Portugal

Health Care & Long-Term Care Systems

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Portugal

Health care systems

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2.22. PORTUGAL

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2015, Portugal's GDP was around €180 bn or 21,400 PPS per capita, below the EU average GDP per capita of €29,600. The population of Portugal is estimated to be around 10 million inhabitants in 2016. Over the coming decades it is projected to fall gradually to 8.0 by 2070. This decrease of 23% contrasts with the expected increase of 2% for the EU as a whole.

Total and public expenditure on health as % of GDP

Total expenditure ([311]) on health as a percentage of GDP (9.1% in 2015, latest available data) has fallen since its peak of 10.8 in 2008 and is below the EU average ([312]) of 10.2% in 2015. Throughout the last decade, public expenditure has decreased as % of GDP: from 7.1% in 2009 to 6.1% of GDP in 2015 (EU: 7.8% in 2015), although it has been relatively stable from 2013. Looking at health care without long-term care([313]) reveals a smaller gap between public spending in Portugal and the EU average (5.9% vs 6.8% in 2015).

When expressed in per capita terms, also total spending on health at 1,942 PPS in Portugal in 2015 was far below the EU average of 3,305. So was public spending on health care: 1,297 PPS vs. an average of 2,609 PPS in 2015.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 2.4 pps of GDP, above the average growth expected for the EU of 0.9 pps of GDP, according to the "AWG reference scenario". When taking into account the impact of non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 3.3 pps of GDP from now until 2070 (EU: 1.6) ([314]).

Portugal faces low fiscal sustainability risks in the short run.

Risks appear, on the contrary, to be high in the medium term from a debt sustainability analysis perspective due to the still high stock of debt at the end of projections (2028).

In the long term, Portugal appears to face medium fiscal sustainability risks ([315]).

Health status

In the last decades, the health status of the Portuguese population has improved considerably. This evolution seems to be correlated with increases in financial resources devoted to health care and to improvements in socio-economic conditions. Life expectancy (84.3 years for women and 78.1 for men in 2015) is just above the EU average (83.3 for women and 77.9 for men). However, healthy life years (55 years for women and 58.2 for men in 2015) are below the EU average (63.3 and 62.6 respectively). Infant mortality is below the EU average (2.9‰ vs. 3.6‰). The incidence of HIV/AIDS and tuberculosis has been defined as a public health priority.

System characteristics

Coverage

A National Health Service (NHS) provides 100% population coverage (to all the resident population and Portuguese citizens). The NHS is mainly funded by general taxation. There are also a number of complementary public and private health insurance schemes (called "health subsystems") covering certain professions. These include the banking sector private schemes and the three public subsystems for civil servants, police

([311]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

([312]) The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

([313]) To derive this figure, the aggregate HC.3 is subtracted from total health spending.

([314]) The 2018 Ageing Report: https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf.

([315]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

and military (ADSE, SAD and ADM). ADSE and SAD are funded on a voluntary basis by employees' contributions collected centrally, while ADM is also funded by state budget. These schemes cover about 14% of the population.

Administrative organisation and revenue collection mechanism

The budget for the health sector is defined annually in parliament when the general budget is approved. In recent years, authorities have tightened the monitoring over the budget execution. The information system has been strengthened and financial flows are regularly followed up on both an accrual and cash basis.

In 2015, 66.8% of total health expenditure funding came from government sources (direct and indirect taxes collected centrally). The remaining part is private expenditure on health including private voluntary health insurance and out-of-pocket payments. A large part of private expenditure is out-of-pocket which represents 27.7% of total expenditure on health (EU average of 15.9% in 2015), showing an increase since 2005 (23.3) but a decrease since 2010 (28.2). The rest comes from private insurance.

The Ministry of Health sets the national health policy strategy, defining public health and policy priorities, specifying the regulatory framework, defining the system organogram and providing the overall management of the health care system.

The "Administração Central do Sistema de Saúde" (ACSS) implements the decisions of the Ministry of Health under its supervision. It coordinates, monitors and controls NHS resource allocation and use, human resources policies and health facilities management. The ACSS is responsible for defining the budget allocation across regions and areas of provision (e.g. contractos-programa for hospitals), for defining hospital capacity and the service network (e.g. definition of health centres and hospital catchment areas and services provided by different hospitals) and for developing the contracting procedures within the sector. ACSS is also responsible for defining financial and activity targets and for monitoring the financial and activity flows in the system. Together with "Servicos Partilhados do Ministerio da Saúde" (SPMS), it is responsible for developing information systems that support monitoring, assessment and policy implementation in the system.

The "Servicos Partilhados do Ministerio da Saúde" is the centralised purchasing agency for the Ministry of Health and tenders for and purchases centrally a variety of medical goods and services from medicines and medical devices to ICT services. The "National Agency for Pharmaceuticals" (Infarmed) is in charge of developing and implementing pricing and reimbursement policies, clinical and economic evaluation and monitoring prescription and dispensing practices together with SPMS.

There are also five regional health authorities which are responsible for implementing public health objectives and for purchasing primary, specialist and hospital care for their respective catchment population under the framework defined by the ACSS. Nevertheless, decision-making remains highly centralised (which may actually have helped with the implementation of cost-containment policies in recent times).

Role of private insurance and out of pocket co-payments

Co-payments (fixed fees) apply to primary care and specialist consultations, hospital care, home care and emergency care. Fees are lower for primary care than for specialist consultations and these are lower than emergency care to encourage a more cost-effective path of care. Cost-sharing also applies to pharmaceuticals (a share of the price) and public coverage of eye care and dental care is limited. There are exemptions based on income, for certain population groups (e.g. fireman) and certain medical conditions. As a result, more than 55% of the population is exempted from any cost-sharing in publicly provided/ publicly funded services and goods.

The take up of private voluntary health insurance has been growing over the years, mainly through employers as benefits package. 20.2% of the population takes up private voluntary health insurance, but it only accounts for 5.5% of health expenditure in 2015.

Coverage of services, types of providers, referral systems and patient choice

The NHS provides coverage for a wide range of health care services and goods. NHS supplies primary health care (including family medicine, pre-natal and post-natal follow up, prevention and promotion), outpatient specialist consultations and hospital care (day-case and inpatient) directly through a network of publicly owned facilities. The NHS also provides a wide range of related services including diagnostic services, physiotherapy and dialysis care either directly or through contracts with private providers.

Primary care functions as the central pillar of the system. NHS primary health care is provided through a network of group practices which include health centres, the more recent Family Health Units (Unidades de Saude Familiares - USFs) and mobile units to outreach the more rural/ isolated parts of the country. There is a 24-hour primary care and paediatric counselling phone helpline. Primary care provision is mostly performed by the public sector.

Residents have to register with a family doctor (a general practitioner – GP). As about 7,7 of the population is not currently registered with a family doctor (October 2018 data), a national patient registry has been put in place to eliminate duplicate registration, identify vacancies in family doctors lists and allocate patients to family doctors. NHS family doctors refer patients for specialist care, operating as gatekeepers. In other words, a compulsory referral system is in place from primary care and the family doctor to the outpatient specialist. NHS outpatient consultations typically take place in hospital outpatient departments. There is an integrated nationwide electronic system to manage primary care referrals to specialty consultations across the country. This aims to ensure timely access to specialist consultations.

