World Health Organization

European Region

Can people afford to pay for health care?

New evidence on financial protection in Portugal

Pedro Pita Barros
Jorge Alejandro García-Ramírez

Portugal

WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage (UHC). It works with Member States in Europe and central Asia to promote evidence-informed policy making. It also offers training courses on health financing.

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Abstract

This review is part of a series of country-based studies generating new evidence on affordable access to health care (financial protection) in health systems in Europe. Financial protection is central to universal health coverage and a core dimension of health system performance. Catastrophic health spending is higher in Portugal than in many European Union countries but has decreased in recent years. It is heavily concentrated in the poorest consumption quintile and mainly driven by outpatient medicines, especially in households with low incomes. Although entitlement to publicly financed health care is based on residence and the benefits package is relatively comprehensive, gaps in coverage persist. Coverage of medical products is limited and access to publicly financed dental care is restricted due to the lack of sufficient public facilities; waiting times are an issue for primary care visits, outpatient specialist visits and elective surgery; there are heavy percentage co-payments for medical products and outpatient prescribed medicines; existing exemptions from co-payments are not enough to protect people with low incomes and are not applied automatically; and there is no cap on co-payments. The Government can reduce unmet need and financial hardship by enhancing access to outpatient prescribed medicines as part of primary care; improving protection from co-payments, particularly for people with low incomes; continuing efforts to reduce waiting times and improve access to primary care; expanding access to publicly financed dental care; and expanding coverage of medical products.

Keywords

AFFORDABLE ACCESS
COVERAGE POLICY
FINANCIAL PROTECTION
HEALTH FINANCING
OUT-OF-POCKET PAYMENTS
PORTUGAL
POVERTY
UNIVERSAL HEALTH COVERAGE
USER CHARGES (CO-PAYMENTS)

About the series

This series of country-based reviews monitors financial protection in European health systems. Financial protection – ensuring access to health care is affordable for everyone – is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? Out-of-pocket payments can create a financial barrier to access, resulting in *unmet need*, and lead to *financial hardship* for people using health services. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection can undermine health, deepen poverty and exacerbate inequalities. Because all health systems involve a degree of out-of-pocket payment, unmet need and financial hardship can occur in any country.

How do country reviews assess financial protection? Each review is based on analysis of common indicators used to monitor financial protection: the share of people foregoing health care due to cost (*unmet need*) and the share of households experiencing financial hardship caused by out-of-pocket payments (*impoverishing* and *catastrophic health spending*). These indicators are generated using household survey data.

Why is monitoring financial protection useful? The reviews identify the health system factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate international comparison, the reviews follow a standard template, draw on similar sources of data and use the same equity-sensitive methods. Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by WHO

headquarters and the WHO Regional Office for Europe. The UHC watch website has more information on methods and indicators.

What is the basis for WHO's work on financial protection in Europe?
Financial protection is a Sustainable Development Goal, part of the European Pillar of Social Rights and at the heart of the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe" – the WHO Regional Office for Europe's strategic framework. Through the European Programme of Work, WHO supports national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments. Other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

UHC watch

5 things to know about UHC watch

A digital platform tracking progress on affordable access to health care in Europe and central Asia

#1

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#4

Country-level and comparative analysis

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Contents

Figures, tables and boxes	viii
Acknowledgements	x
Abbreviations	xi
Countries	xi
Executive summary	xii
1. Introduction	1
2. Methods	3
2.1 Financial hardship linked to out-of-pocket payments	4
2.2 Unmet need for health care	6
3. Coverage policy	7
3.1 Population coverage	8
3.2 Service coverage	11
3.3 User charges (co-payments)	14
3.4 The role of VHI	17
3.5 Summary	20
4. Spending on health	21
4.1 Public and private spending on health	22
4.2 Out-of-pocket payments	27
4.3 VHI premiums	34
4.4 Informal payments	35
4.5 Summary	36
5. Financial protection	37
5.1 Household capacity to pay for health care	38
5.2 Financial hardship: impoverishing and catastrophic health spending	40
5.3 Unmet need for health care	49
5.4 Summary	52
6. Factors that strengthen and undermine financial protection	53
6.1 Coverage policy	54
6.2 Public spending on health	59
6.3 Summary	59
7. Implications for policy	61
References	64

Figures

Fig. 1. Households with spending on VHI premiums by consumption quintile
18

Fig. 2. Out-of-pocket payments as a share of current spending on health, Portugal and selected EU countries
22

Fig. 3. Health spending per person by financing scheme
23

Fig. 4. Public spending on health and GDP per person, Portugal and the EU, 2022
24

Fig. 5. Public spending on health as a share of the government budget in the EU, 2022
25

Fig. 6. Breakdown of current spending on health by type of care and financing scheme, Portugal and the EU, 2022
26

Fig. 7. Households with out-of-pocket payments by consumption quintile
27

Fig. 8. Annual out-of-pocket payments per person by consumption quintile
28

Fig. 9. Out-of-pocket payments as a share of household consumption by consumption quintile
28

Fig. 10. Out-of-pocket payments as a share of household consumption in the EU, latest available year
29

Fig. 11. Breakdown of out-of-pocket payments by type of care
30

Fig. 12. Breakdown of out-of-pocket payments by type of care and consumption quintile
31

Fig. 13. Annual out-of-pocket payments per person by type of care
32

Fig. 14. Annual out-of-pocket payments per person by type of care and consumption quintile
33

Fig. 15. Annual spending on VHI premiums per person by consumption quintile
35

Fig. 16. Changes in the cost of meeting basic needs, capacity to pay for health care and the share of households living below the basic-needs line
39

Fig. 17. Population at risk of poverty or social exclusion by age in Portugal and the EU
40

Fig. 18. Households at risk of impoverishment after out-of-pocket payments
41

Fig. 19. Households with catastrophic health spending
42

Fig. 20. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health in the WHO European Region, latest available year
43

Fig. 21. Breakdown of households with catastrophic health spending by risk of impoverishment
44

Fig. 22. Breakdown of households with catastrophic health spending by consumption quintile, age and occupational status and incidence of catastrophic health spending in the poorest quintile and in households headed by older people and pensioners
45

Fig. 23. Households with catastrophic health spending by region
46

Tables

Fig. 24. Breakdown of catastrophic health spending by type of care
47

Fig. 25. Breakdown of catastrophic health spending by type of care and consumption quintile
48

Fig. 26. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, Portugal and the EU
49

Fig. 27. Income inequality in self-reported unmet need for health care and dental care due to cost, distance and waiting time
50

Fig. 28. Income inequality in self-reported unmet need for prescribed medicines, health care and dental care due to cost, Portugal and the EU, 2019
51

Fig. 29. Share of generic medicines in the pharmaceutical market in selected EU countries and the United Kingdom, 2021
57

Table 1. Key dimensions of catastrophic and impoverishing spending on health
4

Table 2. Changes to coverage policy, 2000–2025
9

Table 3. User charges (co-payments) for publicly financed health care, 2025
15

Table 4. Gaps in coverage
19

Boxes

Box 1. Unmet need for health care
6

Box 2. Regulation of complementary VHI covering HIIS co-payments
58

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Abbreviations

COICOP	classification of individual consumption by purpose
COVID-19	coronavirus disease
EHIS	European Health Interview Survey
EU	European Union
EU14	European Union Member States from 1 January 1995 to 30 April 2004, excluding the United Kingdom
EU27	European Union Member States as of 1 February 2020
EU-SILC	European Union Statistics on Income and Living Conditions
GDP	gross domestic product
GP	general practitioner
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
VHI	voluntary health insurance

Countries

ALB	Albania
ARM	Armenia
AUT	Austria
BEL	Belgium
BIH	Bosnia and Herzegovina
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
IRE	Ireland
ISR	Israel
ITA	Italy
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MDA	Republic of Moldova
MKD	North Macedonia
MNE	Montenegro
POL	Poland
POR	Portugal
ROM	Romania
SPA	Spain
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TJK	Tajikistan
TUR	Türkiye
UKR	Ukraine
UNK	United Kingdom

Executive summary

This review assesses the extent to which people in Portugal face financial barriers to access or experience financial hardship when they use health care. It covers the period from 2000 to 2025, using data from household budget surveys carried out between 2000 and 2022 (the latest available year), data on unmet need for health services up to 2024 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to May 2025.

The review's main findings are as follows.

- Financial hardship caused by out-of-pocket payments is higher in Portugal than in many European Union (EU) countries but has decreased over time. In 2022 7.5% of households experienced catastrophic health spending, down from a peak of 11% in 2010, and 3.3% of households were impoverished or further impoverished after out-of-pocket payments.

- Catastrophic health spending is heavily concentrated in the poorest consumption quintile. It is also concentrated in households headed by older people and pensioners.

- Outpatient medicines, followed by medical products and dental care, are the main drivers of catastrophic health spending on average. In the poorest quintile catastrophic health spending is mainly driven by outpatient medicines, medical products and outpatient care. Dental care and inpatient care are much smaller drivers in the poorer quintiles than the richer quintiles.

- Unmet need for health care in Portugal has been similar to the EU average in the study period but unmet need for dental care has been much higher. Both types of unmet need are mainly driven by cost. During the study period there was significant income inequality in unmet need for both types of care.

Coverage policy in Portugal has notable strengths. Entitlement to publicly financed health care is based on residence; refugees, asylum seekers, the children of undocumented migrants and some undocumented migrants are entitled to the same benefits as residents; the benefits package is relatively comprehensive; and several co-payments have recently been abolished (co-payments for primary care visits and diagnostic tests in primary care in 2020 and co-payments for some emergency care in 2022).

However, persistent gaps in coverage undermine financial protection, particularly for people with low incomes.

- Outpatient medicines incur heavy percentage co-payments (ranging from 10% to 85% of the price) and are also subject to reference pricing. Although there are exemptions in place, they only apply to percentage co-payments and to some health conditions. Exemptions on the basis of income were only introduced in 2024 and apply to a small group of people (people aged over 65 years with low incomes receiving social support), and exemptions are not automatically applied. There are no caps on co-payments. Reference pricing for covered medicines leads to "avoidable co-payments"; there is no protection from these co-payments and people may pay out of pocket for a medicine that is more expensive than the lowest-priced alternative due to stock issues in pharmacies.

- Access to publicly financed dental care is restricted due to a lack of public facilities. A system of National Health Service (NHS) dental care vouchers provides access to regular check-ups and preventive treatment in private facilities without payment but these only cover 20% of the population (based mainly on income and age). A pilot project set up in 2016 to improve access to dental care in NHS primary care centres for people with specific conditions and people with low incomes has been expanded over time but still only operates in around a third of municipalities in mainland Portugal.

- Coverage of medical products is limited in the benefits package and heavy percentage co-payments are applied to covered products (mostly in the form of percentage co-payments ranging from 15% to 85%) without exemptions and caps in place.

- Waiting times are an issue in primary care, for outpatient specialist visits and for elective surgery.

- Existing exemptions from co-payments for outpatient specialist visits and diagnostic tests are not applied automatically and there is no cap on co-payments for any user charges.

Building on recent efforts to improve access to care, the Government could consider the following steps to reduce financial hardship, particularly for people with low incomes.

- Enhance access to outpatient prescribed medicines as part of primary care. Options include replacing percentage co-payments with low fixed co-payments and ensuring people can access at least one of the three lowest-priced medicines in each reference group free at the point of use.

- Improve the protection mechanisms from co-payments for people with low incomes, especially for outpatient prescribed medicines.
- Continue with efforts to reduce waiting times and improve access to primary care.
- Expand access to publicly financed dental care.
- Expand coverage of medical products (including corrective lenses).
- Evaluate the benefits and costs of tax subsidies for out-of-pocket payments and voluntary health insurance premiums.

1. Introduction

This review assesses the extent to which people in Portugal experience financial hardship when they use health care. It covers the period from 2000 to 2025 using data from household budget surveys carried out between 2000 and 2022 (the latest available year), data on unmet need for health care up to 2024 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to May 2025. See UHC watch (2025) for updates.

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; 2007; WHO, 2010; WHO Regional Office for Europe, 2019; 2023). Increases in public spending or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however; policy choices are also important.

All residents in Portugal are entitled to health care provided by the Portuguese National Health Service (NHS) which is financed from general taxation. User charges apply to most types of care (except primary care visits, diagnostic tests in primary care and inpatient care), which is one reason why out-of-pocket payments as a share of current spending on health (30% in 2023) are much higher than the European Union (EU)27[1] average (19% in 2022) and the EU14[2] average (17% in 2022). The out-of-pocket payment share grew sharply between 2010 and 2012 in response to a sharp drop in public spending on health per person caused by NHS budget cuts following the global financial crisis. It has remained at this higher level since then, with just one drop observed in 2020 – the first year of the coronavirus disease (COVID-19) pandemic.

Public spending on health as a share of GDP (6.5% in 2022) is on a par with the EU27 average but lower than the EU14 average of 7.3% (WHO, 2025). Public spending on health fell between 2011 and 2012 due to NHS budget cuts that mainly affected prices and wages but also increased user charges (co-payments) for some groups of people. Some of these policy measures were reversed in 2015, leading to an increase in public spending on health between 2015 and 2021. Public spending on health has fallen again since the COVID-19 pandemic.

This review is the first in-depth analysis of financial protection in Portugal. Other studies have found improvements in financial protection in the country from 2005 to 2015 and noted the role of out-of-pocket payments on medicines as a major element of household's spending on health (Kronenberg & Barros, 2014; Quintal & Lopes, 2016; Pinhão, 2018; Quintal, 2019). The methods used in this study are different from those used in previous analyses (Yerramilli, Fernández & Thomson, 2018).

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of coverage policy, drawing information from UHC watch. Sections 4 and 5 present the results of the statistical analysis in financial protection, with a focus on out-of-pocket payments in Section 4 and financial protection in Section 5 (covering both financial hardship and unmet need). Section 6 provides a discussion of the results of the financial protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy.

1. European Union Member States as of 1 February 2020.

2. European Union Member States from 1 January 1995 to 30 April 2004, excluding the United Kingdom.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found on the Methods page of UHC watch (2025).

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus, Thomson & Evetovits, 2018; WHO Regional Office for Europe, 2019; 2023), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003).

2.1 Financial hardship linked to out-of-pocket payments

Financial hardship is measured using two main indicators: impoverishing and catastrophic health spending. Table 1 summarizes the key dimensions of each indicator.

Table 1. Key dimensions of catastrophic and impoverishing spending on health

Note: see the Glossary provided by UHC watch (2025) for definitions of words in italics.

Source: WHO Regional Office for Europe (2019).

	Impoverishing health spending
Definition	The share of households *impoverished* or *further impoverished* after *out-of-pocket payments*
Poverty line	A *basic needs line*, calculated as the average amount spent on food, housing (rent) and utilities (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household *consumption* distribution who report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development (OECD) equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, *basic needs* for food, housing and utilities; this standard amount is also used to define a household's *capacity to pay for health care* (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household *quintiles* by consumption and by other factors where relevant
Data source	Microdata from national *household budget surveys*
	Catastrophic health spending
Definition	The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care. This includes all households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they have no capacity to pay before or after out-of-pocket payments).
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a *poverty line* (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

Financial hardship indicators are generated by analysing data from household budget surveys. This study analyses anonymized microdata from the household budget surveys conducted by Statistics Portugal between 2000 and 2022 (the latest available year). Data are usually collected throughout the year of study. The data sample consisted of 10 020 households in 2000 (with a response rate of 82.8%), 10 403 in 2005 (response rate 62.3%), 9489 in 2010 (response rate 56.4%), 11 398 in 2015 (response rate 64.1%) and 11 701 in 2022 (response rate 58.6%).

Since 2022 the classification of the consumption categories of the household budget survey has been updated to the classification of individual consumption by purpose (COICOP) 2018 (the previous years used COICOP 1999), which allows data to be collected in alignment with the International Classification of Health Accounts (United Nations Department of Economic and Social Affairs, 2018). This has led to the following changes in health spending categories:

- dental care: dentures moved from medical products to dental care and outpatient dental care was grouped under dental care;
- inpatient care: overnight dental care is now recorded as part of inpatient care;
- diagnostic tests: medical analyses and x-rays moved from inpatient care to diagnostic tests; and
- outpatient care: immunization, preventive care and general medical services provided in hospitals (without an overnight stay) moved from inpatient care to outpatient care; laboratory and imaging services for preventive care (when billed with health workers' time and skills) moved from diagnostic tests to outpatient care; and some outpatient curative and rehabilitative care (e.g. physical, psychological and speech therapy) moved from paramedical services (diagnostic tests) to outpatient care.

Due to these changes, data for 2022 should be compared to earlier data with caution. These breaks in series are signalled in the figures in sections 4 and 5.

National survey instruments do not yet routinely capture spending on long-term health care, and even when they do, it is likely to be underestimated because household budget surveys do not include people living in institutions. COICOP does not include a category on mental health care; this type of spending is reported under the other categories.

The review also draws on data from national health accounts, which use the standardized System of Health Accounts to collect internationally comparable data on health spending at national level (OECD, Eurostat & WHO, 2017).

All currency units in the study are presented in euros (€), with notes on inflation-adjusted spending where relevant.

2.2 Unmet need for health care

Unmet need for health care due to cost, distance and waiting time (health system factors) is measured using data from European or national surveys (Box 1).

Box 1. Unmet need for health care

Unmet need is defined as instances in which people need health care but do not receive the care they need because of access barriers. Self-reported data on unmet need should be interpreted with caution, especially across countries. However, analysis has found a positive relationship between unmet need and a subsequent deterioration in health (Gibson et al., 2019) and between unmet need and the out-of-pocket payment share of current spending on health (Chaupin-Guillot & Guillot, 2014), which suggests that unmet need can be a useful indicator of affordable access to health care.

Every year EU Member States collect data on unmet need for health care (medical examination or treatment) and dental care (dental examination or treatment) through European Union Statistics on Income and Living Conditions (EU-SILC) (Eurostat, 2025a). EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS), carried out every 5–6 years (Eurostat, 2025b). The third wave of this survey was launched in 2019. EHIS provides information on unmet need among people reporting a need for health care and asks households about unmet need for prescribed medicines, in addition to health care and dental care. EU-SILC typically provides information on unmet need as a share of the population but in recent years it has started to provide this information among people reporting a need for health care (Ingleby & Guidi, 2024).

Financial protection analysis that does not account for unmet need could be misleading. A country may have a relatively low incidence of catastrophic health spending because many people face barriers to access and are unable to use the health care they need. Conversely, reforms that increase the use of health care can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place; in such instances, reforms might improve access to health care but at the same time increase financial hardship.

Source: WHO Regional Office for Europe (2019; 2023).

3. Coverage policy

This section briefly describes the governance and key dimensions of publicly financed health coverage – population coverage, service coverage and user charges (co-payments) – and reviews the role played by voluntary health insurance (VHI). It draws on information from the policy explorer on UHC watch (2025).

3.1 Population coverage

The basis for entitlement to publicly financed health care provided by the Portuguese NHS is permanent residence, as set out in the 2005 Constitution of the Portuguese Republic (Article 64). The autonomous regions of the Azores and Madeira have their own regional health systems that are independent from the NHS but follow the same constitutional principles and offer the same benefits package. The NHS is primarily financed by the government budget.

Refugees, asylum seekers, the children of undocumented migrants and some undocumented migrant adults (those in a family regrouping process with a family member who is a social beneficiary) are entitled to the same benefits as residents (Portuguese Health Regulatory Authority, 2023). Other undocumented migrants are not entitled to any type of publicly financed health care and are the main group of people lacking NHS coverage. The number of people who lack coverage is not known.

