



NHS PERFORMANCE IN 2025

June 2026

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The Portuguese Public Finance Council is an independent body established by Article 3 of Law No. 22/2011 of 20 May, which introduced the fifth amendment to the Fiscal Framework Law (Law No. 91/2001 of 20 August, republished by Law No. 37/2013 of 14 June). The final version of the CFP's Statutes was approved by Law No. 54/2011 of 19 October.

The CFP commenced its activities in February 2012, with the mission of conducting an independent assessment of the consistency, compliance and sustainability of fiscal policy, whilst promoting its transparency, in order to contribute to the quality of democracy and economic policy decisions and to strengthen the State's financial credibility.

This Report has been drawn up on the basis of information available up to 22 June 2026.

A spreadsheet file containing the figures underlying all the charts and tables in this report is available at www.cfp.pt, in the 'Publications' section. The main public finance concepts used in this Report are explained in the CFP [Glossary](#), which is available online.

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NON-TECHNICAL SUMMARY

Users and General Practitioners

- 10.7 million patients registered with the National Health Service (NHS) in 2025 (235,000 more than in 2024), of whom 75% are registered with Family Health Centres.
- The number of patients without a family doctor has risen to 1.56 million (14.6% of the total number of patients registered with the National Health Service), 41,000 more than in 2024; Lisbon and the Tagus Valley account for over 70% of patients without a GP.

Healthcare Activity

- A 4.0% decrease in face-to-face medical consultations in primary care, to 18,457, and an increase in remote medical consultations to 15,303 (+3.3%);
- Nursing consultations: +3.3%; other healthcare professionals: +14.7%.
- Hospital activity: +2.4% in consultations and +1.6% in surgical procedures.
- Problems persist in A&E and inpatient services (occupancy >100%).

Continuing Care

- National Network for Integrated Long-Term Care: +1.7%; Total: 10,278 inpatient beds and 6,903 home care places.
- The waiting list has grown, particularly in inpatient units: 159 more patients compared with 2024.
- Lisbon and the Tagus Valley have the lowest regional coverage: the national average is 729 places per 100,000 inhabitants aged 65 or over, whilst the LVT region has 618 places.

Fiscal Implementation

- SNS balance in 2025: -€1,035 million (€534 million less than in 2024).
- SNS balance including the capital injection in 2025: €264 million (an increase of €857 million compared to 2024).
- Total revenue: 15,926 M€ (+10.8%); total expenditure: 16,962 M€ (+6.4%).
- Current revenue: 98.7% of the total; capital: 1.3%.
- Staff costs: +7.5%; stock: +4.9%; external supplies and services: +6.2%.
- Capital expenditure: -7.8%.

Debt and average payment terms

- Debt to external suppliers: +€148 million, total: €1.5 billion.
- Overdue payments: +€48 million.
- 23.4% of organisations met the statutory payment deadline (60 days).

EXECUTIVE SUMMARY

Healthcare Activity

In 2025, the number of patients registered with the National Health Service (NHS) rose again, reaching around 10.7 million. The trend towards strengthening Family Health Centres continued, with these centres now covering 75% of those registered. Conversely, and following the improvement observed in 2024, the number of patients without a GP also rose again, reaching 1.56 million, concentrated mainly in the Lisbon and Tagus Valley region. This development comes against a backdrop of an ageing workforce of medical professionals specialising in General and Family Medicine, which could exacerbate difficulties in accessing primary care and increase pressure on hospital and emergency services.

Medical activity in primary healthcare declined slightly in 2025, following the increase recorded in 2024, reflecting above all the decrease in the number of face-to-face consultations, whilst remote consultations continued to grow. By contrast, consultations with nurses and other healthcare professionals increased, highlighting a greater diversification of the care profile in primary care. In hospitals, the upward trend in healthcare activity that began in 2021 continued. The number of hospital medical consultations rose by 2.3% compared with 2024, whilst the total number of surgical procedures increased by 1.6%, driven mainly by the expansion of scheduled outpatient surgery.

The National Network for Integrated Long-Term Care continued to expand its capacity in 2025, albeit at a more moderate pace than in the previous year, reaching 17,181 placements (16,902 placements in 2024). Growth was concentrated mainly in the Integrated Long-Term Care Teams, both in terms of installed capacity and the number of service users referred and cared for. Nevertheless, the increase in demand continued to outstrip the expansion of supply, resulting in a further worsening of waiting lists, particularly in inpatient units.

Fiscal implementation

According to the provisional consolidated accounts drawn up by the ACSS, the NHS recorded a deficit of €1,035 million in 2025, representing an improvement of €534 million compared with the previous year. This development reflected a rise in revenue to 15 926 M€ (+1548 M€ compared with 2024), which exceeded the increase in expenditure, which totalled 16 962 M€ (+1014 M€).

Current revenue accounted for 98.7% of total revenue, reaching €15,725 million (+10.3%), whilst capital revenue stood at €201 million, corresponding to 1.3% of the total (+62.2% compared with the previous year). In terms of structure, current transfers and subsidies from the State Budget (OE) continued to dominate, accounting for around 93.9% of the NHS's total revenue.

Among the main components of expenditure, and compared with the previous year, the following stand out: staff costs, which rose by 7.5% (+€502 million); external supplies and services (FSE), which grew by 6.2% (+€333 million); and purchases of stock, which rose by 4.9% (+€158 million). Conversely, capital expenditure fell by 7.8% (€37 million), continuing to account for a small proportion of total NHS expenditure (2.6%).

Nevertheless, there was an improvement in the implementation rate for this component, which rose from 59.6% in 2024 to 76.5% in 2025, reflecting greater progress in the implementation of investments funded by the RRP.

The National Health Service continued to benefit from extraordinary capital injections allocated by the State, mainly intended to settle debts owed to suppliers. In 2025, these transfers amounted to 1.3 thousand M€, bringing the cumulative total since 2016 to around 7.9 thousand M€. The frequency and scale of these injections suggest that significant financial pressures on the system persist.

Debt and average payment terms

In 2025, the NHS's debt to external suppliers stood at 1,500 M€, 148 M€ more than in the previous year. Overdue payments also worsened compared with 2024, rising by 48 M€ to stand at 60 M€. Despite the capital injections provided by the State to NHS entities, which totalled €1,299 million in 2025 and were intended to cover accumulated losses, these proved insufficient to ensure a structural and sustained reduction in the system's level of indebtedness. At the same time, there was an increase in the average payment period, with only 23.4% of NHS bodies meeting the statutory 60-day payment deadline to suppliers.

Risks and uncertainties

The NHS continues to face structural challenges that constrain its performance and sustainability, both in terms of healthcare provision and finance.

Although the Health Emergency and Transformation Plan has made significant progress, the most visible results have been concentrated in short-term operational measures. Reforms of a more structural nature have progressed more slowly, with persistent problems in access to care, as demonstrated by the 1.56 million patients without an assigned family doctor and the still incomplete implementation of various measures envisaged in the areas of mental health and community and family health. Improving the responsiveness of the NHS remains dependent on the implementation of structural reforms that strengthen access to care, coordination between levels of care and the efficient use of available resources, particularly through health promotion measures.

From a fiscal perspective, the heavy reliance on transfers from the State Budget and the structural growth in healthcare expenditure continue to pose significant challenges to the financial sustainability of the NHS. In particular, expenditure on staff and hospital medicines remains among the main factors putting pressure on public healthcare expenditure. In the case of staff costs, this trend reflects not only the continuation of measures to enhance the career prospects of healthcare professionals and the multi-year agreements already in place, but also the ongoing need to strengthen the NHS's care capacity, including through the recruitment of new staff and the expansion of Model B Family Health Units (USF). At the same time, delays in the implementation of certain investments funded by the RRP continue to pose risks to the realisation of the expected gains in terms of the modernisation and efficiency of the health system.

INTRODUCTION

This Report analyses the provisional fiscal implementation of the NHS in 2025, based on information prepared and made available by the Central Administration of the Health System, IP (ACSS), relating to the NHS budget implicit in the State Budget for 2025 (OE/2025), approved by [Law No. 45-A/2024 of 31 December](#), and referred to in this Report as the 'NHS budget'. The main objective of the Report is to analyse the NHS's healthcare and economic-financial performance in 2025, including an analysis of its level of indebtedness. The list of entities that form part of the SNS and are covered by this analysis is set out in Annex 4.3. It should be noted that the following do not form part of the SNS, despite being part of the Health Programme: the Directorate-General for Health (DGS), INFARMED – National Authority for Medicines and Health Products, I.P., the Shared Services of the Ministry of Health, E.P.E. (SPMS), the General Secretariat of the Ministry of Health (SGMS), the Joint Hospital Services (SUCH), the General Inspectorate of Health Activities (IGAS), the Service for Intervention in Addictive Behaviours and Dependencies (SICAD) and the Health Regulatory Authority (ERS). Accounting information relating to these bodies is not included in documents that focus on the NHS as the reporting entity; it therefore falls outside the scope of the SNS Accounts.

The Report is structured into three chapters, in addition to this introductory chapter. The first chapter analyses trends in the NHS's healthcare provision, covering the different levels of care (primary, hospital and long-term care). It also includes international comparisons, notably with member states of the European Union and the OECD. The second chapter focuses on analysing the trends in the main aggregates of the NHS Account, as well as the deviations from the corresponding ACSS provisional account which formed the basis for the 2025 State Budget (OE). The third and final chapter analyses the evolution of the NHS's debt, including its composition and the trend in average payment terms to suppliers. It also highlights the main risks and uncertainties affecting the sector, as well as the NHS's capacity to meet its future responsibilities, both in terms of care provision and finance.

This report was drawn up on the basis of information provided by bodies within the Ministry of Health, in particular the ACSS, the Executive Directorate of the National Health Service, I.P. (DE-SNS), and INFARMED, to whom the Portuguese Public Finance Council (CFP) extends its thanks for their cooperation. However, during the preparation of this report, the CFP encountered difficulties in establishing the institutional coordination necessary to obtain statistical and operational information in the health sector. These limitations resulted in constraints on timely access to relevant data, as well as difficulties in harmonising and validating the information provided, thereby affecting the analysis of certain indicators. This was reflected in the absence of data for 2025 regarding: i) requests for first consultations; ii) waiting lists for first consultations; iii) first consultations carried out; and iv) the percentage of consultations carried out within the Guaranteed Maximum Response Times.

1. ANALYSIS OF HEALTHCARE ACTIVITY

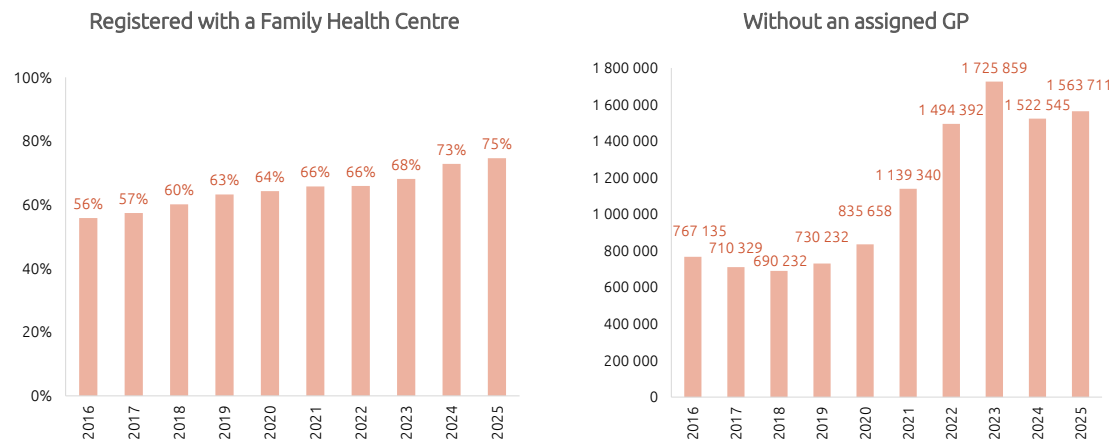
1.1 Primary healthcare

In 2025, the number of patients registered with the NHS rose again, reversing the decline recorded the previous year. In total, there were around 10.7 million registered patients, 235,000 more than in 2024. By the end of 2025, 75 per cent of patients were registered with Family Health Units (USFs), confirming the trend towards strengthening this organisational model in primary healthcare (for a detailed description of the various types of USF, see Box 1) (Chart 1, left-hand panel). This development reflects the policy of expanding and converting units to the USF model, in particular the USF Model B, which is associated with greater organisational autonomy, contractual targets and performance incentives, with a view to improving access, continuity and efficiency of care. Nevertheless, around 24% of patients remained registered with Personalised Healthcare Units (UCSP), structures that continue to be more prevalent in areas facing difficulties in retaining healthcare professionals and experiencing greater shortages of human resources, particularly of general practitioners, reflecting persistent regional disparities in access to primary care.

In 2025, the number of patients without an assigned GP rose again, reversing the upward trend observed in the previous year. This figure stood at 1.56 million patients, around 41,000 more than in 2024. The Lisbon and Tagus Valley region continues to account for the majority of these cases, with over 1.1 million patients without a family doctor, corresponding to around 70 per cent of the national total (Chart 1, right-hand panel). This situation is particularly significant against the backdrop of an ageing medical workforce in the specialism of General and Family Medicine. According to the latest information available from the Portuguese Medical Association, at the end of 2024, 9,343 doctors were registered in this speciality (compared with 8,856 at the end of 2023), of whom 45% were over 65 years of age.¹ The foreseeable increase in retirements may therefore exacerbate restrictions on access to primary care. This pressure is likely to have knock-on effects on hospital services, compromising the proper referral of patients and leading to direct use of hospital A&E departments.

¹ As at the closing date for this report, the Portuguese Medical Association had not yet published the annual statistics on the number of doctors by specialism for 2025.

Chart 1 – Coverage of patients registered with the NHS, by Family Health Centre (USF) and GP
(% of total SNS patients and number of patients)



Source: ACSS.

In 2025, the number of medical consultations in primary healthcare within the NHS fell slightly, bringing the growth seen in the previous year to a halt. This trend mainly reflected the decline in face-to-face consultations, as non-face-to-face consultations continued to rise. Meanwhile, nursing consultations and those carried out by other healthcare professionals recorded growth, highlighting a diversification in the care profile of primary care (Table 1). This shift in activity did not, however, translate into a significant improvement in utilisation indicators. In 2025, the utilisation rate for medical consultations stood at 0.787 and that for nursing consultations at 0.770, suggesting that the level of activity remains below what is necessary to fully meet the population's needs.

Table 1 – Healthcare activity in primary care
(figures in thousands, unless otherwise stated)

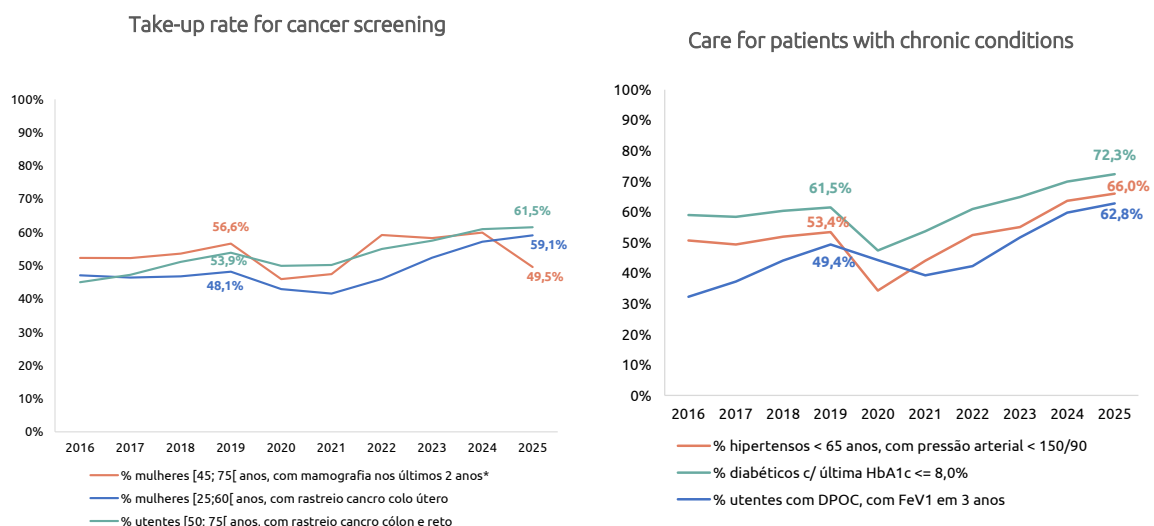
	EXECUÇÃO						Var. 2024/2025	
	2020	2021	2022	2023	2024	2025		%
Consultas Médicas	32 554	36 038	34 544	33 677	34 051	33 760	-291	-0,9
Presenciais*	14 035	15 888	18 529	18 677	19 231	18 457	-774	-4,0
Não presenciais	18 519	20 150	16 015	15 000	14 820	15 303	483	3,3
Consultas de enfermagem	16 507	25 389	18 413	18 080	19 513	20 158	646	3,3
Consultas de outros técnicos de saúde	540	728	837	959	1 090	1 250	160	14,7
Índice utilização consultas médicas**	0,740	0,789	0,783	0,772	0,803	0,787	-0,016	-2,0
Índice utilização consultas enfermagem**	0,633	0,714	0,656	0,672	0,762	0,770	0,009	1,1

Source: ACSS. | Note: * Includes the number of face-to-face medical consultations, home visits and consultations in supplementary care (in thousands). **The utilisation rate for medical consultations (indicator 2017.330.01) and nursing consultations (indicator 2017.331.01) is calculated by the ACSS, in accordance with the rules set out in [the Primary Healthcare Indicators Factsheet](#). These indices measure the frequency with which consultations that are expected to be necessary to meet the population's needs – taking into account sociodemographic and morbidity criteria – are actually carried out in primary healthcare. The indices are calibrated to result in a scale of values ranging from a minimum of '0', meaning no response, to 'approximately 1', representing utilisation appropriate to needs.

Cancer screening programmes generally maintained a positive trend in 2025, albeit with varying developments. Coverage of cervical cancer screening continued to rise, reaching 59.1% of women aged between 25 and 60, consolidating the recovery that began after the pandemic period. Colorectal cancer screening continued its upward

trend, reaching 61.5% of service users aged between 50 and 75 – the highest figure in the series analysed. In contrast, the proportion of women who had undergone a mammogram in the last two years fell to 49.5%, having reached 59.9% in 2024. However, according to the ACSS, this development does not reflect a decline in screening activity, but is primarily the result of a methodological change arising from DGS Standard No. 012/2024. From 2025 onwards, the Breast Cancer Screening Programme began to cover women aged between 45 and 74, significantly expanding the eligible population compared with the previously considered age range (50 to 69 years). This change led to an increase of more than 50% in the indicator's denominator, whilst the number of women undergoing mammography rose by around 25%. Consequently, the observed decrease in the ratio reflects a statistical break in the series associated with the expansion of the target population; therefore, it is not possible to make a direct comparison with figures prior to 2025 (Chart 2, left panel). In the management of patients with chronic conditions, the indicators in Figure 2 (right-hand panel) reflect the effectiveness of primary healthcare in managing conditions that the literature classifies as suitable for outpatient care, and where timely and continuous monitoring helps to reduce exacerbations and prevent hospital admissions. Between 2016 and 2025, the trend is structurally upward across all three dimensions: (i) the proportion of people under 65 with hypertension who have their blood pressure under control rose from 52% to 66%; (ii) that of people with diabetes rose from 56% to 72%; and, finally, (iii) that of patients with COPD diagnosed in the last three years rose from 26% to 63%. This improvement was only interrupted in 2020 due to the COVID-19 pandemic. The recovery of these indicators following the pandemic suggests genuine improvements in performance, which have a direct impact on the fiscal budget, as better intermediate management of these conditions reduces the demand for avoidable hospital care.