The NHS, through a network of general and specialised hospitals (including 3 oncological centres), provides most of the outpatient specialist care and hospital day-case and inpatient care. In order to improve access and reduce the waiting time for hospital surgery, authorities have in place an integrated central and nationwide electronic system to manage patients on waiting list. In addition, they have introduced clinically defined maximum waiting times for visits to GPs, outpatient specialist consultations and hospital surgery. The NHS also contracts hospital services from several private and social entities. When 75% of the maximum waiting time for surgery has elapsed, the patient can choose a private provider to have access to care. This mechanism has allowed reducing waiting times for surgery by more than 50% since 2006. The vast majority of hospitals are public (85.7% of total acute care beds, with 6.6% owned by private not-for-profit hospitals and 7.7% owned by private for-profit hospitals).

Ambulatory diagnostic services, physiotherapy and dialysis care are often provided by the private sector (private for-profit and not-for-profit entities) contracted by the NHS to provide care for NHS users. The contracting rules have been harmonised with NHS conditions (e.g. fees have been aligned with NHS costs) in recent years. Since 2013, NHS developed the legal framework to implement tender processes to select providers thought the lowest bid increasing providers' competition.

In addition, those who have enrolled in one of the public sub-systems have directly access to specialist or hospital care allowed by their scheme (which contracts only private specialists or hospitals) or provided by their own facilities. For these patients service coverage overlaps to a certain extent with that of the NHS, notably in terms of mainstream ambulatory specialties. The government also has a system of vouchers for dental care for certain population groups (pregnant women, elderly beneficiaries of the solidarity supplement and young people under 16 years) based on an indication of a family doctor and based on clinical criteria. The goal is to improve access to these services as NHS coverage is limited. For low income populations, there are also additional benefits, e.g. increased medicines reimbursement, prescription glasses.

Finally, specialist outpatient care can also take place in specialists' private individual or group practices and hospital care in private clinics and hospitals for private users at the cost of patient. Often, private provision, especially outpatient consultations, is conducted by the same specialists that work for the NHS although the public wage and working time is adjusted accordingly.

In mainland Portugal (public sector, august 2018) there are 29,481 practicing physicians (2.93 per 1,000 inhabitants) and they are disaggregated by specialists (19,304) and interns (10,177). The specialty of family medicine started in the early eighties and is recognised worldwide as it can be verified by The "World Health Report 2008" - primary health care ("Now More Than Ever") and "World Organisation of Family Doctors" reports. Within the total number for public sector, there are 5,598 family physicians (0.56 per 1,000 inhabitants, year 2018) working in family practices.

Portugal suffered from staff shortages and an unequal distribution of resources with a high concentration of physicians including GPs in big urban areas and a higher concentration in the region Centro. To address these, two medical degrees were created – with a focus on improving the skill mix towards primary care and needed specific specialties – and mobility rules have been changed slightly. Also, a small monetary bonus is given to doctors who moved to disadvantaged areas and further measures have been taken to encourage the mobility of doctors and other health workers. Acute hospital beds stand at 326 per 100,000 inhabitants in 2015 below the EU average of 4026 per 100,000 inhabitants, showing a reduction over the decade with the increase of one day surgery and long term care network.

Staff supply is regulated: there are quotas for medical students and by specialty and there is now some regulation regarding the opening of vacancies to improve staff distribution. In addition, the definition and adoption of the recently developed 3-year hospital strategic plans has implications for staff distribution and vacancies. Authorities are also developing a human resources planning instrument to help identify in which geographic areas or medical specialties there may be staff shortages developing and adjust training accordingly.

Purchasing and contracting of healthcare services and remuneration mechanisms

Remuneration is defined by the government. USFs primary care doctors receive capitation wages which are based on the characteristics of the population served and pay for performance. In addition, as USFs are part of an ongoing reform to create more autonomous and multidisciplinary teams in primary care and incentives for better performance (e.g. better follow up of patients, notably chronic patients, better pre and post-natal care, more cost-effective use of medicines). In this context a small performance-related team bonus is paid to the practice on the basis of achieving pre-negotiated targets. Health centres' doctors receive a salary.

NHS specialists working in hospitals are paid a salary. Hospitals are paid on prospective global budgets based on DRGs, with the possibility to reallocate resources across cost-categories. In addition to the transfers from the government, hospitals generate their own revenue, through flat-rate user charges for outpatient and diagnostic services, special services (e.g. individual private rooms) and from privately insured patients.

Doctors in outpatient private practices are paid a fee for service and are paid a wage when providing hospital services.

Doctors' consultations per capita were below the EU average in 2012 (4.1 vs. 6.2). When looking at hospital activity, inpatient discharges per 100 inhabitants are lower than the EU average (respectively 7.8 vs. 16.5) while day-cases per 100,000 inhabitants are higher at 8,243 vs. 7,635 in 2015. The proportion of surgical procedures conducted as day cases (51.2%) is therefore much higher than the EU average of 32.3% in 2015. Hospital average length of stay for curative care is above the EU average (8.8 days vs. 7.6 days in 2015), though this may be a result of having a greater proportion of complex cases as inpatient.

Measures of input, process, output and outcome are used on a regular basis to compare the relative performance of hospitals (available at a website). This process has been extended to primary care providers since 2014.

There have been however increasing concerns about hospital arrears, which have continued to increase over the last few years and required several injections of money from the Ministry of Finance.

Although increasing demand and personnel expenses have been cited as factors, the recurrent accumulation of arrears in certain hospitals

highlights possible issues of under-budgeting, monitoring and budget-enforcement practices. The periodic injections of funds for clearing arrears alleviates the impact on suppliers, but so far does not appear to tackle the underlying hospital management issues which lead to in their accumulation.

The matter of arrears is a top priority for the Health and Finance Ministries. For that purpose the 'Estrutura de Missão para a Sustentabilidade do Programa Orçamental da Saúde' was created. This Structure was designed to follow up on the financial performance of the entities that are integrated in the national health budget program, and intends to identify and evaluate any budget imbalances as well as promote measures that favor stability and sustainability.

The market for pharmaceutical products, the use of Health Technology Assessment and cost-benefit analysis

The authorities have in place a large number of policies to control expenditure on pharmaceuticals. The initial price of all reimbursable medicines is based on clinical performance, economic evaluation, the cost of existing medicines and international prices (based on the minimum manufacturing price in ES, FR and Italy for 2018). Overall payback agreements and specific payback and price-volume agreements control expenditure directly. The authorities apply internal reference pricing, whereby the maximum reimbursement level of a product is based on the average of the 5 cheapest products of same active ingredient, form and dosage. There is a positive list of reimbursed products which is based on health technology assessment information.

In addition to compulsory e-prescription and INN prescription, authorities promote rational prescribing of physicians through compulsory treatment guidelines or practice protocols and prescription targets in primary care. Pharmacies have to dispense one of the five cheapest products of the same active ingredient. This is complemented with monitoring of prescribing and dispensing behaviour and education and information campaigns on the prescription and use of medicines. Direct advertisement of reimbursed pharmaceuticals is not allowed.