Citizens and residents should have an NHS number, which they can obtain by registering with a primary care centre. Non-citizens require a valid residence permit or other proof of legal residence in Portugal to obtain their number. People without an NHS number can be treated in case of need and will be given a provisional number. There is a clear policy of not denying care to anyone using NHS facilities, but this may not include referrals to specialist care, diagnostic tests or prescribed medicines. Some migrants may also face administrative, language and other barriers to accessing NHS care and have to rely on services provided by non-governmental organizations (Portuguese Health Regulatory Authority, 2015; Caldas et al., 2023).

Key changes to coverage policy are summarized in Table 2.

Table 2. Changes to coverage policy, 2000–2025

Year	Month	Change
2000	September	Percentage co-payments for generic outpatient prescribed medicines are reduced for group B (20% down from 30%) and group C (50% down from 60%). These categories had been previously introduced in 1992 (see Table 3 for details).
2000	September	Co-payments for some outpatient prescribed medicines are increased through the addition of a new group (group D) with a percentage co-payment of 80%
2002	May	Introduction of a special programme to reduce surgical waiting lists
2003	March	Introduction of reference pricing for medicines. People pay the difference between the reference medicine (the most expensive generic and at least 35% cheaper than the originator) and the retail price
2003	July	Introduction of an exemption from co-payments for outpatient care visits, diagnostic tests and emergency visits during pregnancy and for children < 13, pensioners and workers with low incomes and their dependants, pensioners with disability ≥ 50% of their functional capacity, pensioners receiving social support, people with chronic conditions, firefighters, blood donors and people receiving social support (including people living in government institutions)
2003	August	Fixed co-payments for outpatient care, diagnostic tests and emergency visits are set and cannot be higher than one third of the official NHS price
2004	November	Introduction of an integrated management system for the surgical waiting list to identify and manage waiting lists and reduce waiting times
2005	August	A percentage co-payment for outpatient prescribed medicines in group A (5%) is introduced
2005	October	Percentage co-payments for generic outpatient prescribed medicines are abolished
2006	December	Percentage co-payments for outpatient prescribed medicines are increased in group B (31% up from 30%), group C (63% up from 60%) and group D (85% up from 80%)
2007	January	Introduction of a fixed co-payment for inpatient care (€5 a day up to a maximum of 10 days) and ambulatory surgery in outpatient facilities (€10)
2007	May	Introduction of an exemption from co-payments for all types of care related to domestic violence
2008	February	The National Programme for Oral Health Promotion introduces NHS dental care vouchers for covered pregnancy and pensioners with low incomes; the vouchers provide free access to dental care in private facilities
2008	April	Fixed co-payments for all types of care are reduced by 50% for people ≥ 65
2008	July	Introduction of a one-year intervention programme in ophthalmology to reduce cataract visits and surgeries
2008	October	The price of generic medicines is reduced by 30%
2009	January	The NHS dental care vouchers are extended to covered children < 7 and children aged 10 and 13
2010	January	Co-payments for inpatient care and ambulatory surgery in outpatient facilities are abolished
2010	March	Introduction of an exemption from co-payments for primary care visits for blood, cell and organ donors, people with transplants and military and veterans who are permanent incapacitated in the line of duty

Source: UHC watch (2025).

Table 2. Contd

Year	Month	Change
2010	April	NHS dental care vouchers are extended to cover children < 15 (previously only available to children < 7 and aged 10 and 13)
2010	August	Introduction of a change in the rules used to calculate the average household income of pensioners and unemployed people for exemption from co-payments. All annual incomes are divided by 14 and by the number of household members (the household size was not previously considered in the calculation) increasing the number of people exempt in these groups.
2010	October	NHS dental care vouchers are extended to people living with HIV/AIDS
2011	August	Introduction of mandatory e-prescribing for outpatient prescribed medicines
2012	January	Tax subsidies for VHI premiums purchased by individuals are reduced to 10% of the value of the premium (down from 30%)
2012	January	Co-payments are abolished for some types of outpatient care (e.g. family planning, several medical conditions (detailed in the law), respiratory home care, dialysis, official screening programmes, home visits initiated by the NHS, treatment related to domestic violence, treatment for drug and alcohol addiction, vaccination and emergency care with referral or emergency care that results in a hospital admission)
2013	August	NHS dental care vouchers are extended to cover children < 16 (previously only available to children < 15)
2014	March	NHS dental care vouchers are extended to people at high risk of oral cancer (e.g. male smokers > 40 with drinking habits and people with lesions in the mouth)
2014	July	Exemption from co-payments for outpatient visits are extended to children ≤ 18, people ≤ 25 under social support, asylum seekers, refugees and people with specific conditions (e.g. cancer or a disability > 60%)
2015	January	Tax subsidies are introduced for out-of-pocket payments; households can deduct 15% of out-of-pocket payments from annual taxable income, up to a maximum of €1000 per household a year
2015	April	Exemption from all co-payments is extended to children < 18 and young adults receiving social support
2015	October	Re-introduction of fixed co-payments (€7.75) for NHS abortion services (under the circumstances allowed by law)
2015	November	Co-payments for primary care visits are merged into one co-payment of €5 (removing any differentiation in co-payments for primary care visits based on the time of day)
2015	November	Co-payments for emergency care in primary care settings are abolished
2015	December	Public subsidies for coverage by subsystems (a form of VHI) are abolished. The Government no longer pays premiums on behalf of public employees enrolled in a subsystem.
2016	February	Fixed co-payments for abortion services in the NHS are abolished
2016	March	NHS dental care vouchers are extended to cover children < 18 (previously only available to children < 16)
2016	March	Introduction of a pilot project to improve access to dental care by integrating dentists in 13 NHS primary care centres in the regions of Alentejo and Lisbon and the Tagus Valley. The pilot covers people with specific conditions (diabetes, cancer, chronic cardiac or respiratory conditions, renal failure in haemodialysis or peritoneal dialysis and transplant recipients) and people with low incomes

Table 2. Contd

Year	Month	Change
2016	April	Co-payments for emergency care with a referral from primary care, the NHS helpline or the emergency helpline are abolished
2016	April	Co-payments for primary care visits with a referral from the NHS helpline are abolished
2016	April	Co-payments for a first hospital outpatient specialist visit with a referral from primary care and for diagnostic tests prescribed in the NHS are abolished
2017	May	Waiting times targets are set for outpatient care and some elective surgeries
2020	July	The dental care access pilot project introduced in 2016 is extended to 91 (out of 278) municipalities in mainland Portugal. This change was not defined by the authorities as a response to coronavirus disease (COVID-19)
2020	April	Co-payments for primary care visits and diagnostic tests carried out by the NHS in primary care or prescribed by an NHS doctor in primary care (diagnostic tests related to a hospital emergency episode are not exempt) are abolished. Implemented in April 2020 for primary care visits, September 2020 for diagnostic tests performed in the NHS and January 2021 for diagnostic tests prescribed by an NHS doctor and carried out in public or private facilities. This change was not defined by the authorities as a response to COVID-19
2022	June	Co-payments for emergency care (except for hospital emergency care without a referral if the patient is not admitted to hospital for at least one night) are abolished. This change was not defined by the authorities as a response to COVID-19
2024	June	Introduction of an exemption from co-payments for outpatient prescribed medicines for pensioners with low incomes who are also receiving social support
2024	December	Co-payments for outpatient prescribed medicines for retired military staff are reduced to 50% (applicable to the reference price and percentage co-payments). This reduction will increase to 100% in 2026

3.2 Service coverage

Most of the publicly financed benefits package is not explicitly defined but there are positive lists for medicines and medical products. These lists are overseen by Infarmed – the National Authority for Medicines and Health Products – and informed by health technology assessment (Ministry of Health, 2015; Perelman et al., 2019; Infarmed, 2025a).

The maximum price of covered medicines is set using external reference pricing while the price of generic medicines is set as the first generic in a class which must be at least 60% cheaper than the original product (originator). The originator prices drop after the patent expires. Pharmacies must have available stock of at least three of the five lowest-cost generics per class (Simões et al., 2017). However, pharmacies do not always have available stock of the lowest-price alternatives due to wholesaler shortages (in which case pharmacists are required to notify Infarmed within 24 hours) or due to issues in pharmacy stock

management (i.e. pharmacies do not have the required medicine in stock even though it is available from the wholesaler). In either case pharmacies should be able to provide users with the medicine in 24 hours but some people may pay out of pocket for a more expensive alternative rather than waiting for the pharmacy to make the lowest-priced alternative available or trying another (DECO PROteste, 2024; Costa, 2025; Infarmed, 2025b). A recent study found that in 2023 nearly half of all people surveyed reported waiting at least 24 hours for a medicine that was not immediately available in the pharmacy; 19% of these people paid out of pocket for a more expensive alternative to avoid waiting (DECO PROteste, 2024).

The benefits package is relatively comprehensive but access to publicly financed dental care (which is covered in theory) is limited due to the lack of sufficient public facilities. Many types of dental care (e.g. root canal and prosthodontic treatment, periodontal treatment, implant-borne restoration and prosthetic rehabilitation for edentulous users) are either not covered or are almost fully paid out of pocket (Winkelmann et al., 2022). The Government has introduced two policies to address this issue. First, since 2008, a few groups of people (children under 18 years old, pregnancy, people over 65 years receiving social support, people living with HIV/AIDS and people at high risk of oral cancer) have been eligible for NHS dental care vouchers that give them access to some publicly financed dental care in private facilities and are subject to time and volume limits (Simões et al., 2018; Fronteira, Augusto & Maresso, 2025). Each voucher covers a dental care visit and the necessary treatment derived from that episode of care. People need to request these vouchers when visiting their general practitioner (GP). In 2025 around 20% of the population were entitled to dental care vouchers (authors' calculations). Second, since 2016 a pilot project in 13 NHS primary care centres has provided dental care for people with specific conditions (diabetes, cancer, chronic cardiac or respiratory conditions, renal failure in haemodialysis or peritoneal dialysis and transplant recipients) and people with low incomes (Ministry of Health, 2016). Currently, it covers all regions (91 out 278 municipalities) (National Health Service, 2025a).

Coverage of medical products is also limited – for example, corrective lenses are only covered for people over 65 years with low incomes receiving social support (Centro Nacional de Pensões, 2025). In Madeira corrective lenses are covered for people aged 65 years or over with low incomes and children aged 14 years or below (Instituto de administração de saúde, 2025).

Publicly financed health care is provided mainly in public facilities, with some referral to publicly financed private providers, typically for diagnostic tests such as laboratory and imaging tests. Outpatient specialist visits require a referral from a GP. Covered outpatient prescribed medicines require a prescription and people can access them at any pharmacy. Doctors must prescribe medicines by the international nonpropietary name and generic substitution by the pharmacist is allowed. All benefits are provided in kind and there is no cap on the volume of covered care.

Waiting times are an issue for primary care visits in areas with a shortage of GPs, outpatient specialist visits (partly due to a lack of staff in some specialties and physiotherapy, diagnostic tests and renal dialysis) and elective surgery.

Since 2017, waiting time targets are as follows but are exceeded in many areas (National Health Service, 2025b; National Health Service, 2025c):

- emergency care in primary care should be provided on the same day;
- non-urgent primary care should be provided in less than 15 days;
- repeat prescriptions of outpatient medicines for chronic conditions should be processed in 3 days;
- outpatient home visits should be scheduled in 24 hours if approved by a primary care professional;
- referrals from primary care to hospitals for outpatient specialist visits should take place in 30 days for high-priority cases, 60 days for priority cases and 120 days for normal cases; and
- for people with cancer waiting times targets vary depending on the type of care and the priority of the condition, with shorter targets for more severe conditions; prescribed diagnostic tests (30–90 days), cancer surgery (3–60 days), radiotherapy (15 days) and cardiovascular surgery (15–90 days).

Waiting lists for elective surgery are managed centrally. The *Sistema Integrado de Gestão de Inscritos para Cirurgia* [Integrated Management System for Surgical Patients] set up in 2004 (and still in place) initially led to a large reduction in waiting times (Barros, Cristovão & Gomes, 2013). However, in 2022 more than 40% of people were waiting more than 3 months for an elective hip replacement, cataract or knee surgery, which is higher than in countries such as Ireland and Spain (OECD & European Observatory on Health Systems and Policies, 2023). Although the NHS provides people with vouchers that allow them to be treated in other NHS hospitals and contracted private hospitals, people with high incomes often resort to treatment in the private sector, which exacerbates unequal access to health care and reduces the availability of doctors in the public system (dual practice by doctors is allowed).

Access to mental health care professionals (psychologists and psychiatrists) is limited due to workforce shortages, long waiting times and an uneven distribution of professionals across the country (OECD & European Observatory on Health Systems and Policies, 2023). Around 40% of NHS facilities exceeded the maximum waiting time for priority psychiatric consultations in 2022 (Portuguese Health Regulatory Authority, 2022; National Health Service, 2025b).

Other access barriers include a shortage of health professionals working in the NHS. Over the last two years, there has been a lack of GPs in public primary care facilities in some areas. About 25% of people in the Lisbon region do not have a GP, compared to less than 5% in the North

region (National Health Service, 2025c). There are occasional shortages of medicines due to exports or problems in the production supply chain (Infarmed, 2023a; 2023b). The archipelagos experience barriers to access covered care (as not all islands have hospitals and transport can be affected by weather conditions), particularly in the Azores.

3.3 User charges (co-payments)

Portugal applies co-payments to most types of care – except primary care visits, diagnostic tests in primary care and inpatient care – using a mixture of fixed and percentage co-payments (Table 3).

Mechanisms in place to protect people from co-payments include:

- reduced co-payments for outpatient prescribed medicines for pensioners with low incomes and retired military staff;
- exemption from co-payments for outpatient specialist visits and diagnostic tests on the basis of income (people with an average monthly income lower than €783.75 and their dependants), age (children under 18 years), health (people with chronic conditions and transplants and in pregnancy), occupational status (unemployed people and their dependants) and other criteria (e.g. asylum seekers, refugees, firefighters and veterans and their partners); and
- exemption from co-payments for outpatient prescribed medicines on the basis of income (e.g. pensioners with low incomes who are also receiving social support for older people) and health (e.g. people with rheumatoid arthritis and pain treatment for people with cancer).

As of 2025 exemptions from co-payments for pregnancy and children under 18 years are applied automatically. Other exemptions will continue to require application. People with low incomes or unemployed people must apply through the NHS portal, the NHS hotline or at a primary care centre and income-based exemptions are verified by the tax authority. The Ministry of Health assesses people with chronic conditions and grants them exemption status.

There is no protection from co-payments for outpatient prescribed medicines for working-aged people with low incomes; there is no cap on any co-payments; and VHI does not cover co-payments.

The application of co-payments has also fluctuated over time (see Table 2).

Table 3. User charges (co-payments) for publicly financed health care, 2025

Note: NA: not applicable.

Source: UHC watch (2025).

Service area	Type and level of user charge	Reduced user charges	Exemption from user charges	Cap on user charges
Outpatient primary care visits	None	NA	NA	NA
Outpatient specialist visits	Fixed co-payments: €7 per visit	No	• children < 18 • people with an average monthly income < €783.75 and unemployed people and their dependants • people with chronic conditions, people with a disability ≥ 60% of their functional capacity, pregnancy and people with transplants • military staff and veterans with disabilities, asylum seekers, refugees, blood, cell, tissue or organ donors, firefighters and veterans and their partners	No
Outpatient emergency visit	None with referral from primary care or via ambulance services Without referral (and if the person is not admitted to at least one night in hospital), fixed co-payments: • €18 (emergency department in main hospitals) • €16 (basic surgery emergency departments) • €14 (basic emergency departments) An additional co-payment of up to €40 can be applied to diagnostic tests provided as part of the episode of emergency care	No	No	No
Outpatient prescribed medicines	**Percentage co-payments:** • group A (e.g. antituberculosis antibiotics, some hormones and eye medicines):10% of the price • group B (e.g. antibiotics, medicines for cardiovascular disease and anticoagulants): 31% of the price • group C (e.g. antiparasitic, central nervous system and anaemia medicines and antihistamines): 63% of the price • group D (e.g. new medicines): 85% of the price **Reference pricing:** people pay the difference between the reference price and the retail price	For pensioners with low incomes (scoring < 7129.64 on the annual index for social support or with an annual pension < €12 180): • group A: 5% • group B: 16% • group C: 48% • group D: 70% Retired military staff only pay 50% of the difference between the reference price and the retail price and 50% of the percentage co-payment	For percentage co-payments: • pensioners with low incomes who are also receiving social support for older people • people with specific conditions (e.g. rheumatoid arthritis and pain treatment for people with cancer)	No

Table 3. Contd

Service area	Type and level of user charge	Reduced user charges	Exemption from user charges	Cap on user charges
Medical products	**No co-payments:** • needles, syringes and lancets for people with diabetes • hearing aids (provided through social security) • mobility and daily living aids for people with disabilities (provided through social security; no co-payment after registration and approval) • medical products for incontinence or urinary retention support (for people registered and approved by Infarmed) **Fixed co-payment:** €53 for glucose meters **Percentage co-payments:** • glucose meters: 85% of the maximum regulated price allowed • corrective lenses: 25 % of the price with a limit coverage limit of €100 every 2 years for people > 65 with low incomes receiving social support • inhalers and nebulizers: 20% of the price • glucose test strips for people with diabetes: 15% of the price	No	No	No
Diagnostic tests	Diagnostic tests in primary care or with a prescription: none All other diagnostic tests: fixed co-payments of €0.35–€40 per test based on NHS prices	No	• children < 18 • people with an average monthly income < €783.75, unemployed people and their dependants • people with chronic conditions, people with a disability ≥ 60%, pregnant women and people with transplants • military staff and veterans with disabilities, asylum seekers, refugees, blood, cell, tissue or organ donors, firefighters and veterans and their partners	
Dental care visits	NHS dental care vouchers cover selected treatment in private dental facilities (preventive treatment, scaling and root planning) as follows: • children < 18: one to three vouchers a year • pregnancy: up to three vouchers per pregnancy to be used up to 60 days after delivery • people over 65 years receiving social support: up to two vouchers a year to be used within a year with a coverage limit of €80 a year • people living with HIV/AIDS: up to six vouchers a year for first access and two additional vouchers after 2 years • people at high risk of oral cancer: two diagnostic vouchers a year and two biopsy vouchers a year For other groups of people: fixed co-payments based on the NHS price list	No	No	No

Table 3. Contd

Service area	Type and level of user charge	Reduced user charges	Exemption from user charges	Cap on user charges
Dental care treatment	As for dental care visits Removable dental prostheses: 25% of the price up to a limit of €250 every 3 years for people > 65 with low incomes receiving social support (provided through social security)	No	No	No
Inpatient care	None	NA	NA	NA

3.4 The role of VHI

VHI plays a supplementary role providing people with faster access to health care or increased choice of provider and is provided by two types of entities: so called subsystems and commercial insurance companies. In 2023 31% of the population had some form of VHI (Observatório dos Seguros de Saúde, 2025) and subsystem and commercial VHI together accounted for 7.6% of current spending on health in 2023 (WHO, 2025).

