Portugal

Health care systems

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1.22. PORTUGAL

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

GDP per capita (20.3 thousand PPS in 2013) is lower than the EU average (27.9 thousand PPS). Portugal's current population is estimated at 10.5 million people in 2013 and is expected to fall to 8.2 by 2060.

Total and public expenditure on health as % of GDP

Total expenditure ([237]) on health as a percentage of GDP (9.7% in 2013, latest available data) has remained relatively stable over the last decade (from 9.7% in 2003) and is slightly below the EU average ([238]) of 10.1% in 2013. Throughout the last decade, public expenditure has decreased as % of GDP: from 6.7% in 2003 to 6.3% of GDP in 2011 (EU: 7.8% in 2013).

When expressed in per capita terms, also total spending on health at 1,903 PPS in Portugal in 2013 was far below the EU average of 2,988. So was public spending on health care: 1,338 PPS vs. an average of 2,218 PPS in 2011.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 2.5 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 3.5 pps of GDP from now until 2060 (EU: 1.6). ([239])

Overall, for Portugal no significant short-term risks of fiscal stress appear at the horizon, though some variables point to possible 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 (2026) and the high sensitivity to possible shocks to nominal growth and interest rates.

No sustainability risks appear over the long run thanks to the pension reforms implemented in the past and conditional on maintaining the government structural primary balance at a level as high as forecasted by the Commission services for 2017 (close to 2% of GDP) well beyond that year.([240])

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 years for women and 77.6 for men in 2013) is about the EU average (83.3 for women and 77.8 for men). However, healthy life years (62.2 years for women and 63.9 for men in 2011) are above the EU average (61.95 and 61.4 respectively). Mortality by prostate cancer, stroke and road accidents is quite high according to OECD standards though mortality by road accidents has decreased in recent years. Infant mortality is below the EU average (2.9‰ vs. 3.9‰). 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

([237]) 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.

([238]) 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.

([239]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([240]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

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 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 2013, 64.7% 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-pockets which represent 26.6% of total expenditure on health (EU average of 14.1% in 2013), showing a slight increase since 2003 (24.8) but a decrease since 2010 (28.9). 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 8.7% of health expenditure in 2013.

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 11% of the population does not currently have a family doctor, 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. In addition, the number of patients per family doctor has been increased to about 1,900 patients per doctor in traditional health centres and will be potentially increased in USFs.

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, 2013) there are 28,886 practicing physicians (2.91 per 1,000 inhabitants) and they are disaggregated by specialists (20,067) and internships (8,819). 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 Organization of Family Doctors" reports. Within the total number for public sector, there are 7,651 family physicians (0.77 per 1,000 inhabitants, year 2013) working in family practices and they are disaggregated by specialists (6,106) and internships (1,545).

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 284 per 100,000 inhabitants in 2013 and significantly below the EU average of 356 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-negociated 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 are below the EU average (4.1 in 2012 vs. 6.2 in 2013). When looking at hospital activity, inpatient discharges per 100 inhabitants are lower than the EU average (respectively 7.9 vs. 16.5) while day-cases per 100,000 inhabitants are slightly higher at 7,533 vs. 7,031 in 2011. The proportion of surgical procedures conducted as day cases (48.7%) is therefore much higher than the EU average of 30.4% in 2013. Hospital average length of stay for curative care is above the EU average (7.2 days vs. 6.3 days in 2013), though this may be a result of having only 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.

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 SI). 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.

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

The authorities have introduced a number of eHealth 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

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 medicines and the less costly available products;
- Enacted legislation aimed at removing all effective entry barriers for generic medicines, in particular by reducing administrative/legal hurdles 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 downsising 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.