Portugal has made a very strong effort to promote the use of generics and there is an explicit policy target on generics equal to 60% for the NHS market. The price of generics must be 50% less than the branded product when it enters the market and subsequent price reductions apply. Generics application for pricing and reimbursement is evaluated faster than other medicines and legal and administrative rules have been simplified. These new regulations, in the medicines department, have led to an increase in the use of generics. The Infarmed (that regulates and controls pharmaceuticals) publishes an annual statistical report on sales growth of pharmaceuticals and the impact on the NHS and on patients direct cost.

E-health (e-prescription, e-medical records) and information and reporting mechanisms;

The authorities have introduced a number of e-health actions including the individual electronic NHS card, e-prescribing, e-appointments and electronic patient records. These e-actions help improving monitoring and control of prescription and consumption of services and goods and render the referral system and care coordination more effective, reducing the use of unnecessary pharmaceutical, specialist and hospital emergency care.

Health promotion and disease prevention policies

Despite the large health improvement since the 1970s, the authorities point to the need to improve health status further through promotion and prevention activities. Moreover, the authorities propose to continue the ongoing primary care reform to reinforce promotion and prevention for all including to those who are more vulnerable or at greater risk. The National Health Plan 2012-2016 defined strategies, priorities and targets to the development of health prevention policies.

Transparency and corruption

Since 2011, different measures have been implemented to address corruption and increase transparency. In terms of addressing corruption, the Ministry of Health developed a structured partnership with the judicial and police authorities, and created an anti-corruption intra-ministerial coordination group. With the aim of preventing

corruption, several legal frameworks have been improved, reinforcing competition and transparency (e.g. medical prescription, public contracting). The automation of invoice verification (e.g. medicines, ancillary exams, long term care) increased the ability to detect fraud and increased dramatically the number of criminal prosecutions. In parallel, since September 2011, financial, economic (P&L), activity, efficiency and quality data is publicised monthly for each NHS institution, contributing to the transparency of the all health system.

Recently legislated and/or planned policy reforms

As previously mentioned, the creation of the 'Estrutura de Missão para a Sustentabilidade do Programa Orçamental da Saúde' proposes that the Health and Finance Ministries are given tools that allow them to identify budget imbalances, and so promote approaches that favor the stability and sustainability of the hospitals. This includes measures that contribute to the reduction of payment deadlines towards suppliers of the health sector. In addition, the Structure has the objective of presenting medium term strategic options that will contribute to the sustainability of the NHS. For this, there will be the need to produce studies in the financial, investment and global resource management areas as well as in the organisation model.

Recent policy response

Fiscal consolidation to bring government revenues and spending into line had implications for the health sector through the adoption of a wide range of reforms in this area. Reforms aimed at further improving its efficiency and controlling spending in this area. Recent policies included:

- Review and increase overall NHS moderating mainly emergency services;
- Enacted legislation which automatically reduces the prices of medicines when their patent expires to 50 per cent of their previous price;
- Annual revision of prices of medicines and of countries of reference in order to achieve cost savings;
- Improvement of the monitoring system of prescription of medicines and diagnostic;
- Enacted compulsory prescriptions by INN for physicians at all levels of the system, both public and private, to increase the use of generics and biosimilar medicines and the less costly available products;
- Enacted legislation aimed at removing all effective entry barriers for generic and biosimilar medicines, in particular by reducing administrative/legal hurdles and timeframes for its health technology assessment in order to speed up the use and reimbursement of generics;
- Enacted prescription guidelines with reference to medicines and the realisation of complementary diagnostic exams on the basis of international prescription guidelines and integrated them in the electronic prescription system;
- Reinforcement of the centralised acquisition of vehicles, utilities, external services and other cross functional goods and services;
- Enacted measures to increase competition among private providers and reduction of fees;
- As part of the reorganisation of health services provision and notably the concentration and specialisation of hospital services and the further development of a cost-effective primary care service, reinforcement measures aimed at further reduce unnecessary visits to specialists and emergencies and to improve care coordination;
- On the basis of a comprehensive set of indicators, publication of regular trimestral reports comparing hospital performance (benchmarking);
- Ensured full interoperability of IT systems in hospital, in order to gather real time

information on hospital activities and to produce monthly reports;

– Set-up of a system of patient electronic medical records and ensure access to all relevant health care facilities;

– Reorganisation and rationalisation of the hospital network through specialisation, concentration and downsizing of hospital services, joint management and joint operation of hospitals;

– Updated the legal framework applying to the organisation of working time of healthcare staff;

– Reduction of patient transportation costs.

Policy changes under preparation/adoption

There are several policies under preparation/adoption:

– Strengthening the model of integrated care, in permanent coordination between the Ministry of Health and the Ministry of Labour, Solidarity and Social Security, to consolidate the co-responsibility between both sectors, which guaranteeing access to care that meet the health and social needs of patients' chronic conditions and of people in situation of dependence;

– Implementation of the figure of the family nurse (in line with family doctor);

– Implementation of an integrated management program for chronic disease;

– Develop a forecast mapping for human resources;

– Implementation of measures for territorial distribution of services to ensure equity in access and rationality in care provision;

– Development of services according to the European Network of Reference Centres;

– Increased freedom of choice of providers in the NHS to ensure competition and more access to care provision;

– Implementation of health education, literacy and self-care program.

Possible future policy changes

Some possible future policy changes include:

– Integrating primary care, hospital services and continuous care;

– Increasing access at the primary care level by enabling the possibility to contract services with private primary care units;

– Taking measures to organise and prepare the health sector to face an ageing population;

– Increase price competition for generics and biosimilar;

– Dissemination information to health professionals about new medicines (innovation, biosimilar, generics) and other relevant aspects;

– Create incentives to hospitals for the use of generics and some specific biosimilar;

– Give benchmark information and monitor the consumption of medicines and its expenditure in hospitals;

– Improve health technology assessment and economic evaluation of specific groups of medical devices;

– Implement a system for monitoring hospital consumption of medical devices.

Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, to a large extent successfully (e.g. the policies to control pharmaceutical expenditure or to strengthen primary care or to reduce hospital use or to improve data collection and monitoring), and which Portugal should continue to pursue and

consolidate. The main challenges for the Portuguese health care system are as follows:

- To continue to enhance primary care provision by increasing the numbers and spatial distribution of GPs and nurses and increasing opening hours in health centres. This could improve access to care while reducing unnecessary use of hospital care and therefore overall costs. This can be helped through implementing the comprehensive e-agenda planned by the authorities.

- To investigate if there is room to include an element of activity related payment in outpatient care (e.g. through the use of mixed payment schemes) to induce a higher number of outpatient consultations.

- To increase hospital output per bed while reducing the use of unnecessary hospital care and to strengthen the management and the budget control of hospitals. In addition to consolidate/ finalise the measures pursued in recent years to reduce duplication and improve efficiency and quality in the hospital sector (e.g. concentration and specialisation of hospitals within regions), authorities could perhaps also consider including an element performance related payment in hospital budgeting procedures notably using information on output and outcomes. They could also consider increasing the supply of follow-up care for long-term care patients so as to reduce the unnecessary use of acute care settings for long-term care patients.

- To continue to improve decision-making coherence across levels of government and between the NHS central authority and its regional branches.

