

Health Systems

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1 Introduction

The health sector constitutes an increasingly large portion of developed countries' economies, both in terms of total resources consumed and public expenditure. This development is a consequence of the progress made in most countries in terms of universal access to health care, technological change and ageing populations.

Individually, the uncertainty as to the timing and level of health care spending and, socially, the positive external factors associated with health care justify the existence of risk transfer systems, as well as State contributions to their funding.

Health systems are complex, they involve economic agents with diverse goals and require the decision-makings in situations where the information is usually asymmetric. According to the definition adopted by the World Health Organization (WHO, 2000):

"A generic health system is composed by people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health."

Although it would be very difficult, if not impossible, to find identical health systems in two different countries, it is still possible to classify them into major groupings according to their features. There is no evidence in the literature that leads to the definitive conclusion that one system is superior to another, even though health systems evaluations are being increasingly common, and it is possible to attribute a rating. However, such evaluations have a tendency to take an arbitrary approach, to a certain extent, to the selecting and weighting of the factors to be evaluated (WHO, 2000; Health Consumer Powerhouse, 2018).

The various health systems in existence across the world are the result of the interaction of a range of factors, particularly in regard to the people covered by the system and the services it provides, the financing sources and the available resources, as well as the way supply is organised and services are rendered. The financing sources and the type of service provision are important features that distinguish the systems and both of these features cover a broad spectrum from predominantly public to predominantly private. Associated with all of them is a welfare component, which grows more important as the scope of the public component shrinks.

Section 2 of this publication describes the key elements that characterise a health system and compares the features of Portugal's current system with a range of alternative health systems. Section 3 gives a more detailed description of the Portuguese model, of its key performance indicators and the financial resources allocated to it.

2 Health System Characteristics

This section describes the key features of a health system and examines the systems to be found in OECD member countries. The information used was extracted from the Health System Characteristics data base, which was set up under the [Health Systems Characteristics Survey](#), conducted by the OECD, and which at this time includes information relating to 2009, 2012 and 2016.¹

2.1 Risk coverage

The transfer of individual financial risk to a third party is an intrinsic characteristic of systems providing protection against possible expenditure on health care. Through these systems the participation of a large number of people with non-correlated episodes of ill-health brings risk diversification.

The percentage of the population that has insurance against the financial risks flowing from an episode of ill-health is referred to as the insured population, which in technical terms can be anything from 0 to 100. This coverage may be classified according to the way in which the beneficiaries sign up for health insurance.

Automatic coverage arises when health systems are financed by taxation. This form of membership is based on the Beveridge model, under which the State takes on the role of health insurer, and also takes responsibility for funding, provides health facilities and manages a network of primary, hospital and long-term care providers, while also hiring the resources needed to operate the network.

Compulsory coverage is linked to the payment of social contributions or a risk premium set for the community as a whole.² Under this social health insurance model (the Bismarck model) the State's functions are to define the general principles as to how health insurance and service provision systems work, to approve cost containment measures, and to undertake accreditation, quality control and funding of care for those people excluded from the insurance systems, and the State may manage a hospital network, without restricting the type of providers that render services and receive a public contribution. In countries with this type of health insurance, we generally see supplementary payments, financed by taxation, made to an insurer or insurers. When compulsory coverage is not determined by a person's occupation (employed, unemployed or retired), rules are introduced to avoid insurers excluding people with a high risk of ill-health.

The individual and voluntary payment of a risk premium to take out individual insurance is the main feature of **voluntary coverage**. In addition to individual preferences, the demand for private health insurance may stem from coverage gaps (in the people covered or the type of specialised medical care provided), from waiting times or the quality of the services rendered.

¹ The countries that have taken part in the OECD Health Committee Survey on Health Systems Characteristics are: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom, USA, Costa Rica, Lithuania and South Africa.

² The larger the number of people insured the lower the correlation between any episodes of ill-health that arise.

The classification “**uninsured**” makes sense in cases where, by default, there is supposedly universal (automatic) coverage, but the system performs imperfectly. When the system is not universal, there is room for voluntary cover. In this situation the classification “uninsured” may stem from a voluntary act of a citizen or the system’s inability to act.

Risk coverage for financial expenditure derived from receiving primary health care by health insurance systems with compulsory coverage is the most frequent type of coverage in the States under review, having been identified in 21 of the 38 countries that replied to the health systems survey in 2016 (Table 1). In addition, there are ten countries where a portion of the population, a small percentage on average, has no coverage.

Table 1 – Primary health care – coverage, main coverage type

	Countries
Automatic	Australia, Canada, Denmark, Finland, Iceland, Ireland, Israel, Italy, Latvia, New Zealand ^(a) , Norway, Portugal, Spain, Sweden, United Kingdom, Costa Rica, South Africa, United States ^(a) (32,2%), Chile (18,4%), Korea ^(a) (3,4%)
Compulsory	Czech Republic, France, Germany, Greece, Hungary ^(a) , Netherlands, Eslovak Republic ^(a) , Slovenia, Switzerland, Turkey, Austria (99,9%), Belgium(99%), Lithuania (99%), Japan (98,3%), Korea ^(a) (96,6%), Estonia (95%), Costa Rica (94,7%), Luxembourg (94,6%), Poland (92,2%), Chile (56,8%), Mexico (47%)
Voluntary	Slovenia (73%), United States ^(a) (63,9%), Mexico (49%), South Africa (16%), Spain (15,6%), Luxembourg (1,3%), Estonia (<1%)
Uninsured	Mexico (18%), United States ^(a) (15,7%), Poland (7,8%), Costa Rica (5,3%), Estonia (5%), Luxembourg (4,1%), Japan (1,7%), Belgium (1%), Lithuania (1%), Austria (0,1%)

Source: *OECD Health Systems Characteristics Survey 2016*. | Notes: (a) – information for 2012; the numbers in brackets show the percentage of the population covered; in the countries for which no percentage is shown there is 100% coverage; the reported degree of coverage in Spain, USA, Costa Rica and South Africa exceeds 100%, as these countries report both main and secondary coverage.

2.2 Organisation of supply (provision)

The OECD identified four main models for organizing the provision of primary health care in 2016: i) **national health system**, ii) **local health systems**, iii) **single insurer health insurance system** and iv) **multiple insurer health insurance system**. The expression local health system refers to systems that are either strictly local or regional, depending on the way the various member countries organise their territories. As for multiple insurer health insurance systems, they may or may not allow beneficiaries to choose the insurer.

As regards primary health care provided by a predominant insurer or insurers in each country, the most common organisation model of provision is the national health system (Table 2), which was identified in 14 of the 38 countries, followed by multiple insurer health insurance systems (12 out of 38 countries).

The option of choosing the insurer is available in most of the health insurance systems that offer multiple insurers, except in Austria and Japan. In those countries the health insurer is usually allotted according to the beneficiary’s occupation (Paris & al., 2010). That characteristic is pertinent since a number of health risks are linked to the nature and duration of the person’s occupation. On the

other hand, higher homogeneity among the insured may bring into question the system's efficiency and its financial sustainability, since the ill-health risks correlation is higher.

Table 2 - Primary health care – provision, main organisation type

	Countries
National	Australia, Canada, Denmark, Finland, Iceland, Ireland, Italy, Latvia, New Zealand ^(a) , Norway, Portugal, Spain, United Kingdom, South Africa
Local	Sweden
Single insurer	Estonia, France, Greece, Hungary ^(a) , Korea ^(a) , Luxembourg, Poland, Slovenia, Turkey, Costa Rica, Lithuania
Multiple insurers	Austria ^(b) , Belgium, Chile, Czech Republic, Germany, Israel, Japan ^(b) , Mexico, Netherlands, Slovak Republic ^(a) , Switzerland, United States ^(a)

Source: *OECD Health Systems Characteristics Survey 2016*. | Notes: (a) - information for 2012; (b) – means that coverage is automatic, rather than there being free choice, which occurs in other countries where health care is provided by multiple insurers.

Table 3 - Primary and specialised health care – nature of main provider

	Public	Private
PHC	Chile, Finland, Greece, Hungary ^(a) , Iceland, Israel, Latvia, Mexico, Poland, Portugal, Slovenia, Spain, Suécia, Turkey, United Kingdom, Costa Rica, Lithuania, South Africa	Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Estonia, France, Germany, Ireland, Italy, Korea ^(a) , Luxembourg, Netherlands, New Zealand ^(a) , Norway, Switzerland
SHC	Chile, Denmark, Estonia, Finland, Israel, Italy, Latvia, Norway, Poland, Portugal, Slovenia, Sweden, Turkey, United Kingdom, Costa Rica, Lithuania, South Africa	Australia, Austria, Belgium, Canada, Czech Republic, France, Germany, Greece, Hungary ^(a) , Iceland, Ireland, Japão ^(a) , Korea ^(a) , Luxembourg, Mexico, Netherlands, New Zealand ^(a) , Slovak Republic ^(a) , Spain, Switzerland, United States ^(a)

Source: *OECD Health Systems Characteristics Survey 2016*. | Notes: PHC – primary health care; SHC – specialised health care; (a) – information for 2012; there is no information relating to PHC for Japan, Slovak Republic and USA.

2.3 Health care provision

Health care provision may be undertaken by **public** or **private** organisations. However, for classification purposes, a distinction must be made between primary health care and specialised health care. Primary health care is most commonly provided by public institutions, which is the case in 18 countries (Table 3). As for specialised health care, private provision is the most common.

In terms of health care involving hospital admission, health systems often provide services through public institutions and private institutions, both for- and not-for-profit. The payment method adopted by the insurer(s) in each health system is the main difference, and it may be *a priori* or *a posteriori*.

The payment method for hospital discharges **by diagnosis-related groups** (DRG), also known as payment per case, refers to the payment of a predefined and fixed sum for the case to be treated. This amount is based on diagnosis and the associated costs, defined in line with the quantity and types of procedure usually required for such cases.

Payment **by prospective budget** implies the defining of an overall limit for expenditure resulting from care provision over a limited period, usually a tax year. Although a number of countries have reported this method, the actual payment method usually combines the prospective budget with a component based on the expected service volume, in order to promote access and quality, as well as cost control (EC, 2016).

