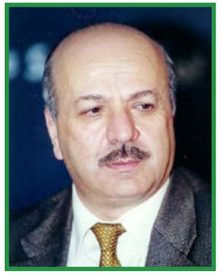
# The Health System in Portugal: a Sustained Success



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## 1. Introduction

The Portuguese health system (PHS) ensures compliance with the Constitution of the Portuguese Republic concerning the right to health. The goal of the health system is to protect the health of the population. It promotes equality of access to health care for all citizens, irrespective of economic condition and geographic location, ensures equity in the distribution of resources and use of health care services.

The main essence of the PHS has not changed in the last 30 years. It provides universal public coverage to all residents; it is regulated by the Ministry of Health, and it is described as a mixed type of health system. The main trends of changes in PHS for the last 30 years can be stated as follows : 1985-1995: expansion of health care to the non-profit and private sector, in both financing and delivery; the slight decentralization of the national health system; increase in the number of public hospitals; 1995-2000: reinforcement of the basics of the health system by enhancing public responsibilities; reorganizing hospital and health center unit networks; introduction of health care services contracting; 2000-2005: experiences with private management of public health care units; the setting of a public health strategy and the creation of the health regulatory authority; 2005-2013: expansion and realignment of public health policy; a new view of the role of the public, private and social sectors in the health care system; bottom-up organizational changes in primary care; introduction of good governance practices in health.

The national health system is financed by taxes and coexists with i) public insurance schemes (called subsystems), based on employee/employer contributions, and ii) the private voluntary health insurance. The subsystems cover around 20-25% of the population and private health insurance is purchased by 20% of the population. Out-of-pocket expenditures represented 27.3% of total health spending in 2013, and the total hospital debt was about €1.314 billion in 2014.

## 2. THE PHS CLASSIFICATION FOR THE LAST 30 YEARS

Researchers and policy makers have suggested several different health systems typologies over the last 30 years. A brief overview and description for Portugal is presented in Table 1.

Table 1: The classification of the Portuguese health system in the last 30 years.

| Year | Author | Classification |
|---|---|---|
| 1987 | OECD | Beveridge model |
| 1997 | WHO | Mixed system in transition from insurance-financed to tax-financed system |
| 1998 | European Parliament | Public taxation and direct payments |
| 2000 | Moran | Insecure command and control state |
| 2003 | OECD | Public integrated model |
| 2007 | Busse et al. | Tax financed system with high private share |
| 2009 | Thompson et al. | Tax financed model |
| 2009 | Wendt | Low budget restricted access |
| 2010 | Reibling | Mixed regulation states |
| 2010 | Jourmard et al. | Mostly public provision and public regulation, with gate-keeping and limited choice of providers, under strict budget constraint (special case of Portugal) |
| 2012 | EU | Centralized but structured at the territorial level |

The historical profile of the Portuguese Health System shows that it has been classified as a health system financed by taxes, public provision and publicly controlled, as shown in table 1. In 1997, the PHS was described to shift from an insurance-financed to a tax-financed system. A significant share of out-of-pocket payments in the funding of the health system has been identified in 1998, 2007 and 2009 typologies.

In 2000, the Moran typology suggests that access to health services is based on citizenship, and provision and governance of resources are mainly public; however there is a strong private sector which is regulated by the government. For instance, in 2013 there were 226 hospitals of which 107 were private, and of about 35500 hospital beds 10500 were in private hospitals; additionally, around 30% of all medical consultations take place in private hospitals.

Other features of the PHS are the low level of total health expenditure per capita reported by Wendt, the strong control of access to physicians, because of either gate-keeping or cost-sharing, and a relatively strict budget constraint for public health units.

Finally, it is worth mentioning that the PHS is centralized so that most responsibilities are controlled by the central government. However, the implementation of health policy is under regional level bodies who represent the central administration, albeit to a limited extent.

Despite some changes that have been made, the nature of the PHS has not greatly changed in the last 30 years. The general description provided by the different typologies for this period reflects the overall features of the PHS, even today.

## 3. PHS Final Goals

The PHS was created in 1975, so it is a young health system with more than 40 years of age and has not changed much ever since. It has been able to achieve good outputs and final goals as well as continuously improving them.

