PORTUGAL

	ITEMS AND INDICATORS		DATA 2009	DATA 2010	DATA 2011	Notes	DEF.
A	DEMOGRAPHIC AND SOCIO-ECONOMIC INDICATORS	A1 **Population**	10.632.482	10.573.100	10.556.999		see def.
		A2 **Area** (square Km)	92.090	92.090	92.090		see def.
		A3 **Average population density per square Km**	115,46	114,81	114,64		see def.
		A4 **Birth rate per 1000 population**	9,36	9,59	9,17		see def.
		A5 **Death rate per 1000 population**	9,87	10,05	9,78		see def.
		A6 **Life expectancy at birth** (years)	79,61	80,06	80,90		see def.
		A6a Men	76,48	76,81	77,61		
		A6b Women	82,62	83,16	84,05		
		A7 **Real Gross Domestic Product (GDP)** PPP$ per capita	24.888,00	25.519,20	25.564,30		see def.

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B1	**Healthcare coverage of population**	The National Health Service (NHS) covers all the residents in the country and it is universal, comprehensive and almost free of charge at the point of use (in accordance with the Article 64 of the Portuguese Constitution). The NHS predominantly provides direct acute hospital care, general practice, and mother and child care. Difficulties in the public services (e.g long waiting times) led to the increase of private healthcare and insurance services. Specialist and dental consultations, diagnostic services, renal dialysis and physiotherapy treatments are normally provided in the private sector (but with public funding to a considerable extent). Diagnostic services, renal dialysis and physiotherapy treatments are typically carried out under contractual arrangements with the NHS. Most dental care is paid by out of pocket, as are many specialist consultations in private ambulatory care. However, NHS covers through the Oral Health Promotion national Programme, four vulnerable population segments, namely infants and adolescents, pregnant women, the elderly and AIDS and HIV patients (who receive a dental check to pay the dental treatments). Cost-sharing is a part of the NHS. The common forms of cost-sharing present in the NHS are the co-payments (or user charges – designated in Portugal by Taxas moderadoras. The patient has to pay a user charge for a service, in most public health care services. User charges are defined with a fixed fee for consultations (primary care and hospital outpatient visits), emergency visits, home visits, diagnostic testing and therapeutic procedures. Fees (taxas moderadoras) are only due in ambulatory care.				see def.
B2	**Gate-keeping system**	The first point of contact is the General Practitioner (GP) in a Primary Health Care Centre. Patients in the NHS must register with a General Practitioner (GP) in his or her region of residence or workplace (patient can only choose the GP among the available providers within a geographical area based on their residence). The GPs work with lists around 1.500 patients. Secondary care is subject to strict referral rules from primary care GP to outpatient appointments and emergency room episodes.				see def.
B3	**Total health expenditure**, PPP$ per capita	2.691,70	2.766,80	2.618,80		see def.

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B	HEALTHCARE SYSTEM	B4 **Public sector health expenditure as % of total health expenditure**	66,50%	65,90%	65,00%		see def.
		B5 **Total health expenditure as % of Gross Domestic Product (GDP)**	10,80%	10,80%	10,20%		see def.
		B5a Public sector health expenditure as % of GDP	7,20%	7,06%	6,64%		see def.
		B5b Private sector health expenditure as % of GDP	3,62%	3,68%	3,72%		
		B6 **Expenditure on inpatient care per capita** (PPP$)	523,50	534,90	518,70		see def.
		B7 **Public inpatient expenditure as % of total inpatient expenditure**	...	...	...		see def.
		B8 **Total inpatient expenditure as % of total health expenditure**	19,40%	19,30%	19,80%		see def.
		B9 **Public funding**	Portuguese health care system is based on a mix of public and private financing. The NHS is mainly financed by general taxes (direct and indirect taxes, namely IRS - Income Tax for Individual People IRC - Corporate Income Tax) and VAT. The main tax fund sources are indirect taxes (approximately 60% of total tax revenue). Tobacco consumption taxes represent more than 6% of this amount. Taxes on income are another source of tax revenue (39% of total tax revenue). The health subsystems provide comprehensive or partial health care coverage to about one fifth and a quarter of the population and are financed mainly through employee and employer contributions (including state contributions as an employer). Private Voluntary Health Insurance covers between 10% and 20% of the population. A proportion of financing is private, mostly in the form of out of pocket payments (co-payments and direct payments by the user), and to a smaller extent in the form of premiums to private insurance schemes and mutual institutions. Funding through social security represents only a small share of the total funding.				see def.

