# Portugal

## Health system summary 2024

European Observatory on Health Systems and Policies
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**This Health System Summary is based on the *Portugal: Health System Review* (HiT) published in 2017 but is significantly updated, including data, policy developments and relevant reforms as highlighted by the Health Systems and Policies Monitor (HSPM) (www.hspm.org). For this edition of the Summary, key data have been updated to those available in September 2024 unless otherwise stated. Health System Summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.**

**Main sources:**

Simões J, Augusto GF, Fronteira I, Hernández-Quevedo C. Portugal: Health system review. *Health Systems in Transition*; 2017; 19(2): 1–184.

Health Systems and Policy Monitor (HSPM) – Portugal (2024). European Observatory on Health Systems and Policies, https://eurohealthobservatory.who.int/monitors/health-systems-monitor.

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# How is the health system organized?

The National Health Service is universal and co-exists with special health insurance schemes serving particular segments of the population

## Organization

Portugal has a predominantly tax-based health system with universal coverage. The National Health Service (NHS) co-exists with two other systems: the special health insurance schemes for particular professions or sectors (such as civil servants, military personnel, the police and employees at banks and insurance companies), called the Health Subsystems; and private voluntary health insurance (VHI). The Azores and Madeira, as autonomous regions, have broad powers for their own health care systems.

A new NHS Statute passed in 2022 established the NHS Executive Directorate, tasked with management and coordination across the different elements of the NHS and overseeing the implementation of the National Health Plan 2021–2030 with other health system bodies. It also established intermediate management structures (Local Health Systems) aimed at promoting the coordination of health care providers locally and managing NHS resources.

The Ministry of Health consolidates most planning, monitoring, guidance and regulatory activities (also see Box 1). Further reforms to the organization of the NHS in September 2024 abolished the five Regional Health Administrations that used to manage and deliver health care services and transferred a wide range of functions to the NHS Executive Directorate. These functions include the regional planning of the NHS workforce, monitoring infrastructure funding and the management of primary care, including the implementation and development of Family Health Units (FHUs) (see Section on Primary and ambulatory care).

Municipalities also hold some health sector responsibilities. These include managing and investing in primary care infrastructure and overseeing programmes that promote healthy lifestyles.

**Box 1** Capacity for policy development and implementation

The new Health Basic Law (2019), followed by the new statutes of the NHS (2022) initiated a series of reforms in the health sector that are aligned with the overall reform framework for the country and the national Recovery and Resilience Plan. The creation of the NHS Executive Directorate (2022) has led to the revision of the role and functions of several institutions in the health sector. This has created a momentum for innovation that can positively influence the efficiency of the health system and the pursuit of a more equitable, person-centred and integrated provision of health services. The new roles of the institutions within the Ministry of Health are being defined. Concurrently, the expansion of the Local Health Units model (see subsection on Primary and ambulatory care) has also created the opportunity to upgrade management practices and the integration of primary and hospital care, as well as contributing to the reform of public health services.

## Planning

Overall planning and regulation take place largely at the central level by the Ministry of Health and its institutions. Under the new structural changes, the operational management of the NHS, along with many regional planning functions, take place through the NHS Executive Directorate.

A comprehensive, long-term National Health Plan for 2021–2030 was approved in 2023 (with delays due to the COVID-19 pandemic). Its primary goal is to promote a sustainable health system, with key objectives focusing on reducing inequalities in population health, addressing behavioural risk factors such as smoking and obesity, and effectively managing major communicable and noncommunicable diseases. It also encompasses emergency preparedness, looking at potential risk scenarios such as those associated with climate change or epidemiological threats. A Monitoring and Evaluation Plan as well as a Strategic Communication Plan will support the implementation of the National Health Plan.

## Providers

Primary and hospital care are delivered by a mix of public and private providers, with general practitioners (GPs) acting as gatekeepers to specialist and secondary care. The NHS predominantly provides primary care and acute general and specialized hospital care. Dental consultations, diagnostic services, renal dialysis and rehabilitation are more commonly provided in the private sector (but with public funding to a considerable extent) under contractual arrangements with the NHS. The creation of Family Health Units in 2007 and Primary Healthcare Centre Groups in 2008 restructured the organization of Portuguese primary care in order to provide more integrated primary care for the local population. In the hospital sector, NHS public hospitals make up just under half (112) of all hospitals (243). Among the not-for-profit private operators are charitable institutions known as *Misericórdias*, which have agreements to provide services (through their 24 hospitals and 120 nursing homes) to both the NHS and the Health Subsystems.

# How much is spent on health services?

Health spending has gradually increased, although it remains below the EU average. Out-of-pocket payments currently contribute nearly a third of health financing while Voluntary Health Insurance also plays a role.

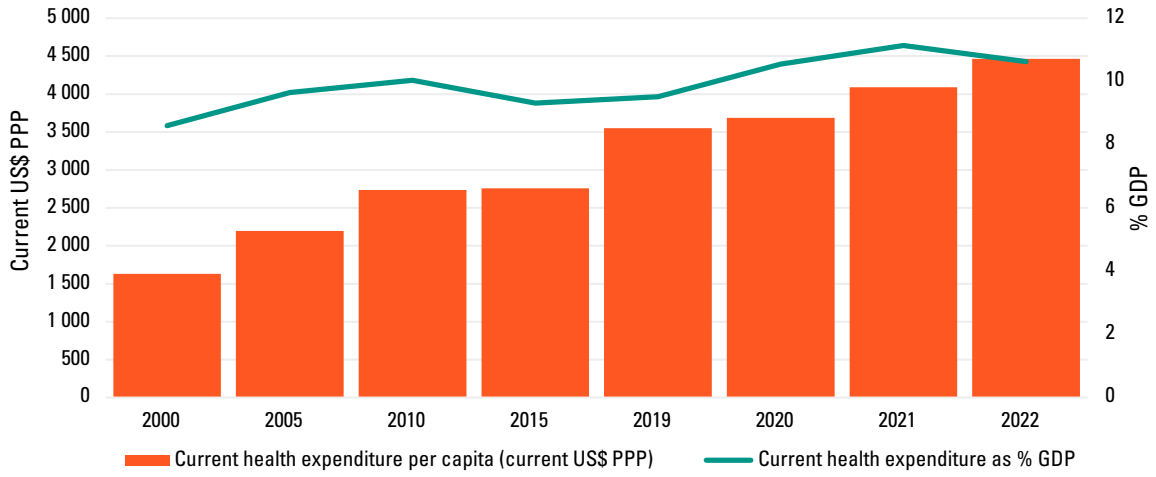
## Funding mechanisms

The NHS is predominantly funded through general taxation via a transfer from the state budget. The Health Subsystems, which provide either comprehensive or partial health care coverage for approximately 35% of the population, are financed mainly through employee and employer contributions, including the national government as an employer. Voluntary Health Insurance (VHI) is funded through the premiums paid by policy holders.

# Health expenditure

Per capita, health spending in Portugal has increased over the past two decades (Fig. 1). In 2022, current health expenditure represented 10.6% of GDP, which amounted to US$ PPP 4464 per capita, below the average for EU/European Economic Area (EEA) countries and the United Kingdom (Fig. 2). Health expenditure from public sources accounted for 62% of the total, well below the EU average of 81%. Private expenditure on health is mostly driven by out-of-pocket (OOP) payments by households (see below). Private (voluntary) health insurance also plays a role in financing, representing around 8% of health expenditure in 2022.