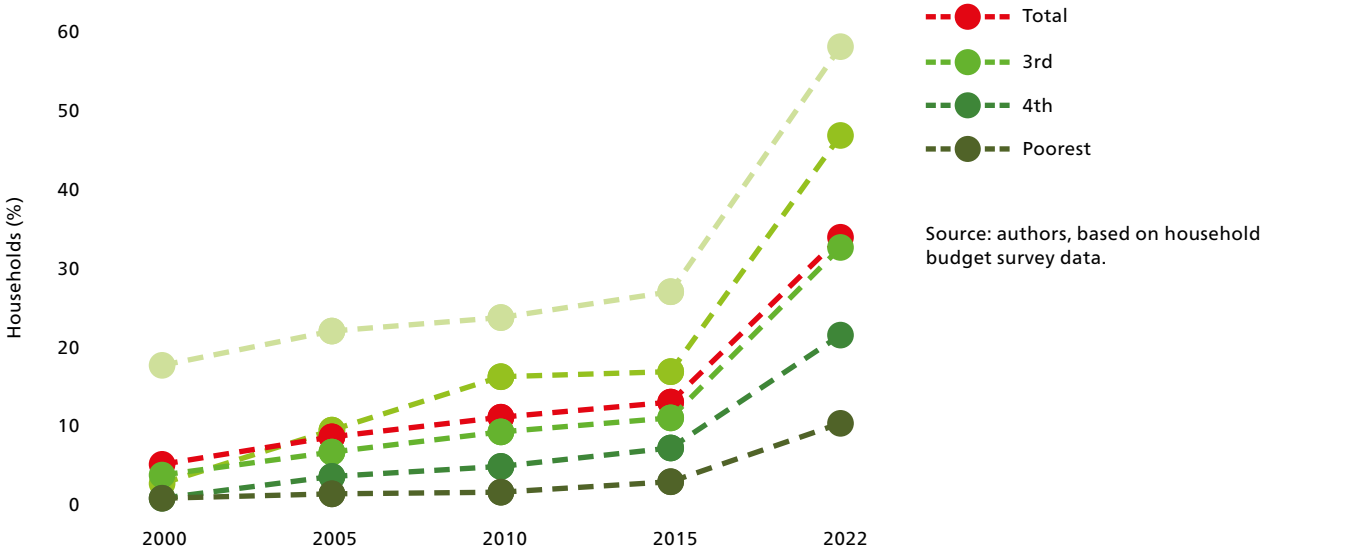
Subsystems were created in 1963 and are employment-based schemes that predate the NHS and have traditionally been initiated and run by public entities (e.g. military staff and civil servants) or private entities (e.g. banks, airlines and utility companies). Since 2015 the schemes have been fully funded by beneficiaries and the Government no longer pays premiums on behalf of public employees. In 2023 the subsystem for civil servants (known as ADSE) covered over 1 million employees and retired people (Simões et al., 2017; Instituto Público de Gestão Participada, 2023).

Commercial (for-profit) insurance companies are regulated by the Insurance and Pension Funds Supervisory Authority while the subsystems are regulated by the Ministry of Health. Commercial insurers sell VHI to individuals and groups, often through employers. In the last 20 years many private insurers have transitioned from providing VHI for subsystems to commercial VHI. There were 23 commercial insurers selling VHI in 2023, with four companies responsible for almost 80% of the market share (Observatório dos seguros de saúde, 2025). Basic VHI contracts covering inpatient care, outpatient specialist care, primary care and diagnostic tests dominate the market (Silva, 2009).

Most people with VHI (subsystems and commercial) are aged between 20–54 years, live in urban areas, have medium to high incomes and work for medium to large companies (Sagan & Thomson, 2016). Even though there is no denial of access to particular risk groups, age and health-related exclusions are common; in practice this means that people over 60 years old or with a history of illness may not be able to purchase VHI (Silva, 2009).

About a third (34%) of households reported spending on VHI premiums (subsystems and commercial insurance) in 2022, ranging from 11% in the poorest quintile to 58% in the richest (Fig. 1). The sharp increase in 2022 is related to the abolition of government subsidies for all employment-based schemes subsystems in 2015.

Fig. 1. Households with spending on VHI premiums by consumption quintile



Source: authors, based on household budget survey data.

Households can deduct 15% of any spending on health (NHS co-payments, other out-of-pocket payments and VHI premiums) from their annual taxable household income, up to a maximum deductible amount of €1000 a year per household (Saldo positivo, 2025) – a policy that is more likely to benefit richer households.

Table 4 summarizes the main gaps in publicly financed coverage and describes the role of VHI in filling these gaps.

Table 4. Gaps in coverage

Source: UHC watch (2025).

Coverage dimension	Main gaps in publicly financed coverage	Are these gaps covered by VHI?
Population coverage	Entitlement is based on residence, so there are no gaps in population coverage for permanent residents. Refugees, asylum seekers, the children of undocumented migrants and some undocumented migrant adults are entitled to the same benefits as residents; however, administrative barriers may hinder access to health care for these groups of people.	No. VHI plays no role in filling gaps in population coverage.
Service coverage	Access to dental care is restricted due to the lack of sufficient public facilities. Corrective lenses are limited to people over 65 years with low incomes receiving social support only. Waiting times are an issue, particularly for outpatient specialist visits and elective surgery and partly due to a shortage of health professionals. Waiting time targets are often exceeded. As a result, people with high incomes resort to treatment in the private sector. The archipelagos experience access challenges, especially in the Azores; not all islands have hospitals and transport can be affected by weather conditions.	To some extent. VHI offers people faster access to treatment (including access to specialists without a referral).
User charges (co-payments)	User charges are applied to most types of care except primary care visits, diagnostic tests in primary care and inpatient care. Percentage co-payments of up to 85% are applied to outpatient prescribed medicines and medical products. Very few people with low incomes (older people receiving social support only) are exempt from co-payments for outpatient prescribed medicines, there are no exemptions from co-payments for medical products and existing exemptions are not applied automatically. There is no cap on co-payments. People may pay more than expected out-of-pocket for covered medicines as the lowest-priced alternatives are not always available in pharmacies.	No. VHI does not cover user charges (co-payments).

3.5 Summary

The basis for entitlement to publicly financed health care provided by the NHS is permanent residence, so all permanent residents are covered. Refugees, asylum seekers, the children of undocumented migrants and some undocumented migrant adults (those in a family regrouping process with a family member who is a social beneficiary) are entitled to the same benefits as residents but administrative barriers may hinder access to health care for these groups of people. Other undocumented migrants are not entitled to any type of publicly financed health care. The number of people who lack coverage is not known.

The benefits package is relatively comprehensive but access to publicly financed dental care is restricted due to the lack of sufficient public facilities. Coverage of corrective lenses is limited to people over 65 years with low incomes receiving social support.

Waiting times are an issue, particularly for outpatient specialist visits and elective surgery and partly due to a shortage of health professionals. Waiting time targets are often exceeded. As a result, people with high incomes often resort to treatment in the private sector, which exacerbates unequal access to health care.

Other access barriers include a shortage of health professionals working in the NHS (particularly GPs) and barriers to access covered care in the archipelagos (especially in the Azores) as not all islands have hospitals and transport can be affected by weather conditions.

User charges are applied to most types of care except primary care visits, diagnostic tests in primary care and inpatient care. Percentage co-payments of up to 85% are applied to outpatient prescribed medicines and medical products. Very few people with low incomes (older people receiving social support only) are exempt from co-payments for outpatient prescribed medicines, there are no exemptions on co-payments for medical products and existing exemptions are not applied automatically. There is no cap on co-payments.

People may pay more than expected out-of-pocket for covered medicines as the lowest-priced alternatives are not always available in pharmacies.

VHI provides around a third of the population with faster access to health care or increased choice of provider but take up is heavily concentrated in richer households.

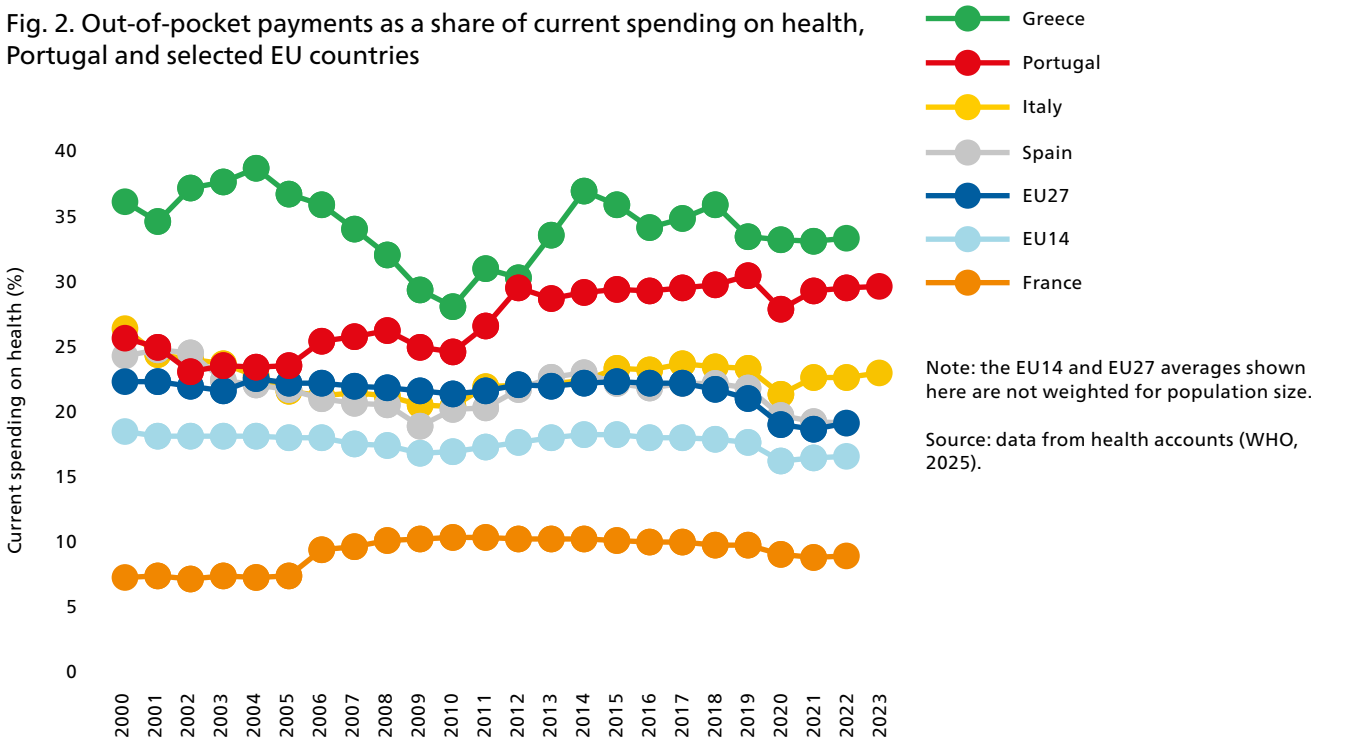
4. Spending on health

The first part of this section uses data from national health accounts to present patterns in public and private spending on health. The second and third parts use household budget survey data to review out-of-pocket payments (the formal and informal payments made by people at the time of using any good or service delivered in the health system) and household spending on VHI. The fourth part considers the role of informal payments. The indicator explorer by UHC watch (2025) provides further data for most of the figures in this chapter.

4.1 Public and private spending on health

Data from national health accounts indicate that out-of-pocket payments in Portugal accounted for 30% of current spending on health in 2023 – much higher than the EU27 average of 19% and the EU14 average of 17% in 2022 (Fig. 2). The out-of-pocket payment share grew sharply between 2010 and 2012 – in response to a sharp drop in public spending on health per person (Fig. 3) caused by NHS budget cuts following the global financial crisis – and has remained at that higher share since, with just one fall in 2020, the first year of the COVID-19 pandemic. Public spending on health per person began to grow again from 2015 but not enough to lower the out-of-pocket payment share of current spending on health.

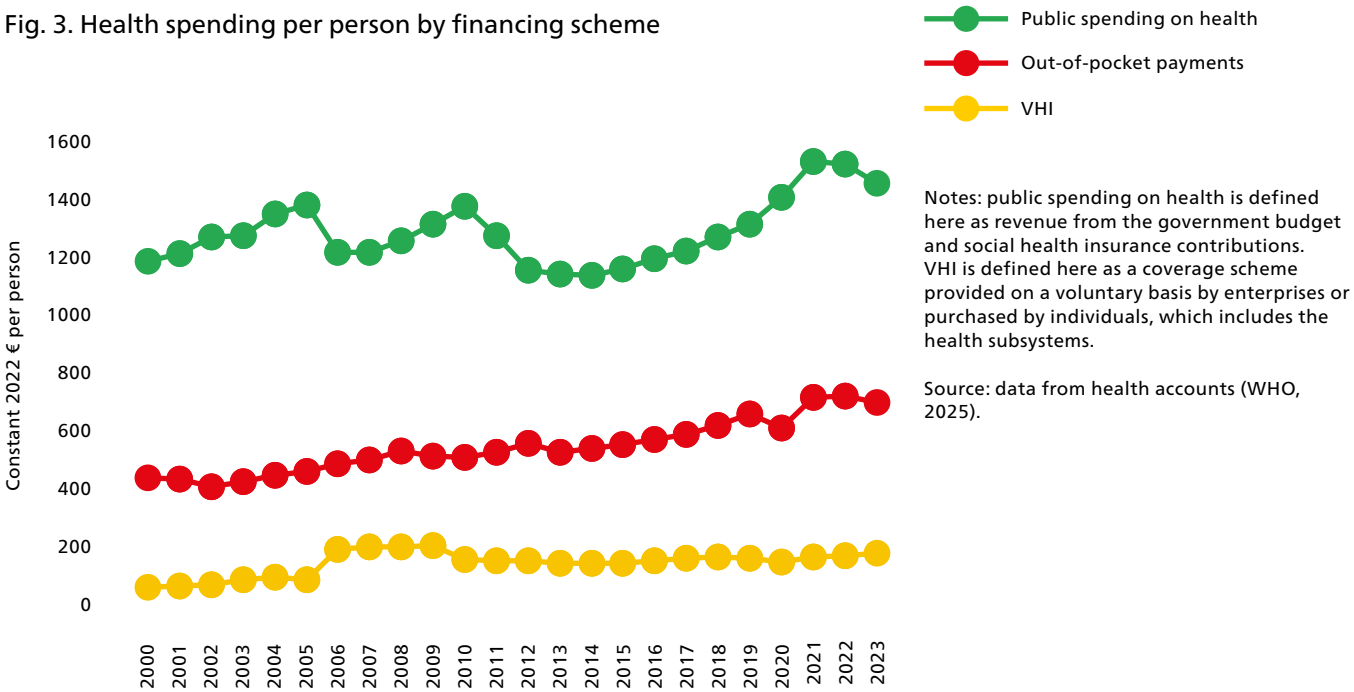
Fig. 2. Out-of-pocket payments as a share of current spending on health, Portugal and selected EU countries



Note: the EU14 and EU27 averages shown here are not weighted for population size.

Source: data from health accounts (WHO, 2025).

Fig. 3. Health spending per person by financing scheme



Notes: public spending on health is defined here as revenue from the government budget and social health insurance contributions. VHI is defined here as a coverage scheme provided on a voluntary basis by enterprises or purchased by individuals, which includes the health subsystems.

Source: data from health accounts (WHO, 2025).

In 2022 public spending on health accounted for 6.5% of GDP, similar to Italy (6.7%) and the EU27 average (6.5%) but lower than Spain (7.2%) and the EU14 average (7.3%) (Fig. 4). Public spending on health accounted for 15% of total government spending in 2022, similar to the EU27 average (15%) but lower than the EU14 average (16%) (Fig. 5).

Fig. 4. Public spending on health and GDP per person, Portugal and the EU, 2022

Note: public spending on health is defined here as revenue from the government budget and social health insurance contributions. The figure excludes Ireland and Luxembourg because they are outliers in terms of GDP per person and Netherlands (Kingdom of the) because the Dutch data on public spending on health are not internationally comparable. The list of country codes used here can be found in the Abbreviations.

Source: data from health accounts (WHO, 2025).

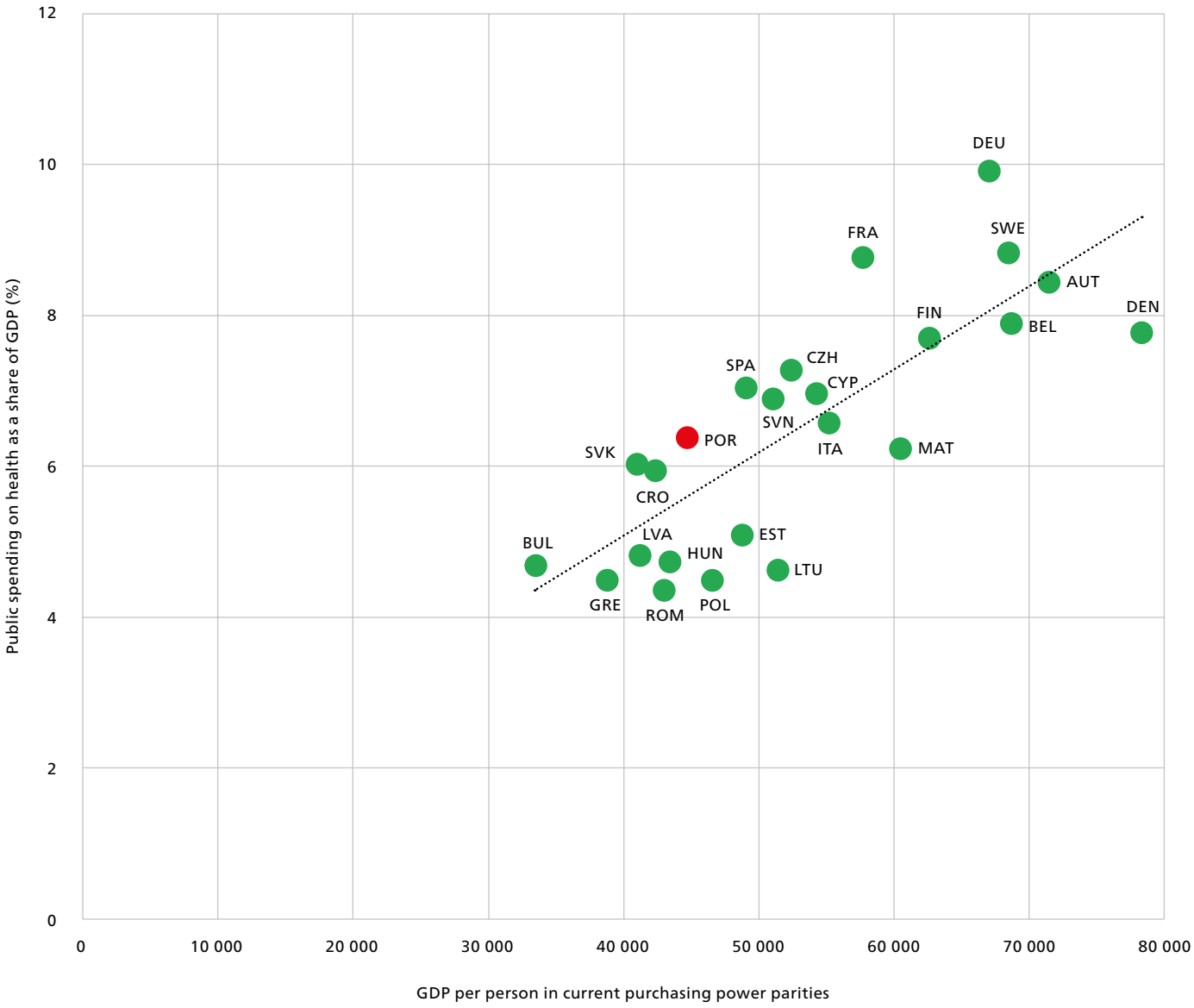
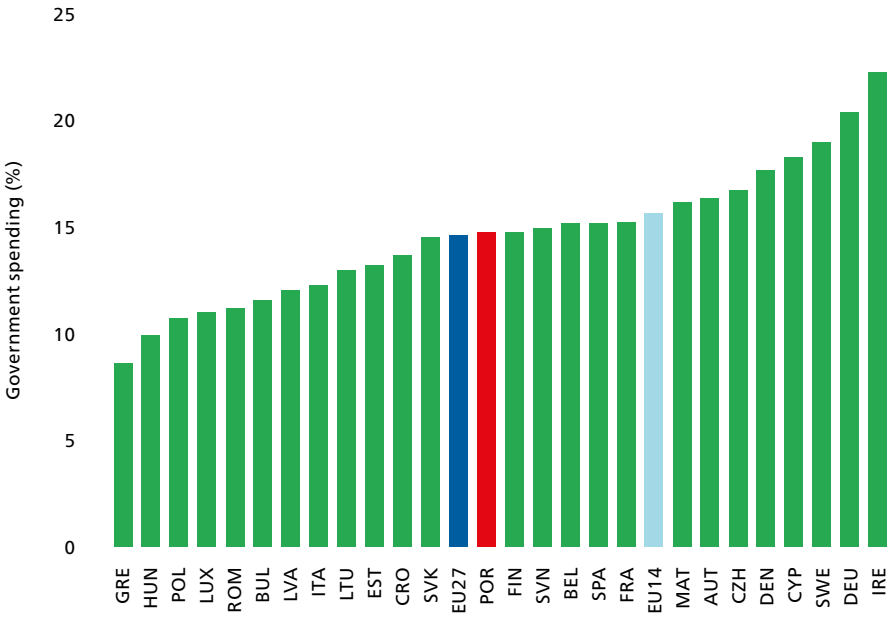