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. 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 1.22.1: **Statistical Annex – Portugal**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	146	152	159	166	175	179	175	180	176	168	170	9289	9800	9934
GDP per capita PPS (thousands)	19.4	19.4	20.3	20.7	21.2	20.7	19.8	20.5	20.4	20.7	20.3	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	-1.6	1.0	0.3	1.1	2.1	-0.1	-3.0	1.9	-1.1	-2.8	-0.5	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	6.4	4.3	3.3	-2.0	1.7	2.2	2.6	1.8	-6.3	-5.6	-2.8	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	9.7	10.1	10.4	10.0	10.0	10.2	10.8	10.8	10.2	9.9	9.7	10.4	10.1	10.1
Total current as % of GDP	9.2	9.5	9.8	9.4	9.4	9.7	10.2	10.2	9.7	9.3	9.1	9.8	9.6	9.7
Total capital investment as % of GDP	0.6	0.6	0.6	0.6	0.6	0.6	0.6	0.7	0.6	0.6	0.6	0.6	0.5	0.5
Total per capita PPS	1639	1765	1889	1915	2009	2091	2168	2219	2058	1917	1903	2828	2911	2995
Public as % of GDP	6.7	6.8	7.0	6.7	6.7	6.7	7.2	7.1	6.7	6.4	6.3	8.1	7.8	7.8
Public current as % of GDP	6.4	6.6	6.8	6.4	6.3	6.4	6.9	6.8	6.3	6.1	6.1	7.9	7.7	7.7
Public per capita PPS	1060	1138	1214	1177	1228	1255	1332	1351	1338	:	:	2079	2218	2208
Public capital investment as % of GDP	0.3	0.2	0.2	0.4	0.3	0.3	0.3	0.3	0.3	0.2	0.2	0.2	0.2	0.1
Public as % total expenditure on health	68.8	68.1	68.0	67.0	66.7	65.3	66.5	65.9	65.0	64.0	64.7	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	15.0	15.2	15.5	14.8	14.9	14.7	14.5	13.0	13.2	12.9	:	14.8	14.9	:
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	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	24.8	24.8	25.2	26.8	27.2	28.5	27.3	27.4	28.9	27.4	26.6	14.1	14.4	14.1

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												**2009**	**2011**	**2013**
Population, current (millions)	10.5	10.5	10.5	10.5	10.5	10.6	10.6	10.6	10.6	10.5	10.5	502.1	504.5	506.6
Life expectancy at birth for females	80.8	81.8	81.5	82.5	82.5	82.7	82.8	83.2	83.8	83.6	84.0	82.6	83.1	83.3
Life expectancy at birth for males	74.2	75.0	74.9	75.5	75.9	76.2	76.5	76.8	77.3	77.3	77.6	76.6	77.3	77.8
Healthy life years at birth females	61.8	52.4	57.1	57.9	57.9	57.6	56.4	56.7	58.6	62.6	62.2	:	62.1	61.5
Healthy life years at birth males	59.8	55.4	58.6	60.0	58.5	59.2	58.3	59.3	60.7	64.5	63.9	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	133	117	111	97	98	94	90	85	171	171	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	4.1	3.8	3.5	3.3	3.4	3.3	3.6	2.5	3.1	3.4	2.9	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	2.18	2.17	2.19	2.00	1.98	1.94	2.01	1.98	1.91	1.71	1.68	3.13	2.99	3.01
Day cases curative and rehabilitative care	0.31	0.33	0.39	0.36	0.40	0.48	0.59	0.58	0.58	0.69	0.71	0.18	0.18	0.19
Out-patient curative and rehabilitative care	3.01	3.18	3.28	3.22	3.20	3.40	3.78	3.94	3.84	3.66	3.63	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	2.02	2.12	2.15	2.13	2.10	2.08	2.09	1.99	1.83	1.56	1.43	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.34	0.33	0.33	0.33	0.33	0.35	0.36	0.37	0.36	0.38	0.39	0.31	0.31	0.32
Prevention and public health services	0.19	0.19	0.20	0.17	0.17	0.18	0.21	0.22	0.20	:	0.16	0.25	0.25	0.24
Health administration and health insurance	0.12	0.13	0.13	0.14	0.14	0.15	0.16	0.17	0.17	0.20	0.20	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	1.46	1.45	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	0.66	0.67	0.16	0.16	0.18
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	2.24	2.28	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	1.16	1.22	1.22	1.18	1.17	1.17	1.24	1.25	1.01	0.83	0.78	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.10	0.10	0.10	0.10	0.10	0.10	0.12	0.11	0.12	0.11	0.11	0.13	0.12	0.13
Prevention and public health services	0.13	0.13	0.14	0.11	0.11	0.12	0.15	0.15	0.14	0.07	0.06	0.25	0.20	0.19
Health administration and health insurance	0.08	0.09	0.08	0.09	0.09	0.08	0.10	0.10	0.11	:	0.11	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.22.2: **Statistical Annex - continued – Portugal**