- To improve data collection in some crucial areas such as resources and care utilisation. Better monitoring of activity in the sector could be used for planning and budgeting purposes. This should include efforts to assess and publish evaluations of the quantity and quality of care provided by the various providers for example. To increase the use of health technology assessment in decision-making, including for assessing new equipment or pharmaceuticals and before buying new equipment.

- To further enhance health promotion and disease prevention activities i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, obesity) in various settings (at work, in school). The authorities could also consider what other complimentary measures such as higher excise taxes on tobacco, alcohol, soft-drinks or tighter road safety measures could complement existing measures including the smoking ban recently introduced.

Table 2.22.1: **Statistical Annex - Portugal**

General context												EU- latest national data			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	159	166	175	179	175	180	176	168	170	173	180	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	21.3	21.8	21.9	21.4	20.3	20.9	20.3	20.1	20.2	20.7	21.4	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	0.6	1.4	2.3	0.1	-3.1	1.9	-1.7	-3.6	-0.6	1.4	2.2	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	-1.7	1.9	2.4	2.5	1.8	-6.9	-8.2	-2.5	0.9	-1.8	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	10.4	10.0	10.0	10.2	10.8	10.8	10.2	9.7	9.6	9.5	9.1	10.2	10.1	10.1	10.2
Total current as % of GDP	9.4	9.1	9.1	9.4	9.9	9.8	9.5	9.4	9.1	9.0	9.0	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.9	0.9	0.9	0.9	0.9	1.0	0.7	0.4	0.5	0.5	0.2	0.9	0.6	0.2	0.3
Total per capita PPS	1,921	1,948	2,044	2,127	2,205	2,257	2,093	1,911	1,904	1,936	1,942	2,745	2,895	2,975	3,305
Public total as % of GDP	6.9	6.5	6.4	6.6	7.1	7.1	6.7	6.3	6.2	6.1	6.1	8.0	7.8	7.8	8.0
Public current as % of GDP	6.7	6.3	6.2	6.4	6.9	6.9	6.5	6.1	6.1	6.0	5.9	7.7	7.6	7.6	7.8
Public total per capita PPS	1,278	1,263	1,315	1,374	1,449	1,492	1,367	1,232	1,233	1,235	1,297	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.16	0.18	0.20	0.20	0.19	0.29	0.23	0.15	0.10	0.10	0.15	0.2	0.2	0.2	0.2
Public as % total expenditure on health	66.5	64.8	64.4	64.6	65.7	66.1	65.3	64.5	64.7	63.8	66.8	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	15.6	16.3	16.3	16.9	14.8	12.7	12.3	13.2	12.4	11.8	12.6	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	23.3	25.1	25.7	25.8	24.6	24.6	26.3	28.2	27.0	27.7	27.7	14.6	14.9	15.9	15.9

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	10.5	10.5	10.5	10.6	10.6	10.6	10.6	10.5	10.5	10.4	10.4	502.1	503.0	505.2	508.5
Life expectancy at birth for females	81.5	82.5	82.5	82.7	82.8	83.2	83.8	83.6	84.0	84.4	84.3	82.6	83.1	83.3	83.3
Life expectancy at birth for males	74.9	75.5	75.9	76.2	76.5	76.8	77.3	77.3	77.6	78.0	78.1	76.6	77.3	77.7	77.9
Healthy life years at birth females	57.1	57.9	57.9	57.6	56.4	56.7	58.6	62.6	62.2	55.4	55.0	62.0	62.1	61.5	63.3
Healthy life years at birth males	58.6	60.0	58.5	59.2	58.3	59.3	60.7	64.5	63.9	58.3	58.2	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	111	97	98	94	90	85	123	119	114	115	111	64	138	131	127
Infant mortality rate per 1 000 live births	3.5	3.3	3.4	3.3	3.6	2.5	3.1	3.4	2.9	2.9	2.9	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	2.1	2.0	1.8	1.8	1.8	1.7	1.7	1.7	1.7	1.7	1.6	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.4	0.4	0.5	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.8	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	3.2	3.2	3.2	3.4	3.7	3.9	3.8	3.6	3.6	3.6	3.5	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	2.1	2.0	2.0	2.0	2.0	1.9	1.8	1.6	1.4	1.4	1.4	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.4	0.3	0.3	0.4	0.4
Prevention and public health services	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.2	0.3	0.3
Health administration and health insurance	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	2.0	1.8	1.7	1.6	1.6	1.5	1.5	1.5	1.5	1.4	1.3	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.4	0.4	0.4	0.5	0.6	0.6	0.6	0.7	0.7	0.7	0.7	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	2.2	2.1	2.1	2.2	2.5	2.5	2.4	2.2	2.3	2.2	2.2	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	1.2	1.1	1.1	1.1	1.2	1.2	1.0	0.8	0.8	0.8	0.8	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2
Prevention and public health services	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3
Health administration and health insurance	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.22.2: **Statistical Annex - continued – Portugal**

												EU- latest national data			
Composition of total as % of total current health expenditure	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	22.3%	21.7%	20.2%	19.6%	18.1%	17.4%	17.3%	18.2%	18.4%	18.4%	17.6%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	4.2%	4.0%	5.1%	5.2%	6.2%	6.1%	6.4%	7.6%	7.9%	8.0%	8.5%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	33.8%	34.6%	34.8%	35.8%	37.7%	39.2%	39.5%	38.9%	39.4%	39.5%	39.4%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	22.1%	22.3%	22.2%	21.2%	20.1%	19.2%	18.4%	16.7%	15.6%	15.4%	15.5%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	3.6%	3.7%	3.7%	3.9%	3.8%	3.9%	4.0%	4.1%	4.1%	4.1%	4.1%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	2.3%	2.1%	2.1%	2.2%	2.1%	2.1%	2.1%	2.0%	1.8%	1.8%	1.8%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	1.6%	1.8%	1.8%	1.8%	1.6%	1.9%	2.0%	2.0%	2.0%	2.0%	1.9%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	29.0%	28.6%	26.8%	25.6%	23.3%	22.5%	22.6%	23.7%	23.8%	24.0%	22.6%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	5.7%	5.5%	7.1%	7.3%	8.4%	8.3%	9.0%	10.9%	11.3%	11.6%	12.3%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	32.7%	32.9%	33.7%	34.1%	35.9%	36.9%	37.7%	36.4%	37.2%	37.1%	37.0%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	17.6%	17.7%	17.7%	17.5%	17.2%	17.4%	15.0%	13.5%	12.8%	12.8%	12.8%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	1.5%	1.7%	1.6%	1.7%	1.7%	1.8%	1.9%	1.8%	1.6%	1.7%	1.7%	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	1.9%	1.6%	1.6%	1.7%	1.6%	1.5%	1.6%	1.3%	1.2%	1.2%	1.0%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	1.5%	1.6%	1.6%	1.6%	1.4%	1.6%	1.7%	1.6%	1.6%	1.3%	1.3%	4.1%	4.0%	3.6%	3.4%