Fig. 5. Public spending on health as a share of the government budget in the EU, 2022

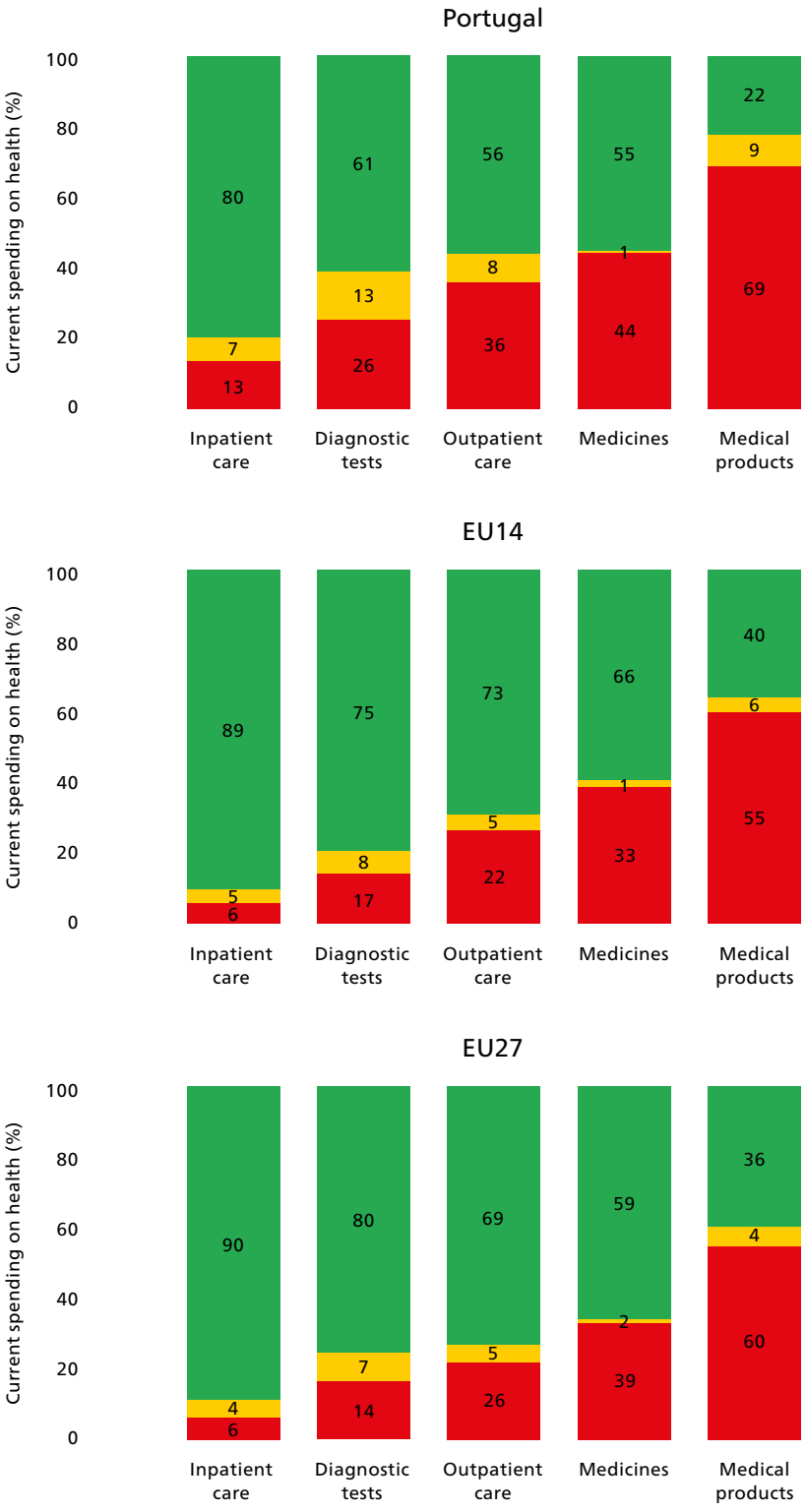


Notes: public spending on health is defined here as revenue from the government budget and social health insurance contributions. The figure excludes Netherlands (Kingdom of the) because of lack of comparability of the data on public spending on health. The EU14 and EU27 averages shown here are not weighted for population size.

Source: data from health accounts (WHO, 2025).

Broken down by type of care, the out-of-pocket payment share of current spending on health in Portugal is highest for medical products (69%), followed by outpatient medicines (44%) and outpatient care (36%, which includes dental care) (Fig. 6). The out-of-pocket payment share is above the EU and EU14 average for all types of care in Portugal (Fig. 6).

Fig. 6. Breakdown of current spending on health by type of care and financing scheme, Portugal and the EU, 2022



Public spending on health

VHI

Out-of-pocket payments

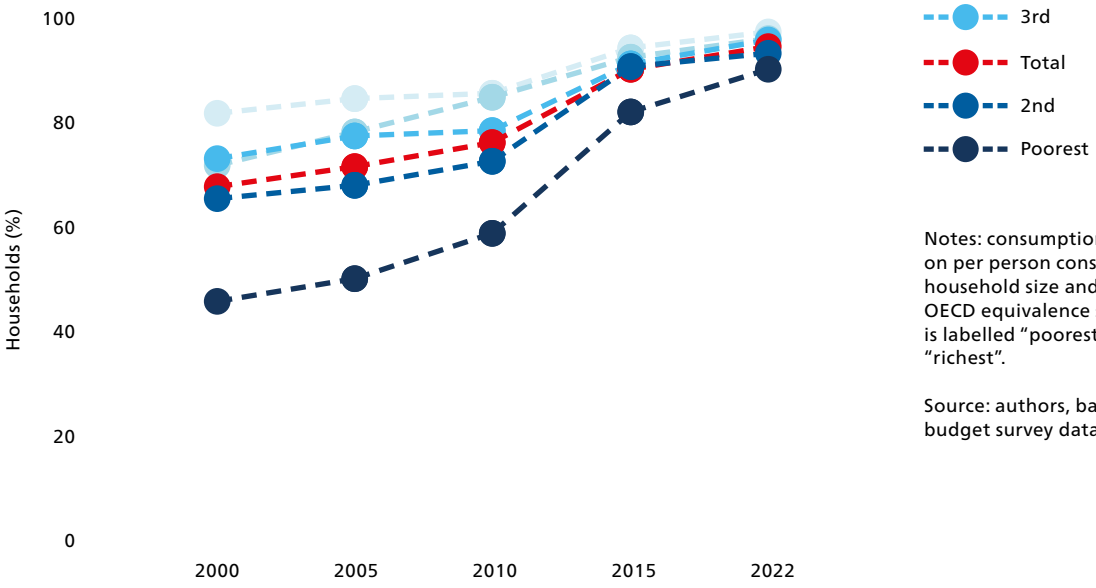
Notes: national data sources for Portugal do not report dental care separately from other types of outpatient care and patient transport separately from diagnostic tests. The EU14 and EU27 averages shown here are not weighted for population size.

Source: data from health accounts (OECD, 2025).

4.2 Out-of-pocket payments

Around 95% of households reported out-of-pocket payments on average in 2022, ranging from 91% in the poorest consumption quintile to 98% in the richest (Fig. 7). These shares have increased in all households over time, with a steeper increase since 2010, particularly for the poorest households.

Fig. 7. Households with out-of-pocket payments by consumption quintile



Notes: consumption quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales. The first quintile is labelled "poorest" and the fifth quintile "richest".

Source: authors, based on household budget survey data.

The average amount spent out of pocket per person was €336 in 2022, ranging from €172 in the poorest quintile to €616 in the richest (Fig. 8). The average amount spent has decreased since 2015 in all quintiles.

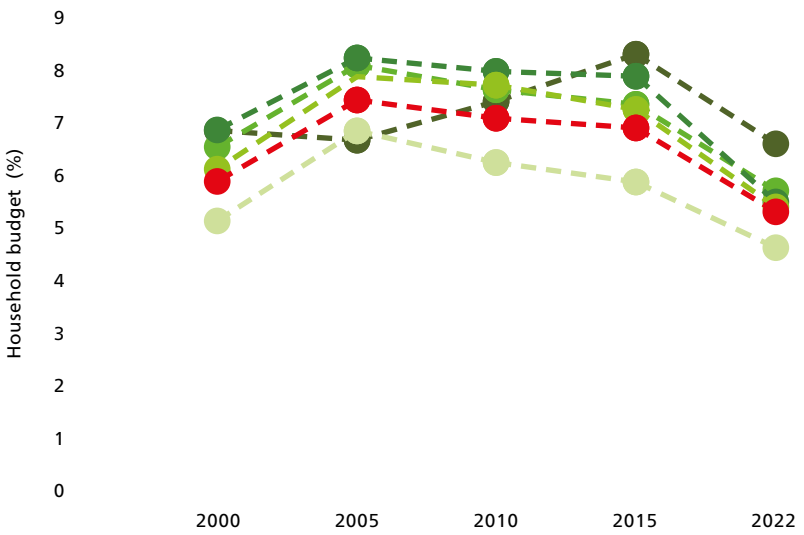
Fig. 8. Annual out-of-pocket payments per person by consumption quintile

Note: amounts are shown in real terms (base year 2020).

Source: authors, based on household budget survey data.

In 2022 out-of-pocket payments accounted for 5.3% of total household consumption (the household budget) on average, down from 7.5% in 2005 (Fig. 9). This share ranged from 4.6% in the richest quintile to 6.6% in the poorest. It has decreased since 2015 in all quintiles but remains higher on average in Portugal than in many other EU countries (Fig. 10).

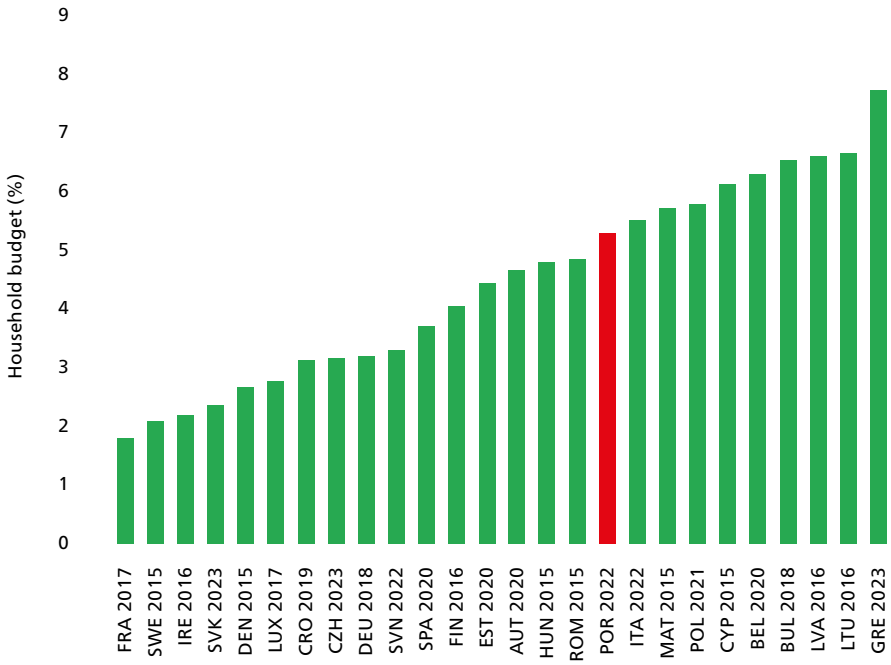
Fig. 9. Out-of-pocket payments as a share of household consumption by consumption quintile



Source: authors, based on household budget survey data.

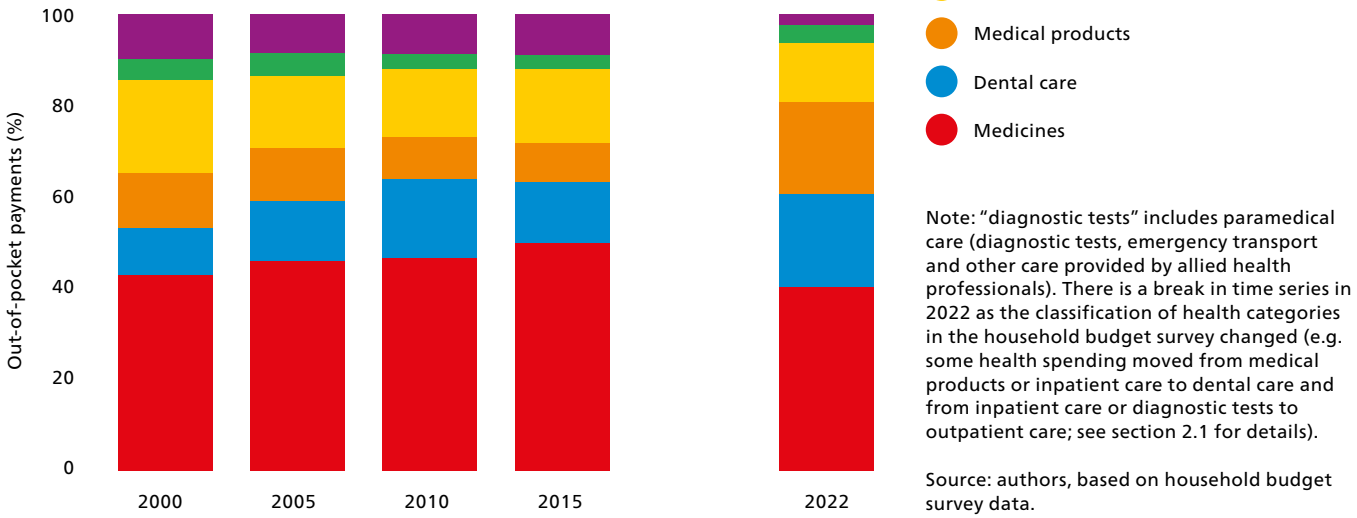
Fig. 10. Out-of-pocket payments as a share of household consumption in the EU, latest available year

Source: UHC watch (2025).



Outpatient medicines consistently account for the largest share of out-of-pocket payments. In 2022 out-of-pocket payments were mainly driven by spending on outpatient medicines (40%), followed by dental care and medical products (both at 20%) (Fig. 11). The share spent on outpatient medicines decreased in 2022 (after a trend upwards in the previous years) and the share spent on medical products and dental care increased sharply in 2022.

Fig. 11. Breakdown of out-of-pocket payments by type of care

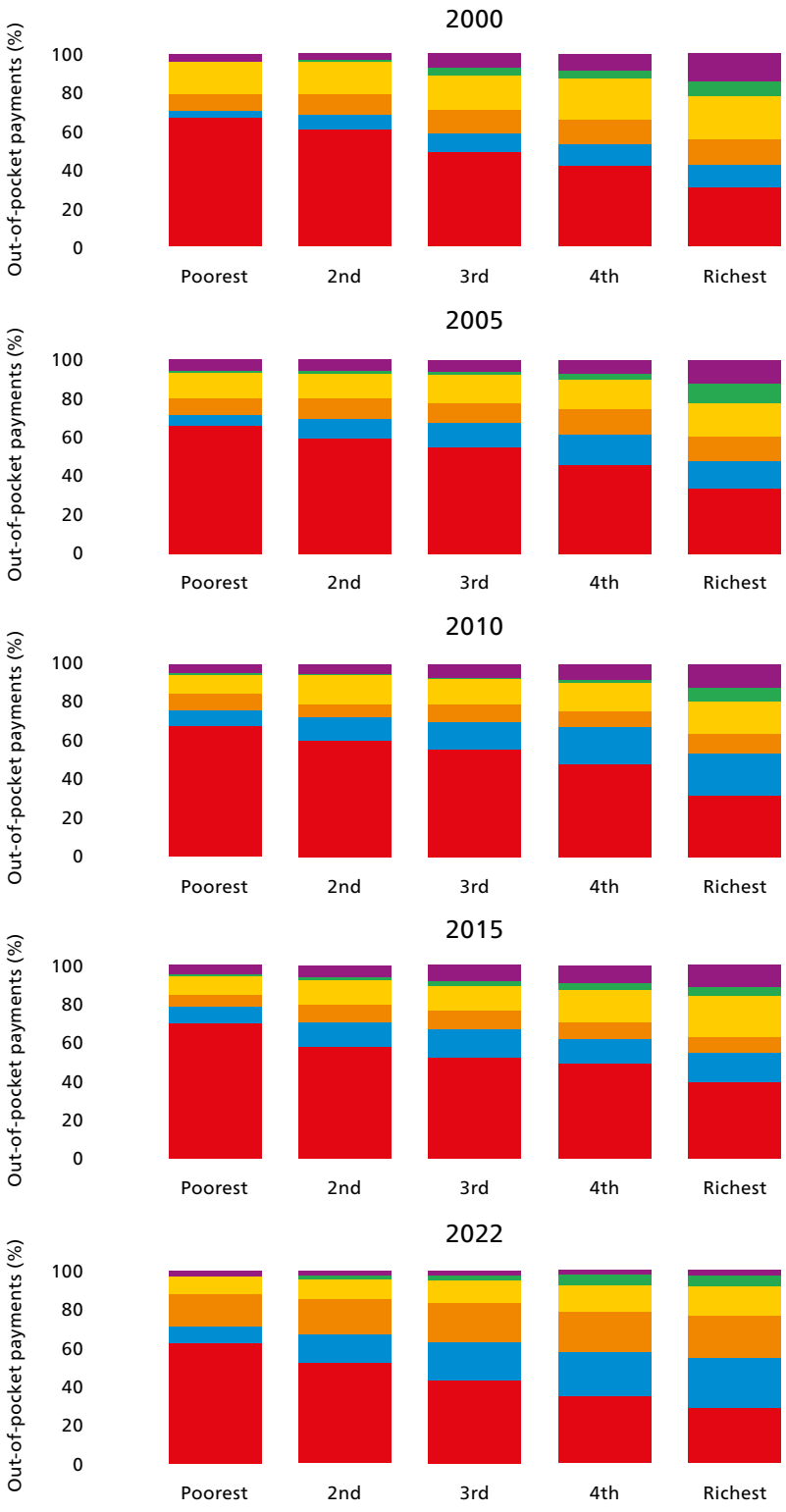


Note: "diagnostic tests" includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). There is a break in time series in 2022 as the classification of health categories in the household budget survey changed (e.g. some health spending moved from medical products or inpatient care to dental care and from inpatient care or diagnostic tests to outpatient care; see section 2.1 for details).

Source: authors, based on household budget survey data.