												EU- latest national data		
Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	23.8%	22.9%	22.4%	21.3%	21.2%	20.1%	19.6%	19.5%	19.8%	18.3%	18.4%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	3.3%	3.5%	4.0%	3.8%	4.2%	4.9%	5.8%	5.7%	6.0%	7.4%	7.7%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	32.9%	33.5%	33.5%	34.3%	34.2%	35.2%	36.9%	38.8%	39.8%	39.2%	39.7%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	22.0%	22.3%	22.0%	22.7%	22.5%	21.6%	20.4%	19.6%	18.9%	16.7%	15.6%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	3.7%	3.4%	3.3%	3.5%	3.5%	3.6%	3.6%	3.6%	3.8%	4.0%	4.2%	3.2%	3.3%	3.3%
Prevention and public health services	2.1%	2.0%	2.0%	1.8%	1.8%	1.9%	2.1%	2.2%	2.1%	:	1.7%	2.6%	2.6%	2.5%
Health administration and health insurance	1.3%	1.4%	1.3%	1.5%	1.5%	1.6%	1.6%	1.7%	1.8%	2.1%	2.1%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	23.8%	23.8%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	:	10.7%	11.1%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	:	:	:	:	:	:	:	:	:	36.4%	37.5%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	18.1%	18.5%	17.8%	18.5%	18.5%	18.3%	17.9%	18.3%	16.0%	13.5%	12.8%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	1.5%	1.6%	1.5%	1.6%	1.6%	1.6%	1.7%	1.6%	1.8%	1.7%	1.8%	1.6%	1.6%	1.6%
Prevention and public health services	2.0%	2.0%	2.0%	1.7%	1.7%	1.9%	2.2%	2.2%	2.2%	1.1%	1.0%	3.2%	2.7%	2.5%
Health administration and health insurance	1.3%	1.3%	1.2%	1.4%	1.4%	1.3%	1.5%	1.5%	1.7%	:	1.8%	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	:	:	:	0.58	0.89	0.92	:	:	:	:	:	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	:	:	0.5	:	:	:	:	:	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	:	2.6	2.6	2.6	2.7	:	:	:	:	:	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	:	0.1	:	:	:	:	:	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	15.4	:	:	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	:	:	18.6	:	:	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	12.7	12.2	12.1	11.7	11.3	11.2	10.9	10.8	10.3	:	:	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	267	273	273	279	279	285	291	295	304	321	337	329	335	344
Practising nurses per 100 000 inhabitants	419	435	456	481	509	534	560	587	634	580	610	840	812	837
General practitioners per 100 000 inhabitants	45	46	46	47	47	48	49	50	51	54	57	:	78	78.3
Acute hospital beds per 100 000 inhabitants	293	292	289	283	279	277	276	278	280	288	284	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	3.7	3.8	3.9	3.9	4.1	4.5	4.0	4.1	4.2	4.1	:	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	:	:	9.1	9.5	14.4	16.8	17.5	15.1	:	:	7.9	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	:	:	954	1,343	6,426	8,671	9,497	8,615	:	:	7,533	6368	6530	7031
Acute care bed occupancy rates	74.0	73.0	74.0	75.0	75.0	75.3	75.7	76.0	75.0	76.9	74.9	72.0	73.1	70.2
Hospital curative average length of stay	7.1	7.1	7.0	7.1	6.9	6.8	7.0	7.1	7.0	7.5	7.2	6.5	6.3	6.3
Day cases as % of all hospital discharges	:	:	9.5	:	:	:	35.2	36.4	:	:	48.7	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	6.0	6.4	7.1	7.8	8.3	8.5	2.5	0.9
AWG risk scenario	6.0	6.6	7.6	8.6	9.2	9.6	3.5	1.6