Chart 2– Screening and monitoring of patients in primary healthcare
(% of the total patient population)



Source: ACSS. | * Up to and including 2024, this screening programme covered women aged between 50 and 69.
Notes: The cancer screening uptake rate is calculated in accordance with the screening rules set out in indicators 2013.044.01, 2013.045.01 and 2013.046.01, available in [the Primary Healthcare Indicators Handbook](#). HbA1c –

Glycated haemoglobin | COPD – Chronic obstructive pulmonary disease. | FEV1 – Forced expiratory volume in the first second, following a maximum inhalation, measured by spirometry.

Box 1 – Primary Healthcare Units of the National Health Service

Family Health Units (USF) are multi-professional teams, comprising doctors, nurses and healthcare assistants, responsible for providing personalised healthcare to the population registered in a specific geographical area, in accordance with [Decree-Law No. 298/2007](#) of 22 August, as currently in force. Until 2024, the USFs were organised into three models, A, B and C; model C, although provided for in [Order No. 24101/2007](#) of 22 October, was never implemented to any significant extent and is still in progress. With the entry into force of [Decree-Law No. 103/2023](#) of 23 August, which approved the new legal framework for primary healthcare as part of the reform of the NHS promoted by the 23rd Constitutional Government, Model A USFs were abolished, and Model B became the standard. This change sought to standardise the operation of Family Health Units (USFs), establishing common rules for organisation, operation and contracting. Model A Family Health Units (USF-A) continue to exist within the NHS, but their relative importance has diminished substantially as a result of the conversion of many units to the Model B system. The distinction between the models is based primarily on the degree of organisational autonomy, the funding model and the level of development of the professional teams:

- **USF-A** units correspond to the initial phase of organisational development. They have some autonomy in the management of care provision, but do not benefit from performance-related financial incentives. They often serve as a transitional stage towards more advanced models;
- **USF-B** units demonstrate a higher degree of organisational maturity, with care objectives set out in contracts and remuneration systems that include performance-related financial incentives. This model currently constitutes the main model for the expansion of USFs;
- **USF-C** units, provided for in the NHS Statute and to be regulated in 2024, are distinguished by the fact that they may be managed by entities from the social, cooperative or private sectors, under contracts with the SNS. Unlike USF-A and USF-B units, which are exclusively part of public structures, USF-C units are based on a model of contracted provision of primary care funded by the SNS.

There are also Personalised Healthcare Units (UCSPs), which are functional units within primary healthcare that ensure the provision of personalised care to the registered population, through multi-professional teams organised around health promotion, disease prevention, clinical monitoring and the ongoing follow-up of service users. The UCSPs do not have the same level of organisational autonomy as the USFs, nor do they have performance-related remuneration mechanisms.

The literature on primary healthcare in Portugal highlights significant differences between UCSPs and USFs with regard to GP coverage. A case study conducted in 2023, based on data collected during a random week in 2022 across three functional units (USF-A, USF-B and UCSP), involving 62,841 patients, concluded that the UCSP had the highest proportion of patients without a family doctor ([Rosana Rocha, 2023](#)). In this unit, 63.5% of patients did not have an assigned GP, representing almost half of all those registered, whilst at USF-B this proportion was negligible (0.1%). This pattern is also reflected in the national data. According to the [Health Regulatory Authority's Primary Healthcare Monitoring Report](#), UCSPs have a more significant organisational presence only in the Alentejo region, where they account for 64.4% of operational units; in the remaining regions, USFs predominate, particularly USF-Bs. In turn, the [ERS study on the quality and efficiency of UCSPs](#) and USFs showed that, in 2022, UCSPs had the highest proportion of patients without a registered GP across all regions. The differences were particularly marked in Lisbon and the Tagus Valley, where 57.8% of patients registered with UCSPs did not have an assigned GP, as well as in the Alentejo (20.3%) and the Algarve (18.7%).

In contrast, in USF-Bs, the proportion of patients without a GP was less than 6% in all regions. Taken together, these results suggest that UCSPs account for a substantial proportion of patients without a GP, reflecting the human resource constraints and inequalities in access that persist in primary healthcare in Portugal.

Table 2 – Patients registered at USFs and USCPS by region and family doctor allocation (2022)

Região	UF	Utentes com MF		Sem MF por opção		Sem MF		Total utentes inscritos ativos
		Nº	%	Nº	%	Nº	%	
Norte	UCSP	663 830	95,1%	1 935	0,3%	32 220	4,6%	697 985
	USF-A	858 147	97,4%	368	0,0%	22 627	2,6%	881 142
	USF-B	2 149 917	98,1%	389	0,0%	41 783	1,9%	2 192 089
	Total	3 671 894	97,4%	2 692	0,1%	96 630	2,6%	3 771 216
Centro	UCSP	719 888	87,2%	3 316	0,4%	102 743	12,4%	825 947
	USF-A	526 822	93,9%	2 055	0,4%	32 457	5,8%	561 334
	USF-B	400 570	97,3%	82	0,0%	11 073	2,7%	411 725
	Total	1 647 280	91,6%	5 453	0,3%	146 273	8,1%	1 799 006
Lisboa e Vale do Tejo	UCSP	562 504	41,2%	12 780	0,9%	788 905	57,8%	1 364 189
	USF-A	1 047 793	88,0%	743	0,1%	142 782	12,0%	1 191 318
	USF-B	1 235 707	98,8%	496	0,0%	14 903	1,2%	1 251 106
	Total	2 846 004	74,8%	14 019	0,4%	946 590	24,9%	3 806 613
Alentejo	UCSP	242 342	79,3%	1 249	0,4%	62 055	20,3%	305 646
	USF-A	92 616	86,6%	416	0,4%	13 906	13,0%	106 938
	USF-B	95 802	94,8%	7	0,0%	5 245	5,2%	101 054
	Total	430 760	83,9%	1 672	0,3%	81 206	15,8%	513 638
Algarve	UCSP	168 911	81,1%	445	0,2%	38 914	18,7%	208 270
	USF-A	132 563	91,3%	2	0,0%	12 678	8,7%	145 243
	USF-B	124 981	100,0%	0	0,0%	14	0,0%	124 995
	Total	426 455	89,1%	447	0,1%	51 606	10,8%	478 508
Portugal Continental	Total	9 022 393	87,0%	24 283	0,2%	1 322 305	12,8%	10 368 981

Source: ERS (2024). | GP = General Practitioner.

1.2 Hospital care

In 2025, the growth trend in hospital care activity that began in 2021 continued. The number of hospital consultations rose by 2.4% compared with 2024, mainly due to follow-up consultations (3.3%), whilst the number of initial consultations remained virtually unchanged (0.3%). Among first consultations, there was a 1.3% decrease in consultations carried out under the 'Consulta a Tempo e Horas' (CTH) programme, compared with a 1.2% increase in the remaining consultations (Table 3). The proportion of first consultations remained stable at 28%, as did the number of unfulfilled requests for first consultations. In 2025, the total number of surgical procedures rose by 1.6%, reaching 904,000 operations. This growth was driven mainly by scheduled outpatient surgery, which increased by 3.3% and now accounts for 73% of all scheduled surgeries performed. In contrast, conventional surgery saw a slight reduction, reflecting the gradual shift from inpatient to outpatient care.

In 2025, several structural constraints already observed in previous years persisted in A&E and inpatient departments. The number of A&E visits fell by 7.2 per cent, with a reduction in the proportion of cases classified as low-priority (blue, green and white). This trend may reflect a more appropriate use of these services. There was also a slight improvement in compliance with the maximum treatment times recommended by the Manchester Triage System. Nevertheless, these times were met in only 44% of cases, highlighting persistent difficulties in the timely response capacity of hospital A&E

departments. The proportion of cases resulting in hospital admission remained stable at 8%.

At the same time, hospital admission indicators continued to show high levels of pressure on existing capacity. In 2025, day hospital activity continued to expand, with a 7.3% increase in the number of sessions carried out, reinforcing the gradual replacement of conventional hospitalisation wherever clinically appropriate. However, this progress was not sufficient to alleviate the pressure on inpatient capacity. In 2025, the average occupancy rate reached a new high, standing at close to 90% of available beds, accompanied by an increase in the average length of stay. Particularly critical situations were observed in several EPE Local Health Units, with occupancy rates exceeding 100%, notably in the Tâmega e Sousa Local Health Unit (136%), the Braga Local Health Unit (116%), the Oeste Local Health Unit (114%), ULS do Médio Ave (102 per cent) and ULS de Barcelos/Esposende (101 per cent). The combination of high occupancy and a rising average length of stay is consistent with constraints on hospital discharges, namely the continued presence of patients who have been clinically discharged but are awaiting a response from the National Network for Integrated Continuing Care or social support services, thereby limiting the turnover of available beds.

Table 3 – Hospital care activity
(figures in thousands, unless otherwise stated)

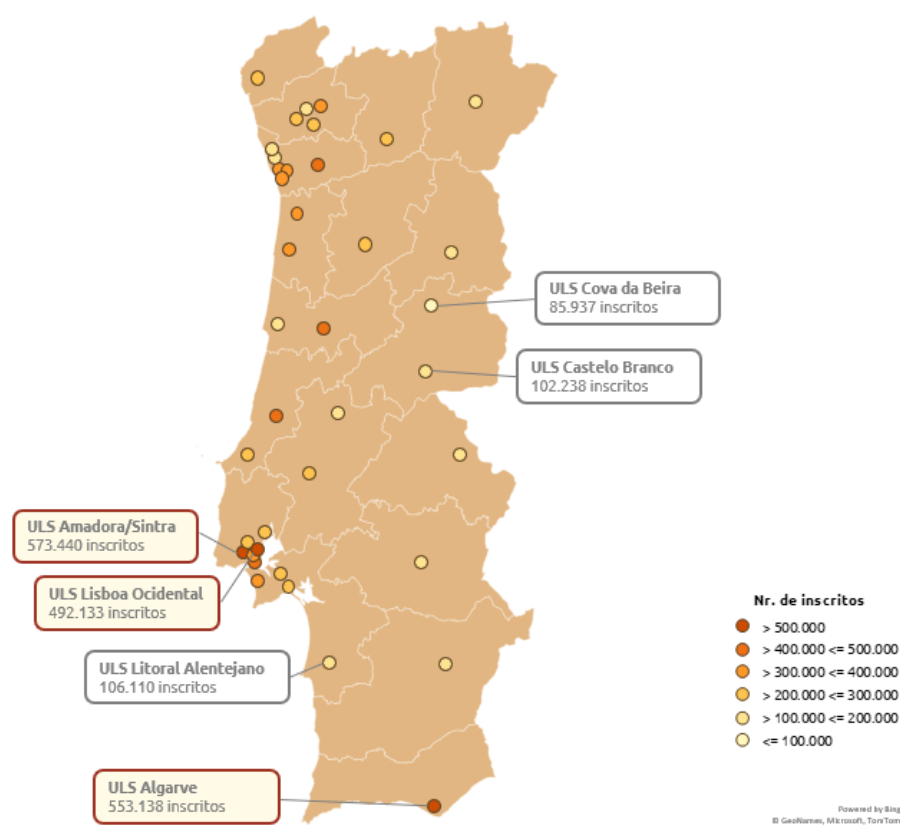
	EXECUÇÃO						Var. 2025/2024	
	2020	2021	2022	2023	2024	2025	em milhares ou p.p.	%
Consultas médicas hospitalares	11 130	12 413	12 779	13 280	14 018	14 358	340	2,4
Primeiras consultas	2 998	3 517	3 658	3 784	3 953	3 963	10	0,3
Primeiras consultas CTH	970	1 103	1 244	1 335	1 459	1 441	-19	-1,3
Outras primeiras consultas	2 028	2 442	2 483	2 449	2 494	2 523	29	1,2
Consultas subsequentes	8 132	8 897	9 121	9 496	10 064	10 394	330	3,3
Primeiras consultas (% total de consultas)	27%	28%	29%	28%	28%	28%	-0,6	-
Doentes saídos do internamento	676	726	750	768	778	757	-21	-2,7
Demora média (em dias)*	8,8	8,7	8,8	8,9	8,8	9,0	0,1	1,4
Taxa de ocupação (%)	77%	81%	86%	89%	89%	90%	0,4	-
Intervenções cirúrgicas	579	709	759	817	890	904	14	1,6
Cirurgia Programada	488	614	662	715	789	803	14	1,8
Cirurgia em ambulatório	322	420	462	509	566	585	19	3,3
Cirurgia convencional	166	194	200	207	222	218	-4	-2,0
Cirurgia em ambulatório (%)	66%	68%	70%	71%	72%	73%	1,0	-
Cirurgia urgente	91	95	97	102	102	102	0	-0,1
Episódios de urgência	4 553	5 196	6 232	6 193	6 176	5 729	-446	-7,2
Azuis, verdes e brancos (%)	43%	44%	44%	42%	40%	35%	-5,4	-
Cumprimento dos tempos de triagem (%)	76%	66%	61%	60%	65%	66%	0,3	-
Episódios que originam internamento (%)	10%	9%	8%	8%	8%	8%	0,6	-
Sessões de hospital de dia	1 149	1 318	1 456	1 580	1 694	1 817	123	7,3

Source: ACSS and the SNS Transparency Portal. | * The change in the average length of stay in 2024/2025 is expressed in days. | Note: CTH refers to the 'Consultation on Time and at Scheduled Hours' Programme, in accordance with [Ministerial Order No. 95/2013](#) of 4 March. Data on hospital medical consultations and their components were obtained from the NHS Transparency Portal and may differ from those published in the previous report, which drew its data from the SNS Executive Directorate.

The distribution of patients registered with Local Health Units (ULS) reveals significant variation in the size of these units. The concentration of the population in metropolitan areas, particularly in the Lisbon region, results in ULS with over 500,000 registered patients, whilst in several inland areas the number of patients is below 100,000. This disparity is not, in itself, an indicator of pressure on healthcare services, as this depends on the relationship between demand and the resources available in each unit, rather than on the absolute size of the registered population. It does, however, have

significant implications for the funding and management of the system. On the one hand, it requires that the resource allocation model reflect not only the number of registered patients but also the characteristics of the population served, namely the age structure and morbidity profile. On the other hand, it poses distinct management challenges: (i) large Local Health Units (ULS) face risks of overcrowding and organisational complexity; and (ii) smaller ones face difficulties in retaining staff due to their scale.

Chart 3 – Geographical distribution of the three ULSs with the highest and lowest numbers of registered users
(measured by number of registered patients)

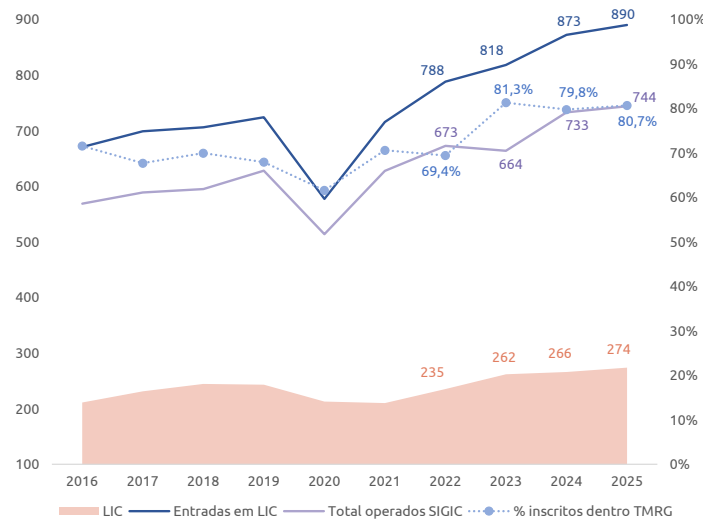


Source: ACSS. | Note: In the ULS model, the analysis considers users registered for primary healthcare (CSP), rather than the resident population. Consequently, the number of registered users may include those residing outside the geographical area of the respective ULS.

In 2025, surgical activity within the NHS continued to grow, but access indicators show signs of increasing pressure on the system. The number of patients on the Surgery Waiting List (LIC) rose to 890,000, compared with 873,000 in 2024, whilst the number of patients awaiting surgery stood at 274,000, the highest figure in the series analysed. At the same time, the total number of patients operated on under the SIGIC (Integrated Management System for Surgery Registrants) rose from 733,000 to 744,000, reflecting sustained high levels of surgical output. However, the percentage of patients who underwent surgery within the Guaranteed Maximum Response Time (TMRG) rose

slightly to 80.7 per cent, though it remained below the peak figure recorded in 2023 (81.3 per cent). These results suggest that, despite the increase in surgical activity, the growth in demand continues to outstrip the system's capacity to respond, resulting in a rise in the waiting list and persistent difficulties in meeting the established response times (Chart 4).

Chart 4 – Scheduled access to surgery
(figures in thousands, unless otherwise stated)



Source: ACSS. | Notes: TMRG – Guaranteed Maximum Response Times; LIC – Surgery Waiting List; SIGIC – Integrated Surgery Waiting List Management System.

1.3 National Network for Integrated Long-Term Care

The National Network for Integrated Long-Term Care (RNCCI) continued to expand its capacity in 2025, albeit at a significantly slower pace than in the previous year. The total number of places reached 17,181, an increase of 1.7 per cent, compared with 16,902 places and an increase of 7.0 per cent in 2024. This growth was mainly driven by an increase in home-based places within Integrated Continuing Care Teams (ECCI). Compared with 2024, there were 191 new home-based places available, and a further 88 inpatient beds. On the demand side, growth was stronger, with the number of referred service users increasing by 4,834 (9.8%), particularly for referrals to ECCI. The number of service users receiving care followed this trend, rising by 2,351 (4.3%), also driven by the ECCI. The mismatch between the growth in the number of referred service users (on the demand side) and the growth in installed capacity thus resulted in a further increase in the waiting list, which reached 1,910 service users in 2025 (+159 or +9.1% compared with 2024), with a particular impact on inpatient units (Chart 5, right-hand panel). This pressure on the RNCCI's inpatient services is consistent with the constraints identified at the point of hospital discharge, suggesting that the Network's capacity shortfall has an upstream impact on the occupancy of acute care beds.