Outpatient medicines are the main driver of out-of-pocket payments in all quintiles and all years but poorer households consistently spend a much higher share of out-of-pocket payments on medicines (62% in 2022) than the richer households (29%) – a pattern that is reversed for dental care (Fig. 12). The much lower share of spending on dental care in the poorest households is likely to reflect a higher degree of unmet need.

Fig. 12. Breakdown of out-of-pocket payments by type of care and consumption quintile

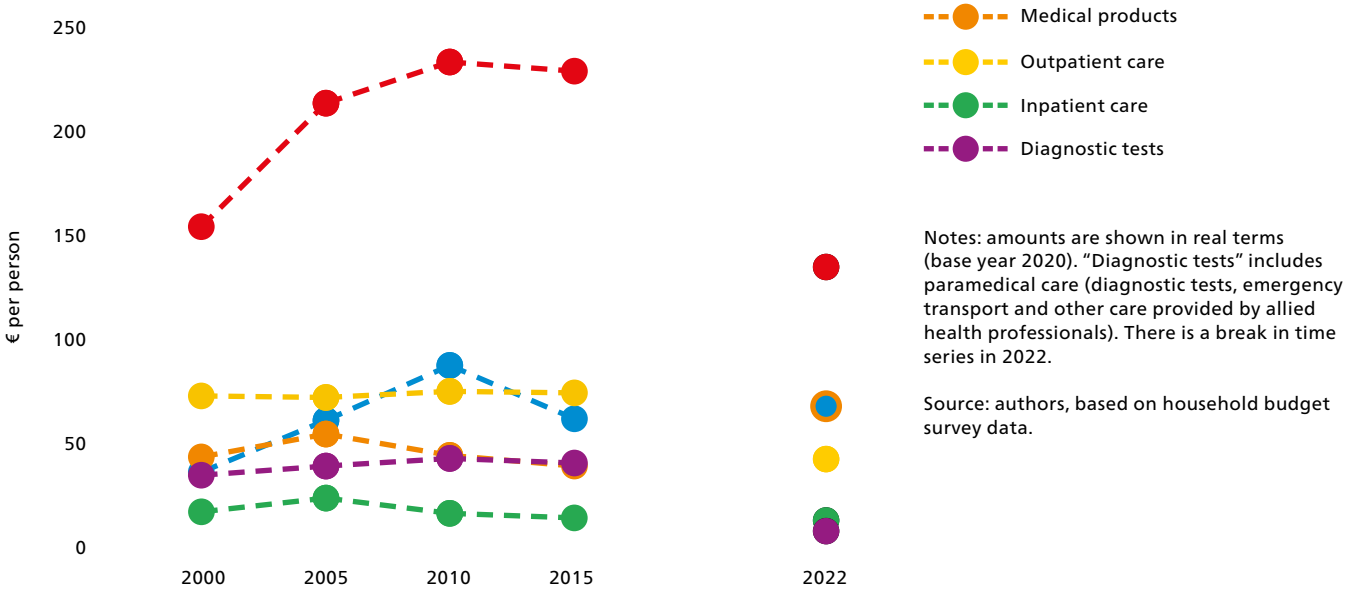


Notes: "diagnostic tests" includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). There is a break in time series in 2022.

Source: authors, based on household budget survey data.

In 2022 per person spending on health was highest for outpatient medicines (€135) followed by dental care (€68) and medical products (€68) (Fig. 13), with substantial variation across quintiles for most types of care (Fig. 14). Spending on most types of care (except medical products and dental care) decreased in 2022 in all quintiles (Fig. 13); the exemption from co-payments for children in 2015 or the abolition of co-payments for emergency care in 2016 or for primary care and diagnostic tests in primary care in 2020 (see Table 2) may explain some changes in spending on medical products and dental care in 2022.

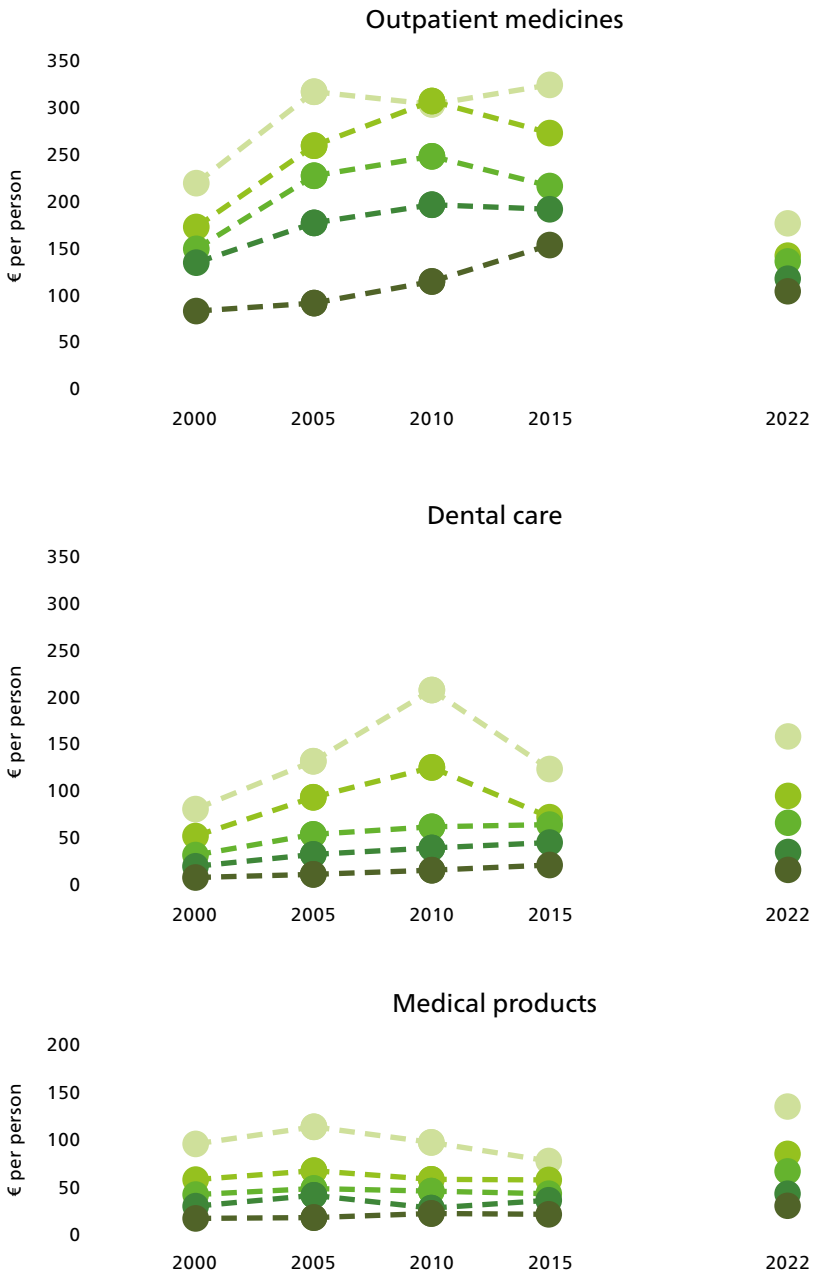
Fig. 13. Annual out-of-pocket payments per person by type of care



Notes: amounts are shown in real terms (base year 2020). "Diagnostic tests" includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). There is a break in time series in 2022.

Source: authors, based on household budget survey data.

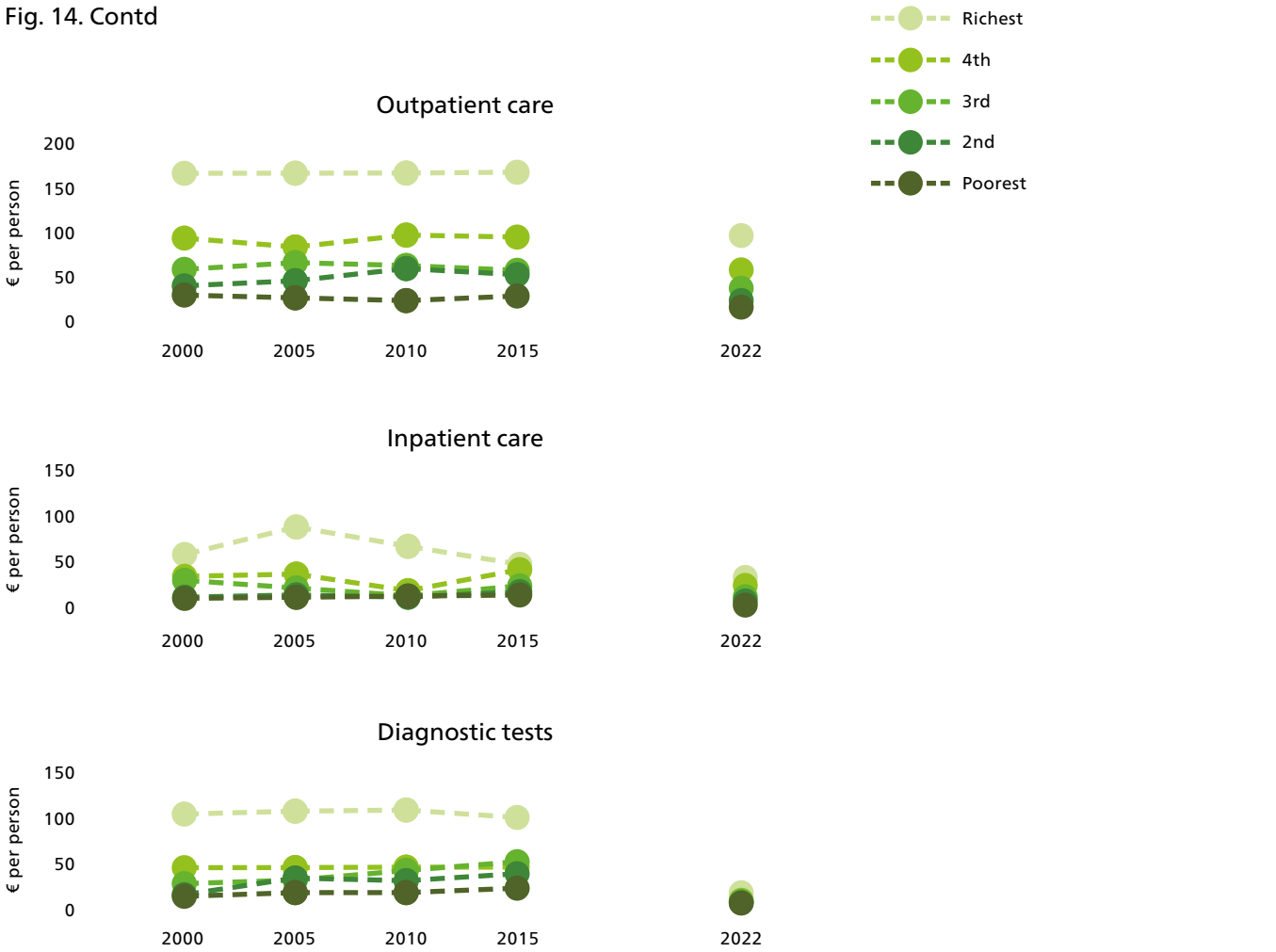
Fig. 14. Annual out-of-pocket payments per person by type of care and consumption quintile



Notes: amounts are shown in real terms (base year 2020). "Diagnostic tests" includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). There is a break in time series in 2022.

Source: authors, based on household budget survey data.

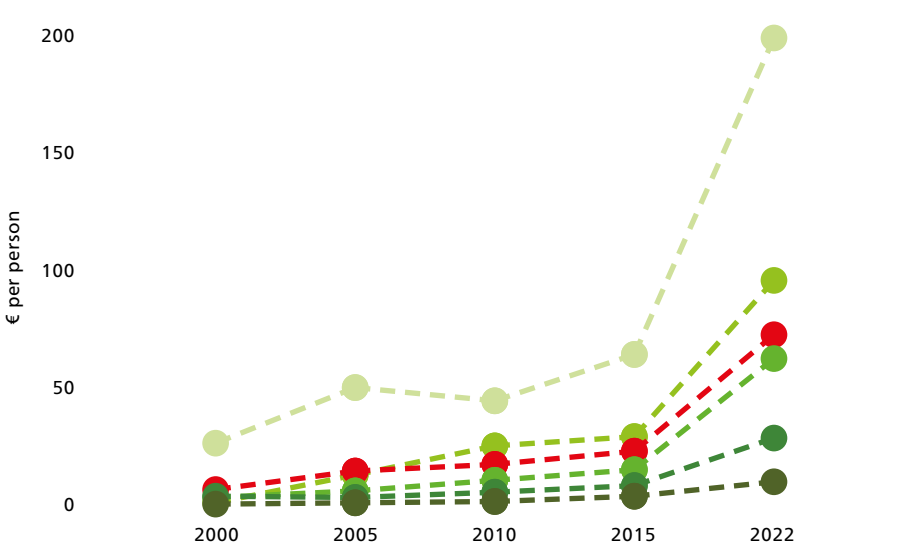
Fig. 14. Contd



4.3 VHI premiums

In 2022 the average amount spent per person on VHI premiums was €73, ranging from €10 in the poorest quintile to €199 in the richest (Fig. 15). This amount has increased over time in all quintiles, especially in 2022 after public subsidies for VHI coverage by subsystems were abolished in 2015.

Fig. 15. Annual spending on VHI premiums per person by consumption quintile



Note: amounts are shown in real terms (base year 2020).

Source: authors, based on household budget survey data.

4.4 Informal payments

Informal payments are not an issue. The 2024 Special Eurobarometer survey on corruption found that 1% of respondents in Portugal who had visited a public health care provider in the previous 12 months reported informal payments, compared to an EU average of 3% (European Commission Directorate-General for Migration and Home Affairs & Kantar, 2024).

4.5 Summary

Data from national health accounts indicate that out-of-pocket payments in Portugal accounted for 30% of current spending on health in 2023 – much higher than the EU27 average (19% in 2022) and the EU14 average (17% in 2022).

In 2022 public spending on health accounted for 6.5% of GDP, similar to Italy (6.7%) and the EU27 average (6.5%) but lower than Spain (7.2%) and the EU14 average (7.3%). Public spending on health accounted for 15% of total government spending in 2022, similar to the EU27 average (15%) but lower than the EU14 average (16%).

Broken down by type of care, the out-of-pocket payment share of current spending on health is Portugal is above the EU14 and the EU27 average for all types of care. It is highest for medical products, followed by outpatient medicines and outpatient care (the latter includes dental care).

Around 95% of households reported out-of-pocket payments on average in 2022, ranging from 91% in the poorest consumption quintile to 98% in the richest. These shares have increased in all households over time.

Out-of-pocket payments accounted for 5.3% of total household spending in 2022 on average, down from 7.5% in 2005. This share ranged from 4.6% in the richest quintile to 6.6% in the poorest. It is higher on average in Portugal than in many other EU countries.

Outpatient medicines consistently account for the largest share of out-of-pocket payments in all quintiles in all years. However, poorer households spend a much higher share on outpatient medicines than richer households, who spend a higher share on dental care.

In 2022 per person spending on health was highest for outpatient medicines (€135) followed by dental care (€68) and medical products (€68). Spending on most types of care (except medical products and dental care) decreased in 2022 in all quintiles.

Informal payments are not an issue.

5. Financial protection

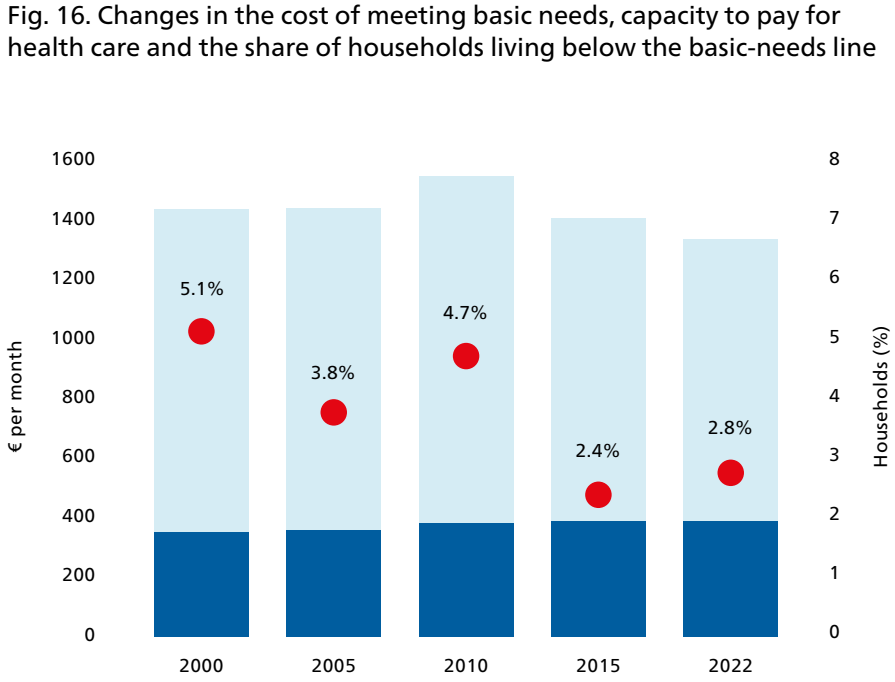
This section uses data from the Portuguese household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households that use health care. It looks at household capacity to pay for health care, the relationship between out-of-pocket spending on health and poverty – impoverishing health spending – and the incidence, distribution and drivers of catastrophic health spending. The section also draws on other survey data to assess unmet need for health care. The indicator explorer by UHC watch (2025) provides further data behind the figures in this chapter.

5.1 Household capacity to pay for health care

Household capacity to pay for health care is what is left of a household's budget after spending on basic needs. In this study, basic needs are defined as the average cost of spending on food, housing and utilities (water, electricity and fuel) among a relatively poor part of the Portuguese population (households between the 25th to 35th percentiles of the consumption distribution), adjusted for household size and composition. In 2022 the monthly cost of meeting these basic needs (the basic needs line) was €390 (Fig. 16) which was low compared to Portugal's monthly national poverty line of €550 in 2022 (62% of median income) (Observatório Nacional de Luta Contra a Pobreza, 2025).

On average household capacity to pay for health care has decreased since 2010 and was lower in 2022 than it had been at the start of the study period (Fig. 16). The share of households living below the basic needs line has generally decreased over time but it increased sharply in 2010, following the global financial crisis, and again in 2022, after the COVID-19 pandemic (Fig. 16).

Fig. 16. Changes in the cost of meeting basic needs, capacity to pay for health care and the share of households living below the basic-needs line

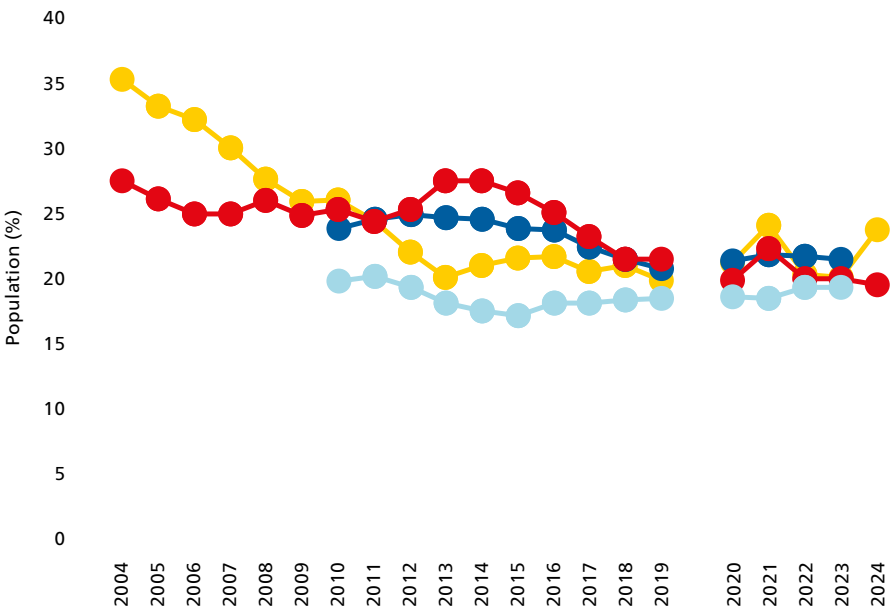


Notes: capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. Amounts are shown in real terms (base year 2020).