As the names suggest, there may also be payments **by procedure** performed, **by item consumed** during in-hospital stay and **by day** spent at the hospital. Finally, there are some health systems where payment is made **by retrospective budget**, under which expenditure stemming from the provision of health care is reimbursed after the services have been rendered.

Table 4 – In-hospital admission, main payment method

	Public	Private (not-for-profit)	Private (for profit)
DRG	Australia, Austria, Belgium, Czech Republic, Finland, France, Germany, Greece, Hungary ^(a) , Italy, Netherlands ^(a) , Poland, Slovenia, Switzerland, United Kingdom, United States ^(a) , Lithuania	Austria, Belgium, Chile, Czech Republic, Estonia, France, Germany, Greece, Hungary ^(a) , Italy, Netherlands, Poland, Slovenia, Switzerland, United States ^(a)	Austria, Czech Republic, Estonia, France, Germany, Greece, Italy, Norway, Poland, Slovenia, Spain, Sweden, Switzerland, Lithuania
Budget	Canada, Chile, Denmark, Iceland, Ireland, Latvia, Luxembourg, Mexico, New Zealand ^(a) , Norway, Portugal, Spain, Sweden, Turkey	Canada, Ireland, Luxembourg, Norway	Canada, Latvia
Procedure	Israel, Japan, Korea ^(a)	Australia, Japan, Korea ^(a) , Mexico, Portugal, Turkey ^(a) , United Kingdom, South Africa	Australia, Chile, Hungary ^(a) , Israel, Japan, Mexico, Portugal, Turkey ^(a) , United States ^(a) , South Africa
Other	Costa Rica ^(b) , South Africa ^(b)	Israel ^(c)	United Kingdom ^(d)

Source: *OECD Health Systems Characteristics Survey 2016*. | Notes: DRG – diagnosis-related group; (a) - information for 2012; (b) – per item; (c) – per day; (d) - retrospective; there is no information for Estonia (public), Slovak Republic (public, private for- and not-for-profit), Finland (private for- and not-for-profit), Spain (private not-for-profit) and Ireland (private for-profit).

The payment scheme diversity results from the demand for an efficient financing method, which allows control over costs, while promoting population access and quality. The HDG method is the most common form of payment for hospital stays among the health systems that took part in the OECD survey, be it a public institution, a private not-for-profit organisation or a commercial private body (Table 4), followed by the forecast budget payment method.

As a rule, *a posteriori* payment systems do not encourage cost containment, since they offer incentives to increased service provision, and that provision may go beyond the means needed to treat the patient. As for payment by prospective budget, it encourages resource savings but, on the other hand, it does not necessarily encourage improved quality of service and generates greater financial uncertainty for the hospital.³

2.4 Other characteristics

Attention will also be drawn, in a non-exhaustive manner, to other health system characteristics, such as: the existence or otherwise of a share in the cost at the time the care is provided, the possibility of a partial reimbursement of expenditure, controlled access to the system and the users' degree of freedom.

³ For a theoretical analysis of these implications see Barros (2013, chap. 14).

2.4.1 Co-payment and reimbursement

Regulating the use of health services by sharing the cost with the patient is a tool employed by both public and private insurers, with the aim of promoting rational use. It is not used primarily to raise revenue but rather to moderate excessive demand for health care (Schokkaert & van de Voorde, 2011).

The **co-payment**, or user fee, is the fixed sum paid by the user when the health service is provided (Paris & *al.*, 2016). Most health systems employ, along with a co-payments policy, measures to protect patients with higher health risks and those financially deprived, by exempting them from payment.

Among the health systems under review, 18 of the 38 countries charged user fees when providing primary health care in 2016 (Table 5). In the case of specialised health care, the number of countries that have a co-payments policy rises to 23. As for hospital stays, fees were charged in 50% of the health systems in the countries taking part in the OECD survey. In terms of laboratory analysis and imaging exams, 21 and 17 countries, respectively, of the 38 under review require a co-payment at the time the service is used. The dispensing of medicine, the conducting of oral health consultations and the supply of dental prostheses in the various health systems under review reveal a similarity: only one or two countries (Mexico and Costa Rica for medicines; Hungary and Mexico for oral health care; and Poland for dental prostheses) do not require the patient to share the cost.

The possibility of a **reimbursement** for part of the cost borne by the patients, generally up to a set limit, is another factor that varies across the health systems. Most systems include this possibility: reimbursement is an option in 22 of the 38 health systems under review (Table 5).

Table 5 – Co-payments and reimbursement in the main organisation

	No	Yes
PHC visit	Australia ^(b) , Canada, Czech Republic, Denmark, Estónia, Germany ^(b) , Greece ^(b) , Hungary ^(a) , Israel, Italy, Mexico ^(b) , Netherlands, Poland, Slovak Republic ^(a) , Spain, Turkey, United Kingdom, Costa Rica, Lithuania, South Africa ^(b)	Austria, Belgium, Chile ^(b) , Finland, France, Iceland, Ireland ^(b) , Japão, Korea ^(a) , Latvia, Luxembourg, Norway, New Zealand ^(a) , Portugal, Slovenia, Sweden ^(a) , Switzerland, United States ^(a,b)
SHC consultation	Australia ^(b) , Canada, Czech Republic, Denmark, Germany ^(b) , Greece ^(b) , Mexico ^(b) , Hungary ^(a) , New Zealand ^(a) , Poland, Slovak Republic ^(a) , Spain, United Kingdom, Costa Rica, South Africa ^(b)	Austria ^(b) , Belgium, Chile, Estonia, Finland, France, Iceland, Ireland ^(b) , Israel, Italy, Japan, Korea ^(a) , Latvia, Luxembourg, Netherlands, Norway, Portugal, Slovenia, Sweden ^(a) , Switzerland, Turkey, United States ^(a) , Lithuania
In-hospital admission	Australia ^(b) , Canada, Czech Republic, Denmark, Hungary ^(a) , Iceland, Israel, Italy, Mexico ^(b) , New Zealand, Norway, Poland, Portugal, Slovak Republic ^(a) , Spain, Turkey ^(b) , United Kingdom, Costa Rica, Lithuania	Austria, Belgium, Chile, Estonia, Finland, France, Germany, Greece, Ireland ^(b) , Japan, Korea ^(a) , Latvia, Luxembourg, Netherlands, Slovenia, Sweden ^(a) , Switzerland, United States ^(a,b) , South Africa
Laboratory analysis	Australia ^(b) , Canada, Czech Republic, Denmark, Estonia, Finland ^(b) , Germany, Greece, Hungary ^(a,b) , Israel ^(a) , Ireland ^(b) , Luxembourg, Mexico ^(b) , New Zealand ^(a,b) , Poland, Slovak Republic ^(a) , Spain, Turkey, United Kingdom, Costa Rica, Lithuania	Austria, Belgium, Chile, France, Iceland, Italy, Japan, Korea ^(a) , Latvia, Netherlands, Norway, Portugal, Slovenia, Sweden ^(a) , Switzerland, United States ^(a,b) , South Africa
Imaging exams	Australia ^(b) , Canada, Czech Republic, Denmark, Estonia, Germany, Greece, Hungary ^(a,b) , Ireland ^(b) , Mexico ^(b) , New Zealand ^(a,b) , Poland, Slovak Republic ^(a) , Spain, Turkey, United Kingdom, Costa Rica	Austria, Belgium, Chile, Finland, France, Iceland, Israel, Italy, Japan, Korea ^(a) , Latvia, Luxembourg, Netherlands, Norway, Portugal, Slovenia, Sweden ^(a) , Switzerland, United States ^(a,b) , Lithuania, South Africa ^(b)
Medicines	Mexico ^(b) , Costa Rica	Australia, Austria, Belgium ^(b) , Canada ^(a) , Chile ^(b) , Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary ^(a) , Iceland, Ireland, Israel, Italy, Japan, Korea ^(a) , Latvia, Luxembourg, Netherlands ^(b) , New Zealand ^(a) , Norway, Poland, Portugal, Slovak Republic ^(a) , Slovenia, Sweden ^(a) , Spain ^(b) , Switzerland, Turkey, United Kingdom, United States ^(a) , Lithuania, South Africa
OHC consultation	Hungary ^(a) , Mexico	Australia, Austria, Belgium, Canada ^(c) , Chile, Czech Republic, Denmark ^(c) , Estonia ^(c) , Finland, France, Germany, Greece, Iceland, Ireland ^(b) , Israel, Italy, Japan, Korea ^(a) , Latvia ^(c) , Luxembourg, Netherlands ^(c) , New Zealand ^(a,c) , Norway ^(c) , Poland, Portugal ^(c) , Slovenia, Sweden ^(a) , Spain ^(c) , Switzerland ^(c) , Turkey, United Kingdom ^(b) , United States ^(a) , Costa Rica ^(d) , Lithuania, South Africa
Dental prosthesis	Poland	Australia, Austria, Belgium, Canada ^(c) , Chile, Czech Republic, Denmark ^(c) , Estonia ^(c) , Finland, France, Germany ^(b) , Greece, Hungary ^(a) , Iceland, Ireland ^(b) , Israel ^(d) , Italy ^(d) , Japan, Korea ^(a,c) , Latvia ^(c) , Luxembourg, Mexico ^(d) , Netherlands, New Zealand ^(a,d) , Norway ^(c) , Portugal ^(c) , Slovenia, Sweden ^(a) , Spain ^(c) , Switzerland ^(d) , Turkey, United Kingdom ^(c) , United Kingdom ^(a) , Costa Rica ^(d) , Lithuania ^(d) , South Africa
Reimbursement	Belgium, Chile, Czech Republic, Denmark, Estonia, Finland, Israel, New Zealand ^(a) , Slovak Republic ^(a) , Slovenia, Spain, Sweden, Turkey, United Kingdom, Costa Rica, Lithuania	Australia, Austria, Canada, France, Germany, Greece, Hungary ^(a) , Iceland, Ireland, Italy, Japan, Korea ^(a) , Latvia, Luxembourg, Mexico, Netherlands, Norway, Poland, Portugal, Switzerland, United States ^(a) , South Africa

Source: *OECD Health Systems Characteristics Survey 2016*. | Notes: (a) - information for 2012; (b) – exceptions apply; (c) - generally not covered; (d) – no coverage; PHC - primary health care; SHC – specialised health care; CSO – oral health care; there is no information for Slovak Republic (oral health care oral consultation, dental prosthesis and reimbursement).