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

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	10.5	10.1	9.8	9.4	8.8	8.2	-21.6	3.1

Sources: EUROSTAT, OECD and WHO

Portugal

Long-term care systems

2.22. PORTUGAL

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

In 2013, Portugal's GDP was around EUR 170 bn or 20,300PPS per capita, below the EU average GDP per capita of EUR 27,900. The population of Portugal is estimated to be around 10 million inhabitants in 2013. Over the coming decades it is projected to fall gradually to 8.2 by 2060. This decrease of 22% contrasts with the expected increase of 3% for the EU as a whole.

Health status

Life expectancy at birth for men and women was, in 2013, respectively 77.6 years and 84 years, close to the EU average (77.65 and 83.3 years respectively). In 2013 the healthy life years at birth were 62.2 years (women) and 63.9 years (men) below the EU-average (61.5 and 61.4 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 (39.8% and 32.5% respectively in 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities was in 2013 9.3%, far above the EU-average (8.7%).

Dependency trends

The share of dependents in Portugal is set to increase from 8.5% in 2013 to 13.4% of the total population in 2060, an increase of 57%. This is well above the EU-average increase of 36%. From 0.89 million residents living with strong limitations due to health problems in 2013, an increase of 57% is envisaged until 2060 to 1.1 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 0.4 pps of GDP by 2060. ([428]) 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 2.1 pps of GDP by 2060.

Overall, for Portugal no significant short-term risks of fiscal stress appear at the horizon, though some variables point to possible 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 (2026) and the high sensitivity to possible shocks to nominal growth and interest rates.

No sustainability risks appear over the long run thanks to the pension reforms implemented in the past and conditional on maintaining the government structural primary balance at a level as high as forecasted by the Commission services for 2017 (close to 2% of GDP) well beyond that year. ([429])

System Characteristics ([430])

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

([428]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.
([429]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.
([430]) This section draws on OECD (2011b) and ASISP (2014).

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 2015:

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

No. Agreements for users with 2nd degree of dependency	470
No. users with 2nd degree of dependency identified on agreements for users with 2nd degree of dependency	3717
No. Agreements exclusively for users with 2nd degree of dependency (1 agreement for Alzheimer's patients)	46
No. users of agreements exclusively for users with 2nd degree of dependency (the agreements for Alzheimer's patients is for 30 users)	1845

Source: Portugal Ministry of Finance

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 reached 0.5% of GDP in 2011 in Portugal, below the average EU level of 1.0% of GDP. 99.3% of the benefits were in-kind, while 0.7% were cash-benefits (EU: 80 vs 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 34.1% lower in Portugal. Overall, 2.9% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%). 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 31.8% of public in-kind expenditure (EU: 61%), 68.2% being spent for LTC services provided at home (EU: 39%).

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 Social Solidarity.

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 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 17,147 graduates and totalled 9,748 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
Total	890	9748	17147

Source: Portugal Ministry of Finance

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; Organization 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 noninvasive 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. It provides convalescence care, post-acute rehabilitation services, medium and long-term care, home care and palliative care.

The network operates according to a purchaser/provider split. The portfolio of institutional care services within RNCCI by typology is shown in Table 2.22.3, where it can be seen that long and medium term care are largely the predominant types of care.