Source: authors, based on household budget survey data.

The share of the population at risk of poverty or social exclusion is close to the EU average in 2023 but was higher than the EU average after the global financial crisis and the COVID-19 pandemic (Fig. 17). The characteristics of poor households have evolved over time. Single-person households, single-parent households and many people who work and have children are still falling below the poverty line (Carvalho et al., 2025).

Fig. 17. Population at risk of poverty or social exclusion by age in Portugal and the EU



Note: break in series in 2020.

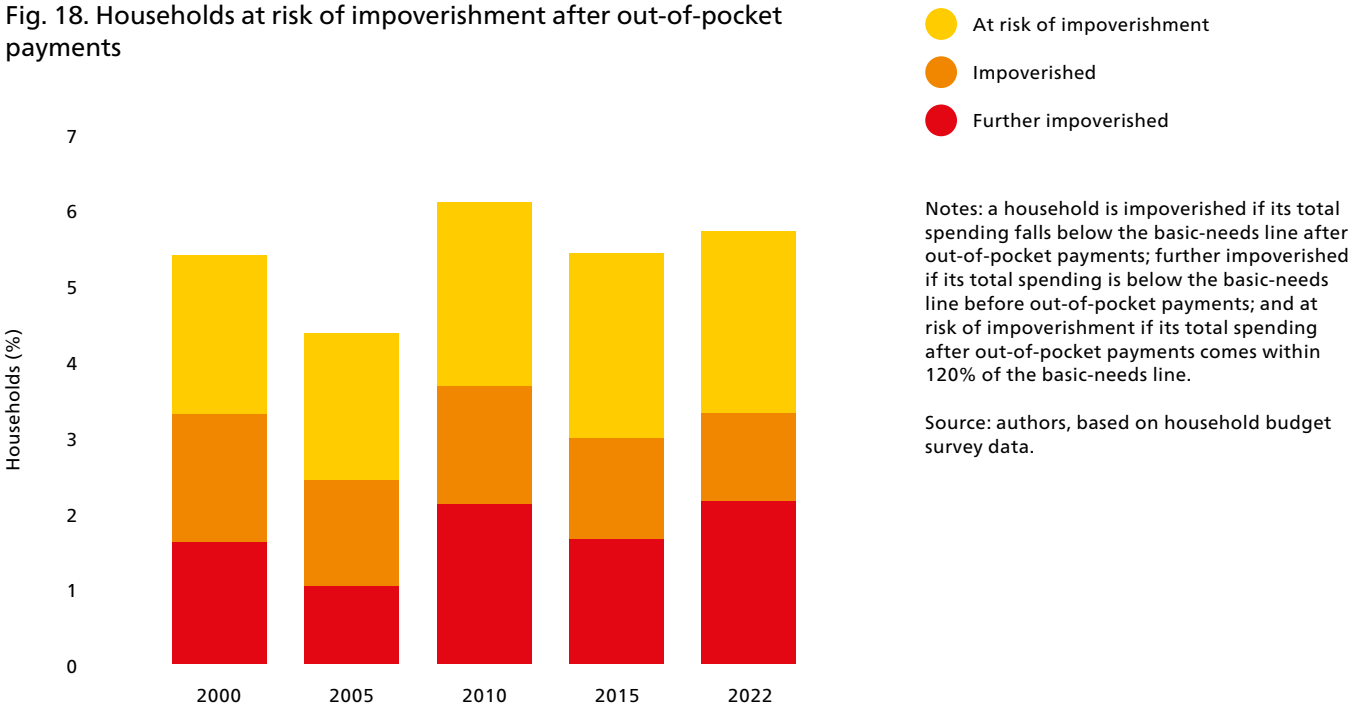
Source: Eurostat (2025c).

5.2 Financial hardship: impoverishing and catastrophic health spending

How many households experience financial hardship?

Impoverishing health spending is defined in this study as out-of-pocket payments that push people into poverty or deepen their poverty. In 2022 3.3% of households were impoverished or further impoverished after out-of-pocket payments, up from 2.4% in 2005 (Fig. 18). The share of households at risk of impoverishment has been stable since 2010.

Fig. 18. Households at risk of impoverishment after out-of-pocket payments



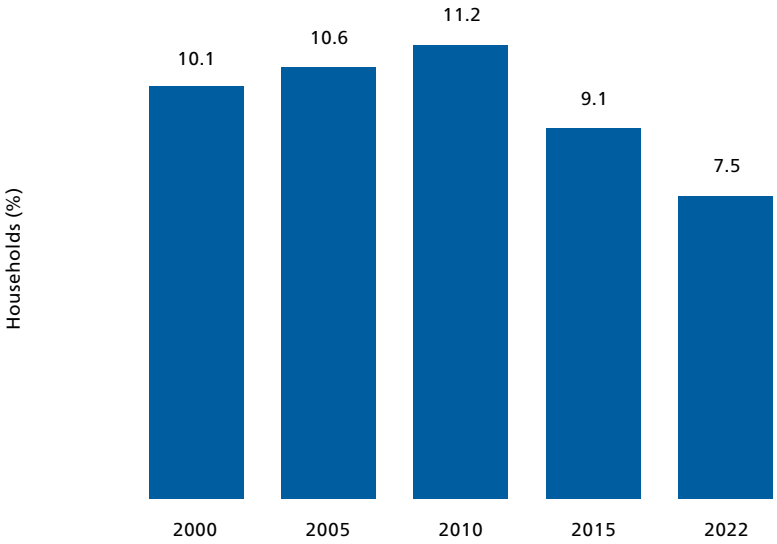
Notes: a household is impoverished if its total spending falls below the basic-needs line after out-of-pocket payments; further impoverished if its total spending is below the basic-needs line before out-of-pocket payments; and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic-needs line.

Source: authors, based on household budget survey data.

Households with catastrophic levels of out-of-pocket spending are defined (in this review) as those with out-of-pocket payments that are greater than 40% of their capacity to pay for health care. This includes households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they had no capacity to pay before paying out of pocket for health care).

In 2022 7.5% of households – around 700 000 people – experienced catastrophic health spending, down from a peak of 11% in 2010 (Fig. 19).

Fig. 19. Households with catastrophic health spending



Note: households with catastrophic health spending are households with out-of-pocket payments that are greater than 40% of their capacity to pay for health care, which may mean that they can no longer afford to meet other basic needs (food, housing and utilities).

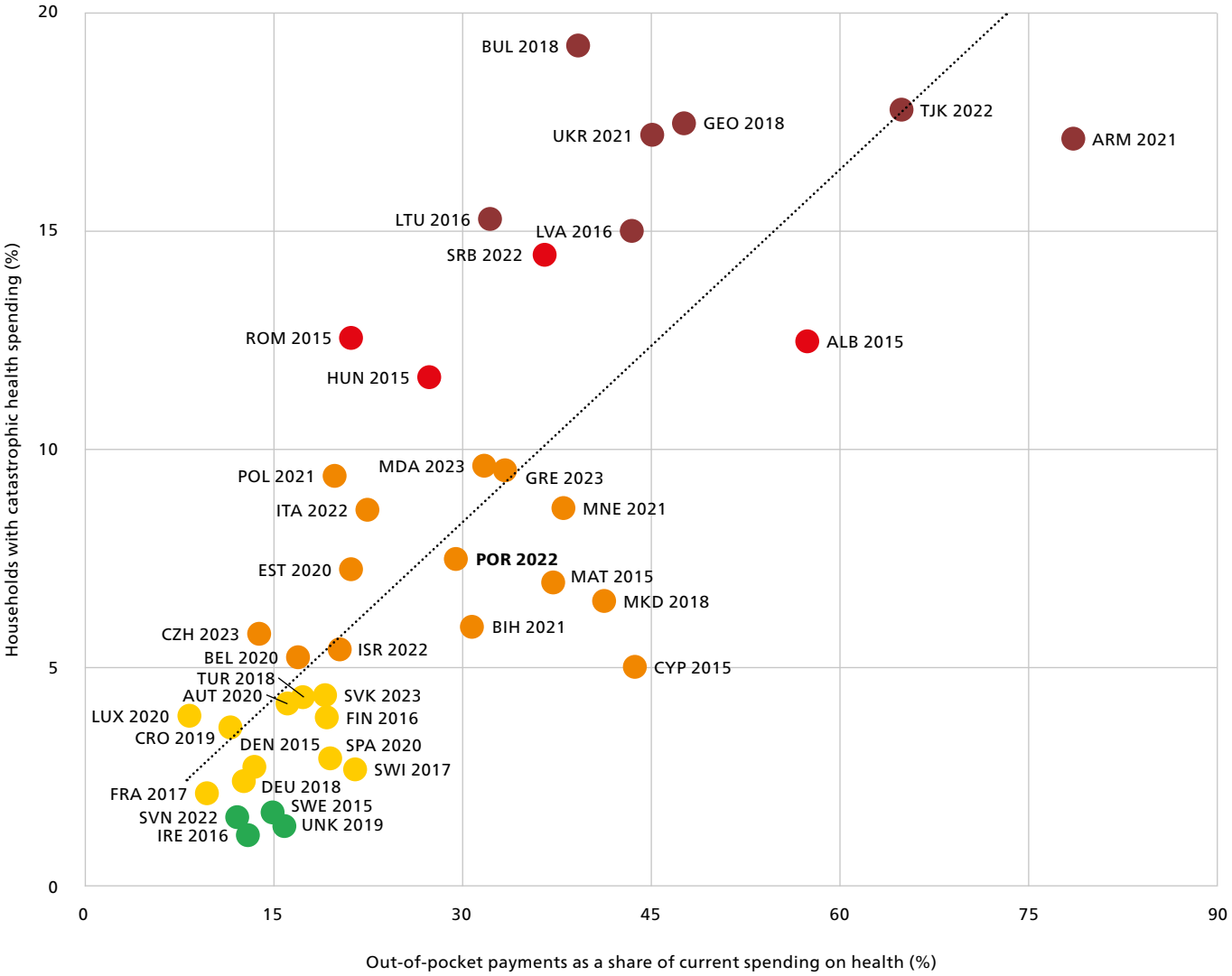
Source: authors, based on household budget survey data.

The incidence of catastrophic health spending is higher in Portugal than in many EU countries (Fig. 20). However, it is lower than in Hungary, Italy, Poland and Romania, even though Portugal relies more heavily than these countries on out-of-pocket payments to finance the health system (Fig. 20).

Fig. 20. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health in the WHO European Region, latest available year

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year, except for Greece, the Republic of Moldova and Slovakia where out-of-pocket payments are for 2022. Dots are coloured by the incidence of catastrophic health spending: green < 2%, yellow < 5%, orange < 10%, red < 15%, dark red > 15%.

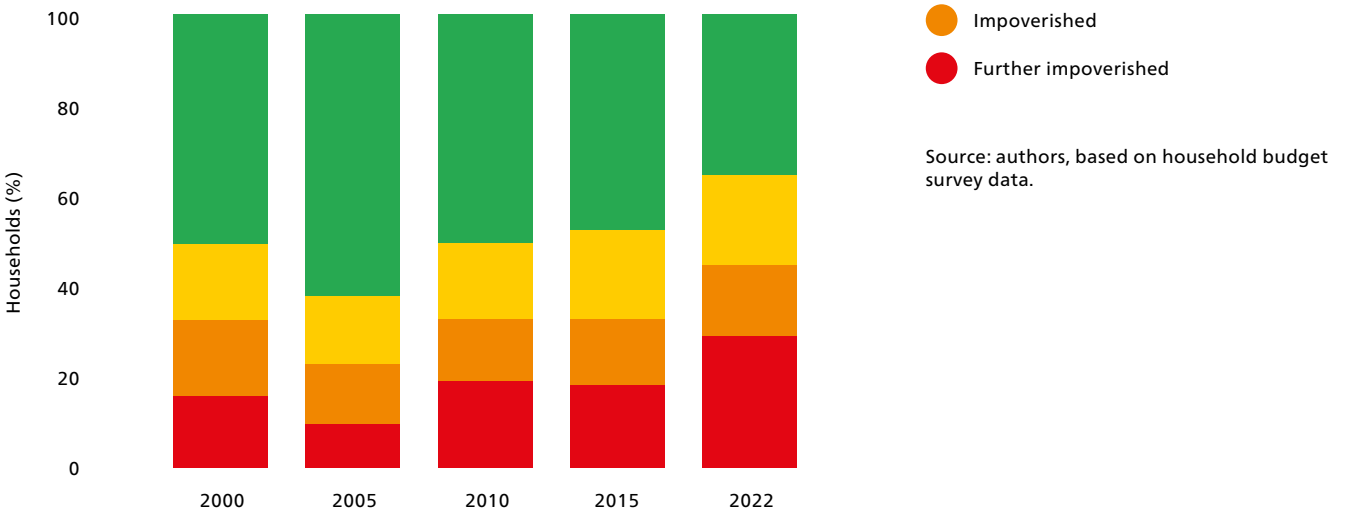
Source: UHC watch (2025) and WHO (2025) for data on out-of-pocket payments.



Who experiences financial hardship?

Most households with catastrophic health spending are further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 21). In 2022 further impoverished households accounted for 29% of households with catastrophic health spending, up from 10% in 2005.

Fig. 21. Breakdown of households with catastrophic health spending by risk of impoverishment



Source: authors, based on household budget survey data.

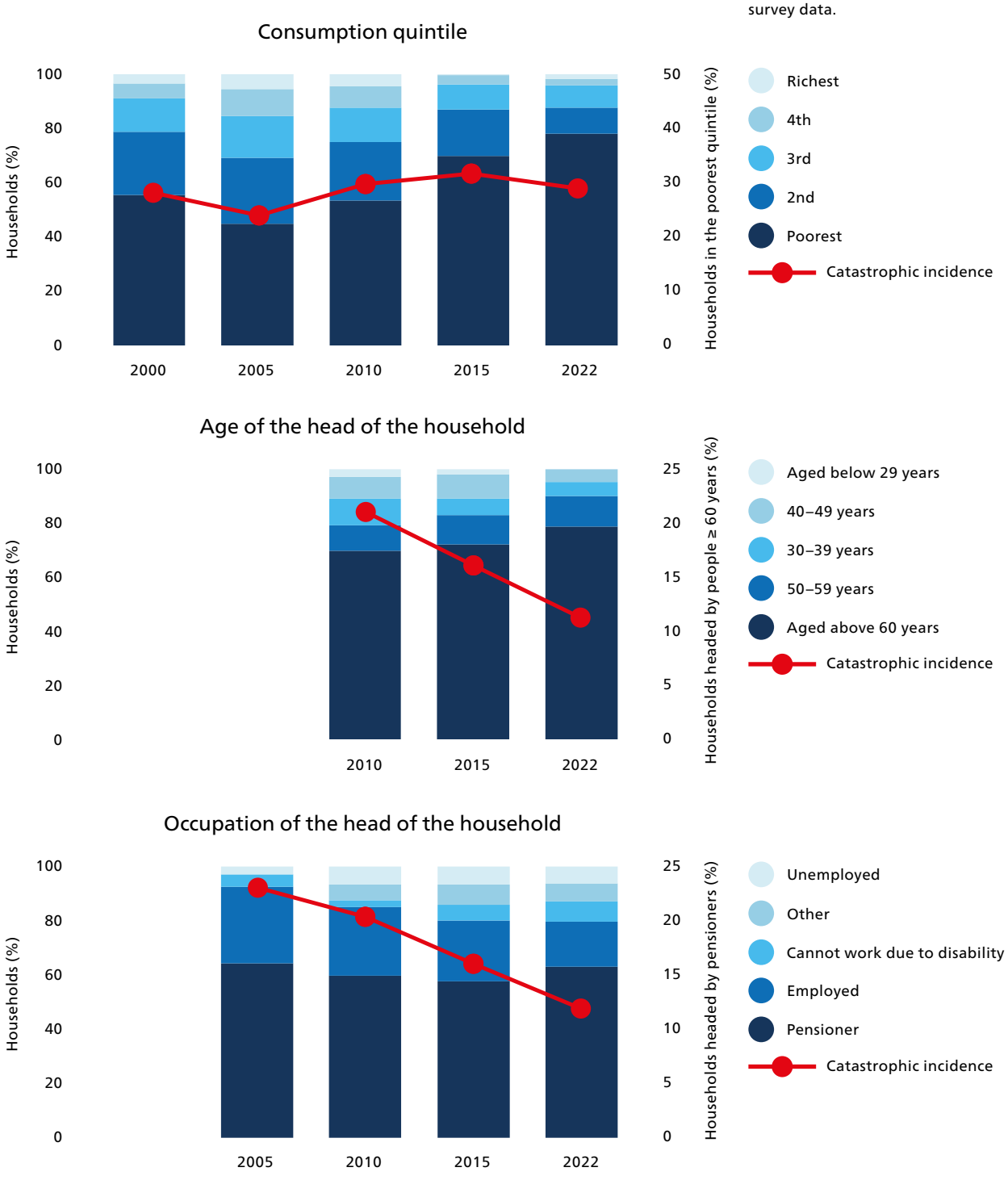
In 2022 over three quarters (78%) of households with catastrophic health spending were in the poorest quintile – a substantial and steady increase from 45% in 2005 (Fig. 22). Nearly a third (29%) of households in the poorest quintile experienced catastrophic health spending in 2022, four times higher than the average (7.5%) and much higher than the richest quintile (1%, data not shown). The incidence of catastrophic health spending in the poorest quintile grew between 2005 and 2015 but fell in 2022 (Fig. 22).

Looked at by age and occupational status of the head of the household, catastrophic health spending is heavily concentrated in households headed by older people or pensioners (Fig. 22) and in households in rural areas (data not shown). The incidence of catastrophic health spending is also generally much higher than average (7.5%) in households headed by older people (11%) or pensioners (12%) (Fig. 22).

Fig. 22. Breakdown of households with catastrophic health spending by consumption quintile, age and occupational status and incidence of catastrophic health spending in the poorest quintile and in households headed by older people and pensioners

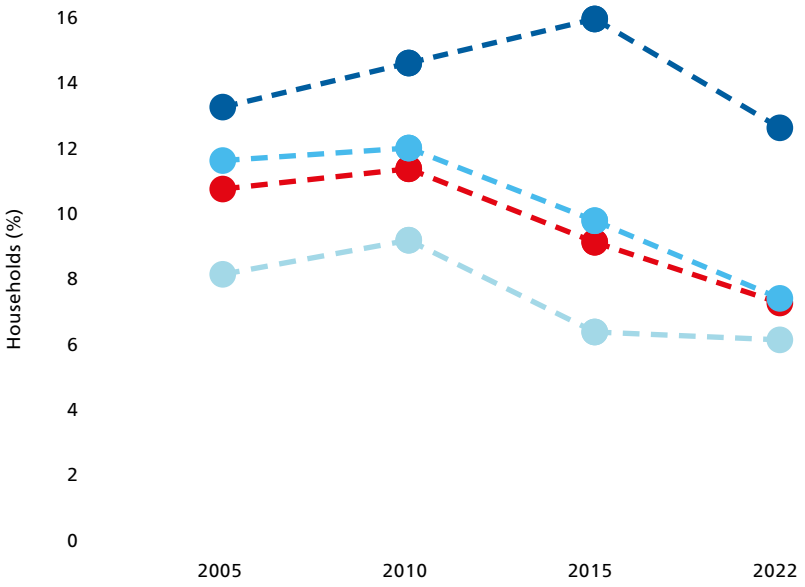
Notes: the age categories in 2005 are not comparable to other years. For occupation, other corresponds to students and domestic work. Disaggregation by age or occupation is not available for 2000.