2.4.2 Gatekeeping

Users first contact with the health system takes place in the primary health care units, by way of specialists in general and family medicine, which treat conditions that do not require hi-tech solutions, but rather require a wide ranging and long-term knowledge of the patient and their circumstances. In addition these units develop and undertake acts of prevention, as well as referring patients to other levels of care when circumstances so justify.

Gatekeeping is a mechanism employed by health systems to optimize the allocation of demand for health care, thereby reducing the search cost for users and maximizing the health system's productive capacity.⁴ Of the 38 countries that replied to the questionnaire on health system characteristics in 2016, 18 require or encourage users to register with the system before providing them with primary health care (Table 6). The referral to specialised health care providers, by way of specialists in general and family medicine, is compulsory or encouraged in 24 of the 38 countries under review.

2.4.3 Patient choice

The possibility of users having a choice in regard to health care is a feature of competitive health systems, generally employed as a tool to control prices and/or improve the quality of services. In certain circumstances there are rules that restrict choice: national health systems with local providers usually restrict users' choice to a specific geographical area, or devise incentives for some provider groups to the detriment of others.

At one extreme are the health systems with **prohibited choice**, under which patients may not choose their health care providers. **Limited choice** generally refers to the geographical area or the predefined provider network, which facilitates investment and the distribution of the resources available within the health system. In more competitive health systems, one comes across **permitted choice**, that is to say no restrictions are imposed on users when choosing their health care provider. At the opposite extreme there may be health systems with **fostered choice**, under which financial incentives exist to encourage choice of providers within a predefined network, rather than the choice of providers that are not part of the network.

Permitted choice is the most common characteristic of the health systems in the 38 nations under review (Table 7). In 2016 the choice of primary health care provider was optional in 26 countries. Regarding specialised health care providers and hospitals, in 27 of the 38 countries permitted choice was also a characteristic. It is also noted that fostered choice of a provider or provider network is a common practice, found more often regarding the choice of specialised health care providers (10 countries) and hospital admission (11 countries), than in the case of primary health care (5 countries).

⁴ One Portuguese translation of gatekeeping is control over access which describes the concept. In such systems the specialist in general and family medicine is seen as the manager and coordinator of referrals to more complex health services. The appearance of this type of health professional is a response to the increasing specialisation in medicine (Dranove & Satterthwaite, 2000).

Table 6 – Gatekeeping on main organisation

	Compulsory	Incentivised (financially)	Free
PHC registration	Chile, Estonia, Finland, Ireland, Italy, Latvia, Portugal, Slovenia, Spain, Turkey, Lithuania	Belgium, Denmark, France, Germany, New Zealand ^(a) , Norway, Switzerland	Australia, Austria, Canada, Czech Republic, Greece, Iceland, Israel, Japan, Korea ^(a) , Luxembourg, Mexico, Netherlands, Poland, Sweden, United Kingdom, Costa Rica, South Africa
SHC via PHC	Australia, Canada, Chile, Estonia, Finland, Ireland, Italy, Netherlands, New Zealand ^(a) , Poland, Portugal, Slovenia, Spain, Sweden, United Kingdom, Costa Rica, Lithuania	Belgium, Denmark, France, Latvia, Mexico, Norway, Switzerland	Austria, Czech Republic, Germany, Greece, Iceland, Israel, Japan, Korea ^(a) , Luxembourg, Turkey, South Africa

Source: *OECD Health Systems Characteristics Survey 2016*. | Notes: PHC - primary health care; SHC – specialised health care; (a) - information for 2012; there is no information for Hungary, Slovak Republic and USA.

Table 7 – Provider freedom of choice on main organisation

	Forbidden	Limited	Allowed	Incentivised (financially)
PHC	Mexico, Portugal, Costa Rica	Denmark, Finland, Iceland, Italy, Spain, United Kingdom, Lithuania, South Africa	Australia, Austria, Belgium, Canada, Chile, Czech Republic, Estonia, France, Germany, Hungary ^(a) , Ireland, Israel, Japan, Korea ^(a) , Luxembourg, Netherlands, New Zealand ^(a) , Norway, Poland, Slovenia, Sweden	Greece, Latvia, Switzerland, Turkey, United States ^(a)
SHC	Chile, Hungary ^(a) , Mexico, New Zealand ^(a) , Portugal, Costa Rica	Canada, Spain, Lithuania	Australia, Austria, Belgium, Czech Republic, Denmark, Germany, Iceland, Ireland, Italy, Israel, Japan, Luxembourg, Norway, Poland, Slovenia, Sweden, United Kingdom	Estonia, France, Greece, Korea ^(a) , Latvia, Netherlands, Switzerland, Turkey, United States ^(a) , South Africa
In-hospital admission	Mexico, Costa Rica	Canada, Chile, Finland, Hungary ^(a) , Israel, New Zealand ^(a) , Portugal, Spain	Australia, Austria, Belgium, Czech Republic, France, Iceland, Ireland, Italy, Japan, Luxembourg, Norway, Poland, Slovenia, Sweden, United Kingdom, Lithuania	Denmark, Estonia, Germany, Greece, Korea ^(a) , Latvia, Netherlands, Switzerland, Turkey, United States ^(a) , South Africa

Source: *OECD Health Systems Characteristics Survey 2016*. | Notes: (a) - information for 2012; there is no information for Slovak Republic.

3 The health system in Portugal

3.1 Characteristics of the Portuguese health system

In Portugal, the organisation of public health services goes back to the beginning of the 20th century, when the Public Health and Charity Services regulations came into force in 1903. Up to then health care had been in private hands, as the State only provided assistance to the more financially deprived.⁵ The right to health protection for all citizens, by way of a universal national health service, was guaranteed in 1976, when the new Portuguese Constitution was approved (Law nº 56/79, of 15 September). Pursuant to Article 64 (2) and revisions:

“The right to health protection is implemented: a) by a universal and general national health service and, taking into account each citizen’s economic and social conditions, tending towards free; b) by the creating of economic, social, cultural and environmental conditions that guarantee protection during childhood, adolescence and old age, and by the systematic improvement in living and working conditions, as well as by promoting physical exercise and sport at school and in society, and also by developing public health education and healthy living practices.”

Portugal has a mixed health system, under which residents have automatic protection, which is the State’s responsibility, and they may also voluntarily take out additional protection through public or private health insurers. The public component automatically covers residents against the financial risk associated with an episode of ill-health, through the State’s role as an insurer, as occurs in the other 19 health systems of OECD countries (Chart 1). Bearing in mind that the National Health Service provides universal coverage, the portion of the population that makes contributions to another health subsystem, or pays risk premiums to private health insurers, has double coverage against the financial risks associated with seeking health care.

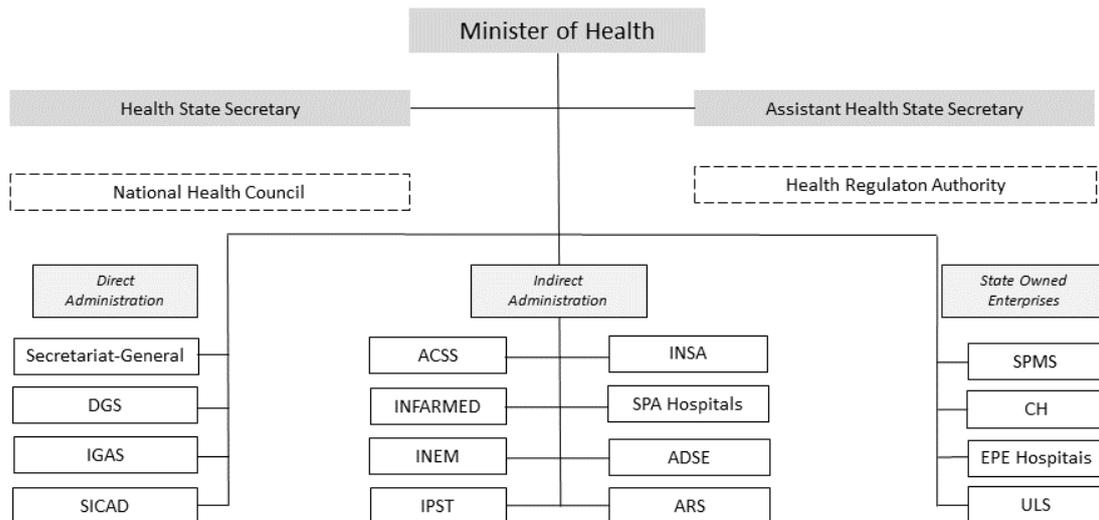
The predominant form of health care provision organisation is a national health system. This type of organisation is the most common among the countries under review (Chart 1). Public and private health subsystems and private health insurers organise the provision of services in a free manner, by way of agreements with health care providers in Portugal, that are supervised by the Ministry of Health.

Pursuant to the [Health Framework Law](#), health care is provided by State services or enterprises or, under its supervision, by public organisations or private for- or not-for-profit entities. Each of these entities, according to its legal status, is in some way connected to the Ministry of Health, which also negotiates with the various professional associations and is supported by the National Health Council (Table 8).⁶

⁵ The provision of health services and assistance has its origins in religious and corporate practices. Since the Middle Ages the Mercy Hospitals have played an important role in healing the sick, due to their proximity to the people and their presence across Portugal (Rodrigues & Leão, 2014).

⁶ The Health Framework Law (Law nº 48/90) is currently under [review](#).

Figure 1 – Overview of the health system in Portugal



Source: Adapted from Simões & al., 2017.

Health care is mainly provided by public organisations (Chart 1). In the case of primary health care, provision is generally undertaken by public health centres, the so-called Personalised Health Care Units and Family Health Units, with the latter having greater flexibility in terms of organisation and management (Barros, 2013). The provision of specialised health care is undertaken in hospital, most of which have the status of public corporations. In these cases, ultimately, the State owns the institutions, but grants some level of autonomy to their management. Health care provided by private institutions plays a complementary and supplementary role and is especially important in terms of specialised care services which, at least for most of the population, are not included in the National Health Service (such as dentistry) or for which there are long waiting lists.