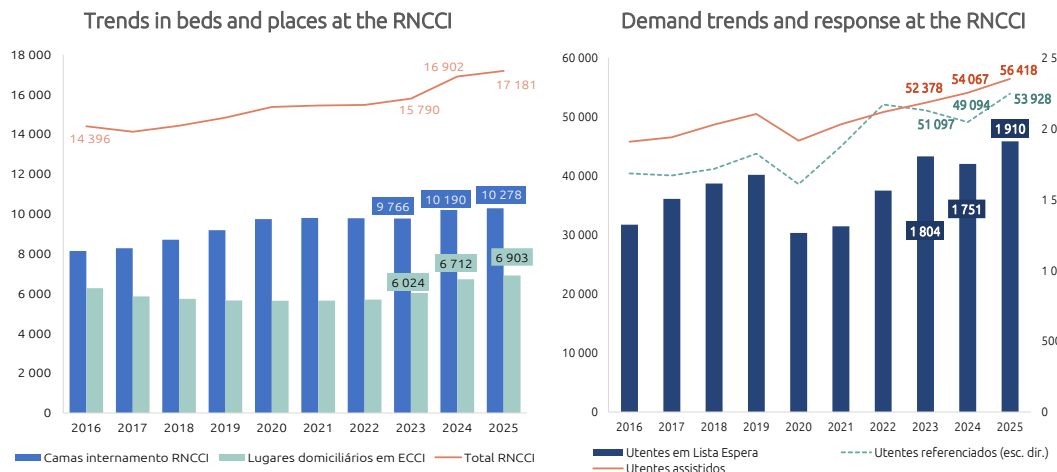
Table 4 – Supply and demand in the RNCCI
(figures in thousands, unless otherwise stated)

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Var. 2025/2024
Total RNCCI	14 396	14 123	14 430	14 833	15 374	15 443	15 473	15 790	16 902	17 181	279 1,7%
Camas internamento RNCCI	8 132	8 271	8 702	9 182	9 737	9 797	9 783	9 766	10 190	10 278	88 0,9%
Lugares domiciliários em ECCI	6 264	5 852	5 728	5 651	5 637	5 646	5 690	6 024	6 712	6 903	191 2,8%
Taxa Crescimento RNCCI	2,3%	-1,9%	2,2%	2,8%	3,6%	0,4%	0,2%	2,0%	7,0%	1,7%	-5,4% -76,6%
Utentes referenciados (esc. dir.)	40 407	40 061	41 166	43 750	38 586	44 977	52 063	51 097	49 094	53 928	4 834 9,8%
Referenciados para internamento	28 655	29 217	30 546	30 839	26 272	28 898	34 942	34 568	33 084	35 293	2 209 6,7%
Referenciados para ECCI	11 752	10 844	10 620	12 911	12 314	16 079	17 121	16 529	16 010	18 635	2 625 16,4%
Utentes assistidos	45 768	46 525	48 677	50 473	45 959	48 733	50 793	52 378	54 067	56 418	2 351 4,3%
Unidades internamento	30 186	31 310	32 013	33 417	29 788	32 495	34 229	34 915	36 351	37 149	798 2,2%
ECCI	15 582	15 215	16 664	17 056	16 171	16 238	16 564	17 463	17 716	19 269	1 553 8,8%
Utentes em Lista Espera	1 322	1 504	1 612	1 674	1 264	1 310	1 562	1 804	1 751	1 910	159 9,1%
Para unidades internamento	1 218	1 365	1 420	1 423	1 062	1 067	1 292	1 451	1 245	1 390	145 11,6%
Para ECCI	104	139	192	251	202	243	270	353	506	520	14 2,8%

Source: ACSS and Transparency Portal.

Significant regional disparities in RNCCI coverage also persist. Against a national average of 729 RNCCI places per 100,000 inhabitants aged 65 or over, the Lisbon and Tagus Valley (LVT) region had the lowest ratio, with just 618 places. At the other end of the scale, the Algarve recorded the highest population coverage (1,135 places per 100,000 inhabitants aged 65 or over), followed by the Alentejo (1,125), the Centre (840) and the North (656). The gap between the extremes – coverage in the Algarve is almost double that of the LVT – is all the more significant given that the latter region accounts for the largest share of the national population.

Chart 5– Supply and demand at the RNCCI



Source: ACSS. Notes: RNCCI – National Network for Integrated Long-Term Care | ECCI – Community Teams for Integrated Long-Term Care.

1.4 Overall situation and future prospects for care provision

The Health Emergency and Transformation Plan,² approved in May 2024, was implemented only partially and inconsistently. The plan comprised 54 measures spread across five strategic areas. The [Second Progress Report](#), which drew on information available up to 31 March 2025, acknowledged a trend of sustained progress but highlighted significant limitations, namely: i) a lack of data to assess various measures; ii) the persistence of regional disparities; and iii) delays in structural measures relating to mental health, GP coverage and the reorganisation of A&E services. This pattern suggested that operational and short-term measures (such as increasing service provision, recruitment, incentives and the reorganisation of care) were being implemented more rapidly than more complex structural reforms, such as: i) the implementation of Model C Family Health Units (USF) (see Box 1); ii) the reform of access to surgery (SINACC³); or iii) the reconfiguration of the operation of A&E departments. According to information released by the Government on 28 May 2026, only six measures remained to be completed, concentrated in the strategic areas of community and family healthcare and mental health.

The working group that produced the Second Progress Report acknowledged improvements in various areas of access to and delivery of healthcare, but the report also highlights that pressure on the NHS remains high, particularly in primary and long-term care. In the area of surgical care, the OncoStop programme⁴ reduced the number of patients exceeding the guaranteed maximum response times by 87.7% (from 1,469 cases in March 2024 to 180 cases in March 2025), whilst non-oncological surgeries increased by 6.3% compared with the first quarter of 2024. Since the plan began, the SNS Grávida helpline has referred 36,500 pregnant women to alternative care options, thereby avoiding direct use of A&E services. In urgent and emergency care, the 15 Clinical Care Centres already established (for acute situations of lower complexity and clinical urgency) attended to more than 30,000 patients, and most of the priority measures in this area had been completed by the date of the report. The main exception was the physical refurbishment of A&E departments, which was deemed unfeasible within the initially defined timeframe. In primary and family healthcare, progress was visible but insufficient, as 1.56 million patients still did not have a GP. The establishment of Model C Family Health Units (USF) was underway, with 19 applications registered and the potential to cover 191,000 patients; even if fully implemented, this figure would fall far short of resolving the situation of the 1.56 million patients without a GP. In mental health, the recruitment of psychologists for primary care and the establishment of community teams had been completed, but the deinstitutionalisation of chronically ill patients and intervention programmes for anxiety and depression were not yet operational. The report recommended rescheduling certain deadlines,

² The Emergency and Transformation Plan for Healthcare was approved by the Council of Ministers of the 24th Government on 29 May 2024. This plan included urgent measures, priority measures and structural measures divided into five strategic areas: 1) timely response; 2) safe babies and mothers; 3) urgent and emergency care; 4) local and family healthcare; and 5) mental health.

³ SINACC is the [Integrated Management System for Surgery](#) and Consultation [Bookings](#), which replaces the former SIGIC (Integrated Management System for Surgery Bookings) and enables real-time monitoring of positions on waiting lists and the management of appointments and surgery bookings.

⁴ [Ordinance No. 154/2024/1, of 17 May](#).

introducing real-time monitoring systems and ensuring more effective communication with the public regarding access routes to the NHS.

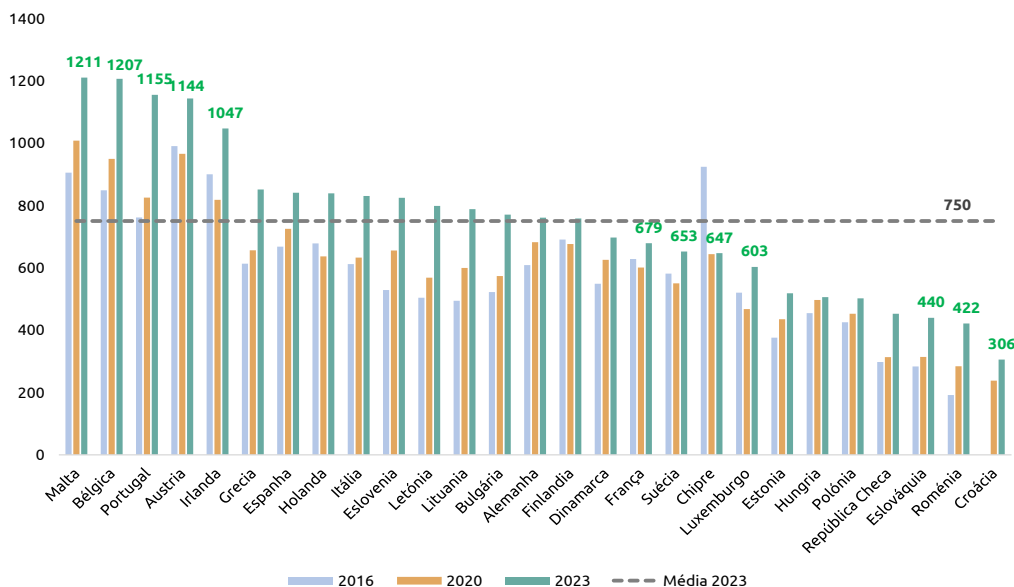
According to the OECD, the proportion of people aged 45 or over with at least one chronic condition who report having good experiences with healthcare in Portugal is below the OECD average, except where it comes to confidence in managing their own health. Indeed, the results of the OECD's [PaRIS](#) (*Patient-Reported Indicator Surveys*) [survey](#), published in March 2025, show that Portugal performs below the OECD average overall on several indicators of health perception and experience of care. This survey, which focuses on the experiences and outcomes reported by patients with chronic conditions in primary healthcare, reveals that only 42 per cent of Portuguese participants consider themselves to be in good general health, 57 per cent report good physical health and 67 per cent good mental health, the latter being the lowest figure recorded among the participating countries. The survey also highlights weaknesses in the coordination of care, in trust in the healthcare system and in support for self-management of illness, as well as low levels of digital health literacy. On a positive note, Portugal stands out in the use of electronic health records and in the confidence that users have in their own ability to manage their health.

The results of the PaRIS survey also reveal significant socio-economic inequalities, with lower-income groups showing poorer indicators of well-being and care experience.

According to the OECD, *"In Portugal, six out of ten people with chronic conditions (64%) on higher incomes trust the healthcare system, compared with 48% of those on lower incomes. Trust in the healthcare system is below the OECD average in the PaRIS survey, for both high-income groups (70%) and low-income groups (59%)"*. In fact, people on lower incomes face greater difficulties in accessing healthcare, as they rely primarily on services provided by the NHS, which tend to be free of charge.

Weaknesses in the National Health Service's (SNS) accessibility and responsiveness result in a shift of the financial burden onto households. In Portugal, public funding and compulsory insurance account for 62 per cent of total health expenditure, compared with an OECD average of 75 per cent, leaving households to bear a comparatively high share of the costs. Direct payments by households (*out-of-pocket*), which include both the direct purchase of public or private health goods and services and cost-sharing under co-payment schemes, often represent a significant proportion of the household budget. Indeed, these constitute the most regressive component of health financing, as they are not linked to the ability to pay. According to [Health at a Glance 2025](#), *out-of-pocket* payments amounted to 29% of health expenditure in 2023 in Portugal, compared with an average of 19% across OECD countries. In 2023, private health expenditure – which includes private insurance and *out-of-pocket* payments – was the third highest in the EU27, amounting to €1,155 *per capita*, measured in Purchasing Power Parities.

Chart 6 – Private healthcare expenditure in the EU27 in 2023 (€, PPP)



Source: OECD (data extracted on 24 March 2026). Notes: Figures in Purching Power Parity (PPP).

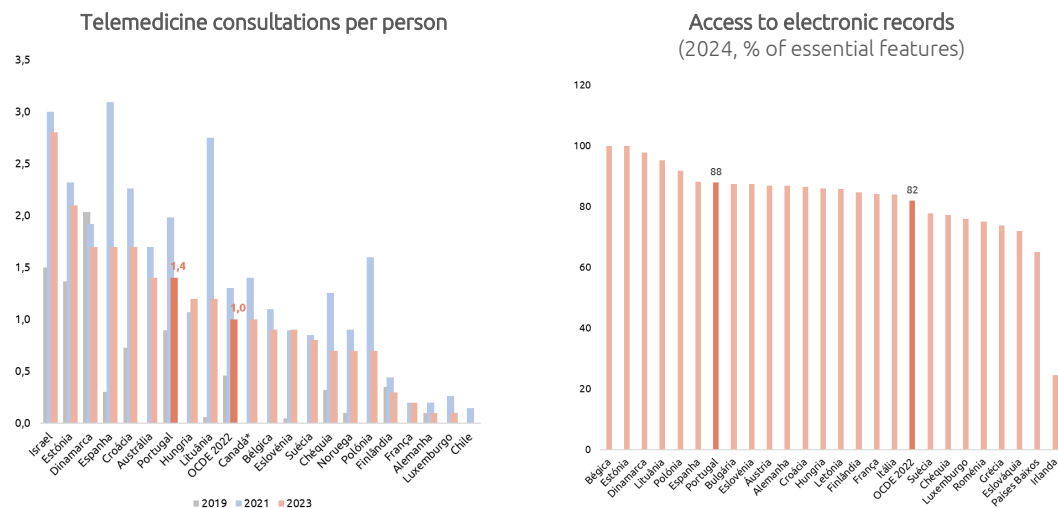
Health promotion is making significant progress in Portugal, but remains underdeveloped given the burden of chronic diseases and the rapid ageing of the population – a structural weakness that hampers the overall performance of the NHS. Data from [the 2025 National Health Profile](#) show that, although Portugal has a life expectancy above the EU average, a large proportion of those years are lived with significant limitations, particularly amongst women. Only 54 per cent of adults report being in good or very good health – the third lowest proportion in the EU – and more than half of people aged 65 or over live with limitations in their activities of daily living. Behavioural risk factors continue to weigh heavily: the country has one of the highest levels of alcohol consumption in the EU, the prevalence of obesity has stabilised above the European average, and levels of physical activity remain very low. According to the same report, “*behavioural and environmental risks accounted for 22 per cent of all deaths in Portugal*”, which underlines the need to strengthen preventive policies. Despite these challenges, there are areas of progress, such as the gradual improvement of screening programmes and positive results in indicators such as immunisation and preventable hospital admissions⁵. The situation described above calls, in any case, for more robust, cross-sectoral and sustained prevention policies, aimed at reducing inequalities and increasing healthy life years.

On a positive note, Portugal stands out favourably in terms of digital access to electronic health records, with 88% coverage of essential functionalities by 2024, above the OECD average of 82%. Only Belgium and Estonia currently offer full access to the functionalities of electronic health records, whilst Ireland is at the opposite end of the scale, with less than 30% coverage. It is worth noting that Portugal was one of the countries that recorded the largest increases in access to electronic health records since

⁵ For further details, see the occasional publication [‘The Portuguese health system in an international perspective: a comparative analysis’](#).

2022, alongside the Czech Republic, France, Ireland and Slovakia. With regard to the use of teleconsultations, Portugal also ranks above the OECD average, with 1.4 teleconsultations per person in 2023, compared with an average of 1 teleconsultation per person across the OECD. Taken together, these indicators position Portugal as one of the OECD countries making the most consistent progress in the digitalisation of healthcare, both in terms of data infrastructure and citizens' trust in and uptake of digital tools (*Health at a Glance 2025*).

Chart 7 – Digitalisation in healthcare



Source: OECD. | *The data presented for Canada refer to 2022.

1.5 Current health expenditure

Current health expenditure is one of the main indicators used to analyse and compare a given country's health expenditure internationally:

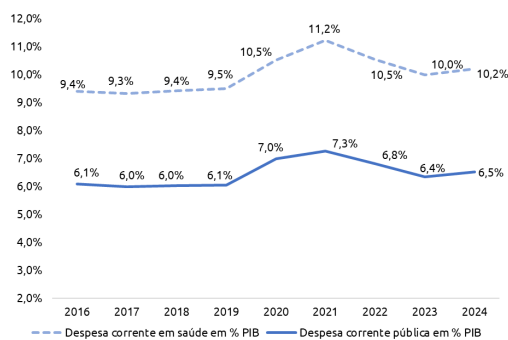
- Current health expenditure: this encompasses current public and private health expenditure, including direct payments by households, health insurance schemes and sub-systems, and is the indicator commonly used in international comparisons.
- Current public expenditure on health in Portugal: this corresponds to the public component of current expenditure on health as calculated in the Health Satellite Account published by INE, including not only expenditure by the NHS, but also that of other public bodies in the health sector, namely the Regional Health Services (SRS) of the Azores and Madeira, the public health subsystems, other public administration bodies and the Social Security Funds.

According to the most recent INE data, relating to 2024, the public component accounted for around two-thirds of current health expenditure. From a broader perspective, it is common to use the indicator for current health expenditure, which

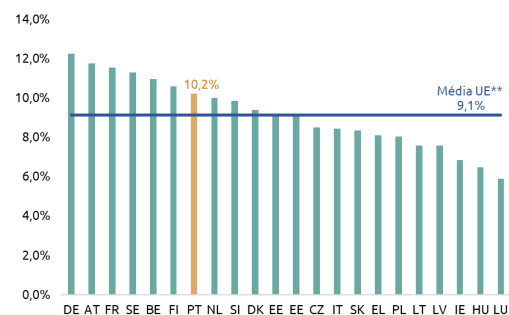
includes both the public and private components.⁶ The growth in current health expenditure has been a trend across most countries in the European Union (EU), reflecting factors such as an ageing population and the incorporation of new technologies and treatments into healthcare systems. In Portugal, current health expenditure – an aggregate comprising both public and private components – reached 29.2 thousand M€ in 2024⁷ (26.9 thousand M€ in 2023), corresponding to 10.2% of GDP, with the public component accounting for approximately two-thirds of this total (Chart 8, bottom left panel). By way of comparison, Portugal ranks among the EU countries with the highest share of health expenditure in GDP (Chart 8, top right-hand panel). However, when measured on a *per capita* basis, Portuguese expenditure remains below the European average (Chart 8, bottom right-hand panel).