												EU- latest national data			
Expenditure drivers (technology, life style)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
MRI units per 100 000 inhabitants	:	0.58	0.89	0.92	:	:	:	:	:	:	:	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	:	:	:	0.5	:	:	:	:	:	:	:	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	2.6	2.6	2.6	2.7	:	:	:	:	:	:	:	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	:	:	:	0.1	:	:	:	:	:	:	:	0.1	0.1	0.2	0.2
Proportion of the population that is obese	:	15.4	:	:	:	:	:	:	:	16.1	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	:	18.6	:	:	:	:	:	:	:	16.8	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	13.3	13.1	12.6	12.4	12.0	12.3	11.9	12.0	10.0	9.9	:	10.4	10.3	10.1	10.2
Providers	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Practising physicians per 100 000 inhabitants	273	279	279	282	288	295	304	321	337	350	365	324	330	338	344
Practising nurses per 100 000 inhabitants	456	481	509	534	560	587	634	580	610	:	:	837	835	825	833
General practitioners per 100 000 inhabitants	46	47	47	48	49	50	51	54	57	59	62	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402
Outputs	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Doctors consultations per capita	3.9	3.9	4.1	4.5	4.0	4.1	4.2	4.1	:	:	:	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	8	8	8	8	8	8	8	8	8	8	8	17	16	16	16
Day cases discharges per 100 000 inhabitants	1,012	1,450	7,520	8,451	9,327	9,692	9,905	10,152	7,530	7,918	8,243	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	74.0	75.0	62.9	63.0	63.6	64.3	63.6	66.2	64.2	64.8	64.0	77.1	76.4	76.5	76.8
Hospital average length of stay	7.0	7.1	8.5	8.4	8.6	8.7	8.7	9.0	8.9	8.9	8.8	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	9.5	:	:	:	53.7	54.9	55.7	56.2	48.7	50.3	51.2	28.0	29.1	30.9	32.3

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**
AWG reference scenario	5.9	6.2	6.5	6.9	7.2	7.5	7.8	8.0	8.2	8.3	8.3	8.3
AWG risk scenario	5.9	6.3	6.7	7.2	7.7	8.1	8.5	8.8	9.0	9.2	9.3	9.2

Change 2016-2070, in pps.	
Portugal	**EU**
2.4	0.9
3.3	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**
Population projections until 2070 (millions)	10.3	10.2	10.0	9.9	9.7	9.6	9.4	9.1	8.8	8.6	8.3	8.0

Change 2016-2070, in %	
Portugal	**EU**
-22.6	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Portugal

Long-term care systems

3.22. PORTUGAL

General context of long-term care system: Expenditure, fiscal sustainability

In 2015, Portugal's GDP was around €180 bn or 21,400 PPS per capita, below the EU average GDP per capita of €29,600. The population of Portugal is estimated to be around 10 million inhabitants in 2016. Over the coming decades it is projected to fall gradually to 8.0 by 2070. This decrease of 23% contrasts with the expected increase of 2% for the EU as a whole.

Health status

Life expectancy at birth for men and women was, in 2015, respectively 78.1 years and 84.3 years, close to the EU average (77.9 and 83.3 years respectively). In 2015 the healthy life years at birth were 55 years (women) and 58.2 years (men) below the EU-average (63.3 and 62.6 respectively). At the same time, the percentage of the Portuguese population having a long-standing illness or health problem is higher than in the Union as a whole (42.7% and 34.1% respectively in 2015). The percentage of the population indicating a self-perceived severe limitation in its daily activities was in 2015 9.4%, far above the EU-average (8.1%).

Dependency trends

The share of dependents in Portugal is set to increase from 8.3% in 2016 to 11.5% of the total population in 2070, an increase of 38%. This is well above the EU-average increase of21%. From 0.86 million residents living with strong limitations due to health problems in 2016, an increase of 7% is envisaged until 2070 to 0.92 million.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care (LTC) as a percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.9 pps of GDP by 2070 ([556]). The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 2.6 pps of GDP by 2070.

Portugal faces low fiscal sustainability risks in the short run. Nonetheless, there are some indications that the fiscal side of the economy poses potential short-term challenges.

Risks appear, on the contrary, to be high in the medium term from a debt sustainability analysis perspective due to the still high stock of debt at the end of projections (2028). In contrast, in the long term, Portugal appears to face medium fiscal sustainability risks ([557]).

System Characteristics ([558])

Public long-term care is provided through residential structures for elderly (ERPI - *Estrutura Residencial para Pessoas Idosas*) and Long-term Care National Network (RNCCI - "*Rede Nacional de Cuidados Continuados Integrados*").

The ERPI were designed to provide temporary or permanent accommodation for persons at retirement age, without autonomy and without need of continuous access to nursing and medical care, therefore promoting a healthy ageing and higher quality of life.

The ERPI is managed by the Ministry of Labour, Solidarity and Social Security and is financed by budget transfers and a monthly user co-payment determined by a percentage of the per capita household income, variable between 75% to 90%, according to the user dependency degree.

The following table shows the number of agreements and users of ERPI in December 2017:

([556]) The 2018 Ageing Report : https://ec.europa.eu/info/sites/info/files/economy-finance/ip065_en.pdf .
([557]) Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.
([558]) This section draws on OECD (2011b) and ASISP (2014).

Table 2.22.1: **Number of agreements and users by degree of dependency**

No. total of agreements	**1623**
No. total of users	**59151**
No. agreements for users with 2nd degree of dependency	713
No. users with 2nd degree of dependency identified on agreements for users with 2nd degree of dependency	3486
No. agreements exclusively for users with 2nd degree of depnedency (1 agreement for Alzheimer's patients)for users with 2nd degree of dependency	40
No. users of agreements exclusively for users with 2nd degree of dependency (the agreements for Azheimer's patients is for 30 users)	1573
No. agreements with positive discrimination and consequently with a higher funding	23
of which:	
for users with dependency of 20%	6
for users with dependency between 21% and 40%	3
for users with dependency between 41% and 60%	4
for users with dependency between 61% and 80%	6
for users with dependency higher than 80%	4
No. positive discrimination users identified on agreements for users with positive discrimination	817
of which:	
for users with dependency of 20%	208
for users with dependency between 21% and 40%	155
for users with dependency between 41% and 60%	98
for users with dependency between 61% and 80%	223
for users with dependency higher than 80%	133

Source: Portugal Ministry of Labour, Solidarity and Social Security.

The Long-term Care National Network (RNCCI - "Rede Nacional de Cuidados Continuados Integrados") was established in 2007. Its aim is to provide post-acute health care and social assistance for persons who are dependent (whether this is due to age and/or illness) who are referred to it by hospitals as well as health primary care units. It is under the coordinated jointly by the Ministries of Health and of Social Solidarity.

Since the beginning of RNCCI, monitoring reports are published twice a year including analysis of its structure, processes and outcomes. This is based on a mandatory minimal data set for all levels of the system.

Public spending on LTC ([559]) reached 0.5% of GDP in 2016 in Portugal, below the average EU level of 1.6% of GDP. 99.8% of the benefits were in-kind, while 0.2% were cash-benefits (EU: 84.4 vs 15.6%).

In the EU, 50% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 38.6% lower in Portugal. Overall, 3.2% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.6%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 13.4% of public in-kind expenditure (EU: 66.3%), 86.6% being spent for LTC services provided at home (EU: 33.7%).