**Fig. 1** Trends in health expenditure, 2000–2022 (selected years)




**Note:** PPP: purchasing power parity.

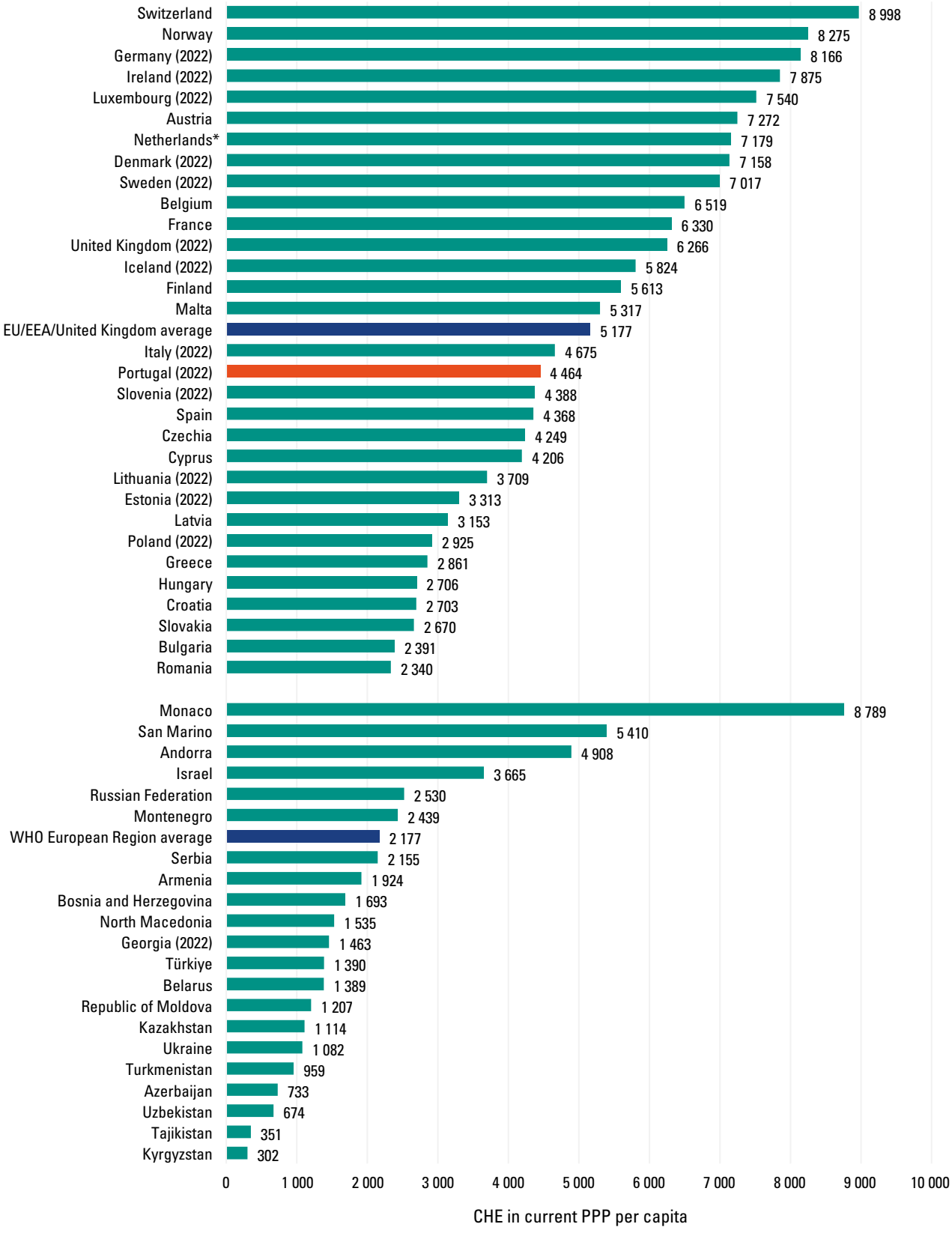
**Source:** WHO, 2024.

# Out-of-pocket payments

The share of OOP payments has been stable over the past decade and accounted for 30% of total health spending in 2022, which is double the average among EU countries (15%). In 2022, OOP spending was related mainly to outpatient medical care (54% of total OOP payments), pharmaceuticals (22%), and inpatient hospital care (10%) (Fig. 3). Until 2022 there were two types of cost-sharing: fixed-rate charges payable for most services within the NHS, including consultations (primary care and out-patient visits), emergency visits, diagnostic tests and therapeutic procedures; and co-insurance (a varying percentage of the cost) for pharmaceuticals covered by the NHS and for other health insurance arrangements (subsystems and VHI). Moreover, a considerable portion of the population opt to purchase outpatient care directly from private providers, in some cases motivated by long waiting lists for consultations in certain medical specialties.

In recent years, exemptions from the fixed-rate user charges had been extended to a number of groups, including those experiencing economic hardship, unemployed people, pregnant women, children under 18 years of age and for certain patient groups. In 2020, the government removed the flat-rate charges for primary care and NHS-prescribed services while in 2022 all flat-rate charges within the NHS were abolished, except for visits to hospital emergency departments without a referral (from a health centre or the NHS 24 hour telephone line) or which do not require a hospital admission afterwards.

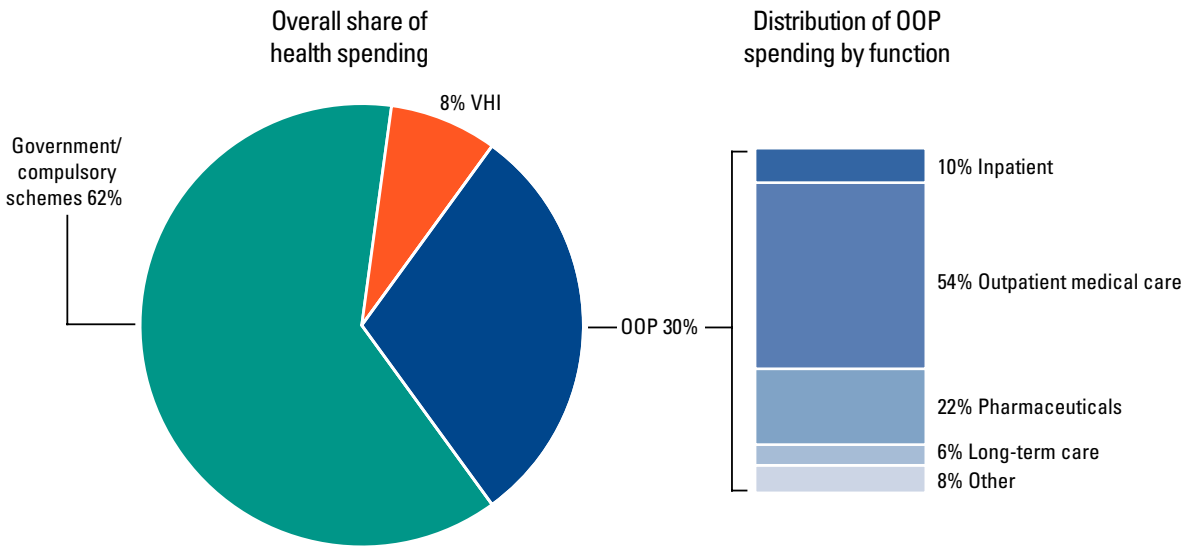
**Fig. 2** Current health expenditure (US$ PPP) per capita in WHO European Region countries, 2021 or latest available year




**Notes:** CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity. *Note that Netherlands (Kingdom of the) comprises six overseas countries and territories and the European mainland area. As data for this report refer only to the European territory, the report refers to it as the Netherlands throughout.

**Source:** WHO, 2024.

**Fig. 3** Composition of out-of-pocket payments, 2022




**Notes:** OOP: out-of-pocket; VHI: voluntary health insurance.
**Source:** OECD, 2024

## Coverage

Eligibility for care under the NHS is based on residency and includes asylum seekers and migrants in the process of regularizing their legal status. Unemployed people, dependent family members and retirees are still covered by the health system even though they may not pay taxes or social security contributions. The benefits package is broad, encompassing most primary, diagnostic, secondary and emergency care services; however, there is relatively little coverage for optical care and adult dental care (Box 2).