Chart 8 – Current health expenditure

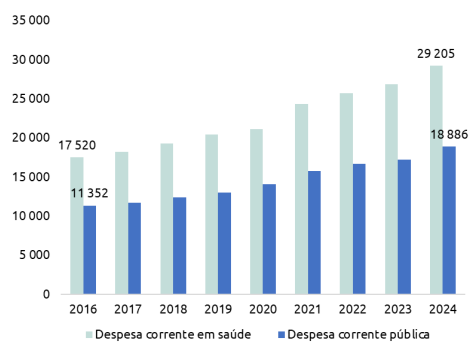
Trends in current health expenditure and current public expenditure in Portugal, as a % of GDP



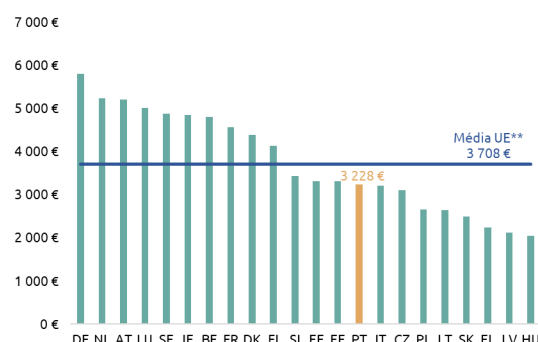
Current health expenditure in European Union countries in 2024, as a percentage of GDP



Trends in current health expenditure and current public expenditure in Portugal (M€)



Per capita current health expenditure in European Union countries in 2024 (€)*



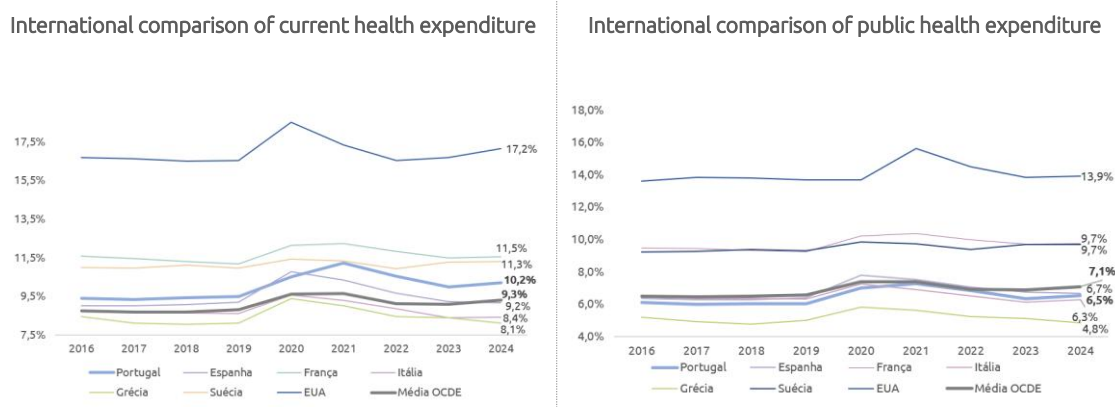
Source: INE, [health satellite account](#) and OECD (charts on the right). Note: * Figures in Purchasing Power Parity (PPP). **The EU average refers to countries with data available for 2024. Bulgaria, Cyprus, Croatia, Malta and Romania have been excluded due to the unavailability of data for that year.

⁶ Private current expenditure corresponds to expenditure borne by insurance companies and other entities, by private healthcare sub-systems, by other non-profit institutions serving households, and by households themselves (usually referred to as *out-of-pocket* payments).

⁷ Preliminary figures for 2024 based on the latest available data from [the Health Satellite Account](#), published by INE in July 2025.

In 2024, the share of health expenditure increased in most OECD countries, a trend that Portugal followed. The average share of current health expenditure rose to 9.3% of GDP across OECD countries (Chart 9, left-hand panel). Following the stabilisation observed in 2023, this rise may reflect increased cost pressures in the health sector, particularly regarding staff and intermediate goods, as well as a possible recovery in demand for healthcare. In Portugal, the share of total current expenditure (10.2 per cent of GDP) lies above that average. As regards public expenditure, the situation is reversed, as the average share in the OECD rose to 7.1% of GDP in 2024, whilst in Portugal this expenditure stood at 6.5% of GDP, remaining below the OECD average, albeit following a similar trend over the period under review (Chart 9, right-hand panel). This dual situation – namely, total current expenditure above the average and public expenditure below it – confirms the comparatively high proportion of private funding in the Portuguese healthcare system, in line with what was noted earlier regarding direct payments by households.

Chart 9 – International comparison of health expenditure in 2024 (% of GDP)



Source: INE (data for Portugal) and OECD (other countries – data extracted on 23 March 2026). Note: The OECD average was calculated as the arithmetic mean of the share of health expenditure in GDP for OECD member countries for which data were available in 2024. The data for 2024 correspond to the latest year available in the OECD *Health Statistics* database. For all countries shown, the figures for 2024 are classified by the OECD as estimates or provisional figures.

2. ANALYSIS OF THE NHS ACCOUNTS

In 2025, the NHS Accounts began to reflect the new institutional structure resulting from the reorganisation of the SNS. By the end of the year, the scope of consolidation encompassed 47 entities within the public health service, distributed as follows:

- (i) **the public administrative sector (SPA)**, comprising 5 entities: the ACSS, the Portuguese Institute of Blood and Transplantation, IP (IPST), the Dr Ricardo Jorge National Institute of Health, IP (INSA), as well as the Executive Directorate of the NHS and the National Institute of Medical Emergency (INEM); and
- (ii) **the public business sector (SPE)**⁸, comprising 42 public business entities (EPE), governed by Decree-Law No. 133/2013 of 3 October, and by Decree-Law No. 18/2017 of 10 February, including 39 Local Health Units (ULS) and the three Portuguese Institutes of Oncology (IPO).

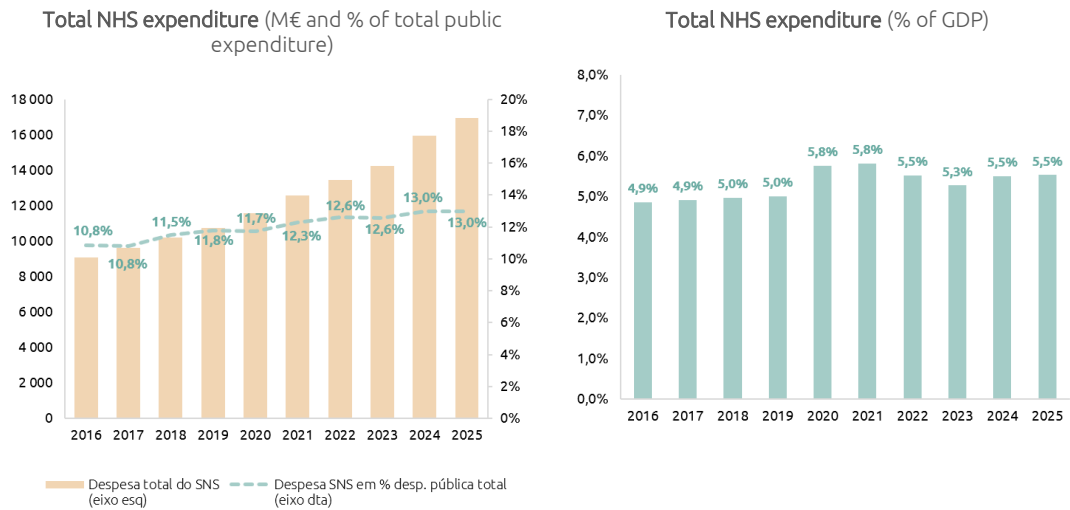
The NHS Accounts and Budget provide a limited perspective on the sector's economic and financial performance. This limitation is evident in two respects. In fiscal terms, although the NHS Budget consolidates the budgets of its constituent bodies, it is still not included in the Report accompanying the draft State Budget, but is only published subsequently in the Ministry of Health's Explanatory Note, as part of the specialised parliamentary debate. Although, by its consolidated nature, it is not subject to direct parliamentary approval, its inclusion in the Report would represent an important contribution to enhancing fiscal transparency. In terms of assets and liabilities, a comprehensive analysis of the NHS's financial position would require a consolidated balance sheet, the preparation of which is the responsibility of the ACSS and which includes information on assets, liabilities and net assets. However, at the time of completion of this report, the balance sheet for 2025 had not yet been published, making it impossible to analyse it (see Box for an analysis of changes in net assets between 2017 and 2024). We therefore reiterate the importance of their timely publication, preferably in line with the deadlines for the General State Account. It should also be noted that the consolidated accounts of entities in the health sector are subject to audit by the Court of Auditors, which has been issuing recommendations aimed at mitigating the material risks identified in this context.⁹

⁸ Annex 4.4 provides details and a list of the entities forming part of the National Health Service (SNS) as at 31 December 2025.

⁹ The most recent [follow-up audit](#) dates from May 2022. This audit examined the status of implementation of the recommendations previously made by the Court of Auditors and their effects on the 2019 consolidated accounts, whilst also analysing the 2020 accounting information, where appropriate, to provide an update on the situation.

In 2025, expenditure on the NHS, as calculated by the ACSS, , maintained its relative share of the economy and of public expenditure. Total NHS expenditure reached €16,962 million, corresponding to 5.5% of GDP and 13.0% of public expenditure (Chart 10). Despite the nominal increase in expenditure, its relative share of the economy and public expenditure remained broadly stable compared with the previous year.

Chart 10 – Relationship between total NHS expenditure, total public expenditure and GDP

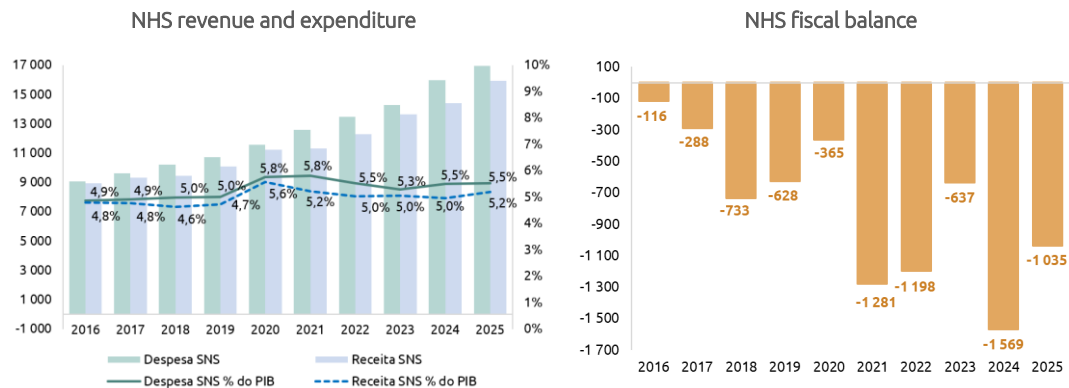


Sources: ACSS (National Health Service expenditure) and INE. | Note: The figures for 2025 are provisional. Total National Health Service expenditure is presented from a financial implementation perspective and may not be fully comparable with general government expenditure in the national accounts. COFOG-Health data are not used as they are not limited to National Health Service expenditure.

2.1 Trends in the NHS balance

In 2025, the NHS balance improved compared with the previous year, but remained negative and significantly higher than forecast in the State Budget for that year. The NHS recorded a fiscal deficit of €1,035 million in 2025, representing a reduction of €534 million compared with 2024, the year in which the highest figure for the period under review was reached. This improvement stemmed from revenue growth (+€1,548 million) outpacing the increase in expenditure (+€1,014 million). Nevertheless, the balance remained negative, continuing the trend observed since 2016 (Chart 11, right-hand panel). Compared with the State Budget, which had forecast a deficit of €217 million, the deviation was €818 million. Thus, the observed deficit was almost five times the budgeted figure, highlighting the initial under-budgeting of the NHS. An analysis of the deviations from the budget can be found in the section 2.3 .

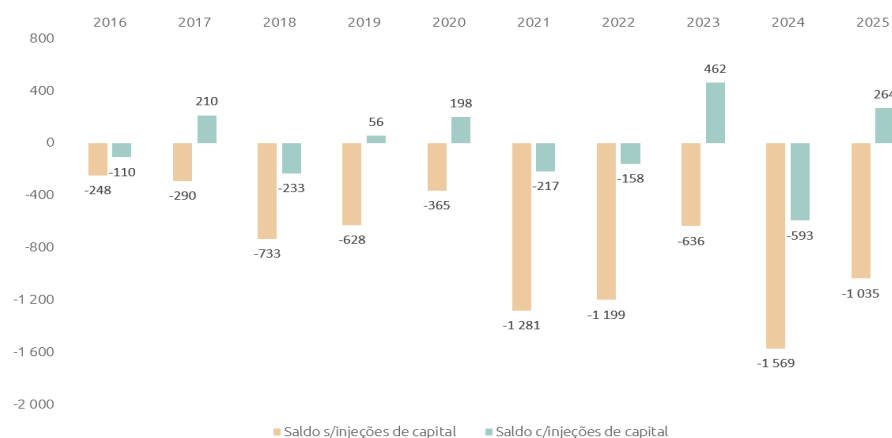
Chart 11 – Trends in the main fiscal aggregates (M€)



Source: ACSS. | Note: The figures for 2025 are provisional.

The financial situation of the NHS continued to depend on extraordinary capital injections provided by the State, which are not reflected in the SNS's balance.¹⁰ As in previous years, these injections were mainly used to settle debts owed to suppliers. In this context, the Chart 12 provides an illustrative analysis of the evolution of the SNS's balance, including these extraordinary capital injections. The analysis shows that the evolution of the SNS balance would be substantially different, reflecting a persistent structural imbalance between the funding initially planned and its actual needs. Between 2016 and 2025, the cumulative extraordinary capital injections amounted to around 7.9 thousand M€. In 2025, taking into account the State's total financial contribution, which amounted to 16 253 M€, the adjusted balance would have been 264M€.

Chart 12 – NHS balance with and without extraordinary capital injections



Source: ACSS, CFP calculations. | Note: The balance including capital injections corresponds to the balance of the National Health Service's consolidated account, plus the capital injections made by the State into National Health Service entities, intended to settle debts to suppliers.

¹⁰ From a National Accounts perspective, these extraordinary capital injections are classified as capital revenue for the National Health Service (SNS), with a positive impact on the balance.

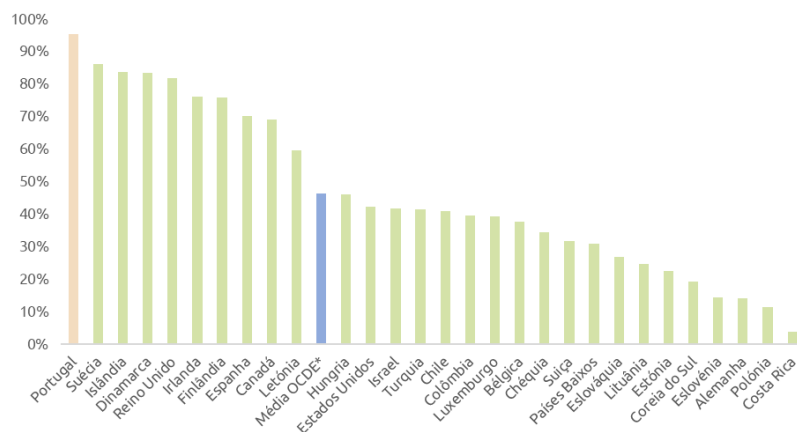
In 2025, the need to strengthen the mechanisms for managing and controlling NHS expenditure remained evident, in order to ensure greater efficiency in the use of public resources and fiscal planning better aligned with the system's actual needs. The structural reorganisation initiated in recent years – characterised by the creation of the ULSSs, the abolition of the ARSs and the consolidation of the SNS Executive Directorate – sought to strengthen the autonomy and management capacity of service providers through new planning and coordination tools. However, the information available on the degree of implementation and the actual impact of the measures to optimise public expenditure announced in the fiscal documents remains limited. The persistent discrepancies between the initial budget and the actual implementation of the NHS highlight recurring difficulties in planning healthcare provision and anticipating the associated costs. Despite the improvement observed in 2025 compared with the previous year, fiscal implementation continued to require the State to repeatedly mobilise additional resources through extraordinary capital injections. In this context, there is a clear need for a structural approach aimed at strengthening planning and transparency, involving realistic initial budgeting in line with known needs and the monitoring of the main sources of pressure on expenditure identified in this report, thereby promoting greater alignment between available resources and the NHS's healthcare objectives.

2.2 Structure and variation in revenue and expenditure

2.2.1 Revenue

In 2025, the National Health Service's (SNS) revenue increased, remaining heavily reliant on transfers from central government. The SNS's total revenue stood at 15 926 M€, representing an increase of 1548 M€ compared with 2024 (+10.8%). Transfers from central government remained the main source of funding, accounting for 93.9% of the total, comprising mainly transfers from the State to the SNS and earmarked revenue. This structure reflects the SNS's funding model, which is based predominantly on general taxation, and places Portugal amongst the European countries where tax revenue plays the most significant role in funding the public health system (Chart 13).

Chart 13 – Transfer of public revenue to fund the health system in 2023 (% of total revenue)



Source: ACSS (data for Portugal) and OECD (data for other countries – data extracted on 24 March 2026).
Note: The chart does not include all EU countries due to a lack of data from the OECD.

In 2025, the National Health Service's (SNS) revenue remained heavily concentrated in the current component, with transfers and subsidies clearly predominating. Current revenue accounted for 98.7% of total revenue, reaching €15,725 million (+10.3%). Capital revenue, meanwhile, remained a minor component (1.3%), totalling €201 million, though it still showed significant growth (+62.2%). Within current revenue as a whole, current transfers and subsidies stand out, accounting for 96.7% of this aggregate. This item amounted to €15,208 million, an increase of €1,634 million compared with 2024 (+12%). This item breaks down as follows:

- (i) Transfers from central government totalled 14 954 M€ in 2025, reflecting an increase of 1 552 M€ compared with the previous year (+11.6%), and continued to account for the lion's share, representing 93.9% of total revenue. This component includes tax revenue allocated to the NHS as a specific allocation,¹¹ including earmarked revenue from the extraordinary levy on the pharmaceutical industry (€26.2 million, €9 million more than in 2024),¹² from the excise duty on beverages containing added sugar and sweeteners¹³ (€63 million, an increase of €4.6 million compared with the previous year) and the extraordinary levy on suppliers to the National Health Service's medical devices sector (€24.8 million, up €7 million on 2024).¹⁴ It should also be noted that, in accordance with CGE/2025, the mechanism for allocating a portion of tobacco tax revenue resulted in a transfer of €176.6 million to the NHS in 2025;¹⁵
- (ii) transfers from the Local Government sub-sector, made by the Directorate-General for Local Authorities (DGAL) to the ACSS, via the mechanism of deducting amounts owed by local authorities in respect of the National Health Service's costs for the provision of healthcare and the dispensing of medicines to their employees.¹⁶ In 2025, this item accounted for just 0.1% of total

¹¹ A specific allocation is a sum entered in the State Budget earmarked for the funding of a particular area of public intervention or a specific purpose.

¹² The extraordinary contribution on the pharmaceutical industry (CEIF) aims to ensure the sustainability of the National Health Service (SNS) in terms of expenditure on medicines, and is levied on the pharmaceutical industry's sales volume, net of research and development expenditure. This contribution was established by Article 168 of Law No. 82-B/2014 of 31 December.

¹³ This revenue is earmarked for the sustainability of the National Health Service (SNS) and the Regional Health Services of Madeira and the Azores, in accordance with the district in which the medicines are consumed. It was introduced by Article 212 of Law No. 42/2016 of 28 December.