The health care provision model adopted in Portugal (“public-public”) is in line with approximately half of the health systems that serve for comparison in this document. Primary health care is provided by public institutions in 51% of the predominant health insurance systems. As for specialised health care, its provision by public institutions is the most common form in 45% of the systems.⁷

Regarding the payment method for hospital admission, payment by overall budget is the method most used in public hospitals belonging to the National Health Service, by way of program-contracts drawn up beforehand (Chart 1). This type of contract combines the prospective budget and **diagnosis-related groups** payment methods, as they call for the setting of an annual target for the volume of activity.⁸ There are also four hospitals that operate as a public-private partnership, under which management of the facility and of service provision has been transferred to private institutions.⁹ As for the private not-for-profit organisations and the private hospitals, the most common

⁷ In the Danish, Italian and Norwegian health systems which share the characteristics of automatic coverage for the population and provision organised by means of national health systems, the provision of primary health care is mainly undertaken by private entities. As for specialised health care, the three models are like that adopted in Portugal as it is mainly provided by public hospitals.

⁸ See Barros & Braun (2016) for a recent empirical evidence on this payment method in Portugal.

⁹ The hospitals operating under these conditions are Hospital Beatriz Ângelo, Hospital de Braga, Hospital de Cascais Dr. José Almeida and Hospital Vila Franca de Xira.

method is payment by procedure, unlike in the majority of the health systems in the countries under review.

In terms of the costs borne by the patients in return for the publicly provided services (the predominant form), the National Health Service adopted a policy of sharing the costs by collecting user fees (co-payments), except for hospital admission.¹⁰ The public and private health subsystems, as well as the private health insurers are governed by their own rules as to the charging of user fees.

By way of the reimbursement of a percentage of the costs of acquiring public and private health goods and services, be they co-payments, insurance premiums or direct payment of health services, the State provides for a reduction in these expenses' weight in a household's total consumption. Under current legislation, it is possible to obtain an individual tax deduction of up to 15% of the sums paid, with an annual limit of one thousand euros.

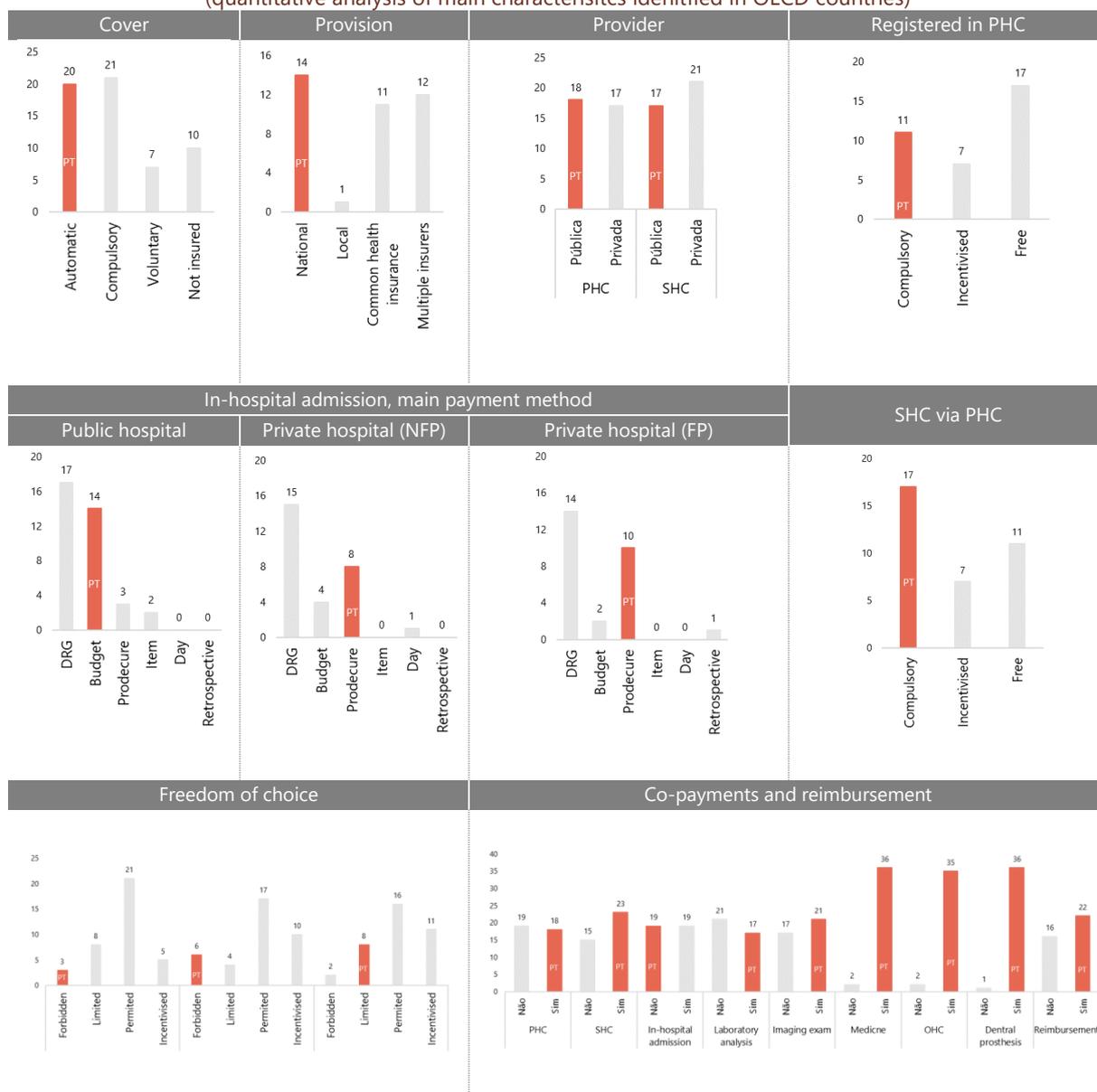
Portugal employs gatekeeping mechanisms to ensure a better allocation of available resources and demand for services within the National Health Service, as well as to moderate the excess demand for health care. These mechanisms take the form of compulsory registration prior to receiving primary health care and of general and family practitioners referring patients for specialised health care. However, these mechanisms have limited effectiveness regarding a decrease in demand for primary health care in the ambulatory and emergency (A&E) departments of public hospitals. According to the latest OECD report on the Portuguese health system, 42% of the consultations conducted in those A&E departments could have taken place at primary health care units (OECD, 2015).

As for freedom of choice over health care providers, in 2016, those using the Portuguese National Health Service were banned from choosing their primary health care and specialized health care providers. Regarding hospital admission, they had a limited choice. However, this characteristic has been undergoing modification since the implementation of the Free Access and Movement in the National Health Service policy [Livre Acesso e Circulação no Serviço Nacional de Saúde](#).¹¹ Under the new rules the patient, together with their family doctor, may choose the specialist health care provider, taking into account their own interests, geographical proximity and waiting lists. Nonetheless this change does not have any effect on freedom of choice as to primary health care provider, unlike the situation in most of the other health systems used for comparison here.

¹⁰ Although Portugal practises a co-payments policy, around 60% of the population is exempt from paying user fees when they use services covered by the National Health Service (Paris & al., 2016). This figure compares with 55% of people being exempt in 2009 (Paris & al., 2010).

¹¹ Set out in Ministerial Dispatch n° 5911-B/2016 of 3 May.

Chart 1 – Characteristics of predominant health insurance systems
(quantitative analysis of main characteristics identified in OECD countries)



Source: OECD Health Systems Characteristics Survey 2016. | Note: the characteristics of the predominant health insurance system in Portugal are highlighted in orange; NFP – not-for-profit; FP – for-profit; PHC – primary health care; SHC – specialised health care.

3.2 Key indicators

A health system’s performance may be evaluated by disease, by health system subsector and by the health system as a whole. Nonetheless it is a complex topic and the subject of debate among experts.

The disease level approach is theoretically attractive, but there are significant internal barriers to its implementation. The treatment of a disease may involve primary care, specialised care, the use of drugs, among other items. Consequently, any cost-efficacy analysis requires information from a range of sources, which is not always possible. On top of that it is difficult to make international comparisons of the results, as different methodologies may have been used.

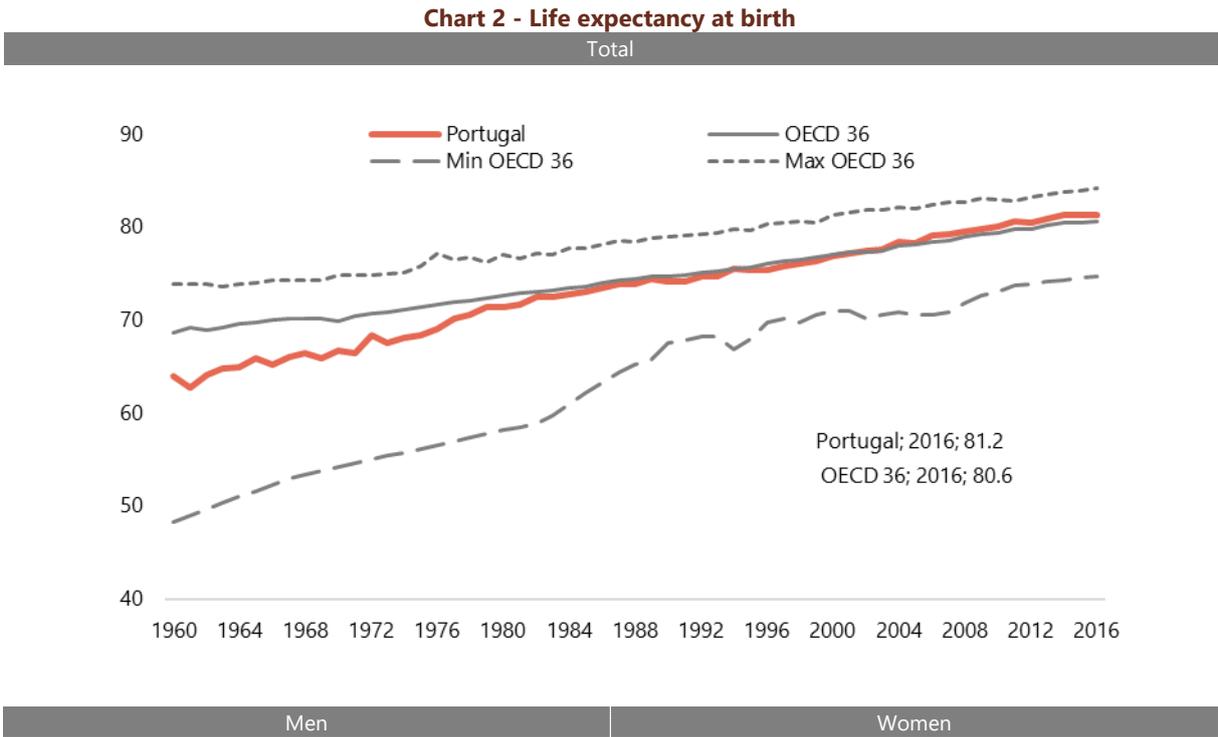
At the subsector level the indicators measure, above all, performance in the hospital subsector by monitoring efficiency measures based on activity, such as the number of consultations conducted by health professionals or the average cost of hospital care (OECD, 2010). Higher homogeneity

among the services provided in hospitals and improved activity recording systems allow for international comparisons but they still have their limitations.¹²