**Box 2** What are the key gaps in coverage?

The NHS has been able to provide universal and comprehensive health coverage with a broad benefits package. The exception is dental care, which is mainly based on private providers and funded by individuals. In order to increase access to publicly-funded dental services within some primary care facilities, a National Programme for Oral Health Promotion was launched in 2008. It operates via a voucher system allowing voucher holders to receive regular check-ups and preventive treatments free of charge. The Programme was expanded in 2021 and eligible individuals now include all children aged 4 and those aged between 7 and 18 years old, pregnant women, people with HIV/AIDS and other vulnerable groups.

Although flat-rate user charges have been abolished (since 2022), cost-sharing is still in place for pharmaceuticals, while long waiting times continue to drive direct OOP payments by households, particularly for privately provided outpatient services.

## Paying providers

Several payment mechanisms are used to reimburse providers (Box 4). Primary care providers within the NHS are paid using a combination of salary, fee-for-service and pay-for-performance depending on the type of unit; for example Model B and Model C Family Health Units (FHUs) have payment structures that include performance and quality-based financial incentives while Model B FHUs do not. NHS outpatient services

are paid according to risk-adjusted capitation and pay-for-performance components, while risk-adjusted capitation was introduced in all Local Health Units, which are responsible for integrating primary and hospital care services, in 2024. Hospitals are paid mainly via case-based payments (diagnosis-related groups).

**Fig. 4** Provider payment mechanisms in Portugal

| GPs | Specialists | Acute hospitals | Hospital outpatient services | Dentists | Pharmacies |
|---|---|---|---|---|---|
| Salary and performance-based incentives (NHS primary care units)<br>Fee for service (subsystems and other) | Salary and financial incentives (NHS)<br>Fee for service (subsystems and other) | Case payments (DRGs) | Pay-for-performance and risk-adjusted capitation | Fee for service | Fee for service |

**Notes:** DRG: diagnosis-related group; GP: general practitioner; NHS: National Health Service.

# What resources are available for the health system?

Initiatives for the strategic planning of the health workforce are underway in order to strengthen forecasting and address capacity needs

## Health professionals

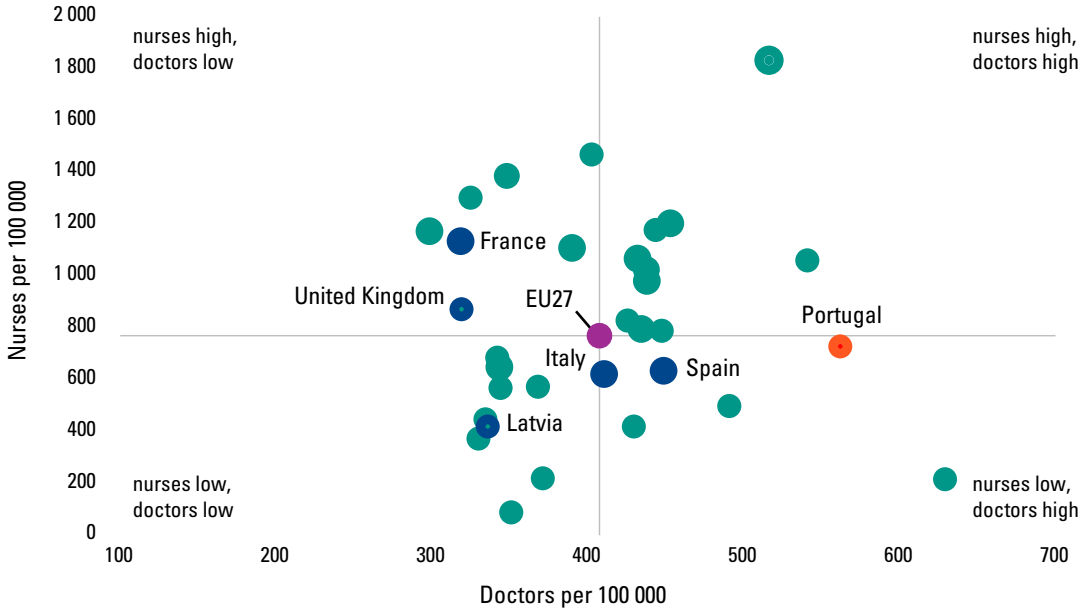
The number of doctors in Portugal has grown steadily over the past two decades and was higher than the EU average, at 562 physicians per 100 000 population in 2021 (Fig. 5). However, this is partly because all doctors who are licensed to practise are recorded in the data, rather than just those who are professionally active, leading to an overestimation. Compared to many other European countries, a much larger proportion of doctors in Portugal (53%) are general practitioners but there are still shortages recorded for GPs working in public facilities.

Despite a growth of around 30% in the number of practising nurses since 2010, Portugal had a lower number of 728 nurses per 100 000 population in 2021 compared to the EU average of 770. Some of the reasons contributing to lower nurse numbers

include relatively low pay, stressful working conditions and limited career prospects, the emigration of nurses to work in other countries (particularly Spain, Switzerland and the United Kingdom) and stagnating numbers of nursing graduates over the past decade. To address some nurse retention issues, in 2022 the government reinstated the nurses' salary progression scheme and began recruitment of approximately 1900 specialist nurses and nurse managers (OECD/European Observatory on Health Systems and Policies, 2023).

In 2023 the government established several initiatives aimed at strengthening planning and strategic management of human resources within the NHS, including an inventory of existing workforce capacity, studies on human resources gaps and the development of the Human Resources in Health (HRH) Information System.

**Fig. 5** Practising nurses and physicians per 100 000 population, 2021



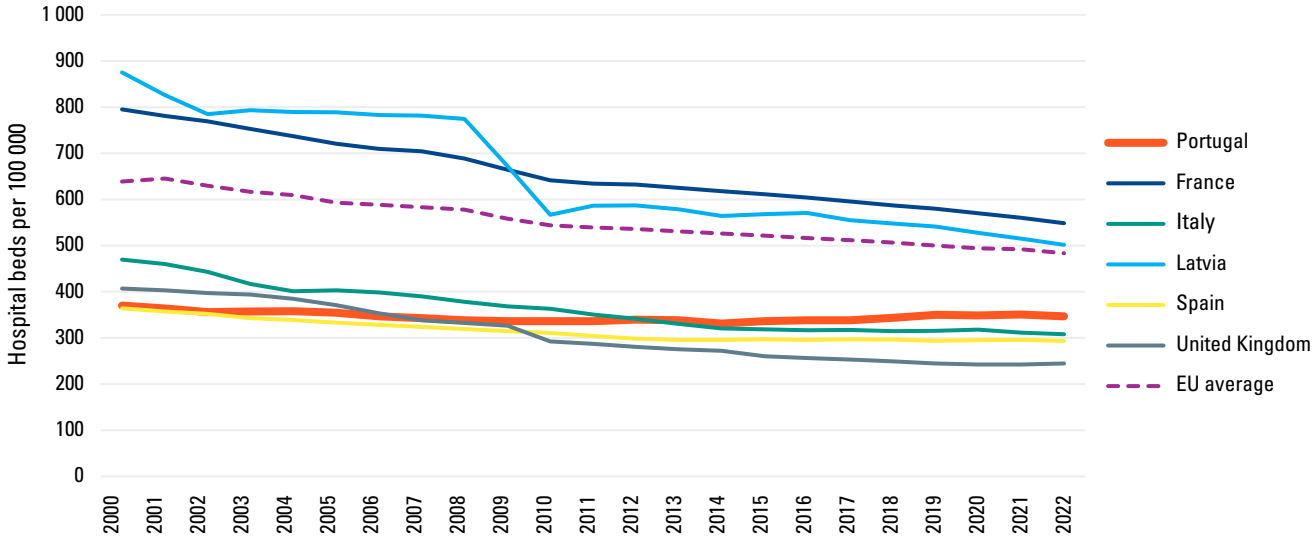

**Notes:** In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. around 30% in Portugal). The internationally reported data for nurses in Portugal also refer to the number of nurses licensed to practise (with EU-recognized qualification) and not those actually practising.
**Sources:** Eurostat, 2024; OECD, 2024 for United Kingdom.