Administrative organisation

As explained above, from 2007 onwards, the provision of both long-term health care and social assistance to dependent persons made vulnerable by age and/or disease has been fostered by the RNCCI and coordinated by Ministries of Health and of Labour, Solidarity and Social Security.

The RNCCI is responsible for monitoring both the health care provided by units within the network as well as the quality of their organisation. It has defined standards and measures of quality and audits them on a regular basis, in parallel with the assessment and review of recipient satisfaction and claims. Units and teams in the network are periodically evaluated by regional coordination teams. The RNCCI employs more than 3,000 professionals, coached through a comprehensive training plan. The five regions, through the Regional Coordinating Teams (ECR) in conjunction with the Local Coordination Teams (ECL), have the skills to ensure the criteria application relating to the referral of users to the Long Term Care National Network (RNCCI) circuit, ensuring continuous monitoring of providers to improve aspects related to its structure, process and results, to consolidate good practices, obtain autonomy gains and guarantee continuity of care beyond the permanence in the network, sharing information with other health and social services and discharge support.

In complying with the "Strategy for Quality" set by RNCCI, some actions have been progressively implemented in order to improve the system. Thus, it is important to have periodic monitoring visits conducted by the ECL provision units, in which

([559]) Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with IADL tasks).

the parameters, contained in the consensual follow-up grids, agreed between the Health Ministry and the Social Security, are checked. These grids are related with the definitions of values, goals and key factors, as well as the assessment of compliance with the agreements and the appropriate use of the resources units. It is a battery of measurable items from which it is possible to develop a plan of ECL feasible recommendations. One of the main constraints pointed out, regarding the organisation of these teams, relates to the fact that the elements of ECL perform functions other than those assigned to RNCCI, both in of Health and Social Security. The population covered by the ECL can be different according to the different regions. The ECL are present in all Health Center Groupings (ACES) and in some cases they also exist in some extensions of these groupings.

Considering the importance that training plays in developing the skills of professionals, RNCCI has developed, since the beginning of the network, several training events regarding coordination, monitorisation, referral and care. Thus, there were several training courses organised by the Regional Health Authorities, Social Security Institute and District Centres. The training provided, with different pedagogical approaches, covered 18,853 graduates and totalled 10,335 hours of training, according to the following table.

Table 2.22.2: **Number of training courses, hours and graduates per year**

	Training courses	Training hours	Graduates
2007	75	345	3312
2008	246	1752	1842
2009	110	908	2756
2010	138	1208	2331
2011	141	2238	2404
2012	67	1475	1443
2013	38	543	1075
2014	51	951	1113
2015	24	328	871
2016	21	380	729
2017	20	207	977
Total	931	10,335	18,853

Source: Portugal Ministry of Health.

The decrease in training hours since 2011 relates to certain management constraints by the financing entity who delayed the implementation of training for subsequent years. On the other hand, the need to invest in some training areas, including coordination and functioning of the network, decreased, due to the network consolidation and also due to financial restrains and limitations in human resources influence the dynamics of the courses.

Training carried out the following themes, among others: Skills and strategies in the development of RNCCI; Work Methodologies in LTC; Organisation and operation of the RNCCI units/ teams; Bioethics; Training professionals in inpatient reference units; Implementation of the Status of Resources Law in RNCCI; Continuous Improvement in LTC; Quality evaluation and auditing; Dementia in LTC; Assessment and intervention in situations of elderly violence and mistreatment; Palliative Care: Basic course of Palliative Care, Intervention in Grief and Loss; Respect for Human Dignity in RNCCI; Chronic Pain; Geriatrics and Gerontology; Clinical Training in geriatric syndromes, treatment of wounds / pressure ulcers, compression therapy and non-invasive ventilation; Clinical Risk Management in LTC; Prevention and Control of Infection in LTC; Individual Intervention Plan; Nutritional intervention in LTC; Implementation of International Classification of Functionality (ICF); Diabetes in LTC.

Types of care

RNCCI offers a range of formal care on the basis of diversified coordinated interventions that take place in different types of RNCCI units.

For adults it provides convalescence care, post-acute rehabilitation services, medium and long-term care and home care. Palliative care moved to an autonomous network of care since 2017.

In 2016, Paediatric Integrated care was implemented, institutional (Integrated paediatric care unit Level 1- UCIP N1) and ambulatory care (Paediatric Ambulatory care – UAP).

In 2017 began pilot-experiments of Mental Health long-term care, consisting of inpatient units, ambulatory care and home care. The different types of care in this area are shown in the table below.

Table 2.22.3: **RNCCI Mental Health – Pilot-experiments**

RA	Autonomus Home (Residência Autónoma)
RAMa	Home w ith maximum support (Residência de Apoio Máximo Adultos)
RAMo	Home w ith medium support (Residência de Apoio Moderado)
RTA	Home w ith developing training autonomy (Residência de Treino de Autonomia)
RTA/A	Home w ith developing training autonomy - childhood and youth (Residência de Treino de Autonomia - Tipo A infância e adolescência)
USO	Occupational health unit (Unidade Sócio Ocupacional)
USO/IA	Occupational health unit - childhood and youth (Unidade Sócio Ocupacional - Infância e Adolescência)
EAD	Home care teams (Equipa de Apoio Domiciliário)

Source: Portugal Ministry of Health

The network operates according to a purchaser/provider split. The portfolio of institutional care services within RNCCI by typology is shown in Table 2.22.4, where it can be seen that long and medium term care are largely the predominant types of care.

Table 2.22.4: **Portfolio of institutional long-term care services end of 2018**

Type of service		Number of places 31-12-2018
Adults	Convalescence care	935
	Medium term and Rehabilitation care	2674
	Long term and maintenance care	4794
Integrated Pediatric Care (RNCCI-CPI)	Integrated pediatric care level 1 (UCIP N1)	10
Mental Health Integrated Care (RNCCI SM)	RA - Autonomous Residence	27
	RAMa - Adults Maximum support residence	48
	RAMo - Adults Moderate support residence	28
	RTA - Adults Autonomy training residence	19
	RTA-A - Pediatric Autonomy training residence	18
Total		**8553**

Source: Portugal Ministry of Health.

Compared to 2017, the number of medical inpatients facilities grew 5%, up to a total of 8,553, without palliative care. This growth is explained by the increase in the type of the Convalesce Care, Medium term and rehabilitation care (UMDR – Unidade Média Duração e Reabilitação) and long duration and maintenance units (ULDM – Unidade de Longa Duração e Manutenção) and Mental Health . Currently ULDM beds represent 56% of the beds available for admission. Institutional care services within RNCCI are provided by a range of agents: non-profit organisations (75.7% of the bed supply), private health and residential care facilities, SNS public hospitals and other health care units as shown on Table 2.22.5. All must act within common technical standards and their services are subsidised by the state.

Table 2.22.5: **Providers of institutional long-term care**

Entities		31-12-2017		31-12-2018		Variation	
		N.º of agreements	N.º of beds	N.º of agreements	N.º of beds	Agreements	Beds
National Health Service (SNS)		7	190	9	219	28,6%	15,3%
Charities (IPSS)	SCM	180	3 985	183	4 112	1,7%	3,2%
	Other	90	2 186	92	2267	2,2%	3,7%
TOTAL IPSS		270	6 171	275	6 379	1,9%	3,4%
Private sector		60	1721	63	1825	5,0%	6,0%
TOTAL		**337**	**8 082**	**347**	**8 423**	**3,0%**	**4,2%**

Source: Portugal Ministry of Health.