Table 2.22.3: **Portfolio of institutional long-term care services (2008-15)**

Type of services	No. places 31/12/2008	No. places 31/12/2010	No. places 31/12/2012	No. places 31/12/2015	Changes 2015/12
Convalescence	530	682	867	764	-12%
Medium term care	922	1,497	1,820	2,306	27%
Long-term care	1,325	2,286	3,031	4,411	46%
Palliative care	93	160	193	278	44%
Total	2,870	4,625	5,911	7,759	31%

Source: Portugal Ministry of Finance

Compared to 2012, the number of medical inpatients grew 31%, up to a total of 7,759. This growth is explained by the increase in the type of the long duration and maintenance units (ULDM – Unidade de Longa Duração e Manutenção) admittance and Palliative care units (UCP), with ULDM representing 74.7% of total new beds. Currently ULDM beds represent 57% of the beds available for admission.

Institutional care services within RNCCI are provided by a range of agents: non-profit organisations (75.3% of the bed supply), by private health and residential care facilities, by SNS public hospitals and by other health care units as shown on Table 2.22.4. All must act within common

technical standards and their services are subsidised by the state.

Table 2.22.4: **Providers of institutional long-term care**

	2014		2015	
	No. of agreements	No. Beds	No. of agreements	No. Beds
National Health Service (SNS)	26	443	15	299
Charities (IPSS)	238	5,194	261	5,845
of wich:				
SCM	169	3,596	177	3,799
other	69	1,598	84	2,046
Private sector	52	1523	60	1,615
Total	316	7,160	336	7,759

Source: Portugal Ministry of Finance

In 2015, the development of medical inpatient responses in RNCCI, based on services hired with Private Institutions of Social Solidarity (IPSS – Instituições Privadas de Solidariedade Social), represents 78% of all agreements (75% in the previous year), representing the hiring of 5,845 beds , about 75% 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 3,799 contracted beds, representing about 49% of the total.

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.

Table 2.22.5: **RNCCI referring teams, by region**

	EGA - hospitals		EGA - ACES
	pilot experiment	2014	2014
North	20	23	227
Center	17	18	87
Lisbon and Tagus Valley (LVT - Lisboa e Vale do Tejo)	21	27	117
Alentejo	5	5	55
Algarve	2	3	35
Total	65	76	521

Source: Portugal Ministry of Finance

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, existing 76 referring teams in hospitals, by the end of 2014.

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 are existing in all hospitals.

The reform of primary health care initiated the implementation of Health Centers referring teams, thus constituting a benchmark circuit, and by the end of 2014, there were 521 referring teams and by the end of 2015, there were 613 (RNCCI non-published data).

Table 2.22.6: **Number of ECCI and vacancies in 2015**

	Number of ECCI	Number of vacancies
North	82	1,673
Center	72	1,062
Lisbon and Tagus Valley (LVT - Lisboa e Vale do Tejo)	63	2,136
Alentejo	37	549
Algarve	32	1,165
Total	286	6585

Source: Portugal Ministry of Finance

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) at the end of 2015 is 14,344, representing 740 places per 100.000 inhabitants with equal or more than 65 years, shown in table 2.22.7.

Table 2.22.7: **Number of ECCI and vacancies in 2015**

Region	Inhabitants aged ≥ 65 years	Nº Beds	Beds/ 100.000 Inhab. ≥ 65 Years end 2015	Nº Vacancies Home Care	Nº Vacancies Home Care/ 100.000 Inhab. ≥ 65 Years end 2015	Total Vacancies	Total Vacancies/ 100.000 Inhab. ≥ 65 Years end 2015
Norte	631.439	2177	345	1673	265	3850	610
Centro	393.338	2271	577	1062	270	3333	847
LVT	696.815	2020	290	2136	307	4156	596
Alentejo	128.427	765	596	549	427	1314	1023
Algarve	87.769	526	599	1165	1327	1691	1927
TOTAL	1.937.788	7759	400	6585	340	14344	740

Source: Portugal Ministry of Finance

"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 2013, 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 EUR 19.81 and for the long duration and maintenance units (ULDM – Unidade de Longa Duração e Manutenção) was EUR 30.34. Monitoring and follow-up made showed that on average the contribution of social security was EUR 11.31 per day of hospitalisation by patient in UMDR and EUR 17.14 in ULDM, i.e. 57.11 % and 56.50%, respectively, of the cost was paid by social security([431]).