## Health infrastructure

Portugal has 243 hospitals, with 112 of these being public hospitals run by the NHS and which account for around two thirds of the country's inpatient capacity (INE, 2024a). The density of hospital beds has remained fairly stable over the last two decades and did not increase during the years of the COVID-19 pandemic, as the existing bed stock was sufficient to deal with the health emergency. Hospital bed numbers are relatively low, registering at 348 beds per 100 000 population in 2022, compared to 485 beds per 100 000 across the EU (Fig. 6). Of these, the majority are curative (acute) care beds (330 beds per 100 000 population).

Data for the number of magnetic resonance imaging (MRI) units and computerized tomography (CT) scanners in Portugal only covers equipment available in hospitals (Fig. 7). The number of these hospital-based units has increased over the last 10 years, with MRI units increasing more substantially from 7.2 units per 1 million population in 2015 to 12.3 per 1 million in 2022 while CT scanners rose from 16.0 per 1 million population to 18.2 per 1 million population during the same period.

**Fig. 6** Hospital beds per 100 000 population in Portugal and selected countries, 2000–2022




**Sources:** Eurostat, 2024; OECD, 2024 for United Kingdom.

**Fig. 7** Magnetic resonance imaging (MRI) and computed tomography (CT) scanners in Portugal, per 100 000 population, 2022

| | MRI scanners per million population | CT scanners per million population |
|---|---|---|
| Portugal | 12.3 | 18.2 |

**Note:** Data cover only units operating in hospitals.
**Source:** OECD, 2024.

## Distribution of health resources

The majority of both public (NHS) and private hospitals are located in the Northern, Central and Lisbon Regions, accounting for 80% of all hospitals. The distribution of primary care centres varies across regions and districts, with the highest number in Lisbon and Oporto, but almost all of the population lives within 30 minutes from a primary care facility. However, not all facilities are allocated the same level of human resources and thus a patient may live close to a primary care unit but not be registered with a GP. Health workers in Portugal are concentrated in the coastal areas and greater Lisbon and Oporto while the region of Alentejo has the lowest densities of NHS doctors and nurses as well as dentists. A new medical training programme known as More Doctors was launched in 2024, providing salary and housing benefits to attract young doctors to hospitals in sparsely populated districts.

# How are health services delivered?

Efforts to promote greater integration of care between primary care and hospital-level services have been reinvigorated under NHS reform initiatives

## Public health

Currently, the organization of public health services, including the public health surveillance system, is the responsibility of the Directorate-General of Health (DGH) of the Ministry of Health. The DGH is in charge of designing the programmes, defining strategies and approving national plans. At the regional level, public health units (based in Local Health Units), as well as GPs undertake health promotion and prevention activities as part of their work, including family planning, antenatal services and screening programmes.

The NHS is responsible for implementing the National Immunization Programme which includes the most important vaccines as defined by the DGH (according to the epidemiology of disease in Portugal) for protecting population health. Vaccination is strongly advised but not mandatory. People can be vaccinated in local primary care units; vaccines that are included in the national programme are free for all NHS users.

## Primary and ambulatory care

Primary health care within the NHS is delivered through the national network of Primary Healthcare Centre Groups, which mainly comprise Family Health Units (FHUs) of autonomous multidisciplinary teams including GPs, nurses and other health care professionals that provide primary care services for target populations (see also Box 3). Personalized Health Care Units (PHCUs) which are group practices that predated the reform that established the FHUs (in 2007) also deliver primary care services. Additionally, some primary care services are delivered through community care units, which provide care to groups with special needs, including psychosocial support and home care services for older people. Private clinics outside of the NHS and healthcare organizations under the Health Subsystems are also providers of primary care to the population.

**Box 3** What are the key strengths and weaknesses of primary care?

Portugal has a variety of facilities providing primary care under the NHS. It has expanded its primary care network slowly and steadily over the last 15 years, mainly through the expansion of Family Health Units (FHUs). In January 2024, the number of Model B FHUs was increased to 212 and they are expected to gradually become the general model of such units. Model B FHUs are groups of GPs, nurses and administrative personnel that contract a larger package of care (compared to Model A FHUs) and which have a different payment structure that includes an element of pay-for-performance. A new Model C FHU was introduced in September 2024 which will use public funds to contract private providers that will work in group practices in parallel with the public FHUs.

One of the current weaknesses of primary care, particularly since the COVID-19 pandemic, has been the decline in the number of people registered with an NHS family doctor. Despite the increase in NHS primary care facilities, an estimated 1.5 million individuals were without an assigned GP in 2023. The main reason is a shortage of GPs, with many family doctors retiring in recent years and not enough newly trained GPs joining the NHS system. The expansion of FHUs (Model B and Model C) aims to improve primary care coverage, and particularly access to GPs.

Since they were first introduced in 1999, Local Health Units (*Unidades Locais de Saúde*) have been used as an organizational tool to steer coordination and service integration across primary and hospital care services. An expanded set of Local Health Units is being rolled out nationwide under the most recent NHS reforms (Box 4).

**Box 4** Are efforts to improve integration of care working?

The vertical integration of health care has been operationalized in Portugal via Local Health Units. Their management model integrates all the services provided by public hospitals and primary health care, as well as providers under the National Network for Long-Term Care, within defined geographic areas (Goiana-da-Silva et al., 2024). Initial plans to implement these units slowed down after 2012, with seven being established in the first decade of the 2000s, serving around 10% of the population. However, a programme to expand the network of Local Health Units has been reinvigorated under the NHS reform plans launched in 2023. Consistent with the aims of decentralizing governance within the NHS, as well as improving efficiency and streamlining care pathways for patients, the NHS Executive Directorate expanded the network of Local Health Units nationwide to 39 operational units in 2024.

## Hospital care

Secondary and tertiary care is mainly provided in hospitals, which are grouped into Hospital Centres covering a given geographical area. At the start of the 2000s, one of the government's objectives was to increase capacity and value for money in the NHS by increasing private sector involvement in the building, maintaining and operating of health facilities under public–private partnerships, drawing on the British model. However, evidence of their value has been mixed and currently there is only one hospital being run under this framework.

## Pharmaceutical care

There is a maximum number of pharmacies allowed in each community and the location of these pharmacies is highly regulated. Pharmaceuticals that require prescription can only be sold in a pharmacy. Until 2007, pharmacies had to be owned by a qualified pharmacist. However, the Ministry of Health passed a law (Decree-Law No. 307/2007 of 31 August 2007) allowing ownership of a pharmacy to have no constraints other than a maximum number of four pharmacies per owner. It is still mandatory to have a technical director with a degree in pharmaceutical sciences in each pharmacy.

## Mental health care

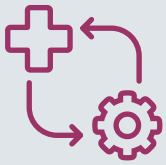
Since the publication of the National Plan for Mental Health Services 2007–2016, Portugal has focused on delivering family-oriented mental health care in the community through locally based services wherever possible. Regional-level services are used whenever local ones are not available. Ambulatory mental health services are based within the network of primary care centres, and GPs are typically the first point of contact for such services. More specialized mental health services are delivered in mental health units by multidisciplinary teams. Inpatient admissions and emergencies are treated in hospitals. Psychiatric hospitals support the local health teams, provide specialized and inpatient care, and provide residential services for patients without any family or social support system. Care for children and adolescents is given by specific teams at the local level.

A renewed framework for mental health services was launched in 2021 in conjunction with the new National Mental Health Plan (Xavier et al., 2024). It continues to stress community-based services and deinstitutionalization. Policies include the greater integration of patients within general hospitals and dedicated units within long-term care facilities as well as measures to address the shortages of mental health professionals across the country.

## Dental care

Dental care services are not part of the NHS standard benefits package and are mainly provided by private sector clinics and paid for directly out of pocket. However, under reforms to increase accessibility, public funding has been made available to deliver certain services, such as regular check-ups and preventative oral care for eligible groups under the National Programme for Oral Health Promotion (see Box 2). These are typically delivered in the dentist's office under a voucher system. Some dentists contract with one or more health subsystems or VHI, with each plan defining its own list of eligible treatments and fees.