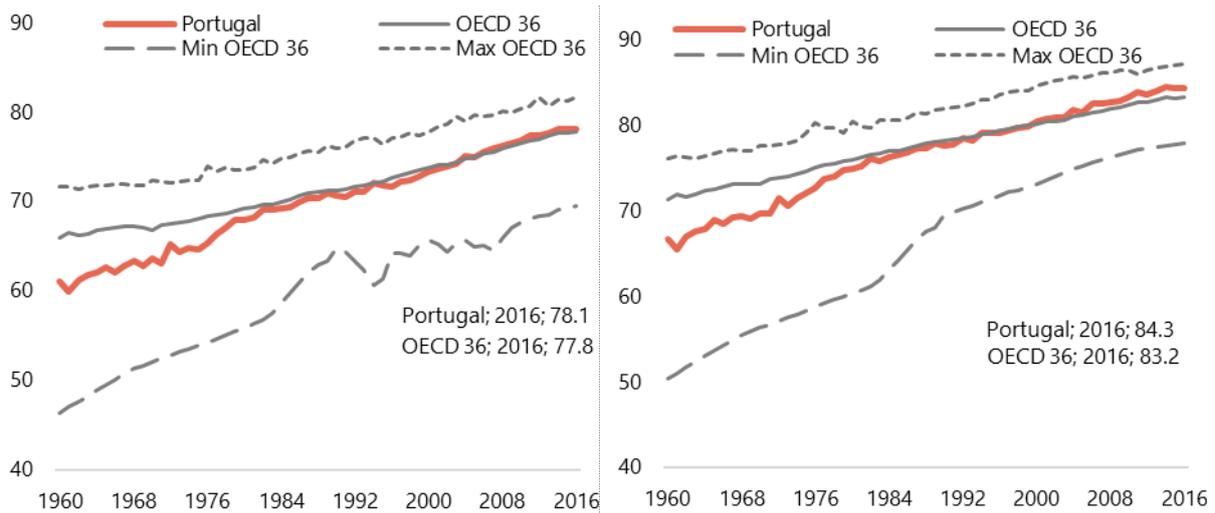
The overall performance of a health system, which is the most common approach, may be measured using a series of indicators generally accepted to be representative of the quality of the services provided and the goods supplied in different countries, such as measures of longevity and mortality. Some indicators covering processes and overall results in the health sector have been increasingly used to complement life expectancy and the mortality rate.

Life expectancy is a common way of characterizing the population’s health status and may be calculated for any age group. This measure is strongly influenced by the health care available to a population, but also by other factors relating to life styles (which often cannot be directly measured).

Life expectancy at birth measures the average number of years a person can expect to live from birth, if the mortality rates by age observed at the time continue. Chart 2 (upper panel) clearly reveals the effort made to develop the health system that led to life expectancy in Portugal (81.2 in 2016) converging on the average figure for the countries used as a comparison (80.6 in 2016). Women’s life expectancy at birth reached the OECD average before that of men (Chart 2, lower panels). The difference in men’s and women’s life expectancy at birth was 6.2 years in 2016. The difference in the averages for OECD countries that same year was 5.4 years.



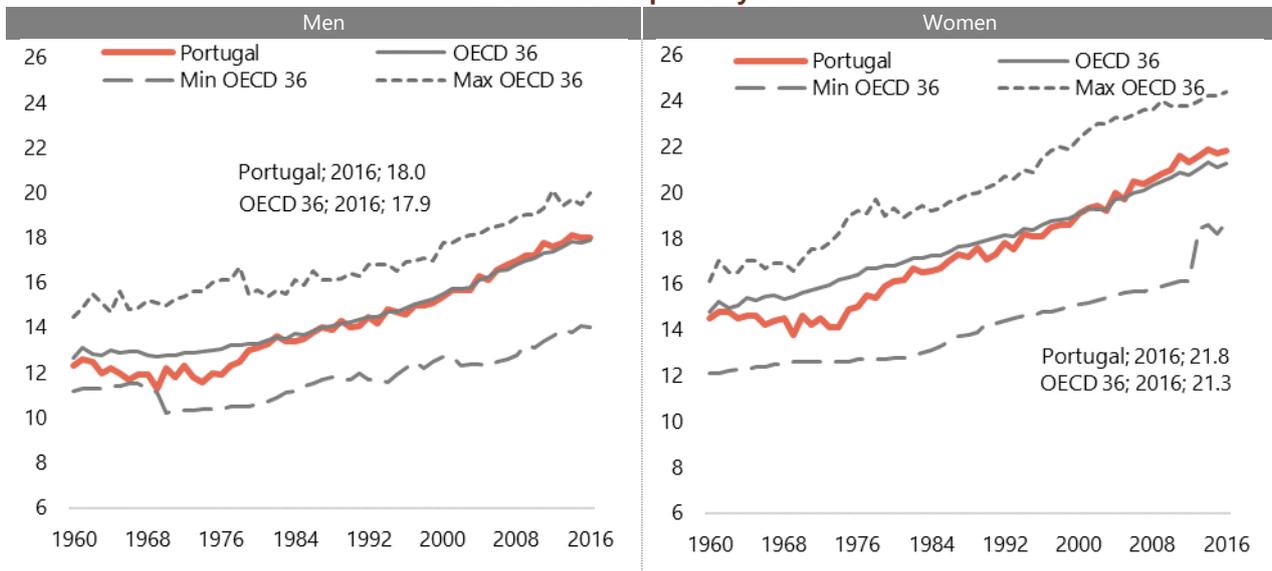
¹² Examples of these limitations include differences in the way indirect costs are allocated, differences in capital costs and lack of information on the quality of the services provided and/or the impact of medical treatment on the population’s health status.



Source: OECD. | Notes: Min – minimum; Max – maximum; OECD member countries: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland and Turkey.

As a complement to an overall assessment of the health system in Portugal, we look at life expectancy at 65 years of age, which captures the longevity gains among the elderly. This indicator also tends to grow over time. As with life expectancy at birth, the value for women is more favourable than the value for men, although both have exceeded the OECD average since 2002 (Chart 3). The difference between women and men was 3.8 years for Portugal in 2016, slightly above the average difference seen in OECD member countries (3.4 years). Based on this indicator, we may conclude that the Portuguese health system performs satisfactorily in terms of unadjusted longevity, when compared with the remaining OECD member countries, although there is greater gender inequality.

Chart 3 - Life expectancy at 65

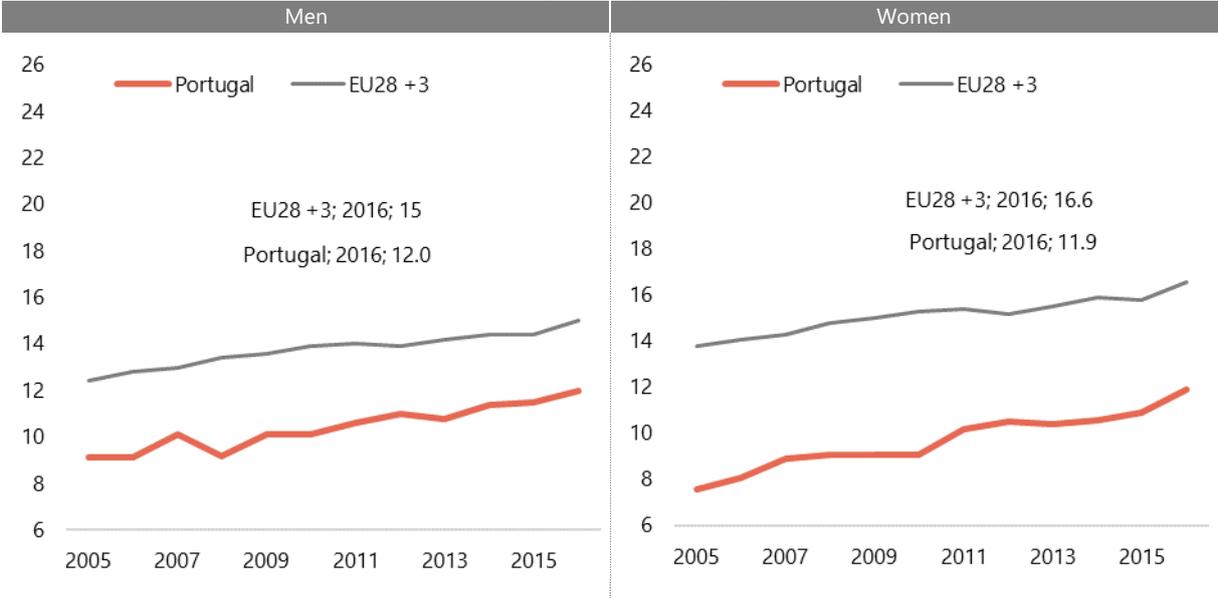


Source: OECD. | Notes: Min – minimum; Max – maximum; OECD member countries: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland and Turkey.