¹⁴ Its purpose is to ensure the sustainability of the National Health Service (SNS) in relation to expenditure on medical devices and *in vitro* diagnostic medical devices by SNS entities, net of value added tax. Established by Article 375 of Law No. 2/2020 of 31 March.

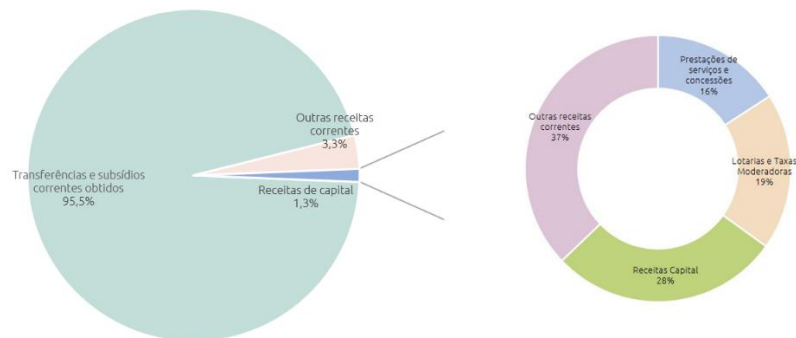
¹⁵ Pursuant to Article 254(3) of the 2024 State Budget Law, as retained by the 2025 State Budget Law, revenue from tobacco duty in excess of €1,466 million is allocated to health promotion and the sustainability of the National Health Service (SNS), centralised within the ACSS, I. P., and to the regional health services of the Autonomous Regions of Madeira and the Azores, in accordance with the district in which the tobacco products are consumed. Settlement and collection charges amount to 3 per cent of the revenue.

¹⁶ Article 225 of [Law No. 71/2018](#) of 31 December stipulates that local authorities, municipalised services and local companies on the mainland shall pay the ACSS for the provision of services and the dispensing of medicines to their employees, in accordance with the capitation method, which stipulates that '[t]he amount payable by each entity corresponds to the figure resulting from multiplying the total number of its employees registered in the SIAL as at 1 January 2019 by 31.22 per cent of the *per capita* cost of the National Health Service (SNS), as published by INE'.

current transfers and subsidies, totalling €21 million (an increase of €20 million compared with 2024); and

- (iii) other transfers and grants from other bodies, accounting for the remaining 1.5 per cent, amounting to €233 million in 2025 (an increase of €79 million compared with 2024).

Chart 14 – Breakdown of NHS revenue in 2025 (% of total)



Source: ACSS.

Other current revenue accounted for a small share, reinforcing the NHS's high dependence on funding from the State Budget. In 2025, this revenue represented just 3.3% of total NHS revenue (4.7% in 2024) (Table 5). This includes:

- (i) revenue from the provision of services and concessions, totalling €114 million in 2025 (€85 million less than in 2024). This category relates to healthcare provided to third parties responsible for the respective payment, including insurers and international organisations. Despite its operational significance, such revenue continues to represent a small proportion of the NHS's revenue, highlighting the importance of ensuring proper invoicing and settlement of charges owed by third parties, particularly in the case of non-resident patients;¹⁷
- (ii) revenue from lotteries, pari-mutuel betting and gambling tax, which totalled 120 M€ in 2025 (an increase of 10 M€ on the previous year). These funds are transferred annually to the ACSS and distributed in accordance with the rules set out in [the Ministerial Order](#);¹⁸ and

¹⁷ For a detailed analysis of the proportion of foreign users not covered by co-payment mechanisms and the constraints on collecting these payments, see the [report by the Inspectorate-General for Health Activities](#), dated November 2024.

¹⁸ The funds transferred stem from a share of the profits from social games and revenue from online gambling, constituting revenue earmarked for the financing of priority areas of healthcare. The relevant framework is set out in [Decree-Law No. 56/2006 of 15 March](#), under which the Ministry of Health is entitled to 16.60% of the net profits from social games operated by Santa Casa da Misericórdia de Lisboa.

- (iii) user fees, which generated €17 million in 2025, €4 million less than in 2024. This trend continues the downward trajectory observed in recent years, linked to the abolition of most of these fees in 2022 and the high number of exempt users.¹⁹

Table 5 – Trends in the main revenue and expenditure aggregates in the National Health Service

	Var. 2025/2024				
	2024	2025*	M€	%	Ctvh (p.p.)
Total da Receita	14 379	15 926	1 548	11	
Receita Corrente	14 255	15 725	1 471	10	11,4
Lotarias, apostas mútuas e imposto do jogo	110	120	10	9	10,4
Taxas moderadoras	21	17	-4	-20	-16,1
Transferências e subsídios correntes obtidos	13 573	15 208	1 634	12	13,5
Prestações de serviços e concessões	199	114	-85	-43	-24,4
Outras receitas correntes	352	267	-86	-24	-18,4
Receita de Capital	124	201	77	62	100,9
Total da Despesa	15 948	16 962	1 014	6	
Despesa Corrente	15 468	16 519	1 051	7	7,3
Despesas com pessoal	6 663	7 165	502	8	8,1
Remunerações	3 655	4 027	372	10	11,2
Suplementos de remunerações	1 076	1 070	-6	-1	-0,6
Subsídio de férias e natal	629	672	42	7	7,2
Encargos sobre remunerações	1 237	1 332	95	8	8,3
Outros gastos com pessoal	67	65	-2	-3	-2,5
Compras de Inventários	3 197	3 356	158	5	5,2
Fornecimentos e serviços externos	5 411	5 744	333	6	6,5
Serviços de saúde	4 008	4 258	249	6	6,6
Meios complementares diagnóstico e terapêutica	1 283	1 374	92	7	7,7
Produtos vendidos por farmácias	1 819	2 056	237	13	14,7
Produtos fornecidos por farmácias hospitalares	0	0	0	-100	0,0
Internamentos	440	367	-73	-17	-13,9
Contratos e acordos (inclui PPP)	365	410	45	12	14,0
Outros subcontratos de serviços de saúde	102	51	-51	-50	-25,0
Outros subcontratos	1	1	0	-18	-14,7
Fornecimentos e serviços	1 401	1 485	84	6	6,4
Juros e gastos similares suportados	1	5	4	480	2 787,3
Transferências e subsídios concedidos	183	242	59	32	42,5
Outras despesas correntes	13	7	-6	-45	-24,8
Despesa de Capital	480	442	-37	-8	-7,2
Aquisição de bens de capital	413	339	-74	-18	-14,7
Transferências de capital	67	103	36	54	83,6
Saldo Global	-1 569	-1 035	534		
<i>Por memória:</i>					
Injeções de capital	975,6	1 299,1	323,6	33,2	44,2

Source: ACSS. Notes: * The 2025 figures are provisional. Ctvh – contribution to the rate of change. Annex 4.2. (Table 7) sets out the implementation of the NHS Account for all years of the 2016–2025 period, the time horizon of this report. Due to rounding effects, the totals presented may not correspond exactly to the sum of the individual items.

2.2.2 Expenditure

In 2025, expenditure on the NHS increased, remaining heavily concentrated in the current expenditure component. NHS expenditure reached €16,962 million, representing a 6.4% increase on the previous year (+€1,014 million). The current expenditure component accounted for 97.4% of total expenditure and was the main driver of growth, with an increase of €1,051 million. This component is concentrated mainly in three categories: staff costs (43.4% of current expenditure), external supplies and services (FSE) (34.8%) and purchases of inventories (20.3%) (Table 5). Capital

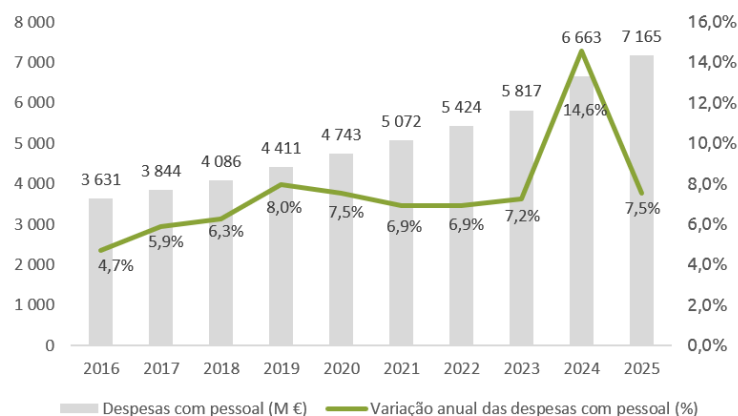
¹⁹ In 2025, 6,248,408 service users were exempt or waived from paying user charges, 24,545 fewer than in 2024. The majority of these cases were due to chronic illness (29.5%), financial hardship (29.2%) and being a minor (26.1%).

expenditure, meanwhile, amounted to €442 million, €37 million less than in 2024, reversing the upward trend recorded in the previous year. Nevertheless, its share remained negligible, accounting for just 2.6% of total NHS expenditure, which highlights the limited scale of investment compared with the predominance of current expenditure. However, from a longer-term perspective, the share of capital expenditure in GDP rose from 0.06% in 2017 to 0.14% in 2025, averaging 0.11% over the period, reflecting a rise in investment, driven in part by projects funded by the RRP, although this is still insufficient to alter the markedly current-expenditure-oriented profile of NHS expenditure (see Box 1 on the implementation of the RRP in the health sector).

2.2.2.1 Staff costs

In 2025, staff costs within the NHS continued to rise, reflecting a sustained upward trend observed over the past decade. Staff costs within the SNS amounted to 7165 M€, representing an increase of 7.5% (+ 502 M€) compared with the previous year and accounting for almost half of the growth in total expenditure. Since 2016, this item has increased by around 97%, rising from €3,631 million to €7,165 million in 2025. The trend observed in 2025 stems from a combination of two factors: on the one hand, pay rises (the price effect) and, on the other, the change in the total number of employees (the volume effect). The number of employees in organisations forming part of the NHS reached 158 595, representing an increase of 3960 (+2.6%) compared with 2024. At the end of 2025, the health sub-sector accounted for more than 20 per cent of total employment in the public sector; according to the [DGAEP's Summary of Public Employment](#), it was the second-largest employer in the public sector, surpassed only by education (32 per cent).

Chart 15 – Trend in staff costs



Source: ACSS.

With regard to remuneration, data from the DGAEP indicate that, in 2025, the average monthly basic salary and average monthly earnings in the health sector rose by 5.7% and 6%, standing at €1,884 and €2,496 respectively.²⁰ The rise in staff costs largely

²⁰ According to the Directorate-General for Administration and Public Employment (DGAEP), the monthly basic remuneration corresponds to the “gross amount (before deduction of any allowances) in cash and/or in kind paid on a regular basis and guaranteed to workers during the reference period and

reflects the implementation of a series of measures to enhance and reorganise human resources within the NHS. These include, in particular: (i) pay rises in the civil service, pursuant to [Decree-Law No. 1/2025 of 16 January](#), which amends the pay scale and updates civil service pay rates; (ii) the new nursing career framework;²¹ (iii) the review of the career framework for pharmacists;²² (iv) changes to the remuneration structure for the medical career;²³ (v) the allocation of allowances linked to the new organisational model for Family Health Units (USFs), introduced in 2024;²⁴ and (vi) the allocation of allowances linked to the performance of emergency services.²⁵

Given the diversity of careers and qualification levels amongst healthcare professionals, it is important to analyse the trends in volume and price effects in greater depth. In 2025, the number of workers increased across all occupational groups, particularly among nurses (+1,347; +2.4 per cent), doctors (+489; +1.5 per cent), diagnostic and therapeutic technicians (+434; +3.8 per cent) and senior healthcare technicians (+173; +9.5 per cent). At the same time, the weight of the variable component of remuneration – namely overtime and allowances – is evident in the divergence between the trends in basic monthly pay and monthly earnings (Chart 16). The medical profession stands out for having the widest gap between these indicators, which widened again in 2025, reaching €1,622, compared with €1,465 recorded the previous year. This reliance on the variable component, particularly overtime, is a sign of pressure on existing capacity, particularly in A&E departments, and introduces unpredictability into expenditure.

corresponding to the normal working hours". Monthly earnings are defined as the "gross amount (before deduction of any deductions) in cash and/or in kind paid monthly on a regular basis for hours worked. In addition to basic pay, this includes all regular bonuses, allowances or supplements, as well as payment for overtime or extra hours".

The monthly basic pay and monthly earnings figures for 2025 correspond to the month of October, the date of the most recent data made available by the DGAEP. Consequently, the changes shown are calculated in relation to October 2024.

The careers that can be directly classified as belonging to the health sector in [the Public Employment Summary](#) are: (i) doctors, (ii) nurses, (iii) diagnostic and therapeutic technicians, and (iv) senior health technicians.

²¹ [Decree-Law No. 111/2024 of 19 December](#), amending the special nursing career scheme and the nursing career scheme in public enterprise bodies and health partnerships, and revising the respective pay scales, with effect from November 2024.

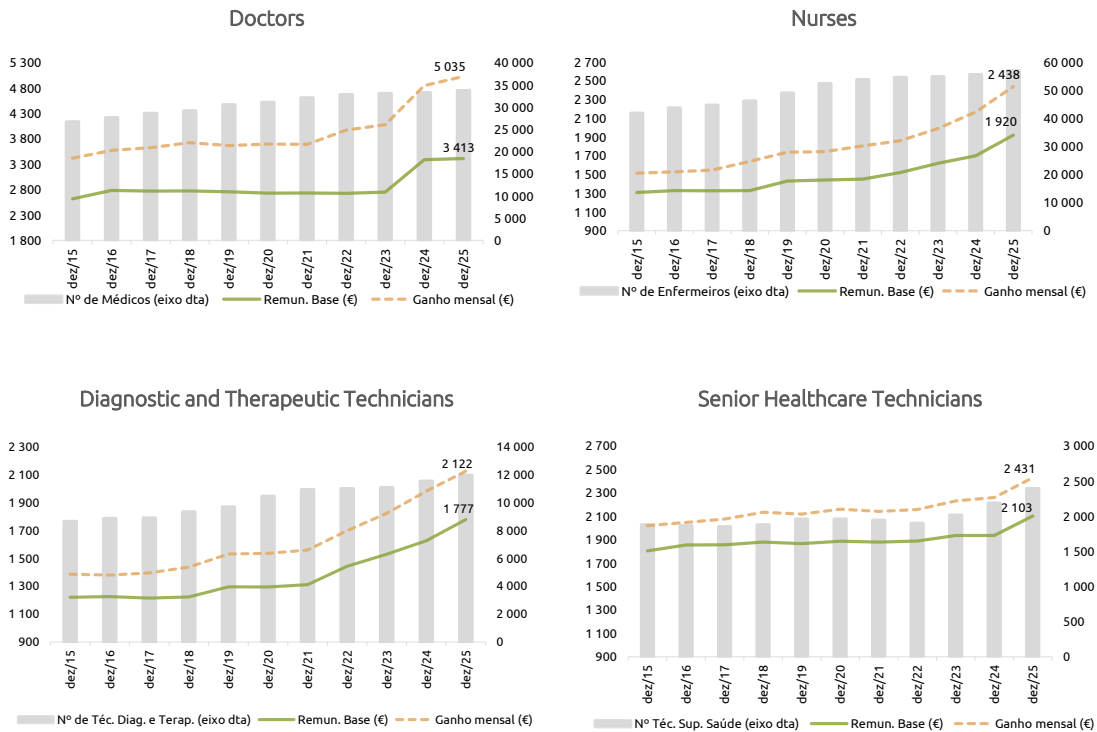
²² [Decree-Law No. 45/2025 of 27 March](#), amending the special pharmaceutical career scheme, as well as the pharmaceutical career scheme in public enterprise bodies forming part of the National Health Service (SNS).

²³ [Decree-Law No. 46/2025 of 27 March](#), amending the various pay structures applicable to full-time medical staff, medical staff in the special medical career scheme and junior doctors.

²⁴ [Decree-Law No. 103/2023 of 7 November](#), which approves the legal framework for full-time employment within the National Health Service (SNS) and the organisation and operation of Family Health Units (USFs).

²⁵ With regard to the allowances provided for in [Decree-Law No. 45-A/2024 of 12 July](#), these establish a mechanism for compensating doctors' performance through the award of a remuneration allowance intended to ensure the functioning of emergency services when the legal limits on overtime are exceeded.

Chart 16 – Trends in the number of staff, basic monthly pay and monthly earnings in the NHS



Source: DGAEP. Note: There are four main breaks in the time series that influence the trend in the number of employees in the health sector, namely the inclusion within the public management framework of the following: (i) Braga Hospital, EPE, from September 2019; (ii) Vila Franca de Xira Hospital, EPE, from June 2021; (iii) the Loures Hospital, EPE in 2022; and (iv) INEM, IP in 2023.

The use of overtime remained high in 2025, reflecting persistent difficulties in meeting care needs and the pressure on the National Health Service's (SNS) human resources.

SNS organisations recorded 19.8 million hours of overtime, representing an increase of 2.8% compared with the previous year. The cost associated with this type of work rose by 11.4%, amounting to €468 million in 2025. Doctors accounted for 36% of the total overtime worked, corresponding to 7.1 million hours, whilst nurses accounted for 31.5%, with 6.2 million hours. In financial terms, overtime is predominantly concentrated among doctors, accounting for 55.5% of this expenditure (€260 million), with nurses accounting for the remaining 27.3% (€128 million), reflecting the difference in hourly rates between the two professions. The Coimbra, Santa Maria and São José Local Health Units stood out as the organisations making the greatest use of overtime, recording 1.7 million, 1.4 million and 1.2 million hours respectively, and combined costs of approximately €92 million, corresponding to around 20% of the National Health Service's total expenditure on this type of work. This volume is partly attributable to the high degree of specialisation of these units, which provide a wide range of clinical services and function as national referral centres, treating patients from various regions of the country.

The procurement of medical services continued to account for a significant proportion of expenditure in 2025, highlighting the persistent constraints on the National Health Service's (SNS) capacity to respond using its own resources. In 2025, 6.6 million hours were procured, an increase of 6% compared with the previous year, corresponding to expenditure of 265 M€ (+37 M€ compared with 2024). As this expenditure is recorded

under the accounting heading 'External Supplies and Services' (FSE), it is not reflected as staff costs, thereby underestimating the total cost of labour. Of the total hours contracted, 86.9% (5.7 million hours) corresponded to the procurement of services from doctors on a fee-for-service basis ("casual doctors"). The Local Health Units (ULS) of the Algarve, Médio Tejo and Oeste stood out among the entities with the highest volume of contracted hours, recording 470,000, 388,000 and 359,000 hours respectively, accounting for 18.4% of the total contracted hours within the NHS. It should be noted that the geographical pattern differs from that observed for overtime: whilst the latter is concentrated in large specialist hospital centres, the use of external providers is mainly focused on organisations that face greater difficulty in attracting and retaining healthcare professionals.