# What reforms are being pursued?



The organization and governance of the NHS has been a key target of reforms, along with enhanced accessibility and the targeted strengthening of primary and integrated care

Following the global financial crisis in 2009 and Portugal's Economic and Financial Adjustment Programme some key objectives during the period 2011–2015 were to reduce prices in the NHS through workforce salary decreases (which were later reversed in line with the economic recovery), lowering pharmaceutical prices and reduced contracting with private providers. Measures were particularly focused on the pharmaceutical market, given the high level of public pharmaceutical expenditure. From 2016 priorities included continuing the reform of primary health care, for example, to expand the network of primary care centres and increase the number of NHS users enrolled in GP patient lists. Other areas of focus were to facilitate the reorganization of the hospital sector into Hospital Centres, expand the national network of long-term care providers and to set up a national network for palliative care to improve access and delivery of end-of-life services.

Accessibility and financial protection have also been key areas of reform action (Box 5). Acknowledging an important gap in the provision of dental health services, the expansion of the voucher system under the National Programme for Oral Health Promotion in 2021 has targeted children and adults belonging to vulnerable groups to improve access to regular check-ups and free preventive dental care (see Box 2). The staged abolition of flat-rate charges on a wide range of health services between 2020 and 2022 contributed somewhat to alleviating health-related cost pressures on households although the impact is not yet visible in the available OOP payment data.

Another area of reform activity has been in the governance of the NHS. With the establishment of the new NHS Executive Directorate in 2022, the aim is to strengthen the coordination and management of NHS providers. Ongoing implementation in this area has seen the transfer of key competencies from the Regional Health Administrations (RHAs) to the NHS Executive Directorate in September 2024.

Finally, both the network of primary care providers and the implementation of integrated care are being strengthened. Since 2024, Family Health Units have been augmented both in number and scope while the nationwide rollout of Local Health Units throughout 2023 and 2024 has seen a significant expansion of the tool that aggregates primary care services, hospital and continued care services under the same management at the local level.

**Box 5** Key health system reforms over the past 15 years

**Pharmaceutical policies 2010–2015:** changes to reference pricing (2010) revision of reimbursement rules in the NHS (2010–2015), and use of clinical guidelines for prescription (since 2010).

**National Health Plan 2012–2020:** with a focus on equity and access to healthcare, health citizenship, quality of health services and promoting good health.

**Strategic Plan for Primary Healthcare Reform (2016):** reprioritized the 2005 primary care reform.

**Abolition of flat-rate charges for NHS services (2020 and 2022):** primary care flat-rate charges removed in 2020, followed by removal of charges for all NHS prescribed services in 2022.

**Expansion of National Programme for Oral Health Promotion (2021):** voucher scheme expanded to include a wider number of eligible people.

**NHS Statute (2022):** broad set of arrangements for the NHs including new governance model for hospitals and for the organization of the NHS.

**Establishment of Executive Directorate for the NHS (2022):** the new management body, located in Porto, will coordinate the management and operations of NHS healthcare providers.

**National Health Plan, 2021–2030 (implemented from 2023):** with a focus on reducing population health inequalities, behavioural risk factors, management of major communicable and noncommunicable diseases and emergency preparedness

**Nationwide expansion of Local Health Units (2023–4):** implementation of plan to integrate all NHS hospitals and primary care centres into Local Health Units covering designated geographical areas throughout the country.

**Family Health Units (FHUs), 2024:** expansion of Model B FHUs and introduction of Model C FHUs.

# How is the health system performing?

Portugal aims to improve quality of care while also enhancing health system efficiency

## Health system performance monitoring and information systems

Since 2013, the Central Administration of the Health System has been responsible for benchmarking analysis within the NHS. Both NHS hospitals and primary care units are currently included in this benchmarking analysis, whose methodology covers performance and activity-based indicators on access, quality, productivity and financing. Additionally, several reports are produced analysing the performance of the NHS, for example the Council of Public Finances report in 2024, containing international comparisons and historical data on a number of indicators (CFP, 2024).

The Ministry of Health has a dedicated service responsible for the assessment and implementation of information technology systems and platforms employed within the health system. The NHS website and app MySNS gives individuals access to their patient record as well as to a range of information on NHS facilities and services, including waiting lists for

registered surgeries and waiting times for emergency visits at NHS hospitals and outpatient consultations in both hospitals and primary care units. Developments in the digitalization of the health system include the Medical Electronic Prescription system which allows paperless prescription of health care products, medicines and exams to be issued electronically and the clinical registration software (SClinico) that collects standardized clinical records across NHS primary care units and hospitals. Additionally, the Live Health Data Platform (PDS Live) not only enables real-time video teleconsultations (see below) but also allows for the sharing of related clinical information, such as diagnostic images and the transmission of medical results.

## Accessibility and financial protection

In 2023, 2.8% of the Portuguese population reported that they had unmet needs for medical care due to cost, travel distance or waiting times, a rate that is slightly higher than the EU average (2.4%). Those from the poorest households report higher unmet needs than those from the richest income group, around six times greater (Fig. 8). Unmet needs for dental care are higher, with 8.7% of the population experiencing difficulties in obtaining care in 2023, one of the highest rates among EU countries, and with a significantly higher rate (19.3%) among those in the poorest households compared to high income households (1.4%). Unmet needs for dental care in particular are driven mainly by cost.

Spurred by the need to ensure accessibility of primary care during the COVID-19 pandemic, the enabling of digital solutions, via remote consultations, was able to substitute for a fall in face-to-face physician visits in Portugal. Take up of these types of consultations was particularly strong during pandemic surge times in 2020 and 2021. The Live Health Data Platform (PDS Live) continues to provide the possibility of video teleconsultations with physicians for patients who are unable to attend a visit in person.

## Health care quality

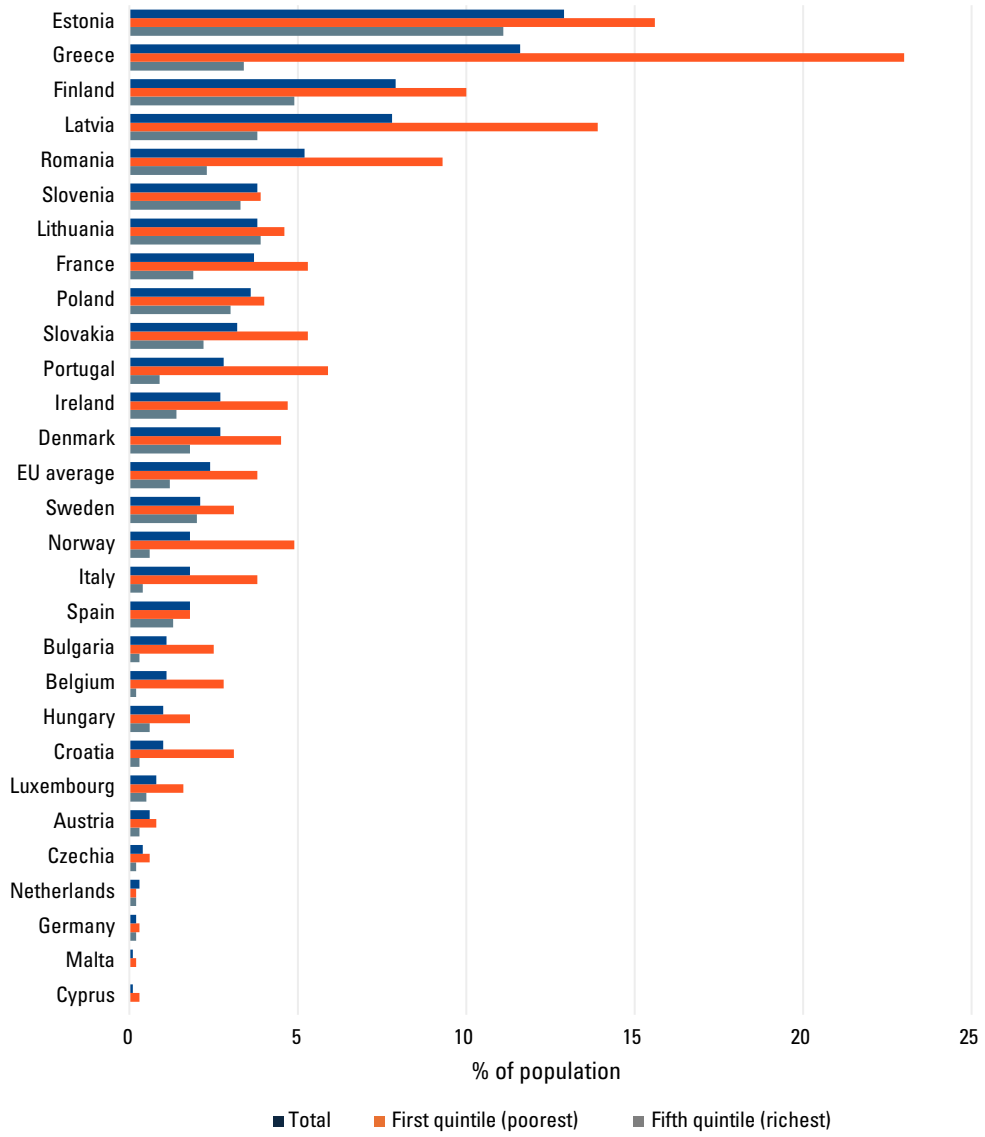
Portugal's National Strategy for Health Quality 2015–2020, which is still in place, focuses on a number of targets to improve clinical and organizational quality within the NHS and highlights the need to scale up the accreditation of health care institutions and providers. The monitoring of patient satisfaction with specific services within the NHS is captured by various reports as, for example, this is one of the indicators used for benchmarking primary care units. The last national-level survey into patient satisfaction was conducted in 2015 but more recently, the annual Stada Report (Ordem farmaceuticos, 2024) provides an insight into the population's attitudes on health in general and on health services (Box 6).