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C1	**Administration and management**	The public hospitals belong to the state. Hospitals have administrative and financial autonomy, according with the ministry of health normative. The majority of the Portuguese hospitals are now grouped in Hospitals Centres. Since 1990, the management of public hospitals may be delegated to the private sector on the basis of contracts. In that case, the hospitals become public enterprises. As a consequence of NHS reform a redefinition of the existing NHS supply of hospital services as taken place Consequently, in 2011, the NHS net comprised 7 Local Health Units (local health unit by effective integration of the hospital and related health centres in an unique provider entity); 21 Hospital Centres (which aggregate two or more hospitals); 22 Hospitals and 3 Oncology Institutes (4). To improve NHS capacity and value for money the government associated private entities in the sphere of public responsibility to build, maintain and operate health facilities under the Public-Private Public Partnerships (PPP)(1). Between 2007 and 2010 the Ministry of Health celebrated four contracts with PPP (5). In 2011 there were only two PPP (Braga Hospital and Cascais Hospital). Between the years 2012 and 2013, two more PPP where celebrated (Loures Hospital and Vila Franca de Xira Hospital).				see def.

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C	HOSPITAL GOVERNANCE	C2 **Surveillance authority**	In Portugal, surveillance is the role of tree institutions focusing on specific areas: The Directorate-General of Health (DGS) which is a central institution under direct administration of the Ministry of Health and with administrative autonomy. Among others its roles are to coordinate and ensure the epidemiologic surveillance of the Health determinants and of communicable and non-communicable diseases, as well as those associated with appropriate alert and response systems to public health emergencies at national level and the relevant contribution at international level. The INFARMED - Autoridade Nacional do Medicamento e Produtos de Saúde, is a public institute under indirect administration, with administrative and financial autonomy and its own assets. It follows the attributions of the Ministry of Health under the supervision of the Minister. The attributions of the INFARMED are to regulate, evaluate, authorize, discipline, supervise, and act as a laboratory of reference, thus ensuring the research surveillance and control, production, distribution, commercialization and use of medicines, medical devices, cosmetics and of personal body hygiene, according to the relevant juridical systems. It is also incumbent to monitor the consumption and use of medicines. The Instituto Nacional de Saúde Dr. Ricardo Jorge (INSA), is a public institute under indirect administration of the State, with scientific, administrative and financial autonomy and its own assets. The INSA follows the attributions of the Ministry of Health under the supervision and tutelage of the Minister. It is a health state owned laboratory of national relevance and reference. Its attributions are to cooperate in the epidemiological surveillance of communicable and non communicable diseases and to develop or validate tools for health observation, to ensure the laboratory response in cases of biological hazard both of natural, fortuitous or deliberate causes and to monitor the consumption of additives and the populations exposure to contaminants and possible harmful substances in the existing in food.				see def.

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D	**HOSPITAL FINANCING**	D1 **Hospital financers**	The Ministry of Finance Annually sets NHS budget based on historical spending and on plans presented by the Ministry of Health. Ultimately, the Ministry of Health receives a global budget for the NHS which is then allocated to the institutions within the NHS (Hospitals, Regional Health Administrations - RHA and Special Programmes). The funds are then distributed by the RHA. Hospital budgets are established and allocated by the Ministry of Health				see def.
		D2 **Modes of payment**	The Ministry of Health allocates funds to the regional health administrations based on the combination of historical expenditure and capitation; these funds pay for primary care and special programmes. (1, 2). Since 1990, 30% of global hospital budgets are based on production costs calculated according to homogeneous patients groups and 70% on healthcare services provided the previous year. Hospitals also benefit from patients contribution. In 2003, DRGs started to being used to set the totality of the funding for NHS hospitals and inpatients. (1,2). The payment model used in the Local Health Units (ULS) is based on capitation, through a risk adjusted budget (population characteristics, health needs and health provision). The payment model for each ULS for 2010/2012 determines that the value per capita in each of the ULS is composed by each of the health expenditure (40%) and by the health status of the populations (60%). The health status of the population is evaluated by the standardized mortality rate by age (European Standardized Population). The expense determinants are based on a model according to the expense variation (7).				see def.
		D3 **Use of DRGs**	Portugal always adopted the grouper used in the United States of America. The grouper in use is the All Patient DRG, version 21 (AP-DRG), which applies to hospital admission and outpatient episodes. (6)				see def.
		D4 **Hospital investments**	The management of investments is strongly centralized. The Ministry of Health funds hospital investments, sometimes with the help of the European Union through the European Regional Development Fund (ERDF).				see def.