Absenteeism remained high in 2025 and continues to pose a significant challenge for human resources management and the responsiveness of the NHS. The average absenteeism rate across SNS organisations stood at 9.5 per cent, remaining in line with the figure recorded in the previous year.²⁶ The highest rates were recorded in the Local Health Units (ULS) of the Tagus Estuary (13.2%), the Alentejo Coast (12.8%) and the Middle Ave (12.7%). Absenteeism is of particular concern due to the impact it can have on expenditure, notably through the need to increase temporary recruitment and make greater use of overtime. Furthermore, high levels of absenteeism can affect productivity and the quality of care provided, indirectly contributing to increased costs for the system. By professional group, the highest rates were observed among junior doctors (13.4%), healthcare assistants (11.7%) and operational assistants (11.5%).

2.2.2.2 External supplies and services

In 2025, the increase in External Supplies and Services (FSE) remained largely concentrated on the procurement of healthcare services. FSE recorded growth of 6.2 per cent, totalling 5,744 M€ (+333 M€). This category covers expenditure on the procurement of goods and services from entities outside the scope of the NHS. Its composition is dominated by health services, which accounted for 74.1% of expenditure on FSE, whilst other supplies and services accounted for 25.9%.

Expenditure on health services totalled 4258 M€ in 2025, representing an increase of 6.2% compared with 2024 (+249 M€). The following expenditure components were the main contributors to this trend (Chart 17, right-hand panel):

- (i) products sold in community pharmacies, which reached 2,056 M€ in 2025, 13% higher than in the previous year (+237 M€). This component includes expenditure on medicines covered by the NHS, which amounted to 1,894 M€, the highest figure since 2014, reflecting a 12.4% increase, according to INFARMED data available on [the SNS Portal – transparency section](#). This trend reflected both the increase in the number of subsidised packs dispensed in

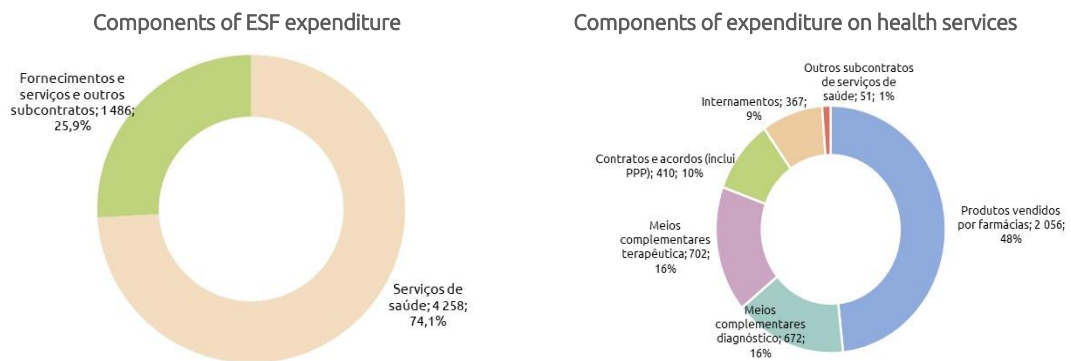
²⁶ The average absenteeism rates were calculated on the basis of absenteeism rates by occupational group and by NHS entity, as provided by the ACSS. The absenteeism rate is calculated as the ratio of the total number of days of absence for all workers (excluding holidays) to the total number of potential working days. The data for 2024 should, however, be interpreted with caution, as the gradual integration of staff into the Local Health Units (ULS) throughout that year, under Decree-Law No. 102/2023 of 7 November, may affect the comparability and estimation of absenteeism, due to constraints associated with the Human Resources and Pay (RHV) system.

outpatient settings (+5.2%) and the rise in the average cost borne by the NHS per pack (+6.8%), highlighting both volume and average cost effects, according to INFARMED data;

- (ii) complementary diagnostic and therapeutic resources, which stood at €1,374 million, representing an increase of 7.1% (+€92 million). This trend was driven, in particular, by increased expenditure on physical medicine and rehabilitation (+€11 million) and on home respiratory care (+€27 million);
- (iii) contracts and agreements, including public-private partnerships, which totalled €410 million, an increase of 12.4% (+€45 million) compared with 2024, with the agreements component standing out at €166 million (+€58 million); and
- (iv) conversely, the items relating to hospital admissions and 'Other subcontracts for health services' recorded reductions of €73 million and €51 million, respectively, compared with the previous year. In the case of the latter, the decrease was almost entirely due to the reduction in expenditure associated with international agreements (-€43 million), relating to the costs of healthcare provided to Portuguese citizens abroad.

Expenditure on other supplies and services increased by €84 million (+6%), totalling €1,485 million in 2025. This expenditure covers a diverse range of specialised services procured,²⁷ including the contracting of medical services, commonly known as 'tarefeiros' (Chart 17, left-hand panel).

Chart 17 – Breakdown of ESF expenditure in 2025 (M€ and %)



Source: ACSS.

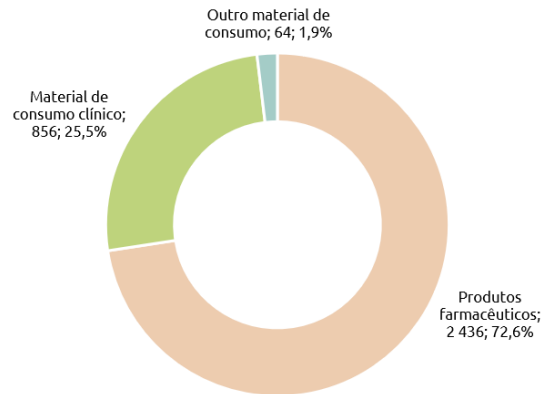
2.2.2.3 Purchases of supplies

Expenditure on inventory purchases increased by €158 million (+4.9%) compared with the previous year, totalling €3,356 million. This increase was driven by growth in purchases of pharmaceutical products (+7.7% or +173 M€), which accounted for 72.6% of the total for this category, whilst the remaining components together recorded a slight reduction (Chart 18). Expenditure on pharmaceutical products reached 2,436 M€,

²⁷ This includes services related to information systems, clinical services, catering, laundry, security and surveillance, consumables, electricity, water and transport, amongst others.

mainly relating to medicines dispensed in hospitals, the trends for which are analysed in greater detail in the following section (2.2.2.4).

Chart 18 – Breakdown of expenditure on stock purchases in 2025 (M€ and %)



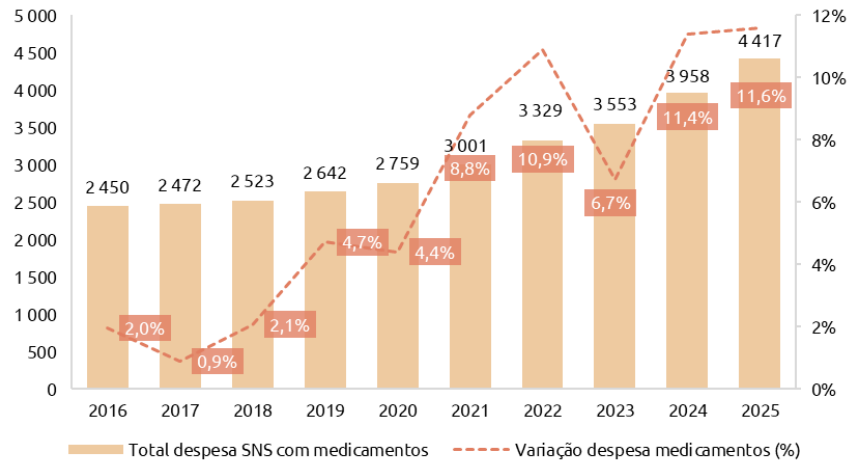
Source: ACSS.

2.2.2.4 Expenditure on medicines

Expenditure on medicines continued to grow in 2025, remaining one of the main components of NHS expenditure.²⁸ The NHS's expenditure on medicines amounted to 4.4 thousand M€, covering both medicines dispensed in community pharmacies (outpatient market) and those used or supplied in a hospital setting (hospital market). The 11.6% increase in 2025 reflects a slight acceleration compared with the rate observed in the previous year (11.4%). The trend in these expenditure figures shows a pattern of growth over the last decade, with an average annual rate of 6.4%. Following growth of 6.7% in 2023, expenditure accelerated again in 2024 and maintained this high rate in 2025 (Chart 19).

²⁸ The data provided by INFARMED (collected via the [National Health Service \(SNS\) Portal](#), under the 'Transparency' section) is taken into account. Overall expenditure on medicines is recorded under different accounting headings; consequently, there are differences in figures compared with the NHS accounts, due to: i) different sources of data, whereby the NHS accounts are drawn up on the basis of the entities' accounting information, whilst the expenditure on medicines under consideration here is compiled by INFARMED through a specific report submitted by the entities; and ii) the NHS accounts include other products managed by hospital pharmacy services, such as certain medical devices and healthcare products.

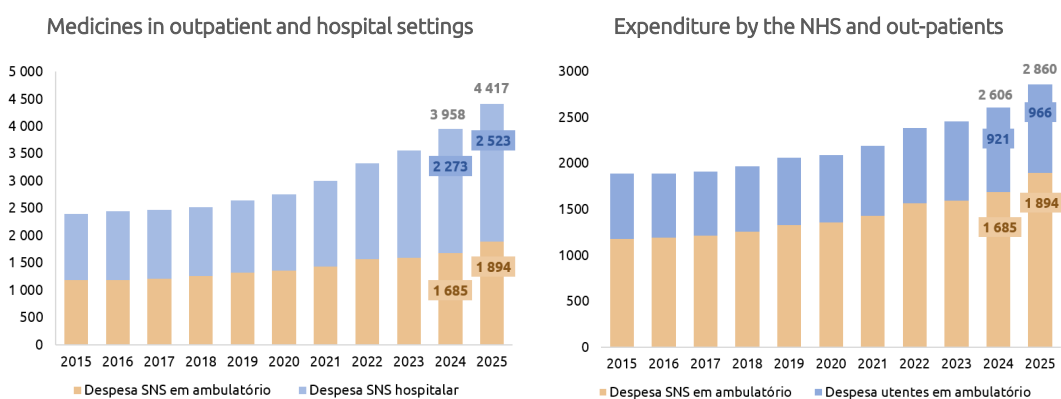
Chart 19 – Trends in expenditure on medicines within the National Health Service (M€ and %)



Source: NHS Transparency Portal.

The growth in expenditure on medicines continued to be driven primarily by the hospital sector, although the outpatient market also maintained a growth trajectory in 2025. Expenditure on medicines in the hospital setting reached 2 523 M€ (+250 M€; +11%) compared with the previous year, accounting for around 57% of total expenditure on medicines. Meanwhile, expenditure on medicines in the outpatient sector reached 1 894 M€ (+208 M€; +12.4% compared with 2024) (Chart 20, left-hand panel). Also in this segment, expenditure borne directly by patients totalled 966 M€, 45 M€ more than in the previous year (Chart 20, right-hand panel). On average, this cost amounted to €4.74 per pack, a figure virtually unchanged from that recorded in 2024 (-€0.01).²⁹

Chart 20 – Trends in the structure of expenditure on medicines in the National Health Service (M€)

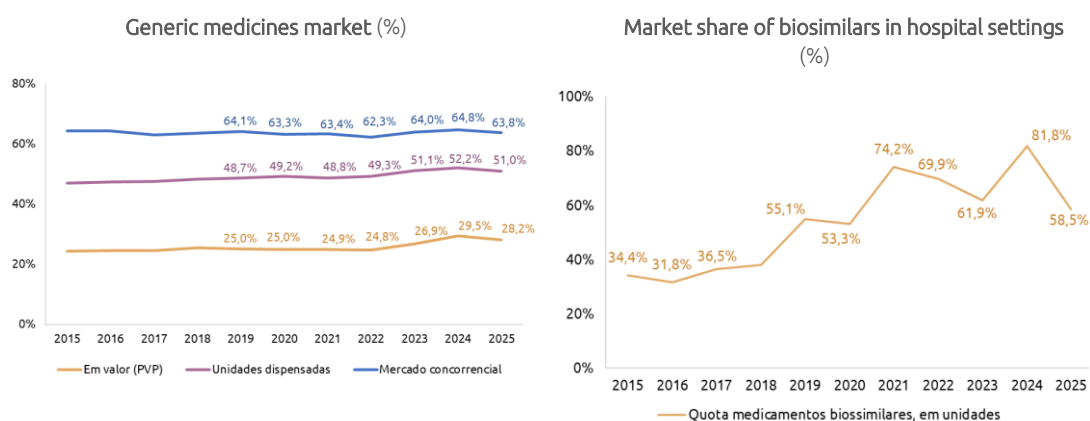


Source: NHS Transparency Portal.

²⁹ Information published by INFARMED in [the Monthly Monitoring of Outpatient Medicines Expenditure](#).

The use of generic medicines³⁰ and biosimilars³¹ continues to be of particular importance in promoting the efficiency and sustainability of pharmaceutical expenditure within the NHS, as highlighted by the OECD.^{32,33} In the outpatient market, the share of generic medicines in expenditure fell slightly to 28.2% (29.5% in 2024), corresponding to 51% of the units of medicines dispensed and 63.8% of the competitive market³⁴ (Chart 21, left-hand panel). In hospital settings, meanwhile, the share of biosimilar medicines fell to 58.5%, compared with the 81.8% observed in 2024 (Chart 21, right-hand panel). It is important to bear in mind, however, that the trend in this indicator may be influenced by changes in the range of medicines considered and by the degree of adoption of biosimilars across different molecules.

Chart 21 – Share of generic and biosimilar medicines in the National Health Service



Source: SNS Transparency Portal and APIFARMA, Economic Bulletins. Note: The market share of biosimilars depends on the set of molecules included in each analysis period. The introduction of new biosimilars, particularly for high-volume molecules, can significantly influence the aggregate share, as these tend to have initially low levels of use. Thus, the variations observed over time may reflect not only changes in the use of already established biosimilars, but also composition effects arising from the expansion of the range of molecules considered, as well as the timing of market entry and the degree of adoption of biosimilars.

³⁰ A generic medicine is a medicine with the same active substance, pharmaceutical form, strength and therapeutic indication as the original, branded medicine that served as the reference.

³¹ A biosimilar medicine is a biological medicine (meaning it is produced from living cells using biotechnology methods), which is developed with the aim of being similar to another biological medicine that has already been approved (the so-called 'reference medicine') and which meets the same standards of quality, safety and efficacy that apply to all biological medicines.

³² For further information, see the OECD's '[Health at a Glance 2025](#)' report.

³³ In 2016, Portugal adopted a [National Strategy for Medicines and Health Products 2016–2020](#), setting out the objective of "promoting a sustainable policy in the field of medicines, so as to reconcile fiscal discipline with access to therapeutic innovation, increasing the share of generic medicines and the use of biosimilars, and stimulating national research and production in the sector".

³⁴ According to the [methodological notes](#) published by INFARMED, "The share of generics expressed in units covers the entire range of medicines, eliminating the effect of different pack sizes. However, it does not take into account the different dosages of the medicine" and "The share of generics in the competitive market corresponds to the percentage of units of generic medicines dispensed out of the total number of units of medicines dispensed where the active substances have commercially available generics."

2.3 Deviations from the initial budget

The deviation in the NHS balance from that forecast in the State Budget for 2025 (OE/2025) primarily reflected the execution of current revenue and expenditure components. The deficit observed in 2025 was significantly higher than that forecast in the OE/2025 (Table 6).³⁵ The breakdown shows that around 70% of the deviation stemmed from the current balance, reflecting both lower-than-estimated revenue and higher-than-budgeted expenditure. Meanwhile, in terms of the capital balance, revenue fell short of forecasts (–€377 million), only partially offset by lower-than-planned capital expenditure (–€136 million).

The National Health Service's (SNS) current revenue fell short of forecasts, reflecting shortfalls in various components, notably service provision, but particularly other current transfers. The SNS's current revenue was €226 million below the figure estimated in the 2025 State Budget. This shortfall resulted mainly from services rendered and concessions (–€96 million) and from current transfers and subsidies received (–€88 million).

The SNS's capital revenue fell short of forecasts, reflecting a lower-than-initially-estimated execution of capital transfers. In 2025, capital revenue recorded a shortfall of €377 million compared with the figure forecast in the 2025 State Budget. This development was mainly due to lower implementation of capital transfers associated with investment financing, notably through European funds, including the RRP.

Current expenditure by the NHS exceeded projections, reflecting mainly pressures in the categories of external supplies and services and staff costs. Current expenditure by the NHS was €350 million higher than the figure forecast in the 2025 State Budget. Among the main items, the ESF stood out, with a deviation of €201 million, and staff costs, which exceeded the budget by €110 million. In the case of the FSE, the deviation is mainly linked to products sold by pharmacies (+€159M), complementary diagnostic and therapeutic resources (+€144M), as well as the 'supplies and services' category. (+€60 million), partially offset by the negative deviation in hospital admissions (–€111 million) and other subcontracts (–€103 million). As regards staff costs, the increase reflects a number of factors previously identified, not all of which were fully incorporated into the 2025 State Budget forecasts.

In 2025, the National Health Service's capital expenditure fell short of initial forecasts, reflecting, above all, a lower-than-budgeted level of capital transfers. Capital expenditure recorded a deviation of €136 million from the figure set out in the 2025 State Budget, concentrated mainly in capital transfers. Nevertheless, the implementation rate improved significantly compared with 2024, rising from 59.6% to 76.5%. According to the 2025 General State Account, this development reflected greater implementation of projects under the RRP, coupled with growing pressure to meet implementation targets. Of particular note were investments in the digital transition of the healthcare system and in the acquisition of heavy medical equipment, as part of the NHS's technological modernisation programme.

³⁵ At this point, an analysis is carried out of the observed deviations based on the provisional National Health Service (SNS) accounts for 2025 set out in the State Budget.