Meanwhile, the adoption of the National Plan for Patient Safety 2015–2020 (renewed for the period 2021–2026) is compulsory for health care institutions, and provides support for NHS managers and clinicians to apply methods for improving the management of risks associated with health care provision.

Key indicators of the quality of primary care, such as avoidable hospital admissions for ambulatory-sensitive chronic conditions, show relatively good results for Portugal, with the combined rates for chronic obstructive pulmonary disease (COPD) and asthma being 60% lower than the EU average (OECD/European Observatory on Health Systems and Policies, 2023), coupled with relatively low rates for hypertension and diabetes. However, Portugal has a high avoidable hospital admissions rate for congestive heart failure relative to the other countries featured in Fig. 9. These are defined as admissions for medical problems that are potentially avoidable if effectively managed in outpatient settings.

Regarding the effectiveness of secondary care, the rate of 30-day mortality after admission from acute myocardial infarction is higher than in many other EU countries and has improved only marginally since 2011 (Fig. 10).

**Fig. 8** Unmet needs for a medical examination (due to cost, waiting time, or travel distance), by income quintile, EU/EEA countries, 2023

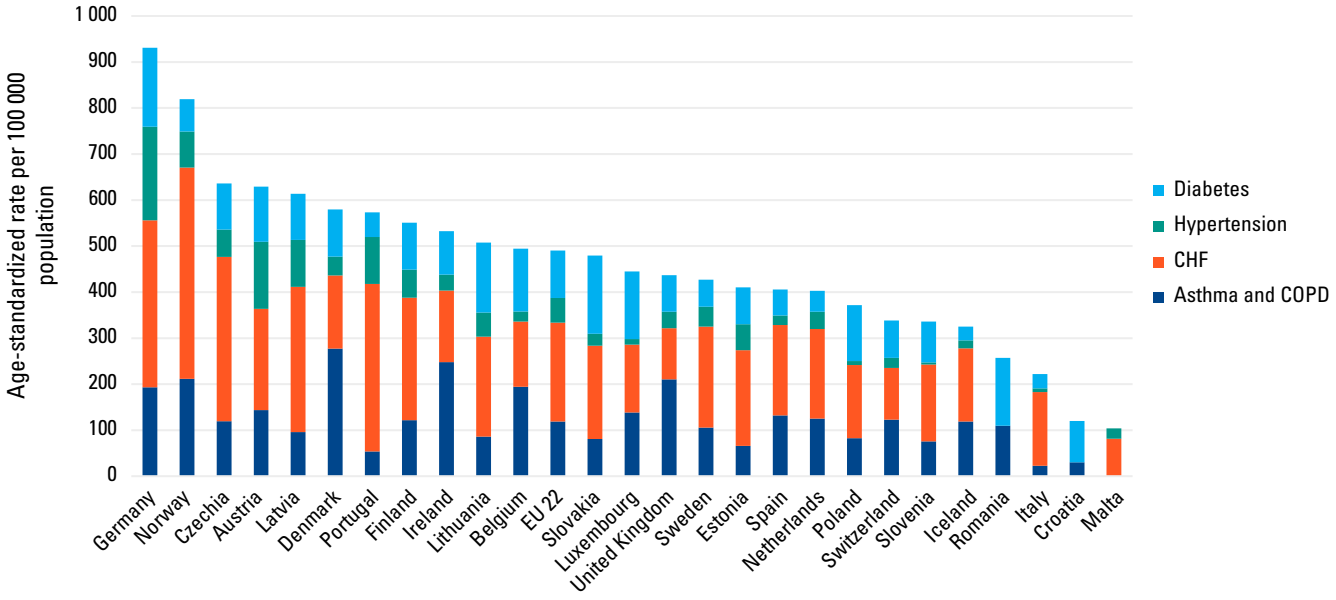



**Notes:** EEA: European Economic Area; EU: European Union.
**Source:** Eurostat, 2024.

## Box 6 What do patients think of the care they receive?

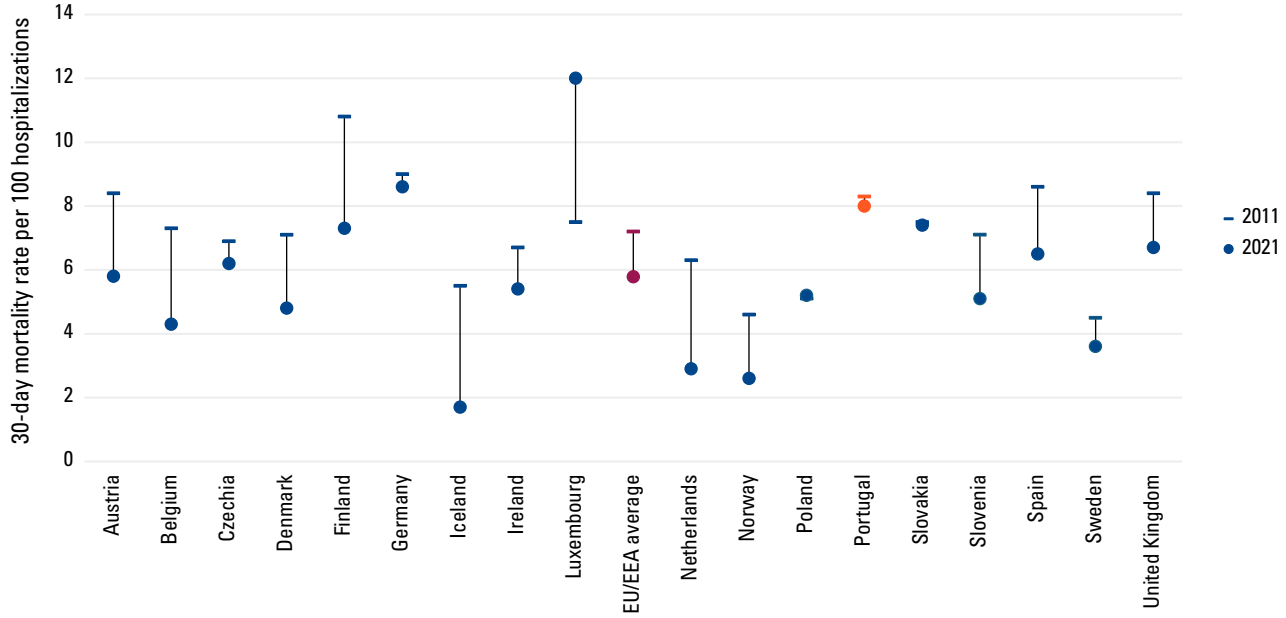
In 2024, the Stada Report revealed that 49% of the Portuguese people surveyed were satisfied with their health service, the NHS (compared to an EU average of 56%). Dissatisfaction was mainly due to difficulties in obtaining an appointment (46%), perceived inadequate care (55%) or lack of trust in decision makers (43%) (Ordem farmaceuticos, 2024). Additionally, only 32% of those surveyed said that they trust conventional medicine (compared to an EU average of 69%) and 43% stated that they trust that their doctor knows what is best for them. Some 46% of people affirmed that they would like a more holistic approach to their health.