### 3.1. Health Improvement

Female life expectancy at birth is now 84 years, which is above the OECD average. The health improvement in the recent years can be observed in the increase in the number of healthy life years at 65. In 2008, at 65 women were expected to have 5.6 years and men 6.7, respectably, of healthy life. In 2012, these figures had risen, respectively, to 9 and 9.9 years of healthy life. However, in 2014, these numbers have fallen for 5.6 and 6.9, respectively, while in average for the EU is 8.6 for both men and women.

Infant mortality has registered a significant improvement over a 10-year period. In 2000, the infant, neonatal and perinatal mortality rates were, respectively, 5.5%, 3.4% and 6.2%. In 2011 those rates had fallen to 3.1%, 2.4% and 3.8%, respectively.

However, the life expectancy at birth for men is somewhat lower than for women, by just over 6 years. When it comes to life satisfaction, however, which measures how people assess life as whole and not just their current feelings, the Organization for Economic Cooperation and Development (OECD) life satisfaction index shows that Portugal has a relatively low level of overall life satisfaction.

### 3.2. Responsiveness and Consumer Satisfaction

The Health Consumer Index placed Portugal 10th out of 28 European Union (EU) countries or 13th out of 37 health

systems and the patient experience with ambulatory care in Portugal is very positive.
Despite the cultural limitation, when asked "How is your health in general?" only 46% of people in Portugal reported to be in good health, much less than the OECD average of about 68% and one of the lowest scores across the OECD countries.
The percentage of people reporting unmet need for dental examination is very high, no matter the level of income. One likely reason is that dental care is not a part of the PHS and it is therefore only used by those who can afford it.
Complementary and alternative medicine are often used by people who pay for it in full, but this is very often not reported because of the social and medical taboos around these medicines.

**3.3. Social and Financial Risk Protection**
The financial function of the PHS is mainly financed by taxes and some proportion by employee/employer contributions. The pool of contributors is large enough to allow the pooling of financial risk across the population. The PHS is designed to accomplish the financial policy goals of financial protection, equity in finance and equity of access. However, this design may be more utopian than real.

Catastrophic health expenditure is defined as payment for health services that exceeds 40% of household disposable income after subsistence needs are met. There are vulnerable groups subject to these expenditures, including children, people with disabilities and individuals suffering from chronic conditions. The prevalence of catastrophic health expenditures in Portugal is 2.1%, which is high percentage for a developed country with a universal national health system, and the main factor associated with such expenditures is the presence of at least one elderly person in the household.

## 4. Strengths within the Functions of the Health System

**4.1. Stewardship**
The planning and resource allocation in the Portuguese health care system is centralized, even though it accounts for some territorial structures. Despite some attempts at decentralization, the idea prevails that the benefits arising from decentralization are dubious, it might increase the complexity of the system and most likely it would increase inequity.

Hospital management has taken different forms, such as public enterprises and public and private partnerships, and the payment system is grounded on a negotiated contract, which in turn is based on DRG (diagnostic related groups). Grouping, fee for services, fee per chronic patient and pay-for-performance. These models of hospital management have been giving the health system quality and efficiency. Another strength of the system that should be mentioned is centralized procurement, not only for the hospital sector but for the whole set of public health units. This enables the Central Purchasing Authority to control costs through price-volume agreements.

Finally, the last strength of the PHS to be mentioned is the separation of the provider, regulator and payer. This contributes to the good governance of the system.

**4.2. Delivery**
Considering the principles of the PHS, the constitution, the general organization and management of the health care services, the Portuguese people ought to have access to primary, hospital and long term care.

**4.3. Financing**
The PHS is mainly financed by taxes, but it is also financed by occupation-based health insurance, either public or private, for some occupational categories. The public insurance arrangements (the subsystems) are additional to the national public health system and cover civil servants, the military and police forces. At present, and after the change of rules for financing under the Memorandum of Understanding (MoU), these public insurance arrangements have become financially self-sustainable.

**4.4. Resource Generation**
**4.4.1. Resource Generation - Human Capital**
The country is endowed with eight medical schools which guarantee the quality and supply of doctors. The number of doctors per capita is even above the average of the EU12. There are about forty nursing schools in the country recognized by the nurses' professional society and by the government. Both doctors and nurses are regulated by professional societies so that the quality of health services is kept at high standards.