In 2018, the development of medical inpatient responses in RNCCI, including Paediatric care (inpatient and ambulatory care), based on services hired with Private Institutions of Social Solidarity (IPSS – Instituições Privadas de Solidariedade Social), represents 79% of all agreements, representing the hiring of 6,379 vacancies , about 76% of supply. Within the private institutions of social solidarity (IPSS), the Holy Houses of Mercy (SCM - Santas Casas da Misericórdia) represent 53% of all agreements, with 4,112 contracted vacancies, representing about 49% of the total.

The development of medical inpatient responses in Mental Health Integrated Care (RNCCI SM), until now are based on services hired with Private Institutions of Social Solidarity (IPSS – Instituições Privadas de Solidariedade Social).

Table 2.22.5a: **Providers of institutional long term care – Mental health care**

Entities		31-12-2017		31-12-2018		Variation	
		N.º of agreements	Vacancies	N.º of agreements	Vacancies	Agreements	Vacancies
Charities (IPSS)	SCM	0	0	1	24	-	-
	OUTRAS	16	189	20	255	25%	34,9%
TOTAL IPSS		**16**	**189**	**21**	**279**	**31%**	**47,6%**

Source: Portugal Ministry of Health.

Within the private institutions of social solidarity (IPSS), the Holy Houses of Mercy (SCM - Santas Casas da Misericórdia) represent 5% of all agreements on Mental health care (covering beds, ambulatory and home care) and 8.6% of the vacancies (0.6% of total contracted vacancies with this type of institution). Other charity institutions represent 95% of all agreements, with 255 contracted vacancies (beds, ambulatory and home care) representing about 91.4% of the total (see Table 2.22.5a).

In hospitals, specialised teams (EGA – Equipas de Gestão de Altas) prepare patient discharge by referral to other settings.

Home Long-Term Care Multidisciplinary Teams (ECCI - Equipas de Cuidados Continuados Integrados) provide local primary health care and social support to patients not requiring a stay in institutions, and are coordinated by "community care" units (UCC – Unidade de Cuidados Continuados) within the local health organisations (ACES - Agrupamentos de Centros de Saúde). Long-term Care at home is provided by ECCI.

Referral routes are defined at a central level in order to enable interdisciplinary teams to operate consistently at regional and local level in referring patients in according to the capacity of the local network as well as with the personal and therapeutic profiles of recipients. Most EGA (86%) were built in the pilot phase (2006-2007), being noted as one of the key factors that contributed to the success of RNCCI. Now all hospitals have EGA. Since hospitals have been aggregated in Hospital Centers (CH – Centros Hospitalares) and Local Health Units (ULS – Unidades Locais de Saúde), the number of EGA are being adjusted to this reorganisation, but exist in all hospitals.

The reform of primary health care initiated the implementation of Health Centers referring teams, thus constituting a benchmark circuit, and now all Health Centers have referring teams.

Table 2.22.6: **Number of ECCI and vacancies in 2018**

Region	Nº ECCI	Vacancies
North	92	1606
Center	68	727
Lisbon and Tagus Valley (LVT)	59	2092
Alentejo	37	553
Algarve	26	750
TOTAL	**282**	**5728**

Source: Portugal Ministry of Health.

The number of vacancies as shown on Table 2.22.6 depends on human resource allocation to the ECCI. The total number of vacancies in RNCCI (Home Care, and inpatient units related to adults) at the end of 2018 were 14,131 (without Palliative care), representing 729 places per 100.000 inhabitants with equal or more than 65 years, shown in table.

Table 2.22.7: **Total number of vacancies in Adults RNCCI (Home Care and inpatient units) end of 2018**

Region	Inhabitants aged ≥ 65 years	Nº Beds	Nº Beds/100.000 Inhabitants aged ≥ 65 years	Nº Vacancies Home Care	Nº Vacancies Home Care/ 100.000 Inhabitants aged ≥ 65 years	Total Vacancies	Total Vacancies/10^6 Inhabitants aged ≥ 65 years
North	631 439	2 635	417	1 606	254	4 241	672
Center	393 338	2 321	590	727	185	3 048	775
Lisbon and Tagus Valley (LVT)	696 815	2 114	303	2 092	300	4 206	604
Alentejo	128 427	804	626	553	431	1 357	1 057
Algarve	87 769	529	603	750	855	1 279	1 457
TOTAL	**1 937 788**	**8 403**	**434**	**5 728**	**296**	**14 131**	**729**

Source: Portugal Ministry of Health.

The total places of home care, ambulatory and inpatient units, in the three areas of RNCCI – adults, Integrated Paediatric care and Mental Health integrated care was 14,430. "Home Long Term Care Multidisciplinary Teams" were created in 2009, through the reform of primary health care. These teams depend directly from ACES.

Eligibility criteria: dependency, care needs, income

Long-term benefits are means-tested. Although there is an assessment of need, there is no minimum dependency criterion above which long-term care is provided.

Co-payments, out of the pocket expenses and private insurance

The financial responsibilities of the public sector are shared between the Ministry of Health and the Ministry of Labour, Solidarity and Social Security. The cost-sharing required by the Long-term Care National Network is determined by the government (Decree Law No. 101/2006, 6 June 2006, Article 12) and co-financed by both the health and social security sectors (Portaria No. 994/2006, 19 September 2006) according to the type of service. Thus, the Ministry of Health finances the costs of health care provision, while care recipients make co-payments for the social care received. The care recipient will have to contribute a co-payment according to the individual's or his/her family's income (see Despacho Normativo No. 34/2007, which specifies the conditions for which social security will pay and the amount).

From the beginning, the RNCCI is the first response with full implementation of the financing model based on family differentiation by social security. The family differentiation financing, which involves the attribution of a contribution to

the user depending on the income of the household, has allowed greater equity and social fairness.

In 2018, the amount per day defined as the cost with social support for care of medium duration and rehabilitation units (UMDR – Unidade de Média Duração e Reabilitação) was EUR19.93 and for the long duration and maintenance units (ULDM – Unidade de Longa Duração e Manutenção) was EUR30.52. Monitoring and follow-up made showed that on average, in 2017, the contribution of social security was EUR10.79 per day of hospitalisation by patient in UMDR and EUR15.41 in ULDM, i.e. 54.47 % and 50.79%, respectively, of the cost was paid by social security([560]).

Prevention and rehabilitation policies/measures

Prevention and rehabilitation are performed by the health care system.

Recently legislated and/or planned policy reforms

Implementation of a contracting process

A working group was created (Ministerial Order No. 1981/2014 of 7 February) with the purpose of presenting a national strategy which contributes to the achievement of excellence levels in the response that is given to users. This strategy should encourage the adoption of procedures that contribute to improved levels of quality of care provide and to foster a culture of commitment, responsibility and assessment of results in the RNCCI. The implementation of contracting processes with the LTC providers should allow to match the adequacy of care to the needs of people who are dependent and to foster the consolidation of the RNCCI, based on an expansion and sustainable development in financial terms and also consistent with its mission.