For its part, healthy life expectancy at 65 measures the length of time that a person can expect to live free of functional limitations and incapacities from that age. This indicator combines information on mortality and morbidity rates. Portugal ranks below the average for the group of countries under review for both men and women (Chart 4). The average length of time a man can expect

to live healthily in Portugal after the age of 65 is 12 years, while women can expect 11.9 years of good health after 65, which implies a slight degree of gender inequality (0.1 years) that favours men. These figures compare with averages of 15 and 16.6 years for men and women, respectively, in the group consisting of the European Union, Iceland, Norway and Switzerland, where the inequality (1.6 years) favours women. This indicator suggests the health system in Portugal has performed unsatisfactorily, despite the reduced gender inequality.

Chart 4 – Healthy life expectancy at 65 anos



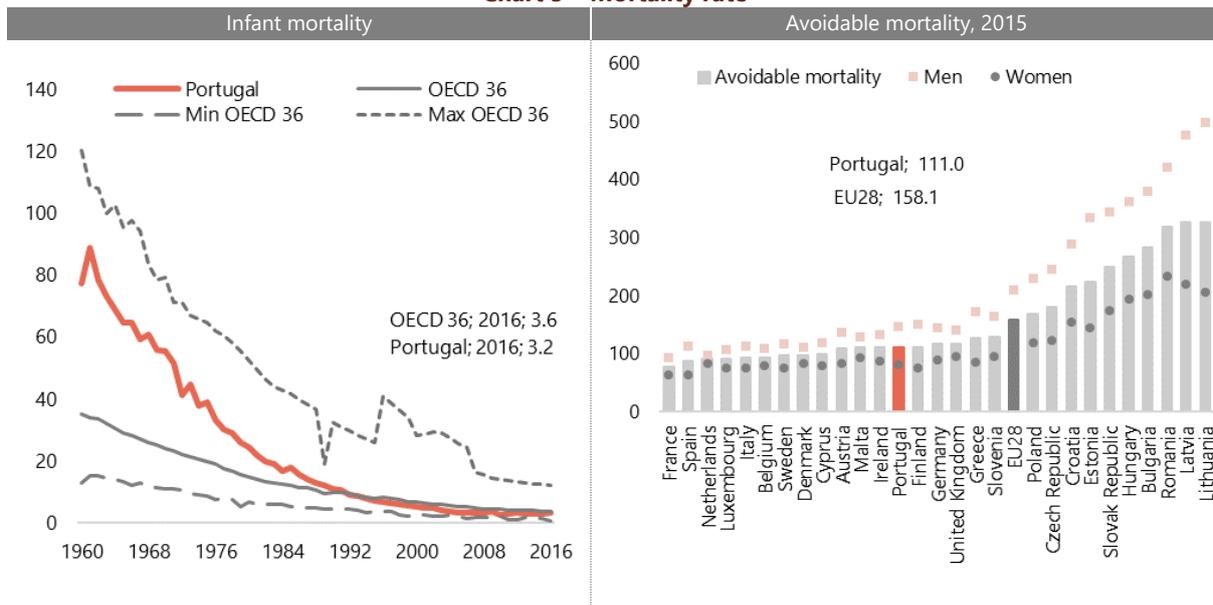
Source: Eurostat. | Notes: EU31 – 28 European Union Member-States, Iceland, Norway and Switzerland; EU Member-States: Belgium, Bulgaria, Czech Republic, Denmark, Germany, Estonia, Ireland, Greece, Spain, France, Croatia, Italy, Cyprus, Latvia, Lithuania, Luxembourg, Hungary, Malta, Netherlands, Austria, Poland, Portugal, Romania, Slovenia, Slovak Republic, Finland, Sweden, United Kingdom.

Another indicator that is representative of a health system’s development as a whole is the infant mortality rate, which is defined as the number of deaths of children under one year of age recorded in a particular period compared to the total number of live births over that period (usually a calendar year). This indicator reflects living conditions, access to health care and the quality of maternal and child health within a population. In Portugal, the infant mortality rate converged with the average rate in the OECD countries in the early 90’s. In 2016, there were 3.2 deaths per thousand live births, a figure that compares with the 78 deaths per thousand live births in 1960 (Chart 5, left hand panel).

Other indicators exist which seek to reflect the health sector’s overall performance, such as the avoidable mortality rate, which measures the number of potential years of life lost per one hundred thousand inhabitants, that is to say, it is the difference between the observed mortality rate and that which would exist in the absence of disease. This indicator acts as an approximate measure of the difference between the observed mortality rate and that which would exist if there were no health system.¹³ Portugal is one of a group of countries where the avoidable mortality rate is lower than the average for OECD member countries in 2015 (Chart 5, right hand panel).

¹³ It is an approximate measure because the mortality rate which would exist in the absence of the health system is not observable and the calculation is difficult to make.

Chart 5 – Mortality rate



Source: OECD and Eurostat (avoidable mortality). | Notes: Min – minimum; Max – maximum; infant mortality rate, for children under one year of age, is calculated per 1 000 live births; the avoidable mortality rate is calculated per 100 000 inhabitants; OECD member countries: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland and Turkey.

The list of indicators relating to health system performance is vast and may be more or less detailed in terms of the items analysed. Process and outcomes indicators, such as appropriate use of drugs and effectiveness of treatment, are used to measure the quality of a health system, given their strong correlation to the system’s overall performance. From among the available measures, mention is made of the volume of antibiotics prescribed, the prevalence of chronic illnesses, the mortality rate for acute myocardial infarction after hospital admission and cancer survival rates.¹⁴

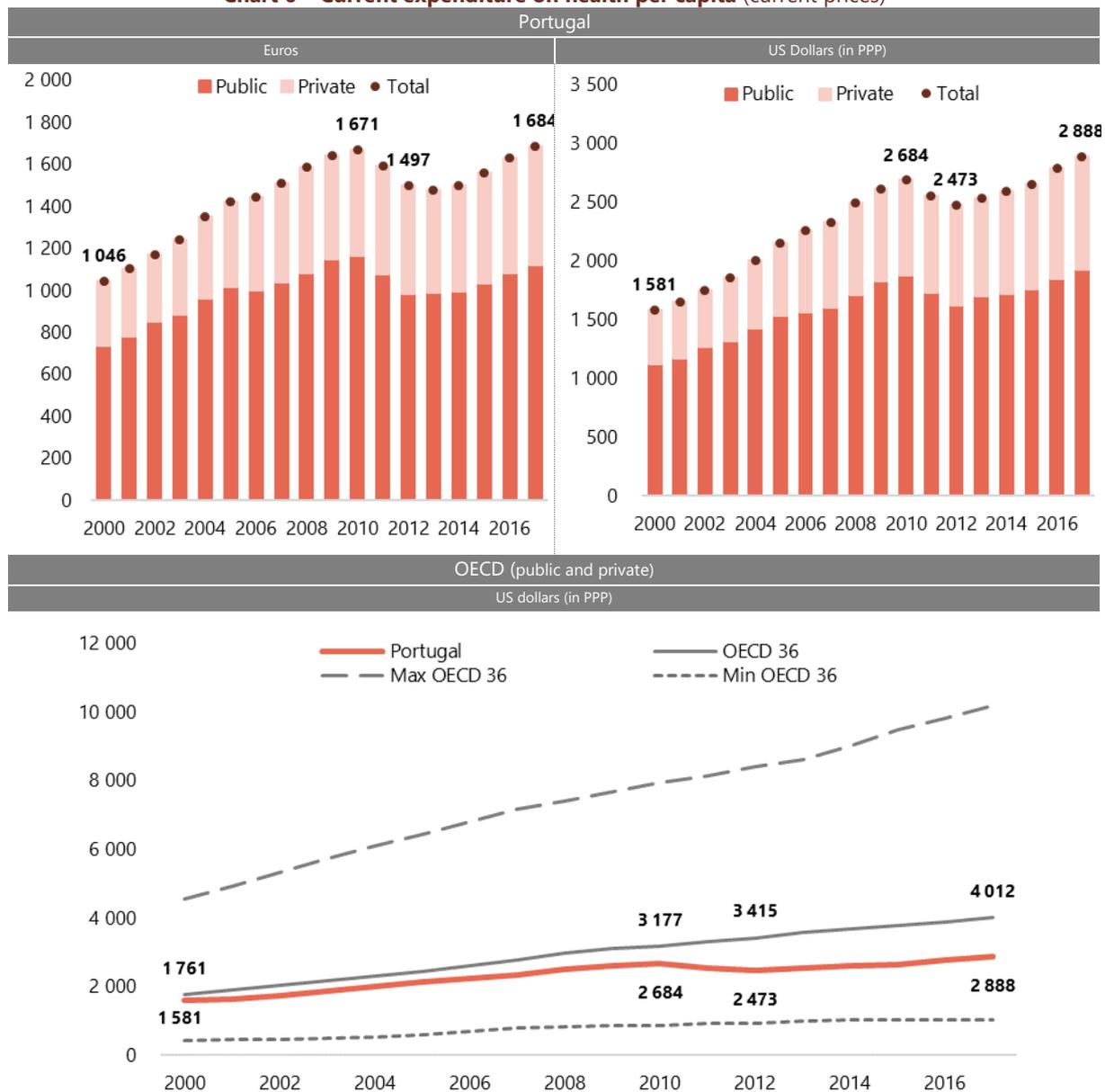
3.3 Financing

The financial resources allocated to the health system depend upon a wide range of social and economic factors, as well as the institutional nature of the systems (EC, 2013; de la Maisonneuve & al., 2016). In Portugal, current expenditure per capita stood at 1 684 euros in 2017 (Chart 6, left hand panel), which is equal to 2 888 USD adjusted for purchasing power parity (Chart 6, right hand panel). Despite the continuous growth since 2013, this figure is below average spending in OECD member countries (Chart 6, lower panel), as the health systems have different characteristics and the social and economic factors vary.¹⁵

¹⁴ For information on the changes in these indicators, see OECD (2017).