**Fig. 9** Avoidable hospital admission rates for asthma and chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes, 2021




**Notes:** CHF: congestive heart failure; COPD: chronic obstructive pulmonary disease. Croatia and Romania: no data for CHF or hypertension; Malta: no data for Asthma & COPD or diabetes.
**Source:** OECD, 2024 (data refer to 2021 or nearest year).

**Fig. 10** In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, Portugal and selected countries, 2011 and 2021



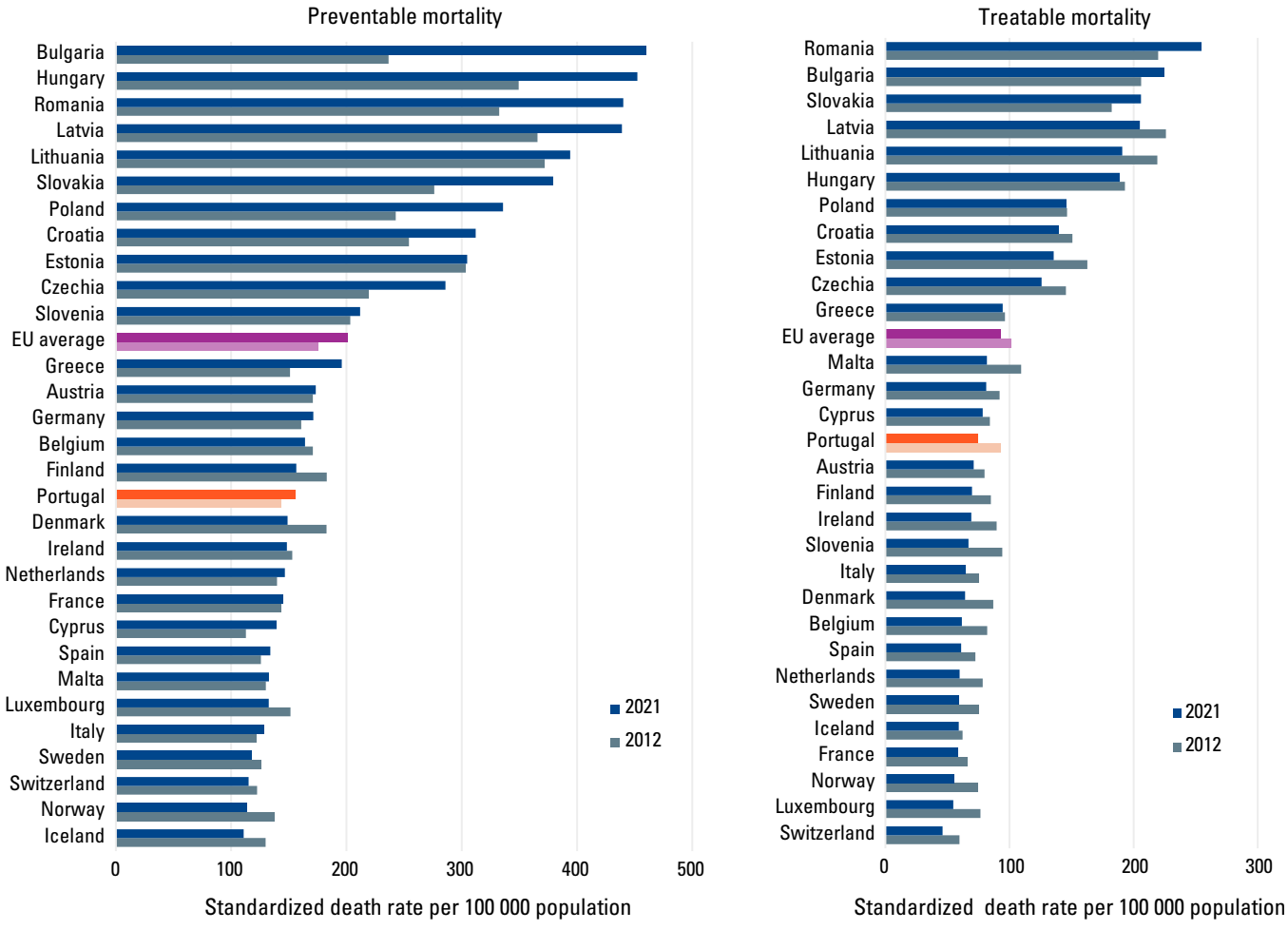

**Source:** OECD, 2024 (data refer to 2011 and 2021 or nearest years).

# Health system outcomes

In Portugal the rate of premature deaths from preventable causes remained below the EU average in 2021 (156 compared to 201 per 100 000 population) but it is still higher than the best performing Member States (Fig. 11). The preventable mortality rate had been declining incrementally since 2012 but registered increases in both 2020 and 2021 due to the fact that COVID-19 deaths are classified as preventable deaths. In 2021, the leading causes of deaths that could be avoided through public health and primary prevention interventions included COVID-19, lung cancer, ischaemic heart disease and cerebrovascular diseases (Eurostat, 2024). Robust prevention policies targeting health risk factors such as smoking and obesity could help to reduce preventable mortality (Box 7).

Mortality due to treatable causes in Portugal has reduced by 20% since 2012, and in 2021 was 75 per 100 000 population, below the EU average of 93 (Fig. 11). Colorectal cancer, ischaemic heart disease, cerebrovascular diseases and breast cancer (women only) are among the leading treatable causes of premature mortality in Portugal (Eurostat, 2024), which could be reduced through earlier diagnosis and timely and effective treatment.

**Fig. 11** Mortality from preventable and treatable causes 2012 and 2021




**Note:** After 2020, deaths due to COVID-19 are counted as preventable deaths, resulting in an increase in mortality from preventable causes for most countries.

**Source:** Eurostat, 2024.

**Box 7** Are public health interventions making a difference?

Portugal has seen a reduction in smoking prevalence in recent years: for example, daily smoking rates among adults declined from nearly 17% in 2014 to 14% in 2019 while among adolescents, there was a reduction in reported cigarette smoking from 11% in 2018 to 9% in 2022. However, among teenagers the use of e-cigarettes increased slightly (from 12.4% to 13.4%) in the period 2015–2019. While evidence on the effectiveness of interventions addressing risk factors such as tobacco consumption is limited, the reductions in smoking prevalence rates can be attributed, at least in part, to the measures implemented under the National Programme for the Prevention and Control of Tobacco Use, including smoking bans in public places, prohibiting the sale of cigarettes to minors and stricter controls over the sale and marketing of tobacco products.