Source: authors, based on household budget survey data.



The incidence of catastrophic health spending in the Azores and Madeira (13% in 2022) is almost twice as high as for the total population (7.5%) (Fig. 23). Catastrophic health spending has fallen in most regions since 2015 but remained stable in Lisbon.

Fig. 23. Households with catastrophic health spending by region



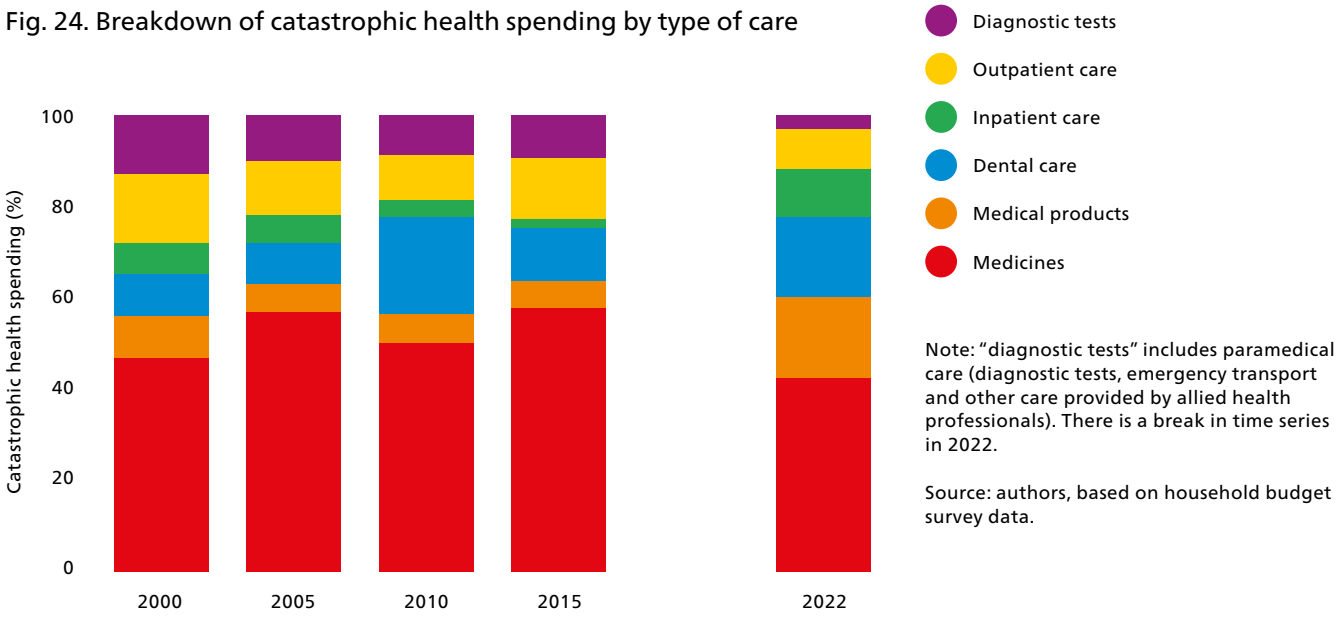
Note: disaggregation not available for 2000.

Source: authors, based on household budget survey data.

Which health services are responsible for financial hardship?

Catastrophic health spending is consistently mainly driven by spending on outpatient medicines (42% in 2022). In the same year the other main drivers were medical products (18%), dental care (18%), inpatient care (11%) and outpatient care (9%) (Fig. 24).

Fig. 24. Breakdown of catastrophic health spending by type of care

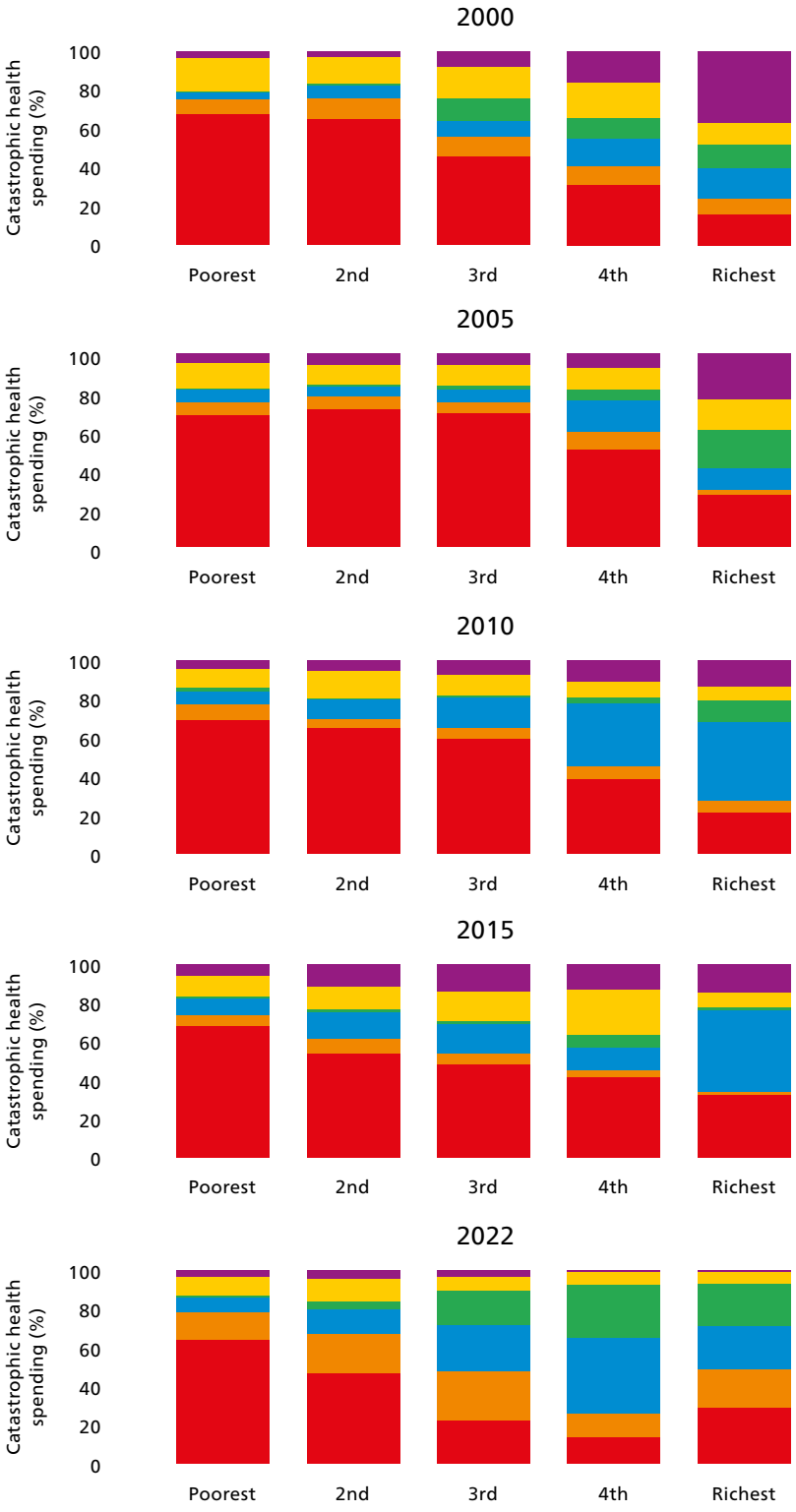


Note: "diagnostic tests" includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). There is a break in time series in 2022.

Source: authors, based on household budget survey data.

Outpatient medicines are consistently the largest driver of catastrophic health spending in the poorest quintile (64% in 2022), followed by medical products (15%) and outpatient care (10%) (Fig. 25). Dental care and inpatient care are much smaller drivers in the poorer quintiles than the richer quintiles.

Fig. 25. Breakdown of catastrophic health spending by type of care and consumption quintile



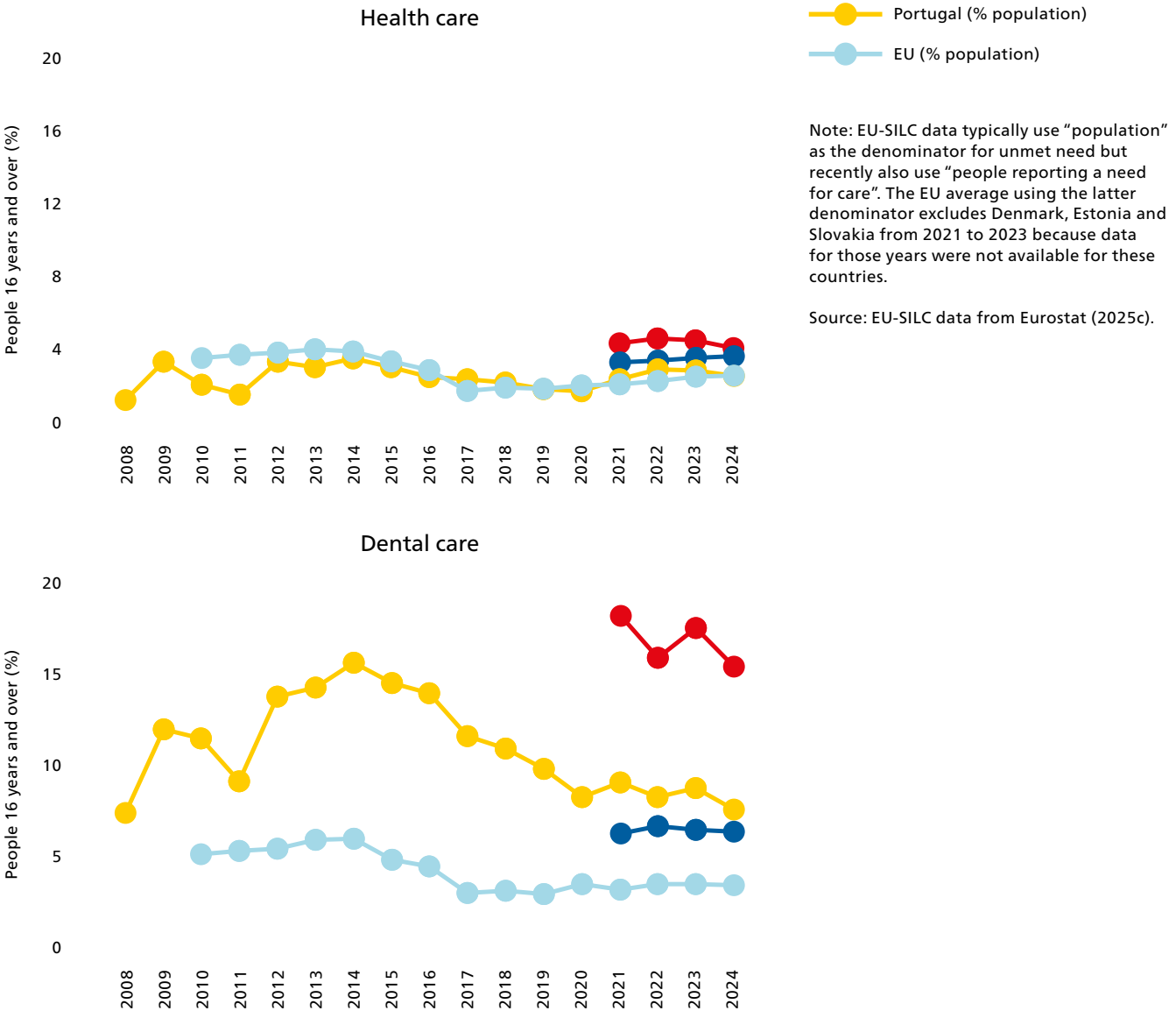
Notes: "diagnostic tests" includes paramedical care (diagnostic tests, emergency transport and other care provided by allied health professionals). There is a break in time series in 2022.

Source: authors, based on household budget survey data.

5.3 Unmet need for health care

EU-SILC data on unmet need (see Box 1) due to cost, distance or waiting time show that unmet need for health care has been similar to the EU average in the study period but unmet need for dental care has been much higher than the EU average (Fig. 26). Unmet need for dental care fell sharply between 2014 and 2020 and has fluctuated since then (Fig. 26). Cost is the main reason for unmet need for both types of care in Portugal.

Fig. 26. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, Portugal and the EU

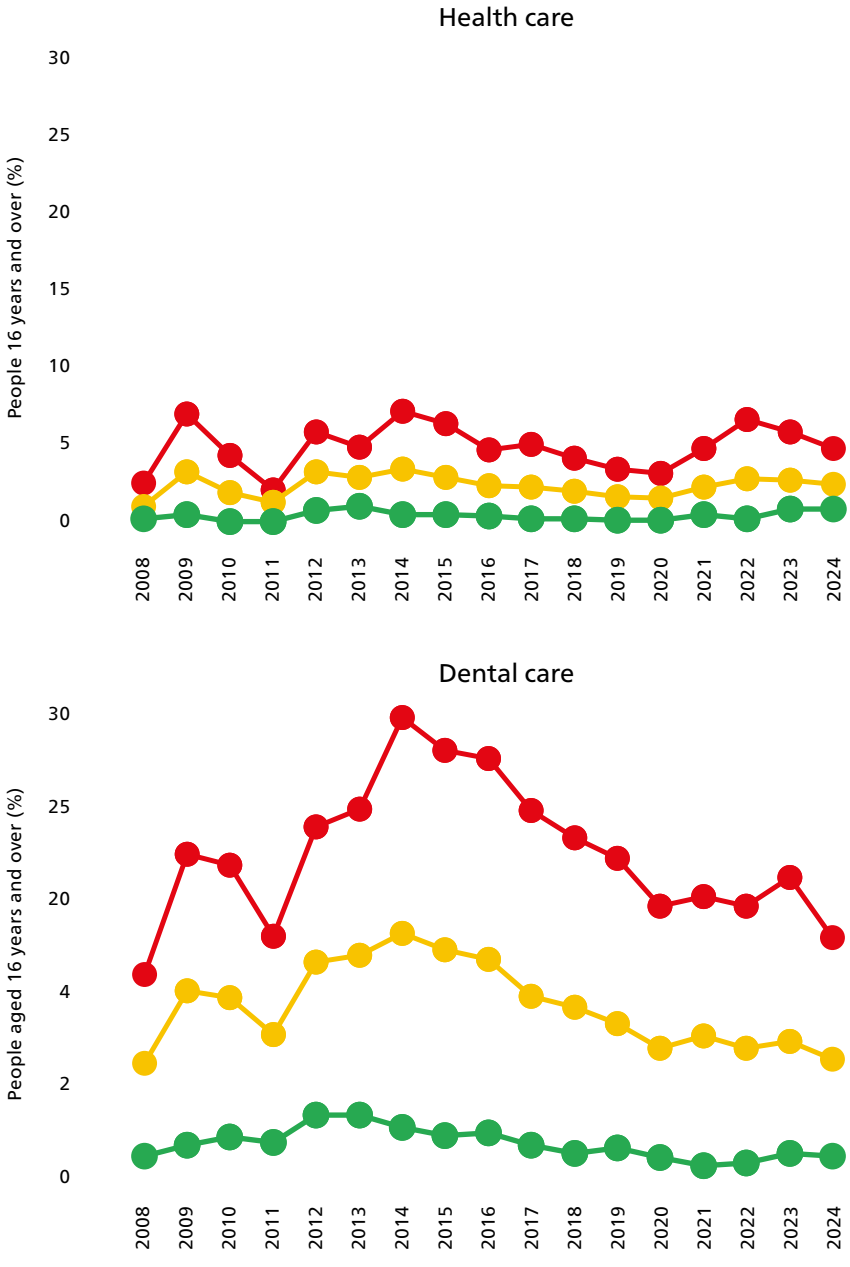


Note: EU-SILC data typically use "population" as the denominator for unmet need but recently also use "people reporting a need for care". The EU average using the latter denominator excludes Denmark, Estonia and Slovakia from 2021 to 2023 because data for those years were not available for these countries.

Source: EU-SILC data from Eurostat (2025c).

There is significant income inequality in unmet need for both types of care. In 2024 levels of unmet need for health care were more than five times higher in the poorest than the richest quintile and more than twelve times higher for dental care (Fig. 27). Income inequality was falling before the COVID-19 pandemic, increased in the years immediately after it and decreased again in 2024.

Fig. 27. Income inequality in self-reported unmet need for health care and dental care due to cost, distance and waiting time

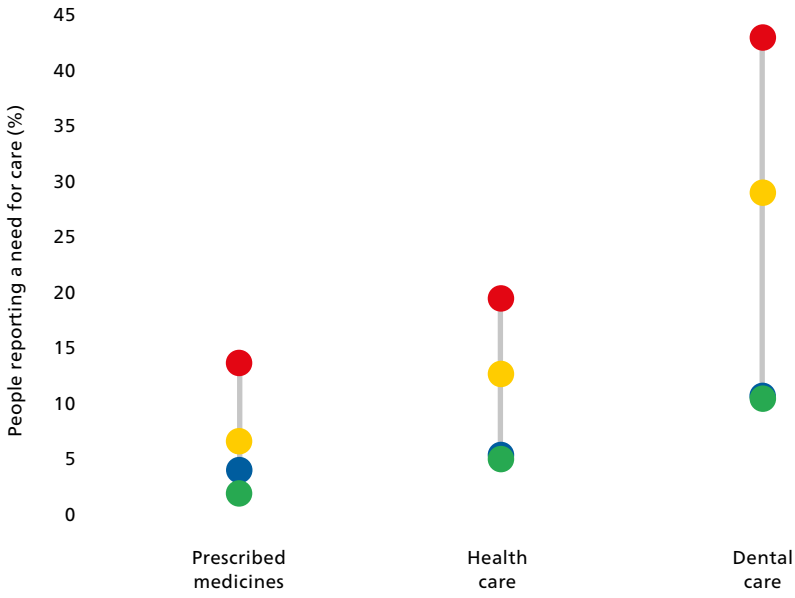


Notes: the EU-SILC denominator for unmet need by quintile is "population". Quintiles are based on income.

Source: EU-SILC data from Eurostat (2025c).

EHIS data show that unmet need due to cost was much higher than the EU average in Portugal for dental care and health care and close to the EU average for prescribed medicines (Fig. 28). Income inequality in unmet need due to cost is substantial for all three types of care, however, and particularly so for dental care.

Fig. 28. Income inequality in self-reported unmet need for prescribed medicines, health care and dental care due to cost, Portugal and the EU, 2019



Notes: the EHIS denominator for unmet need is "people reporting a need for care". Quintiles are based on income.

Source: EHIS data from Eurostat (2025c).

5.4 Summary

In 2022 3.3% of households were impoverished or further impoverished after out-of-pocket payments, up from 2.4% in 2005.

In the same year 7.5% of households – around 700 000 people – experienced catastrophic health spending, down from a peak of 11% in 2010.

The incidence of catastrophic health spending is higher in Portugal than in many EU countries. However, it is lower than in Hungary, Italy, Poland and Romania, even though Portugal relies more heavily than these countries on out-of-pocket payments to finance the health system.

Catastrophic health spending is heavily concentrated in the poorest quintile. In 2022 over three-quarters (78%) of households with catastrophic health spending were in the poorest quintile. Nearly a third (29%) of households in the poorest quintile experienced catastrophic health spending in 2022, four times higher than the average (7.5%) and much higher than the richest quintile.