**4.4.2. Resource Generation - Information System and e-Health**
The recognized ability of Portugal to develop e-government solutions is also present in the health sector. There is a rich health information data system which includes setting-specific information structures, disease-specific registers, electronic patient records and unique patient identifiers.

Some instances of the information systems available are now outlined. One of the e-platforms is the monitoring microsite which includes several indicators for access, efficiency, affectivity, production and satisfaction and which may be used as a hospital benchmarking tool. Another e-tool is the Health Dashboard which monitors the health of the Portuguese population each month. Finally, there is the electronic prescription platform for primary and hospital care which allows prescription by international nonproprietary names (international common denomination) and so it eases and permits the control of the prescription process.

## 5. Opportunities to the Portuguese Health System

The opportunities presented to the PHS may be properly managed, as challenges, leading to an improvement in the quality of the health system and population health.

**5.1. Healthcare is Becoming More Focused on the Person**
First, patient empowerment means that people need to be engaged with health strategies to prevent illnesses and they need to feel empowered to manage their own health. Educating people for health issues can contribute to a smoothly functioning health system, but providing accredited high-quality information also helps people to manage their own health condition.

Second, the development of a person-centered model of healthcare is a challenge that has emerged from the increasing prevalence of chronic diseases in the population. New models of providing health care services will be developed or enlarged, where the patient can become the stakeholder in their care, where home can be the preferred location, where information technology plays a significant role and coordination across the health care services is central.

**5.2. Healthcare is Becoming a Highly Digitalized Sector**
Patient records create a huge amount of information and this digitalized information feeds the possibilities of person-centered and personalized health care. This large amount of information supplies a medicine based on prediction and prevention instead of a breaking and fixing approach. In addition, health authorities may be able to gather plenty of electronic information about patients, such as, information provided by health monitors, ventilators or wearable devices; geographic information system technology, wireless communications and GPS provide more data that can be used to improve both the individual's health and how the health system functions. A wide range of technology, from apps to personal health devices, which gathers information and helps to monitor

peoples' health; the electronic patient record centralizes a set of health information which contributes to faster and easier decisions on one's health.

Finally, big data analysis is already at stack level. Almost everything that determines health can be stored in databases. This information can be used to identify patterns of diseases, links between causes and symptoms, efficacy of treatments and adverse event drivers. Big data analysis will help to improve the efficiency of the health system.
The PHS has much to gain in quality and performance by improving its ability extract the benefits offered by the digitalization of the health sector.

**5.3. Health Technology Assessment (HTA) is Highly Used in the Health Sector**
HTA has been used to search for the best value for money in health care for some years now and the experiences in other countries favor using it. HTA does not only apply to pharmaceuticals, it is for medical technologies and de-investment decisions, too. The importance of health technology assessment in recognizing the value of innovation within limited health system resources justifies the creation or implementation of an organization, body or exploiting the more usual university consulting services to support decision making in the health care sector.
Portugal has a national system of health technology assessment, called SiNATs, which was created in 2014. At present, the assessment is mainly restricted to drugs but it aims to assess health technologies and health programs. Other countries' experience, such as National Institute for Health and Care Excellence (NICE) in the United Kingdom (UK) provide a source of information about the good practice and governance of HTA. Moreover, having a national body for HTA and the European cooperation on this issue through the EUnetHTA encourages the exchange of information and the harmonization of decision making about coverage.

**5.4 A final point to highlight one more opportunity for the PHS: continuous quality improvement.**
This includes quality governance, and the provision of primary and hospital care. This both improves quality, efficiency and efficacy. The adoption of good clinical practices and the use of evidence based practices together with forward-looking leadership and the involvement of society as a whole support such quality improvement.

They demand transparency of data and processes. As a consequence, healthcare organizations will need to focus on how quality outcomes can be published in a meaningful way for patients. Patient safety is the major focus of patient advocacy groups and healthcare leaders. They will enforce deeper investigations of medication errors, hospital acquired infections, wrong site surgery and pressure sores, like never before.