In contrast to smoking rates, levels of overweight and obesity have been slowly rising in Portugal, with self-reported data classifying 17.1% of adults as obese in 2019 (up from 16.1% in 2014) and 20% of Portuguese 15-year olds being either overweight or obese in 2022 (compared to 17% in 2010). Some of the actions taken to date include measures to improve dietary habits under the National Programme for the Promotion of Healthy Eating, such as restrictions on advertising unhealthy foods to children, introducing nutrition standards in schools, no value-added sales tax on healthy foods and a tax on sugar-sweetened beverages and high-salt/high-fat foods. Additionally, the National Physical Activity Promotion Programme contains awareness-raising initiatives and pilot projects to encourage physical activity prescriptions in primary care, with the support of digital tools.

*Source*: OECD/European Observatory on Health Systems and Policies, 2023

## Health system efficiency

A cursory illustration of the health system's performance in terms of input costs and outcomes can be obtained by plotting current health expenditure against the treatable mortality rate (Fig. 11). Given its expenditure level in 2021, which is similar to a cluster of countries such as Cyprus, Italy, Slovenia and Spain, Portugal registers a treatable mortality rate that is comparable. Moreover, its treatable mortality rate is in line with several other countries, such as Austria, Finland and Ireland, which have significantly higher per capita health expenditure. These basic results suggest that given its expenditure levels, Portugal has been able to secure comparatively good health system outcomes.

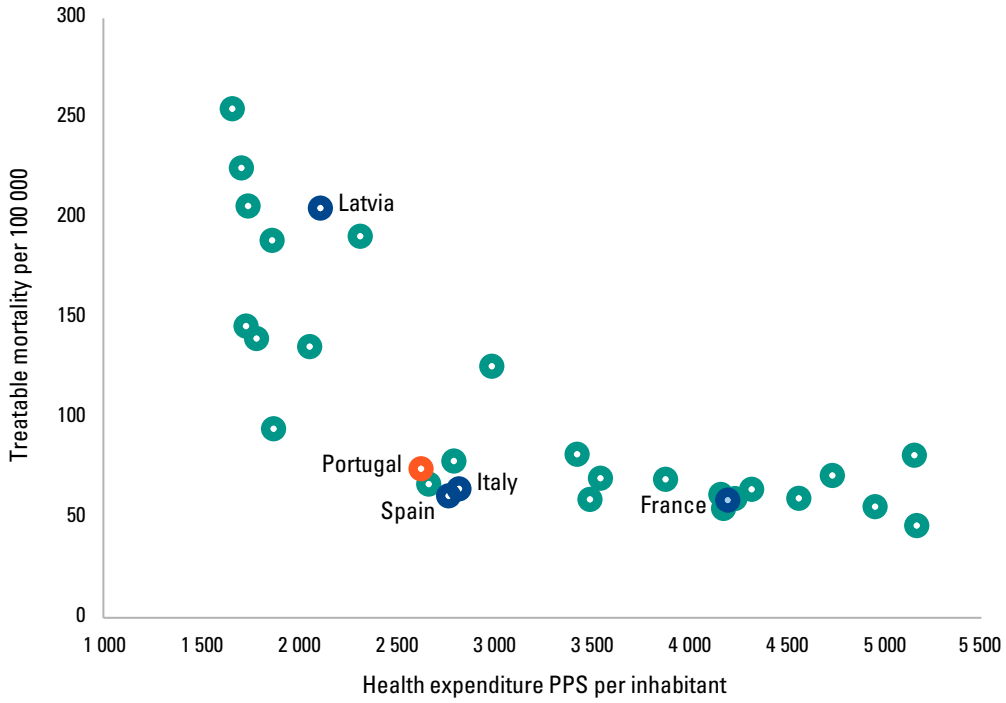
In terms of allocative and technical efficiency, some instructive indicators show that hospital expenditure in Portugal accounts for 42% of total health spending, slightly above the EU average of 40% while outpatient care represents 26% of the total health expenditure, just below the EU average of 28%. Over the past two decades, hospital expenditure has been increasing, with a significant contributor being public funding for private hospitals (Braz et al., 2024). Between 2014 and 2022, hospitals in Portugal accrued a cumulative deficit amounting to 2.5% of GDP, primarily due to underfunding. Additionally, a national assessment of hospital efficiency shows that it declined from approximately 85% in 2012 to 80% in 2022. This drop in efficiency is linked to a reduction in the overall quality of care (INE, 2024b).

Following the severe impact of the COVID-19 pandemic, the healthcare sector is rebounding. In 2022, the number of outpatient consultations and medical exams exceeded pre-pandemic levels, with a total of 825 000 hospitalizations and 7.4 million days of hospitalization in NHS hospitals. The average length of stay was 9.2 days, a slight increase from 2021. Similarly, emergency department visits grew by 24% compared to 2021, reaching approximately 8 million visits, with 6.6 million in NHS hospitals. The number of emergency department visits to private hospitals in 2022 was the highest since 1999, rising by over 43.7% compared to 2021, totaling 1.5 million visits (INE, 2024b). Surgical procedures and medical outpatient appointments have generally increased since the early 2000s, although there were notable drops

in 2019 and 2020 due to the pandemic. This trend of growth in both public and private hospitals has largely continued (INE, 2024b).

Portugal has implemented cost-containment measures for pharmaceuticals since 1996, with a significant increase in the number and variety of such measures starting in 2010, particularly following its Economic and Financial Adjustment Programme. The most frequent measures have focused on reimbursement, pricing, prescription guidelines, and regulations within community pharmacies (Box 8).

**Fig. 12** Treatable mortality per 100 000 population versus health expenditure per capita, Portugal and selected countries, 2021




**Note:** PPS: purchasing power standard.

**Source:** Eurostat, 2024.

## Box 8 Is there waste in pharmaceutical spending?

In 2023, the NHS spent €1593.8 million on pharmaceuticals, a 3.5% increase compared to 2015. Despite cost-control measures, this steady rise in pharmaceutical expenditure highlights the ongoing pressure on the healthcare system. Patients contributed €859.8 million to this total, reflecting their share of the cost burden. The proportion of generic drugs dispensed in the competitive market has steadily increased, now representing 64% of units dispensed (infarmed, 2024). While this shows progress in promoting cost-effective alternatives, the growth has been gradual, suggesting that further efforts are needed to boost generic drug uptake.

Since 2010, several policies have been implemented to control expenses and costs. These have included cost containment (2011–2015), changes to reference pricing (2010), revision of reimbursement rules in the NHS (2010–2015), use of clinical guidelines for prescription (since 2010), electronic prescription (since 2015) and incentives for patients and community pharmacies to use generic drugs (2011–2015).

# Summing up

Portugal's NHS is a universal health system covering all residents, regardless of their socioeconomic, employment or legal status. The NHS also coexists with health subsystems that provide services to specific segments of the population. A comprehensive range of health services are delivered through a mix of public and private contracted providers. Over the past decade and half, there has been a sustained focus on improving equity of access to health care, with enhanced coverage of dental care, the abolition of fixed user-charges for NHS services and expanding the network of primary care centres to better serve population needs and increase the number of people that are registered with a GP. In parallel, the roll out of Local Health Units is a major tool to implement integrated primary and hospital care services under coordinated management. The NHS itself has also undergone significant governance changes, designed to increase its capacity for effective management, monitoring and coordination of health system services.

## Population health context

### Key mortality and health indicators

| Life expectancy (years) | 2023 |
|---|---|
| Life expectancy at birth, total | 82.4 |
| Life expectancy at birth, male | 79.5 |
| Life expectancy at birth, female | 85.2 |
| **Mortality** | **2021** |
| All causes (SDR per 100 000 population) | 1 000.3 |
| Circulatory diseases (SDR per 100 000 population) | 247.9 |
| Malignant neoplasms (SDR per 100 000 population) | 226.1 |
| Communicable diseases (SDR per 100 000 population) | 18.4 |
| External causes (SDR per 100 000 population) | 44.9 |
| Infant mortality rate (per 1 000 live births) | 2.4 |
| Maternal mortality per 100 000 live births (modelled estimates)* | 12.0 |

**Note:** *Maternal mortality data is for 2020
**Sources:** Eurostat, 2024; WHO Regional Office for Europe, 2024

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