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

([431]) ISS, IP data.

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 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.

Paediatric long-term care

A working group was created (Ministerial Order No. 11420/2014 of 11 September) with the purpose of presenting a national strategy which contributes to the achievement of excellence levels in the response of this age group. The working group presented the final report by the end of 2014, focusing responses at home and ambulatory level with multidisciplinary teams, and inpatient facilities of medium term duration for those that cannot be cared at home or in ambulatory care. The implementation has begun in 2016.

Adult Mental health long-term care

It is planned to implement a network of care, from long-term home care to institutional settings, connected to Local Mental Services (SLSM – Serviços locais de saúde Mental), aiming to respond to the different needs of this population. The implementation is set to begin in 2016.

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 2.22.8: **Statistical Annex – Portugal**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	146	152	159	166	175	179	175	180	176	168	170	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	19.4	19.4	20.3	20.7	21.2	20.7	19.8	20.5	20.4	20.7	20.3	26.8	27.6	28.0	28.1	27.9
Population, in millions	10.4	10.5	10.5	10.5	10.5	10.6	10.6	10.6	10.6	10.5	10.5	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	0.5	:	:	1.0	1.0	1.0	1.0	:
Per capita PPS	49.1	53.5	58.5	61.0	65.8	72.9	79.2	85.0	90.0	:	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	0.7	0.7	0.8	0.8	0.9	0.9	0.9	1.0	:	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	80.8	81.8	81.5	82.5	82.5	82.7	82.8	83.2	83.8	83.6	84.0	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	74.2	75.0	74.9	75.5	75.9	76.2	76.5	76.8	77.3	77.3	77.6	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	61.8	52.4	57.1	57.9	57.9	57.6	56.4	56.7	58.6	62.6	62.2	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	59.8	55.4	58.6	60.0	58.5	59.2	58.3	59.3	60.7	64.5	63.9	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	32.2	32.2	30.9	33.2	33.3	34.1	33.9	34.7	37.1	39.8	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	13.0	12.2	11.6	12.9	12.0	10.9	9.4	9.3	9.0	9.3	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	62	61	60	60	61	62	23	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	140	124	109	93	95	96	14	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.9	1.8	1.6	1.4	1.5	1.5	0.4	2.0	2.2	2.2	2.3	2.1
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	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.22.9: **Statistical Annex - continued – Portugal**

PROJECTIONS

Population	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**MS Change 2013-2060**	**EU Change 2013-2060**
Population projection in millions	10.5	10.1	9.8	9.4	8.8	8.2	-22%	3%
Dependency								
Number of dependents in millions	0.89	0.96	1.03	1.10	1.13	1.10	23%	40%
Share of dependents, in %	8.5	9.4	10.6	11.8	12.8	13.4	57%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.5	0.5	0.6	0.7	0.8	0.9	86%	40%
AWG risk scenario	0.5	0.6	0.7	1.0	1.5	2.6	461%	149%
Coverage								
Number of people receiving care in an institution	22,744	24,409	26,652	29,382	30,890	29,932	32%	79%
Number of people receiving care at home	13,962	14,358	15,127	16,642	17,526	17,234	23%	78%
Number of people receiving cash benefits	267,581	293,150	323,348	363,413	400,603	417,809	56%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	2.9	3.3	3.7	4.4	5.1	5.7	95%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	34.1	34.7	35.3	37.2	39.8	42.3	24%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	99.3	99.3	99.3	99.3	99.3	99.3	0%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	0.7	0.7	0.7	0.7	0.7	0.7	7%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	31.8	31.9	31.7	31.0	30.4	29.7	-7%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	68.2	68.1	68.3	69.0	69.6	70.3	3%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	66.8	66.4	63.7	65.5	68.6	69.1	3%	-2%
Unit costs of home care per recipient, as % of GDP per capita	233.3	240.9	241.3	257.6	277.3	284.6	22%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	0.1	0.1	0.1	0.1	0.1	0.1	0%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)