The working group presented a proposal with a set of measures on the implementation of the contracting process with the RNCCI LTC providers; study the different methods of payment applied to LTC; propose initiatives that promote improved quality of care in RNCCI and enhance the gains for users, and; promote the participation of various actors.

Strengthening the outpatient component

There is commitment to push forward the outpatient component of RNCCI through the implementation of "Day and Promotion of Autonomy Units" (UDPA - Unidades de Dia e de Promoção da Autonomia) and strengthen of "Home Long Term Care Multidisciplinary Teams" (ECCI), making them effective, as opposed to institutionalisation of patients as recommended internationally. Therefore, it is planned to return to the underlying intervention principles of the ECCI creation, i.e. focusing on the integration dimension / joint health and social support, which will enable complementarity with a more effective impatient response as the already existing ones, namely UMDR and ULDM, as well as promoting higher mobility of users in the case of discharge preparations, and ensuring continuity of care.

Regarding UDPA, these units may contribute to maintaining at home and at their usual environment people who are currently referred to other types of network. These units can also have a quality response to the needs of the population, if they are directed towards to a more specialised support in the area of dementia. This is an issue of proximity, so its implementation should be based on knowledge of the territory, accessibility, issues of economic and preferences of patients and family.

Quality and continuous improvement

On the one hand, a national project to encourage quality, that ensures the specific regional characteristics, is useful, using common indicators and methodologies as a way that will increase the understanding of the reality of LTC, introducing benchmarking techniques, and developing measures of continuous improvement, among others. On the other hand, evaluation and monitoring of quality parameters is useful as it provides information to users and family, allowing putting into practice the principle of preference and also the informed choice principle, as well as the development of strategies concerning the rights of long term care users.

([560]) ISS, IP data.

Challenges

The main challenges of the system appear to be:

- **Improving the governance framework**: To establish a coherent and integrated legal and governance framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of RNCCI services and its financing; To establish good information platforms; To use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; To share data between government administrations; To improve administrative efficiency; To deal with cost-shifting incentives across health and care.

- **Improving financing arrangements**: To face the increased RNCCI costs in the future e.g. by tax-broadening, which means financing beyond revenues earned by the working-age population; To foster pre-funding elements, which implies setting aside some funds to pay for future obligations; To explore the potential of private RNCCI insurance as a supplementary financing tool; To determine the extent of user cost-sharing on RNCCI benefits.

- **Providing adequate levels of care to those in need of care**: To adapt and improve RNCCI coverage schemes, setting the need-level triggering entitlement to coverage; the breadth of coverage, that is, setting the extent of user cost-sharing on RNCCI benefits; and the depth of coverage, that is, setting the types of services included into the coverage; To reduce the risk of impoverishment of recipients and informal carers.

- **Further encouraging independent living**: To continue providing effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring availability of formal carers**: To determine current and future needs for qualified human resources and facilities for long-term care; To seek options to increase the productivity of LTC workers.

- **Supporting family carers**: To establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care**: Establish better co-ordination of care pathways and along the care continuum; To facilitate appropriate utilisation across health and long-term care; To arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for RNCCI; To create better rules, improving (and securing) safe care pathways and information delivered to chronically-ill people or circulated through the system; To steer RNCCI users towards appropriate settings.

- **Changing payment incentives for providers**: To consider fee-for-service to pay RNCCI workers in home-care settings and capitation payments; To consider a focused use of budgets negotiated ex-ante or based on a pre-fixed share of high-need users.

- **Improving value for money**: To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; To invest in ICT as an important source of information, care management and coordination.

- **Prevention**: To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 3.22.1: **Statistical Annex – Portugal**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	159	166	175	179	175	180	176	168	170	173	180	12,451	13,213	13,559	14,447
GDP per capita, PPS	21.3	21.8	21.9	21.4	20.3	20.9	20.3	20.1	20.2	20.7	21.4	26.8	28.1	28.0	29.6
Population, in millions	10.5	10.5	10.5	10.6	10.6	10.6	10.6	10.5	10.5	10.4	10.4	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	1.1	1.2	1.2	1.2
Per capita PPS	11.4	12.5	14.0	18.2	21.7	24.4	27.7	31.1	32.2	35.1	36.9	264.1	283.2	352.1	373.6
As % of total government expenditure	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.4	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	81.5	82.5	82.5	82.7	82.8	83.2	83.8	83.6	84.0	84.4	84.3	82.6	83.1	83.3	83.3
Life expectancy at birth for males	74.9	75.5	75.9	76.2	76.5	76.8	77.3	77.3	77.6	78.0	78.1	76.6	77.3	77.7	77.9
Healthy life years at birth for females	57.1	57.9	57.9	57.6	56.4	56.7	58.6	62.6	62.2	55.4	55.0	62.0	62.1	61.5	63.3
Healthy life years at birth for males	58.6	60.0	58.5	59.2	58.3	59.3	60.7	64.5	63.9	58.3	58.2	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	30.9	33.2	33.3	34.1	33.9	34.7	37.1	39.8	40.4	42.7	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	11.6	12.9	12.0	10.9	9.4	9.3	9.0	9.3	9.2	9.5	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	62	61	60	60	61	62	23	23	23	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	140	124	109	93	95	96	14	14	14	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	1.9	1.8	1.6	1.4	1.5	1.5	0.4	0.4	0.4	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
Providers															
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	11	12	15	16	16	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.22.2: **Statistical Annex - continued – Portugal**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	10.3	10.2	9.9	9.5	9.1	8.5	8.0	-23%	2%
Dependency									
Number of dependents in millions	0.86	0.89	0.96	1.01	1.03	1.00	0.92	7%	25%
Share of dependents, in %	8.3	8.7	9.7	10.6	11.3	11.7	11.5	38%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	0.5	0.6	0.7	0.9	1.2	1.4	1.4	159%	73%
AWG risk scenario	0.5	0.6	0.9	1.2	1.8	2.4	3.2	486%	170%
Coverage									
Number of people receiving care in an institution	33,227	35,572	41,242	47,579	52,891	55,197	52,417	58%	72%
Number of people receiving care at home	15,933	17,192	20,242	23,778	26,957	28,687	27,806	75%	86%
Number of people receiving cash benefits	283,732	298,223	332,628	375,752	415,273	436,055	417,302	47%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	3.2	3.4	4.0	4.7	5.4	6.1	6.2	93%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	38.6	39.4	41.2	44.2	48.0	52.1	54.0	40%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	99.8	99.8	99.8	99.8	99.8	99.8	99.8	0%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	0.2	0.2	0.2	0.2	0.2	0.2	0.2	-16%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	13.4	13.3	13.1	12.9	12.7	12.5	12.2	-9%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	86.6	86.7	86.9	87.1	87.3	87.5	87.8	1%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	22.6	23.1	22.9	24.2	25.6	26.0	26.2	16%	10%
Unit costs of home care per recipient, as % of GDP per capita	304.1	310.8	308.9	325.9	345.0	351.5	354.0	16%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	0.0	0.0	0.0	0.0	0.0	0.0	0.0	15%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).