Table 6 – Deviation from the 2025 NHS budget

	2025		Desvio		Execução*
	Orçamento	Execução*	M€	%	%
Total da Receita	16 530,0	15 926,4	-603,6	-3,7	96,3
Receita Corrente	15 951,6	15 725,4	-226,2	-1,4	98,6
Lotarias, apostas mútuas e imposto do jogo	128,6	120,2	-8,4	-6,5	93,5
Taxas moderadoras	28,1	16,6	-11,5	-40,9	59,1
Transferências e subsídios correntes obtidos	15 295,5	15 207,7	-87,8	-0,6	99,4
Prestações de serviços e concessões	210,1	114,0	-96,1	-45,7	54,3
Outras receitas correntes	289,3	266,9	-22,4	-7,7	92,3
Receita de Capital	578,4	201,0	-377,4	-65,2	34,8
Total da Despesa	16 747,2	16 961,5	214,3	1,3	101,3
Despesa Corrente	16 168,8	16 519,2	350,4	2,2	102,2
Despesas com pessoal	7 055,1	7 165,4	110,3	1,6	101,6
Compras de inventários	3 346,4	3 355,6	9,2	0,3	100,3
Fornecimentos e serviços externos	5 542,9	5 744,0	201,1	3,6	103,6
Serviços de saúde	4 098,7	4 257,8	159,1	3,9	103,9
Meios complementares diagnóstico e terapêutica	1 229,7	1 374,1	144,4	11,7	111,7
Produtos vendidos por farmácias	1 897,2	2 055,8	158,6	8,4	108,4
Internamentos	478,2	366,9	-111,3	-23,3	76,7
Contratos e acordos (inclui PPP)	340,0	410,3	70,3	20,7	120,7
Outros subcontratos de serviços de saúde	153,6	50,7	-102,9	-67,0	33,0
Outros subcontratos	19,5	1,0	-18,5	-94,9	5,1
Fornecimentos e serviços	1 424,7	1 485,2	60,5	4,2	104,2
Juros e gastos similares suportados	0,5	4,9	4,4	880,0	980,0
Transferências e subsídios concedidos	202,3	242,4	40,1	19,8	119,8
Outras despesas correntes	21,6	6,9	-14,7	-68,1	31,9
Despesa de Capital	578,4	442,3	-136,1	-23,5	76,5
Aquisição de bens de capital	334,4	338,9	4,5	1,3	101,3
Transferências de capital	244,0	103,4	-140,6	-57,6	42,4
Saldo Global	-217,2	-1 035,1	-817,9		

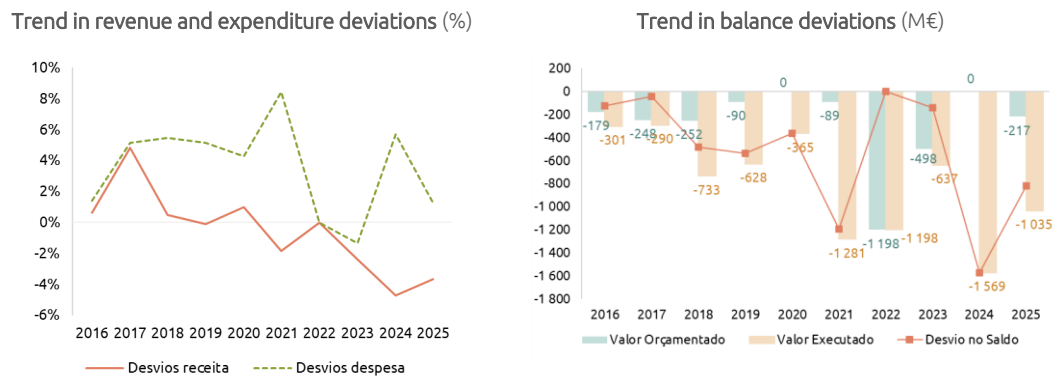
Source: ACSS. | Note: * The figures for 2025 are provisional. | Ctv – contribution to the rate of change. Due to rounding effects, the totals shown may not correspond exactly to the sum of the individual figures.

In 2025, the deviations in the NHS's revenue and expenditure from the initial budget were lower than the average recorded over the period 2016–2024. Significant deviations in revenue and expenditure components have been a recurring feature of the NHS's fiscal implementation over recent years. However, in 2025 there was a reduction in the deviation from the budgeted figures, following the widening of the gap observed in the previous year (Chart 22, left-hand panel). Revenue showed a deviation of -3.7% from the initial budget, deviating from the historical average of -0.2% between 2016 and 2024, whilst expenditure recorded a deviation of +1.3%, below the average of 3.8% observed between 2016 and 2024.

The balance deviation narrowed compared with the previous year, reflecting a smaller discrepancy between actual fiscal expenditure and initial forecasts. The balance deviation stood at -€818 million, representing a favourable trend compared with the figure of -€1,569 million recorded in 2024. This development resulted largely from the performance of revenue, whose deviation from the initial budget, although negative (-3.7%), was less pronounced than in the previous year (-4.7%). Expenditure, in turn, showed a positive deviation of +1.3%, which was also lower than that recorded in 2024 (+5.7%). Nevertheless, the combination of lower-than-expected revenue and higher-

than-budgeted expenditure contributed to a more negative balance than estimated in the 2025 State Budget (Chart 22, right-hand panel).

Chart 22 – Trends in fiscal deviations in the National Health Service



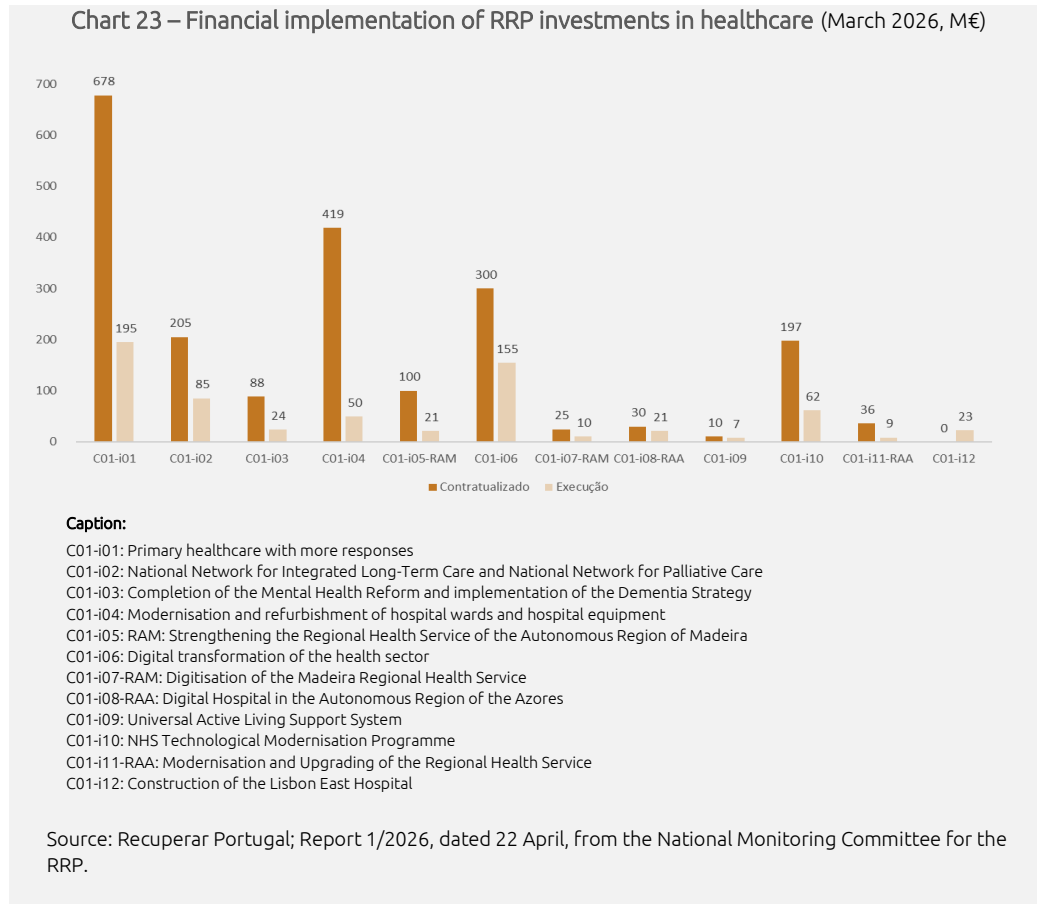
Source: ACSS. | Note: The 2025 figures are provisional. The deviation is calculated as the difference between the actual figure and the budgeted figure. Thus, a positive deviation indicates that the actual figure exceeded the budgeted figure, whilst a negative deviation indicates that the actual figure fell short of the budgeted figure.

Box 2 – Progress report on the implementation of the RRP in the health sector

The Health component of the RRP was initially allocated 1.4 thousand M€, and has been subject to successive increases as part of the reprogramming measures approved in the meantime. In March 2026, the allocation stood at 2 mil M€. However, by that date, financial implementation amounted to only around 661 M€, equivalent to approximately 32% of the planned allocation. The reprogramming proposal presented in March 2026 also provides for a slight reduction in the allocation for this component.

According to Report No. 1/2026 of the National Monitoring Committee for the Recovery and Resilience Plan (CNAPRR), the investments deemed most critical are concentrated in Primary Healthcare, Long-Term and Palliative Care, and hospital modernisation – precisely the areas where implementation was lowest in March 2026, at 29 per cent, 41 per cent and 12 per cent, respectively (Chart 23). In the case of primary healthcare, 100 new healthcare facilities and the modernisation of 392 existing facilities were planned, but only 92 of the 492 planned interventions were considered ‘substantially completed’ by March 2026. The same report identifies various constraints to implementation, notably delays in public procurement, successive project revisions, fragmented governance and a shortage of human resources. The CNAPRR also warns of the risk of merely formal compliance with the targets, without this being fully reflected in structural improvements to the NHS’s response capacity.

Furthermore, concerns remain regarding the operational sustainability of the investments made, since the physical completion of infrastructure alone does not always guarantee that it will actually become operational; this depends on operating and maintenance costs and the ability to recruit healthcare professionals. Indeed, this is a weakness that links the investment funded by the RRP to the pressures on current expenditure previously analysed in this chapter.



2.4 Concluding remarks

In 2025, funding for the NHS continued to rely, almost entirely, on transfers from the State Budget and capital injections. This is a characteristic of the Portuguese Beveridgean model, which in itself need not constitute a weakness, provided that the correct economic incentives are put in place, enabling the costs of healthcare to be known at all times and appropriate management mechanisms to be devised to anticipate and control them. Added to this are the emerging challenges associated with the structural growth in healthcare expenditure, driven by an ageing population, technological innovation and increased demand for care. In this context, and taking into account the average annual growth in public healthcare expenditure of 6.5% between 2016 and 2025, it is important to strengthen the predictability and sustainability of the National Health Service's (SNS) funding model through more robust multi-annual planning and, possibly, greater diversification of funding sources in the medium and long term. A more robust medium-term financial framework could help to increase the predictability of funding allocated to the health sector, promote greater alignment between healthcare objectives and available resources, and reduce dependence on extraordinary capital injections that have influenced the NHS's fiscal cycle.

The sustained growth in NHS expenditure, particularly in the areas of staff costs and hospital medicines, continues to pose a significant challenge to the financial sustainability of the system and public finances. This pressure stems from the aforementioned structural and external factors, such as an ageing population and increasing therapeutic complexity, compounded by internal policy considerations, e.g.

measures to enhance the career prospects of healthcare professionals. In this context, the multi-year agreements concluded with various professional groups, as well as the expansion of Model B Family Health Units (USF) and the continued recruitment of healthcare professionals, are likely to continue to exert pressure on expenditure in the coming years, notwithstanding the genuine need for these measures. On the other hand, the reorganisation of the NHS through the widespread introduction of Local Health Units (ULS) could, in the medium term, help to strengthen the integration of care, improve the planning of activities and promote efficiency gains in the use of available resources.

The financial sustainability of the NHS also depends on strengthening the management capacity and ensuring the stability of governance within health sector bodies.

Management models based on criteria of technical competence, experience and accountability promote a more efficient use of public resources and greater predictability in fiscal implementation. Given the high operational complexity of hospital organisations, the continuity of management teams and the strengthening of performance monitoring and evaluation tools are of particular importance.

Strengthening the public financial management tools provided for in the Fiscal Framework Law is crucial to the sustainability of the NHS. The provision of more robust and systematic information on costs, through management accounting, allows for a more accurate assessment of the cost of activities carried out and enables comparisons between organisations with similar characteristics. As well as supporting budgeting that is more closely aligned with healthcare objectives, these tools are also essential for promoting regular reviews of expenditure, identifying inefficiencies and informing decisions on the allocation of public resources in the health sector. In this context, it is important to highlight the progress made in implementing management accounting within the NHS, notably through the entry into force in 2025 of the Analytical Accounting Plan for Local Health Units (ULS) and Specialised Hospitals (IPO)³⁶, accompanied by regular reporting and monitoring mechanisms coordinated by the ACSS.

Digitalisation plays a central role in the modernisation of the NHS, with the potential to enhance operational efficiency, improve the integration of clinical information and support the provision of more personalised care. In 2025, the RRP continued to play a significant role in financing investments linked to the digital transition in healthcare, including the modernisation of information systems, data interoperability and the technological renewal of equipment and infrastructure. However, the delays observed in the implementation of various investments, as previously noted, highlight the persistence of constraints in bringing these reforms to fruition, and postpone the realisation of the expected gains in the NHS's responsiveness and efficiency.

³⁶ Analytical Accounting Plan for Local Health Units (ULS) and Public Health Institutes (IPO), published by the ACSS via [Regulatory Circular No. 20/2024 of 21 June](#).

Box 3 – Evolution of the NHS's financial position, 2017–2024

An analysis of the NHS's financial situation would benefit from consideration of its balance sheet position, particularly in a context characterised by recurring deficits, successive capital injections by the State and the accumulation of short-term liabilities. The unavailability of the 2025 consolidated balance sheet prevents this analysis. To illustrate the additional information provided by this instrument, the evolution of the main balance sheet aggregates of the NHS between 2017 and 2024 is presented (Table 7). It should also be borne in mind that the 2024 figures were influenced by the institutional reorganisation of the SNS, linked to the creation of the ULS and the abolition of the ARS, the accounting impact of which was not fully reflected in the consolidated accounts at the end of the financial year.

Table 7 – Changes in the main items of the SNS's consolidated balance sheet
(€m, unless otherwise stated)

Rubricas do balanço	2017	2018	2019	2020	2021	2022	2023	2024
Ativo não corrente	2 407	2 388	2 410	2 518	2 613	2 809	2 822	2 863
Ativo corrente	2 292	1 709	1 707	2 316	2 578	2 570	2 774	2 868
Ativo total	4 699	4 097	4 117	4 834	5 191	5 379	5 596	5 731
Património líquido	319	308	171	678	562	518	1 017	586
Passivo não corrente	157	223	394	455	353	403	442	465
Passivo corrente	4 223	3 567	3 552	3 701	4 276	4 458	4 137	4 680
Passivo total	4 380	3 789	3 946	4 156	4 629	4 861	4 579	5 145
Indicadores								
Autonomia Financeira	6,8%	7,5%	4,2%	14,0%	10,8%	9,6%	18,2%	10,2%
Grau de endividamento	93,2%	92,5%	95,8%	86,0%	89,2%	90,4%	81,8%	89,8%
Liquidez geral	0,54	0,48	0,48	0,63	0,60	0,58	0,67	0,61
Peso do passivo corrente	96,4%	94,1%	90,0%	89,0%	92,4%	91,7%	90,3%	91,0%

Source: ACSS, Reports and Accounts of the Ministry of Health and the National Health Service, 2017–2024, and CFP calculations.

The information available for the period 2017–2024 shows an increase in the National Health Service's (SNS) balance sheet, with total assets rising from 4.7 thousand M€ to 5.7 thousand M€ and liabilities from 4.4 thousand M€ to 5.1 thousand M€. Although net assets showed a favourable trend over the period analysed, reaching 586 M€ in 2024, the NHS's financial autonomy remained low, even though it increased from 6.8% in 2017 to 10.2% in 2024. Conversely, the debt ratio fell from 93.2% to 89.8%, whilst remaining at high levels.

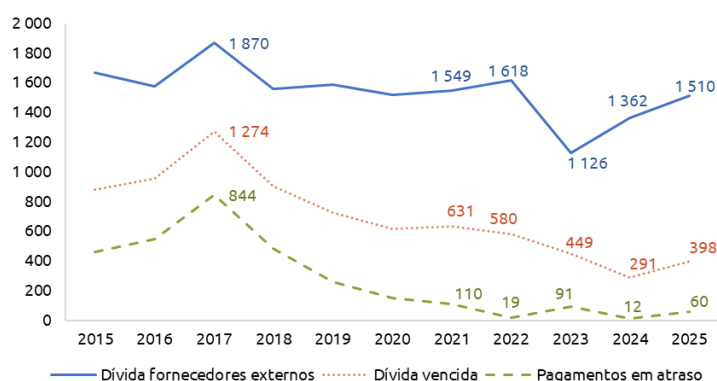
Analysis of the balance sheet also allows us to identify key features of the NHS's financial structure that are not apparent from the NHS's fiscal implementation. In particular, liabilities were heavily concentrated in short-term liabilities, with current liabilities accounting for around 91 per cent of total liabilities in 2024. Furthermore, the overall liquidity ratio stood at 0.61, indicating that current assets were insufficient to fully cover short-term liabilities. These characteristics highlight the importance of balance sheet analysis in assessing the risks associated with liquidity, the accumulation of debt to suppliers and the ability to meet financial obligations on time.

3. DEBT AND AVERAGE PAYMENT TERMS

The NHS's debt to external suppliers rose again in 2025, reflecting the continuing financial pressures on the system. In 2025, this debt rose by €148 million compared with the previous year, reaching €1.5 billion. This increase resulted both from a rise in overdue debt of €107 million and in debt due to fall due of €41 million (Chart 24).³⁷

Consequently, the National Health Service's (SNS) arrears worsened in 2025, highlighting the continuing difficulties in settling financial obligations on time. Arrears totalled €60 million at the end of 2025, representing an increase of €48 million compared with 2024. The fact that liabilities continue to show a pattern of deterioration, despite the revenue received from the State and allocated to the EPEs, confirms that these funds have proved insufficient to keep pace with the accumulation of liabilities. In this context, there remains a need to improve management efficiency, notably by streamlining payment processes and ensuring greater transparency, as well as by strengthening supervision, management control and the treasury function within NHS entities. At the same time, it is important to ensure greater coordination between operational planning, fiscal programming and actual financing needs, promoting a better alignment of revenue transfers from the State to the NHS with the time profile of expenditure, so as to reduce the recurrence of situations of financial imbalance.

Chart 24 – Trends in debt and arrears (M€)

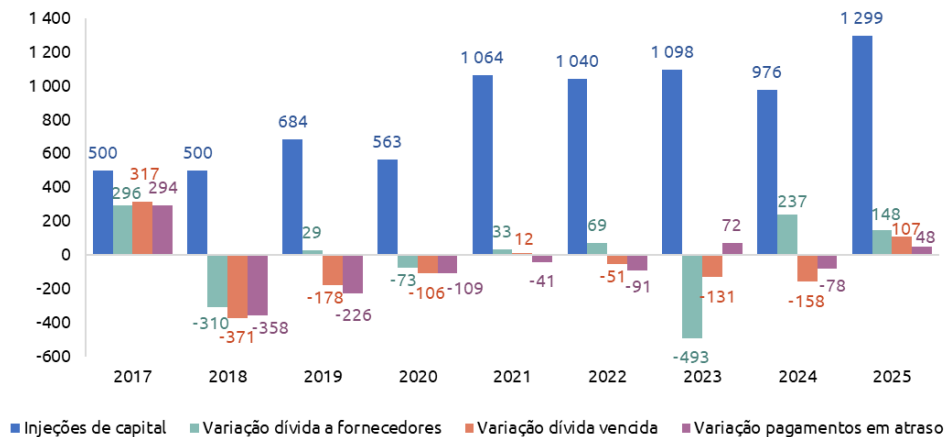


Source: ACSS.