¹⁵ The comparison with the OECD average should not be interpreted as a target to be reached, since the financing volume by itself does not indicate whether the system’s goals in terms of the population’s health are being achieved or not. This analysis is used to identify how health expenditure in Portugal differs from that in the group of countries under review.

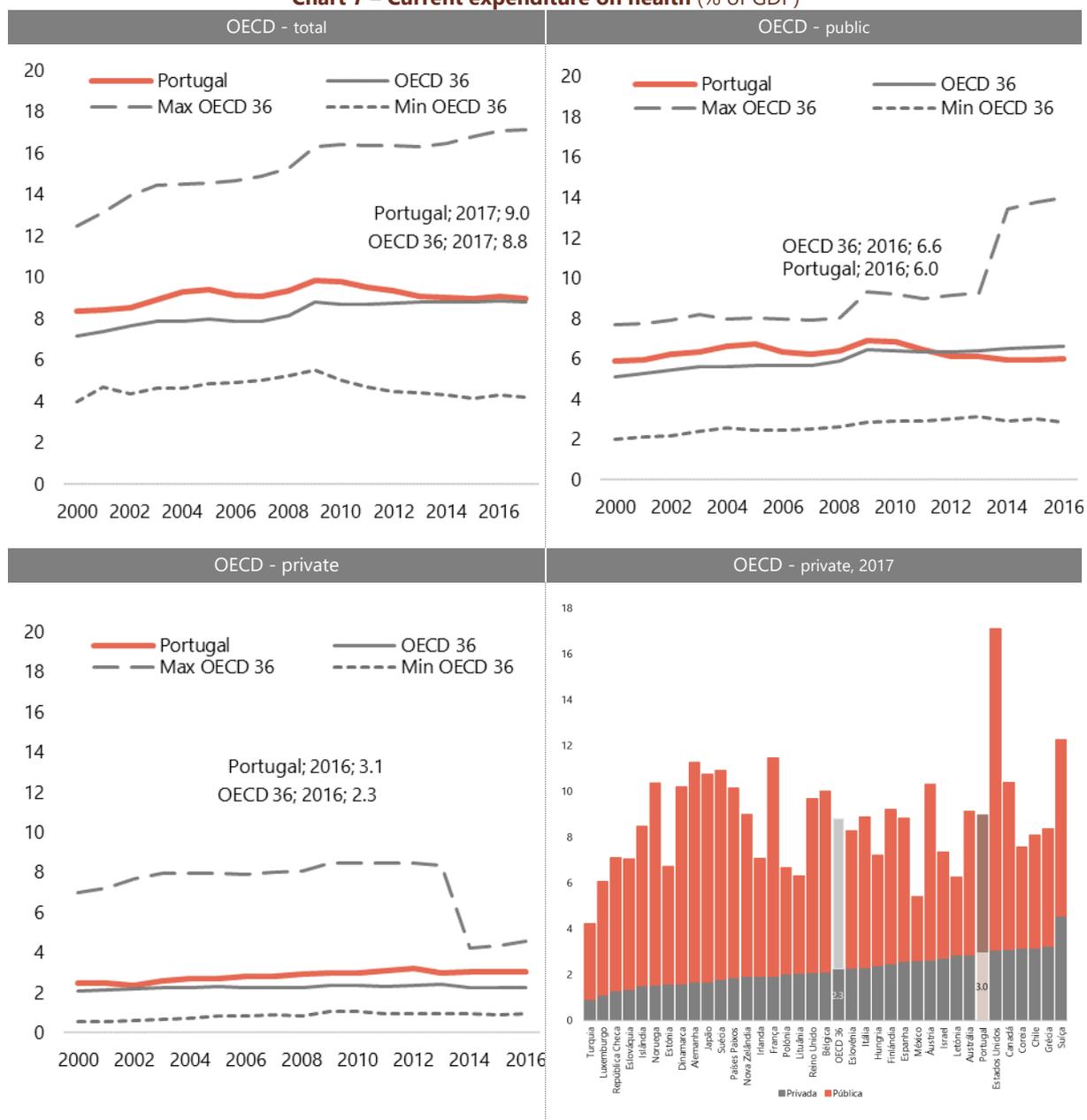
Chart 6 – Current expenditure on health per capita (current prices)



Source: INE and OECD. | Notes: PPP – purchasing power parity; Min – minimum; Max – maximum; OECD member countries: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland and Turkey.

In order to examine health expenditure's relative weight in terms of the financial resources available in a country, we may look at its change compared to GDP. In 2017 current expenditure on health was equal to 9% of GDP in Portugal, up 0.6 p.p. on the 8.4% seen in 2000. From 2000 to 2017 the OECD average experienced cumulative growth of 1.7 p.p., reaching 8.8% of GDP at the end of the period (Chart 7, upper left panel). However, over the period concerned, Portugal's current expenditure on health as a percentage of GDP remained higher than the average for OECD member countries, although this indicator did approach the group average after 2009.

Chart 7 – Current expenditure on health (% of GDP)



Source: OECD. | Note: Min – minimum; Max – maximum; OECD member countries: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland and Turkey.

As for public current expenditure on health as a percentage of GDP, the ratio in Portugal was 6% in 2016, which was lower than the OECD average (6.6% of GDP) in the same year (Chart 7, upper right panel).¹⁶ The accumulated change from 2000 to 2017 was just 0.1 p.p. of GDP in Portugal, going

¹⁶ According to European Commission estimates, the forecast for public current expenditure on health in terms of GDP will grow in the next 30 years, as is expected to be the case for the average of the 28 EU Member-States plus Norway. These estimates are based on assumptions as to changes in the population, the health expenditure profile by age group, changes in costs and the impact of increased earnings on health spending due to income elasticity. It is estimated that public current expenditure on health will see its GDP ratio rise from 6% in 2016 to 8.3% in 2070. For a detailed description of the assumptions and the projected figures see EC (2018).

from 5.9% in 2000 to 6.0% in 2017.¹⁷ That growth compares with an accumulated change of 1.3 p.p. in the average for OECD member countries. Public current expenditure as a percentage of GDP has been below that recorded in OECD member countries since 2009, unlike total current expenditure in terms of GDP.

As regards private current expenditure on health in Portugal, the GDP ratio was 3.1% in 2017, a figure lower than the average for the OECD countries (2.3% of GDP) in the same year (Chart 7, lower left panel). From 2000 to 2017, Portugal saw accumulated growth of 0.5 p.p. in this ratio, going from 2.5% in 2000 to 3.1% of GDP in 2017.¹⁸ While the average for OECD member countries grew by 0.2 p.p. of GDP. As with total current expenditure, Portugal retained a higher ratio than the average for OECD member countries over the course of the period in question.

Given that Portugal has a national health service providing automatic and full coverage, an increase in the GDP ratio of private expenditure on health suggests there are some practical restrictions on people's access to the health care provided by the National Health Service, which justifies more detailed analysis of private current expenditure compared to total current expenditure (Paris & *al.*, 2016).

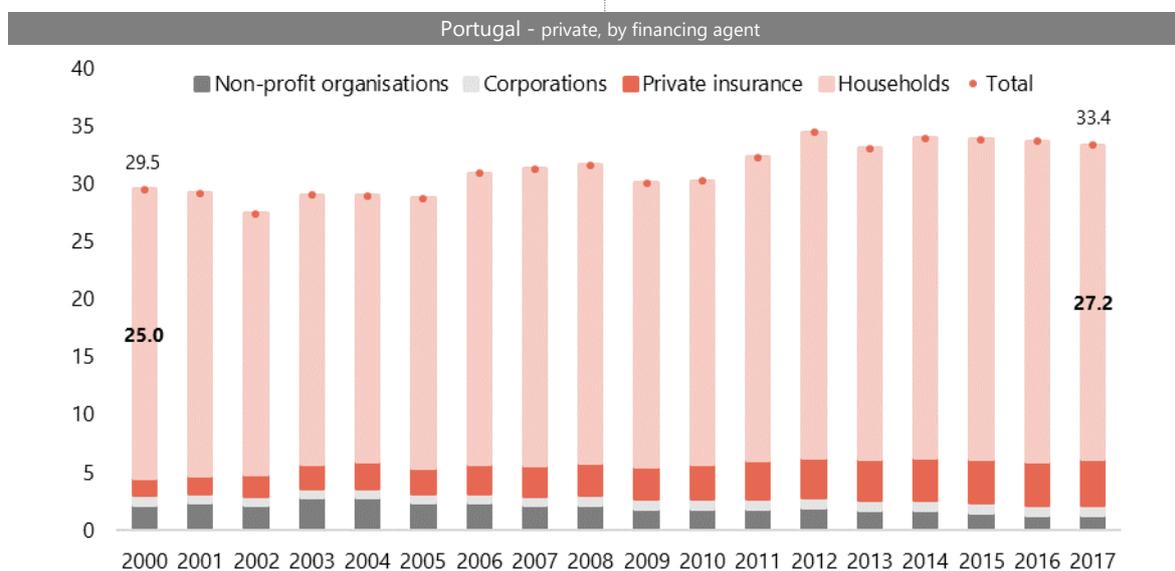
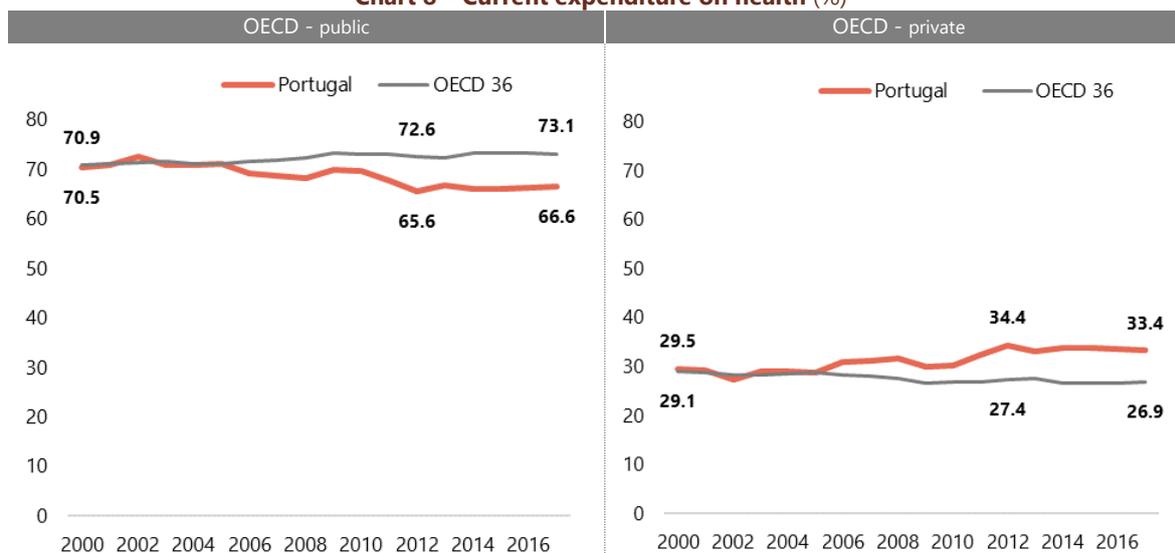
Although the financing of the health system in Portugal is mostly public, the ratio of public current expenditure to total current expenditure is lower than the OECD average (Chart 8, left hand panel). There has been a cumulative decrease of 3.8 p.p. in the ratio of public current expenditure to total current expenditure between 2000 and 2017, having fallen from 70.5% in 2000 to 66.6% in 2017. On the other hand, the ratio of private current expenditure to total current expenditure went from 29.5% in 2000 to 33.4% in 2017. It is noted that for the OECD average the ratio of private current expenditure decreased by 2.2 p.p., as it went from 29.1% in 2000 to 26.9% of GDP in 2017 (Chart 8, right hand panel).