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E	TOTAL HOSPITAL CARE PROVISION	E1 **Public / Private ownership**	Coexistence of public and private hospitals. Private hospitals work either not-for-profit or for-profit.				see def.
		E1a % of hospitals private for profit	n.d.				see def.
		E1b % of hospitals private not for profit	n.d.				see def.
		E2 **Categories**	There are two main categories of acute care hospitals: - Central hospitals (A public hospital characterised by possessing highly specialised human and technical resources, with national or inter-regional scope) - District hospitals (A public hospital characterised by possessing resources equivalent to the basic medical fields, though it may have, when deemed necessary, intermediate, specialised and, in exceptional circumstances, highly specialised specialities. It covers the sub-region in which it is located) * The military hospitals are almost public hospitals. * The private hospitals usually specialise in cutting-edge technology. The Local Health Units range the three levels of care (primary, secondary and tertiary)				see def.
		E3 **Total number of hospitals**	223	231	224		see def.
		E4 **All hospitals per 100.000 population**	2,10	2,18	2,12		see def.
		E5 **Total number of hospital beds**	35.635	35.625	35.671		see def.
		E5a Public inpatient hospital beds (number and % of all beds)	26.077 73,18%	26.027 73,06%	25.898 72,60%		see def.
		E5b Private inpatient hospital beds (number and % of all beds)	9.558 26,82%	9.598 26,94%	9.773 27,40%		see def.
		E6 **All hospital beds per 100.000 population**	335,15	336,94	337,89		see def.
		E7 **Number of inpatient care admissions/discharges**	1.182.255	1.173.454	1.137.038		see def.

ITEMS AND INDICATORS			DATA 2009	DATA 2010	DATA 2011	Notes	DEF.
	E8	**Inpatient care admissions/discharges per 100 population**	11,12%	11,10%	10,77%		see def.
	E9	**Average length of stay for all hospitals (bed-days)**	8,60	8,70	8,90		see def.

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				2009	2010	2011		
F	ACUTE CARE HOSPITAL PROVISION	F1	**Number of acute care hospitals**	170	170	157		see def.
		F1a	Acute care hospitals as % of all hospitals	76,23%	73,59%	70,09%		see def.
		F2	**Acute care hospitals per 100.000 population**	1,60	1,61	1,49		see def.
		F3	**Number of acute care hospital beds**	29.335	29.428	29.639		see def.
		F3a	Acute care hospital beds as % of all hospitals beds	82,32%	82,60%	83,09%		see def.
		F4	**Acute care hospital beds per 100.000 population**	275,90	278,33	280,75		see def.
		F5	**Number of acute care hospital admissions/discharges**	1.164.988	1.156.996	1.121.242		see def.
		F6	**Acute care admissions/discharges per 100 population**	10,96%	10,94%	10,62%		see def.
		F7	**Average length of stay for acute care hospitals (bed-days)**	6,96	7,04	7,17		see def.
		F8	**Bed occupancy rate for acute care hospitals**	75,70%	75,88%	74,27%		see def.

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G	HEALTHCARE WORKFORCE	G1 **Number of General Practitioners (GPs)**	5.160	5.273	5.410		see def.
		G1a General Practitioners per 100.000 population	48,53	49,87	51,25		see def.
		G1b Population per one GP	2.060,56	2.005,14	1.951,39		see def.
		G2 **Number of physicians**	39.327	40.672	42.054		see def.
		G2a Number of physicians per 100.000 population	369,88	384,67	398,35		see def.
		G3 **% of physicians working in hospitals**	55,06%	55,70%	...		see def.
		G4 **Number of nurses**	59.601	62.433	66.857		see def.
		G4a Nurses per 100.000 population	560,56	590,49	633,30		see def.
		G5 **% of nurses working in hospitals**	58,84%	59,26%	...		see def.
		G6 **Number of nurses per doctor**	1,52	1,54	1,59		see def.