Looked at by age and occupational status of the head of the household, catastrophic health spending is heavily concentrated in households headed by older people or pensioners. In the Azores and Madeira this level is almost twice as high (13% in 2022) as for the total population (7.5%).

Catastrophic health spending is consistently mainly driven by spending on outpatient medicines (42% in 2022). In the same year the other main drivers were medical products (18%), dental care (18%), inpatient care (11%) and outpatient care (9%). In the poorest quintile it is mainly driven by outpatient medicines (64% in 2022), followed by medical products (15%) and outpatient care (10%). Dental care and inpatient care are much smaller drivers in the poorer quintiles than the richer quintiles.

EU-SILC data on unmet need due to cost, distance or waiting time show that unmet need for health care has been similar to the EU average in the study period but unmet need for dental care has been much higher than the EU average.

There is significant income inequality in unmet need for both types of care. In 2024 levels of unmet need for health care were more than five times higher in the poorest than the richest quintile and more than twelve times higher for dental care.

6. Factors that strengthen and undermine financial protection

This section considers factors within the health system that may be responsible for financial hardship caused by out-of-pocket payments in Portugal and which may explain the trend over time.

6.1 Coverage policy

Coverage policy in Portugal has some strengths that offer examples of good practice to other countries:

- entitlement to publicly financed health care is based on residence rather than payment of contributions, so there are no gaps in population coverage for permanent residents;
- refugees, asylum seekers, the children of undocumented migrants and some undocumented migrant adults (those in a family regrouping process with a family member who is a social beneficiary) are entitled to the same benefits as residents;
- the benefits package is relatively comprehensive; and
- several co-payments have recently been abolished (co-payments for primary care visits and diagnostic tests in primary care in 2020 and co-payments for some emergency care in 2022 (except for walk-in to hospital emergency care without referral, for which people still incur co-payments).

However, the following findings show that gaps in coverage remain.

- Although catastrophic health spending has decreased over time, it is increasingly heavily concentrated in the poorest quintile and the incidence of catastrophic health spending in the poorest quintile has also increased over time (see Fig. 22).
- Catastrophic health spending is mainly driven by spending on outpatient medicines (as in many EU countries – particularly those with higher levels of catastrophic health spending), especially in households with low incomes, followed by medical products; dental care is the third-largest driver on average but mainly affects richer households (see Fig. 24 and Fig. 25). This is likely to reflect high levels of unmet need for dental care on average and in the poorest quintile (see Fig. 26, Fig. 27 and Fig. 28).
- Although out-of-pocket payments have decreased over time in absolute terms for all types of care (see Fig. 8 and Fig. 14), a larger share of households were paying out-of-pocket in 2022 than in previous years, with a particularly sharp increase in the poorest households (rising from 46% in 2000 to 91% in 2022; see Fig. 7).

The following paragraphs discuss factors associated with the main drivers of catastrophic health spending, starting with the smaller drivers.

Catastrophic health spending on **outpatient care** may reflect gaps in service coverage leading to waiting times, which are an issue in primary care and for outpatient specialist visits. There is a shortage of health professionals working in the NHS, especially GPs in primary care facilities in some areas – for example, about 25% of people in the Lisbon region do not have a GP, compared to less than 5% in the North region (National Health Service, 2025c). As a result, people may pay out of pocket for faster access to covered outpatient care or to a private GP to ensure they can see a regular doctor (without this, people will be seen by the GP on duty at the NHS, which may mean seeing a different GP at every visit).

Catastrophic health spending on **inpatient care** (mainly affecting richer households) may also be related to long waiting times, especially in elective surgery. More than 40% of people in 2022 waiting for an elective hip replacement, cataract or knee surgery, were waiting for more than 3 months, which is higher than in countries like Ireland and Spain (OECD & European Observatory on Health Systems and Policies, 2023). Richer households may pay for privately provided inpatient care to avoid waiting times in public hospitals – a practice that also reduces the availability of doctors in public hospitals.

Access to publicly financed **dental care** is limited due to a lack of sufficient public facilities. Since 2008 the Government has introduced a system of NHS dental care vouchers that provide access to regular check-ups and preventive treatment in private facilities without payment but these only cover a few groups of people (children under 18 years old, pregnancy, people aged over 65 years receiving social support, people living with HIV/AIDS and people at high risk of oral cancer) and are subject to time and volume limits, which adds to complexity (Simões et al., 2018; Fronteira, Augusto & Maresso, 2025). In 2025 around 20% of the population were entitled to dental care vouchers (authors' calculations). A pilot project was set up in 2016 to improve access to dental care in NHS primary care centres for people with specific conditions and people with low incomes but it still only covers 91 out of 278 municipalities in mainland Portugal (National Health Service, 2025a). These gaps help to explain Portugal's high levels of unmet need for dental care and the marked income inequality in unmet need for dental care (see Fig. 26, Fig. 27 and Fig. 28).

Medical products are the second-largest driver of catastrophic health spending and reflects limited coverage in the NHS benefits package (e.g. corrective lenses are only covered for people aged over 65 years with low incomes and also receiving social support) and the presence of heavy user charges for medical products (mostly in the form of percentage co-payments ranging from 15% to 85% of the price) without protection mechanisms such as exemptions and caps in place.

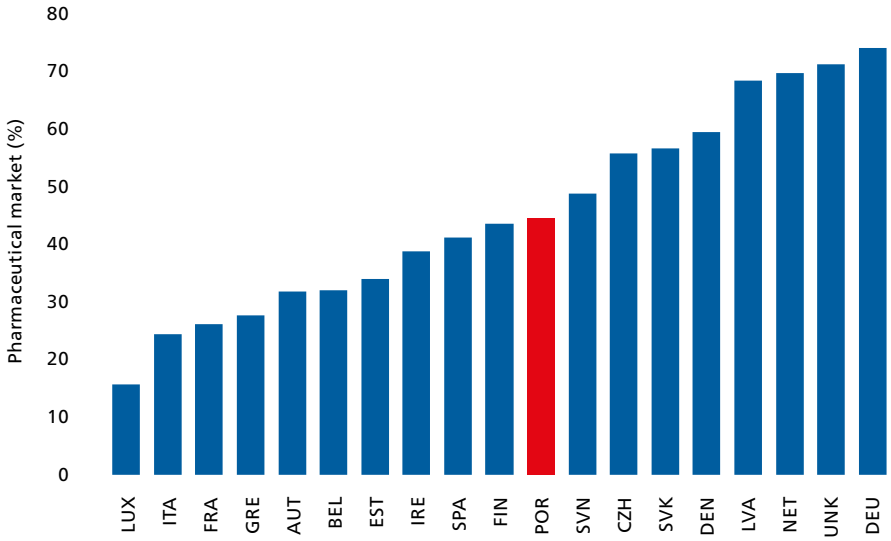
The fact that **outpatient prescribed medicines** are the main driver of catastrophic health spending on average (and especially in the poorest households) can be explained by the following factors.

- Although Portugal has taken steps to enhance access to primary care by abolishing co-payments for primary care visits and diagnostic tests in primary care (in 2020), outpatient prescribed medicines incur heavy percentage co-payments (ranging from 10% to 85% of the price) and are also subject to reference pricing.

- There are very few mechanisms to protect people from co-payments for outpatient prescribed medicines. Exemptions only apply to percentage co-payments and to some health conditions and exemptions on the basis of income were only introduced in 2024 and only apply to a very small group of people (people aged over 65 years with low incomes receiving social support) even though single-person households, single-parent households and many people who work and have children are also at high risk of poverty (Carvalho et al., 2025). These exemptions are not applied automatically and there is no cap on co-payments, unlike in most other EU countries with co-payments for outpatient prescribed medicines (UHC watch, 2025).

- Reference pricing for covered medicines leads to "avoidable co-payments" and there is no protection from these co-payments. International nonproprietary name prescribing is mandatory for covered medicines and generic substitution by pharmacists is allowed (but not mandatory), so in theory people should be supported to opt for the lowest-priced alternative. In practice, however, pharmacies do not always have available stock of the lowest-price alternatives due to wholesaler shortages (in which case pharmacists are required to notify Infarmed within 24 hours) or due to issues in pharmacy stock management (i.e. pharmacies do not have the required medicine in stock even though it is available from the wholesaler). In either case pharmacies should be able to provide users with the medicine in 24 hours but some people may pay out of pocket for a more expensive alternative rather than waiting for the pharmacy to make the lowest-priced alternative available or trying another pharmacy (DECO PROteste, 2024; Costa, 2025; Infarmed, 2025b). A recent study found that in 2023 nearly half of all people surveyed reported waiting at least 24 hours for a medicine that was not immediately available in the pharmacy; 19% of these people paid out of pocket for a more expensive alternative to avoid waiting (DECO PROteste, 2024). The use of generic medicines is lower in Portugal (50% of the pharmaceutical market in 2021) than in many EU countries (Fig. 29), which suggests there is room to strengthen dispensing practices.

Fig. 29. Share of generic medicines in the pharmaceutical market in selected EU countries and the United Kingdom, 2021



Notes: pharmaceutical market refers to the volume of standard units of medicines sold. Data only available for OECD countries.

Source: OECD (2023).

Other factors may also undermine affordable access to health care in Portugal, particularly for people with low incomes.

- Some groups of undocumented migrants (those without an NHS number) are not entitled to publicly financed health care and administrative barriers may hinder access to care for asylum seekers and undocumented migrants – for instance, the NHS primary care system does not allow referral from primary care to other levels of care or for diagnostic tests and prescribed medicines for undocumented migrants, who end up relying on non-governmental organizations to access care.

- Although the archipelagos (Azores and Madeira) have the same benefits package and coverage policy as mainland Portugal, they experience higher levels of catastrophic health spending (see Fig. 23). This can be explained by much higher than average rates of poverty in the archipelagos (Carvalho et al., 2025) and barriers to access care due to shortages of health professionals or health providers.

- Although many people are exempt from fixed co-payments for outpatient specialist visits and diagnostic tests, these exemptions are not enough to protect people with low incomes or older people. As with co-payments for outpatient prescribed medicines, exemptions are not applied automatically and there is no cap on co-payments. As of 2025 automatic exemptions from co-payments are applied for pregnancy and children under 18 years (which is a step in the right direction) but all other groups still need to apply to be exempt.

International evidence and experience indicate that financial protection can be strengthened when co-payments are kept to a minimum, people with low incomes are exempt, caps are linked to income and protection mechanisms are applied automatically, with the help of digital tools (Box 2) (WHO Regional Office for Europe, 2023; Cylus et al., 2024; Thomson et al., 2024; García-Ramírez et al., 2025; Kasekamp & Habicht, 2025).

Box 2. Regulation of complementary VHI covering HIIS co-payments

User charges are a major driver of financial hardship for households in many countries in Europe. Analysis suggests that they are most likely to undermine affordable access to health care when they are applied without multiple mechanisms to protect people (e.g. exemptions and caps) or when protection mechanisms exist but are poorly designed (Cylus et al., 2024; Thomson et al., 2024).

User charges in many countries are also complex and bureaucratic, which undermines transparency, leads to confusion and financial uncertainty and prevents people from accessing entitlements (Salampessy et al., 2018). Percentage co-payments, balance billing (including reference pricing) and extra billing are particularly non-transparent; they also shift financial risk from the purchasing agency to households and expose people to out-of-pocket payments arising from health system inefficiencies.

The harm caused by user charges can be reduced if they are applied sparingly and carefully designed in the following ways:

- exemptions for people with low incomes or chronic conditions;
- an income-based cap on all user charges for everyone;
- exemptions and caps are applied automatically, using digital solutions;
- percentage co-payments are avoided or replaced by low fixed co-payments;
- balance billing and extra billing are avoided or abolished; and
- user charges are as simple as possible, aim to protect people rather than diseases and minimize administrative barriers.

When user charges are carefully designed, people know exactly how much they must pay out of pocket before they visit a doctor, undergo a diagnostic test or collect a prescription; they know that they do not have to pay more than a certain amount a year; and they automatically benefit from exemptions and caps, without having to apply for them.

Source: authors, Sagan & Thomson (2016), Albreht, Kuhar & Rupel (2022) and UHC watch (2025).

6.2 Public spending on health

At 6.5% of GDP in 2022, public spending on health in Portugal is similar to the EU27 average (6.5%) but lower than Spain (7.2%) and the EU14 average (7.3%). Priority to health (15% of the government budget allocated to health in 2022) is also on a par with the EU27 average (15%) but lower than the EU14 average (16%). Data from the same year shows that public spending on all types of care accounts for a lower share in Portugal than the EU27 and EU14 average (see Fig. 6), specially for medical products, outpatient medicines and dental care.

Efforts to reduce out-of-pocket payments may require a further increase in public spending on health but will only be effective if additional funds are carefully targeted to strengthen financial protection. At the same time, the Government should find ways to improve efficiency in allocating and managing existing public resources. One obvious example is to reassess the costs and benefits of tax subsidies for private spending on health (NHS co-payments, other out-of-pocket payments and VHI premiums), which shift public resources away from health needs and are more likely to benefit richer households, who spend up to 20 times more on VHI premiums than the poorest households (see Fig. 15). It would be more efficient to use these public resources to expand protection from co-payments for people with low incomes.

6.3 Summary

Coverage policy in Portugal has some strengths. Entitlement to publicly financed health care is based on residence; refugees, asylum seekers, the children of undocumented migrants and some undocumented migrants are entitled to the same benefits as residents; the benefits package is relatively comprehensive; and several co-payments have recently been abolished (co-payments for primary care visits and diagnostic tests in primary care in 2020 and co-payments for some emergency care in 2022).

However, gaps in coverage persist and explain why although catastrophic health spending has decreased over time it is increasingly heavily concentrated in the poorest quintile and is mainly driven by outpatient medicines (especially in households with low incomes) followed by medical products and dental care.

Catastrophic health spending on outpatient care and inpatient care (mainly affecting richer households) may reflect gaps in service coverage leading to waiting times, which are an issue in primary care, for outpatient specialist visits and for elective surgery. As a result, people may pay out of pocket for faster access to covered care.

Access to publicly financed dental care is limited due to a lack of public facilities. Since 2008 the Government has introduced a system of NHS dental care vouchers that provide access to regular check-ups and

preventive treatment in private facilities without payment but these only cover a few groups of people (based mainly on income and age). A pilot project was set up in 2016 to improve access to dental care in NHS primary care centres for people with specific conditions and people with low incomes has been expanded over time but still only covers under a third of municipalities in mainland Portugal.

Coverage of medical products (e.g. corrective lenses) is limited in the benefits package and heavy user charges are applied to covered medical products (mostly in the form of percentage co-payments ranging from 15% to 85%) without exemptions and caps in place.

Outpatient medicines incur heavy percentage co-payments (ranging from 10% to 85% of the price) and are also subject to reference pricing. Exemptions only apply to percentage co-payments and to some health conditions; exemptions on the basis of income were only introduced in 2024 and only apply to a very small group of people (people aged over 65 years with low receiving social support); and exemptions are not automatic. There are no caps on co-payments. Reference pricing for covered medicines leads to "avoidable co-payments"; there is no protection from these co-payments; and people may pay more than expected out of pocket for covered medicines due to stock issues in pharmacies.

Other factors undermining financial protection include the lack of publicly financed coverage for undocumented migrants without an NHS number and barriers to accessing covered care in the archipelagos.

Public spending on health in Portugal and the share of the government budget allocated to health in 2023 are similar to the EU27 average in 2022 but lower than the EU14 average in the same year. Public spending on health may not be adequately targeted towards protecting people from out-of-pocket payments, particularly for the largest drivers of financial hardship (outpatient medicines, medical products and dental care).

7. Implications for policy

Financial hardship caused by out-of-pocket payments is higher in Portugal than in many EU countries. In 2022 (the latest available year of data) 7.5% of households – around 700 000 people – experienced catastrophic health spending, down from a peak of 11% in 2010. However, it is lower than in Hungary, Italy, Poland and Romania, even though Portugal relies more heavily than these countries on out-of-pocket payments to finance the health system.

Catastrophic health spending is heavily concentrated in the poorest consumption quintile. In 2022 over three-quarters (78%) of households with catastrophic health spending were in the poorest quintile – a substantial and steady increase from 45% in 2005. Nearly a third (29%) of households in the poorest quintile experienced catastrophic health spending in 2022, four times higher than the average (7.5%) and much higher than the richest quintile (1%).

Catastrophic health spending is mainly driven by spending on outpatient medicines on average and especially in households with low incomes but medical products and dental care also play a role. The share of catastrophic health spending on medicines in 2022 is higher in the poorest quintile (64%) than in the richest households (29%). Dental care and inpatient care are much smaller drivers in the poorer quintiles than the richer quintiles.

Unmet need for health care is on a par with the EU average but unmet need for dental care is well above the EU average. Unmet need for both types of care is mainly driven by cost. During the study period there was significant income inequality in unmet need.

Coverage policy in Portugal has some strengths that offer examples of good practice to other countries. Entitlement to publicly financed health care is based on residence; refugees, asylum seekers, the children of undocumented migrants and some undocumented migrants are entitled to the same benefits as residents; the benefits package is relatively comprehensive; and several co-payments have recently been abolished (co-payments for primary care visits and diagnostic tests in primary care in 2020 and co-payments for some emergency care in 2022).

However, income inequality in financial hardship and unmet need reflect persistent gaps in coverage that mainly affect people with low incomes. There are gaps in the benefits package for medical products (corrective lenses); access to publicly financed dental care is limited due to a lack of public facilities; waiting times (and regional variation in waiting times) are an issue for primary care visits, outpatient specialist visits and elective surgery; there are heavy percentage co-payments for medical products and outpatient prescribed medicines and people may not be able to access the lowest-priced alternatives due to stock issues in pharmacies; existing exemptions from co-payments are not enough to protect people with low incomes and are not applied automatically; and there is no cap on co-payments.

Building on recent efforts to improve access to care (e.g. abolishing some co-payments for primary care and enhancing access to dental care in NHS primary care centres), the Government could consider further steps to reduce financial hardship and unmet need, particularly for people with low incomes.

- **Enhance access to outpatient prescribed medicines as part of primary care.** Options include replacing percentage co-payments with low fixed co-payments (which are more transparent); ensuring people can access at least one of the three lowest-priced medicines in each reference group free at the point of use; monitoring prescribing patterns, including the role of generic medicines; making generic substitution mandatory in pharmacies (but allowing users to opt for a more expensive alternative if they prefer); introducing penalties for pharmacies that are not able to provide people immediately with the lowest-priced medicine; and avoiding further increases in medicine prices.

- **Improve protection mechanism from co-payments for people with low incomes, especially for outpatient prescribed medicines.** Extend exemptions from outpatient prescribed medicines to all people with low incomes, not just pensioners; introduce a cap on all co-payments and link the cap to household income; and make sure exemptions and caps are applied automatically, using digital tools, for everyone.

- **Continue with efforts to reduce waiting times and improve access to primary care.** Closely monitor waiting times to make sure targets are met and facilitate access to NHS family doctors by ensuring sufficient staff numbers and enhancing the role of other health professionals in providing care (e.g. nurses, dentists, psychologists and social workers) to increase access to care.

- **Expand access to publicly financed dental care.** Options include extending the number of municipalities in the pilot project on access to dental care in NHS primary care centres; implementing planned investment in dedicated offices for dental care in primary care; selectively contracting private providers where needed; and simplifying the dental care voucher system – for example, by extending vouchers to all people with low incomes, without time or volume limits on care.

- **Expand coverage of medical products (corrective lenses), especially for people with low incomes.**

- **Evaluate the benefits and costs of tax subsidies for out-of-pocket payments and VHI premiums.** These tax subsidies typically favour richer households and shift public resources away from health need. Public resources are more likely to meet equity and efficiency goals if they are used to reduce financial hardship and unmet need for households with low incomes.

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