As with private current expenditure as a whole (households, insurers, not-for-profit organisations and corporations), household direct expenditure saw cumulative growth of 2.2 p.p. from 2000 to 2017, going from 25% to 27.2% of total current expenditure (Chart 8, lower panel), which means they are financing an ever-larger portion of the Portuguese health system.

¹⁷ This path was influenced by recommendations made by international institutions during the 2011-2014 Economic and Financial Assistance Program and later, during the post-program monitoring phase. Examples of these recommendations may be found in IMF (2016).

¹⁸ This ratio places Portugal in the highest quintile, along with USA, Canada, Korea, Chile, Greece and Switzerland, (Chart 7, lower right panel).

Chart 8 – Current expenditure on health (%)



Source: OECD and INE. | Notes: ISFLSF – not-for-profit organisations aiding families; OECD member countries: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Lithuania, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland and Turkey.

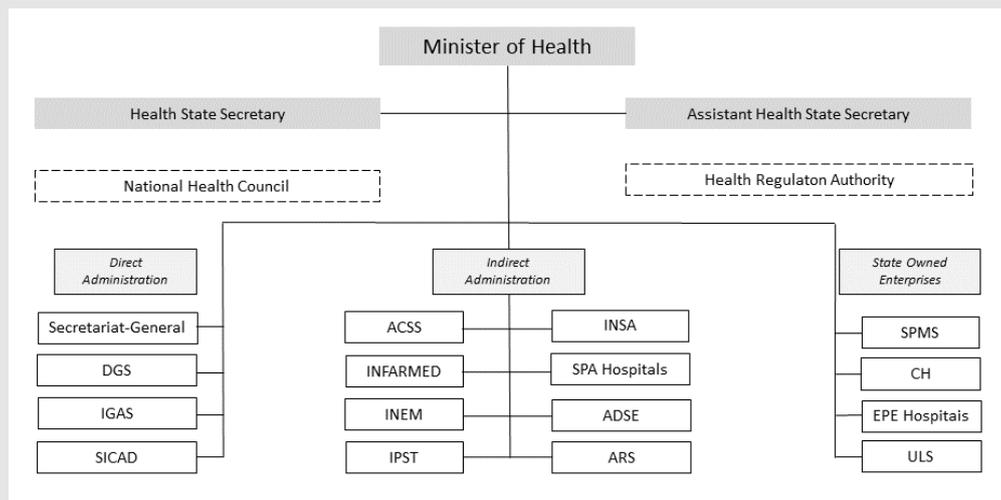
Box 1 - Organisation of the Ministry of Health in Portugal

The Ministry of Health Statute, enacted as Decree-Law n° 124/2011 of 29 December, lays down the mission and responsibilities of the Ministry of Health (MoH). The MoH is the government department responsible for devising, implementing, monitoring and evaluating the country's health policy, by regulating, planning, financing, coordinating, monitoring, evaluating, auditing and inspecting of the National Health Service, as well as by regulating, inspecting and auditing the private sector's activities and service provision, plus the managing of the Civil Service health subsystem. It exercises those responsibilities through entities directly and indirectly administered by the State, and through consultative bodies, other structures and organisations belonging to the State corporate sector.

The Health Regulation Authority is an independent administrative body charged with supervision and regulating. The National Health Council is a consultative body.

The central departments, connected to the MoH, directly administered by the State are: a) The Secretariat-General for Health; b) The Inspectorate-General of Health-related Activities; c) The Directorate-General of Health; and d) The Directorate-General for Intervention on Addictive Behaviours and Dependencies.

The State indirectly administers the following public corporations relating to health: a) Central Administration of the Health System; b) The National Authority on Drugs and Health Products; c) The National Institute for Medical Emergencies; d) The Portuguese Institute for Blood and Transplantation; e) Dr. Ricardo Jorge National Health Institute; f) Institute for Protection and Assistance in Illness; g) Northern Regional Health Authority; h) Central Regional Health Authority; i) Lisbon and Tagus Valley Regional Health Authority; j) Alentejo Regional Health Authority; k) Algarve Regional Health Authority; and l) all the public services and entities providing health care, regardless of their category (health centres, hospitals and local health units).



Source: CFP, based on Decree-Law n° 124/2011 of 29 December, rectification and amendments. Rectified by Rectification Statement n° 12/2012 of 27 February. Amended by: Decrees-Law no. 126 and 127/2014 of 22 August, Decree-Law no. 173/2014 of 19 November, Decree-Law n° 152/2015 of 7 August and Decree-Law n° 7/2017 of 9 January. | Notes: DGS = The Directorate-General of Health; IGAS = The Inspectorate-General of Health-related Activities; SICAD = The Directorate-General for Intervention on Addictive Behaviours and Dependencies Intervention Department; ACSS = Central Administration of the Health System; INFARMED = The National Authority on Drugs and Health Products; INEM = The National Institute for Medical Emergencies; IPST = The Portuguese Institute for Blood and Transplantation; INSA = Dr. Ricardo Jorge National Health Institute; SPA Hospitals = General Government Hospitals; ADSE = Institute for Protection and Assistance in Illness; ARS = Regional Health Authorities; SPMS = Shared Services, Ministry of Health; CH = Hospital Centres; EPE Hospitais = State Owned Public Hospitals; Health ULS = Local Health Units.

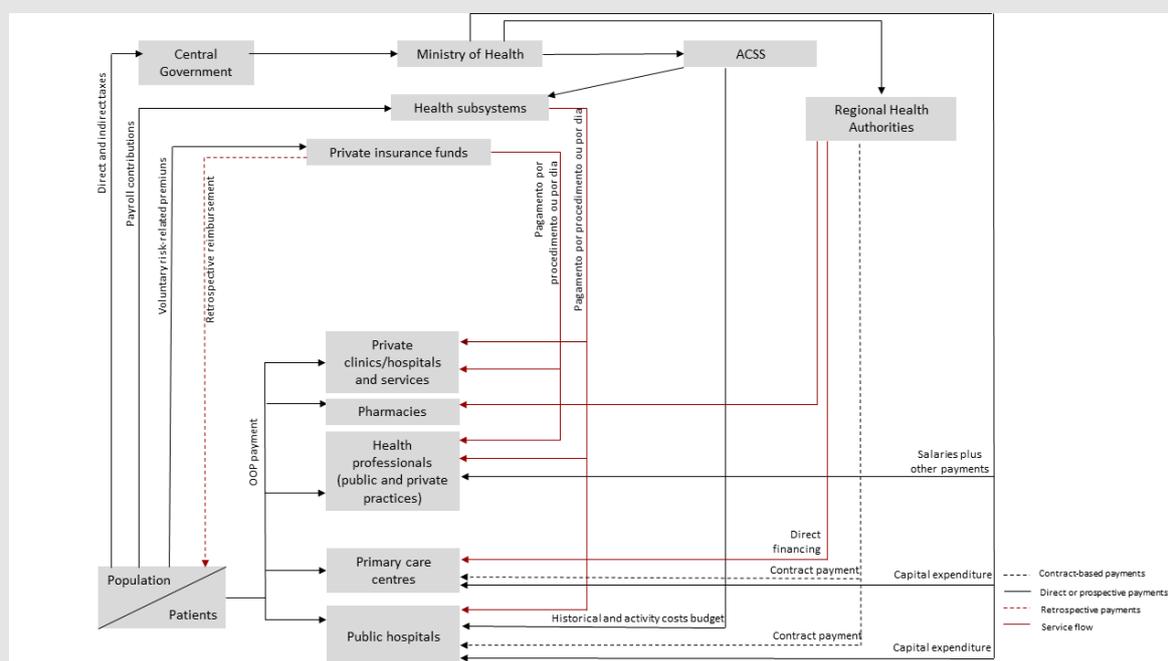
Box 2 - Health system financial flows in Portugal

The Portuguese health system is financed by resources flowing from taxation, employees and employers' contributions, voluntary risk premium payments and out-of-pocket payments.

The Ministry of Health (MoH), through tax revenues, is charged with financing the National Health Service, which is achieved through direct transfers to health care providers and through the Central Administration of the Health System and the Regional Health Authorities. The level of financial resources allocated to the MoH is set in the Annual State Budget.

The public and private health subsystems, by way of employees and employers' contributions, make payments for the health care provided to their insured persons to the various service providers.

Similarly, but through the contribution flowing from voluntary risk premiums paid by a percentage of the population, private health insurers make payments to health care providers. Lastly, individuals make direct payments to the various health care providers that make up the health system.



Source: Adapted from Barros & al, 2011.

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