1988, there was one dentist per 30,461 population (OECD 1994).

Primary health care nurses
Primary health care nursing is scarcely developed, given the small ratio of nurses per inhabitant (with 3.1/100,000 about half the average in the EU countries) and the relative concentration of health professionals in the bigger cities.

Community pharmacists
Community pharmacies are subject to a numerus clausus. Drug prices are decided centrally by comparison with neighbouring countries. Pharmacists are allowed a profit margin of 20% on the product sold. In general, drugs are subject to a state contribution of 30–60%, but for the treatment of certain diseases the state’s contribution may rise to 100%. Co-payments for retired patients vary between 15% and 45% but may be as much as 100%.

Hospital care
Some 83% of all hospital beds are in the public sector. Hospitals are run by management boards and have administrative and financial autonomy. Technically, they have to follow guidelines laid down by the General Directorate of Health, part of the Ministry of Health (HOPE 1993).

Central hospitals are located in the Lisbon, Oporto and Coimbra areas and there is a district hospital, at least, in the main town of every district. Secondary care should only be available upon referral by a GP. The hospital network includes some specialized psychiatric, oncology, maternity and rehabilitation hospitals. There is a clear shortage of geriatric and nursing beds for the growing number of elderly people, who have to rely on informal family care (Boerma et al. 1993). However, some private old people’s homes are available for the wealthiest part of the population (OECD 1994).

Private sector
The recent development of a private sector in order to meet unmet needs has created a growing problem of equity. In particular, as mentioned above, those few old people’s homes that exist are in the private sector and very expensive (OECD 1994). Patients sometimes have to pay private practitioners themselves. Private health insurance is a new phenomenon which is still developing. Foreign insurance companies are active in this market (Boerma et al. 1993). Despite important developments in this area in the 1980s, and despite the fact that private insurance contributions are partially tax-deductible, only 10% of Portuguese have private insurance (Berthod-Wurmser 1994). The relationship with the private sector is settled by contracts or agreements.

Health expenditure
International comparisons of health care indicators are extremely difficult because the definitions underlying health statistics as well as accounting practices vary from one country to another. A recent comprehensive study (Schneider et al. 1995) tried to improve comparability by presenting a set of indicators based on adjusted national data. According to this study, Portugal spent 6.6% of its GDP on health in 1992 (7% according to OECD), the second lowest percentage in the EU. Portugal managed to keep hospital costs down and to remain in the lowest position as regards the proportion of GDP spent on inpatient care. The proportion spent on nursing also remained almost stable at the second lowest in 1992. Rising by less than the EU average, the proportion
of GDP spent on medication dropped from second highest in 1980 to just above the EU average in 1992, while that spent on ambulatory medical care rose from below to above average.

A breakdown of total health expenditure by services and goods provided also reveals the comparatively large segments of Portugal’s health budget spent on medication and ambulatory medical care, while the proportion dedicated to nursing is rather small.

Source: Schneider et al. 1995

* Data for Finland not available
Health care reforms

The law of January 1993 established five health regions with maximum autonomy. Under the new regions, health centres are to be grouped together with hospitals to form health units. In addition, the law allows full-time salaried physicians to engage in private practice provided this does not interfere with their SNS duties. It is intended that co-payments will vary according to the income of the patient or the family. The law also provides for public services to be managed or provided by other organizations (public or private) under contract.

The provision stated in the January 1993 law is somewhat controversial as regards the incentive to move from public to private insurance. For each insured person, private insurers would receive from the Government part payment of the premium according to the age, sex and income of the insured at a rate below the average cost per head of the SNS. The insurers would decide with which providers to make contracts and how to pay them, but free choice of health care provider will be an exception and lead to higher co-payment. It is hoped that group practices will be formed to provide out-of-hospital care. Insurance would be lifelong and the insurance companies would not be able to cancel it. There would be no age or health limitations on joining (OECD 1994).
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Cardiovascular diseases (CVDs): all diseases of the circulatory system, including coronary heart disease and cerebrovascular diseases.

Dependency ratio: The ratio of the population defined as dependent (those under 15 and those over 64 years of life) to the working-age population, aged 15-64 years.

Incidence rate: the number of new cases of a disease occurring in a population during a specified period (usually a year) per 100,000 of that population.

Infant mortality rate (IMR): the yearly number of deaths of children aged less than one year per 1000 live births.

Life expectancy at birth: An estimate of the average number of years a newborn can expect to live provided that the prevailing age-specific patterns of mortality at the time of birth were to stay the same throughout the child’s life.

Loss of life expectancy due to deaths before the age of 65 years: describes the effect of premature death on life expectancy, and it measures the potential number of years that could be added to life expectancy at birth if all deaths before the age of 65 were eliminated.

Prevalence rate: the total number of people in a population who have a disease or any other attribute at a given time or during a specified period per 100,000 of that population.

Purchasing power parity (PPP): a “standardized” measure of the purchasing power of a country’s currency, based on a comparison of the number of units of that currency required to purchase the same representative basket of goods and services in a reference country and its currency (usually US$). The EU unit of PPP is PPS (purchasing power standard).

Standardized death rate (SDR): a death rate (usually per 100,000 population) adjusted to the age structure of a standard European population.

Total fertility rate (TFR): the average number of children that would be born alive per woman during her lifetime, if she were to bear children at each age in accord with prevailing age-specific birth rates.