³⁷ SNS entities report three types of debt owed to entities outside the public administration: i) debt to suppliers; ii) overdue debt; and iii) payments in arrears. Debt to external suppliers comprises debt due (for which the payment period is still ongoing) and overdue debt (for which the agreed payment period has already expired). The latter also includes payments in arrears, which are defined as overdue debt where the payment deadline expired more than 90 days ago (Article 3(e) of [Law No. 8/2012](#) of 21 February, as currently worded).

As in previous years, further capital injections were made into the NHS in 2025 to settle debts owed to external suppliers.³⁸ These capital injections granted by the State to SNS entities amounted to 1299 M€ in 2025, compared with 976 M€ in 2024. Even so, this measure continued to prove insufficient to ensure a structural reduction in the NHS's debt. Although the growth in debt to external suppliers slowed in 2025, increasing by €148 million compared with the €237 million recorded in 2024, it continued to follow an upward trajectory (Chart 25).

Chart 25 – Capital injections and change in debt (M€)



Source: ACSS.

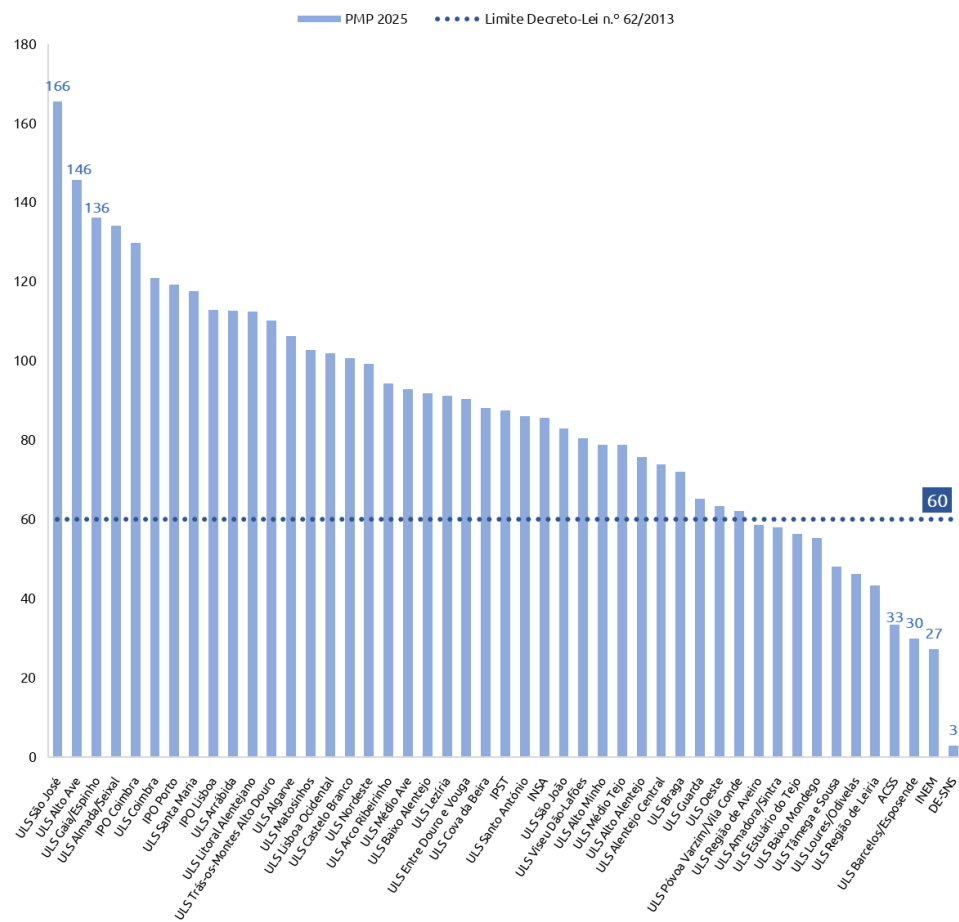
In 2025, the average payment period³⁹ for NHS organisations stood at 95 days,⁴⁰ representing a deterioration of 18 days compared with the previous year. Of the 47 organisations that make up the NHS, only 11 (23.4%) met the target of keeping the average payment period (PMP) below 60 days, as stipulated in [Decree-Law No. 62/2013](#) of 10 May, applicable to public healthcare providers (Chart 26). In contrast, 36 organisations (76.6%) exceeded the established limit.

³⁸ Increases in authorised capital and other equity instruments, aimed primarily at settling liabilities, in particular overdue debts to suppliers with a payment term exceeding 90 days.

³⁹ The average payment period to suppliers is calculated and published by National Health Service (SNS) bodies, in accordance with the applicable regulations, namely [Council of Ministers Resolution No. 34/2008](#) of 22 February; [Council of Ministers Resolution No. 191-A/2008](#) of 27 November; [Order No. 9870/2009](#) of 6 April, published in the 2nd Series of the Diário da República on 13 April. Each year, the decree-laws on the implementation of the State Budget also set out requirements regarding payment terms (PMPs). Information on the different payment terms of National Health Service (SNS) bodies is available [online](#). Cases where the payment periods of public bodies providing healthcare exceed 60 days are subject to statutory interest on late payments. Under Article 3(a) of [Decree-Law No 62/2013](#) of 10 May, which transposed [Directive 2011/7/EU](#) of the European Parliament and of the Council of 16 February, a payment delay consists of any failure to pay the amount due within the contractual or statutory time limit, where the creditor has fulfilled their obligations, unless the delay is not attributable to the debtor. This definition corresponds to the concept of overdue debt reported by National Health Service (SNS) bodies, thereby subjecting it to the measures against late payments in commercial transactions established by this Decree-Law.

⁴⁰ In the case of State-Owned Enterprises within the NHS, the average payment period stood at 90 days at the end of 2025, representing a deterioration of 10 days compared with 2024.

Chart 26 – Average payment terms of NHS bodies at the end of 2025 (days)



Source: ACSS. | Notes: PMP stands for average payment period. The meanings of the other abbreviations are set out in the list of bodies comprising the National Health Service (Annex 4.4.).

4. ANNEXES

4.1 Annual trends in healthcare provision within the National Health Service

Table 8 – Primary Health Care (thousands, unless otherwise stated)

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Consultas Médicas	30 475	30 951	30 692	31 184	31 569	32 554	36 038	34 544	33 677	34 051	33 760
Presenciais*	22 468	22 429	21 940	22 238	22 328	14 035	15 888	18 529	18 677	19 231	18 457
Não presenciais	8 007	8 522	8 753	8 946	9 241	18 519	20 150	16 015	15 000	14 820	15 303
Consultas de enfermagem	20 074	19 255	18 756	19 108	19 286	16 507	25 389	18 413	18 080	19 513	20 158
Consultas outros técnicos saúde	359	445	487	587	664	540	728	837	959	1 090	1 250
Índice utilização consultas médicas**	n.d.	0,895	0,828	0,830	0,828	0,740	0,789	0,783	0,772	0,803	0,787
Índice utilização consultas enfermagem**	n.d.	0,774	0,703	0,729	0,742	0,633	0,714	0,656	0,672	0,762	0,770

Source: ACSS. | Notes: * Includes face-to-face medical consultations, home visits and 'urgent' medical consultations (carried out in out-of-hours services and similar settings). | ** The utilisation rate for medical consultations ([indicator 2017.330.01](#)) and nursing care ([indicator 2017.331.01](#)) is calculated by the ACSS, in accordance with the rules set out in [the Information Sheet d entity of the Primary Healthcare Indicators](#).

Table 9 – Hospital Care (thousands, unless otherwise stated)

	EXECUÇÃO						
	2019	2020	2021	2022	2023	2024	2025
Consultas médicas hospitalares	12 420	11 130	12 413	12 779	13 280	14 018	14 358
Primeiras consultas	3 575	2 998	3 517	3 658	3 784	3 953	3 963
Primeiras consultas CTH	1 299	970	1 103	1 244	1 335	1 459	1 441
Outras primeiras consultas	2 230	2 028	2 442	2 483	2 449	2 494	2 523
Consultas subsequentes	8 846	8 132	8 897	9 121	9 496	10 064	10 394
% primeiras consultas total consultas	29%	27%	28%	29%	28%	28%	28%
Doentes saídos internamento	787	676	726	750	768	778	757
Demora média (em dias)	8,6	8,8	8,7	8,8	8,9	8,8	9,0
Taxa ocupação (%)	87%	77%	81%	86%	89%	89%	90%
Intervenções cirúrgicas	704	579	709	759	817	890	904
Cirurgia Programada	603	488	614	662	715	789	803
Cirurgia em ambulatório	399	322	420	462	509	566	585
Cirurgia convencional	204	166	194	200	207	222	218
% Cirurgia em ambulatório	66%	66%	68%	70%	71%	72%	73%
Cirurgia urgente	101	91	95	97	102	102	102
Episódios urgência	6 426	4 553	5 196	6 232	6 193	6 176	5 729
% azuis, verdes e brancos	42%	43%	44%	44%	42%	40%	35%
% Cumprimento tempos triagem	63%	76%	66%	61%	60%	65%	66%
% episódios que originam internamento	8%	10%	9%	8%	8%	8%	8%
Sessões hospital dia	1 326	1 149	1 318	1 456	1 580	1 694	1 817

Source: ACSS, Transparency Portal and Executive Directorate of the NHS. | Note: CTH refers to the 'Consultation on Time and at Scheduled Hours' Programme, in accordance with [Ministerial Order No. 95/2013](#) of 4 March. Data on hospital medical consultations and their components were obtained from the NHS Transparency Portal and may differ from those published in the previous report, which drew its data from the NHS Executive Directorate.

4.2 Annual trend in the implementation of the NHS budget

Table 10 – Annual execution of the NHS budget (M€)

	2019	2020	2021	2022	2023	2024	2025*
Total da Receita	10 099,0	11 209,4	11 303,5	12 267,3	13 618,2	14 378,8	15 926,4
Receita Corrente	10 048,8	11 151,8	11 219,8	12 159,5	13 472,7	14 254,9	15 725,4
Lotarias, apostas mútuas e imposto do jogo	122,9	98,5	108,6	108,6	117,7	109,8	120,2
Taxas moderadoras	178,0	97,4	66,6	45,9	25,8	20,8	16,6
Prestações de serviços e concessões	187,4	148,5	135,6	157,7	187,3	198,5	114,0
Transferências e subsídios correntes obtidos	9 486,3	10 724,3	10 837,2	11 626,8	12 899,6	13 573,4	15 207,7
Outras receitas correntes	74,2	83,1	71,8	220,5	242,3	352,4	266,9
Receita de Capital	50,2	57,6	83,7	107,8	145,5	123,9	201,0
Total da Despesa	10 727,0	11 574,2	12 584,5	13 465,8	14 254,5	15 947,9	16 961,5
Despesa Corrente	10 566,0	11 285,1	12 302,8	13 177,1	13 875,2	15 468,3	16 519,2
Despesas com pessoal	4 410,8	4 743,4	5 072,1	5 423,6	5 816,7	6 663,4	7 165,4
Compras de inventários	1 926,7	2 249,3	2 458,7	2 600,1	2 772,9	3 197,4	3 355,6
Fornecimentos e serviços externos	4 138,0	4 135,3	4 632,5	5 003,6	5 128,3	5 410,6	5 744,0
Serviços de saúde	3 264,3	3 214,4	3 574,1	3 719,2	3 722,7	4 008,4	4 257,8
Meios complementares diagnóstico e terapêutica	968,3	968,1	1 248,7	1 316,0	1 245,0	1 282,5	1 374,1
Produtos vendidos por farmácias	1 434,7	1 471,0	1 548,9	1 739,9	1 714,0	1 819,3	2 055,8
Produtos fornecidos por farmácias hospitalares	0,0	0,0	0,0	0,0	3,9	0,0	0,0
Internamentos	275,1	308,6	303,5	330,9	381,9	440,2	366,9
Contratos e Acordos (sem PPP)	108,5	113,5	115,4	118,5	122,3	130,7	188,9
PPP	416,9	277,7	285,5	145,0	158,4	234,2	221,4
Outros subcontratos de serviços de saúde	60,8	75,5	72,1	68,9	97,2	101,5	50,7
Outros subcontratos	0,5	1,5	1,7	2,3	2,5	1,2	1,0
Fornecimentos e serviços	873,2	919,4	1 056,7	1 282,1	1 403,1	1 401,0	1 485,2
Juros e gastos similares suportados	0,8	0,6	0,8	1,0	0,8	0,8	4,9
Transferências e subsídios concedidos	61,3	145,1	128,2	141,7	148,0	183,4	242,4
Outras despesas correntes	28,4	11,4	10,5	7,1	8,5	12,6	6,9
Despesa de Capital	161,0	289,1	281,7	288,7	379,3	479,6	442,3
Aquisição de bens de capital	158,6	288,4	281,1	287,1	358,7	412,6	338,9
Transferências de capital	2,4	0,7	0,6	1,6	20,6	67,1	103,4
Saldo	-628,0	-364,8	-1 281,0	-1 198,5	-636,3	-1 569,1	-1 035,1
<i>Por memória:</i>							
Injeções de capital	683,6	563,0	1 064,1	1 040,1	1 098,2	975,6	1 299,1

Source: ACSS | Note: * The figures for 2025 are provisional. | Due to rounding, the totals shown may not correspond exactly to the sum of the individual figures.

4.3 Entities comprising the NHS in 2025

Entidade	Sigla	Natureza	Tipo
1 Administração Central do Sistema de Saúde, I.P.	ACSS	SPA	SPA
2 Direção Executiva do Serviço Nacional de Saúde, I.P.	DE-SNS	SPA	SPA
3 Instituto Nacional de Emergência Médica I.P.	INEM	SPA	SPA
4 Instituto Nacional Saúde Dr. Ricardo Jorge - Lisboa	INSA	SPA	SPA
5 Instituto Português de Oncologia de Coimbra, E.P.E.	IPO Coimbra	EPE	IPO
6 Instituto Português de Oncologia de Lisboa, E.P.E.	IPO Lisboa	EPE	IPO
7 Instituto Português de Oncologia do Porto, E.P.E.	IPO Porto	EPE	IPO
8 Instituto Português de Sangue e da Transplantação, IP	IPST	SPA	SPA
9 Unidade Local de Saúde da Arrábida, E.P.E.	ULS Arrábida	EPE	ULS
10 Unidade Local de Saúde da Cova da Beira, E.P.E.	ULS Cova da Beira	EPE	ULS
11 Unidade Local de Saúde da Guarda, E.P.E.	ULS Guarda	EPE	ULS
12 Unidade Local de Saúde da Lezíria, E. P. E	ULS Lezíria	EPE	ULS
13 Unidade Local de Saúde da Região de Aveiro, E.P.E.	ULS Região de Aveiro	EPE	ULS
14 Unidade Local de Saúde da Região de Leiria, E.P.E.	ULS Região de Leiria	EPE	ULS
15 Unidade Local de Saúde de Almada-Seixal, E.P.E.	ULS Almada / Seixal	EPE	ULS
16 Unidade Local de Saúde de Amadora/Sintra, E.P.E.	ULS Amadora/Sintra	EPE	ULS
17 Unidade Local de Saúde de Barcelos/Esposende, E.P.E.	ULS Barcelos / Esposende	EPE	ULS
18 Unidade Local de Saúde de Braga, E.P.E.	ULS Braga	EPE	ULS
19 Unidade Local de Saúde de Castelo Branco, E.P.E.	ULS Castelo Branco	EPE	ULS
20 Unidade Local de Saúde de Coimbra, E.P.E.	ULS Coimbra	EPE	ULS
21 Unidade Local de Saúde de Entre Douro e Vouga, E.P.E.	ULS Entre Douro e Vouga	EPE	ULS
22 Unidade Local de Saúde de Gaia/Espinho, E.P.E.	ULS Gaia / Espinho	EPE	ULS
23 Unidade Local de Saúde de Lisboa Ocidental, E.P.E.	ULS Lisboa Ocidental	EPE	ULS
24 Unidade Local de Saúde de Loures-Odivelas, E.P.E.	ULS Loures/Odivelas	EPE	ULS
25 Unidade Local de Saúde de Matosinhos, E.P.E.	ULS Matosinhos	EPE	ULS
26 Unidade Local de Saúde de Santa Maria, E.P.E.	ULS Santa Maria	EPE	ULS
27 Unidade Local de Saúde de Santo António, E.P.E.	ULS Santo António	EPE	ULS
28 Unidade Local de Saúde de São João, E.P.E.	ULS São João	EPE	ULS
29 Unidade Local de Saúde de São José, E.P.E.	ULS São José	EPE	ULS
30 Unidade Local de Saúde de Trás-os-Montes e Alto Douro, E.P.E.	ULS Trás-os-Montes Alto Douro	EPE	ULS
31 Unidade Local de Saúde de Viseu Dão-Lafões, E.P.E.	ULS Viseu Dão-Lafões	EPE	ULS
32 Unidade Local de Saúde do Alentejo Central, E.P.E.	ULS Alentejo Central	EPE	ULS
33 Unidade Local de Saúde do Algarve, E.P.E.	ULS Algarve	EPE	ULS
34 Unidade Local de Saúde do Alto Alentejo, E.P.E.	ULS Alto Alentejo	EPE	ULS
35 Unidade Local de Saúde do Alto Ave, E.P.E.	ULS Alto Ave	EPE	ULS
36 Unidade Local de Saúde do Alto Minho, E.P.E.	ULS Alto Minho	EPE	ULS
37 Unidade Local de Saúde do Arco Ribeirinho, E.P.E.	ULS Arco Ribeirinho	EPE	ULS
38 Unidade Local de Saúde do Baixo Alentejo, E.P.E.	ULS Baixo Alentejo	EPE	ULS
39 Unidade Local de Saúde do Baixo Mondego, E.P.E.	ULS Baixo Mondego	EPE	ULS
40 Unidade Local de Saúde do Estuário do Tejo, E.P.E.	ULS Estuário do Tejo	EPE	ULS
41 Unidade Local de Saúde do Litoral Alentejano, E.P.E.	ULS Litoral Alentejano	EPE	ULS
42 Unidade Local de Saúde do Médio Ave, E.P.E.	ULS Médio Ave	EPE	ULS
43 Unidade Local de Saúde do Médio Tejo, E.P.E.	ULS Médio Tejo	EPE	ULS
44 Unidade Local de Saúde do Nordeste, E.P.E.	ULS Nordeste	EPE	ULS
45 Unidade Local de Saúde do Oeste, E.P.E.	ULS Oeste	EPE	ULS
46 Unidade Local de Saúde do Tâmega e Sousa, E.P.E.	ULS Tâmega e Sousa	EPE	ULS
47 Unidade Local de Saúde Póvoa de Varzim/Vila do Conde, E.P.E.	ULS Póvoa Varzim/Vila Conde	EPE	ULS

Notes: EPE = Public Enterprise; SPA = Entity within the Public Administrative Sector; IPO = Portuguese Institute of Oncology; ULS = Local Health Unit .

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